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An Examination of Child-Centered Play Therapy and Synergetic Play Therapy

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31 *Keywords:* Child-Centered Play Therapy, Synergetic Play Therapy, counseling theories
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An Examination of Child-Centered Play Therapy and Synergetic Play Therapy

In the field of play therapy, numerous theoretical approaches abound. Child-Centered Play Therapy (CCPT) is a widely known theory and is often used as the standard by which to compare the efficacy of other approaches (Bratton et al., 2005). The ideas behind CCPT arose from theory and experience (Ray et al., 2013), and its interventions have been researched since the 1940s (Lin & Bratton, 2015). In experimental studies and meta-analyses, CCPT interventions show statistically significant differences compared to control groups and yield small to large effect sizes (LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Muro et al., 2006; Ray et al., 2015; Wilson & Ray, 2018). Synergetic Play Therapy (SPT) was developed from personal experience, but this experience was heavily based in research on neuroscience, Interpersonal Neurobiology, and attachment theory (see Badenoch, 2008; Porges, 2011; Schore, 1994; Siegel, 1999 for coverage of the ideas behind SPT). Preliminary results suggest that SPT significantly improves emotional tolerance and regulation (Dion & Gray, 2014; Simmons, 2020), yet it is a relatively new theory and currently lacks the depth and support of research studies.

Various theoretical approaches exist because both clients and therapists are unique. Child-Centered play therapists pose that children possess all of the necessary qualities to grow into healthy adults (Landreth, 2012). Other practitioners believe that children learn in relationships and thus cannot instinctively generate healthy self-regulation if the template has not been laid by attuned caregivers (Eisenberg et al., 1996; Schmidt, 2009). Synergetic Play Therapy is built on the latter philosophy and is both a stand-alone model and a model that may be incorporated into existing play therapies. For CCPT therapists who have discovered that some of their clients do not spontaneously self-actualize, SPT may prove helpful in building the neural pathways that are lacking (Simmons, 2020). However, it is seldom effective to arbitrarily

combine techniques without a solid grasp of the underlying theories (Liddle, 1982). To help clinicians better understand the theory, practice, and possible integration of SPT with CCPT, this article compares and contrasts the two theories to examine the philosophical constructs that influence goals, therapists' roles, methodologies, and the therapeutic relationship. Because of its familiarity, information on CCPT is presented first, then the SPT view immediately follows to allow the reader to directly compare and contrast within each section.

Background and Philosophy

Drawing from Carl Rogers' Person-Centered approach, Child-Centered Play Therapy was developed by Virginia Axline and expanded by Garry Landreth (Porter et al., 2009). According to Ray (2019), CCPT is based on relational humanism and adheres to its principles of the innateness of development, the use of play as the child's natural language, and the primacy of relationships. The drive toward self-actualization is inherent but may be inhibited when the environment is invalidating, incongruent, or unaccepting (Ray et al., 2015). Conversely, self-actualization is amplified in warm, genuine, and accepting relationships (Ray, 2019).

To use Rogers' (1961) metaphor, children develop problematic behaviors when their environmental soil does not contain the proper ingredients for the drive to self-actualize, resulting in incongruence between their self-concept and actual experiences. Behavior is thus not pathologized but seen as goal-directed to satisfy legitimate needs (Landreth, 2012). When the therapist provides the core conditions of unconditional positive regard, empathy, and genuineness, the child is free to explore and express internal experiences through play and to move toward self-enhancement (Landreth, 2012; Rogers, 1961). Child-Centered play therapists believe that a safe and consistent environment fosters the child's abilities to move in a growth-oriented direction (Carnes-Holt, 2014; LaBauve et al., 2001).

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4 Synergetic Play Therapy was developed by Lisa Dion in 2008 and is a research-informed
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6 model that combines the powers of play with diverse fields such as neuroscience, Gestalt and
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8 Experiential play therapies, and mindfulness (Dion, 2015, 2016). Although SPT arose from and
9
10 overlaps with CCPT, SPT also incorporates many ideas from Interpersonal Neurobiology
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12 (IPNB), which posits that relationships influence neural wiring, which color perceptions, which
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14 shape responses and relationships (Siegel, 1999). Problems arise when patterns of thinking and
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16 interacting become rigid or chaotic, and problems are resolved when an individual can connect
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18 and differentiate in both interpersonal and intrapersonal realms (Siegel, 1999, 2010). Synergetic
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20 play therapists use IPNB's concept of the window of tolerance to understand nervous system
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22 dysregulation. According to Siegel (1999), each individual has optimal zones of arousal—
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24 influenced by temperament and experiences—in which they can tolerate natural fluctuations in
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26 different emotions. Children with narrow windows of tolerance can easily be thrown into
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28 emotional dysregulation, resulting in hyper- or hypo-arousal (Dion, 2015; Siegel, 2010).
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36 Like CCPT therapists, SPT therapists hypothesize that children's problematic behaviors
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38 arise out of difficult relationships and experiences; however, SPT therapists suggest that these
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40 experiences not only affect the child's perception of self but alter the patterns of dysregulation in
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42 the nervous system (Dion, 2020b). To affect neural change and repattern the nervous system, the
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44 SPT therapist's ability to attune, engage in mindfulness, and become the child's external
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46 regulator (the model to help the child regulate emotional intensity) allows the child to borrow the
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48 therapist's regulatory capacity and develop their own ability to manage dysregulation, thereby
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50 widening their window of tolerance (Badenoch, 2008; Dion, 2015; Siegel, 1999). The therapist's
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52 empathic attunement and authentic expressions are necessary because the child's observations of
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54 the therapist activate mirror neurons, which contribute to awareness, empathy, and a sense of self
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(Hudspeth & Matthews, 2016). Thus, a core premise of SPT is the therapist's ability to actively engage in co-regulation while targeting the child's dysregulated nervous system, which helps promote neural repatterning and integration (Dion, 2018; Siegel, 1999). The therapist's ability to self-regulate, be authentic, and stay attuned to the child helps the child learn to regulate and develop a healthy attachment to self, which is the foundation of healing (Dion, 2020b).

