A publication of the Canadian Association for Play Therapy (CAPT)

Playground

Winter 2026

Incorporating Families into Therapy: The Beauty of Filial Therapy (part 2)

Theraplay®

Emotional Intelligence Development in Children's Play Therapy

Synergetic Play Therapy: History, Science and Clinical Applications

Animal-Assisted Therapy: A Story About Getting Started

CANADIAN ASSOCIATION FOR PLAY THERAPY

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GRAPHIC DESIGN & PRODUCTION
Catalyst Creative Inc., Calgary, AB

Publications Mail Agreement #42054516

Playground
Canadian Association for Play Therapy

Contents

CAPT Foundation Play Therapy Training 2026

Training will be presented on-line in one or two-day trainings with individual instructors over a period of six weeks. Each day offers six educational units toward the 180 educational units required for Foundation Play Therapy Training for Certification as a Play Therapist.

Live On-line Instructor Lead Individual Full Days of Training for 2026

May 4 – 15, 2026

- Introduction to Play Therapy
- Play Therapy History, Models and Process (2 days)
- Assessment & Treatment Planning in a Play Therapy Setting
- Ethical Practice in a Play Therapy Setting
- Using Play with Families
- Non-Directive Play Therapy and Filial Therapy (2 days)
- Attachment Theory and Therapy in a Play Therapy Setting
- Theraplay as a Play Therapy Model

June 8 – 19, 2026

- Using Sandtray in Play Therapy (2 days)
- Brain Research and Child Development in a Play Therapy Setting
- Understanding Traumatized Children and Applying Play Therapy Tools in the Treatment of Trauma in Children
  Day 1: Physical and Emotional Abuse
  Day 2: Sexual Abuse
- Creating an Inclusive and Culturally Competent Play Therapy Practice
- Storytelling in a Play Therapy Tool
- Understanding and Treating Anxious Children using Play Therapy
- Play Therapy with Abused Children
  Day 1: Physical and Emotional Abuse
  Day 2: Sexual Abuse

August 3 – 14, 2026

- Treating Disruptive Behaviour Problems in a Play Therapy Setting (2 days)
- Art Therapy in a Play Therapy Setting
- Play Therapy with Adults
- Group Therapy in a Play Therapy Setting
- Play Therapy for Children and Families Coping with Loss (2 days)
- Using Puppet as a Play Therapy Tool
- Vicarious Trauma and Self Care in a Play Therapy Environment
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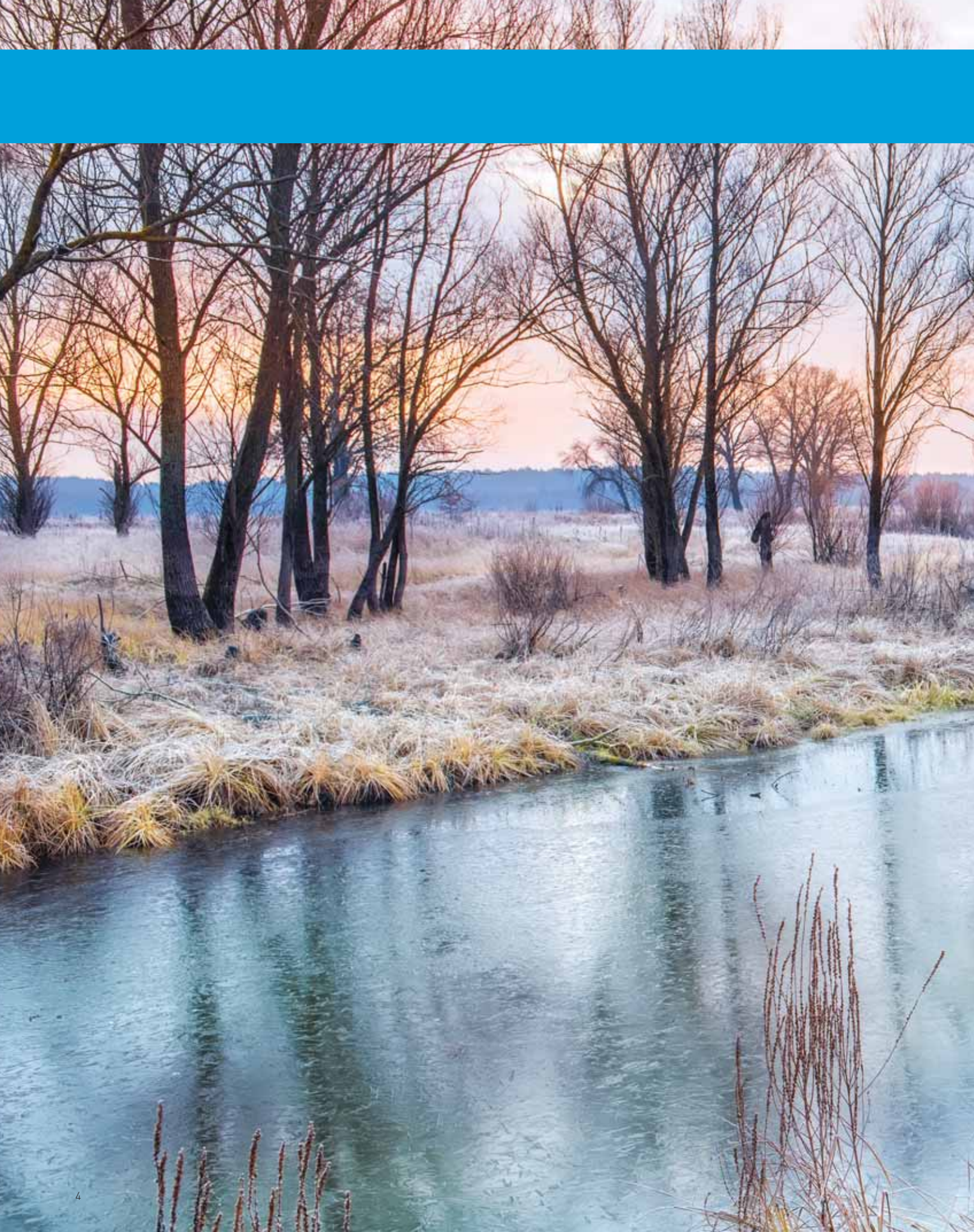

Message from the Executive Director

Greeting CAPT Members,

I'm truly honoured to have been selected as the new Executive Director of the Canadian Association for Play Therapy. Over the past two weeks, I've received so many warm messages of welcome—thank you! Your kind words have meant a lot as I step into this new role.

As many of you know, my relationship with CAPT goes back more than 30 years—as a board member, committee member, and trainer. Now, I'm putting on a new hat (maybe more like a Sombrero), and I'm genuinely excited about the year ahead.

The past year has brought some challenges with the departure of our previous Executive Director. But thanks to an incredible team, the heart and work of the Association kept beating strong. Kevin heroically juggled two hats, supported by Nicole, Ineke and Liz as executive members. Our dedicated board—Caileigh, Hannah, Justine, and Lindsay—provided steady leadership. A special shout-out to our talented training team—Kip, Elizabeth, and Theresa—who ensured another successful year of training.

Our committees, led by Hannah, Lindsay, Donna, Ricky, Krysteli and Barbara, continued their important work with energy and commitment. And let's not forget the various contractors who quietly but consistently keep our "ship" afloat behind the scenes. I know I may have missed mentioning some individuals, but please know your contributions are deeply valued.

In these early weeks, one theme that has surfaced clearly is communication. The gap created by not having an Executive Director for a time has understandably made it harder for inquiries and issues to be addressed promptly. Strengthening our communication processes will be one of my top priorities moving forward.

The recent needs assessment has provided a wealth of insight into what's working well and where we can grow. I'll be reviewing the themes that emerged and working closely with the Board to develop a clear plan to address them—together.

