Exploring Play Therapies through a Neuro-Affirmative Lens

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Abstract

This Capstone research project focuses on neurodiversity-affirming care and its application to neurodivergent children as they access play therapies. I discuss a variety of play therapy models and how each of them works through a neuro-affirmative lens. Finally, I do a deep dive into synergetic play therapy, its tenets and what makes it the best fit for practitioners and parents looking for a neuro affirmative therapy for their neurodivergent child.

Keywords: *neurodiversity, neurodiverse, neuro-affirmative, play therapy, sand tray therapy, parent-child interactive therapy, child-centered play therapy, Synergetic Play Therapy,*

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Chapter One: Introduction

Throughout this paper, I will research different play therapies commonly used with children in counselling. I will also be exploring Neurodivergence—what it is, how it has evolved over time and what therapies are best suited for working with children who are neurodivergent.

Background Information

Sociological researcher Judy Singer coined the term "Neurodiversity" to refer to naturally occurring diversity in human cognition (Singer,1999). Neurodiversity is considered a more appropriate term than previous umbrella terms, such as "specific learning difficulties, neurodevelopmental disorders or hidden/invisible impairments" (Doyle & McDowall, 2021, p. 353). Walker (2014) states that Neurodiversity is a natural and essential human variation composed of infinite forms of neurocognitive functioning and not a deficit. Those who are neurodiverse or neurodivergent are sometimes considered to be part of a "neurominority" (Bottema-Beutel et al., 2020; Doyle, 2020; Singer, 1998; Walker, 2012). Elsabbagh et al. (2012) reported that one in one hundred and sixty children have Autism, making it one of the most well-known neurological disorders. As a result, the term neurodiverse is synonymous with Autism for many people. On the other hand, *neurotypical* is a term used for those who fall into a statistical norm based on relevant cognitive tests or behavioural assessments.

ADHD has been found in approximately 5% of the population worldwide (Catala-Lopez et al., 2017; Shelley-Tremblay and Rosen, 1996) but higher in the USA (Danielson et al., 2018). Autism is approximately between <1 and 1.6% globally, significantly affected by diagnostic criteria and access to services (Elsabbagh et al., 2012). Tourette's Syndrome is found in about 1% of the population worldwide (CDC, 2009; Robertson, 2006), and Dyslexia up to 10% (Snowling, 2010). Developmental coordination disorder (DCD), also known as dyspraxia, is

found in up to 6% of people globally (Blank et al., 2019), and lastly, Dyscalculia up to 6% (Snowling, 2005).

The neurodiversity movement has fought to bridge the gap between neurodivergent individuals and neurotypical members of society (den Houting, 2019), suggesting that neurodiversity is not a problem that needs to be fixed but rather as a slight deviation from the norm that makes up our wonderfully diverse and charismatic society (Comberousse, 2019). Advocates for the neurodiversity movement believe that neurodivergent individuals should not need to change to access our society but instead, society needs to learn to adapt to those with limitations in order to provide a more approachable and cohesive environment (den Houting, 2019). The neurodiversity movement also recognizes that we need different types of accessibility in mainstream society to accommodate different, non-mainstream ways of thinking (Comberousse, 2019).

Runswick- Cole (2015) argues that using the terms ‘neurodivergent’ and ‘neurotypical’ divides society by creating an ‘us’ and ‘them’ mentality and can sometimes do more harm than good (Russell, 2019). Armstrong (2015) believes there should be no standard way of thinking or behaving as everyone is different, arguing against the term “neurotypical”. In his writing he questions “…how do we decide whether any individual human brain or mind is abnormal or normal?” (Armstrong, 2015, as cited in Russell, 2019, p. 290).

Neurodivergent children may experience several barriers as they navigate through their lives. Comberousse (2019) names anxiety, sensory overload, meltdowns, and the invisibility of a child’s diagnosis as some common obstacles the neurodiverse population faces. The majority of neurodivergent children are classified with *invisible disabilities* meaning that their neurodiversity is not obvious to the naked eye. Anxiety is often experienced by children for several reasons

including the fact that autistic children can be easily overwhelmed by their external sensory environments, resulting in tantrums which are often misinterpreted as challenging behaviours. This can result in children being asked to permanently leave schools.

Purpose Statement

The purpose of this capstone is to explore the literature on play therapy with neurodivergent children, specifically synergetic play therapy, through a neuro-affirming lens with the goal of providing skills for counsellors, play therapists, and parents to use with neurodivergent children.

Theoretical/Conceptual Framework

The Theoretical Framework I will be using for my capstone research project is play therapy. Play therapy emerged because children do not possess the complex language skills needed to express themselves (Simmons, 2020). A child's cognitive brain is not fully developed and play therapy requires a low level of communication. Play therapy is used for several therapeutic reasons including helping children who are in a transition period of their lives such as during a loss or divorce, or about to undergo a major surgery. It is helpful for children who have difficulties in managing feelings, socializing, or exhibiting behavioural problems. Play therapy is also helpful for children who have been the victim of abuse or have witnessed domestic violence. Lastly, play therapy is also used with children who are neurodivergent (Koukourikos et al., 2021).

