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## Moving Toward Regulation Using Synergetic Play Therapy

### Évoluer vers les principes régulateurs au moyen de la thérapie du jeu synergique

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#### ABSTRACT

Children generally do not possess the complex, expressive language skills needed to communicate the struggles they are experiencing. In response to this, a variety of play therapy models have emerged. This article concentrates on the application of a research-informed model of play therapy delivery called synergetic play therapy (SPT), which combines interpersonal neurobiology, attachment theory, nervous system regulatory principles, mindfulness, physics, and the self of the therapist. By combining this model with child-centred play therapy (CCPT), the author draws on two case study examples to demonstrate the efficacy of the SPT model when it is coupled with CCPT. The findings and case studies suggest that this approach reduces the severity of identified behavioural concerns. Future investigations in this area are recommended given the gap in the literature regarding combining SPT and CCPT.

#### RÉSUMÉ

En règle générale, les enfants ne possèdent pas les compétences linguistiques complexes et expressives qu'il faut pour communiquer les luttes intérieures qu'ils éprouvent. C'est pour combler cette lacune que divers modèles de thérapie par le jeu ont vu le jour. Le présent article est centré sur l'application d'un modèle inspiré par la recherche portant sur la prestation d'une thérapie par le jeu et appelée thérapie par le jeu synergique (TJS), qui conjugue des éléments de neurobiologie interpersonnelle, de la théorie de l'attachement, des principes régulateurs du système nerveux, de la pleine conscience et du Soi du thérapeute. En associant ce modèle à la thérapie par le jeu centrée sur l'enfant (TJCE), l'auteure s'inspire de deux exemples de cas à l'étude pour démontrer l'efficacité du modèle TJS utilisé en conjonction avec la TJCE. Les résultats et les études de cas semblent indiquer que cette approche réduit la gravité des problématiques comportementales décelées. On recommande d'effectuer de plus amples analyses dans ce domaine étant donné la pénurie de données sur la combinaison de la TJS et de la TJCE.

Play is the way children express their inner world. According to Landreth (2012), a pioneer in the field, "Play is the language of the child and toys are their

words.” It is a key part of healthy child development. Further, as play researcher Marshall (2012) noted,

Research about play highlights its role in supporting cognitive, social-emotional, and physical development. Play is also seen to strengthen creativity and academic achievement, and relieves the symptoms of attention deficit disorder, anxiety, depression, and other potentially debilitating health conditions like obesity and diabetes, among its numerous major health benefits. (p. 3)

According to Brown (University of Minnesota, Center for Spirituality and Healing, 2011), not only will play improve physical and emotional well-being, but also, its neurobiological effects optimize the learning process.

Taking a closer look at the types of play children engage in, it is important to be aware of six primary developmental play stages identified by Mildred Parten (as cited in Geismar-Ryan, 2012) through observation: solitary play, onlooker play, parallel play, associative play, co-operative play, and games with rules. In turn, these six levels appear to correspond with both children’s developmental growth continuum and chronological age. Solitary play appears typically from birth to 2 years of age, parallel play from 2.5 to 3.5 years of age, associative play from 3 to 4.5 years of age, co-operative play from 4 to 4.5 years of age, games with rules from 6 years on, and onlooker play at all ages (York Region Preschool Speech and Language Program, 2014).

This is significant because the stage of play that children engage in initially can be a further indication of their developmental age. As therapy progresses, we can expect to see the child’s type of play change and move toward matching their developmental age.

### **Play Therapy Defined**

According to the American Association for Play Therapy (n.d.), this form of therapy intervention is defined as “the systematic use of a theoretical model to establish an interpersonal process wherein trained Play Therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.” Since children communicate their wants, needs, and feelings largely through play behaviours, play therapy becomes the natural pathway for a child’s communication system and the primary vehicle through which the child is able to express an understanding of their world.

The primary reason for play to be viewed as the major communication system of children is due largely to the limitations of their brain function. Children’s brains are underdeveloped so that the part of the brain responsible for understanding and articulating with any accuracy what is being felt has not matured. These

executive functions require the prefrontal cortex, which in the case of a young child is in its infancy of development.

