The Sandplay Therapy for Obsessive-Compulsive Disorder (OCD) Symptoms: Case Report with One-Year Follow Up

Mariana Foo[1*], Willy Tasdin[2]
Applied Counseling Study Program, Faculty of Applied Counseling, Politeknik Bentara Citra Bangsa (Bentara Campus), Central Jakarta, Special Capital Region of Jakarta, Indonesia[1]
Psychology Study Program, Faculty of Psychology, Universitas Tarumanagara, West Jakarta, Special Capital Region of Jakarta, Indonesia[2]

[*]Corresponding Author: Mariana Foo (Applied Counseling Study Program, Faculty of Applied Counseling, Politeknik Bentara Citra Bangsa (Bentara Campus), Central Jakarta, Special Capital Region of Jakarta, Indonesia).
E-mail: mariana@bentaracampus.ac.id
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Abstract

This study is the first case study in the Indonesian population to examine SPT for OCD, providing complete visual documentation of the sandplay process and a 1-year follow-up. This case report evaluates Sandplay Therapy (SPT) in alleviating obsessive-compulsive symptoms comorbid with health anxiety in a middle-aged Indonesian male worker. The participant underwent 18 SPT sessions over a six-month period. Symptoms were tracked before, during, and after treatment (including 3-month and 1-year follow-ups) using standard measures (Y-BOCS, HARS, DASS-42, CORE-OM). Sandplay imagery was analyzed thematically. Results showed significant improvement, with Y-BOCS scores reduced from 23 (moderate OCD) to 2 (normal), and HARS scores falling below clinical significance. The therapeutic effects were not only retained but also continued to improve during follow-up. By post-treatment, all clinical measures were back to normal in this case. The sandplay content indicated issues of psychological wholeness and independence. This study also addressed two important gaps: long-term evidence of SPT and its potential acceptability within a specific Indonesian clinical sample. Although limited in its single-case format, the results support the feasibility of SPT as a potentially useful, culturally sensitive adjunct treatment for OCD, especially for cases with somatic and/or contamination fears. Further studies are necessary to validate these results.

Keywords: Anxiety disorder; Mental health; Non-verbal therapy; Obsessive-compulsive disorder; Sandplay therapy

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INTRODUCTION

Obsessive-Compulsive Disorder (OCD), impacting around 1-3% of the worldwide population (Stein et al., 2019), is defined by enduring, intrusive thoughts (obsessions) and repetitive actions (compulsions) executed to mitigate related suffering (American Psychiatric Association, 2022). Common manifestations include contamination fears leading to excessive cleaning, pathological doubt resulting in checking behaviors, and preoccupations with symmetry or exactness (Mataix-Cols et al., 2005). A key feature is significant cognitive dissonance, individuals recognize the irrationality of their obsessions and compulsions yet feel unable to stop them (Abramowitz, 2006). Cognitive models posit that catastrophic misinterpretation of intrusive thoughts drives compulsive neutralizing behaviors (Clark & Beck,2010). Historically, psychoanalytic theories suggested symptoms represent unconscious conflicts expressed symbolically (Freud,1955). Neurobiological research implicates dysfunction within the cortico-striato-thalamo-cortical (CSTC) circuit, particularly impacting error detection and behavioral inhibition mechanisms (Gillan et al., 2016). This neural dysregulation may underlie the characteristic co-occurrence of insight into the disorder's irrationality with the persistence of compulsive actions (Menzies et al., 2008).

The first 4 years of the COVID-19 pandemic in Indonesia were characterized by extensive public health rules with moderate effects. The pandemic was a major trigger for OCD relapses globally (Fineberg et al., 2020), with Indonesia suffering from marked impacts as well, possibly due to socio-economic strains. Intense media coverage of rates of infection and death also exacerbated fear among the population (Safran et al., 2020; Sastramidjaja, 2023). In addition, there is evidence to suggest that the pandemic resulted in new presentations of OCD in those with a pre-existing risk, often in the form of atypical features, including health anxiety and culturally mediated expressions such as religious scrupulosity (Juliana et al., 2024). Despite their clinical implications, however, data on the incidence and prevalence of post-pandemic OCD in Indonesia remain limited, as part of broader gaps in post-disaster psychiatric surveillance (Juliana et al., 2024).

Critical research gaps persist regarding the etiological pathways contributing to post-pandemic OCD and the efficacy of interventions. Early diagnostic protocols remain underdeveloped. The apparent effectiveness of Sandplay Therapy (SPT), traditionally applied in child therapy, for adult OCD populations warrants specific investigation. Key unresolved questions include the timeliness of pharmacological interventions for adult patients and the therapeutic mechanisms of SPT in this demographic.

