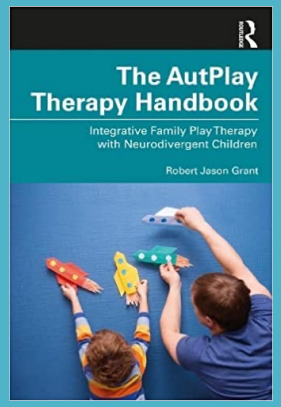
AutPlay® Therapy Training:
An Integrative Family Play Therapy Framework

Robert Jason Grant Ed.d, LPC, NCC, RPT-S

info@autplaytherapy.com
www.autplaytherapy.com



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Tracy Turner-Bumberry LPC, RPT-S

Disclosures:

Financial — Trainer of AutPlay Therapy, co-author of one AutPlay book; receives royalty payments on trainings given and book sales.

Nonfinancial — member of the Association for Play Therapy. Receives no compensation as member.

Professional Responsibility

Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of your professional status. As a professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your profession standards.

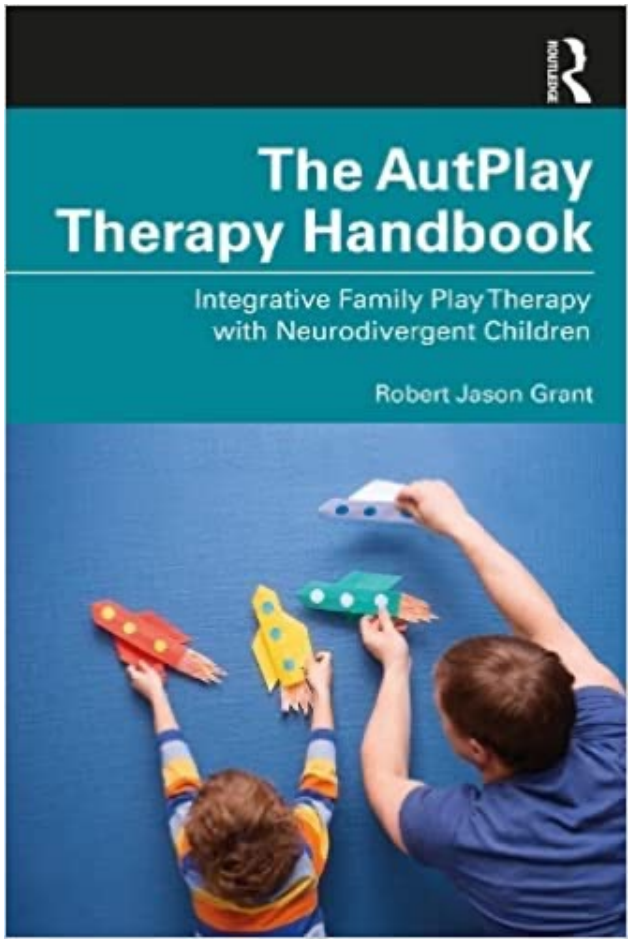
Learning Objectives

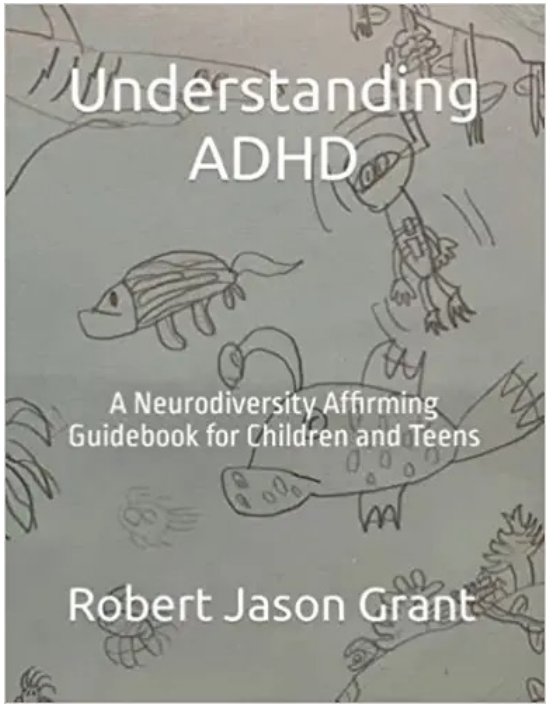
1) Explain neurodiversity and implementing a neurodiversity affirming approach.
2) Describe the components of AutPlay Therapy including conducting an AutPlay Therapy session, theoretical underpinnings, phases of therapy, assessment, and goal planning.
3) Describe common mental health goals addressed in AutPlay Therapy.
4) Identify several structured play therapy interventions to use for addressing goals.
5) Discuss how to involve parents and other family members as co-change agents (partners).
6) Describe the AutPlay model of dysregulation.

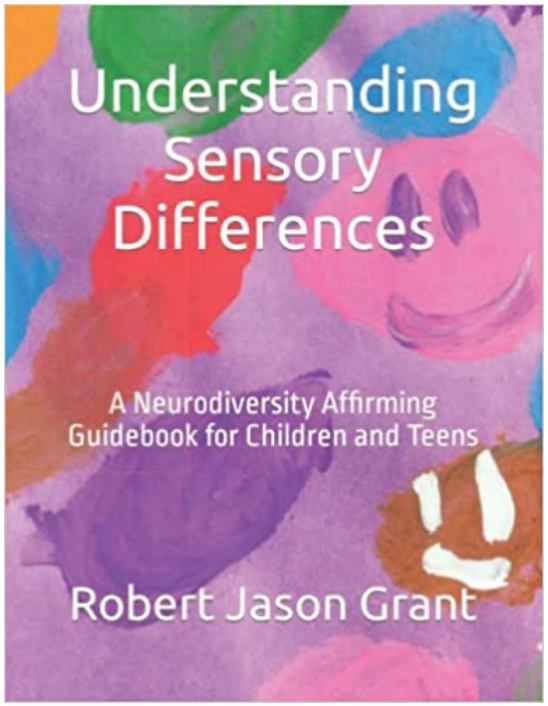
Learning Objectives

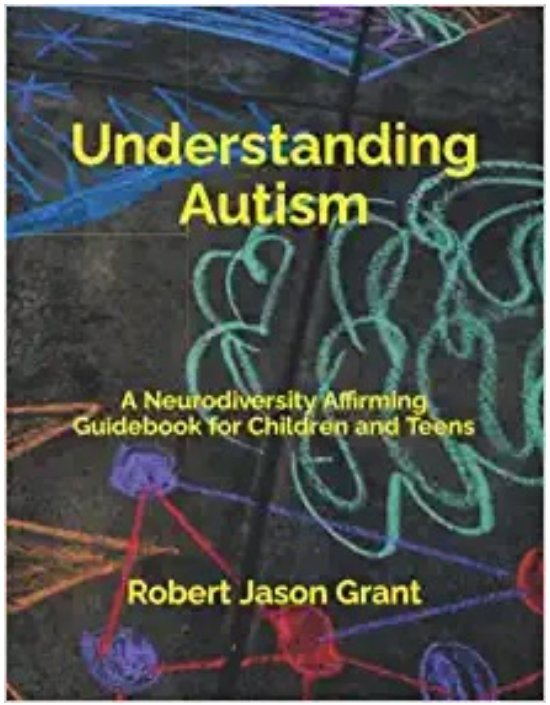
7) Identify play therapy interventions to address dysregulation issues.
8) Implement the AutPlay Follow Me Approach, designed for children with higher needs.
9) Describe how to work with parents in implementing AutPlay Follow Me play times at home.
10) Explain research and evidence-based practices in AutPlay Therapy.
11) Outline the theoretical underpinnings of AutPlay, including seminal play therapy theories and other integrated methods.
12) Identify at least 6 AutPlay interventions to increase experiential knowledge.

Required Reading – *The AutPlay Therapy Handbook: Integrative Family Play Therapy with Neurodivergent Children* by Robert Jason Grant









Recommended Reading

Reminder: Complete the Recorded Webinar

Introduction to AutPlay Therapy

Introduction to AutPlay Therapy

Remember – you are required to watch the 4 hour webinar Introduction to AutPlay Therapy as part of completing your Certification Training. This training is free and can be accessed here - https://courses.jentaylorplaytherapy.com/courses/intro-autplay-therapy

NOTE

This training will primarily default to identity first language (autistic child) as research supports that the majority of autistic individuals prefer identity first language. We will also use terms such as neurodiverse, neurodivergent, and neurotypical.

Mental health professionals should take care to address clients in the way they prefer and gain further training in neurodiversity affirming and informed processes.

Overview of the Training

An Overview of Neurodiversity

An Overview of Autism

Play and the Neurodivergent Child

AutPlay Theoretical Underpinnings and Integration

AutPlay Therapy Basics

Phases of Therapy

Mental Health Needs and Play Therapy Interventions

Parent Partnering (training)

AutPlay Follow Me Approach

Limit Setting

Dysregulation/Regulation/Behavior

Neurodiversity Review

Neurodiversity Terms Defined

Neurodiversity
Is the diversity of human minds, the infinite variation in neurocognitive functioning within our species. Everyone is neurodiverse (all humans).

The diversity of neurotypes.

Neurodiversity Terms Defined

Neurodivergent
Sometimes abbreviated as ND, means having a brain that functions in ways that diverge significantly from the dominant societal standards of "normal."

Neurotypical
Often abbreviated as NT, means having a style of neurocognitive functioning that falls within the dominant societal standards of "normal."

Non-Autistic
Anyone who does not have autism. This can include neurodivergent individuals who are not autistic but have some other neurodivergence.

Neurodiversity Movement
Is a social justice movement that seeks civil rights, equality, respect, and full societal inclusion for the neurodivergent.

Neurodiversity Terms Defined

Neurodiversity Paradigm
Is a specific perspective on neurodiversity – a perspective or approach that adheres to these fundamental principles:

1.) Neurodiversity is a natural and valuable form of human diversity.

2.) The idea that there is one "normal" or "healthy" type of brain or mind, or one "right" style of neurocognitive functioning, is a culturally constructed fiction, no more valid (and no more conducive to a healthy society or to the overall well-being of humanity) than the idea that there is one "normal" or "right" ethnicity, gender, or culture.

3.) The social dynamics that manifest regarding neurodiversity are like the social dynamics that manifest regarding other forms of human diversity (e.g., diversity of ethnicity, gender, or culture). These dynamics include the dynamics of social power inequalities, and the dynamics by which diversity, when embraced, acts as a source of creative potential.

Neurodiversity Terms Defined

Ableism
The discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior.

Neurodiversity Affirming
A philosophy, approach, and choice to work with clients through a neurodiversity lens, especially neurodivergent clients. Being mindful that processes, theories, approaches, and techniques are free of ableism and working to build up the client's individual identity instead of trying to change them to a neurotypical standard.

Identity-First Language
Using language that places a person's identity first such as saying, "autistic child" or "autistic person." Research supports that the majority of autistic adults prefer identity first language over person-first language (child with autism).

Affirming Definition of Autism

Autism Self Advocacy Network

https://autisticadvocacy.org/

Much of what is described here could apply to any neurodivergent child, not just autistic children.

Autism Review, Autistic Self Advocacy Network (ASAN) - https://autisticadvocacy.org/about-asan/about-autism/

Autism is a developmental disability that affects how individuals experience the world around them. Autistic people are an important part of the world. Autism is a normal part of life.

There is no one way to be autistic. Some autistic people can speak, and some autistic people need to communicate in other ways. Some autistic people also have intellectual disabilities, and some autistic people don't. Some autistic people need a lot of help in their day-to-day lives, and some autistic people only need a little help. All of these people are autistic, because there is no right or wrong way to be autistic. All experience autism differently, but all contribute to the world in meaningful ways. All deserve understanding and acceptance.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

From the Autistic Self Advocacy Network (ASAN) - Every autistic person experiences autism differently, but there are some things that many of us have in common.

1. **We think differently.** We may have very strong interests in things other people don't understand or seem to care about. We might be great problem-solvers, or pay close attention to detail. It might take us longer to think about things. We might have trouble with executive functioning, like figuring out how to start and finish a task, moving on to a new task, or making decisions. Routines are important for many autistic people. It can be hard for us to deal with surprises or unexpected changes. When we get overwhelmed, we might not be able to process our thoughts, feelings, and surroundings, which can make us lose control of our body.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

2. We process our senses differently. We might be extra sensitive to things like bright lights or loud sounds. We might have trouble understanding what we hear or what our senses tell us. We might not notice if we are in pain or hungry. We might do the same movement over and over again. This is called “stimming,” and it helps us regulate our senses. For example, we might rock back and forth, play with our hands, or hum.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

3. We move differently. We might have trouble with fine motor skills or coordination. It can feel like our minds and bodies are disconnected. It can be hard for us to start or stop moving. Speech can be extra hard because it requires a lot of coordination. We might not be able to control how loud our voices are, or we might not be able to speak at all–even though we can understand what other people say.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

4. We communicate differently. We might talk using echolalia (repeating things we have heard before), or by scripting out what we want to say. Some autistic people use Augmentative and Alternative Communication (AAC) to communicate. For example, we may communicate by typing on a computer, spelling on a letter board, or pointing to pictures on an iPad. Some people may also communicate with behavior or the way we act. Not every autistic person can talk, but we all have important things to say.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

5. We socialize differently. Some of us might not understand or follow social rules that non-autistic people made up. We might be more direct than other people. Eye contact might make us uncomfortable. We might have a hard time controlling our body language or facial expressions, which can confuse non-autistic people or make it hard to socialize. Some of us might not be able to guess how people feel. This doesn't mean we don't care how people feel! We just need people to tell us how they feel so we don't have to guess. Some autistic people are extra sensitive to other people's feelings.

Autism Review, ASAN - https://autisticadvocacy.org/about-asan/about-autism/

6. We might need help with daily living. It can take a lot of energy to live in a society built for non-autistic people. We may not have the energy to do some things in our daily lives. Or, parts of being autistic can make doing those things too hard. We may need help with things like cooking, doing our jobs, or going out. We might be able to do things on our own sometimes but need help other times. We might need to take more breaks so we can recover our energy.