My long history with CAPT and my ongoing passion for play therapy are what inspire me to take on this new role. CAPT has always been more than just an association—it's a vibrant community that trains, advocates, and champions the power of play in mental health.

I look forward to connecting with you throughout the year, hearing your ideas, and continuing to build this amazing organization together. You can always reach me at: ed@canadianplaytherapy.com — I'd love to hear from you.

Let's keep making play a part of everyone's lives!

Warmly,

Greg Lubimiv
Executive Director, CAPT

Theraplay®

Michelle Wolfe Miscio MSW, RSW, CPT-S,
Certified Theraplay Practitioner

Please note: Article is republished due to an omission in the "Theraplay Dimensions" table (pg 5) in the 2024 fall issue of Playground.

Theraplay® is a relationship-focused Play Therapy model rooted in attachment theory. It is modeled after healthy parent-child interactions associated with secure attachment (Booth & Jernberg, 2010). The focus of Theraplay treatment is the relationship between caregiver(s) and child, with the goal being to "enhance attachment, increase self-regulation, promote trust and joyful engagement, and empower parents to continue … the health-promoting interactions developed during the treatment sessions" (Booth & Jernberg, 2010, p. 3)

Booth and Jernberg (2010) identify seven core concepts of this model. According to them:

Theraplay is

- Interactive and relationship based;
- A direct, here-and-now experience;
- Guided by the adult [therapist/practitioner and caregivers];
- Responsive, attuned, empathic, and reflective;
- Geared … to the preverbal, social-emotional, right-brain level of development;
- Multisensory, including an extensive use of touch
- Playful (p.42).

Positive healthy touch is an important component of Theraplay. Not only is touch between caregivers and infants necessary for survival, research on touch indicates its importance throughout the lifespan for social development, physiological and intellectual development, regulating stress, and body image (Booth & Jernberg, 2010). Some children may feel anxious or avoid touch for various reasons; therefore, it is necessary that the practitioner and caregiver are attuned to the child's response and use touch in a way that can be accepted by the child (Booth & Jernberg, 2010)..

Theraplay activities fall into four dimensions, which Booth and Jernberg (2010) consider essential to developing healthy attachment relationships: engagement, nurture, structure and challenge. Table 1 describes these dimensions and some corresponding activities.

Each Theraplay session is structured similarly, with opening activities followed by a series of activities incorporating the four dimensions and closing activities, entirely led by the adults. A typical session including the practitioner, child and caregiver(s) may look like this:

Table 1: Theraplay® Dimensions

DIMENSION	DESCRIPTION	EXAMPLES
Engagement	Caregivers "provide attuned, playful experiences that create a strong connection, an optimal level of arousal, and shared joy" (Booth & Jernberg, 2010, p. 21).	Peek-a-boo Tinfoil imprints of body parts Piggyback ride Clapping games
Nurture	Caregivers provide child with a sense of self-worth through caring, empathic responses that are "warm, tender, calming, and comforting" (Booth & Jernberg, 2010, p. 21).	Blanket swing Feeding child Checking and caring for hurts Face painting
Structure	Caregivers provide child with a sense of safety and regulation through organized, predictable sequences of activities and responses (Booth & Jernberg, 2010).	Hand stacking Red light, green light Trace around hand/foot Measure body parts
Challenge	Caregivers provide a secure base that encourages child "to take risks, to explore, to feel confident, and to enjoy mastery" (Booth & Jernberg, 2010, p. 21).	Punch sheets of newspaper Crush newspaper and throw into basket made by adult's arms. Balancing activities Thumb wrestling

- Practitioner warmly greets child and caregiver(s) upon arrival.
- Everyone enters therapy room in a special way which is a surprise each week.
- Checkup in which the adults look for hurts on the child and put lotion on them.
- Caregiver and child play "row your boat" with different tempos.
- Everyone keeps a balloon in the air, hitting it with one specific body part.
- Simon Says.
- Pass funny faces to each other.
- Put temporary tattoo on child's arm.
- Caregiver feeds child goldfish crackers.
- Closing ritual which includes a song and special handshake.
- Adults help the child to put on shoes/coat.
- Caregiver(s) and child leave the session holding hands.

The recommended course of Theraplay treatment is 18-25 sessions for mild to moderate issues (Booth and Jernberg, 2010). This includes a caregiver interview, a Marschak Interaction Method (MIM) assessment, caregiver feedback sessions and caregiver-child sessions. Four follow up sessions over the year following treatment are also recommended. While treatment focuses on one individual child, more than one caregiver may be involved, and it is considered most beneficial when all important caregivers are using this attuned approach (Booth and Jernberg, 2010).

History of the Model

Theraplay was developed in the late 1960's-early 1970's in response to the lack of available treatment for children in need of psychological services in the Chicago area (Booth & Jernberg, 2010). Ann Jernberg & Phyllis Booth collaborated to develop a treatment program modeled on healthy parent-child interactions. Borrowing from the works of Viola Brody who emphasized the nurturing relationship between child and therapist, Austin Deslauriers who incorporated Bowlby's ideas about attachment theory, and Ernestine Thomas' strength-based view of children, Theraplay was born (Booth & Jernberg, 2010). The Theraplay® Institute was developed in 1971 and became a not-for-profit corporation in 1995, offering information, training, supervision and certification in Theraplay.

Over the years, with the production of films, publications and research demonstrating its effectiveness, Theraplay has gained more acceptance and support as a therapeutic treatment model. It is practiced worldwide, and the Association for Play Therapy (APT, 2024) identifies Theraplay as a historically significant Play Therapy approach.

Research of Efficacy as a Family Therapy Model

Theraplay has been researched extensively. The Theraplay® Institute (2024) lists 36 peer-reviewed articles on its website and research is continuing (Norris & Lender, 2020). The California Evidence-Based Clearinghouse (CEBC) rated Theraplay as Promising, while the US Substance Abuse and Mental Health Services Administration (SAMHSA) accepted Theraplay for inclusion on the national registry for evidence-based programs and practices (Theraplay® Institute, 2024).

A recent study of Theraplay with clinically anxious mothers and children found that anxiety scores decreased (Smithee et al, 2021). Another study with children and their parents in a psychiatric outpatient setting demonstrated that Theraplay was able to increase the quality of parent-child interaction and reduce the internalizing and externalizing symptoms of children (Salo et al, 2020).

Whole Family Theraplay (WFT) integrates Theraplay with Family Systems Theory, including parents and all siblings in the family. A study with adoptive families demonstrated improvement in family communication, interpersonal relational skills of adoptive parents and overall behavioural functioning of the children (Weir, Lee, et al, 2013). Another study on WFT with mothers in recovery from substance use and their children found that family systemic functioning improved, as well as symptom distress and overall functioning of mothers. The children showed improvement in interpersonal relations, intrapersonal distress and overall well being (Weir, Pereyra, et al, 2021).

Additional research has been conducted on the use of Theraplay for attachment with mothers and children who experienced domestic violence, children displaying emotional and behavioural difficulties and diagnosable psychiatric problems as well as children with Autism Spectrum Disorder (France, McIntosh and Woods, 2023).

Risks and Benefits with Specific Populations

Theraplay provides an opportunity for caregivers and their child to fully engage with each other while becoming close both physically and emotionally. It teaches caregivers to become attuned to their child so the child "gains a true sense of herself and the parent sees the child for who she is" (Booth and Jernberg, 2010, p. xxii). The fun and playful interactions during sessions create joy while the child learns important relationship skills and a sense of safety (Booth and Jernberg, 2010).

While Theraplay is effectively used with children to build secure and trusting relationships, some issues and challenges may require a more integrative approach, such as Theraplay in combination with Dyadic Developmental Psychotherapy, EMDR or Cognitive Behavioural Play Therapy (Hong and Coleman, 2023).