Many scientists contributed to the development of play therapy including Jean Piaget, Anna Freud, Melanie Klein, Donald Winnicott, and Virginia Mae Axline. Piaget (Koukourikos et al., 2021) classified play into three types: practice (begins in the first month of life), symbolic (begins at two years old) and social (between seven to eleven years old). Alternatively, Anna

Freud (Koukourikos et al., 2021) worked with children in a manner similar to adult psychoanalysis. She believed the child's ability to play is based on interactions with their mother, where, playing with their own body and their mother's body learns to differentiate themself from others, thus discovering how to differentiate reality from fantasy. Melanie Klein's research showed that play therapy allows direct access to the child's unconscious (Koukourikos et al., 2021). Winnicott on the other hand, strongly believed that the first three years of a child's life should be focused on the development of a close relationship with their mother (Koukourikos et al., 2021). Once that has been established, then the child can move to separation and individualization. Individuation can be developed using transitional objects and transitional space with the mother and child. Winnicott states that the relationship between the child and mother is the foundation of the child's emotional development, and play is an important part of this relationship.

Virginia Mae Axline was the first to introduce play as a form of therapy and saw conceptual expression in the process of play (Koukourikos et al., 2021). Axline believed eight key principles were necessary for play therapy: development of good communication/relationship, acceptance of the child as they are, provision of opportunities for the child to express their feelings, awareness of the feelings expressed by the child and their reflection, the belief that the child has the ability to solve their problems, non-directional play, not rushing to the child, secure boundaries around the treatment, and lastly to maintain contact with reality (Koukourikos et al., 2021).

Jean Piaget, Anna Freud, Melanie Klein, Donald Winnicott, and Virginia Mae Axline have all contributed to the field of play therapy to make it what it is today. Play therapy allows counsellors to communicate with children through the world they created (Simmons, 2020), and

assist children with co-regulating their emotions (Schore, 2004). Synergetic play therapy (SPT) is a new form of play therapy which treats both deficits through play. This paper will examine synergetic play therapy and its use with neurodivergent children.

Contribution to the Field

This research capstone is beneficial for any professional who works with the neurodivergent population, specifically children. It is also helpful for any parents considering neuro-affirmative therapy for their children. Historically, children with developmental disabilities have been viewed as "less-than", or problems that need to be fixed. There has been significant movement in the therapeutic world as more neurodivergent individuals have advocated for their voices to be heard. Dallman and colleagues (2022) believe there is an ethical and moral obligation to support clients with neuro-diversity-affirming practices. There are many play therapies available however not all are neurodivergent affirming. This paper will outline which therapies best support neurodivergent clients in a neuro-affirming way.

Reflectivity and Positionality Statement

I have worked with children my entire life in a variety of different ways both recreationally and therapeutically. I have always been drawn to the way children communicate and find pleasure in play at different stages. With each child I have worked with, my desire to learn about child development and neurodiversity has grown. Throughout my years as a play therapist, I have been trained in various play-based and behavior-based models, which have allowed me to have an advantage when learning about different types of play therapies. Each type of therapy has had value and has taught me something at the time. How I worked with neurodivergent children has changed over the years as I learned more and grew as a therapist.

Now as a play therapist, I am embracing the Neurodiversity Affirmative model and using play-based therapies which help children reach their goals rather than make them appear "less autistic." I am aware I hold biases and assumptions around this topic, specifically that I believe neurodiversity-affirming care is essential, and necessary when working with neurodivergent children. I also have a special place in my heart for children since I have spent so much time with them and want to promote the best possible care.

Definition of Terms

Attunement

When the therapist and the child come together as a system and a synergy appears, allowing the therapist to know exactly what to do next at the moment (Dion, 2015a)

Children with Developmental Delays

A developmental delay refers to a child who has not gained the developmental skills expected of him or her compared to others of the same age. Delays may occur in the areas of motor function, speech and language, cognitive, play, and social skills (SSM Health, n.d.).

Co-regulation

Co-regulation is a complex process that develops within the attachment relationship and starts at infancy. It is developed through an attuned caregiver who can provide consistent and safe responses to an infant's distress. The attunement, attachment, and regulation skills are imprinted in memory and form the basis for self-regulation (Schore, 2004).

Neuroception of Safety

This term was conceived by Dr. Stephen Porges and describes our body scanning the environment for cues of safety or danger (Dion, 2018).

Neurodivergent

Sometimes abbreviated as ND, means having a mind that functions in ways which diverge significantly from the dominant societal standards of “normal”. This includes but is not limited to: Autism, ADHD, bipolar, synesthesia, and misophonia (Autistic Self Advocacy Network, n.d.)

Neurodiverse

Neurodiverse is when there’s a group of people who all have different minds/brains in comparison to each other. An individual cannot be neurodiverse because there is only one mind/brain. Even if an individual has multiple neurodivergence, it’s still only one brain. Diversity refers to the variance in a population, place, or group (Autistic Self Advocacy Network, n.d.).

Neurodiversity Affirming Model

NAM is a framework that validates and affirms neurodivergent people’s experiences. It recognizes that neurodivergent people are essential to our society and deserve respectful and affirming care. It is trauma-informed and acknowledges that there is a natural variation in human cognitive function. It rejects the idea that neurodivergent people need “fixing.” (RDS for Neurodiversity Online Continuing Education, n.d.)

Play Therapy

According to the American Association for play therapy (n.d.), this form of therapeutic intervention is defined as “the systematic use of a theoretical model to establish an interpersonal process wherein trained Play Therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (para. 3)

Outline of the Capstone Project Chapters

In this capstone project, I will introduce what neurodiversity is, and its prevalence globally by showcasing statistics, then describe different neurodiversity affirming models and therapies that are being used in current literature. Finally, I will describe different types of play therapy that are being used for children in counselling, including synergetic play therapy and its applications.