Diagnostic and Statistical Manuel (DSM) Criteria for an Autism Diagnosis

This manual as serves as the guide in the United States (and other countries) for providing a formal diagnosis of autism, ADHD, learning Disorders, etc. Typically, the process of a formal psychological evaluation diagnosis uses the protocol outlined in the DSM and thus works out of a medical model, which views neurodivergence as problematic, highlighting deficits and struggles and the need to cure or correct deficits.

The medical model looks at neurodivergence as something that should not be happening regarding “normal” development and must be addressed to help the child become more neurotypical.

Diagnostic and Statistical Manuel (DSM) Criteria for an Autism Diagnosis

Under the medical model, diagnosis is given so impairments or differences can be “fixed/cured” or changed by medical and other treatments, even when the impairment or difference does not cause pain or illness.

The medical model looks at what is “wrong” with the person, instead of strengths or what that person needs and does not consider the concept of neurodiversity or neurodivergent as identity.

When working with parents, it is important to help them understand the limits and bias in the current evaluation process.

Diagnostic Criteria from the DSM-V (Autism Spectrum Disorder)

A) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:

1) Deficits in social-emotional reciprocity, ranging for example, from abnormal social approach and failure of normal back and forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

Diagnostic Criteria (Autism Spectrum Disorder)

2) Deficits in nonverbal communication behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and non-verbal communication.

3) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Diagnostic Criteria (Autism Spectrum Disorder)

B) Restricted repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

1) Stereotyped or repetitive motor movements, use of objects, or speech (simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (extreme distress at small changed, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

Diagnostic Criteria (Autism Spectrum Disorder)

3) Highly restricted, fixated interests that are abnormal in intensity or focus (strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4) Hyper or Hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (apparent indifference to pain/temperature, adverse response to specific sounds, textures, excessive smelling or touching of objects, visual fascination with lights or movement).

- Diagnostic and Statistical Manual, 2013

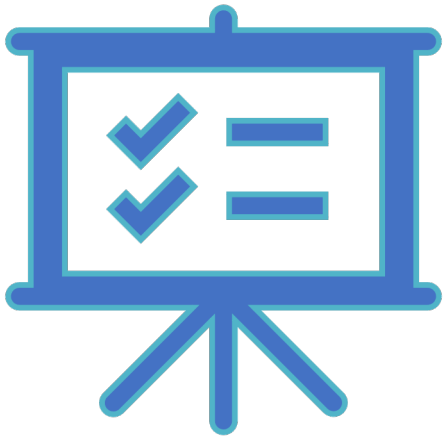
Diagnostic Criteria (Autism Spectrum Disorder)

Severity Level for ASD	Social Communication	Restricted interests & repetitive behaviours
Level 3 - 'Requiring very substantial support'	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others	Preoccupations, fixated rituals and/or repetitive behaviours markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.
Level 2 - 'Requiring substantial support'	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others	RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB's are interrupted; difficult to redirect from fixated interest
Level 1 - 'Requiring support'	Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions	Rituals and repetitive behaviours (RRB's) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB's or to be redirected from fixated interest.

Autistic Self Advocacy Network (ASAN) ASD in DSM-5: What the Research Shows and Recommendations for Change

Read through information regarding suggested changes to the DSM from ASAN: https://autisticadvocacy.org/wp-content/uploads/2012/06/ASAN_DSM-5_2_final.pdf

For Consideration



Review Matt Lowry's Strengths Based ASD Diagnostic Criteria

Matt Lowry created a version of the what the DSM criteria could look like if it working from a strengths-based approach.

See the approach on the next slide.

Strengths-Based ASD Diagnostic Criteria

To meet diagnostic criteria for ASD according to DSM-5, a child must have persistent differences in each of three areas of social communication and interaction (see A1-A3 below) plus at least two of four types of repetitive behaviors (see B1-B4 below).

A. Different social communication and interaction as evidenced by the following:

1- Differences in communication- tendency to go off on tangents, tendency to talk passionately about special interests, and tendency to not engage in small talk.

2- Differences in nonverbal communication, including stimming while talking, looking at something else while talking, and being bored with conversations

3- Due to the above differences in communication, autistic people tend to be shunned by neurotypicals and therefore are conditioned to believe that we're somehow less social.

B) Repetitive behavior or interests as evidenced by at least two of the following:

1- Stimming or engaging in echolalia

2- Security in routines. Autistic people do not have a sensory filter, so the world is perceived as a constant state of chaos. Routines and expectations give comfort to overwhelmed autistic people.

3- SPecial INterests (SPINs)- Due to hyperconnected brains, autistic people feel more passionately about what we love, so when we have a special interest, we tend to fawn over and fixate on it.

4- Hyper or hyporeactivity to stimuli- Again, due to hyperconnections, we feel things more intensely. Sometimes, however, we feel things less intensely because we tune them out in favor of other stimuli.

C- We're born with these traits, but learn how to mask them. Sometimes, they only show up when we're stressed and let our guards down.

D- These traits cause other people distress. Note- the DSM ONLY indicates impairment when it affects other people or jobs, but not when it's a daily issue that we learn to live with.

E- It's not due to intellectual disability.

Matt Lowry, MS, Eds, LPP
Child & Adolescent Psychological Evaluations, LLC
St. Matthews, KY

Understanding Neurodivergence

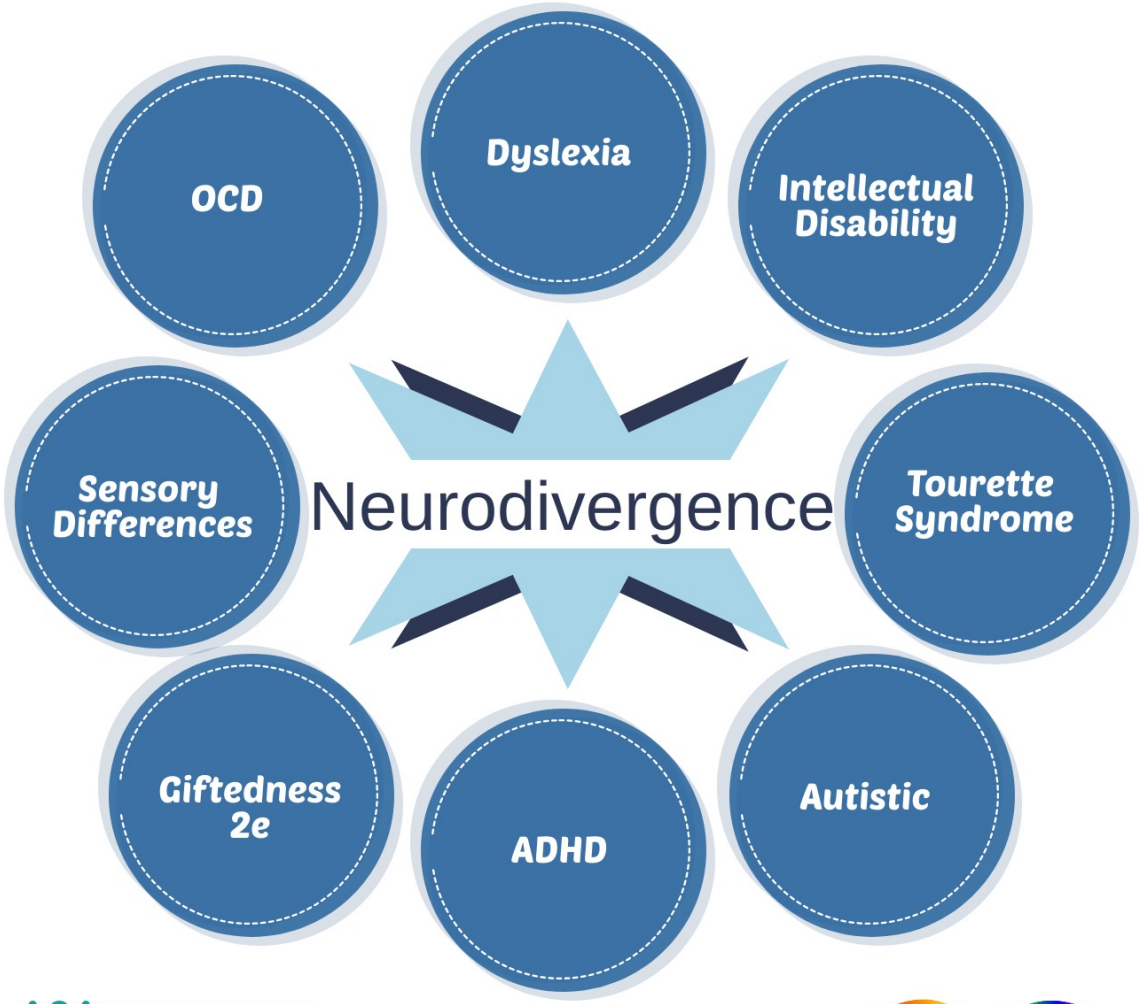
Therapists working with autistic and neurodivergent children must be flexible and adaptable. Each autistic child will present differently - strengths, needs, and issues.

Therapists must also understand that there could be multiple diagnosis or issues with the child. The child may be involved in multiple therapies and interventions such as speech, physical therapy, and occupational therapy.

Professionals should try to work collaboratively with other professionals. A multidiscipline approach addresses the myriad of issues and presents the best outcomes.

Who's Neurodivergent?

- Autistic
- ADHD
- Sensory Differences (SPD)
- Learning Disorders
- Intellectual Developmental Disorder
- Tourette Syndrome
- Developmental Disabilities
- Others


OCD
Dyslexia
Intellectual Disability
Sensory Differences
Neurodivergence
Tourette Syndrome
Giftedness 2e
ADHD
Autistic

The Neurodivergent Spectrum

Autistic children, those with ADHD, sensory differences, giftedness, learning struggles, etc. will all present on a spectrum in terms of strengths and needs.

This is an essential feature in understanding the neurodivergent child.

A one size fits all play therapy approach will not work.

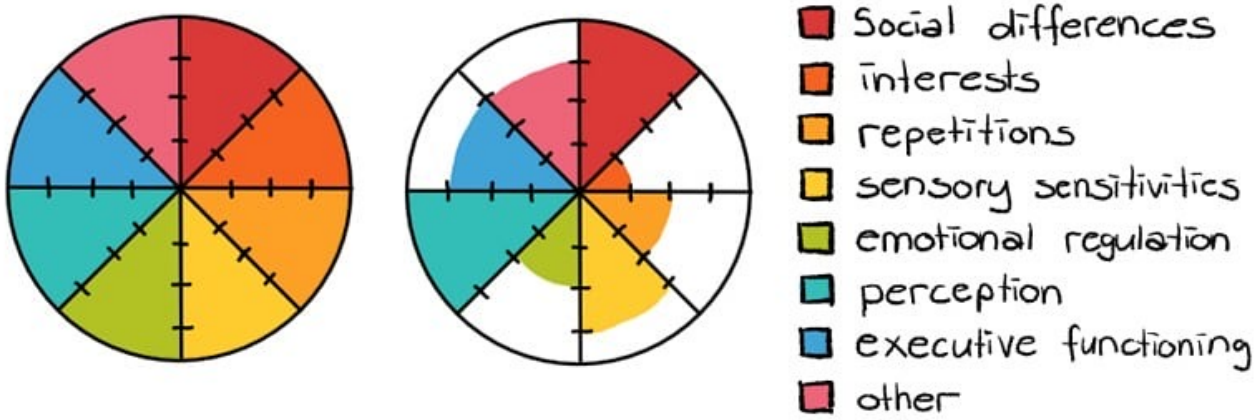
Just as each spectrum with shine its own uniqueness, play therapy sessions should reflect this individualization and uniqueness.

Autism Spectrum

The Autism Spectrum is NOT linear

less autistic very autistic

The Autism Spectrum looks more like:



Terms like "high functioning", "low functioning" and "Asperger" are harmful and outdated.

Autism_sketches

Neurodivergent Spectrum of Presentation

Review The Handout

The Neurodivergent Spectrum of Presentation

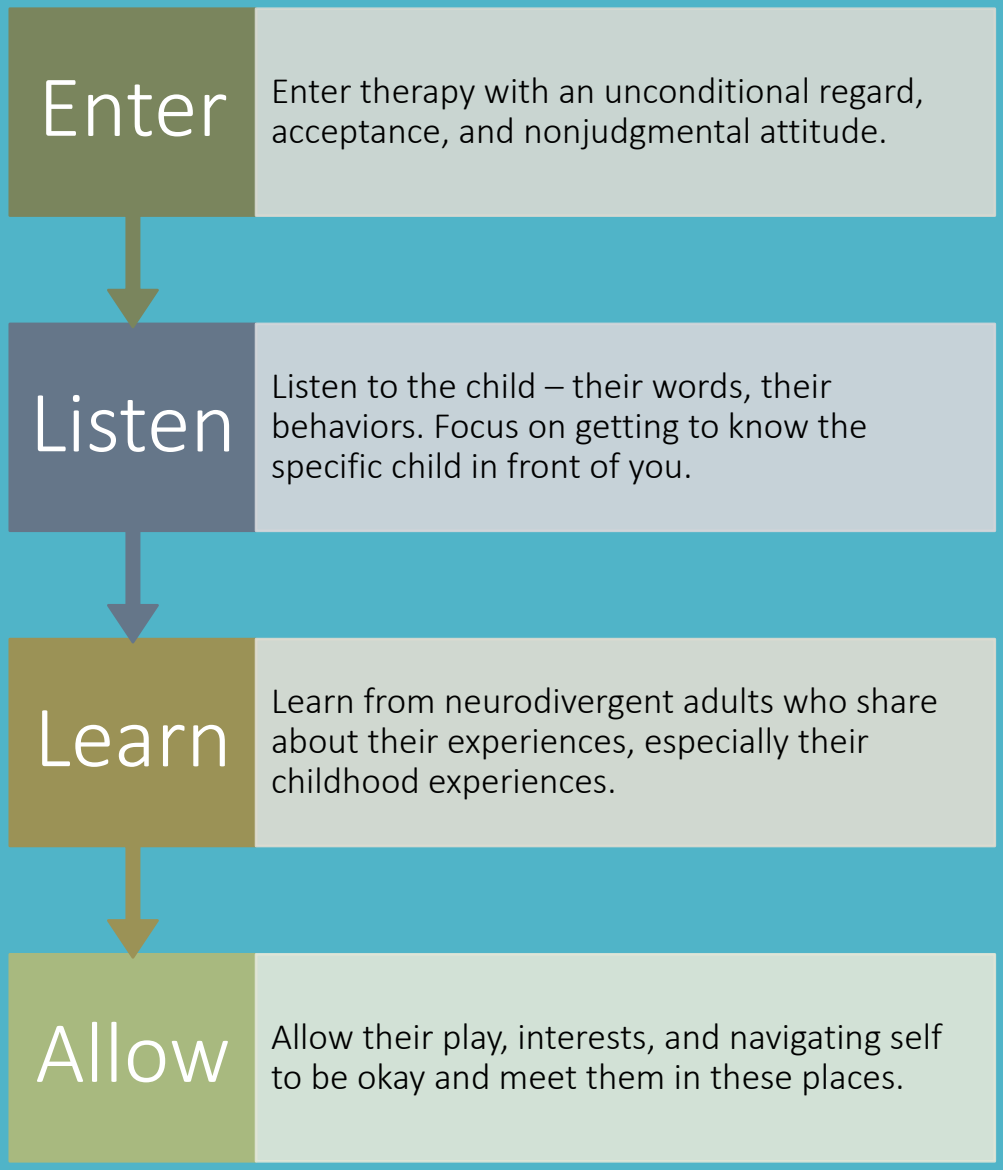
This spectrum wheel can be used to write down strengths, needs, etc. for a quick overview of the neurodivergent child.