Theraplay requires a high level of commitment from caregivers, who need to be emotionally stable, capable of self-reflection and insight into their child's behaviour and willing to participate fully. Practitioners need to be clear with caregivers about what is involved in treatment and what is expected of them

Ideal Populations

Theraplay has been used with many different populations to address several presenting concerns. In their book Theraplay®, Booth and Jernberg (2010) include chapters on the application of Theraplay for children with regulation disorders, autism spectrum disorders, histories of complex trauma, and children who are adopted or in foster care. There are also chapters about Theraplay with adolescents and group Theraplay. As mentioned earlier, research has also been conducted on the use of Theraplay with other populations.

Training and Supervision Requirements

Theraplay® is a registered service mark of The Theraplay® Institute, Chicago, IL. People interested in becoming Certified Theraplay® Practitioners are required to have a Master's degree in a mental health field specializing in working with children and families, and be allowed to practice independently. More details about certification can be found on the Theraplay® Canada website (https://www.theraplaycanada.ca/certification).

Tools Needed

The primary tool of Theraplay is the relationship between the adults and child in sessions. Sessions are recorded for review by the practitioner and with caregivers, so a recording device is necessary. The MIM assessment activities require items such as: squeaky toys, blocks, paper, pencil, lotion, hats and food. During Theraplay treatment sessions, however, very few items are needed and when an activity does call for something, it is often as basic as pillows, lotion, cotton balls or food.

Case Example

A 6-year-old boy who had experienced neglect and abuse was placed in a foster home with experienced caregivers. He presented with toileting issues, nightmares and aggression. Shortly after his placement, the foster mother and child were involved in Theraplay. The focus of caregiver-child sessions was to help the child feel secure by building a trusting relationship between him and the

foster mother. Caregiver sessions with the foster mother helped her to better understand the child, learn how to provide attuned caregiving, and taught her how to do the Theraplay activities while understanding the rationale for them. She also learned activities to do at home with the child throughout the week, such as checking and caring for hurts, to build on the work being done in sessions. She taught these activities to the foster father so they could all participate at home.

In one parent session, the foster mother shared that one day she noticed the child was feeling angry and was beginning to escalate toward aggressive behaviour. She tried one of the Theraplay activities that both she and the child had enjoyed in sessions (newspaper punch). This activity allowed the child to express the anger in a safe way and to calm down without escalating further.

At the end of Theraplay treatment, the child was more emotionally regulated and experienced fewer nightmares. The toileting issues, in combination with medical treatment, had also improved. The foster mother was more attuned to the child's signals and was able to support and co-regulate with him. The child demonstrated more comfort with the foster mother, allowed more physical closeness and accepted nurturing from her. A strong sense of family had developed in the home.

Recommended Books and Resources

Books:

- Theraplay®: Helping Parents and Children Build Better Relationships Through Attachment-Based Play (3rd Ed) (Phyllis Booth and Ann Jernberg, 2010).
- The Practitioner's Guide to Theraplay® (Vivien Norris and Dafna Lender, 2020).
- Parenting with Theraplay®: Understanding Attachment and How to Nurture a Closer Relationship with Your Child (Helen Rodwell and Vivien Norris, 2017).
- Theraplay®: Innovations and Integration (Rana Hong & A. Rand Coleman, 2023)

Websites:

- Theraplay® Canada: https://www.theraplaycanada.ca/
- The Theraplay® Institute: https://theraplay.org/the-theraplay-institute/

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About the Author

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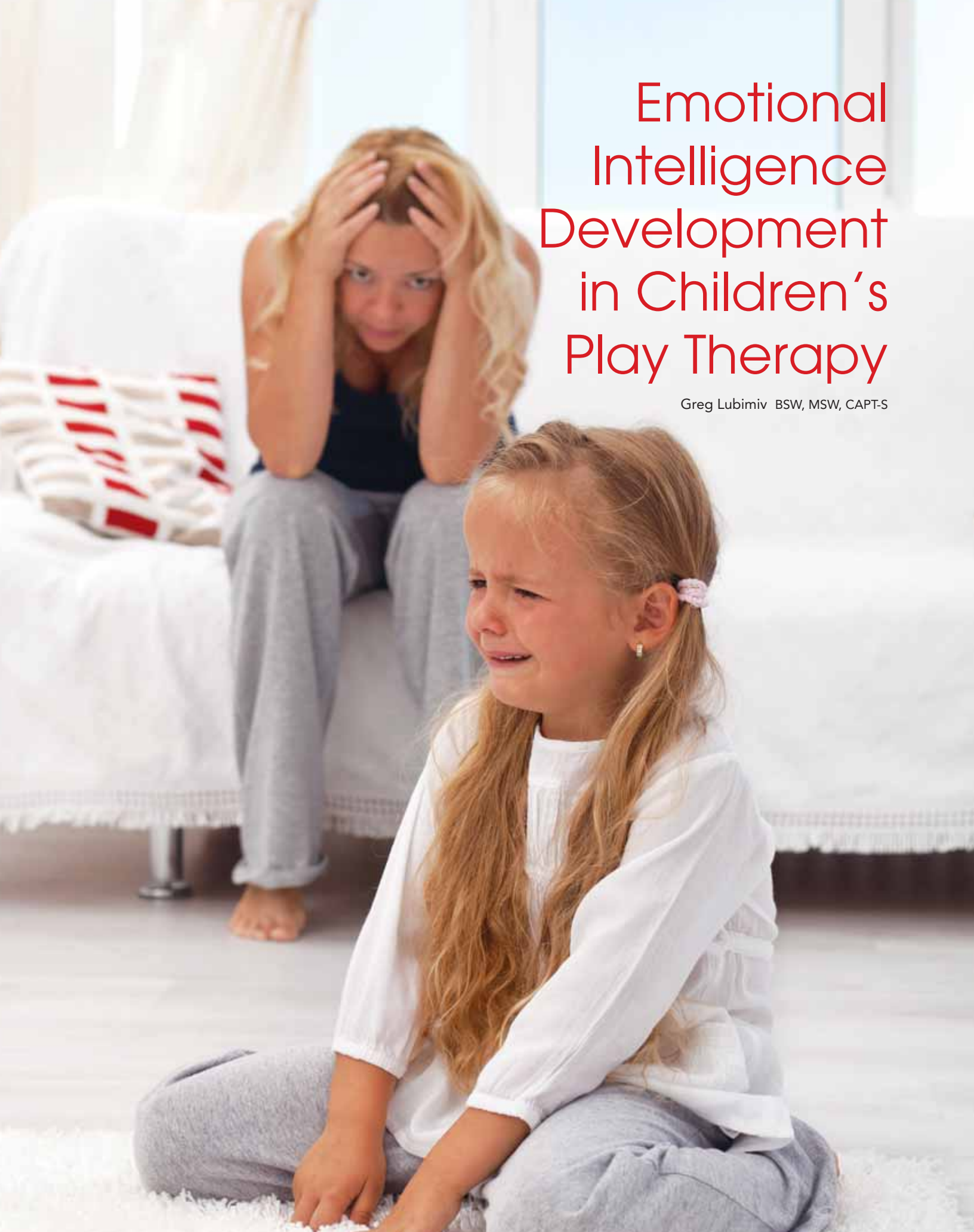
Michelle has been working with children, youth and families for over 20 years. She offers Play Therapy and Theraplay® supervision and can be contacted at: michelleawolfe@yahoo.ca.



Emotional Intelligence Development in Children's Play Therapy

Greg Lubimiv BSW, MSW, CAPT-S

Importance of Emotional Intelligence: Emotional intelligence (EI) is foundational to children's mental health, learning, and social functioning. Building emotional skills early has been linked to improved academic performance, positive social behavior, and reduced psychological distress. In other words, children who can understand and manage emotions tend to do better in school and form healthier relationships (Greenberg, 2023) This makes EI a critical focus in play therapy, where clinicians use play to nurture emotional development.