Chapter Two: Literature Review

According to a study done from 2009–2017, Approximately one in six children are considered neurodivergent (Zablotzsky et al., 2019). Included in this study were developmental disabilities such as Attention-deficit/hyperactivity disorder, Autism spectrum disorder, Blindness, Cerebral palsy, moderate-to-profound hearing loss, learning disabilities, intellectual disabilities, any child who had seizures in the past 12 months, any child who experienced stuttering or stammering in the past 12 months, and any other developmental delays (Zablotzsky et al., 2019). There are many different types of play therapy available for children who are seeking counselling and special consideration should be given for those who are neurodivergent.

This literature review is divided into three sections; section one will introduce neurodiversity-affirming models and how it shows up in the playroom, section two will explore current play therapies to support neurodivergent children, and the third section will describe Synergetic Play Therapy in detail, and its applications.

Section I: Neurodiversity-Affirming Therapy

As a play therapist who specializes in working with neurodivergent children, I am often looking for therapies that are neurodivergent affirming. Some researchers have cast doubt on the use of current treatments for treating autism spectrum disorder (ASD) symptoms, noting that these approaches treat a person with ASD as "a problem to be solved rather than an individual to be understood" (Prizant, 2015, p. 17). It was discovered through in-depth interviews that young adults with ASD face immense pressure to mask their traits and act neuro-typical (Prizant, 2015). Neuro-affirmative therapies focus on the goals and well-being of the client, rather than targeting specific behaviors. For example, verbal expression is often prioritized in therapies, rather than accommodating alternative forms of communication that may be preferred by the individual such

as sign language, or augmented communication. Neuro-affirmative therapists can support clients in a multitude of ways including promoting self-advocacy and awareness of how their brain works, de-stigmatization through books, puppets, or social stories for siblings and classmates to teach about neurodivergence and inclusivity and referring clients to other neurodiversity-affirming professionals (Dallman et al. 2022). Bottema-Beutel et al. (2021) speak about the importance of using neuro-affirmative language as opposed to outdated terms like “at risk for autism” or “special needs” (p. 1), stating that once researchers begin using non-ableist language in their work, then service providers, and society, in general, may become more accepting of autistic people.

The neurodiversity affirming model (NAM) is a trauma-informed framework that validates and affirms neurodivergent people’s experiences. It recognizes that neurodivergent people are an essential part of our society and deserve respectful and affirming care rather than needing “fixing”. The NAM is based on Thomas Kuhn’s paradigm shift and is informed by five pillars: anti-oppressive and anti-ableist, leadership of those most impacted, acceptance-based, trauma-informed, and body-mind liberation (RDs for Neurodiversity, n.d.). The NAM holds roots in a variety of studies including disability studies, disability justice, critical autism studies and neurodiversity studies (RDs for Neurodiversity, n.d.).

With research moving towards a more neurodiversity-affirming framework, it is important to find therapies that are following the same theoretical stand. While many play therapies are available, Synergetic play therapy (SPT) works best with a Neuro-diversity affirmative model. SPT is a way of being in relationship with a child and is unique in that it can also be applied to many other forms of play therapy. It also includes many key concepts that can easily be explained to parents so that they can incorporate them inside and outside the session to

strengthen their relationship. Tenets of SPT such as attunement, co-regulation, redirection, working with aggression, and emotional flooding work to support both the child and therapist's (or parent's) regulation simultaneously while allowing the child to be their authentic self and act out their feelings (Dion, 2015b). These core concepts will be discussed in detail throughout the paper and will empower parents and professionals to work with children in a neuro-affirming way.

Section II: Play Therapies for Neurodivergent Children

This section will explore the following play therapies: Sand tray therapy, child-centered play therapy, expressive play therapy, and parent-children interaction therapy.

Sand Tray Therapy

Sand play therapy is a symbolic form of play created by Dora Kalff in the 1950s. Kalff combined Carl Jung's analytical psychology and Margaret Lowenfeld's "world technique" and integrated them with Eastern thoughts and philosophies. Sand play is an effective intervention for children as they can express their emotions freely using sand, water, and miniature objects in a safe and contained environment. Sand play therapy requires little language skill and allows children to express themselves or respond nonverbally through their sand play creations. Sand play therapy enables children to express their emotions, reveal traumas, and develop safe relationships and self-actualization (Tan et al., 2021). Children use a sand tray to create a fantasy world using different figurines. With the sand tray, they can depict their understanding of the world and their reality, providing the therapist with a symbolic representation of their inner world. This playful approach works, because it provides children with a protected and contained space where they can share facets of their experience with the therapist. A standard sand play therapy session requires a quiet room with a sandbox with the bottom painted blue to reflect

water or the sea, sand (water should also be provided so that the children have a choice of both wet and dry sand), and miniature objects organized in categories for the children to choose from (Tan et al., 2021).

During sand play, it is important to pay attention to both the child's behaviours and the emerging themes of the game. Observations may include how children play with the sand, the number of toys used, how children engage in play, and any changes or revisions made to the game (Tornero & Capella, 2017). Research has also been done using sand play with child victims of sexual assault. This revealed that children might externalize conflict and take control over negative experiences, opening the possibility to portray, manipulate, alter, and destroy facets of the traumatic experience. These are all crucial to psychotherapeutic work in the sense that they allow individuals to resignify events (Tornero & Capella, 2017). Research in sand tray therapy also points to its effectiveness in reducing symptoms of oppositional defiant disorder and conduct disorder (Chalfon and Ramos, 2022).