As Ludy-Dobson and Perry (2010) described in their extensive research, brain development begins with the most primitive part of the brain, the brain stem, which is responsible for survival functions (e.g., arousal states, controlling key body functions, heartbeat, swallowing, and breathing). This is followed by the emergence of the diencephalon, the part of the brain that guides sensory functions, after which limbic activity emerges where important tasks of the developing brain integrate further, which helps to manage arousal states such as fear, stress, and sleep patterns. Thus, the groundwork has been laid for the emergence of the higher order cognitive functions of thinking, sequencing, problem-solving, planning, organizing, and all the responsibilities associated with abstract thinking as well as the process of social-emotional integration.

According to Siegel (2014), all of this is preparatory to higher order thinking and processing, which does not appear to mature fully until people reach the ages of 25 to 28 years. Furthermore, Siegel and Bryson's (2011) research supports the theory that children are essentially right brain dominant and that play is considered a right brain dominant activity.

Because a child's cognitive brain is so underdeveloped, talk therapy is ineffective. Play therapy does not require a high level of communication. Play therapy allows therapists to communicate to a child through the world that they have created. Furthermore, a child can recreate their world in play and in the play therapy session. Whatever the child presents can be seen as a metaphor for the child's own experience(s). A play therapist then works to stay in the child's metaphor, reflecting its content and the feelings associated with the metaphor. Through the play, children are able to confront their own issues safely because the play distances them from having to unpack the more literal content. In general, children are inclined to move toward positive health (Landreth, 2012) and the play allows for working with the psychological material at a safe distance and in a safe way, guided by and witnessed by the play therapist.

If the child enters the play therapy process with some indication of trauma exposure, the play behaviours of the child will provide important information about the child's age when the traumatic events were experienced. This is because brain development becomes arrested at the site of the developing portion when the event(s) occur (Ludy-Dobson & Perry, 2010). Through play, the therapist is able to meet the child at their developmental age, which may not be the child's chronological age. It then becomes possible to observe and to bear witness to the child's play behaviours in order to assess a true developmental age over time. We can possibly draw the conclusion that the same holds true for the types of play. The type of play that a child engages in becomes arrested at the age a traumatic event occurred as well.

## Child-Centred Play Therapy

Both Axline (1969) and Landreth (2012) hold the belief that children know what they need to move toward growth and change. CCPT allows children to orchestrate the direction and the pace of therapy. One of the most commonly practised approaches is CCPT. It is an evidence-based approach (Ray, 2006) that is referred to commonly as non-directive play therapy. The therapist tracks, reflects, and creates an ongoing safe environment in which the child can proceed to do the work needed to move toward repair and healing. This is all provided within the context of unconditional regard and full acceptance of who the child is, all primary tenets of play therapy practice.

CCPT, one of the many play therapy approaches, was created by Axline (1969) in 1947, based on the teachings of Rogers (1995), who believed that the therapist's genuineness or congruence, unconditional positive regard, and empathic understanding create the foundation for this work to take place. These three conditions, Rogers wrote, are essential for growth. He stated that the more therapists are themselves, the greater the likelihood of change. Rogers wrote that therapists must be congruent in what is experienced at the "gut level" (p. 116) and in what is expressed to the client. Unconditional positive regard means that the therapist accepts the client however and with whatever they present. Empathic understanding means that the therapist senses the feelings and meaning of the client's experience accurately.

## Regulation

To enter a regulated state, Dion (2018) wrote that one would need to display many of the following: the ability to think clearly and logically, to make eye contact, to display a wide range of emotional expression, to take full breaths, to feel grounded, to communicate in a clear manner, and to have an internal awareness of both body and mind.

For this study to have an appropriate context, it is important to acknowledge the role that the concept of regulation plays in identifying and assessing ongoing growth and competence in children. Increasingly, researchers and practitioners alike are exploring the importance of brain science and the factors that impact and determine what will benefit children's brain structures most and what will enable children to know and to be able to access their own internal resources.