Stage 1: Identifying and Labeling Emotions

The first stage of emotional development is learning to recognize and name feelings. Young children gradually expand their emotional vocabulary. By around age 3–4, most can identify about four to five basic emotions (e.g. happy, sad, fear, anger). By age 6–8, children recognize additional feelings (~7 or more), including more nuanced emotions like frustration or excitement. By late childhood (8+ years), many can discern a dozen or so distinct emotions, even distinguishing similar ones (for example, telling apart disappointment vs. sadness or anger vs. jealousy). Play therapy strategy: To support this skill, therapists often use games or creative activities that practice emotion naming. For example, using picture cards or puppets with different facial expressions, children can practice labeling the feelings ("This puppet looks angry") and learn new emotion words. A playful face-imitating game – making a "mad" or "happy" face and having the child name it – is an engaging way to build emotional vocabulary.

Stage 2: Expressing Emotions to Others

Once children can identify feelings, they learn to express those emotions to others in appropriate ways. This ability typically blossoms around age 3–4 as language skills improve. Instead of only showing emotions through behaviors (e.g. tantrums or crying), a preschooler starts to say "I feel sad" or "I'm mad at you." By about 4 years old, many children begin to use words to communicate feelings rather than acting them out (e.g. saying "I'm angry" instead of hitting). Play therapy strategy: Play provides a safe practice ground for healthy expression. Therapists might encourage children to role-play emotions with dolls or puppets – for instance, a puppet can "tell" a story about being scared or sad, and the child helps the puppet express those feelings in words. Art and sandplay can also give young clients a way to symbolically express emotions to the therapist. One simple activity is the "feelings check-in" during play: a child might place a toy on a "feeling thermometer" or choose a crayon color to show how they feel, thereby actively communicating their internal state.

Stage 3: Understanding Cause and Effect of Emotions

Around early school age (often by ~5 years old), children begin to understand why they or others feel a certain way. They start linking emotions to causes ("I'm angry because I can't play outside") and grasp that external events or situations trigger feelings. This emotional reasoning grows as their cognitive empathy develops. For example, a 6-year-old can comprehend that a peer is crying because the peer's parent left on a trip, even if the emotion isn't directly observable. In therapy, this stage is about helping the child make those connections between feelings and triggers. Play therapy strategy: Therapists may use storytelling and play scenarios to build cause-effect understanding. A clinician might engage the child with a storybook or figurine scenario and then ask, "What made the doll feel sad? What happened first?" This prompts the child to identify the event behind the emotion. Another activity is creating a feelings scrapbook or drawing scenes: the child draws a face and the "story" of why that character feels that way, which the therapist and child then discuss. Such playful exploration helps the child learn that emotions are responses to specific situations – a key insight for emotional intelligence.

Stage 4: Developing Emotion Regulation

The ability to regulate emotions – to manage strong feelings and calm oneself – typically begins to solidify around age 5 and continues developing throughout childhood. As the brain matures and prior skills (identifying, expressing, understanding) are in place, children slowly gain better "emotional control." They move from relying on adults to soothe them toward using self-soothing techniques learned in therapy and daily life. Notably, emotion regulation skills build on the earlier stages: a child must know what they feel and why in order to appropriately cope with it. Research emphasizes that

when a child understands their emotions and can express them, they are far more able to modulate those feelings' intensity and cope effectively. Early school-age children start using simple strategies to manage feelings – for example, covering their ears when scared of a noise or taking a break when angry. By age 7–8, kids can employ more complex coping strategies (like seeking solutions or venting in acceptable ways) and even mask or modulate expressions to fit social expectations. Play therapy strategy: Therapists often introduce playful techniques to teach self-regulation. For instance, a game of "blowing bubbles" can coach a child in deep-breathing: the child must blow slowly to make a big bubble, a fun way to practice calming breaths. Another activity is creating a "calm-down corner" in the playroom – a cozy spot with pillows, stuffed animals, or a stress ball where the child can retreat and practice skills like squeezing the ball or hugging a plush toy when overwhelmed. Role-play is useful as well: the therapist might act out a scenario (e.g. a toy gets upset) and then guide the child in helping that toy calm down, thereby rehearsing coping strategies. Over time, these playful rehearsals translate into real-world emotion regulation. Importantly, the therapist remains attuned to providing co-regulation (warm, calming presence) as needed, since even at 5–7 years children often need adult support while they build independent regulation abilities.

Clinical Implications

In play therapy, understanding these developmental stages of emotional competence allows clinicians to tailor interventions to the child's level. A sequential framework—moving from simple recognition of feelings to complex self-regulation—guides the selection of play activities that meet the child where they are developmentally. Ultimately, fostering emotional intelligence through play not only helps children manage current behavioral or emotional challenges, but also gives them lifelong tools for resilience, healthy relationships, and learning success. By systematically building emotional intelligence, play therapists contribute to stronger mental health outcomes and social-emotional growth in the children they work with, laying the groundwork for well-adjusted, emotionally competent future adults

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About the Author

Greg Lubimiv earned his Master of Social Work degree from the University of Toronto and brings over 40 years of diverse experience as a clinician, administrator, consultant, and trainer in the field of mental health. His extensive career spans multiple sectors, including school-based social work, children's mental health, child protection, and adult mental health services.

Greg was one of the early pioneers in the growth of CAPT serving as an early Board and Committee member and has been an instructor for the Association since the mid 1990's. Today he continues as a trainer and supervisor/consultant in his private practice and recently has taken on the role of Executive Director for CAPT. Greg is widely celebrated for his playful, practical, and inspiring approach to teaching and case consultation, making him a sought-after presenter and mentor in the field.

Incorporating Families into Therapy: The Beauty of Filial Therapy (part 2)

Heddy Swigger MSW, RSW, CPT

In the previous edition of the Playground Magazine, I wrote an article about Filial Therapy that was focused on the history and the theory. This second part to the article will explain how we can apply the approach to our practice using a masked case example. As a quick reminder, Vanfleet (2014) believed in the strength of this approach as it :"hypothesized that the therapeutic benefit of non-directive play sessions could be made even greater and more efficient by teaching parents/ caregivers how to engage in therapeutic play with their own children, under the supervision of a trained therapist".

Masked Case Example:

Background:

Sam (5) lives with his parents, Teresa and Joe, his twin sister, Ruby (5), and younger brother, Jacob (2). The parents described Sam as a loving, kind, and creative child. However, the parents identified that Sam struggles with anxiety, becoming even more pronounced in recent years. The parents noted a decreased interest in preferred activities; intense, lengthy outbursts; and aggressive behaviours, particularly towards Ruby. The parents shared concerns about the sibling relationships, particularly the lack of connection and attention that Ruby and Jacob were receiving. Teresa and Joe shared that Sam has had therapy before for anxiety but still find the anxiety and outbursts are heavily impacting Sam's life.

Family Play Observations:

As per the Filial Therapy model, the clinician engaged the family in a Family Play Observation. The clinician asked the family to "come into the playroom and feel free to interact as you ordinarily do". A number of interesting and helpful dynamics came to light. Starting with Sam, the clinician noticed a number of possible signs of anxiety in Sam's behaviour. These signs included: frequent reassurance and permission seeking behaviours; close spatial positioning to other family members, particularly his Mom; frequent requests for parents to go with him to explore the playroom, etc. In contrast, Ruby appeared to be much more adventurous and moved more freely around the playroom. Jacob also appeared more independent and settled very quickly into play. At the beginning of the observation, Ruby tried to call her parents' attention to what she was doing. However, the parents frequently disconnected from Ruby to attend to Sam. As the observation progressed, Ruby seemed to experiment with limit testing behaviours to get parental attention. Of significance, each time Ruby engaged in such a behaviour, she would immediately look to see if her parents were watching and/or were going to interact with her.