Current gold-standard treatments for OCD, specifically exposure and response prevention (ERP) integrated with cognitive behavioral therapy and selective serotonin reuptake inhibitor (SSRI) pharmacotherapy, demonstrate suboptimal efficacy for approximately one-third of patients (Stein et al., 2019). In the Indonesian context, therapeutic accessibility and effectiveness are further compromised by cultural stigma toward mental disorders, insufficient mental health infrastructure, and incongruities between Western-developed protocols and local idioms of distress.

Sandplay therapy (SPT), rooted in Kalff (2020) Jungian framework, offers a viable alternative through its non-verbal, symbolic methodology. The modality enables externalization and processing of unconscious material through three-dimensional scenographic construction in sand trays with miniature objects, reducing reliance on verbal expression (Bradway & McCoard, 2022). Emerging evidence suggests SPT's particular utility for anxiety spectra through its capacity to mitigate cognitive resistance

and facilitate affective integration (Foo et al., 2020). Clinical case reports document therapeutic effects in OCD (Freedle, 2017). Despite these promising findings, there remains a paucity of scientifically rigorous research on SPT for adult OCD in non-Western nations, with a specific focus on Indonesia.

Emerging evidence suggests SPT's particular utility for anxiety spectra through its capacity to mitigate cognitive resistance and facilitate affective integration (Foo et al., 2020). Clinical case reports provide evidence of the therapeutic power in the control of OCD, as a warding device preventing confrontation with fear just before response prevention (Freedle, 2017). Even though these are some gruesome discoveries, there is a paucity of scientifically done research on sandplay therapy (SPT) for adult obsessive-compulsive disorder (OCD) in non-Western nations, with a focus on Indonesia. Although Sandplay Therapy has been extensively studied and shown to be effective in children, its application to adults with OCD, particularly in non-Western countries, remains largely unexplored.

This mixed-methods case study examined the therapeutic potential of SPT for an Indonesian adult with treatment-resistant OCD using both standardized outcome questionnaires and qualitative sandplay narrative analyses. To our knowledge, this is the first published case study examining SPT for OCD in an Indonesian adult population. This study differs from previous reports by providing three methodological elements that address long-standing criticisms of symbolic therapy research. First, we provide complete visual documentation of all 18 sand trays, allowing readers to trace the symbolic journey firsthand and enhancing the transparency and replicability of our thematic analysis. Second, we include one-year follow-up data, contributing rare evidence regarding the durability of therapeutic gains in SPT a dimension often neglected in play therapy literature. Third, we apply systematic thematic analysis using Turner's (2017) validated framework, which reduces the interpretive subjectivity frequently criticized in symbolic interpretation studies.

These three elements are theoretically important because they collectively address the "black box" problem in sandplay research: visual documentation opens the box, systematic coding organizes what we see inside, and long-term follow-up tells us whether what happened inside truly matters over time. By implementing weekly 60-minute sandplay sessions using standardized instruments, the study assessed therapeutic changes using Y-BOCS symptom trajectories and examined candidate mechanisms of change.

METHOD

Research Design

This study selected a single-case, mixed-method design to explore how Sandplay Therapy works in one participant with treatment-resistant OCD, with assessments at pretest (before intervention), midtest (session 10), posttest (session 15), and one-year follow-up. This timeline allowed the researchers to track symptom change and evaluate the sustainability of therapeutic effects.

Integration of Quantitative and Qualitative Data

Quantitative data (Y-BOCS, HARS, DASS-42, CORE-OM) were plotted over time to document symptom trajectories, including calculation of percentage change from pretest to follow-up. Qualitative thematic analysis of sand trays (Turner, 2017) was conducted independently by two scorers. Integration occurred at the interpretation stage:

we examined whether shifts in symbolic content (e.g., from peripheral conflict to central organization) corresponded temporally with score reductions on standardized measures. This integration is visually presented in the symptom trajectory graph and the thematic evolution table, where quantitative improvements are mapped alongside qualitative thematic stages. Image analysis of sandplay photographs (18 trays) and projective analysis of Car 'R' Us cards (Deal, 2006) were conducted.

Sample

The target population in this study was adults with Obsessive-Compulsive Disorder (OCD) who demonstrated resistance to pharmacological treatment (at least 1 year of therapy with limited response) and had somatic symptoms or contamination fears as the primary clinical manifestation. From this population, one participant was selected who represented typical characteristics for an exploratory study, namely a middle-aged adult male with OCD who had undergone pharmacological treatment for 1.5 years without significant improvement. The participant was a 46-year-old Chinese-Indonesian male with a bachelor's degree. Married and the father of two children, he was working as an administrative employee. The participant was referred to the Perhati Counseling and Care Center because the participant had made only limited improvement from 1.5 years of pharmacological treatment for his OCD. The participant presented with severe hypochondriasis, mainly characterized by obsessive fears of contracting serious illness.