Goals of Therapy

In Child-Centered Play Therapy, the hope is that children increase self-responsibility, self-directedness, self-insight, and self-acceptance, but no formal goals are set (Landreth, 2012). The practice of goal-setting is inconsistent with CCPT philosophy because directing the session or stipulating alternative behaviors would indicate that children do not know what they need and cannot overcome obstacles themselves (Ray, 2019). Child-Centered play therapists believe that children are goal-oriented and that behaviors represent the child's best attempts at handling internal thoughts, emotions, and perceptions (Guerney, 2001; Wilson & Ray, 2018). Thus, the CCPT therapist does not seek to set goals for alternate behaviors or to change the child but instead to see through the child's eyes and understand the purpose of the behaviors (Wilson & Ray, 2018). In this accepting environment, change is a natural by-product of the innate drive toward self-actualization (Landreth, 2012). When the child feels prized, they demonstrate greater acceptance and compassion for self and others, less behavioral problems, and less internalization of problems, which result in improved relationships (Bratton et al., 2005; Muro et al., 2006).

Like CCPT therapists, Synergetic play therapists believe children will make better choices when they have internalized the proper conditions. In SPT, these conditions not only involve self-awareness and self-acceptance but also nervous system regulation (Dion, 2015). The SPT therapist draws from Interpersonal Neurobiology to create the following framework: a) all

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4 with and safe enough to be who they are (Landreth, 2012, pp. 209-210). The therapist does not
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6 direct the session, instruct, set rigid limits, or rescue the child from difficulty but rather is
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8 genuine, empathic, and shows unconditional positive regard so that the child is free to play out
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10 whatever is needed (Jayne & Ray, 2015b; Landreth, 2012). The therapist's role is to verbally and
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12 non-verbally communicate their presence with, acceptance of, and trust in the child so as to
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14 unlock the child's innate self-enhancing tendency (Guernsey, 2001; Landreth, 2012; Ray, 2019).
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19 Synergetic play therapists also strive to communicate acceptance as well as a message of
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21 "I can hold the energy, and I am willing to be real in this energy with you" (Dion, 2015, p. 76).
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23 The therapist is an active participant in the child's process and uses emotional congruence and
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25 verbal authenticity to support regulation of the child's nervous system. This genuineness creates
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27 a safe environment, like in CCPT, but with a different rationale. Because a child may become
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29 dysregulated when an adult's verbal and non-verbal signals are incongruent, an authentic
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31 therapist not only communicates acceptance but also helps regulate the child's nervous system
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33 (Dion, 2015; Siegel, 1999). The SPT therapist's role is to stay mindfully present in their own
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35 internal experience, maintain empathic attunement with the child, and flexibly respond to the
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37 child's play. When the therapist's verbal and non-verbal communications are congruent, the
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39 child will experience trust and safety, which sets the stage for the therapist to become the
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41 external regulator for the child's dysregulated states as they arise during play (Dion, 2015). The
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43 SPT therapist uses and models research-informed regulation strategies such as breathing,
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45 movement, and voicing the internal experience to support the child through a process of
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47 reflective awareness and change.
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55 In both models, the role of the therapist is more about being than doing. Neither model
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57 has a list of techniques that therapists employ. It is the therapist's presence that matters most.
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Both CCPT and SPT therapists strive to exhibit the qualities of congruence, empathy, and positive regard (Rogers, 1961). A core principle of SPT is the therapist's ability to be authentic in their expressions. This, coupled with the therapist modeling regulation in states of dysregulation, supports the child in staying on the edge of their window of tolerance to ultimately repattern the child's nervous system (Dion & Gray, 2014). In CCPT, there is no safety in the relationship without consistency and unconditional regard (Carnes-Holt, 2014). The philosophy of SPT adds that there is no safety without authenticity because the child's nervous system will respond to incongruence (Dion, 2015). Child-Centered play therapists trust in children's inherent abilities to bring themselves under control and move toward healthy ways of coping (Wilson & Ray, 2018). In contrast, SPT therapists believe in modeling behavior because children cannot do what they have not seen or been taught (Dion, 2015, 2018). Thus, a CCPT therapist is to be a co-journeyer; an SPT therapist additionally seeks to be a co-regulator.

Treatment Methodology

In this section, treatment methodology includes the progression of treatment, use of toys, types of therapeutic statements, and use of limit-setting.