In sand tray therapy, the therapist does not judge or make immediate interpretations, facilitating a safe, protected environment for free expression. Pearson and Wilson (2019) point out that the differential of sand tray therapy in relation to other playful interventions is the containment offered to the patient through three configurations: the concrete limits of the sandbox, the limits of the therapy room, and the relationship of trust with the therapist. In this way, the therapeutic environment provides a protected, safe, and reliable space in which patients can freely expose their emotional vulnerabilities. These authors state that when patients start sand tray therapy, they unload many different memories and emotions. The sand-play room, the therapeutic alliance and the sandbox offer safe limits so that the unconscious contents can be emptied, rearranged, and refilled. Roesler (2019) points out that the sand tray therapy scene

portrays the patient's internal world. sand tray therapy is one of the many effective play therapies available for children currently.

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is a comprehensive, relational counselling approach influenced by Carl Rogers. According to Landreth (2012), play therapy is:

> a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures which provide selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (p. 11)

CCPT is grounded in the belief that an attuned therapeutic relationship between the therapist and client is paramount. Through the CCPT process, children engage in self-directed play, exploring their experiences and emotions. As a result, they gain a sense of mastery and control over their world and, ultimately, become more integrated human beings (Landreth, 2012).

For autistic children, some researchers maintain that the play experience and core relational tenets lead to increased joint attention, environmental exploration, and self-regulation. Ray, Sullivan, and Carlson (2012) reasoned that the experience of an accepting, genuine, and empathic relationship in a non-directive play environment might contribute to improved relational engagement and communication. Similarly, Porges (2011) argued that in relational experiences such as CCPT, which create a soothed autonomic nervous system and secure attachment, children might experience what neuroscientists refer to as *neuroception of safety*.

Thus, the process of CCPT allows children with ASD to experience safety in a relationship, express affective arousal and dysregulation, and practice self-regulatory skills and varying forms of self-expression (Porges, 2011; Schore, 2001). CCPT has been used successfully for more than 60 years.

Parent-Child Interaction Therapy

Parent-child interaction therapy (PCIT) is a well-established, clinic-based, behavioural parent-training program for young children that places central emphasis on improving parent–child interaction patterns and the quality of parent–child relationships. PCIT draws on attachment and social learning theories to emphasize positive attention, consistency, problem-solving, and communication. Parents first learn to build a positive and rewarding parent–child relationship via positive attending skills and differential reinforcement and then learn effective discipline strategies and time-out procedures. The length of PCIT for each family varies based on how quickly the family masters the program. A distinguishing feature of PCIT is the use of in-session parent coaching. The therapist monitors the family from behind a one-way mirror and provides live and individualized coaching where parents wear a device in their ear (Comer et al., 2017). Children receiving PCIT in clinical practice showed a greater reduction in behavior problems compared with children receiving treatment as usual, and their parents' parenting skills improved to a greater degree compared with those receiving treatment as usual (Bjorseth & Wichstrom, 2016).

PCIT differs from the three other modalities in that parents and children meet in parent-child sessions where parent coaching is performed through a wireless in-ear speaker between the parent and therapist while the child and the parent are in a playroom and the therapist works behind a one-way mirror. The therapist watches the family throughout the session and tailors the

treatment to directly observed parent and child behaviors instead of relying solely on parent reports. PCIT was originally developed as an intervention for children with disruptive behavior problems such as Oppositional defiant disorder or conduct disorder. PCIT has also shown promising effects on a variety of problems beyond externalizing, such as depression and anxiety, and it also shows applicability to very young children (Bjorseth & Wichstrom, 2016). Effective results have been obtained in studies of ethnic minority populations seeking treatment in usual care, in treating traumatized children, in the prevention of maltreatment, and for children with developmental delays (Bjorseth & Wichstrom, 2016).

While sand tray therapy, child-centered play therapy, expressive play therapy and parent-child interaction therapy all have benefits, for the purpose of this paper I will be showcasing why synergetic play therapy is one of the most effective forms of play therapy for both parents and children who are seeking healing, and looking to transform themselves in a neurodivergent affirming way (Dion, 2015a).

Section III: Synergetic Play Therapy and Applications

Synergetic play therapy (SPT) is a model of play therapy which blends the therapeutic power of play with nervous system regulation, interpersonal neurobiology, attachment, mindfulness, and therapist authenticity. The therapist's ability to engage in mindfulness and model regulation of their own nervous system is the foundation for clients to learn how to manage their own nervous system. In SPT, the therapist leads the way, just like a caregiver leads the way for an infant (Schore, 2004). Synergetic play therapy results in the child healing from the inside out and from the lowest parts of the brain up (Dion & Gray, 2014). SPT is about being in relationship with the child and can be applied to supplement any form of play therapy or be used independently.

Synergetic Play Therapy

This section begins with a discussion of the history and function of SPT followed by caveats and limitation of such therapy and conclude with highlighting the importance of attunement between the child and the therapist.

History. Synergetic play therapy is a relatively new theory, developed by Lisa Dion in 2008 through her personal experience and a combination of child-centered play therapy, Experiential play therapy and gestalt play therapy. In a live webinar (2023), Lisa Dion describes the attunement she had with her daughter while inside the womb and how she witnessed the co-regulation by watching the fetal heart rate monitor in real-time.