This case study used purposive sampling. The participant was selected based on the following inclusion criteria: 1) had been diagnosed with OCD by a psychiatrist, 2) demonstrated resistance to pharmacological treatment (at least 1.5 years with limited response), 3) had somatic symptoms and/or contamination fears as the primary complaint, 4) was willing to participate in 18 therapy sessions over 6 months, and 5) was willing to comply with follow-up procedures up to 1 year. The selection of this case was considered typical for an exploratory study because it represents a common clinical challenge encountered in adult OCD patients in Indonesia, namely resistance to standard treatment and the need for a non-verbal adjunctive therapy approach.

Instrument

Four standardized psychological instruments were used to assess symptom severity. Indonesian-language versions of the instruments were available and administered where appropriate. These measures have been widely used internationally and have demonstrated acceptable psychometric properties in previous clinical research. The Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) is a clinician-administered instrument used to assess the severity of obsessive–compulsive symptoms on a scale ranging from 0 to 40, with higher scores indicating greater symptom severity (Goodman et al., 1989). An Indonesian-language version of the instrument was used in this study.

The Hamilton Anxiety Rating Scale (HARS) is a 14-item, clinician-rated instrument that assesses the psychological and somatic symptoms of anxiety (Thompson, 2015). An Indonesian-language version of the HARS was administered in this study. The Depression Anxiety Stress Scales–42 (DASS-42) is a self-report instrument comprising three subscales that measure depression, anxiety, and stress (Lovibond & Lovibond, 1995; Henry & Crawford, 2005). The Indonesian version has been widely used in both clinical and community research settings.

The Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM) is a 34-item self-report instrument that assesses psychological functioning across four domains: well-being, symptoms, functioning, and risk (Evans et al., 2002). An Indonesian-language version of the CORE-OM was used to evaluate treatment outcomes.

In addition, the projective assessment tool Car 'R' Us (Deal, 2006) facilitated symbolic expression. We acknowledge that all instruments, including the Car 'R' Us cards, originate from Western contexts. Their use here is pragmatic, as no equivalent validated Indonesian tools exist for this specific construct. The Car 'R' Us cards lack established psychometric properties; they serve a heuristic role, supporting the qualitative narrative of change rather than providing independent validation.

Procedure

The participant provided informed consent after receiving comprehensive information regarding the research purpose, methodologies, possible emotional distress, and confidentiality measures. SPT was delivered by the first author (M.F.), a licensed sandplay therapist, certified by the International Society for Sandplay Therapy (ISST). Sessions followed the Kalffian sandplay protocol (Kalff, 2020): 60 minutes, free and protected space, with photography after each tray. No verbal interpretation was given during tray construction. Clinical assessments were administered at four time points (sessions 1, 10, 15, and 18). In the final session, the participant was invited to select two Car 'R' Us cards, one representing them at the beginning of therapy and another at its end.

Data Analysis

Quantitative data were analyzed by comparing scores across the four time points. Percentage change was calculated using the formula: (Pretest − Follow-up) / Pretest × 100. Qualitative data consisted of symbolic elements in the sand trays and projective responses to Car 'R' Us cards. Each tray was photographed and analyzed using Turner's (2017) thematic framework, focusing on progression of symbolic imagery, figure location, repetition, and transformation. Two independent scorers evaluated the data; discrepancies were discussed, and consensus was reached.

Research Ethics

This case study was conducted in accordance with rigorous ethical standards. Ethical approval was obtained from the KPIN Ethics Committee (Approval No. 192/2024 Etik/KPIN). The participant provided comprehensive informed consent and was informed that participation was voluntary, with the right to withdraw at any time without consequence.

RESULTS AND DISCUSSION

Results

This section presents the participant's demographic characteristics before describing clinical outcomes. The participant was a 46-year-old Chinese-Indonesian man employed in an administrative position. The participant held a bachelor's degree and was married with two children. His clinical presentation was characterized by treatment-resistant obsessive-compulsive disorder accompanied by prominent health-related anxiety and somatic concerns. These demographic and clinical characteristics provide important context for interpreting the subsequent quantitative and qualitative findings.