Progression of Treatment

Child-Centered play therapists are non-directive and trust the child to lead the sessions because they believe that each child is unique and will progress at their own pace (Guerney, 2001). Therefore, therapists follow the child's lead in sessions to allow freedom and creativity to move toward self-actualization (Landreth, 2012). Though all children progress at their own pace, Landreth (2012) identified typical progressions of treatment seen in CCPT. The first stage of play is characterized by creative, exploratory, and relatively uncommitted play. The second stage involves increases in aggression as well as the amount the child talks about self and others. In the

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4 third stage, the child focuses on the connection with the therapist, engages in more dramatic play,
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6 and conveys emotions such as anger and anxiety. According to Landreth, this progression is
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8 evidence that children are accepting and expressing themselves more fully and directly.
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11 Building on and extending CCPT philosophy, Dion (2020a) outlined a three-step process
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13 of transformation for the child that highlights the role of the Synergetic play therapist in each
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15 step. In step one, the child begins to become aware that they are dysregulated and begins to
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17 explore the sensations, emotions, and thoughts through the projective process of setting up the
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19 therapist and the toys to feel how the child feels (e.g., if the child feels powerless, they will offer
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21 the therapist and the toys an experience of what it feels like to feel powerless). During this step,
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23 the therapist becomes the child's external regulator by verbally tracking the play and modulating
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25 the dysregulation through movement, breath, and vocalization of internal states, allowing the
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27 child to move toward the discomfort that is arising, thus bringing these internal states into the
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29 child's awareness more fully. During step two, the therapist presents alternative behavioral and
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31 cognitive patterns to the child by modeling and teaching within the play experience, usually in a
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33 non-directive format. The child then begins to realize that there are other choices. Finally, in step
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35 three, the child tries on a new choice once they perceive more benefits than drawbacks to making
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37 the new choice. The therapist highlights the behavioral and cognitive changes in the play to
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39 reinforce the pattern into the child's newly created neural network.
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48 Synergetic Play Therapy is both non-directive and directive in its application. According
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50 to Dion (2015), the SPT therapist typically begins in a non-directive manner similar to CCPT. As
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52 the child is working through the process, the SPT therapist will directly model ways to regulate
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54 the dysregulation in the nervous system (such as breathing, naming the experience, and/or
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56 rubbing hands together) and may bring in other specific interventions based on the child's needs
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(such as incorporating a parent or sibling into the play, engaging the child in more directive work with sand or art, and/or practicing specific breathing techniques). Synergetic play therapists incorporate various modalities that they perceive will best support the child with integration and healing while still allowing the child to be the expert in their own healing (Dion, 2018).

Use of Toys

Although the session itself is completely led by the child in Child-Centered Play Therapy, these therapists provide structure in their selections for toys. Landreth (2012) created guidelines for toys that should and should not be allowed in the playroom to maximize creativity, expression, imagination, and flexibility. In addition, Ray (2011) urged therapists to consider whether the toy serves a therapeutic purpose, facilitates the child's expression, and promotes relationship-building between the child and therapist. In CCPT, the toys are the language; therefore, the therapist focuses both on the toys used and the process of play (Landreth, 2012). To allow for creativity and autonomy, the toys are not labeled by the therapist until the child labels them (Giordano et al., 2012).

Synergetic play therapists use many of the same toys as prescribed in CCPT, although they differ in terms of the purpose of the toys and the quantity that may be needed. First and foremost, SPT is built on the assertion that the therapist is "the most important toy in the playroom" and that attunement facilitates the process of the child's work rather than the child needing specific toys through which to do the work (Dion, 2015, p. 156). In SPT, the toys themselves are not as important as the energy and emotions that arise as a result of how the child plays with the toys. Thus, toys and language are ultimately not required because play is understood to be something that can occur in the relationship between the therapist and the child (Dion, 2015). For example, play can occur through engaging in peek-a-boo or creating rhythms

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4 together using sound and tapping. The SPT therapist is more concerned with the affective states
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6 that arise within the child during play because these represent the dysregulation that the child
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8 experiences in life (Dion, 2015). Therefore, whereas therapists from both theories attend to the
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10 processes of play, SPT therapists are less concerned with the specific toys and more concerned
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12 with how the child's nervous system states are displayed through the play. For this reason, there
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14 is no rule regarding whether SPT therapists do or do not label toys before the child has labeled
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16 them, although the therapist typically is not the first to label the toy unless it is obvious.
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21 *Therapeutic Statements*