Neurodivergent children may have co-occurring issues. There may be multiple diagnosis or other issues such as trauma or attachment issues. The initial presentation may involve a variety of therapy issues that will need to be prioritized.

Image from: https://www.wtt.org.uk/

Co Occurring Issues in Neurodivergence

Understanding Neurodivergent Children



Common Terms

Stimming – regulatory repetitive body movements/actions such as hand flapping.

Echolalia – repetition of vocalizations made by another person.

Receptive Language – the comprehension of language, listening and understanding what is communicated.

Hyperlexia - is characterized by having an average or above average IQ and word-reading ability well above what would be expected at a given age. It can be viewed as a super ability in which word recognition ability goes far above expected levels of skill.

Alexithymia - is a personality trait characterized by the subclinical inability to identify and describe emotions experienced by oneself.

Common Terms

Dysregulation – when a person's system has become overwhelmed.

Masking - The act of hiding autism features and/or characteristics. Also, hiding one's identity as being autistic. This is typically done in response to neurotypical expectations to act a certain way. Over time, this process can become psychologically distressing to autistic individuals.

Medical Model of Disability - Regarding neurodivergence, this model views autism and neurodivergence as a disorder, something that is a problem that needs to be fixed, treated, or cured.

Social Model of Disability - Regarding neurodivergence, this model views neurodivergence as a person's identity and not what makes a person disabled. Rather, it is society's views of neurodivergence that makes a neurodivergent person disabled.

Double Empathy - when people with very different experiences of the world interact with one another, they will struggle to empathize with each other.

Common Terms

Sensory Processing - the way the nervous system receives messages from the senses and turns them into appropriate motor and behavioral responses. Processing issues exist when sensory signals do not get organized into appropriate responses which create challenges in performing everyday tasks and may manifest in motor clumsiness, behavioral problems, anxiety, depression, and school failure. The seven sensory areas are sight, smell, taste, hearing, touch, vestibular, proprioception, and interoceptive.

Terminology and Language

Read the PDF
https://hiehelpcenter.org/

Disability Terminology: Choosing the Right Words When Talking About Disability.

Language preferences for specific neurodivergent groups.

Lifelong Needs?

Neurodivergent individuals and those with developmental disabilities may have lifelong issues or needs in which they require support(s) and/or therapies.

These Individuals may be involved in therapies and other interventions throughout their lifetime.

Therapeutic expectations might include seeing clients longer than typical and progress and gains may move at a different pace than seen with neurotypical clients.

Neurodivergence and Play Therapy

Why is the Neurodivergent Child in Therapy?

They are not in therapy because they are autistic or neurodivergent. They are in therapy because they have a need(s) that can be helped through play therapy. Some reasons why a Neurodivergent child might benefit from play therapy:

- Anxiety issues
- Trauma
- Depression
- Social navigation needs
- Regulation struggles
- Healthy relationship development
- Life Issues (parents divorce, bullying, grief, etc.)
- Co-occurring conditions
- Parent/child strain
- Self worth issues
- Sensory struggles
- Self advocacy needs


Play Break!

Play and Neurodivergent Children

A Closer Look

What Play Might Look Like with Neurodivergent Children

Manipulating objects in a detached fashion, not really playing with any toy or material but touching it or noticing it.

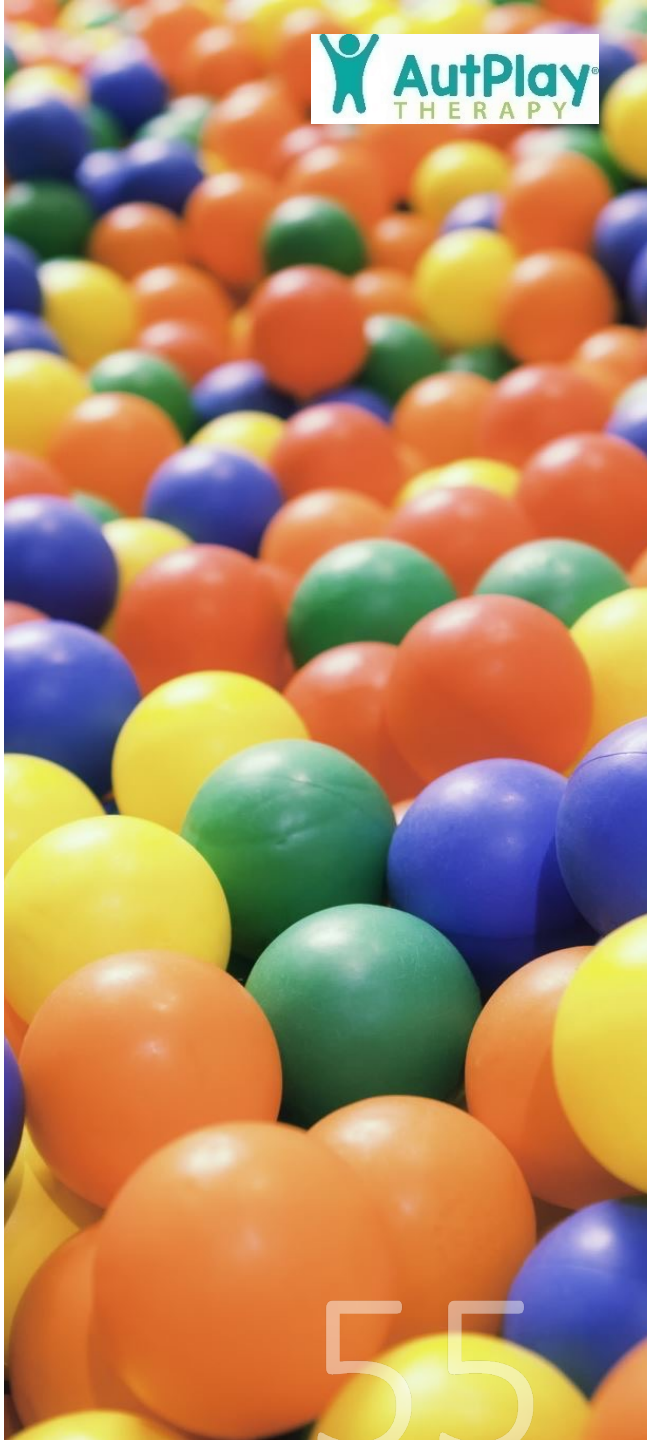
Repetitious play. Playing with the same toy in the same way each session – no variance.

Playing out a script from a movie or TV show. Playing the scene repeatedly each session.

Continually roaming around the room without playing with or manipulating anything in the playroom.

Anxiousness during play. Displaying a stress or anxiousness being in the playroom or attempting to play.

A lot of movement and changing focus in play.



What Play Might Look Like with Neurodivergent Children

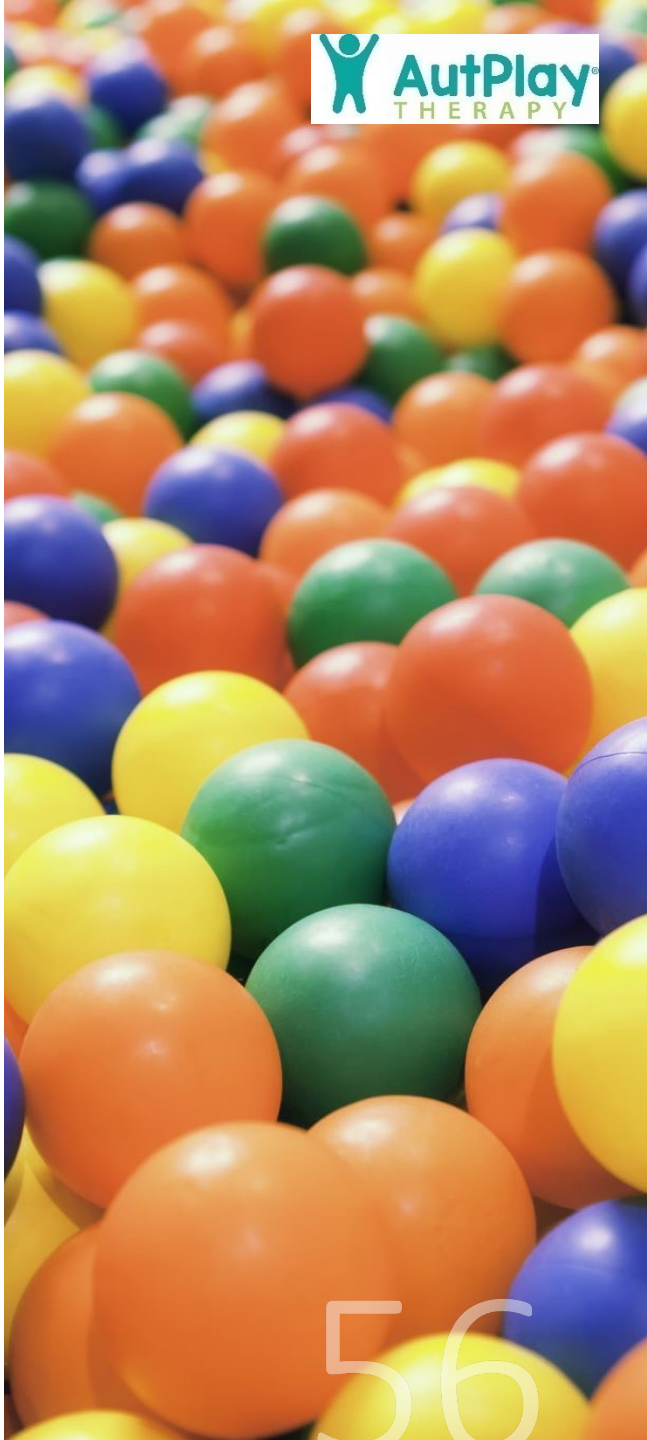
Isolated or withdrawn play. Coming into the playroom and isolating themselves in play – distancing from the therapist.

May play but have a hard time involving the therapist or participating in any play with the therapist.

Strong preference-based play. Will play but the play must be done a specific way with no changes and no input from the therapist.

Playing with objects not considered toys. May want to play with office cleaning utensils or other items that would not be considered toys.

Playing in a societal typical or expected way to play.



Play That May Not Be Displayed

- Pretend Play
- Symbolic Play
- Metaphor Play
- Group/Peer/Interactive Play

Play That May Not Be Displayed

Autistic and some neurodivergent children may not prefer or may not understand pretend, symbolic, and abstract play processes. This can include metaphor play and reciprocal interactive play with another person.

The play therapist will want to be mindful of these possibilities when working with autistic children. Implementing a play approach that relies on these types of play with a child with these manifestations would be counter productive to therapy goals.

Children to not have to display a specific type of play. Ideally, therapists will work from the child's play preferences and interests.

Typical Play Displayed

- Constructive Play
- Functional Play
- Sensory Play
- Technology Play

Typical Play Displayed

Play strengths often include constructive play – Legos, blocks, train track, car racing track, Mr. and Mrs. Potato Head, Minecraft, any building or constructing toy.

Sensory play – Play Doh, putty, sandtray, sensory balls, exercise ball, weighted balls, trampoline, movement toys, and messy play such as shaving cream, water beads, finger paints, etc.

Functioning play – Items being used the way they were intended: a small plastic bowling set, a basketball hoop, a puzzle, books to read.

Technology play – Using an iPad, a video game system, a virtual reality system, or even a computer to play games alone or with others.

Play Preferences and Interests

When working with autistic and neurodivergent children and adolescents thinks about, observe, and focus on the types of play they prefer and enjoy doing. Focus on their interests and design play therapy interventions around their preferences and interests.

Play Works

Research supports the use and benefits of play interventions with autistic and neurodivergent children and related conditions across the spectrum of professionals who typically work with these populations.

Points To Remember

- Play is the natural language for all children.
- Play can look differently from a neurotypical presentation – different is not wrong.
- Engage with the neurodivergent child in the way they prefer to play – explore their interests.
- Help parents understand the play preferences of their child and how to relationally play with their child.
- Play is the agent of change not a manipulative to get the child to do something.

AutPlay Therapy

Therapeutic Powers of Play – Core Change Agents

Schaefer & Drewes (2014) presented twenty core change agents of the therapeutic powers of play.