In the clinician's opinion, both parents played different roles within the family. Teresa seemed to solve problems and do things for Sam very frequently. Teresa attempted to connect with Ruby but was immediately pulled back if Sam asked for her attention. Joe sat back and observed for most of the session. Most of Joe's interactions were to set a limit or give a reminder to the children.

Demonstration and Training Phases:

The clinician engaged Teresa and Joe in the Demonstration and Training Phases of Filial Therapy.

This included: demonstrating non-directive play sessions with each child, a skills-training session, and two mock play sessions, in which the clinician role-played a child with each parent and supported them in practicing their skills. During mock sessions, the clinician used positive reinforcement, cueing, and modelling to support the parents in growing their skills.

Supervised Filial Play Sessions:

The family participated in 6 supervised sessions in the clinician's office. Because of his young age and developmental stage, Jacob was not included in the supervised sessions. The parents alternated with each child each week (i.e., Week 1: Dad and Sam followed by Mom and Ruby; Week 2: Mom and Sam followed by Dad and Ruby, etc.).

During the first three play sessions, Sam continued to show possible signs of anxiety with his parents. Sam selected the same activity (building) repeatedly and built the same creation from session to session with occasional changes. Sam did not explore beyond the Lego blocks, the closest item to the playroom door. In the debrief sessions, both parents expressed frustration with this pattern and worried that the process was not working/could not work if Sam stayed at the Lego blocks. Joe especially seemed to have a hard time with this pattern and, in session 3, began to encourage Sam to make a different choice. The clinician validated the parents' concerns and asked if there was another way of viewing Sam's choices. The clinician pondered that it could be an activity that feels safe to Sam and/or allows him to feel in control. Joe and the clinician worked together to come up with empathic listening statements that he could say if Sam chose to build again, instead of trying to lead him.

From play session 4 on, both the clinician and the parents began to see noticeable changes in Sam's presentation in play sessions and in his day-to-day life. In the playroom, Sam began to: explore more of the playroom, participate in markedly less reassurance and permission-seeking behaviours, and demonstrate different play themes. One of the pre-dominant themes of Sam's play at this time was power and control. Sam would name himself the King and offer to grant his parent's wishes. Sam would then follow up each wish granted with a punishment, often putting the parent in jail or having them endure an uncomfortable experience (i.e., pretending to eat disgusting food, etc.). Additionally, school became a familiar theme in Sam's play. Sam's school play frequently featured peer interactions, both positive and negative, as well as teachers managing students, often ineffectively. At home, Joe and Teresa reported that Sam's meltdowns became less frequent and less intense. The parents described Sam as being more flexible in his thinking and being in an overall more positive mood. The parents also noted improvements in the interactions between Sam and Ruby.

Ruby's play sessions seemed to develop a pattern almost immediately from play session 1. Ruby would start with an aggressive play sequence, often sword fighting, and would play until she defeated her parent. Once she had defeated her parent, Ruby would cuddle up with her parent and ask them to read to her for the remainder of the session. The parents hypothesized that this sequence represented their relationship with Ruby. The parents stated that they were beginning to notice that Ruby used misbehaviour to capture their attention from her brother and felt that the sequence she was playing out reflected

that. During debriefs, Teresa expressed feeling grateful to have the "cuddle time" with Ruby and could see how much she enjoyed it. At home, the parents expressed that they had begun to practice telling Sam to wait if they were giving attention and connection to Ruby. The parents shared that this had not been easy and often provoked a tantrum from Sam. However, the parents stated that they felt it was important to give Ruby space in their home.

Transfer Home and Generalization:

By the end of supervised session #6, it was clear that Teresa and Joe had drastically improved their skills and that they felt ready to take these skills into their home life. The parents and the clinician met, without the kids present, and discussed the logistics of "special play time" at home.

The parents immediately set up a schedule for special play time with each child and created a plan for providing privacy without interruptions. The parents continued to meet with the clinician each week to discuss the play sessions and begin the generalization process.

As special play time became more and more engrained for Teresa and Joe, the discussion during debriefs was able to shift to how to use the four skills outside of play time. Teresa and Joe found empathic listening to be one of the most helpful skills outside of the playroom, as they were able to validate and regulate Sam during moments of stress/anxiety but also put language to what Ruby needed. The parents identified that they were trying to be more playful in their day-to-day life and employ the imaginary play skill to infuse more fun into their family life.

Outcomes:

As of discharge, this family is doing very well. Both Joe and Teresa have continued to hold special play time weekly with each child and have both communicated that they really look forward to that time with their children. Teresa shared that she feels like she finally understands her kids, Sam especially, and feels much more prepared to support them. Additionally, the parents reported that Sam has been able to ask for special play time when he is feeling dysregulated, instead of having meltdowns.

The parents highlighted that Sam and Ruby's interactions have improved. The parents shared that Ruby seems much happier and is engaging in less "troublesome behaviours towards Sam". The parents noted that Ruby seems to be more able to ask for what she needs around the house as well as at school.

Books or Resource Recommendations

- Filial Therapy: Strengthening Parent-Child Relationships Through Play by Risë VanFleet
- Group Filial Therapy: The Complete Guide to Teaching Parents to Play Therapeutically with their Children by Louise Guerney and Virginia Ryan
- https://risevanfleet.com/professionals/resources/
- https://risevanfleet.com/online-courses/

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About the Author

Heddy holds a Bachelor's degree in Neuroscience as well as a Masters of Social Work degree. During her journey to become a certified play therapist (CPT), Heddy developed a passion for to Child-Centered Play Therapy (CCPT) and Filial Therapy. Heddy had the opportunity to complete all of her Filial Therapy training under world-renowned play therapist, Dr. Risë VanFleet. Today, Heddy is the founder of Tessellate Child and Family Therapy and focuses primarily on teaching and working with her clients utilizing CCPT and Filial Therapy.

Currently accepting new supervisees

Celebrating Excellence in Service:

2025 Betty Bedard Bidwell Volunteer Award: Honouring the Spirit of Service at CAPT

Why This Award Matters

From our earliest days, CAPT's growth and impact—across Canada and internationally—have been powered by dedicated volunteers and ambassadors. This annual award formalizes our gratitude by celebrating a member whose service strengthens our mission, our profession, and the communities we serve.

Honouring Dr. Betty Bedard Bidwell

The award is named for Dr. Betty Bedard Bidwell, a foundational leader in CAPT's history. Betty. helped form the original CAPT Board. She was instrumental—alongside like-minded therapists—in creating foundation training, and she taught in CAPT's foundation play therapy training for many years. Dr. Bedard Bidwell served on numerous committees over many years.

About the Award

Named in honour of CAPT pioneer Betty Bedard Bidwell, this award celebrates volunteers whose sustained contributions strengthen the association's mission, elevate the profession, and meaningfully serve children, families, and communities through play therapy.

Beyond CAPT, Betty's professional legacy includes:

- Registration as a Psychotherapist, Art & Play Therapist, and Supervisor, and certification as a Trauma and Loss Consultant Supervisor,
- American Art Therapy Board Certification, making her the only dual American and Canadian registered Art and Play Therapist in Canada with this level of credentials,
- Completion of Animal Assisted Therapy certification for the therapeutic use of pets in practice,
- Multiple honours, including TLC Supervisor of the Year and the 2001 Premier's Award,
- Co-founder and coordinator/instructor of the Art and Play Therapy Program at the University of Western Ontario, and
- Owner/operator of Betamarsh Incorporated, a residential and foster care agency, while serving as a treatment foster parent for over 29 years.

Establishing this award is a fitting tribute to Betty's long-standing, loving service and leadership.

The Canadian Association for Play Therapy (CAPT) is proud to announce the recipients of the 2025 Betty Bedard Bidwell Volunteer Award, presented annually to a Board of Directors member who has demonstrated outstanding commitment, leadership, and service to CAPT. In recognition of an exceptional year of volunteerism and impact, the Board has honoured two recipients: Ineke Guadagnin and Caileigh Flannigan.