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23 Child-Centered Play Therapy also has more structure regarding therapeutic reflections
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25 (Landreth, 2012). Giordano et al. (2005) identified various types of verbalizations, including
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27 statements that track behavior, reflect emotions, return responsibility, and build esteem.
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29 Examples of each include (respectively): *You're lining them up straight, You're mad that it*
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31 *won't move, You can decide how to use that, and You know just how you want it to look.*
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35 Giordano et al. also recommended that responses be brief, flow smoothly with the play, return
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37 ownership to the child, and usually begin with *you*. However, these verbalizations cannot be used
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39 robotically without warmth, congruence, and empathy (Jayne & Ray, 2015a). These
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41 verbalizations are the vehicles that convey the therapist's acceptance of the child and thus
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43 intentionally promote the philosophies of CCPT (Wilson & Ray, 2018).
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48 Similar to CCPT therapists, Synergetic play therapists use observational statements. They
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50 expand on the reasoning for the use of these statements to include helping the child stay within
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52 their window of tolerance and/or titrate the energy in the room (Dion & Gray, 2014). A striking
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54 difference between the two modalities is that SPT therapists use a variety of self-reflective
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56 statements to name their experiences out loud in response to the child's play (Dion, 2015).
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4 Synergetic play therapists understand that self-reflection creates a sense of safety for the child,
5 similar to when a caregiver models self-reflection (Fonagy & Target, 2002). Just as children use
6 the reflective function of the caretaker to become curious about their experiences (Levy, 2011),
7 SPT therapists also engage in self-reflection to model and teach children about the world of
8 emotions. Naming internal experiences aloud allows a person to move through painful states and
9 helps regulate the nervous system (Siegel & Bryson, 2011), a primary focus of SPT. For
10 example, as the child stealthily brings the shark puppet closer, the therapist may say, *The shark is*
11 *coming closer. I feel scared and my heart is beating fast.* These statements help the therapist to
12 regulate their own nervous system, help the child to feel felt by the therapist, and provide the
13 child with both language and permission to describe their internal states (Dion, 2015).
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28 Both Child-Centered and Synergetic play therapists emphasize the need for authentic and
29 congruent responses. Landreth (2012) cautioned CCPT therapists against stating their
30 experiences so as not to influence the child's play. However, Ray et al. (2014) recommended that
31 verbalizations be congruent with the therapist's internal experience as long as the intensity is
32 appropriate and the statement benefits the therapeutic relationship. Aligning with Rogers' (1980)
33 view, the SPT therapist posits that the relationship deepens when the therapist's authentic
34 experiences are communicated. In SPT, therapist authenticity allows the child to become aware
35 of internal states, to manage these states and promote nervous system integration, and to
36 experience empathy for self and others (Dion & Gray, 2014). Because the SPT therapist does not
37 want to emotionally flood the child, there is a balance of observational and self-reflective
38 statements to enhance a neuroception of safety and help the child move toward the dysregulated
39 states (Dion, 2018). In both theories, therapeutic statements focus on therapist attunement and
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promotion of the child's self-acceptance; however, the wording of these reflections differs based on each theory's conceptualization of what is needed for self-awareness and self-acceptance.

Limit-setting

Differences also exist between Child-Centered Play Therapy and Synergetic Play Therapy in terms of limit-setting. In CCPT, limits are set when needed to ensure the safety of the child and/or property and are necessary to establish feelings of safety and consistency (Carnes-Holt, 2014; Jayne & Ray, 2015b). Limits are also set if the child's behavior is impacting the therapist's acceptance of the child, but the therapist must discern if the limit is to promote personal preferences or the relationship and must provide other outlets for the child to express the underlying emotion or desire (Ginott, 1959). In the ACT protocol created by Landreth (2012), the therapist acknowledges the child's feelings, communicates what the limit is, and targets alternatives for behavior. The therapist may say, *You're mad, and you want to hit me. I am not for hitting. You may pretend the doll is me and hit it.* These structured responses are not mandated, but they are encouraged because they capture the spirit of trying to connect with and empower the child while still maintaining boundaries. Limits are set with validation and warmth and preserve the relationship because the therapist can stay accepting of the child, and the child can experience decision-making and self-control without incurring guilt (Landreth, 2012).

Synergetic play therapists also set limits to maintain the integrity of the relationship, but the rationale is slightly different. Unless there is a safety issue—in which case, the therapist does whatever is needed to maintain safety—the therapist sets the boundary that is needed to allow the therapist to stay within their own window of tolerance (Dion, 2015). This allows for presence, attunement, and maintenance of the role as external regulator. The belief is that the therapists' window of tolerance is the container that holds the energy that is emerging from the play (Dion,

2018). In SPT, setting boundaries in this way allows the child to explore and express their dysregulated emotions and behaviors with the therapist's support to regulate through them, which ultimately facilitates integration of the emotions (Dion, 2015).

According to Dion (2015), when a boundary is needed, the therapist will acknowledge and redirect rather than say *no*. The SPT therapist first takes a deep breath to ground, gets present with the child so the child can energetically feel the therapist, uses a non-threatening yet serious voice, makes eye contact if possible, acknowledges before redirecting, and keeps their feelings out of it. The SPT therapist may say, *You are mad and want me to know. Show me another way.* The importance of setting boundaries in this way is so that the energy keeps moving and so that the child does not incur shame or guilt by internalizing messages that they did something wrong.

Therapists from both theories agree that limits are needed to help the therapist stay regulated and present with the child, to respect the child's process, and to maintain consistency without being overly controlling. However, the wording when setting the actual limit differs as well as the language used to explain the rationale for limits. Child-Centered play therapists explain limits in terms of remaining accepting, and SPT therapists explain limits in terms of remaining regulated, but both are focused on setting limits to maintain the relationship.