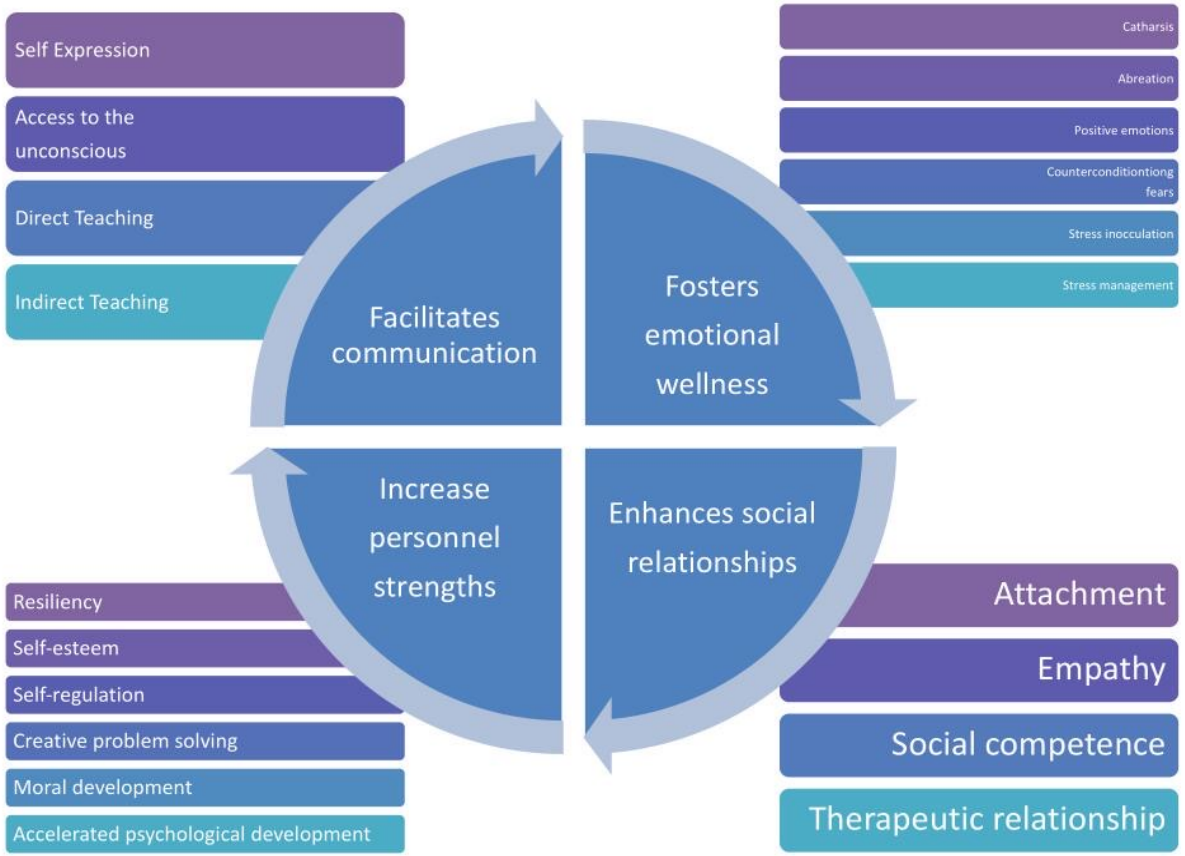
The AutPlay® Therapy protocol can potentially incorporate and address any of the 20 core agents of change of the therapeutic powers of play.

AutPlay® utilizes structed play therapy interventions that are specifically chosen and or created for the individual child. Each intervention embodies one or more of the 20 core agents of change depending on the child's assessed needs.

Therapeutic Powers of Play – Core Change Agents

Although any of the core change agents could be identified and addressed with an autistic child, typically autistic children benefit from a focus on direct teaching, positive emotions, stress management, stress inoculation, empathy, therapeutic relationship, positive peer relationship, counterconditioning fears, social competence, and self-regulation.

Therapeutic Powers of Play



Adapted from Schaefer, C. E., & Drewes, A. A. (2013). *The therapeutic powers of play: 20 core agents of change*. Wiley and from Parson, J. (2017) Puppet Play Therapy – Integrating Theory, Evidence and Action (ITEA) presented at International Play Therapy Study Group. Champneys at Forest Mere, England. June 18, 2017.

JStone, Ph.D., 2020

Typical Play Therapy Ideology and AutPlay Comparison

PLAY THERAPY	AUTPLAY THERAPY
Many theories and approaches.	A specific play therapy approach.
For children and adults.	For children and adolescents.
Various amounts/levels of structure in different approaches.	Structured and non-structured elements.
Most approaches utilize play therapy rooms.	A play therapy room is not necessary but is used in the FMA.

Typical Play Therapy Ideology and AutPlay Comparison

PLAY THERAPY	AUTPLAY THERAPY
Most approaches use toys, props, games, art, music, and movement.	AutPlay uses toys, props, games, art, music, technology, and movement.
Emphasizes importance of relationship development.	Emphasizes importance of relationship development.
Some approaches utilize metaphor, symbolism, and symbolic play as a primary contract.	AutPlay may avoid metaphor, symbolism, and symbolic play (if non preferred play for autistic children).

Watch the Video

Watch the video Hula Hoop Exchange

This clip demonstrates how to implement this intervention designed to help improve engagement, relationship, and regulation. It can be done between therapist and child and with parents.

Link on AutPlay Therapy YouTube Channel
https://youtu.be/8v2lh-VD6bQ


AutPlay® Therapy
Overview

Neurodiversity Affirming Constructs in AutPlay Therapy

Review the Handout

Small Group Discussion

Being Neurodiversity Affirming

AutPlay Therapy

A guide or framework for implementing play therapy and utilizing the therapeutic powers of play to address the mental health needs of neurodivergent children.

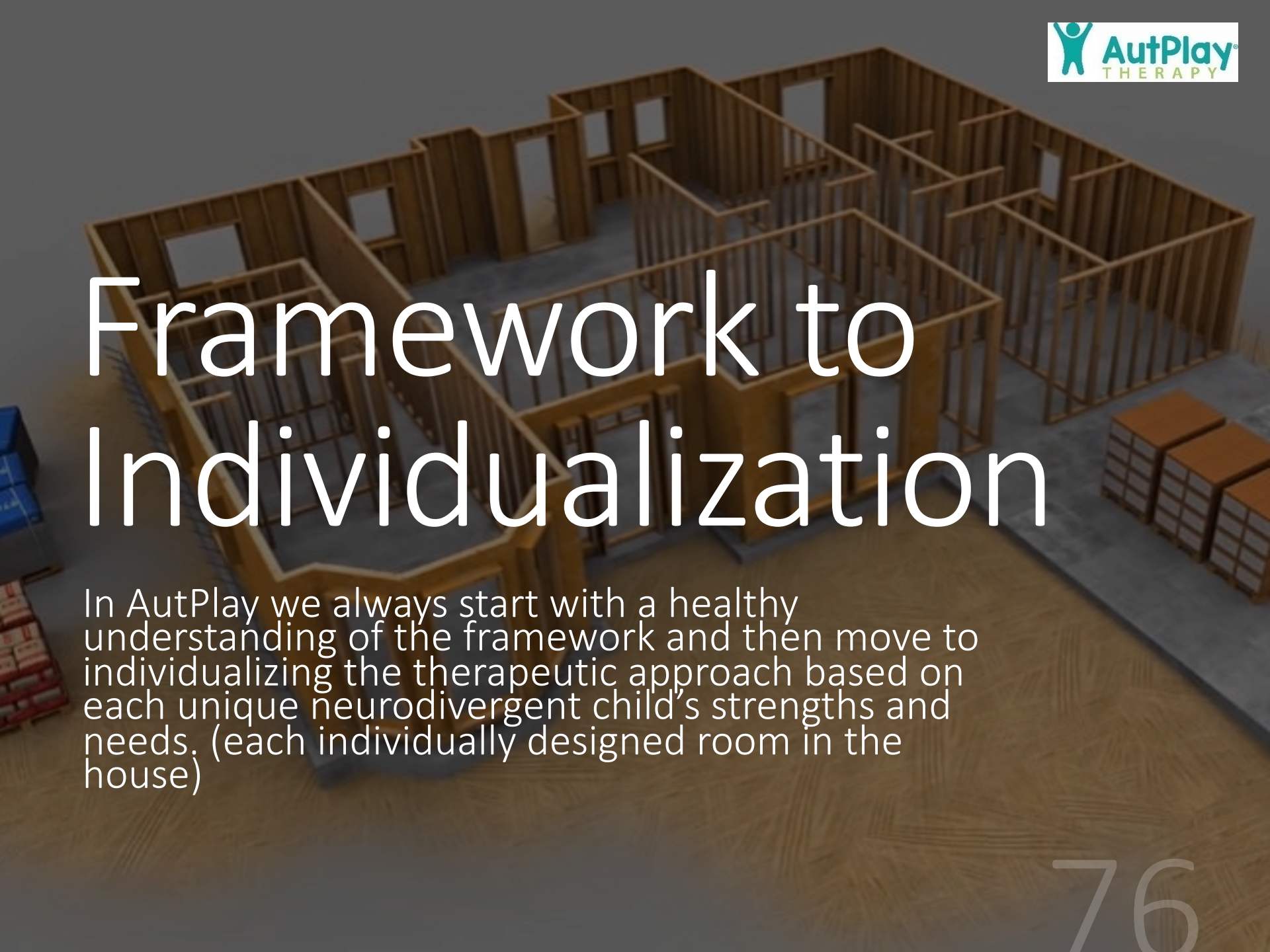
Not implemented to “fix” “cure” or “erase” the child’s neurodivergence.

Implemented to build up the child’s self worth, respect their neurotype, address them according to their neurotype, and help address any mental health needs they are experiencing.

An individualized approach to working with each child.

The Framework

AutPlay protocol is the framework for working with neurodivergent children. It guides the larger and foundation purpose. It serves as a guide for implementing play therapy principles. (the basic framework of the house)



Framework to Individualization

In AutPlay we always start with a healthy understanding of the framework and then move to individualizing the therapeutic approach based on each unique neurodivergent child's strengths and needs. (each individually designed room in the house)

Overview of AutPlay

AutPlay is an integrative family play therapy approach.

AutPlay is designed for children ages 3-18 and can integrate other approaches if beneficial for the child.

AutPlay Therapy is an integration of multiple play therapy theories.

Therapy involves nondirective and directive, relational, play therapy interventions designed to address client needs.

Self awareness, healing, empowerment, and self advocacy are desired outcomes.

Protocol involves a parent/family partnering component where parents are taught AutPlay play approaches and interventions to do at home with their child.

Overview of AutPlay

Protocol involves a thorough assessment process conducted at the beginning of therapy to better understand/know the child/family.

Therapy focuses on mental health needs.

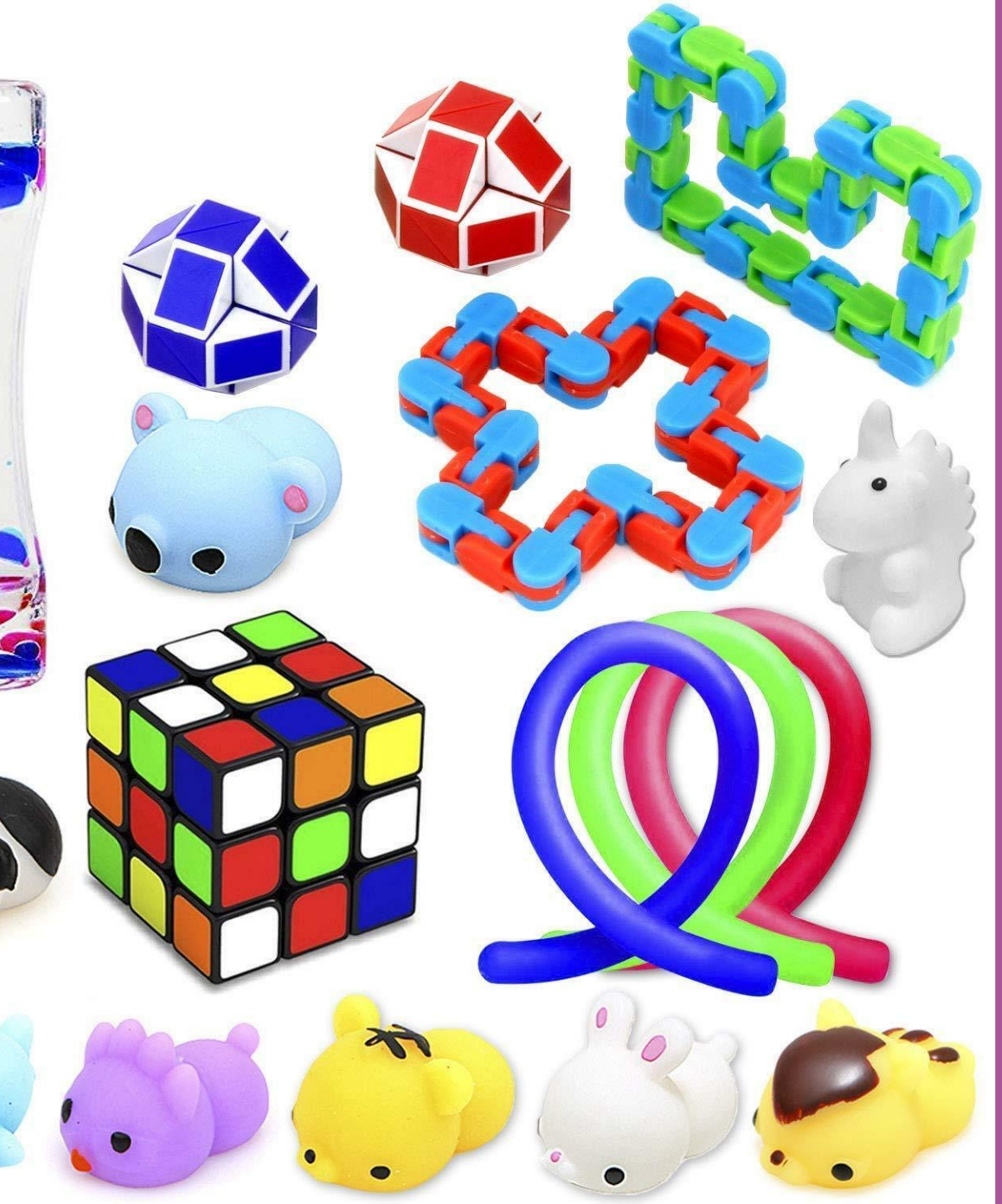
AutPlay approach consists of three phases: intake and assessment, structured play interventions, and termination.

AutPlay addresses children anywhere on the neurodivergent spectrum from high to low needs.

The Follow Me Approach (FMA) is designed for children with higher needs.

Children along with parents are considered partners in the therapeutic process.