Table 1.
Demographic Characteristics of the Participant

Characteristic	Description
Gender	Male
Age	46
Ethnicity	Chinese-Indonesian
Occupation	Administrative employee
Marital Status	Married with two children

Table 2.
Clinical Assessment Scores Across Time Points

Measure	Pretest	Session 10	Session 15	Session 18 (Follow-Up)
HARS	22	16	5	2
DASS-42 Depression	4 (Normal)	9 (Borderline)	0 (Normal)	3 (Normal)
DASS-42 Anxiety	10 (Moderate)	10 Moderate	4 (Normal)	3 (Normal)
DASS-42 Stress	15 (Mild)	14 (Borderline)	3 (Normal)	3 (Normal)
CORE-OM	37 (Mild)	29 (Low)	12 (Healthy)	6 (Healthy)
Y-BOCS	23 (Moderate)	12 (Mild)	2 (Normal)	2 (Normal)

Note: DASS-42 subscales are presented separately for clarity. Categorizations follow Lovibond and Lovibond (1995) and standard cut-offs

Table 3.
Percentage Change from Pretest to 1-Year Follow-Up

Measure	Pretest	Session 18	Absolute Change	Percentage Improvement
Y-BOCS	23	2	21	91.3%
HARS	22	2	20	90.9%
CORE-OM	37	6	31	83.8%
DASS-42 Anxiety	10	3	7	70.0%
DASS-42 Stress	15	3	12	80.0%

Note: DASS-42 Depression started within the normal range (score = 4) and remained normal throughout. Established MCID values are not available for all instruments in this clinical context; therefore, only percentage change is reported.

Table 1 presents the participant's demographic and clinical characteristics at the beginning of the study, including sex, age, ethnic background, occupation, and marital status. The participant was a 46-year-old married Chinese-Indonesian man who worked as an administrative employee and had two children. These characteristics provide important contextual information for understanding the participant's clinical background and the broader context in which the intervention was conducted. Table 2 presents the scores obtained from the Y-BOCS, HARS, DASS-42, and CORE-OM at pretest, during treatment, at Session 18, and during follow-up. The results indicate a progressive reduction in obsessive–compulsive symptoms, anxiety, depression, stress, and

psychological distress throughout the intervention period, with improvements maintained or further enhanced during follow-up. Table 3 presents the absolute and percentage improvements from pretest to Session 18, with higher percentages indicating greater symptom reduction. The classifications follow each instrument's guidelines, and the results describe the clinical course of a single participant.

Baseline Assessments

At baseline, the participant showed moderate obsessive-compulsive symptoms (Y-BOCS = 23), moderate anxiety (HARS = 22), moderate anxiety on DASS-Anxiety (score = 10), mild stress (DASS-Stress = 15), and normal depression levels (DASS-Depression = 4). Psychological distress, as measured by the CORE-OM, was mild (CORE-OM = 37).

Post-Treatment and Follow-Up Evaluations

By Session 15, clinical improvements were evident: Y-BOCS scores decreased to 12 (mild), and HARS to 5 (normal). By Session 18, all DASS-42 subscales had returned to normal levels: Depression = 3, Anxiety = 3, Stress = 3. CORE-OM reduced from 37 to 6, indicating resolution of distress symptoms. As shown in Table 3, percentage improvements ranged from 70.0% (DASS-Anxiety) to 91.3% (Y-BOCS), reflecting substantial clinical gains.

Symptom Trajectory

Figure 1 presents the trajectory of Y-BOCS, HARS, and CORE-OM scores across the four assessment points. The graph visually demonstrates three clinically meaningful patterns: (a) rapid improvement during the active therapy phase (pretest to session 15), (b) continued stabilization in the final sessions (session 15 to session 18), and (c) sustained gains with further mild improvement during the one-year follow-up period. Notably, no symptom rebound was observed.