Importance of the Relationship

Both Child-Centered and Synergetic play therapists regard the therapeutic relationship as the most healing component of treatment (Dion, 2015; Landreth, 2012). In CCPT, the relationship is important because it communicates unconditional acceptance to the child, which then helps the child to develop unconditional self-acceptance (Landreth, 2012). Because the relationship *is* the therapy in CCPT, the therapist is intentional about creating a space in which the child feels accepted and empowered. Landreth (2012) described how the therapist builds this

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4 relationship through engaging with the child at the child's level through play, letting the child
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6 lead the session, and using therapeutic statements that communicate belief in the child. The
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8 relationship is thus strengthened because the child knows the therapist is present, attuned, and
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10 values the child's experiences (LaBauve et al., 2001; Landreth, 2012). A CCPT therapist may
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12 directly interact with the child in play when invited to do so, but playing with the child is
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14 secondary to being present with the child (Landreth, 2012).
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19 In Synergetic Play Therapy, the relationship is important because it is the vehicle for
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21 nervous system regulation and repatterning (Dion & Gray, 2014). Synergetic philosophy
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23 diverges from CCPT in that the SPT therapist must play a more active role in the relationship
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25 because the therapist, in addition to the toys, is understood to be a receiver of the child's
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27 projective process (Dion, 2015). The therapist holds dual awareness of the child's affect and their
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29 own emotional states and voices their internal experiences to facilitate reflective awareness for
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31 the child (Dion, 2018). Though these types of vocalizations may be seen as intrusive in CCPT,
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33 an SPT therapist sees this as a process whereby co-resonance and co-regulation can occur,
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35 thereby creating new neural pathways (Dion, 2015). By verbalizing and modeling, the therapist
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37 influences not only how the child relates to the therapist but also how the child relates to self.
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43 Creating safety in the relationship is a goal that is shared by both therapeutic modalities.
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45 In CCPT, the relationship is both necessary and sufficient; it *is* the therapy (Landreth, 2012). In
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47 SPT, the relationship is necessary but insufficient and also needs to be accompanied by attempts
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49 to increase awareness, nervous system regulation, and the ability to be in relationship with self
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51 and others. In CCPT, the relational emphasis helps the self to emerge; in SPT, the relational
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53 emphasis helps the self to emerge and the symptoms to integrate. Table 1 presents a summary of
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55 key ideas for both theories.
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Hypothetical Case Scenario

The following scenario highlights Child-Centered Play Therapy and Synergetic Play Therapy in action. By using the same hypothetical child, we demonstrate how a CCPT therapist and an SPT therapist would conceptualize the child, be with the child, set limits, and articulate therapeutic responses. To facilitate clarity, the child is referenced with male pronouns and the therapist with female pronouns.

Mom reports that her five-year-old son Ti has witnessed domestic violence between Mom and Dad, though Ti has not been abused. Ti becomes frustrated easily, cries, throws objects, and fights with the other students at school. In play therapy, Ti almost exclusively plays with the plastic animal figurines, having them fight against and kill each other. At least twice per session, Ti brings an animal over to attack the therapist's arms and face, laughing yet scowling as he does so. Occasionally, Ti grabs a doll and either hits it or throws it at the therapist.

Child-Centered Play Therapist Response

The Child-Centered play therapist always begins from the grounding philosophy that play is the language and toys are the words. She combines this philosophy with the *be with* attitudes that involve authentically communicating to the child that she fully sees him, hears him, cares about him, and is present. Ti's aggressive behavior is viewed under the fundamental construct that children have an innate tendency to move toward growth-enhancing experiences that create balance within the sense of self. The CCPT therapist believes that children are self-directed to play out what is concerning them in order to create developmentally appropriate understanding, integration, and inner balance in response to experiences. Therefore, Ti's aggressive play is understood as his way to explore the experiences that have created a sense of incongruence

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4 within his sense of self. Behaviors and emotions surface as Ti tries to explore ways to feel more
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6 successful in his current environment.
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9 The therapeutic relationship between the therapist and child is the necessary and
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11 sufficient component for healing and change. This involves the therapist being able to encompass
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13 unconditional positive regard without judgment or evaluation. As Ti continues to have the plastic
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15 animal figurines fight and kill one another, the therapist would track, reflect content, and reflect
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17 feeling. Some examples of typical CCPT responses would be, “The dragon is fighting the lamb,”
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19 and “The dog sounded scared when the lion came close” (assuming that the child has named
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21 these objects previously). The therapist would be mindful to enter into the child’s world without
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23 an attempt to direct, control, or impose new ideas or solutions to the child’s play. The child’s
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25 play and inner world are treated with the highest respect and belief that the child is capable of
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27 internal growth and healing.
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33 As Ti brings an animal over to attack the therapist’s arms and face while laughing and
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35 scowling, the therapist might simply track this play before assuming an emotional response
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37 because she is unsure what Ti might need from her in this moment. She might simply state, “The
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39 tiger is biting my arm,” followed by whispering to Ti, “I wonder what I should do next?” These
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41 statements communicate the belief that the child will give guidance to the therapist on what he
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43 needs next in the moment. The therapist is mindful to refrain from making statements that may
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45 create a sense of guilt or judgment such as, “It is not funny to laugh when people get hurt.”
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48 Similarly, she does not pretend to be hurt if that was not the child’s intention.
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53 Suddenly, Ti grabs a doll to throw at the therapist. If the therapist perceives she may be in
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55 danger of being hurt, she would implement the ACT limit-setting method and say, “Ti, I know
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57 you are angry and want to throw the doll at me, but I am not for throwing toys at. You can
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pretend the Bobo is me and throw the doll at it.” It is imperative that the limit is communicated to the child with a deep sense of genuine regard for his feelings and with a sense of a clear limit. She would attune to the child’s feelings and needs from this behavior without imposing her own feelings or thoughts connected to this play activity.