Interactions, play interventions, and therapy goals stay focused on an affirming approach.



Toys and Materials in AutPlay

See handout in training documents

Playrooms in AutPlay

Many playrooms are created from a non-directive play therapy philosophy. This is appropriate for neurodivergent children. Autistic and neurodivergent children may play with a variety of toys and materials so the playroom set up and toy selection can have many looks.

Some additional thoughts specific to neurodivergent children:

1) Children can become overwhelmed by too many toys on display.
2) Some of your toys and materials might need to be in baskets or in a cabinet so the child does not become too overwhelmed.
3) Consider having a curtain to cover some of the toys.
4) Make sure to have some variety of sensory toys and materials in your playroom.
5) Consider technology toys in the playroom such as an iPad tablet.
6) Make sure to have constructive play toys such as Legos, blocks, a train track, etc.

Relationship Development in AutPlay

The purpose of a therapeutic relationship is to assist the child and family in therapy to change their life for the better. Such a relationship is essential, as it is oftentimes the first setting in which the person receiving treatment explores intimate thoughts, beliefs, and emotions regarding the issue(s) in question. As such, it is very important that professionals provide a safe, open, and non-judgmental atmosphere where the child can be at ease.

Trust, acceptance, and congruence are major components of a good therapeutic relationship. Professionals are encouraged to show empathy and genuineness. As with any other social relationship, the therapeutic relationship has boundaries which help to define acceptable and unacceptable behaviors.

- GoodTherapy.org (2020)

Relationship Development in AutPlay

Relationship development is foundational and central to the successful implementation of play interventions. It is the relationship that gives the interventions power and effectiveness.

Therapeutic relationship development is a core change agent within the therapeutic powers of play. The AutPlay Therapist should be mindful of relationship development practices at the beginning of therapy and throughout the duration.

Relationship Development in AutPlay

The therapists focus for developing relationship:

- Accept the child and the child's behavior where they are at.

- Do no place judgment on the child and/or parent.

- Provide unconditional positive regard to the child and family.

- Recognize the child is a fully functioning person and is more than their diagnosis or issue.

- Provide empathic responding, reflective responding and active listing skills.

- Relationship development is an active process throughout the duration of treatment.

AutPlay Session Pragmatics

Starting a session – use a structing statement such as “this is the playroom or space and you can play with anything you want, and I will be in here with you.”

Ending a session – provide a five minute and one-minute warning. Provide a transition item (small toy prize, sticker, balloon) the child can take home.

Clean Up – Depends on the developmental level of the child. Typically, children help clean up if it relates to a therapy goal (teamwork), this should be turned into a game and made playful.

Limit Setting – addressed late in this training.

Three Phases of AutPlay Therapy

1) Intake and Assessment Phase
2) Structured Play Intervention Phase
3) Termination Phase

1. Intake and Assessment Phase

Usually the first 3-4 sessions.

Focus is on relationship building, helping the child feel familiar with the therapist and office. Often this includes a tour of the clinic.

Focus is on assessment processes, gathering information about child and family, and creating therapy goals.

AutPlay inventories are given to parents.

A parent and child observation is conducted – the professional observes the child and parent playing together (for observational purposes) – see Parent/Child Observation Form.

A child observation is conducted – the professional observes and interacts with the child in a play time (for observational purposes) – See Child Observation Form.

The therapist sets the context (talks to the child and parent about why we are in therapy-this should be age and development appropriate).

Intake and Assessment Phase - Example Progression

Prior to Session 1 – Going to See a Play Therapist social story.

Session 1 – Try to meet with parents only. Complete intake forms and all paperwork, give parents AutPlay inventories to take home and complete. Explain process to parents.

Session 2 – Parents and child attend. The therapist conducts a parent/child observation, observing the parent and child playing together for approximately 25 minutes. Parent is instructed to play with their child as they normally would at home – therapist observes in the corner. The remainder of the session, the therapist joins in with the parent and child focusing on relationship developmental and increasing familiarity.

Intake and Assessment Phase - Example Progression

Session 3 – Parents and child attend. Therapist conducts a child observation (parents observe). Child observation is typically about 20 minutes of the therapist being non-directive and then switching to 20 minutes of the therapist being more directive (asking questions, trying to engage in conversation, trying to play together). The therapist also takes the child on a tour of facility, focus is on relationship development and creating familiarity. Collect AutPlay inventories from parents.

Session 4 – Try to meet with the parents (and child if appropriate). Review the AutPlay inventories and observations, ask parents/child any follow up questions. Discuss with parents and child priority therapy goals and discuss moving into the structured intervention phase next session – session 5, parent and child will participate together and begin learning play therapy interventions to implement at home.

Assessment in AutPlay Therapy

Areas to Assess in AutPlay

Learn About the Child's:

Social navigation

Emotional awareness/strengths

Regulation needs

Connection ability

Sensory processing differences

Ways of communicating

Unwanted behaviors

Family supports and resources

Other medical conditions

Other psychological conditions

Why are we Assessing

To better understand the specific child we are working with.

To gather more information about the child – their individual strengths and needs.

To help the therapist create therapy goals and a therapy plan.

To assist in selecting play therapy interventions that target the child's needs.

To help provide an evaluation system to make sure therapy goals are being meet.

AutPlay Therapy Inventories

Child Observation Form

Parent/Child Observation Form

Assessment of Play – typically given as part of intake forms

Social Navigation Inventory – typically given as part of intake forms

Emotional Regulation Inventory – typically given as part of intake forms

Connection Inventory – typically given as part of intake forms

Special Interests Inventory – Typically given as part of intake forms

Others

AutPlay Therapy Inventories

https://autplaytherapy.com/about-autplay-therapy/resources/

All AutPlay inventories can be downloaded in PDF version on the AutPlay website on the Resources page. Scroll to the bottom (exclusive content) and enter in the

passcode: autplaycertified

Intake and Assessment Phase Summary Worksheet

Review The Handout

2. Structured Play Intervention Phase

An unlimited number of sessions, this will be different for each child/family. Generally, the higher the support needs, the longer therapy will last.

The therapist should establish therapy goals and a therapy plan.

Who is this child? What do I understand about them? What do I understand about their neurodivergence? Based on what I understand would a less structed, or more structured play therapy process be appropriate?

What are the child's therapy needs? What seems to be the best level of structure to address their therapy needs?

Will I have parent participation? What level of parent participation will I have? What type of play approach or level of structure would be best based on the level of parent involvement?

2. Structured Play Intervention Phase

If I am going to implement structured play therapy interventions, what interventions would best address the therapy needs and goals? Have I filtered the play therapy interventions to make sure they are affirming and non-ableist?

Will the structure involve an integration of nondirective and directive approaches? If so, what will this look like in each session?

Will there be a focus on home play times or interventions? If so, how will I teach, support, help implement home play times? What seems like the best fit for the family and to address therapy needs?

How does the child and parent feel about the plan for the Structured Intervention Phase? Have I shared it with them and gotten their feedback and opinion?

2. Structured Play Intervention Phase

The Structed Play Intervention Phase is where play therapy approaches and/or interventions began to be implemented to address the established therapy goals. Much of the direction in this phase is determined by information gathered in the Intake and Assessment Phase. The therapist may move forward with a more nondirective approach, may begin implementing structured play interventions to address specific needs, or may do some type of combination.

The structured Play Intervention Phase can have different “looks.” Ideally there is a level of parent involvement and a participation where parents become co-change agents, working with their children at home to implement what they are learning in therapy sessions. As much as possible, parents should be taught how to implement play therapy techniques and/or play times at home that mimic what the therapist is doing with the child in sessions.

Resources for Structured Play Interventions

Grant, R.J. (2023). *The AutPlay therapy handbook: Integrative family play therapy with neurodivergent children*. Routledge.

Grant, R.J. (2016) *Play based interventions for autism spectrum disorder and other developmental disabilities*. Routledge.

AutPlay Therapy YouTube Page.

Lowenstein, L. (1999). *Creative interventions for troubled children and youth.* Champion Press.

Lowenstein, L. (2002). *More creative interventions for troubled children and youth*. Champion Press.

Mellenthin, C. (2018). *Play therapy: engaging and powerful techniques for the treatment of childhood disorders.* PESI Publishing.

3. Termination Phase

Typically takes about 3 sessions.

The therapy plan is reviewed with parents and child, it is established that therapy goals have been accomplished and there are no new goals.

The parents and child is told they will be having final session and given the final session date.

Final session is a graduation party for the child. It should be a celebration of what the child and family have accomplished.

3. Termination Phase

Typical Progression:

Session 1 – Discussion about terminating therapy

Session 2 – Termination intervention(s) with client

Session 3 – Graduation party

Exceptions when the client does not want to terminate – decreasing session to slowly terminate.

Maintaining therapy as a maintenance/self care support.

Addressing Mental Health Needs

Common Needs:

- Regulation
- Social Navigation
- Connection (relationship development)

Common Need Areas in AutPlay

Additional Needs That May Be Addressed

- Trauma Issues
- Parent/Child Relationship
- Self Worth and Self Esteem
- Depression and Anxiety Struggles
- Self Advocacy Skills
- Diagnosis Understanding (de-stigmatization)

Parent and Child Involvement in Identifying Needs

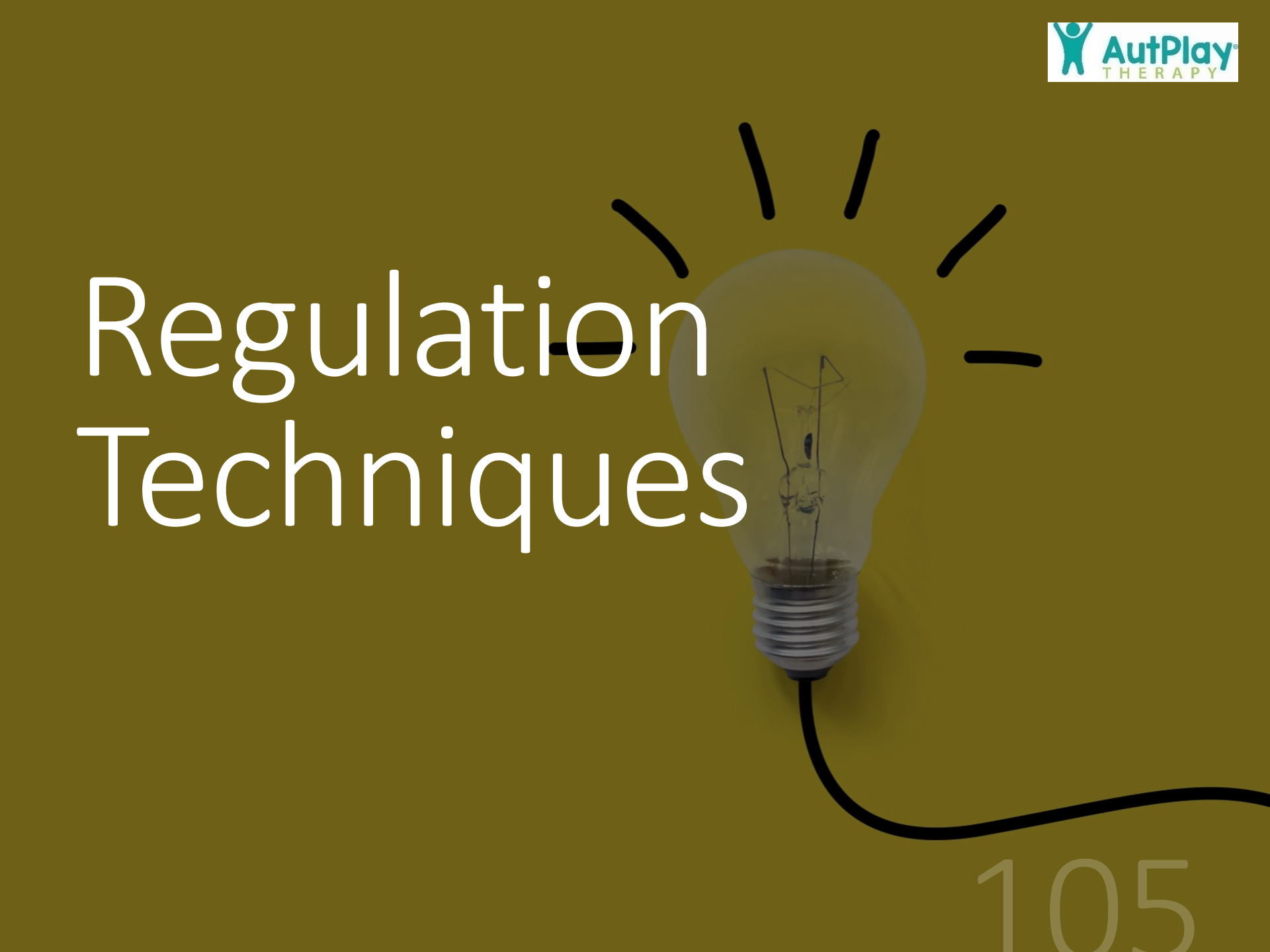
Parents and the child (if the child is capable of participating) should be involved in the process of identifying goals to work on in therapy. The parent and child are considered partners – co-change agents with the therapist.

The therapist should take care to not push their own agenda or ideas/philosophies onto the parent/child.

For example, the parent and child may identify a social need they would like to work on addressing. This would be appropriate for the therapist to pursue as a therapy goal.

The therapist would not want to force the child/parent to work on a "social skill" that is not beneficial or necessary for the child and lacks neurodiversity awareness and supports an ableist perspective.

Regulation Techniques



Feeling Go Find It

This technique can be done in perron or via telehealth.

Explain to the child that each of you are going to go find something that reminds you of a feeling. You can go find anything around you that reminds you of the feeling.

Once both the therapist and child have found something, they come back together and share what they found and how it reminds them of the feeling.