HONOUREE:

Ineke Guadagnin

Nominated by:
Justine Elliott, Lindsay Crowe, and Hannah Sun-Reid

Ineke considers it a privilege to be a Registered Psychotherapist supporting children and families in the Quinte area. Building on a BA in Education and a Master's in Counselling Psychology, she brings years of experience with children and parents into a therapy space that centres relational connection. Ineke integrates attachment-based strategies and compassionate, direct communication to help parents better understand and support their children's mental health needs. She enjoys incorporating expressive arts and nervous-system regulation with clients of all ages and is passionate about holding space for those navigating trauma and loss.

VOLUNTEER IMPACT: In 2024–25, Ineke served as Secretary of the CAPT Board and Chair of the Conference Committee, investing countless hours to plan and deliver a high-quality annual conference while maintaining meticulous board records and supporting healthy board relations.

What nominators said:

"She has dedicated hours beyond a typical volunteer role to prepare the CAPT 2025 conference and continues to serve as Secretary, attending all meetings, including executive meetings." — *Justine Elliott*

"Ineke has been an integral part of many CAPT events and projects—particularly our conference this year. She works diligently, with professionalism, thoroughness, and positivity." — *Lindsay Crowe*

"Ineke has done an excellent job as Secretary—both responsible and responsive. As Conference Chair, she dedicated many hours and attention to detail; she is consistently accountable, responsible, and responsive." — *Hannah Sun-Reid*

HONOUREE:

Caileigh Flannigan

Nominated by:
Hannah Sun-Reid and Ineke Guadagnin

Caileigh is a Certified Play Therapist and Registered Social Worker (Ontario) who supports children, youth, and families through prescriptive therapy that draws on play, art, neuroscience, and nature-based approaches. Beyond clinical practice, she is a published researcher in outdoor play and child development, an advocate for play opportunities in early childhood settings, and a contributor to the design of natural outdoor play spaces and child-friendly gardens in city environments. Caileigh facilitates professional workshops across Canada and writes for multiple online platforms.

VOLUNTEER IMPACT: As the Lead of CAPT's Marketing Team, Caileigh has shaped strategy, launched new initiatives, and advanced CAPT's public presence—often going above and beyond to ensure timely, member-centred communication and creative outreach (including bringing "Sky the Puppet" to life as a playful public face for CAPT).

What nominators said:

"Caileigh has been instrumental in designing new initiatives and implementing marketing strategies for the betterment of CAPT. Her professionalism and energy are evident in every presentation to the Board and in public forums." — *Ineke Guadagnin*

"Her enthusiastic attitude, dedication, and responsiveness have shone in her board work and in leading the marketing team—especially as our board transitioned to a fully engaged working board." — *Hannah Sun-Reid*

Honouring a Culture of Volunteer Leadership

CAPT extends heartfelt congratulations and gratitude to Ineke Guadagnin and Caileigh Flannigan. Their leadership, reliability, and creativity embody the spirit of the Betty Bedard Bidwell Volunteer Award, and their service continues to strengthen CAPT's capacity to champion play therapy across Canada.

Thank you, Ineke and Caileigh, for all that you do!.

Origins, Supporting Research, and Clinical Application in the Playroom

Ricky Joel McIntyre MSW, CPT-S, RSW

Introduction

Play provides children with a natural language for expressing inner experience and mastering developmental challenges (Landreth, 2012; Ray, 2019). Among emerging approaches, Synergetic Play Therapy (SPT)'s central work is in nervous-system regulation, therapist authenticity, and the integration of mind and body in the playroom (Dion, 2018.). Developed in 2008 by Lisa Dion, SPT uses pieces of interpersonal neurobiology, attachment theory, and systems theory to create its relational framework. The idea of authenticity is making some Play Therapists question the importance of transference and counter-transference in this article.The following sections outline the evolution of SPT, its theoretical and scientific bases.It was only written to share the existence of this approach.

Historical Development of Synergetic Play Therapy

SPT emerged from Dion's clinical observation that traditional nondirective play therapy did not always help children access deeper emotional regulation. Drawing upon Gestalt therapy, child-centered play therapy (CCPT), and neuroscience, Dion conceptualized SPT as an integrative model in which both child and therapist participate in mutual regulation and authentic interaction (Dion, 2015.).

Townsend, Ishman, Dion, and Carnes-Holt (2021) describe SPT as both an independent and integrative approach that builds upon CCPT's respect for the child's self-healing tendencies while adding neurobiological precision regarding regulation and therapist use of self. Since its introduction, the model has expanded through formal training programs, research collaborations, and clinical adaptations across cultures and settings (Dion & Gray, 2014; Townsend et al., 2021).

Theoretical and Scientific Foundations

Core Philosophy

SPT suggests that the therapist is the most important toy in the playroom (Dion, 2015.). The therapist's capacity for authentic self-regulation and congruent expression becomes the central mechanism through which the child learns to regulate internal states. Co-regulation, authenticity, and mindful awareness are therefore essential competencies.

SPT differs from purely nondirective approaches in its emphasis on intentional engagement: the therapist mirrors the child's experience while maintaining an anchored, regulated presence. Similar to what EMDR therapists experience with their clients through their trauma processing. The process aims to expand the child's "window of tolerance," a term describing the optimal arousal range in which new learning can occur (Siegel, 1999).

Neurobiological Rationale

SPT draws from interpersonal neurobiology, affective neuroscience, and Polyvagal Theory (Porges, 2011). Key mechanisms include:

1. Neuroplasticity: Safe, attuned interactions foster neural integration between emotional, sensory, and cognitive networks (Schore, 1994).
2. Right-brain attunement: Nonverbal communication—tone, rhythm, posture—supports right-hemisphere-to-right-hemisphere resonance between therapist and child (Siegel, 1999).

3. Autonomic synchrony: Physiological coherence between therapist and client stabilizes arousal states (Marci & Reiss, 2005).
4. Co-regulation cycles: Through repeated sequences of dysregulation and repair, the child internalizes regulatory capacity.
5. Therapist authenticity: Dion and Gray (2014) found that genuine therapist expression correlates with greater emotional tolerance in child clients. This raises concerns for members of the Play Therapy community as mention before.

Evidence Base and Critique

Initial studies demonstrate promising outcomes. Dion and Gray (2014) documented improvements in children's ability to tolerate affect following sessions emphasizing therapist authenticity. Townsend et al. (2021) highlighted conceptual distinctions between CCPT and SPT and called for continued outcome research. Simmons (2020) provided qualitative evidence that SPT interventions enhance regulation and relational safety.

Critics note that SPT currently lacks large-scale randomized controlled trials and standardized fidelity measures. Further empirical validation is necessary to substantiate its mechanisms and efficacy. There is also concerns about transference and counter-transference in the playroom, which Dion addresses in her training and podcast[1].

Discussion

Synergetic Play Therapy (SPT) contributes a distinctive relational-neuroscientific perspective to play therapy. By emphasizing the therapist's embodied presence and authenticity, SPT integrates cognitive, emotional, and physiological dimensions of healing. It aligns closely with contemporary trauma-informed and attachment-based paradigms that view regulation as the foundation of emotional growth (Schore, 1994; Siegel, 1999).

However, the approach also raises important considerations regarding transference and countertransference in the playroom. Because SPT invites deep authenticity and reciprocal regulation, therapists often experience strong emotional responses that mirror the child's internal states (Dion, 2015; Dion & Gray, 2014). These countertransference reactions—such as anxiety, frustration, or helplessness—can evoke fears of over-identification or loss of therapeutic neutrality (Hayes, Gelso, & Hummel, 2011). Therapists may also worry that their personal emotional material could intrude upon the process. Within the SPT framework, such experiences are reframed not as therapeutic "errors" but as valuable regulatory data—indicators of the child's projected states and of the relational field's intensity (Dion, 2019). Recognizing, tolerating, and mindfully integrating these reactions are essential competencies for maintaining co-regulation and presence (Townsend et al., 2021).