Synergetic Play Therapist Response

The Synergetic play therapist views Ti’s aggressive play from an understanding of Interpersonal Neurobiology including the idea that aggression is a normal biological response of sympathetic nervous system activation when a child perceives a threat or challenge. As Ti re-enacts the scenes of fighting that he witnessed, the therapist recognizes that he is using play to help her understand what it feels like to be him, including the difficult thoughts, emotions, sensations, and memories. The therapist also understands that Ti may need the support of an external regulator to help him continue to move toward the intensity without emotional flooding and to further support integration.

As the SPT therapist observes Ti’s play, she begins to make observational statements regarding what is happening. For example, “The animals are moving toward each other. Now they are fighting.” As the intensity increases, the SPT therapist begins to move toward the intensity to help modulate it. To do this, the therapist becomes aware of her own activation in order to stay present with Ti. The therapist regulates the intensity as needed to support Ti in staying in his window of tolerance by taking deeper breaths, moving, and possibly naming the internal states out loud. The SPT therapist also understands that emotional congruence is important for establishing a sense of safety; therefore, the therapist will make genuine statements and have an authentic response to Ti’s initiated play. "Watching them fight is scary and feels

intense in my body," the therapist might say, understanding that she is being set up to witness violence and experience his world.

When Ti laughs while his animal attacks the therapist's arms and face, the therapist demonstrates a genuine startle response and states, "Ow! The animal is attacking me. I feel scared and confused. There's laughing while I'm getting attacked." When Ti returns to his play of the animals fighting, the therapist may take a deep breath, rub her arms where she was "hurt," and gently rock her body. The therapist continues to use both a combination of observational statements and self-reflections including now naming the anxiety and hypervigilance of not knowing if or when she will be attacked again.

Suddenly, Ti grabs a doll and throws it at the therapist. If the therapist feels that this is outside of her window of tolerance, she would acknowledge the child's action and then redirect by saying, "You're angry, and you want me to know. Show me another way." If the therapist felt that this action was within her window of tolerance and that there was not a safety issue, she would offer another authentic response such as, "That was scary and startling. I didn't know if I was going to get hurt. I don't know if the baby is hurt." Throughout, the therapist remains deeply connected and in tune with Ti while also staying connected to herself.

Scenario Summary

In this scenario, the CCPT therapist's belief in self-actualization is evident as the child's behaviors are tracked without the therapist imposing her interpretation of the behaviors. The relationship is the mechanism of change. The SPT therapist becomes the external regulator, attuning and modulating both the child's and her own activation, by verbalizing authentic responses to the play. The child learns how to self-regulate and repattern his nervous system as his challenges are integrated. The hypothetical scenario allows a better understanding of the

nuances between CCPT and SPT by highlighting some key points of each theoretical orientation and showing theory-in-action.

Conclusion

This article is theoretical in nature because only two known studies to date have examined the outcomes of Synergetic Play Therapy (Dion & Gray, 2014; Simmons, 2020). No known studies have examined the efficacy of CCPT versus SPT, the mechanisms behind how SPT might differ from CCPT, or whether one approach is better suited for specific clients. More research is needed in these areas. With SPT's overt emphasis on co-regulation to repattern a child's dysregulated nervous system, it is possible that SPT may reach children who have not responded to CCPT and/or that SPT may augment CCPT to improve outcomes, although more research is needed to corroborate the findings in the case study by Simmons (2020).

Child-Centered Play Therapy has a long-standing history; Synergetic Play Therapy grew from the roots of CCPT and adds concepts from various theories. The foundation of CCPT is obvious in SPT's emphasis on the relationship, the Rogerian conditions, goal-driven behaviors, self-awareness, and self-acceptance. Therapists in both schools emphasize the relational underpinnings of limits, toys, and therapeutic statements, but their practices and use of language differ. In SPT, therapists more freely verbalize their personal experience of the child's initiated play to promote awareness and regulation. Synergetic Play Therapy also adds an emphasis on regulation and helping repattern the activation in the child's nervous system, thus contributing neurobiological research to explain the benefits seen in the play therapy process. The overarching goal of both theories is the same: to help the child improve functioning both on an intrapersonal and interpersonal scale.