SPT has many influences, including mindfulness, the study of the mind, neuroscience and interpersonal neurobiology, physics, the work of Dr. John Demartini, and brain and nervous system states. Other major influences include filial play therapy, theraplay, eye movement desensitization reprocessing (EMDR), Attachment theory and somatic and body-centered therapies and practice (Townsend et al., 2021). Townsend (2021) also discusses how SPT incorporates many ideas from interpersonal neurobiology (IPNB), which influences future relationships, neural wiring, and self-perception. Synergetic play therapy involves teaching children mindfulness by modelling somatic techniques like rocking back and forth, tapping or rubbing your arms or legs, and taking deep breaths. The study of the mind, brain and nervous system states influenced SPT and how children are regulated in a session. Lisa Dion (2015b) compares regulating a child in a playroom, to rocking a baby when they are upset. Lastly, Dion speaks about the importance of relationship in the playroom and building attachment with the child, showing the imperative influence of attachment theory. All the aforementioned therapies and theories have worked together to make Synergetic play therapy what it is today.

The Function of Synergetic Play Therapy. Synergetic play therapy is both directive and non-directive in its use (Dion, 2015b). Whatever the child presents during the play can be viewed as a metaphor for the child's own experiences. The play therapist works to stay within the child's metaphor, using observational and reflective statements. The children can confront their issues safely because the play is contained and metaphorical (Simmons, 2020). The therapist will model ways for the child to regulate their nervous system by breathing, naming the experience and/or rubbing their hands together. The therapist is also free to use other interventions based on the child's needs such as incorporating family members into the session, using sand play, art activities, etc. The SPT therapist believes that the child is the expert in their own healing (Dion, 2018). A Synergetic play therapy session supports children by focusing on being in relationship with the child, not by doing something to the child (Dion & Gray, 2014). Most importantly, the synergetic play therapist supports the child in getting in touch with their authentic self through key components including attunement, observational and self-reflective statements, and co-regulation.

Caveats and Limitations. Research suggests that SPT significantly improves emotional tolerance and regulation (Dion & Gray, 2014; Simmons, 2020); however, there are some limitations surrounding SPT, including the fact that it is a relatively new theory, and more research is needed to be done on the outcomes of therapy. Another limitation is that the therapist must work hard to be attuned to the client during the sessions and be congruent with their verbal and non-verbal communication. If the therapist is having an off day, then it may transfer over into their work and affect the quality of the session. Another important piece to note, is that most of the research surrounding Synergetic play therapy is based on Lisa Dion's (2008) research, rather than other scholars and is a new form of play therapy. The therapist works with the

children to help co-regulate by acting as an external regulator. The therapist does this through observational and reflection statements, being attuned, and redirection. While SPT has some limitations, there are far more benefits, and I plan to use it in my practice.

Synergetic play therapy is an effective therapy to use with children who are neurodivergent, who have experienced trauma and who have a variety of disorders. The attunement needed in an SPT session is similar to that between a caregiver and child and works to co-regulate emotions (Schore, 2004). Synergetic play therapy embodies the ideas of Allan Schore's affect regulation (2004), as the therapists must be attuned to the children's emotions in order to co-regulate. It is vital for children to learn these skills at a young age so that they will have the ability to self-regulate as they get older and are faced with and placed in inevitable emotionally tumultuous situations. SPT has also proven helpful in building the neural pathways lacking for clients that do not spontaneously self-actualize (Simmons, 2020). Synergetic play therapy has an assortment of core concepts which are vital to its implementation that I will be outlining.

Attunement: Relationship between Child and Therapist. In SPT's truest form, toys and speech are not required. The therapist is the most important toy in the playroom; toys are merely used to facilitate the relationship between the child and the therapist. For example, play can occur through engaging in a game of peek-a-boo or making rhythms together using clapping or tapping. In SPT, toys themselves are not as important as the energy and emotions that arise as a result of how the child is playing with them because these represent the dysregulation that the child experiences in life (Dion, 2015b). In SPT it is pertinent that the therapist stays mindfully present in their own internal experience, maintains empathic attunement with the child, and responds flexibly to the child's play, throughout the entire session. When successful, the child

will experience trust and safety as long as the therapist's verbal and non-verbal communications are congruent. The therapist then becomes the external regulator for the child's dysregulated states as they arise during play (Dion, 2015b). A major goal of SPT is to communicate the message of being able to hold and be authentic in this energy with the children to support the child's nervous system. This genuineness creates a safe environment for the child to express themselves (Dion, 2015b).

SPT Applications

In this section, I will be discussing the following subjects: observational statements and self-reflection, co-regulation between the child and therapist, redirection, working with aggression, and emotional flooding.

Observational Statements and Self-Reflection: Supporting Safety. SPT therapists use a combination of observational and self-reflective statements to avoid emotionally flooding the child, which enhance the neuroception of safety and help the child move toward the dysregulated states (Dion, 2018). Observational statements are used to help children stay within their window of tolerance and/or titrate the energy in the room (Dion & Gray, 2014), whereas self-reflective statements are used to name the therapist's experiences out loud in response to the child's play which creates a sense of safety for the child, similar to when a caregiver models self-reflection (Dion, 2015b). SPT therapists also engage in self-reflection to model and teach children about the world of emotions. Naming internal experiences out loud allows a person to move through painful states and can regulate the nervous system (Dion, 2015b).