Similarly, transference from the child can emerge vividly through symbolic or dramatic play. Children may re-enact attachment ruptures, aggression, or fears of rejection through the therapist-child dynamic (Landreth, 2012; Ray, 2019). SPT encourages therapists to embody and process these enactments with attuned self-awareness rather than interpretive distance, using the moment as a co-regulatory opportunity. By doing so, the therapist models authenticity, emotional repair, and integration, transforming transference from a reenactment of trauma into a healing interaction (Dion, 2019).

Nevertheless, managing these dynamics demands rigorous self-reflection, supervision, and personal regulation practices. Without clear internal boundaries, therapist authenticity may blur into enmeshment or emotional over-identification (Hayes et al., 2011). Ongoing consultation, professional development, and mindfulness training help practitioners remain grounded in their own regulatory systems (Porges, 2011). SPT's relational depth therefore offers profound therapeutic potential but requires maturity, ethical awareness, and supervision to prevent countertransference from destabilizing the process (Simmons, 2020).

Conclusion

Synergetic Play Therapy represents an evolution in play-based treatment, emphasizing that healing occurs through authentic, co-regulated relationships rather than technique alone. Its integration of neuroscience and attachment principles offers clinicians a holistic framework for helping children transform dysregulation into co-regulation and self-regulation. Continued research will clarify its mechanisms and cement its role within evidence-based play therapy practice.

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Play Therapy in a World of Change
CAPT June 2025 Conference

Inspiration, connection and joyfulness is how I would describe this really well orchestrated conference!

This June, I had the pleasure of traveling to Victoria British Columbia to the Delta Ocean Pointe Resort with three of our Theraplay Canada Supervisor Trainers (Patti Sutherland, Monique Gougeon and Hannah Sun Reid) to attend the Canadian Association for Play Therapy conference, support CAPT and to promote Theraplay Canada. It was an inspiring and exciting experience to meet so many like minded, creative and dedicated professionals who were not only seeking play therapy inspiration and knowledge but eager to connect with other like-minded individuals who work with children and families across our great nation! As a seasoned oldie (I've been a part of CAPT for over 28 years), I am in awe with how a conference run by our fantastic CAPT Association can bring such inspiration and joy in just two days and reinvigorate our professional juices!

The conference theme sought to highlight how diverse the modality of play therapy can be to meet the challenges posed in a world of constant flux, build communities while at the same time address issues such as trauma, identity, socio-political shifts, digital transformation and the impacts of global crisis on children and family mental health.

Attendees came from many parts of Canada and a few from other countries. Key note speakers, Isabella Cassina, MA, TPS, CAGS, PhD Cand and Claudio Mochi, TMA, RP, RPT-S, came from Switzerland and captivated us for two days with their uniquely playful and insightful research. Other presenters included Monica Bharata, Chris Conley, Chenoa LaCaille, Natasha Lawrence, Greg Lubimiv, Rachael Pasemko, Kevin St. Louis and Hannah Sun-Reid.

P.S. Counselling Matters, Play Space, Maritime Play Therapy, any many more along with Theraplay Canda provided sponsorship and had information booths set up to provide extra resources and information to participants wanting to learn more about each modality.

A HUUUGE thank you to the committee organizers Ineke Guadagnin who made sure all participants were greeted with joyful smiles, well fed and absolutely taken care of to meet all of our conference needs with comfort, accessibility and support. You did a phenomenal job orchestrating this event and made us all want more, more, more. I strongly recommend, to you, our membership, to reach out to our CAPT Board to let them know you are keen to hear when and where their next Play Therapy Conference will be held.

Sending you all joy and playful hugs!

Lorie Walton, M.Ed, CPT-S, CTT-ST, RP,

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Please note that SPC is not currently a CAPT approved provider.

Celebrating the Contribution of Diversity in Our CAPT Members

This article is the first in what will be a regular column in Playground to highlight the importance of diversity within our members to the work that we do. If you are interested in being interviewed to share your diversity and how it positively enriches your work, please reach out to Donna Starling.

Whitney McGeary describes her path to becoming a therapist as "not straightforward". It was initially her plan to become a teacher. As she states "I felt I should be a teacher but did not question why I was going this direction." When some difficult experiences led her to question her choice, she describes feeling lost both emotionally and mentally as she explored the question "if not a teacher, then what?"

She returned to university to pursue psychology but experienced imposter syndrome and decided to take a break. During that "break", she completed a two-year diploma in disability studies, graduating with distinction. With bolstered confidence, Whitney returned to university to complete her BA in Psychology. After graduating, the question of what to do remained. She found herself working at CUPS (Calgary Urban Project Society), supporting clients with complex needs to navigate the systems that support them. Here, Whitney began working with individuals with various types of neurodiversity and mental health issues.

She now understands that this work was a corrective experience for herself – that she was able to ensure others got what she feels she did not. She became very focused at CUPS on understanding others, accepting them and supporting them. Through this process, she began to explore her own neurodiversity and mental health. Whitney identifies as being neurodiverse and as having her own mental health struggles.

Whitney describes that learning about and helping others has helped her to learn about and accept herself every day. Whitney now works at Foothills Academy, a Designated Special Education Private School in Calgary for students in grades 3-12, all of whom have diagnosed learning

disabilities and/or ADHD. Her growing knowledge about herself and her long journey of self acceptance is now a source of information and inspiration to the people with whom she works at Foothills. She describes how her journey has helped with effective use of self within her therapeutic work. Every student requires something different and there is no cookie cutter approach to any one person. As Whitney connects with each student, she can use her own perspective of viewing the world with neurodiversity to ensure empathy and understanding within her strength-based work and can support each student's mental health.

Whitney wonders how her own life would have been different if she had the specialized information and support when she was younger, that she is now sharing with the students at Foothills. She describes times as a youth having a disconnect between her mind and body, feeling like she coped in life by being as agreeable as possible and was a "yes kid", which she now recognizes as a trait of ADHD coping, to navigate the world without standing out. She now can draw from her path of self-learning and acceptance to explore with her students how to value themselves and how to have a good relationship with themselves, whatever their strengths, traits and areas of struggle.

In her current role, Whitney describes her own creativity, and the creativity of those with whom she works as a significantly impactful area. She allows space to play and to express. While important for all children, Whitney describes a playful and creative approach to be especially important for children and teens with neurodiversity and mental health issues. Traditional ways of understanding self, developing insight and expressing may not be effective.

As Whitney teaches others self-acceptance and expression, she continues to ensure she reflects regularly on her own mental health with exercise, healthy eating, sleeping well, social time, plants, podcasts and her on-going journey of learning. She regularly takes feedback from others as an opportunity to reflect and to improve relationships with coworkers and friends. She "leans in" to conversations, even if it is uncomfortable, doing her best to be honest and vulnerable with herself and others.

Whitney is soon going to write her EPPP (Examination for Professional Practice in Psychology) in Alberta. As she teaches strength within neurodiversity, she also continues to model it within her own life.

About the Author

Donna Starling is a Registered Social Worker, Certified Play Therapist and Play Therapy Supervisor, working in private practice at Wonder Therapy Services in Fergus, Ontario. She believes in the ability of play and the power of diversity to make the world a better place.

Healing Spaces

Healing Spaces is an ongoing article in Playground. If you would like your therapy playroom to be featured please contact Greg at ed@canadianplaytherapy.com

This edition of Healing Spaces is focused on Maimoona Batool RP. CCC, interviewed by Ricky Joel McIntyre MSW, CPT-S, RSW

So, what drew you to the field of play therapy? Why did you decide to study Play Therapy?