References

- Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. W. W. Norton & Company, Inc.
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376–390. <https://doi.org/10.1037/0735-7028.36.4.376>
- Carnes-Holt, K. (2014). An interview with Garry Landreth: Play therapy, humanism, and the future of counseling. *Journal of Humanistic Counseling*, 53(1), 47–62. <https://doi.org/10.1037/0735-7028.36.4.376>
- Dion, L. (2015). *Integrating extremes: Aggression and death in the playroom*. Aviva Publishing.
- Dion, L. (2016, August 1). *How a tragedy inspired a new play therapy model*. Synergetic Play Therapy Institute. <http://synergeticplaytherapy.com>
- Dion, L. (2018). *Aggression in play therapy*. W. W. Norton & Company, Inc.
- Dion, L. (2020a). *Process of change*. Synergetic Play Therapy Institute. <http://synergeticplaytherapy.com>
- Dion, L. (2020b). *Tenets for synergetic play therapy*. Synergetic Play Therapy Institute. <http://synergeticplaytherapy.com>
- Dion, L., & Gray, K. (2014). Impact of therapist authentic expression on emotional tolerance in synergetic play therapy. *International Journal of Play Therapy*, 23(1), 55–67. <https://doi.org/10.1037/0735-7028.36.4.376>
- Eisenberg, N., Fabes, R. A., & Murphy, B. C. (1996). Parents' reactions to children's negative emotions: Relations to children's social competence and comforting behavior. *Child Development*, 67, 2227–2247. <https://doi.org/10.2307/1131620>

- 1
2
3
4 Fonagy, P., & Target, M. (2002). Early intervention and the development of self-regulation.
5
6 *Psychoanalytic Inquiry*, 22(3), 307–335. <https://doi.org/10.1080/07351692209348990>
7
8
- 9 Ginott, H. G. (1959). The theory and practice of “therapeutic intervention” in child treatment.
10
11 *Journal of Consulting Psychology*, 23(2), 160–166. <https://doi.org/10.1037/h0046805>
12
13
- 14 Giordano, M., Landreth, G., & Jones, L. (2005). *A practical handbook for building the play*
15
16 *therapy relationship*. Jason Aronson.
17
18
- 19 Guerney, L. (2001). Child-centered play therapy. *International Journal of Play Therapy*, 10(2),
20
21 13–31. <https://doi.org/10.1037/h0089477>
22
23
- 24 Hudspeth, E. F., & Matthews, K. (2016). Neuroscience and play therapy: The neurobiologically-
25
26 informed play therapist. In K. O’Connor, C. Schaefer, & L. Braverman (Eds.), *Handbook*
27
28 *of play therapy* (2nd ed., pp. 583–597). John Wiley & Sons.
29
30
- 31 Jayne, K. M., & Ray, D. C. (2015a). Play therapists’ demonstration of the attitudinal conditions
32
33 in child-centered play therapy. *Person-Centered & Experiential Psychotherapies*, 14(2),
34
35 119–136. <http://dx.doi.org/10.1080/14779757.2014.952899>
36
37
- 38 Jayne, K. M., & Ray, D. C. (2015b). Therapist-provided conditions in child-centered play
39
40 therapy. *Journal of Humanistic Counseling*, 54(2), 86–103.
41
42 <http://dx.doi.org/10.1002/johc.12005>
43
44
- 45 LaBauve, B. J., Watts, R. E., & Kottman, T. (2001). Approaches to play therapy: A tabular
46
47 overview. *TCA Journal*, 29(1), 104–113.
48
49 <https://doi.org/10.1080/15564223.2001.12034583>
50
51
- 52
53 Landreth, G. L. (2012). *Play therapy: The art of the relationship* (3rd ed.). Routledge.
54
- 55 LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling*
56
57 *Psychology Quarterly*, 14(2), 149–163. <https://doi.org/10.1080/09515070110059142>
58
59
60
61
62
63
64
65

- 1
2
3
4 Levy, A. J. (2011). Neurobiology and the therapeutic action of psychoanalytic play therapy with
5
6 children. *Clinical Social Work Journal*, 39(1), 50–60. [https://doi.org/10.1007/s10615-](https://doi.org/10.1007/s10615-009-0229-x)
7
8 [009-0229-x](https://doi.org/10.1007/s10615-009-0229-x)
9
10
11 Liddle, H. A. (1982). On the problems of eclecticism: A call for epistemologic clarification and
12
13 human-scale theories. *Family Process*, 21, 243–250. [https://doi.org/10.1111/j.1545-](https://doi.org/10.1111/j.1545-5300.1982.00243.x)
14
15 [5300.1982.00243.x](https://doi.org/10.1111/j.1545-5300.1982.00243.x)
16
17
18
19 Lin, Y.-W., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy
20
21 approaches. *Journal of Counseling & Development*, 93(1), 45–58.
22
23 <https://doi.org/10.1002/j.1556-6676.2015.00180.x>
24
25
26 Muro, J., Ray, D., Schottelkorb, A., Smith, M. R., & Blanco, P. J. (2006). Quantitative analysis
27
28 of long-term child-centered play therapy. *International Journal of Play Therapy*, 15(2),
29
30 35–58. <https://doi.org/10.1037/h0088914>
31
32
33 Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions,*
34
35 *attachment, communication, and self-regulation*. Norton.
36
37
38 Porter, M. L., Hernandez-Reif, M., & Jessee, P. (2009). Play therapy: A review. *Early Child*
39
40 *Development and Care*, 179(8), 1025–1040. <https://doi.org/10.1080/03004430701731613>
41
42
43 Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and*
44
45 *skills for child practice*. Routledge.
46
47
48 Ray, D. C. (2019). The child and the counselor: Relational humanism in the playroom and
49
50 beyond. *Journal of Humanistic Counseling*, 58(1), 68–82.
51
52 <https://doi.org/10.1002/johc.12090>
53
54
55
56
57
58
59
60
61
62
63
64
65

Ray, D. C., Armstrong, S. A., Balkin, R. S., & Jayne, K. M. (2015). Child-centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, 52(2), 107–123.