Coregulation between Child and Therapist. Coregulation is a vital component of Synergetic Play therapy. The therapist must work at the edge of both their own, and the child's window of tolerance and the regulatory boundary of the dysregulated states to expand those

boundaries and change the nervous system. This happens through the therapist's ability to be authentic and congruent in their expressions, coupled with the ability to co-regulate through the ups and downs in the client's arousal system. This allows the child to move towards uncomfortable thoughts, emotions and sensations that are attempting to be integrated (Simmons, 2020). With repeated observation, the child's mirror neuron system is activated, and the child learns that it is ok to also move towards their own challenging internal states. Children can make better choices when they have internalized proper conditions such as self-awareness, self-acceptance, and nervous system regulation (Dion, 2015a). When a child is regulated, they are not as sensitive to the dysregulation of others, which contributes to a better relationship with themself and others around them (Wheeler & Dillman Taylor, 2016). In conclusion, the therapist maximizes right-hemisphere to right-hemisphere communication and acts as an external regulator for the client's dysregulated states (Schore, 2004).

Redirection: Setting Healthy Boundaries. Redirection is a common tool that SPT therapists use to set boundaries in a session rather than saying "no." To do this, the therapist would first take a deep breath to ground themselves, get present with the child, and ensure the child can energetically feel the therapist. They use a non-threatening yet serious voice, make eye contact, if possible, acknowledge before redirecting and keep their feelings out of it. The SPT therapist may say something like, "You are frustrated and want me to know. Show me another way". Dion (2015b) highlights the importance of setting boundaries in this way, so the energy keeps moving and the child does not incur shame or guilt by internalizing messages that they did something wrong.

Working with Aggression. Lisa Dion (2018) states that "aggression is a symptom of sympathetic nervous system activation when a child is perceiving a threat or challenge" (p. 14).

Many therapists try to discourage or redirect aggression in the playroom; however, synergetic play therapy offers a way to turn it therapeutic. Dion explains how watching or engaging in aggressive play activates our nervous system's sympathetic and dorsal parasympathetic states (2018). Since both extremes are uncomfortable, many therapists try to avoid them. Synergetic play therapy teaches the therapist how to regulate themselves during the play so that the children can explore aggression therapeutically safely in the playroom.

At times, the play may become too aggressive or triggering for the therapist, and boundaries may need to be set. In SPT, boundary setting can be flexible since the therapist's window of tolerance will vary throughout each given day. This flexibility includes setting boundaries as the challenges arise, rather than setting the boundaries ahead of time. This maintains trust between the therapist and the child and keeps the playroom a safe environment. Dion expresses the importance of acknowledging the child before redirecting to avoid shaming the child and staying present in the play. This can be done with phrases like "This is very important to you; show me another way" (Dion, 2018, p. 97). Dion also recommends that therapists do the following things to ground themselves when setting a boundary: taking a deep breath, get present so the child can energetically feel you, use a non-threatening yet serious voice, whenever possible, make eye contact, and keep feelings out if it (they can be discussed later, if at all). Redirection can be done using words, or actions. When redirecting with an action, the therapist can gesture where they want the energy to go, such as "hit me from here down!" (While pointing below your neck) if a child is hitting you on your head. Or, if a child is throwing sand on the ground, quickly lay a shower curtain down and invite them to continue dumping. If you are using your words to redirect, you might say something like "Show me another way" or "I

don’t need to hurt/My body doesn’t need to hurt to understand” If a child is continuing to hurt you in the play after you have tried to redirect (Dion, 2018).

Emotional Flooding. Emotional flooding happens in every play therapy model because emotional flooding is part of a relationship. Both the therapist and the child can experience emotional flooding. When the child is flooded or moving towards flooding, the only task is to help the child perceive safety in the moment. Dion notes that within SPT, “Emotional flooding is inevitable; it's part of [the] relationship. It's not about shame, but connection, providing a platform upon which real repair can flourish” (Dion, 2018, p. 102). Dion provides various tools to help the therapist minimize their emotional flooding. This includes: orienting themselves throughout the session by pausing and looking around the playroom, using breath and movement to ground themself, naming their experience out loud to help calm their amygdala, making sure to use observational statements throughout the session to track the play and keep their rational brain engaged, and lastly by setting boundaries within the play so that they can acknowledge and redirect when the play is going outside of their window of tolerance (Dion, 2018).

Chapter Three: Discussion and Application

The purpose of this capstone was to explore the literature on play therapy with neurodivergent children, specifically SPT, through a neuro-affirming lens with the goal of providing skills for counsellors, play therapists, and parents to use with neurodivergent children. The literature clearly states the importance of using neuro-affirmative language to move away from an ableist perspective and positively influence the way society views the neurodivergent population (Bottema-Beutel et al., 2021). Participating in therapies that are not neuro-affirming can result in sensory overload, autistic shutdown (McGill & Robinson, 2020) as well as long-term feelings of helplessness, diminished self-esteem, motivation, and autonomy (Sandoval-Norton & Shkedy, 2019).