Badenoch (2008) wrote that interacting with a safe, accepting person has the capacity to change a child's brain structure, thereby providing the child with more internal accessible resources. Furthermore, in the process of being in the presence of a safe, accepting person, the child gains the capacity to use that person, in this case the therapist, to regulate toward a state of calm (Badenoch, 2008). Referred

to as co-regulation, this is seen best in the early development of infant to mother attachment, whereby the mother soothes the crying infant through a variety of co-regulating activities such as rocking, swinging, and cooing.

Badenoch observed further, “We don’t come with any kind of regulatory circuitry but it has to be co-built with another person” (Badenoch, 2017, 3:48). In other words, we learn to regulate by experiencing co-regulation first. SPT acknowledges that children use their mothers for regulation before children can regulate on their own and that children’s work with therapists as their co-regulators is an important tenet of SPT (Dion, 2008).

In terms of typical developmental growth, mothers function as the initial “external regulators” (Dion 2018, p. 52) for their children. In play therapy, the therapist works to become the external regulator for child clients. For co-regulation to evolve fully, something that can lead to self-regulation, the development of the cortex and its integration with the limbic system must develop and mature first. Drawing on the research of Iacoboni (as cited in Badenoch, 2008, p. 37), “Mirror neurons are circuits of the brain that are used to internalize the intentional and feeling states of those with whom we are engaged.” Badenoch (2008) added that self-regulation involves the cortex, which is in its infancy of development. For this reason, co-regulation must occur in order to begin creating the integration of the limbic region and the cortex needed for self-regulation.

The intention underlying the therapy delivery process for the two young children in this study is to examine play therapy effectiveness overall and the ways in which the work can be enhanced in terms of its effectiveness. The data provided represent a small sampling of how combining traditional play therapy models, specifically CCPT with SPT, can impact social and emotional growth and lead to several positive outcomes. As previously indicated, research directed at the question of optimal play therapy interventions suggests anywhere from 30 to 40 full sessions to achieve optimal play therapy treatment effect (Lin & Bratton, n.d.). This study was designed to reflect fewer sessions overall with possibly greater intensity delivered throughout each child’s therapy process.

### **Synergetic Play Therapy**

Dion (2008), the creator of SPT, identified what she believed were nine specific tenets to the process of SPT. Strongly influenced by CCPT, experiential play therapy, and Gestalt play therapy, the tenets are condensed and summarized best as follows:

- the attunement between therapist and child,
- the modelling of self-regulation by the therapist,
- the authenticity and the congruence expressed by the therapist,
- the symptoms expressed by the child as the dysregulated states of the nervous system,

- the focus placed on a child being who they are genuinely, rather than functioning as perceived expectations
- the understanding that children project aspects of their inner world onto toys and other play objects,
- the understanding that children also project their inner world ideas and beliefs onto the therapist, and that, in so doing,
- the therapist comes to feel and have the experience of what it is like to be the child client.

Genuine emotional response will be evoked in the therapist who is attuned to the child emotionally, as the child will project their emotions onto the therapist (Dion, 2018). It is important that therapists practising SPT model regulation as they flow through the “crescendos and decrescendos” (Schoore, 2006, as cited in Dion & Gray, 2014, p. 59) of their own internal states. These referenced internal states are like the “crescendos and decrescendos” of a child’s arousal system (Schoore, 2006, as cited in Dion & Gray, 2014, p. 59).

In modelling regulation, the therapist activates the child’s own mirror neuron system. This, in turn, can initiate new neural firing patterns in the child, thereby replacing negative emotions associated with memories (Badenoch, 2008; Siegel, 1999). Throughout this process, as highlighted by SPT, a therapist strives to work at the edge of what is termed a “window of tolerance.” This is identified as a place bordering on the discomfort of their feelings without losing control, somewhere between a regulated state and a dysregulated state. The goal here is to expand mutual windows of tolerance, the child’s and the therapist’s (Dion & Gray, 2014).

What distinguishes Dion’s SPT approach from Landreth’s CCPT model is that the Dion’s approach encourages a therapist to express congruent feelings in the play therapy process, whereas Landreth (2012) argued that the therapist’s statements during sessions may interfere over time with maintaining the child as the primary focus of the therapy experience. This raises the question of which belief system promotes change the most effectively.