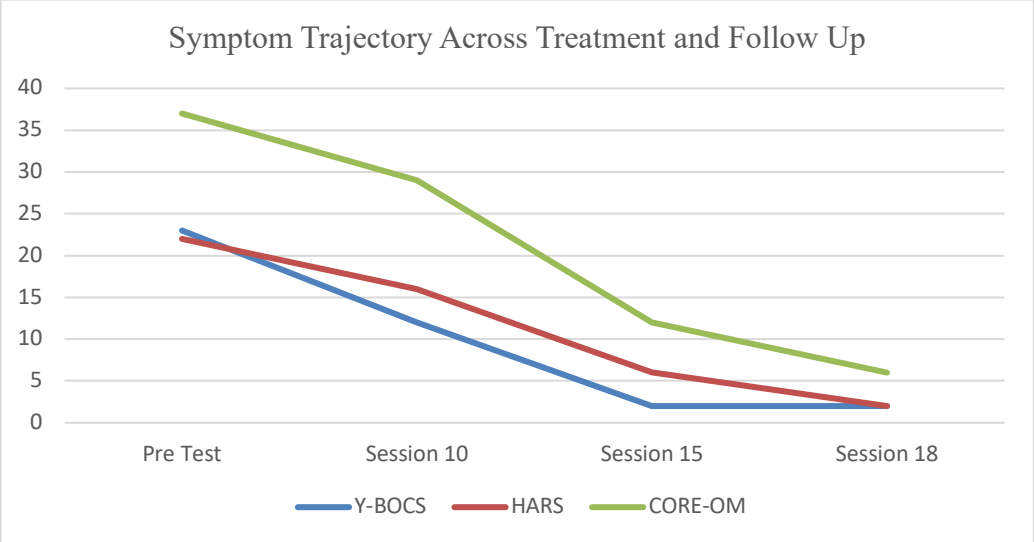


Figure 1. Symptom Trajectory Across Treatment and Follow-Up

Psychological and Functional Improvement

The participant showed signs of improved psychological health and self-regulation. By projective assessment using Car 'R' Us cards, he first identified distress and rigidity. Consistent with reductions in subjectively reported obsessive thinking, improved family interactions, and increased productivity (e.g., establishing a small business), the images chosen in Session 18 suggested individuality and freedom.

Sustained Therapeutic Benefits

The decline in the anxiety, stress, and OCD scores for symptom checklists was clearly supported by persistently lower follow-up assessments of SPT. Crucially, the participant's well-being improved overall from a mild distress baseline level, as assessed by CORE-OM scores, to a healthy range after therapy, showing that this therapy addresses the individual as a whole. These results highlight Sandplay Therapy's potential not only to alleviate negativity but also to support long-term symptom remission, emotional regulation, social attention, and quality of life.

Sandplay Thematic Development

The participant's sandplay journey traversed an involved process of self-discovery imbued with themes of conflict, change, and restoration. Based on Turner (2017) thematic framework, we identified four major evolutionary phases across the 18 trays. [REVISI] Table 4 summarizes this thematic evolution, mapping each phase to dominant symbols, psychological interpretations, and corresponding Turner stages.

Table 4.
Thematic Evolution of Sandplay Process

Tray Range	Dominant Theme	Key Symbols	Psychological Interpretation	Turner Stage
1-4	Rebellion & Initial Struggle	Family figures, Buddha, pagoda, coffin, Hawaiian deities (Kane, Kanaloa)	Internal conflict, avoidance, search for meaning, battle between chaos and order	Initial Conflict
5-10	Rhythm & Pattern	Wooden houses, chairs, tables, family members, airplanes	Growing stability, self-organization, desire for security balanced with movement	Reorganization
11-15	Adventure & Expansion	London Eye, Statue of Liberty, Macau gate, vehicles	Emerging autonomy, future orientation, and integration of personal and professional life	Expansion
16-18	Integration & Wholeness	House, skyscraper, Oriental Pearl Tower (minimalist arrangement)	Psychological consolidation, reconciliation of grandiosity with simplicity, acceptance	Transformation

Phase One: Rebellion and Initial Struggle (Trays 1-4)

In Tray 1, the participant barely touched the sand, indicating possible discomfort with tactile engagement or fear of contamination a clinically significant observation given his contamination-related OCD. This reluctance may represent avoidance of inner problems. The tray contents were dominated by figures representing family (children, grandparents), aspirations (pagoda, Oriental Pearl Tower), spirituality (Buddha, temples), and existential inquiry (Hawaiian deities Kane and Kanaloa). Kane and Kanaloa, as primordial gods of creation and chaos respectively, symbolically capture the participant's internal battle between order and disorder, a struggle that mirrors his obsessive-compulsive symptoms. According to Turner (2017), the absence of tactile engagement may reveal repressed aspects of the psyche. By Tray 4, the participant began simplifying his symbolic repertoire, moving from conflict clustering to more deliberate placement.

Phase Two: Rhythm and Pattern (Trays 5-10)

Trays 5-10 were characterized by recurring wooden houses, furniture, and pagodas. Wooden structures often relate to a desire for stability, while the repeated appearance of airplanes alongside parental figures suggested a yearning for family connection combined with personal and professional integration. The compositions became more balanced spatially. According to Turner (2017), this stage represents the participant's attempt to resolve inner conflicts and achieve a more cohesive sense of self. The regularity of domestic symbols chairs, tables, houses suggests an emerging capacity for daily structure, a psychological foundation that may have supported his symptom reduction during this period (see Figure 4, where Y-BOCS and HARS show steep declines between Session 10 and Session 15).

Phase Three: Adventure and Expansion (Trays 11-15)

From Tray 11 onward, new symbols emerged: the London Eye, Macau gate, and Statue of Liberty, complementing earlier domestic and spiritual motifs. This expansion hinted at a broader vision, incorporating hopes, world culture, and independence themes notably absent in the initial trays. The spatial organization shifted toward the center of the tray, reflecting a new sense of symmetry and unification. This phase temporally coincided with the normalization of all clinical measures (Session 15, Table 2).