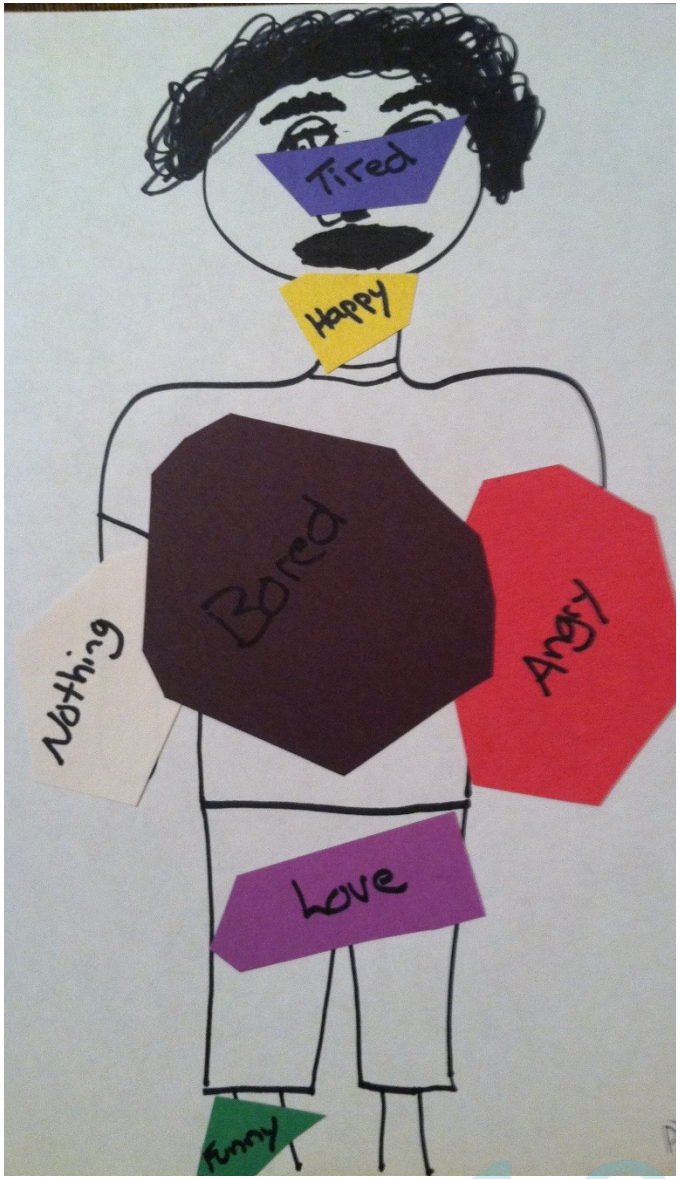
The instruction can be to find a specific feeling such as angry or excited or it can be more general – you choose a feeling and find something that remindes you of the feeling.

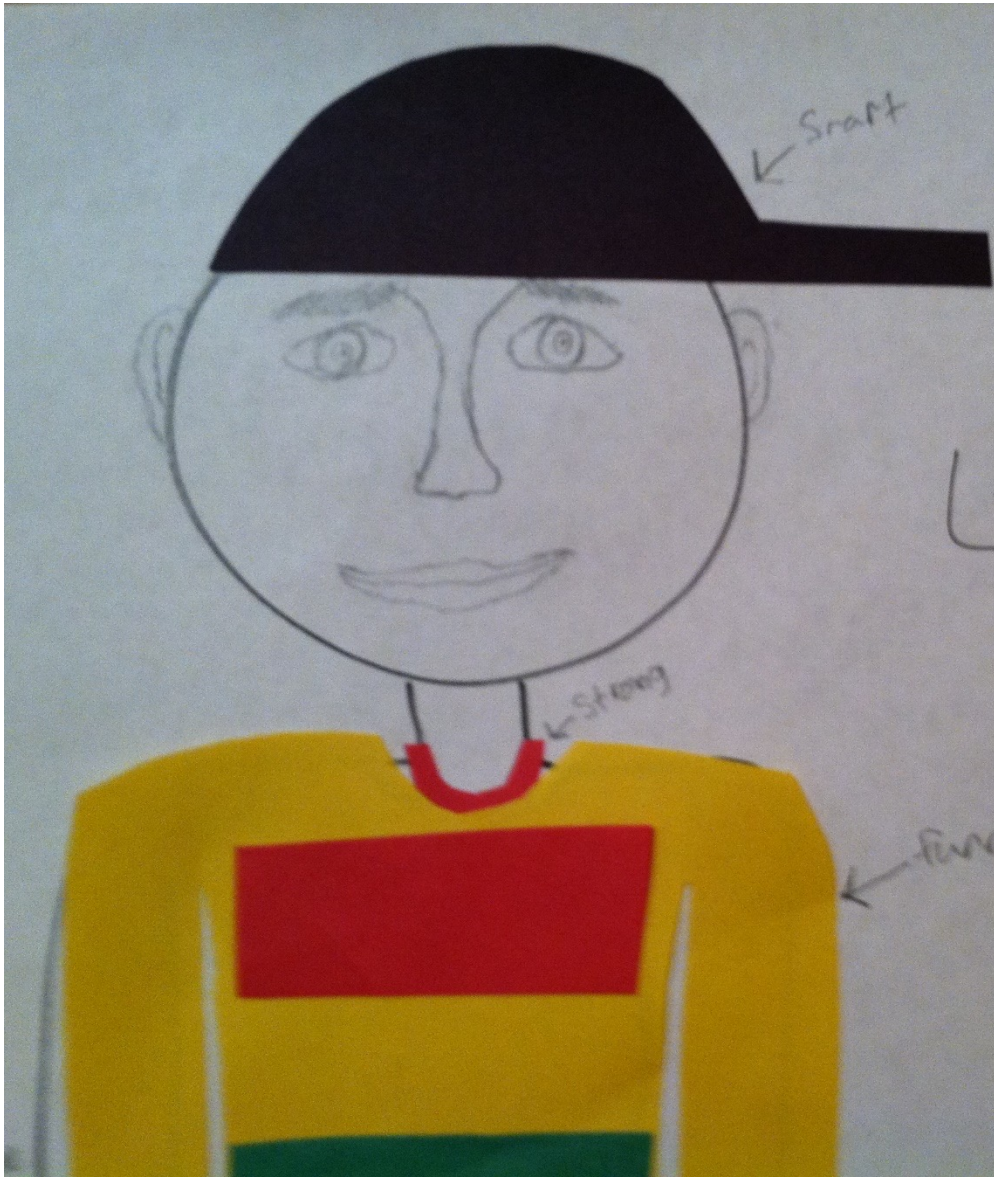
Me and My Feelings

Draw a person outline on a piece of paper, the child makes the person look like themself (face, hair, etc…). Using construction paper, cut out different colors to represent different feelings the child has felt. The color construction paper should be cut in different sizes to represent different levels of feelings; small pieces are feelings that are not felt as often, while larger pieces are feelings the child has more often. The child glues the pieces on their paper person, placing them wherever they want. The therapist discusses with the child the feelings that they selected and when they have felt that way. The therapist and child then practice expressing the feelings verbally.

Me and My Feelings Example

Me and My Feelings Example





Me and My Feelings Example

Midline Mirror Moves

The therapist explains they will be playing a mirroring game. The therapist will go first and make some moves and the child must mirror everything the therapist does.

As the therapist makes different moves, they should make several midline crossing move which activates the whole brain and helps with regulation.

After a few minutes, the child can lead, and the therapist follows. The therapist and child can switch back and forth, taking turns.

Backwards Moves

The therapist explains that they and the child will be doing different things but all of them will be done backwards.

The therapist begins with saying they will walk around the room backwards, after a few minutes it switches to hop backwards, then act like you are swimming backwards, then walk in slow motion backwards, then dance backwards, the final move should be crawl backwards.

The therapist and child can think of as many moves as they like and can play music while they do their backward moves.

This intervention helps regulate the system and decreases anxiety.

Social Navigation Techniques

Find It Show and Tell

The therapist explains that both the child and therapist are going to go find something in their environment that is special to them and bring it back and share with the other person.

The therapist and child both go find something and when both are finished, they take turns sharing what they found and why it is special.

Other ideas for things to find include something that describes you, something you like to do for fun, a positive memory.

Squiggle Draw and Share

The therapist and child each have a piece of white paper and a pen or pencil.

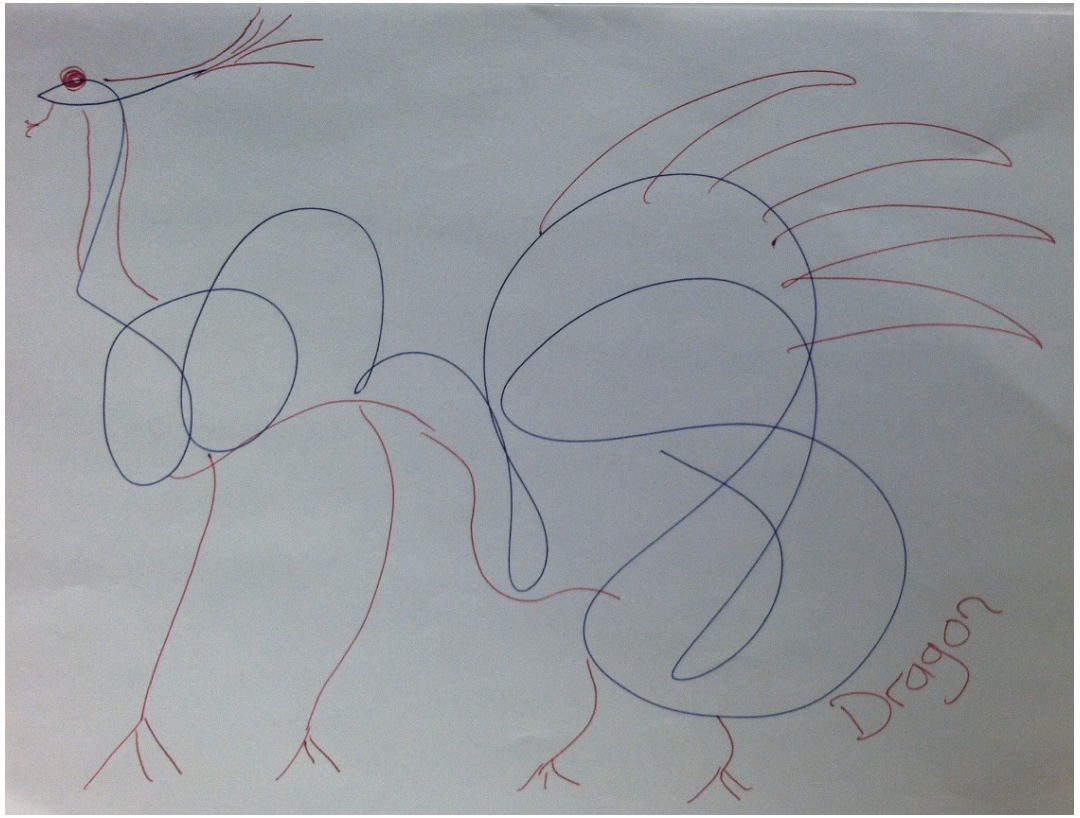
The therapist explains that they are going to say start and then both begin drawing randomly on their papers until the therapist says stop. The time is usually around 5-10 seconds.

After they have stopped, they initial their paper and then hand it to the other person. The other person must turn the scribble into a picture of something.

Once both people have completed their pictures, they sign the picture and give it back to the original person.

Now each person has a drawing that they created together.

Squiggle Draw and Share Example



Bubbles Social Navigation

Bubble blowing is used to help children practice various social navigation. The therapist creates a script to use with the bubbles, and then the therapist and child practice the script using the bubbles for added fun. One example for working on manners: The therapist and child take turns blowing bubbles, one turn blowing the bubbles for each person. The child starts blowing the bubbles, then the therapist says, "I don't like bubbles, please don't blow them by me." The child says "Sorry, I will blow them over here." Then the therapist says, "Thank you." Then the child and therapist switch roles.

Additional bubbles social navigation topics include handling and responding to a bully, handling your sibling bothering you, and asking the teacher a question.

Topics should be based on an understanding of the child and needs to be addressed.

Action Identification

The therapist acts out an action such as running, talking, reading a book, playing a video game, eating, etc... The child has to name the action and tell in what situations it would be appropriate/accepted to do that action and in what situations it would be inappropriate/not accepted to do the action. The therapist and the child can switch roles and the child can act out and action and the therapist has to guess it and say when it would be expected and when it would not be expected.

Some more example actions include yelling, picking your nose, bouncing a ball, sleeping, taking your shirt off, running away from your parents, and playing with friends.

Connection (Relationship Development) Techniques

APT Paper on Touch

Many Connection interventions involve physical touch.

Special considerations when implementing interventions with children that involve physical touch include:

- Are there sensory Issues?

- Are there trauma Issues?

- Do you have parent Permission and Involvement?

- Do you have the child's permission?

Therapists should read the APT Paper on Touch found on the APT website:

http://www.a4pt.org/?page=Research

Connection Interventions

Watch the Video Clip on the AutPlay Therapy YouTube Channel
https://youtu.be/0yHsPjlYLXs

Body Part Bubble Pop

The therapist begins by blowing bubbles and instructs the child that they must pop the bubbles before the bubbles hit the ground. After a couple of bubble blows, the therapist instructs the child that they must pop the bubbles with their thumbs only.

After a couple more bubble blows, the therapist instructs the child that they must pop the bubbles with their elbows. This continues for several rounds. Other body part examples include finger, ear, nose, feet, shoulders, knees, butt, and head. After a while, the therapist and child can switch roles.

Hands, Hands, Hands

The therapist explains to the child they are going to play several games connecting with their hands. The therapist instructs the child to trace around their hands on a piece of paper. The therapist then instructs the child to write on the traced hand all the positive things they can think of to do with their hands that involves another person.

Once the child is finished, the therapist can add to the list if they can think of other positive things. The therapist and child then do or pretend to do all the things on the list. The therapist also discusses with the child how connecting with others can be positive and feel good.

Construction Paper Decoration

Using construction paper, string, aluminum foil, or any other appropriate materials, the therapist and child make items out of the materials to give to the other person.

The items are decorative items the other person can wear such as rings, hats, necklaces, bracelets, glasses, pins, etc…

Once an object has been made, the person who made it places it on the other person.

Several different objects can be created and shared with the other person.

Construction Paper Decoration Example

Parent Training (Partnering)

Parents and Family Members as Co-Change Agents.

Understanding Families

Families with an autistic/neurodivergent child can look like and have the same issues as any family but there are issues that may be specific to these families.