Some barriers still exist within researching neurodivergent care including the fact that research is predominantly done by those who identify as neuro-typical (Bottema-Beutel et al., 2021. Another barrier is that applied behaviour analysis (ABA) is still the most common form of treatment for children with autism, which is rooted in behaviourism. ABA is considered to be the "gold standard" for treating non-desirable behaviours by using techniques like positive/negative reinforcement such as rewards to teach goals through compliance (Dallman et al., 2022). ABA targets specific behaviours such as eye contact despite research showing that the amygdala becomes overstimulated in autistic brains when eye gaze is held for a prolonged amount of time (Dalton et al., 2005, Markram & Markram, 2010). Using toys, candy, and food to motivate, without an understanding of the task, can create individuals who are compliant, anxious, and stressed. Since they are dependent on rewards and punishments, they will likely lack intrinsic motivation and self-esteem. Despite the overwhelming evidence showing the negative effects of

ABA therapy, it is currently estimated to be a 17-billion-dollar industry and perseveres as the most popular therapy to date (Sandoval et al., 2019).

Application

Given the findings, I have created a 'Lunch and Learn' presentation for professionals, parents or caregivers who are involved with any children, specifically for children who are neurodivergent. This presentation will be approximately 15-30 minutes long and will be available as an in-person workshop, and virtually to accommodate a multitude of people. My presentation will provide an opportunity to teach what neurodivergence means, the different terminology and how to work with them in a neuro-affirmative way. It will also give an overview of various play therapies currently available in the counselling world for children. By teaching skills and the tenets of synergetic play therapy, will provide information to help people move away from dehumanizing, compliance-based practices toward a more inclusive, trauma-informed practice.

Presentation Objectives and Summary of Slides

In this presentation, participants will learn what it means to be neuro-affirmative; and understand how play therapies can support children in counselling. The next section will provide a summary of what I will cover in each of the presentation slides. First, I will introduce myself and the purpose of my presentation. In slide two, I will give an overview of all the topics I will be discussing in my presentation, including, what falls under the neuro-divergent umbrella, what neurodiversity is, how to be neuro-affirmative, what neuro-affirmative therapies look like, an overview of play therapies that are appropriate to use with children in counselling, a summary, and end with time for any questions. In slide three and four, I will discuss correct and modern terminology such as "neurodiverse," "neurodivergence," and "neurodivergent-affirming" and

how all the disorders fall under the neurodivergent umbrella. For slide five I will explain what neurodiversity means and on slide six I will discuss what it looks like practically to use a neuro-affirmative lens. I will then outline what neuro-affirmative play therapies look like and on slide 8 discuss the importance of using these therapies. On slide 9 I will shift and contrast the long-term effects of ABA therapy on children.

For slide ten, I will outline the different types of play therapy typically used for children seeking counselling, including sand tray therapy, child centered play therapy, parent-child interaction therapy, and synergetic play therapy. On slide eleven, I will introduce sand tray therapy and explain how it works and why it works for neuro-affirmative care. For slide twelve, I will explain what child-centered play therapy is, as well as the main concepts and why it is a neuro-affirmative therapy. Then on slide thirteen I will discuss parent-child interaction therapy and how it differs from other play therapies.

In slides fourteen and fifteen, I will introduce synergetic play therapy, its history, and the important tenets of SPT including attunement, co-regulation between children and therapist, observational and relational statements, emotional flooding, and aggression.

To end the presentation, slide sixteen and seventeen will summarize the importance of neuro-affirmative therapies, SPT and its tenets. Lastly, slides eighteen and nineteen will be reserved for questions I create for the presentation to promote discussion amongst the group. This presentation can be easily replicated and presented to professionals in a variety of settings due to its versatility of being available in-person and online. In my opinion, this is an important topic that will draw the attention of professionals working with both children and adults, specifically those working with a neurodivergent population.

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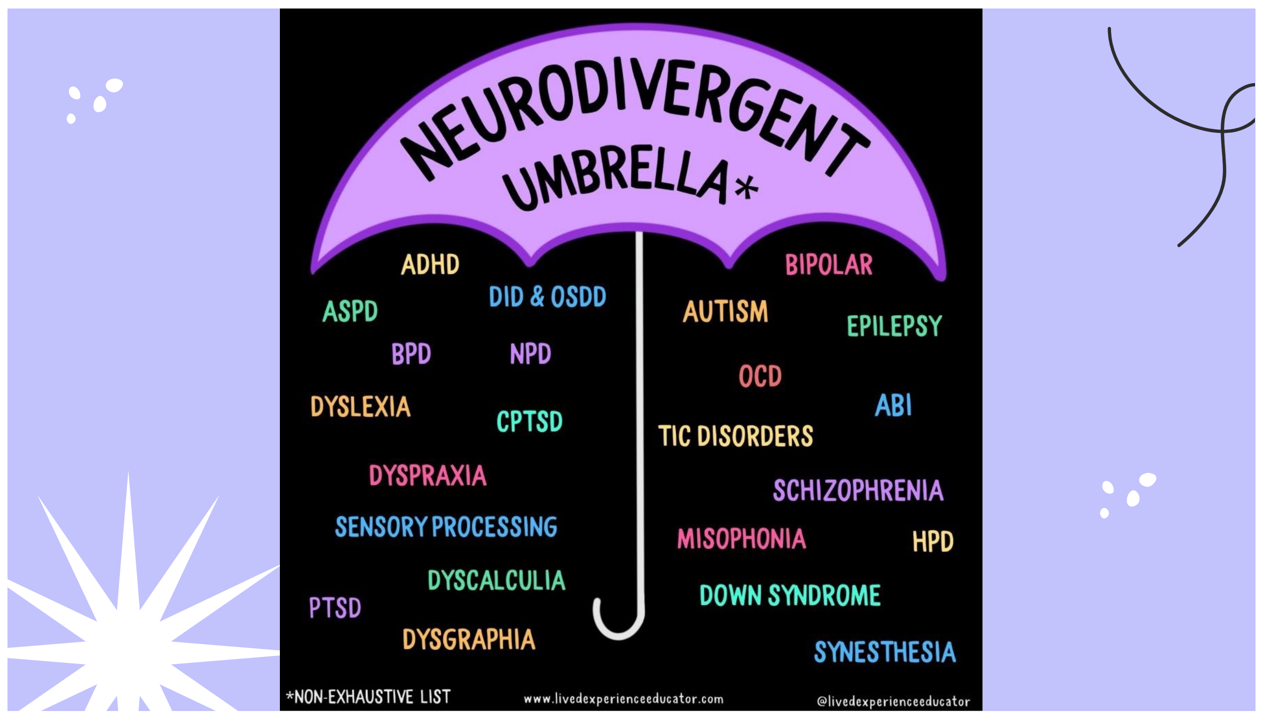
Appendix