To respond to this question, the author of this study has chosen to draw upon SPT, an adjunctive approach, to support the work of CCPT, generally a stand-alone model, in order to assess the benefits of this combined approach. This study will demonstrate that these children moved toward wellness efficiently and more quickly than with CCPT alone. According to Leblanc and Ritchie and to Bratton et al., the optimal play therapy treatment effect falls within 30 to 40 sessions (Leblanc & Ritchie, 2001; Bratton et al., 2005, as cited in Lin & Bratton, n.d.).

### **Purpose of the Study**

Drawing on data gathered through examining the play therapy processes of two male children of preschool age, the author was interested in exploring the efficacy of a combined therapeutic model. The overarching goals in the two cases

were the ability to make gains in observable self-regulatory behaviours and to increase a sense of self-awareness and personal identity. As a result of a combination of non-directive play therapy model and SPT principles, it should be possible to maintain and promote developmental growth stages in the play behaviours expressed by each child, to enable each child to gain personal understanding and appreciation for the transitions being expressed through their play behaviours, and to learn to draw upon the gains made through increased play behaviour transitions to multiple settings (e.g., home, preschool, social settings, and possibly recreational activities).

### **Method**

Using a qualitative case study approach, the therapist sought to explore the efficacy of applying combined play therapy approaches: CCPT with SPT principles. The therapist gathered quantitative data from a pre- and post-therapy checklist that had been designed by her. The checklist was completed by the parents. The therapist's case notes and the parents' anecdotal reports were also taken into consideration for the purpose of this study. This approach allowed the research to focus on a particular phenomenon, to provide rich description, and to offer a different understanding of the core relationship and interactions between child clients and their therapist (Merriam, 1991). Both children worked with the same therapist.

The therapist met with the parents briefly after each session, letting the parents know how they could continue building the regulation skills that had been modelled in session. Parents also presented challenges they had faced at home in order for the therapist to provide support within the framework of the therapeutic model. Psychoeducation regarding brain development, the states of the nervous system (hyperarousal, regulation, and hypoarousal), as well as different activities to help with regulation were also provided to the parents.

### **Study Participants**

Under the pseudonyms of "John" and "Tom," two boys of similar preschool age were identified for this study. John had a chronological age of 4 years and 11 months at the onset of this study while Tom had a chronological age of 4 years and 9 months. Both children were identified as struggling with aggressive behaviours and with difficulty managing their emotional range. Sensory processing issues were also present in each child's overall behavioural presentation. Each of the boys came from a two-parent family system, and both sets of parents had identified that their sons were struggling at home and in their preschool settings equally. In Tom's case, he was diagnosed formally as being on the spectrum of autism along with a high level of functioning overall.



***Participant 1: John***

John was attending his final year of preschool when he was referred for treatment. The single male offspring in his family system, he lives with his twin sister, his younger sister (1 year and 7 months old), his mother, and his father. His parents referred John for play therapy because of his struggles in managing his emotions and because of his aggressive behaviour at school and at home. As well, the family's pediatrician had diagnosed this child previously with an anxiety disorder, a label the parents tended to question. There were, however, indications that John had sensory processing issues, according to both parents. John's mother, a homemaker, and his father, a professional working outside of the home, were both actively involved in raising their son.

Both parents expressed their concerns over John's behaviour pattern when they or other adults attempted to set limits with him. Biting, scratching, kicking, spitting, and hitting seemed to occur regularly and made their son seem fairly volatile. In terms of family interactions, John appeared to get along reasonably well with his twin sister, but he became angry and aggressive in the presence of his younger sister, particularly when she sought their mother's attention. Change, in the form of transitions, generally caused upset for John, who was identified as a sensitive child and who indicated, through his behaviours, that he disliked physical touch. According to the parents, John had had a difficult early birth history having been born three weeks prematurely, unable to breathe initially on his own, and needing to be intubated.