Phase Four: Integration and Wholeness (Trays 16-18)

By Tray 18, the final tray, the participant placed only three symbols: a house, a skyscraper, and the Oriental Pearl Tower. This striking simplification from dozens of figures in Tray 1 to just three in Tray 18 represents reconciliation between aspirations for grandiosity and simplicity, between the domestic self and the ambitious self. The journey progressed from symbolic avoidance (Tray 1) to integration (Tray 18), reflecting SPT's capacity to facilitate unconscious processing and emotional healing.

Summary of Symbolic Progress

The journey became less representative of escape and more about containment, mirroring a return to hope, empowerment, and mental rebirth. This story shows that SPT allowed the individual to work with unconscious and internal narratives, as well as emotional resources most in need of healing and grounding recovery.



Tray 1 – Conflict Clustering, Minimal Sand Contact



Tray 2



Tray 3



Tray 4 – Beginning Simplification

Figure 2. Tray 1 – 4 (Rebellion & Initial Struggle)



Tray 5



Tray 6



Tray-7



Tray 8



Tray 9



Tray 10

Figure 3. Tray 5 - 10 (Rhythm & Pattern)



Tray 11



Tray 12



Tray 13



Tray 14



Tray-15

Figure 4. Tray 11 - 15 (Adventure & Expansion)



Figure 5. Tray 16 - 18 (Integration & Wholeness)
Note: The complete set of all 18 trays is available as Supplementary Material.

Car 'R' Us Projective Cards

The participant selected Car 'R' Us cards at four time points. The images and his accompanying verbal reflections show a clear evolution in self-perception. Session 1 (Pretest) – The participant chose an image depicting a car stuck in mud or confined within narrow walls. He explained:

"I feel trapped. My life feels heavy and uncertain. Every day is the same fear, then cleaning, then fear again. I don't see a way out."

Session 10 (Midtest) – He selected an image of a car beginning to move onto an open road, though still with visible obstacles ahead:

"I am beginning to move forward, although I still feel anxious. The anxiety is still there, but it doesn't paralyze me like before."

Session 15 (Posttest) – The chosen card showed a car on a clear road with sunlight ahead:

"I feel more free and hopeful than before. I can touch things now without washing my hands immediately. My family has noticed the change."

Session 18 (One-year follow-up) – He chose an image representing a car driving freely on an open highway with expansive scenery:

"I finally believe I can enjoy life again. I don't think about illness every minute. I started a small business I never would have done that two years ago."



Figure 6. Car 'R' Us Cards Selected Across Therapy Sessions

Figure 6 illustrates the participant's progressive emotional shift across therapy sessions, from feeling trapped and anxious to feeling free, hopeful, and able to enjoy life. As the Car 'R' Us cards lack established psychometric validation, these data are presented as heuristic illustrations supporting the qualitative narrative, not as independent psychometric evidence.



Figure 7. Comparison of First and Final Sand Tray

Figure 7 therefore illustrates the participant's movement from psychological tension and avoidance toward greater integration, emotional stability, and acceptance of previously distressing experiences. The first tray (left) showed right-sided dominance, clustered symbolic elements, and minimal engagement with the sand, suggesting avoidance and psychological tension. The participant's reluctance to touch the sand is clinically meaningful given his contamination-related OCD. In contrast, the final tray (right) displayed balanced spatial organization, dramatically simplified yet meaningful symbols (only three figures: house, skyscraper, pagoda), and comfortable engagement with the sand medium. This contrast reflects psychological consolidation, improved emotional regulation, and reconciliation between the domestic self and the ambitious self.

Discussion

This case study provides preliminary evidence that Sandplay Therapy (SPT) can be beneficial in reducing obsessive–compulsive symptoms, anxiety, and stress, while at the same time enhancing overall psychological functioning. During treatment, the participant demonstrated measurable clinical improvements. Standardized assessments showed a reduction in Y-BOCS scores from moderate to within the normal range, a

significant decrease in HARS scores, and normalization across all DASS-42 subscales. These changes echo earlier findings that highlight the effectiveness of SPT in addressing anxiety-related conditions (Freedle, 2017; Foo et al. 2020).

A central aspect of this therapeutic process was the symbolic expression facilitated through sand tray imagery, which proved especially helpful in resolving health-related obsessions. As Turner (2017) notes, sandplay creates a "third space" that is simultaneously structured and unstructured, providing a setting in which unconscious material can emerge symbolically and, in turn, allow for deeper therapeutic transformation. The use of supplemental projective tasks, such as the Car 'R' Us task, readily facilitated our understanding of the participant's development, specifically well-timed self-representation, emotional containment, and a sense of agency. These results reflect Freedle (2017) claim that symbolic processing in SPT can bypass rigid cognitive defenses and facilitate emotional integration.