- Financial stressors from services and therapies.
- Social isolation.
- Lack of respite care.
- Sibling struggles.
- Extended family members not understanding the child.
- Waiting lists for therapies.
- Mislabeled and misunderstood.
- Worrying about the future after parents are gone.
- Education struggles, being kicked out of school.
- 24/7 parenting attention, hypervigilance on prevention.
- Highly scheduled and consistent routine.
- Marriage stressors.

AutPlay Parent Training

AutPlay Therapy incorporates a parent training (partnering) component which teaches parents and other family members how to implement play therapy approaches and techniques at home.

Parents learn the play and techniques and are shown how to implement techniques at home to address therapy goals with their child.

Parent training and home implementation usually begins around session five.

What if the Parents are not Ready to Play!

Some parents may enter therapy having never played with their child or possibly never played themselves as a child.

These parents may need some extra sessions with the therapist to practice playing with their child and role playing with the therapist how to implement the play and interventions at home.

If these extra sessions are needed, they are typically scheduled around session 5-6, after the intake and assessment phase and before the structured intervention phase.

Scheduling Parent and Child Sessions

In the Structured intervention Phase sessions will begin that involve working with both the parent and the child. There are multiple ways to schedule this. Typically, it will depend on the logistical needs of the parent and the therapist. Some considerations are listed below:

1) Two sessions per week, one with parents and one with child.

2) Weekly alternating sessions, one week with parents and next week with child.

3) Weekly appointments meeting with child and parent at the same time.

4) Bi-weekly appointments meet with parent and child at the same time.

5) Splitting sessions, half with child and half with parent.

Special Consideration: childcare during parent session?

Parent Training – The Sessions

During parent sessions, the therapist will review how things are going at home and ask the parents for an update on any play therapy interventions the parents have been implementing.

The therapist will also discuss with the parents any new play therapy techniques to begin at home.

The Therapist will continue to meet with parents and work with parents on implementing the techniques at home until therapy goals have been met.

Parent Training – In Home Considerations

Implementing interventions at home – to discuss with parents:

How often will they play the interventions?

When and where will they play?

How will they manage disruptions?

Staying consistent is important.

It will look different from in office implementation.

It will look different when the therapist is not present.

Parent Training – In Home Interventions

Parents may find that they must adjust the time they implement play interventions – some children may tolerate a longer time; some may need a shorter time.

The interventions may be less formal than in the office and may take place around the house instead of one designated location.

Parents should be patient and flexible and execute the time as a playful fun time between child and parent.

Children will be more comfortable at home and without the therapist present so they may be less cooperative and display more behaviors at home with the parents than they do in the office.

Parent Training – Lack of Parent Participation

Possible reasons for lack of parent participation:

- Parent may not fully understand what to do at home.
- Parent may struggle with playing with their child, especially if they did not play as a child.
- Parents may be too overwhelmed, stressed, busy to implement play times at home.
- Parents may forget intervention instructions.
- Parents may have their own mental health challenges or possibly be on the autism spectrum and struggle with teaching their child skill development.

Parent Training – Lack of Parent Participation

The therapist should try to work with parents to eliminate any barriers to the parent participating.

The therapist should provide empathy and encouragement to parents and keep attempting to improve participation.

It's okay if it starts slowly. Whatever the parent can commit to should be supported.

Parent Training – Lack of Parent Participation

Other participation options:

- Involve other family members grandparents, siblings.
- Involve other individuals active in the child's life – nanny, residential worker, etc.
- Meet with the child multiple times per week.
- Involve another professional (intern/supervisee) who will work with you and the meet with the child for additional sessions each week.
- At School: Involve support staff (para, intern, supervisee) who will also meet with the child each week.
- Something is better than nothing. If there is no other option than you meeting with the child once a week, that is better than no intervention.

AutPlay Without Parents

Working with and empowering parents is the ideal scenario in AutPlay Therapy.

In some situations, and with some professionals, working with parents will not be an option.

AutPlay protocol and interventions can still be implemented when working with the child only.

If working with parents is not possible, the professional should still work with the child.

Parent Training – Additional Support

It is likely that parent sessions may venture into the parents own interpersonal issues. If this is occurring too often, then a referral for individual or couples counseling may be appropriate.

Parent sessions may also involve teaching parents all or part of a specific affirming parenting approach.

Parents may also want to discuss specific issues such as how to discipline their child or how to work with the school (IEP issues). In most of these cases, the therapist will want to schedule a separate time to discuss these issues.

Parent sessions will continue until therapy has concluded.

Parent Training Additional Support

The AutPlay Parent Self Care Inventory can be given to parents to help them understand and implement self care strategies.

Self Care for Parents

Research has indicated that stress levels of parents with an autistic child are like those of combat vets.

Research has also indicated that parents can identify free time in their weekly schedule but do no take the time for themselves – instead, they use the time to catch up on tasks they feel they have neglected. Many parents feel guilty taking time for themselves.

It would be beneficial to schedule a couple of self care sessions with the parents you are working with to teach them how to incorporate self care into their daily and weekly life. Helping them not feel guilty and helping them execute a self care plan.

AutPlay Therapy Follow Me Approach (FMA)

FMA Basics

This approach is most appropriate for children who typically have higher needs and cannot engage in directed play therapy interventions.

Usually done with children or adolescents with little or no engaging or attunement ability.

A beginning approach that should lead to the child participating in more directive AutPlay interventions.

Children assessed for the Follow Me Approach with likely be involved in other interventions/therapies as they are likely to have multiple need areas.

FMA Basics

Typically done in a play therapy room.

The child is given no directive instructions from the therapist. The therapist begins the session with a structuring statement such as "You can play with anything you want in here and I am going to be in here with you."

The therapist lets the child lead but periodically attempts to engage with what the child is doing. The therapist transitions as the child transitions.

The therapist notes when the child participates in engagement or connection with the therapist.

Therapist teaches the parents how to have follow me approach play times at home with their child.

Non-Directive Play Therapy Philosophy in The Follow Me Approach

- The therapist recognizes that growth is a slow process, not to be pushed, prodded, and hurried along. This is a time when the child can relax, a place where growth takes place naturally without being forced. – Gary Landreth (Play Therapy: The Art of the Relationship).

- It is the focus on relationship development with the autistic child which facilitates the child becoming more comfortable and confident which promotes engagement gains.

- The Follow Me Approach begins with an emphasis on non-directive, relationship building processes.

Non-Directive Play Therapy Philosophy in The Follow Me Approach

Relationship Development:

- Establish an atmosphere of safety for the child.
- Understand and accept the child's world.
- Encourage the expression of the child's emotional world.
- Produce facilitative responses.
- Produce reflective and tracking attention and statements.
- Establish limit setting (ACT model), reviewed later in PP.

- Landreth, G. L. (1991). Play therapy: The art of the relationship. Muncie, Indiana: Accelerated Development Inc.

Follow Me Approach

The Session Components

Child leads the play session.

Focus is on relationship development and connection.

Therapist provides reflective and tracking statements.

Therapist asks questions periodically.

Therapist follows the child figuratively and literally around the playroom.

Therapist tries to engage with the child in what they are playing with.

Therapist tries to engage with child in ways that promote designated engagement goals.

Therapist is mindful of child's limits.

More About Engaging Goals

Therapist and parent should establish some engagement and connection goals for the Follow Me Play Time.

Examples of engagement and connection goals:

Increases in noticing the therapist, increase in engaging the therapist in and through play, increase in acknowledging therapist (this can be verbal, nonverbal, any method the child chooses).

Increase in the child feeling safe and interacting with the therapist.

More About the Child's Limits

Children at the Follow Me Approach level may experience discomfort from the presence of the therapist.

As the therapist tries to engage with the child in what they are playing with, this may cause some dysregulation for the child.

Challenging the child is appropriate but challenging to the point of elevated stress or dysregulated meltdown should be avoided.

The therapist should stay keenly present with the child and be diligent to notice any frustration appearing on the part of the child.

The therapist can take a break and position themselves away from the child and make tracking and reflective statements for about 5-10 minutes and then try to engage with the child again.

Follow Me Approach Process

Intake and Assessment Phase (3-4 sessions)

Parent observing therapist and learning the Follow Me Approach (4 sessions)

Therapist observing parent implementing approach (2 sessions)

Discuss and establish parent implementing follow me play times at home (1 session)

Parent begins to implement play times at home

Weekly sessions continue with therapist implementing play times and checking in with parents

Move into connecting games when appropriate

Move into directive interventions when appropriate

Teaching Parents the Follow Me Approach

Non-Directive Play Therapy Philosophy in The Follow Me Approach

Filial Therapy Integration:

- An integrative approach including humanistic, cognitive, behavioral, interpersonal, and developmental theories.

- Parents are considered co-change agents with the therapist.

- Parents are taught how to have Follow Me Play Times at home with their child.

- Relationship development focus.

- Empowerment, self efficacy, and education focus.

- Collaboration, family strengths, and family system focus.

- VanFleet, R. (2014). Filial Therapy: Strengthening parent-child relationships through play. Sarasota, FL: Professional Resource Press.

Teaching Parents the Follow Me Approach

Therapist teaches parents how to do the Follow Me Approach at home.

The parents should observe the therapist conducting follow me sessions before practicing at home.

Therapist will establish with the parents how the follow me play times with be facilitated at home.

Implementation will likely look different from in office times.

Ideal scenario would be 20 minutes daily play time. Typically, parents will begin with a time amount the child can handle and work on increasing from there.

Teaching Parents

The Five Components

- Provide handouts

- Explain the components, give examples

- Allow parents to observe FMA sessions

- Observe parents implementing FMA sessions

Parent Training – In Home Considerations

Implementing interventions at home. Before home play times begin, the therapist should have a session with parents to establish the following:

How often with the play times happen?

When and where will they happen?

How will the parents manage disruptions. Parents should consider possible home disruptions and try to minimize for disruptions.

Parents should stay consistent with their play times. If certain days and times are established, the parents will want to make sure those times happen and that they do no change or cancel them often.

It will look different from in office implementation and different when therapist is not present. Typically, the home implementation will look more loose and the play time may move around the house and even outside.

Some parents elect to purchase certain toys and materials they know the child will like and use those toys and materials only during the follow me play time.

Follow Me Approach - The Progression

The progression from the Follow Me Approach to connecting games to directive interventions.

The Progression

1) The Follow Me Approach – Happens until the child shows enough engagement skill to start participating in simple connecting games.

2) Introducing Connecting Games – When the child begins to show attunement and engagement skills.

3) Implementing Directive Techniques – When the child is actively participating in 15 minutes per session of connecting games.

Introducing Connecting Games

Working toward a 15 – 20 minute set of connection-based activities.

Games/activities should be short and simple such as hitting a balloon back and forth.

Activities will likely begin slowly with little or no response from the child. A child may begin by hitting a balloon back once and then walking away. This is progress and the therapist should continue to introduce hitting the balloon and see if the child will increase the length of engagement.

Parents are taught the connecting games at the same time the therapist begins to implement connecting games. The parents are asked to introduce them into the follow me play times at home and work on increasing connecting game time to 15-20 minutes of the play time.

Parents are the better agent to introduce connecting games as they typically have a stronger relationship with the child and have been doing more follow me play times up to this point.

Example Connecting Games

Simple One Step Playful Interactions:

Hitting Balloon Back and Forth

Lotion Games

Thumb Wrestle

Patty Cake (hand clap games)

Feeding Games

Ball Games: toss, roll, kick, etc.

Playing catch

Blowing and Popping Bubble

Follow Me Approach to Directive Interventions

The Follow Me Approach is a beginning approach with the goal of moving into more directive play interventions.

Implementing directive play interventions will likely be a progression with the child engaging in simple play activities before moving into more specific therapeutic play interventions.

When a child can participate for approximately 15 minutes in connecting games, this is a good indication that the therapist can try to introduce a directive play intervention for specific therapy goals.

Watch The Video

Watch the Follow Me Approach Session Clips Video (Found in your training handouts)

These clips provide four examples of the AutPlay Follow Me Approach. Some examples include children beginning to engage in connecting games. Watch and observe the components of the Follow Me Approach being implemented.

See clip descriptions on the next few slides

Watch the FMA Video Clip

Clip One – Joey (16 years old)

Diagnosis: Autism, IDD, Chromosome Disorder, Medical Issues.

In this clip we were working on regulation ability and reducing Joey's anxiety. He was very drawn to Hula Hoops, so we were playing a Hula Hoop intervention that crossed the midline and activated his whole brain to help reduce anxiety and regulate.

Joey's mother was watching from an observation room (learning the intervention) and playing the intervention with him at home.

Joey's follows but also wonders off, I am directive with him but also tracking and reflecting and very quickly and smoothly moving between the FMA and directive intervention.

Joey can mostly do a directive intervention but still goes into his own world occasional and I switch back into the FMA when he does this.

Watch the FMA Video Clip

Clip Two – Abdullah (17 years old)

Diagnosis: Autism and IDD

In this clip Abdullah is working on improving emotional regulation ability. He has difficulty recognizing his feelings and expressing them appropriately. He was becoming angry at home and typically reacting to his anger by hitting people.

We are doing a directive intervention where he identifies a color to go with a feeling – puts the color onto the paper and then tries to share when he felt that way and tries to make a face showing the feeling.

Abdullah is mostly good at participating in interventions but still needs to be directed back to the interventions and prompted often. This is a good example of moving out of the FMA approach but still needing to provide a lot of guidance for the client.

Watch the FMA Video Clip

Clip Three – Jacy (4 years old) and Dad

Diagnosis: Autism

Jacy and her parents were participating in the FMA. When Jacy began therapy she was nonresponsive, no engagement skills. She would come into the playroom and play with the big dollhouse completely ignoring myself and her parents (you can see her do some of this in the clip).

In this clip we are about 3-4 months into therapy, she is now engaging in connection games for about 15 minutes of the session time. She comes in an out of participating in connection games and the FMA. You can see the back and forth in this clip

At this time in therapy, she was participating more with her parents at home as well. Many children will be in a transition stage for a while where the therapist is doing some directive work and some FMA.