The primary direction of the therapeutic intervention for John, in consultation with his parents, was to work to reduce aggressiveness and to create ways in which he could learn some strategies to manage his times of dysregulation ("big emotions" that had got out of control). To this end, John participated in 21 regular play therapy sessions of 1 hour each, with 2-week interruptions in services for the winter holidays and for spring break. Particularly noteworthy were the observable changes that emerged in sessions 6, 9, 16, and 21. Progress reports and ongoing suggestions were provided by John's therapist, and the parents engaged in a similar process of feedback to assess gains and the areas where continued growth was required.

***Participant 2: Tom***

Tom previously had been diagnosed as being on the spectrum of autism. He appeared to be functioning at the higher end of the spectrum, with cognitive capabilities well beyond his chronological age. As well, Tom had a number of sensory sensitivities that included sound, his sense of smell, and his sense of taste. Among his capabilities is his facility with languages, as he speaks and understands both Cantonese and English. At the time of this study, Tom was also involved with a behavioural interventionist who worked one-on-one with Tom to support him



in attaining goals set out by his school. He is a single child in his family with his mother, a homemaker, and his father, who works as a professional. Both parents are actively engaged in their son's rearing process.

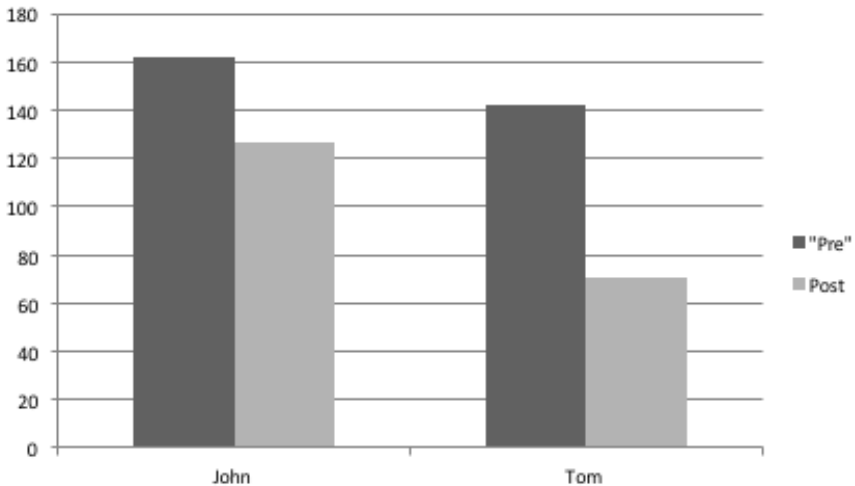
Concerns raised by Tom's parents focused on Tom's tendency to get angered easily, to become very emotional, to shout, to throw things, to run away, to find difficulty in connecting with his peers, and to have difficulty initiating play with other children. Added to the list was his tendency to "script," which his behavioural interventionist felt impeded his progress. The Autism Society of Baltimore-Chesapeake (2020) described *scripting* as "the repetition of words, phrases, intonation, or sounds of the speech of others, sometimes taken from movies, but also sometimes taken from other sources such as favorite books or something someone else has said." While Tom's behavioural interventionist believed the scripting behaviour impacted Tom's overall presentation in negative ways, Dion (personal communication, September 30, 2017) maintained that all children's behaviour represents their attempt to regulate. In this way, Tom could be seen as engaging in a purposeful, intentional act.

The goals the parents identified for Tom's therapy process involved primarily developing self-regulation capabilities, learning to understand and to appreciate empathy, and becoming more prosocial with his peers. As with John, Tom's parents were apprised of their son's progress on a weekly basis and observations by parents and by the therapist were exchanged regularly. Tom participated for a total of 13 weekly 1-hour sessions with a 6-week break during the winter months to accommodate extended family travel. For this child, significant shifts in behaviour began to be seen and were recorded following his seventh session.