Importantly, the therapeutic effects were not only retained but also continued to improve during follow-up. By post-treatment, all clinical measures were back to normal in this case, and the benefits of SPT were substantial and enduring. These findings are consistent with Akimoto et al. and Wisner et al., further supporting SPT as a long-lasting treatment. Finally, the participants' sandplay process that goes from an initial state of dissociation and denial to an experience of wholeness and transcendence may function as a form of adaptation that corresponds to Turner (2017) evolutionary model of therapeutic development.

However, a couple of methodological and contextual caveats should be noted. The fact that this was a single-case design study sets the boundaries of the results' generalizability, especially taking into account his specific cultural condition; psychosocial variables such as family system therapy, pharmacological simultaneous intervention for comorbid Korean depression, and demographic factors (as presented in Table 1) may have had a tremendous influence on the therapeutic process and the results. In addition, the absence of a control group makes causal inferences difficult, as symptom improvement could be attributed to the medicine's effects, spontaneous remission, or life changes rather than SPT's properties. Yet the bias illustrates the need for more RCTs to build stronger evidence.

Furthermore, relying on self-report measures raises concerns about impression management and social desirability. While the Car 'R' Us projective approach yielded deeper access to unconscious material, its psychometric properties need to be further appraised in terms of reliability within various clinical settings. Lastly, the stigmatization of mental health in the large Indonesian sociocultural context might have impacted both treatment seeking and honesty in assessment, highlighting the urgency for culturally adapted interventions and increased levels of therapist sociocultural competence across therapy sessions. A significant limitation is the sole reliance on a Western Jungian framework (Turner, 2017) to interpret non-Western sandplay imagery. While we found thematic congruence, future studies should incorporate emic (culture-from-within) approaches to symbolic analysis, such as consulting with local cultural elders or using Indonesian mythological frameworks (e.g., wayang semar, arjuna, or petruk)

CONCLUSION

This case report suggests that Sandplay Therapy may be a feasible and potentially useful adjunctive intervention for obsessive–compulsive symptoms accompanied by

anxiety and broader psychological distress. Across 18 sessions and subsequent follow-up assessments, the participant demonstrated marked and sustained improvement on standardized clinical measures, alongside qualitative changes in sandplay imagery that were consistent with improved emotional regulation, psychological integration, and engagement with previously distressing experiences. However, these findings should be interpreted cautiously because they are based on a single case without a control condition; therefore, they do not establish treatment efficacy or causal mechanisms. The primary contribution of this report is its detailed longitudinal description of the clinical process and outcome assessment of Sandplay Therapy in an Indonesian context. Future research should use adequately powered controlled and mixed-methods designs, preregistered outcome protocols, longer follow-up periods, and culturally responsive measures to examine the reproducibility, comparative effectiveness, mechanisms of change, and appropriate clinical indications of Sandplay Therapy for obsessive–compulsive and related disorders.

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ETHICAL CONSIDERATION

This case study was conducted in accordance with rigorous ethical standards. Ethical approval was obtained from the KPIN Ethics Committee (Approval No. 192/2024 Etik/KPIN). The participant provided comprehensive informed consent after receiving detailed information about the research purpose, methodologies, possible emotional distress, and confidentiality measures. He was informed that participation was voluntary and that he had the right to withdraw at any time without consequence.

DECLARATION ON AI USE

The Authors did not use AI for this research. Authors remain fully responsible for the accuracy, originality, integrity, and final content of the manuscript.

AUTHOR CONTRIBUTIONS

M.F. as the main authors are responsible for concept, research design, data collection, analysis, and interpretation. W.T. responsible for manuscript writing, review, and editing. All Authors contribute to the research, reviewed and approved the final version of the manuscript, and agreed to be accountable for all aspects of the research.

DECLARATION OF CONFLICTING INTERESTS

The Authors declare that there are no conflict of interest in this research, authorship, or publication.



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REFERENCES

Abramowitz, J. S. (2006). The psychological treatment of obsessive-compulsive disorder. Canadian journal of psychiatry. *Revue canadienne de psychiatrie, 51*(7), 407–416. https://doi.org/10.1177/070674370605100702

Akimoto, M., Tanaka, T., Ito, J., Kubota, Y., & Seiyama, A. (2021). Inter-brain synchronization during sandplay therapy: Individual analyses. *Frontiers in Psychology, 12*, Article 723211. https://doi.org/10.3389/fpsyg.2021.723211

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bradway, K., & McCoard, B. (2022). *Sandplay therapy: A step-by-step manual for psychotherapists of diverse orientations* (3rd ed.). Routledge.

Clark, D. A., & Beck, A. T. (2010). Cognitive theory and therapy of anxiety and depression: Convergence with neurobiological findings. *Trends in Cognitive Sciences, 14*(9), 418–424. https://doi.org/10.1016/j.tics.2010.06.007

Deal, R. (2006). *Cars 'R' Us: A tool for exploring emotions and choices*. [Card set]. Innovative Resources.