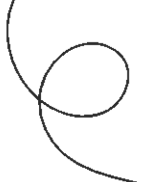
CONTENTS OF THE PRESENTATION*

02 Types of Play Therapies

03 Summary

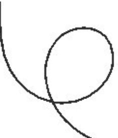
04 Questions and Answers





What is Neurodiversity?

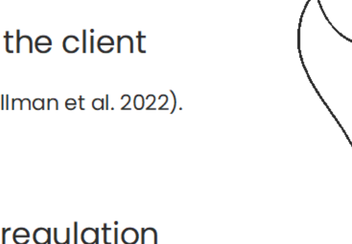
- “Neurodiversity” to refer to naturally occurring diversity in human cognition (Singer,1999).
- Neurodiversity is not a problem that needs to be fixed but a deviation from the norm that makes up our wonderfully diverse and charismatic society (Comberousse, 2019).
- It is not the neurodivergent individual that needs to change to access society, but society which needs to adapt to provide a more approachable and cohesive environment (den Houting, 2018).



How to be Neuro-affirmative

Neuro-affirmative Therapies

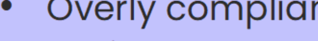
- Create goals that increase the well-being of the client rather than targeting specific behaviours. (Dallman et al. 2022).
- Offer alternative forms of communication
- Acknowledge that stimming is important for regulation



Why does it matter?

- young adults with ASD face immense pressure to mask their traits and act neuro-typical (Prizant, 2015).
- “a problem to be solved rather than an individual to be understood” (Prizant, 2015, p. 17).
- ABA is still considered the “gold standard” for autism treatment

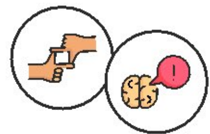
Effects of ABA Therapy



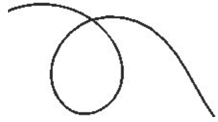
- Overly compliant
- Anxiety
- Stress
- Dependant on rewards and punishments
- Lacking intrinsic motivation
- Low self-esteem
- Prompt dependent
- Overstimulation
- PTSD

(Sandoval et al., 2019)

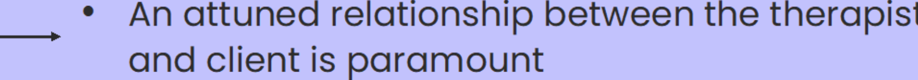
Sand Tray Therapy



- Can be used with children as young as 3
- Uses a contained space, sand, and mini figurines
- Works metaphorically and symbolically



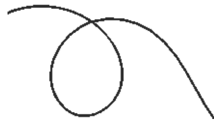
Child- Centered Play Therapy (CCPT)



- An attuned relationship between the therapist and client is paramount
- Children engage in self-directed play, exploring their experiences and emotions.
- Children gain a sense of mastery and control over their world and, ultimately, become more integrated human beings (Landreth, 2012).

Parent Child Interaction Therapy (PCIT)

- Focused on improving parent-child relationships
- The therapist monitors the family from behind a one-way mirror
- The therapist provides live and individualized coaching through a device (Comer et al., 2017).

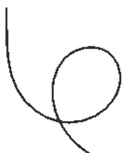


Synergetic Play Therapy (SPT)

- Developed by Lisa Dion in 2008
- Can be applied to supplement any form of play therapy or be used independently.
- Involves teaching children mindfulness by modelling somatic techniques

Tenets of Synergetic Play Therapy

- Observational statements
- Self-reflection
- Co-regulation between the child and therapist
- Redirection
- Working with aggression
- Avoiding emotional flooding.



In Summary...

- Use identity first language
- Neurodiversity is not something that needs to be changed or fixed
- Therapy goals should be focused on the well-being of the client, not changing behaviours or compliance-based

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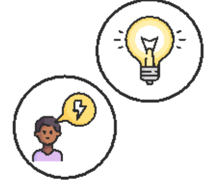
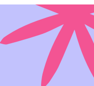
- A neuro-affirmative lens can be applied to many types of play therapies
- Synergetic Play Therapy is a neuro-affirmative and has tenets that can be used by parents and professionals, both inside and outside of the therapy room.



- What are some ways you can be more neuro-affirmative in your everyday life? At work? At school?
- Are you drawn to one play therapy in particular? What characteristics of that therapy appeal to you?
- What was the biggest piece you took away from the presentation today?

Ask away!

RESOURCES



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