### **Instrument**

A questionnaire was used in conjunction with case notes, clinical observations, and parental feedback. The questionnaire was developed by the therapist of the study (Simmons, 2015). This instrument was comprised of 30 different but commonly identified childhood behaviours. They ranged from subject-positive descriptors that were recorded as added values (e.g., *accepts limits, co-operative*) to negative behaviours with lesser values (e.g., *displays aggression, fights authority figures*). With this tool, it has been more possible to quantify gains being made in goal-specific areas such as self-regulation. Data from a 10-point scale with values of 1 to 10 were collected and compiled to assess the efficacy of the therapies being applied. Highlighting emotional development gains in the two therapy cases identified, this study examined the differences from baseline measures, using play as the intervening variable to assess growth and change in these two children before and after play therapy intervention.

Figure 1  
*Questionnaire Scores of Both Boys Comparing Results of Pre- and Post-Therapy Questionnaires*



### Procedure

As each case study subject participated for a different length of time, the use of the study questionnaire was applied at different intervals. For John's parents, the first measurement, following the establishment of a baseline, was at session 8. For Tom's parents, the first measure was done at Session 1.

### Data Analysis

Each questionnaire was tallied to attain a global score (see Figure 1). Scores from each specified question were totalled and the pre- and post-questionnaire figures were compared for each subject from their initial questionnaire results to their second set of measurements. The attained scores were also compared across the two children's total scores achieved as they fell into the same cohort from a developmental perspective. Attained scores, along with case note information and parental feedback, did provide to some degree a measure of emotional/social growth and progress made from their respective time and applied interventions in therapy.

### Results

Overall, the results suggest that both children made gains toward less aggression, more prosocial behaviour, and better management of their regulatory

processes in terms of emotional growth, self-awareness, and more contained transitioning behaviour. In each family's case, the improvement overall was maintained at follow-up a year later. For both families, the challenge of transitioning into kindergarten was met with success, suggesting that the newer learning evidenced in the two children's behaviour was sustained.

### **John: A Clinical Review of the Therapy Process**

Early themes in John's work suggested feelings of overwhelmingness, chaos, and entrapment, while ways of responding were limited initially to bouts of aggression. In his first few sessions, he tended to engage primarily in solitary play, and his behaviours expressed deep feelings and bodily sensations arising from these feelings. These were tracked by the therapist and efforts were made to support these deep-seated expressions. As John displayed his overwhelmingness and chaos in his play, the therapist noticed her breath quickening and a tightness in her chest. As per the SPT model, the therapist expressed these sensations then regulated through these sensations while verbalizing how she was regulating.

Drawing on psychodynamic theory, the therapist identified a self-object dynamic around session 5 that seemed to replicate the child's own early life experience, which was, in turn, replicated through the play. In this dynamic, the therapist was able to feel the same sense of helplessness and need that the client had felt. Feelings of being trapped, of choking, of having to fight for survival were expressed and played out and could be expressed by the therapist as authentic feelings shared by client and therapist alike.

Session 6 was a pivotal one in which John projected an experience of being trapped and unable to move during play. When the therapist tried to regulate through the discomfort, John told her not to move or to breathe. As John was pretending to put things into the therapist's mouth, she noticed an uncontrollable urge to move and to pull things out of her mouth. It was then that the therapist learned that John had been intubated at birth and had removed his tube himself, a big feat for a newborn.

The theme of choking, of having one's breath taken away, was played out in session nine as well, with the therapist verbalizing and modelling co-regulating patterns such as deep breathing and ways of grounding. John played with his self-object where he put the object in water and said that the self-object could not breathe. The therapist noticed a tightness in her chest, which Dion (2018) stated is a projective experience, the child projecting their feelings onto the therapist so that the therapist can experience what the child is feeling. The therapist then regulated through this discomfort, after which John removed the object from the water and went to another area to play.

Later sessions were distinctive in that he chose to bring in his own toys and to engage with the therapist in co-operative and associative play, both developmentally closer to John's chronological age. Having interacted with his play therapist

and witnessed her as the “external regulator” (Dion, 2018, p. 52)—talking, breathing, acknowledging what she was experiencing, and changing physical positions—John was now mirroring the therapist’s breath and movement.

In John’s last few sessions, much of his work expressed a state of regulation, and he was able to demonstrate ways to regain his regulated state. At this same time, John’s mother reported that he was now using his words to describe what was causing his dysregulation at preschool. He was also playing more co-operatively with his twin sister. Previously their play had been parallel play and John would get upset if she tried to engage him in play.