COVID is what started my journey with Play Therapy. I had seen the effect of COVID on children at that time. Specifically starting from my own circle in my own home, then noticing more outwards into, you know, nieces and nephews and cousins and other children in my surroundings.

It's difficult for children to have words for what they're going through. Transitioning from words into play, or using play to express what's going on for them. It was a really insightful approach for me to see, how children's minds are so different than ours, They really do better when we are attuned developmentally with them to say where they are, and what kind of words we need to use, or what kind of play modalities we canto use, or how can we slow ourselves down, and connect with them with their language, in their modality of play.

It just reminded me that it's not about using the right words and saying the right thing; it's about creating a friendly and safe space. Play Therapy relies on being a respectful approach for children, where there is attunement between the children and the therapist. Instead of talk therapy, which can make children scared and feel like they are being interviewed by their parents or adults and asking them these big questions. Children just want to play. That's what we can give them, a space to express themself and play.

When I noticed the effectiveness of play. I was already a registered nurse during COVID. I had a vision of being a play therapist in my region. In Vaughan specifically, where I work, I couldn't find a Certified Play Therapist. I wanted a Play Therapist for my Children and couldn't find anyone. I decided to become one for those who needed this approach.

The only Certified Play Therapist I could find was downtown, or it was in Niagara region. I couldn't find any locals, so it wasn't really feasible for me to take my child, an hour and a half one side, and then take them for a session and come back. It also wasn't going to work out, especially given COVID and the isolation periods and quarantine. So I started my Play Therapy education by reading books and connecting with my children. Then I went to school for that. I got my Master's Degree in Psychology Counseling from Yorkville. After that, I wanted to specialize more in play, so I did all the Foundational Training from the Canadian Association for Play Therapy (CAPT). That led me to where I am today.

What's the first book or the first material that you explored that was linked to play therapy or child therapy?

The Therapist Notebook for Children and Adolescents. Homework, handbooks, and Activities to Use in Psychotherapy. It is by Catherine Ford Sorri. Lorna Hecker and Molly E. Beckenberg. It's a book that is a rich resource of ready-to-use materials (homework assignments, hand-outs, play activity, etc.). It's designed specifically for children and adolescents and their families to use.

What makes, Play Therapy special or unique compared to other modalities?

What makes it unique for me is that the children have so much more to express in a play situation. They're building safety, they're building rapport, they make connections,

they're thinking more, and they have a space to talk it all out. We can use different modalities like sandtray, a dollhouse, or puppetry. We can also use different types of arts forms. We can combine it with any other modality we're using. I find that it's multidimensional. There's no one way to approach it. We can blend it with different modalities that you and I may already practice. We can combine it with Cognitive Behavioral Therapy, or attachment as a perspective. I am also trained in EMDR and combine it with this as well. If I need to bring any of those, it's easier to bring it in a child-friendly way.

What is your main orientation, or what modality do you use the most, in Play Therapy? You mentioned EMDR, CBT. Do you have a main approach that you prefer?

I do an assessment to see where they are in the first few sessions. These are typically Child-Centered Play Therapy, where I would start attunement and building a relationship, and just seeing where they are, and then as we're going more into knowing them, I choose what needs to be used to support the client. But overall, it's really based on the individual circumstances.

I do like the sand tray modality quite a lot. I like to use sand tray, especially for the children to put the miniatures and see how they're building their sanctuary, their world. Then, be able to use that to understand them. One of the other modalities that I would use is puppets. Also the dollhouse, so those are some of the things I use, in all trauma-informed ways. I think TheraPlay is one of the modalities that I'm actually looking to expand on, because I do have now parents who would like to be in the session with their child, and that's something that I'm working on on my own.

Any training supervision that you would recommend?

I think I'm more attuned to my learning gaps. When I'm able to find a learning gap, I will be able to go and fill those learning gaps, either through supervision, my supervisor currently is Hannah Reed from the CAPT supervisory list. But throughout my training, I've met amazing people who I would be reaching out to for consultation as well.

Is there any myth or misconception about play therapeutics you'd like to break?

Our work here is to support the child in the journey, while the journey needs to continue at home. The support needs to continue with the caregivers or whoever is involved in the child's life. Play Therapy is not a fix the child. We need to bring in the parents and caregivers. and oftentimes speak to other people involved in child life. It's a team effort.

But one of the big myths I have is, it's only for kids. No, it's actually not for kids. I have an adult male who comes and sits in my office, and he plays Jenga, and he does all of the different kinds of board games.

I have a female client who comes and sits with the sand tray, and she expresses herself with the sand tray. Every time she has a session, she feels like, you know, it was transformative for her. She feels enlightened, she finds it, she finds it really validating to share what she's experiencing in real life within the miniatures

Another myth that I find is where therapists, the play therapists, are just watching the child play. Yes, observation is a huge part of our work, but it's not passive. Our work involves more actively joining, reflecting, connecting, and creating safety and security. We also create a structure in the therapy space and intentionally guide the child or build insight into whatever they're showing us. We help them build a sense of mastery of their life, etc.

Any advice for people who are either interested in a career in play theory or for play therapy students and interns?

Fight the imposter syndrome. Believe in the process. Stay curious. Imposter syndrome comes in when we feel that we don't know enough. We have all this training, and we have all this education, and years of experience behind us. But then every story that we are brought to in the playroom is unique, right? So every child's experience is unique, and everything that the child comes to us, or the family may bring to us, is unique in its own way. And that's where the imposter syndrome comes in, because I may not feel ready or competent for every single situation that's out there. But we have this knowledge, community, this presence, and this curiosity that will support us through our doubts.

Animal-Assisted Therapy: A Story About Getting Started

Taylor Nelson MSW, RSW, CPT

It started out with showing children pictures of our pets. There's something special about the way a child lights up when they meet a dog. In our play therapy office, those moments have become even more meaningful as we begin our journey into Animal-Assisted Therapy. Our new therapy dog-in-training, Winston, has already taught us so much about connection and attunement.

As play therapists, we understand that growth happens through relationship and experience. Adding a therapy animal invites both. Our young clients often notice Winston's calm breathing or soft eye contact before we even mention regulation. Children mirror it. They soften. The dog becomes a living co-regulator, offering a safe and nonjudgmental presence that bridges connection in ways words sometimes can't. As an adolescent pup in-training, Winston invites playfulness everyday. Winston offers playful invitations for children and adults; from belly scratches to a quick game of tug-of-war or his engaging head tilt.

But starting out in animal-assisted play therapy also means slowing down. We're learning about the foundations of therapist-dog teamwork, ethical practice, and the importance of informed consent for families. There's structure behind the sweetness—training sessions, scheduled breaks, liability considerations, and constant assessment of the Winston's comfort and wellbeing. The most important lesson so far has been remembering that our therapy dog is a partner, not a prop. Respecting the Winston's emotional and physical limits models empathy and boundaries for our clients, too.

If you're considering this path, start small and stay curious. Observe other trained teams, explore the Animal Assisted Play Therapy® guidelines, and seek consultation from certified professionals. Integration doesn't have to happen all at once; even introducing a dog-in-training to the environment gradually can offer gentle shifts in the therapeutic atmosphere.

We're still early in our journey, and Winston is still learning basic cues and how to settle in session. Winston's training is a reminder to children and families that mistakes and learning is all part of the process. We've witnessed moments of spontaneous joy and co-regulation that remind us why this work matters. Healing can begin with a wag of the tail, a soft gaze, or the quiet trust shared between child and animal. Sometimes, that's where the story of safety begins.

About the Author

Taylor Nelson can be found with a pocket full of dog treats in Belleville, Ontario. She is a Certified Play Therapist and Registered Social Worker. Taylor owns Family Tree Therapy, which is group therapy practice that emphasizes belonging and imagination in the world of children's mental health. Taylor can be reached at: taylor@familytreetherapy.ca

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