Evans, C. et al. (2002). Towards standardization of brief outcome measures: CORE–OM psychometrics. *British Journal of Psychiatry, 1*80, 51-60. https://doi.org/10.1192/bjp.180.1.51

Fineberg, N. A., et al. (2020). How to manage obsessive-compulsive disorder (OCD) under COVID-19. *Comprehensive Psychiatry,* 100, 152174. https://doi.org/10.1016/j.comppsych.2020.152174

Foo, M., Freedle, L. R., Sani, R., & Fonda, G. (2020). The effect of sandplay therapy on the thalamus in the treatment of generalized anxiety disorder: A case report. *International Journal of Play Therapy,* 29(4), 191–200. https://doi.org/10.1037/pla0000137

Freedle, L. R. (2017). Healing trauma through sandplay therapy. In B. Turner (Ed.), *The Routledge international handbook of sandplay therapy* (pp. 190-206). Routledge.

Freud, S. (1955). Notes upon a case of obsessional neurosis. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 10, pp. 153-318). Hogarth Press. (Original work published 1909)

Gillan, C. M., Robbins, T. W., Sahakian, B. J., van den Heuvel, O. A., & van Wingen, G. (2016). The role of habit in compulsivity. *European Neuropsychopharmacology, 26*(5), 828–840. https://doi.org/10.1016/j.euroneuro.2015.12.033

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale: I. Development, use, and reliability. *Archives of General Psychiatry, 46*(11), 1006–1011. https://doi.org/10.1001/archpsyc.1989.01810110048007

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-



clinical sample. *British Journal of Clinical Psychology, 44*(2), 227–239. https://doi.org/10.1348/014466505X29657

Juliana, Alshanti, N. W., Fakhrinnisa, T. A., Ramadhanti, N. A., Pradana, A. F., Dwiprawira, R. A., Azkia, R. A., Rizkiawan, R. R., Hafizh, M., Kusumawardhani, A. D., Gunawan, F., Kunigara, M. P., Rahmatsani, J. N., Asyiroh, H., Texaga, D. R., Hidayat, F. F., Pratama, G. Y., Suprijadi, A. A., Martin, T. M. A., Farid, M. R. H., Fadila, S., Nazililah, A. H., Febriyani, P. L., Gabriella, C. C., Naufal, A., Dwiyanti, A. S., & Putri, N. R. (2024). Obsessive compulsive disorder (OCD) during the COVID-19 pandemic. *Jurnal Psikiatri Surabaya, 13*(1), 108–117. https://doi.org/10.20473/jps.v13i1.29425

Kalff, D. M. (2020). *Sandplay: A psychotherapeutic approach to the psyche*. Temenos Press.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Psychology Foundation.

Mataix-Cols, D., Rosario-Campos, M. C., & Leckman, J. F. (2005). A multidimensional model of obsessive-compulsive disorder. *The American Journal of Psychiatry, 162*(2), 228–238. https://doi.org/10.1176/appi.ajp.162.2.228

Menzies, L., Chamberlain, S. R., Laird, A. R., Thelen, S. M., Sahakian, B. J., & Bullmore, E. T. (2008). Integrating evidence from neuroimaging and neuropsychological studies of obsessive-compulsive disorder: The orbitofronto-striatal model revisited. *Neuroscience & Biobehavioral Reviews*, 32(3), 525-549. https://doi.org/10.1016/j.neubiorev.2007.09.005

Shafran, R., Coughtrey, A., & Whittal, M. (2020). Recognizing and addressing the impact of COVID-19 on obsessive-compulsive disorder. *The Lancet Psychiatry, 7*(7), 570–572. https://doi.org/10.1016/S2215-0366(20)30222-4

Sastramidjaja, Y. (2023). Indonesia's COVID-19 infodemic: A battle for truth or trust? ISEAS–Yusof Ishak Institute.

Stein, D. J., Costa, D. L. C., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., van den Heuvel, O. A., & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers,* 5(1), Article 52. https://doi.org/10.1038/s41572-019-0102-3

Thompson, E. (2015). Hamilton Rating Scale for Anxiety (HAM-A). *Occupational Medicine, 65*(7), 601. https://doi.org/10.1093/occmed/kqv054

Turner, B. A. (Ed.). (2017). *The Routledge international handbook of sandplay therapy*. Routledge. https://doi.org/10.4324/9781315656748

Wiersma, J. K., Freedle, L. R., McRoberts, R., & Solberg, K. B. (2022). A meta-analysis of sandplay therapy treatment outcomes. *International Journal of Play Therapy, 31*(4), 197–215. https://doi.org/10.1037/pla0000180