As the progression of John’s play continued, the play itself continued to evolve. He had begun his play therapy process as though a very young child, engaged in parallel play and solitary play exclusively, with very little dialogue, often using guttural sounds instead of words, and ended his process engaging with the therapist in a co-operative form of play usually associated with children ranging in age from 4 to 5.5 years. His journey had helped him develop as a child whose emotional age and chronological age were now matched, which was one indication that the therapy process was nearing the end. Child-centred play therapists and synergetic play therapists hold the belief that the child knows what is needed to heal what has been harmed.

The final session for John appears to reflect this belief system. On entering the play therapy space, he elected to choose a board game to play with the therapist and later proceeded to revisit each of the toys or activities that had activated his dysregulation in earlier sessions. In each case, he was able to process what he had gained from interacting with each particular play experience and to close off his connection with it. A final activity that John chose to play out was when he selected his self-object, a toy lizard, and had his therapist hold it while he created a healing act on it, assuring his therapist that the toy was now all better.

In the year that has passed, John has managed to adapt to his kindergarten program successfully. He has had a good year and looks forward now to his grade 1 year. The process began then moved from assessment and relationship building to a working phase and then to closure, all in a total of 23 sessions with the bulk of the significant and measurable shifts occurring in sessions 14 onward.

### **Tom: A Clinical Review of the Therapy Process**

Tom tended to choose the same form of play in most of his early sessions, playing with Brio trains, building tracks to curve and travel upward and downward while the therapist’s job was to create some tunnels. The developmental stages of the play were a combination of solitary and parallel play. During this play, Tom appeared to be regulated and engaged. In those times when he became dysregulated, he was seen to be scripting, which suggested that he used this behaviour in an attempt to achieve some measure of regulation for himself. As his play therapy

progressed, there appeared to be less scripting behaviour, which he replaced more frequently with calming breaths.

The therapist noticed some visceral impact from the movements of the train. As the toy moved steadily along the tracks, it was possible to use non-verbal tracking to follow its course. But when the train travelled up and down the hills that had been created, the therapist became aware of her own bodily sensations: tension building in her chest followed by a big release of this tension as the train moved quickly down the other side of the created train route. This visceral experience was then communicated verbally to the client in a step-by-step fashion. Speaking of the sensation of having had to hold breath and then releasing it was replicating Schore's discussion of "crescendos and decrescendos" (Schore, 2006, as cited in Dion & Gray, 2014, p. 59) experienced in the autonomic nervous system. In this, the therapist was serving as the child's "external regulator" (Dion, 2018, p. 52). In the early sessions, the transitioning that followed demonstrated that Tom found it hard to complete the play and to leave the play therapy space.

By session 7, Tom had begun to be more exploratory in his play and to vary his choice of play objects and where he moved in the room. Changing the order of his choices, he started to use the sand tray before engaging with the trains. A second observable shift occurred when he started to verbalize at a specific point in the train travelling sequence using the term "biacalee," a word drawn from his imagination. A new pattern then emerged in which Tom would shift his eye gaze to the therapist, and then, just before the train entered the tunnel, mirroring both the gaze and reflecting the word, the therapist would say "biacalee" in tandem with the child. The therapist expressed aloud that she noticed Tom's intention, through his eye contact, to have her join him in this expression and timing. Coinciding with this event, Tom appeared better able to transition out of the play therapy space.

In a subsequent session, the same pattern was seen, and in follow-up, the therapist learned from Tom's father that before Tom became upset, he would take a breath, and that this new behaviour was being seen at home with some consistency. Further, when the father reflected to his son that he noticed the breathing, Tom told his father that "I'm breathing like Johanna [the therapist] taught me to." This coping tool was never directly taught; rather, it was modelled by the therapist, who served as the child's "external regulator" (Dion, 2018, p. 52) during play therapy sessions. Following this, therapy was put on hold as the family was away for six consecutive weeks. When they returned, Tom had continued to maintain the eye contact seen in his previous work, and after several more play therapy sessions, it was felt that his process could begin to wind down.