Watch the FMA Video Clip

Clip Four – Alex (7 years old)

Diagnosis: Autism

In this clip Alex has been in therapy around 6 months. We have begun to introduce structured interventions to address specific therapy goals. Alex began therapy in the FMA and has progressed to this point. The intervention is a feelings kite, chosen because Alex was very interested in kites.

Alex seems to reject the intervention and then I move back into the FMA, you can see all the elements of the FMA in this clip (following the child's lead, tracking, reflecting, asking questions, and trying to get involved in the play). By the end of the session Alex comes back to the intervention and finishes it.

Let's Practice!

Practice and More Practice!

The best way to get more familiar and comfortable with the FMA is to practice it with children.

It is recommended that you practice having some FMA sessions with real child clients before bringing parents into the process.

As a professional, you will want to be comfortable with facilitating an FMA session before you try to teach the process to parents.

Addressing Behavior

Limit Setting

Addressing Dysregulation

Helpful Inventories

Limit Setting

Limits should be set minimally.

Some children will be challenging a limit, maybe on purpose, maybe because they are dysregulated or uncomfortable, maybe because they don't know that something is a limit.

Regardless of the limit setting model chosen, the therapist should be nonjudgmental when setting limits.

Many autistic and neurodivergent children may not understand that a behavior is inappropriate, or they are experiencing dysregulation and anxiety, and this is creating the behavior.

Some autistic and neurodivergent children may produce a behavior that is a limit multiple times because they are still learning about regulating their system, social understandings, and communication.

Limit Setting in AutPlay Therapy

Typically, should be an Integrative or Prescriptive Approach – Issues to consider:

- What works best for the child's age?

- What works best for the child's developmental level?

- What level of language and cognitive comprehension does the child possess?

- What does the child seem to respond to?

Child Centered Play Therapy

The ACT Limit Setting Model:

(A) Acknowledge the child's wants/needs

(C) Communicate the limit in a non-punitive way

(T) Target acceptable alternatives

- (a) I know you want to do that, (c) but in here we cannot do that, (t) but you can do this or this.

- Limits should be set as little as possible.

- Landreth, G. L. (2001). *Innovations in play therapy: Issues, process, and special populations.* Philadelphia, PA: Taylor and Francis.

Filial Therapy

Simple three step process:

1) Reflect the desire and state the limit – “You want to paint on the wall, but in here we can’t do that, you can do almost anything else.”

2) Restate with warning – restate the above if the child continues to break the limit and add a warning. “If you do that again, you choose to lose the paints.”

3) Follow through with warning – if the child continues – “You chose to lose the paints.” Take the paints and remove them from the room.

- VanFleet, R. (2014). *Filial therapy: Strengthening the parent-child relationships through play*. Professional Resource Press.

AutPlay Therapy

The Three R's – Always begins with communicate and educate, communicate to the child (explain, role mode, demonstrate) what the child cannot and can do.

- Redirect
- Replace
- Remove

- See Handout

Understanding Behavior

Inventories that can help discover why a behavior is happening. These inventories are typically given to a parent or teacher who has observed the behavior.

AutPlay Unwanted Behavior Assessment

AutPlay Situation Behavior Assessment

Behavior

Behaviors can get a lot of attention in autistic and neurodivergent children - it could be odd behavior, unique behavior, behavior that is not socially understood, aggressive behavior, meltdown behavior, isolating behavior, just behavior that is different from what neurotypical people generally do, etc.

It is important that therapists remember that most “problematic” behavior from autistic children and children with developmental disabilities is coming from a place of dysregulation – the child does not know how to regulate their emotions or states of being and the result is usually unwanted behavior.

The behavior is communication about something that is going wrong for the child – a sensory struggle, emotional modulation problems, confusion, anxiety, lack of social awarenes, etc.

In some cases, it may be as simple as the child doesn’t understand and is struggling with comprehension and cognitive awareness.

Behavior

Some Case Examples:

S. age 7: Diagnosed Autistic, IDD, Chromosome Disorder – For the first 5 sessions would lay across the hallway floor and refused to move until it was time to leave. Would not go into an office or playroom. Would not speak or interact with anyone.

M. age 5: Diagnosed Autistic – For the first two sessions ran all around the clinic. When the therapist would get him in a room, he would run out as quickly as he could and open all the doors in the clinic.

J. age 14: Diagnosed with Tourette Syndrome, Sensory Processing – Had a meltdown at the end of the session and laid in the hallway screaming and refusing to leave. It took about 20 minutes for the therapist and his mother to get him calm and to their car.

Behavior

A. age 7: Diagnosed Autistic – For about the first 4 months of therapy he would unexpectedly become upset about something (most of the time the therapist did not know what he was upset about) and sit in the middle of the playroom floor and cry.

M. age 9: Diagnosed Autistic – Would randomly come into the playroom, not speak, and crawl under a desk and refuse to come out, speak, or move. He would typically stay this way until the therapist told him the session time was over. He randomly did this the first 5 months of therapy. There were some sessions he would be fine - very interactive, and others he would not.

E. age 4: Diagnosed Autistic – Loved to throw things around the playroom especially sand and other sensory tray items. She would also try to eat the sand and sit in the sandtray. This behavior occurred for about the first 2 months of therapy.

Behavior

The previous cases represent some of the behaviors that have been experienced during sessions and each child presented at different places on the spectrum – some with more needs, some with less.

Behavior can happen at any time but most of the unwanted challenging behaviors experienced occur during the first and early sessions due to the child being dysregulated and anxious in a new place with a new person. Once the child becomes more familiar and comfortable (more regulated), the unwanted behaviors decrease.

The therapist should be prepared for various behavior and have strategies and a protocol in place for addressing behavior.

REMEMBER: How can you help the child regulate?

Guide for Addressing Behavior

1) Remember the behavior is commination, what is creating the behavior?

2) The behavior is not personal; try to temper any personal reaction you may be having.

3) The child is likely dysregulated and not in control. It is not on purpose.

4) Try to stay calm, do not become anxious. React to the child in a calm manner.

5) Do not try to control the situation, force the child to stop.

6) Give the child some space and time to reset or relax.

7) Get through the behavior as smoothly as possible.

8) Once the behavior has passed, try to assess for what created the behavior and implement preventative measures to help the child.

Regulation/Dysregulation

Regulation in AutPlay

Dysregulation – A state of being where a child has become overwhelmed with an inability to control their emotions and reactions. Often not pre-meditated and is usually an upsetting experience for the child.

Skill Based Approach – Teaching a child to recognize when they are becoming dysregulated and address the dysregulation with regulating strategies (co-regulation and self advocacy).

Maintenance Model – Incorporating regulation activities into the child's daily schedule to provide regulation regardless of the child's visible behavior (think about changing oil in your car – you do this as a maintenance to prevent an issue).

AutPlay Model of Dysregulation

AutPlay Model of Dysregulation

The child's dysregulation is like water in a glass, the water can rise (increase in dysregulation) or decline (decrease in dysregulation). Many things can cause dysregulation to increase in a child – social struggles, sensory struggles, unexpected changes, anxiety, new situations, inability to modulate emotions, etc. When the water (dysregulation) gets to the top of the glass and overflows, this is the behavior meltdown.

Dysregulation creates inconsistent behavior – a child may accomplish something one day that seems very challenging and have a behavior reaction to something the next day that seems very easy. The behavior will depend on the level of dysregulation.

AutPlay Model of Dysregulation

Some level of dysregulation is usually present in a child with neurodevelopmental disorders. When it reaches a level the child can no longer control, outward behavior happens, and the child feels and is out of control with little to no ability to regulate.

The dysregulated state and behavior is often mislabeled and misunderstood.

The dysregulated behavior is not pre-planned or pre-meditated on the part of the child.

The child is likely feeling extremely unsettled, scared, and out of control.

AutPlay Model of Dysregulation

When a child is fully dysregulated, the best approach is to let the child calm down in a quiet, private place.

Consequences will not change dysregulated behavior. A preventative approach needs to be implemented. Addressing and improving the areas that are creating the dysregulation and helping the child learn to regulate is the best approach.

Many interventions and activities can help children regulate. Most involve sensory and movement interventions, but each child will be different regarding what helps them regulate their system.

Regulation Based Play Time

Focus on mid-line crossing moves

Focus on whole brain activation

Focus on “resetting” thoughts

Help decrease anxiety and dysregulation

Help create calm and relaxed state

Help increase focus and attention

Usually involve several simple brain-based play activities and interventions.

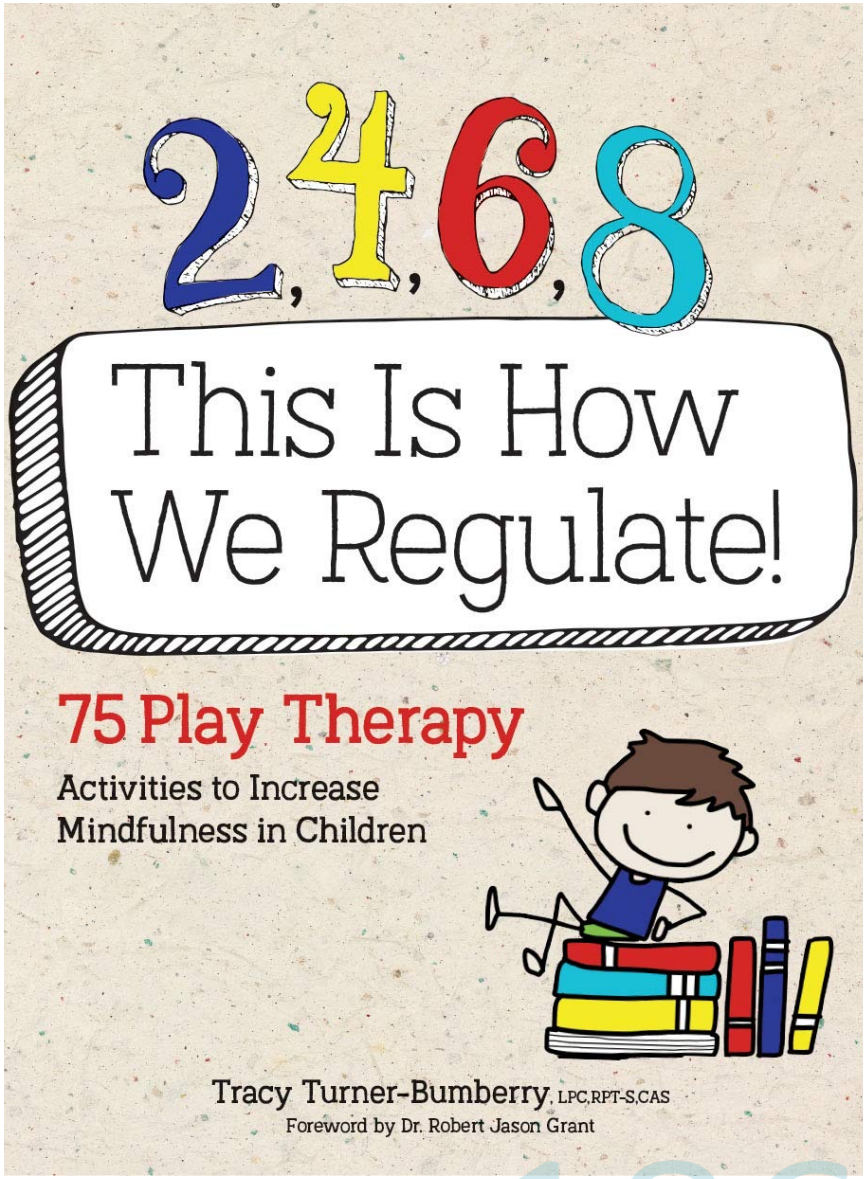
Regulation Play Time Interventions in AutPlay Therapy

Some Ideas

- Yoga for Special Needs
- Exercise and Movement Activities
- Sensory Activities
- Brain Gym Approaches (check out the Brain Gym book and YouTube clips)
- Deep Breathing Exercises
- Mandalas
- Sandtray and other Sensory Trays
- Mindfulness Activities
- Expressive arts

Resource for Regulation Interventions

By AutPlay Therapy Trainer Tracy Turner-Bumberry



AutPlay Therapy Research

Multiple clinical outcomes and case study designs have shown that children and adolescents that participate in AutPlay Therapy for six months or longer show a gains in the three target areas of AutPlay Therapy; emotional regulation ability, social navigation development, and connection (relationship development).

Parent rating scales also support an increase in emotional regulation ability, social navigation, and connection for children and adolescents who have participated in AutPlay Therapy for at least six months.

More controlled studies needed.

AutPlay Therapy Research

Read the AutPlay Research and Theoretical Underpinnings paper found on the Resources page of the AutPlay Therapy website

https://autplaytherapy.com/about-autplay-therapy/resources/

Limitations

More standardized controlled studies are needed on implementing the AutPlay Therapy protocol with autism and other neurodevelopmental disorders.

Further research regarding using play therapy with autistic children and other neurodivergent children is also needed.

AutPlay Supervision

Going beyond the AutPlay Certification Training can be vital for fine tuning skills and staying updated and purposeful when working with clients.

AutPlay supervision provides the ability to engage at a more individualized and deeper level of learning and processing that cannot always be achieved in a training.

Individual and group options available.

https://autplaytherapy.com/supervision-services/

Continue Your Training?

Check out all our online and home study trainings!

Jen Taylor Play Therapy - https://courses.jentaylorplaytherapy.com/collections

Several trainings related to play therapy topics and autism and developmental disorders.

You can also view trainings on the AutPlay Therapy website - https://autplaytherapy.com/trainings/home-study-trainings/

AutPlay® Certification Information

Title: Certified AutPlay® Therapy Provider.

Name and contact information on the AutPlay website.
(Remember to keep address current www.autplaytherapy.com)

Access to forms and inventories on resource page.

Book resources available on the website store page.

AutPlay Therapy Brochures available for purchase.

Visit the website for additional trainings.

Connect with us: AutPlay FB and YouTube.

AutPlay Logo

Download and use the AutPlay provider logo located at the bottom of the resources page on the AutPlay website.
Passcode: autplaycertified

Connect with us

www.robertjasongrant.com

www.autplaytherapy.com

info@autplaytherapy.com

AutPlay Therapy FB Page

AutPlay Therapy FB Group

AutPlay Therapy YouTube Channel

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AutPlay® THERAPY

Thank You
and congratulations on completing this training!