<https://doi.org/10.1002/pits.21798>

Ray, D. C., Jayne, K. M., & Stulmaker, H. L. (2014). A way of being in the playroom: Experience-expression congruence model (EECM). *International Journal of Play Therapy*, 23(1), 18–30. <https://doi.org/10.1037/a0035512>

Ray, D. C., Lee, K. R., Meany-Walen, K. K., Carlson, S. E., Carnes-Holt, K. L., & Ware, J. N. (2013). Use of toys in child-centered play therapy. *International Journal of Play Therapy*, 22(1), 43–57. <https://doi.org/10.1037/a0031430>

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Company.

Rogers, C. R. (1980). *A way of being*. Houghton Mifflin Company.

Schmidt, S. J. (2009). *The Developmental Needs Meeting Strategy: An ego state therapy for healing adults with childhood trauma and attachment wounds*. DNMS Institute, LLC.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Erlbaum.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. The Guilford Press.

Siegel, D. J. (2010). *Mindsight: The new science of personal transformation*. Bantam Books.

Siegel, D. J., & Bryson, T. P. (2011). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*. Delacorte Press.

1
2
3
4 Simmons, J. (2020). Moving toward regulation using synergetic play therapy. *Canadian Journal*
5
6
7 *of Counselling and Psychotherapy*, 54(3), 242–258. <https://cjc->

8
9 [rcc.ucalgary.ca/article/view/69443](https://cjc-rcc.ucalgary.ca/article/view/69443)

10
11 Wheeler, N., & Dillman Taylor, D. (2016). Integrating interpersonal neurobiology with play
12
13
14 therapy. *International Journal of Play Therapy*, 25(1), 24–34.

15
16 <https://doi.org/10.1037/pla0000018>

17
18
19 Wilson, B. J., & Ray. D. (2018). Child-centered play therapy: Aggression, empathy, and self-
20
21
22 regulation. *Journal of Counseling & Development*, 96(4), 399–409.

23
24 <https://doi.org/10.1002/jcad.12222>

25
26
27
28
29
30
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CCPT AND SPT

Table 1*Summary of Key Ideas in CCPT and SPT*

Dimension	CCPT	SPT
Background and philosophy	<p>Roots: Person-Centered Therapy and relational humanism.</p> <p>Problem: Incongruence from lack of core conditions.</p> <p>Solution: Warm, empathic, congruent therapeutic relationship.</p>	<p>Roots: CCPT, IPNB, attachment theory, Gestalt Therapy, Experiential Play Therapy.</p> <p>Problem: Nervous system dysregulation and detaching from core self.</p> <p>Solution: Repatterning the nervous system through attunement and external regulation leads to internal regulation and reattachment to self.</p>
Goals for therapy	<p>No formal goals are set; change results from being free to change.</p> <p>Core objectives include self-insight, self-responsibility, and self-acceptance.</p>	<p>Goals are individualized according to symptoms of nervous system dysregulation.</p> <p>Core objective is to help child reattach to self and learn how to regulate through difficult thoughts, feelings, and sensations.</p>
Role of therapist	<p>Communicate acceptance of, presence with, and trust in the child.</p> <p>Offer core conditions.</p>	<p>Communicate acceptance and become the external regulator.</p> <p>Co-regulate toward challenging internal experiences.</p>
Progression of treatment	<p>Non-directive.</p> <p>3 stages of play: Exploratory and creative, aggressive and communicative, and connected and dramatic.</p>	<p>Both directive and non-directive.</p> <p>3 stages of play: Awareness and set-up, learning new regulation strategies and ways to see challenges, and experimenting with new behaviors.</p>
Use of toys	<p>Only toys that maximize creativity, expression, imagination, and flexibility are allowed in the playroom.</p> <p>Toys are the vehicle for expression.</p>	<p>Toys are ultimately not required because the therapist is the most important toy in the playroom.</p> <p>The child will set up both the toys and the therapist to feel as the child feels.</p>
Therapeutic statements	<p>Various types include statements that track behavior, reflect feelings, return responsibility, and build self-esteem.</p>	<p>Combination of observational statements and self-reflective statements to develop awareness and regulatory capacity.</p>
Limit-setting	<p>Ensures safety of the child, therapist, and property, helps maintain therapist's acceptance of the child.</p> <p>Acknowledge feelings, communicate the limit, target alternative behavior.</p>	<p>Helps therapist remain in their window of tolerance to maintain the role of external regulator, except in safety scenarios.</p> <p>Acknowledge and re-direct to keep the energy moving.</p>
Importance of relationship	<p>Necessary and sufficient.</p> <p>Relationship helps the self to emerge.</p>	<p>Necessary but insufficient.</p> <p>Relationship plus co-regulation helps the self to emerge and the symptoms to integrate.</p>