The family continued to report their son's progress. The father told the therapist that his son had transitioned back to his preschool class without incident and that within two more weeks Tom was working co-operatively with a schoolmate. In a following session, Tom presented the therapist with a train so that her train

could follow his own. The play level by this time had achieved the co-operative level of development. In consultation with the parents, it was agreed that session 13 would be his final one because Tom was displaying observable progress across several areas the parents had identified originally. Key gains were Tom's ability to regulate his anger, to engage in co-operative play, and to make eye contact effectively. These improvements suggested that Tom's developmental and chronological age were now more congruent.

### **Discussion**

While there are numerous methods for engaging in play therapy practice, the use of the therapist as discussed in this study is both distinctive and to some degree controversial. The methodology draws on both historical teachings in the field as well as on newer approaches that are informed strongly by neuroscience.

Children's understanding and generalized perception of their immediate world contains the influences of parents, school, neighbours, friends, and others. This understanding and perception is reflected in the stages of play activity. Growth was evident and measurable in these case studies. In each case, the identified child was able to communicate through his behaviours and the emotions associated with these behaviours that there was struggle, pain, and an inability to engage fully with his world in a successful and maturational fashion. As an exploratory study, the role of the parents was also an important consideration.

Parents, taught to be key observers who can reflect their child's witnessed behaviours and emotions, expand the reach of play therapy effectiveness. In the two case studies described, therapist and parents needed to partner in order to track the effects of the sessions and the carry-over managed by the family between sessions.

### **Limitations and Conclusion**

The small sample size for this study was both an advantage and a disadvantage in terms of the ability to focus on the key elements of working with combined play therapy approaches. It would be of value to be able to expand the sample size to demonstrate further the efficacy of SPT principles with foundational CCPT. Being able to explore these two methodologies with greater cultural variation would also help to increase understanding about the degree of emotional expression typical across ethnic groups, about the role parents play in impacting play behaviours with their children, and about the role "play" actually has in the overall development process of these children.

Further, a comparative look at sampling children who received a single play therapy approach (e.g., CCPT) on its own versus a group who receive the combined approach would enhance our understanding of the efficacy of this combined

approach. In addition, replicating these results with other therapists and clients would lend more weight to the findings of this study.

Communication to parents cannot be controlled between therapists or how parents are supporting or not supporting the process at home. These are factors that can have bearing on the results when replicating this study. Asking not only parents but also teachers and other adults in contact with a child to complete the behaviour assessment would be worth considering for future studies. It is also possible that some of the growth of the child, as noted in the progression through the play stages, is a result of the child becoming more comfortable with the therapist. The child's maturation over the span of therapy may have contributed also to a portion of the growth. Further studies would benefit from using control groups to control for these elements.

The results indicate that in both cases described in this study, the children's negative behaviours decreased: Tom's by 50% and John's by 30%. These changes occurred well below the 30 to 40 sessions suggested by Lin and Bratton (n.d.). In addition, the findings of this study demonstrate that the addition of SPT—allowing for genuine, authentic expression by the therapist of the impact of the play itself and the role of the therapist as “external regulator” (Dion 2018, p. 52) of the child's range of emotions—appears to assist the child actively in learning how to self-regulate.

Therefore, the addition of the synergetic process to the child-centred process enhanced the learning that occurred and enabled John and Tom to become their own internal regulators. Once this occurred, there was no longer a need for the children to express distress through aggression or through any other maladaptive behaviour. Regulation becomes the primary goal for therapy. Dion (2018) stated that symptoms and behaviours are viewed as dysregulated states of the nervous system. The play for each child transitioned from that of a very young child to a stage in which each boy was able to engage in an age-appropriate fashion across different settings and circumstances.

The three goals, as set out in the purpose of the study, have been met. The children have been able to maintain emotional development as reported by the parents one year after the termination of play therapy. The therapist observed the changes in the children's behaviour as expressed through the play by the gains expressed in the pre- and post-assessments as well as through anecdotal reports of the parents. The preschool teachers as well as support staff expressed the progress that they had noted in the children's behaviour and an overall improvement in social behaviour to the parents.

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