

Integrating a Neurosequential Approach in the Treatment of Traumatized Children: An Interview With Eliana Gil, Part II

The Family Journal: Counseling and Therapy for Couples and Families
201X, Vol XX(X) 1-8
© The Author(s) 2013
Reprints and permission:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/1066480713514945
tfj.sagepub.com



Catherine Ford Sori¹ and Sheryl Schnur¹

Abstract

In this article, Catherine Ford Sori interviews Dr. Eliana Gil regarding how to incorporate recent findings in interpersonal neurobiology with current attachment-enhancing play therapy approaches. Dr. Gil discusses how to incorporate the work of Daniel Siegel and Bruce Perry's groundbreaking neurosequential model into clinical practice in the treatment of abused and traumatized children and their families.

Keywords

neurosequential, trauma, abuse, play therapy, brain

Biography: Dr. Eliana Gil is a highly acclaimed lecturer, prolific author, and innovative clinician. She is in a group private practice at the Gil Center for Healing and Play in Fairfax, Virginia, a center that specializes in childhood trauma. Dr. Gil is also the director of the Starbright Training Institute for Child and Family Play Therapy, where she provides 3- and 4-day trainings on family play therapy and specialized therapy with youth (and their families) that experience childhood trauma. In the last decade, Dr. Gil has directed two child sexual abuse treatment programs in Northern Virginia. She has worked in the field of child abuse prevention and treatment for the last 38 years, both in California and in Virginia. Dr. Gil also consults and offers professional trainings locally and across the country. She is an adjunct faculty member at Virginia Tech's Family Therapy Department. Her professional credentials include being a Registered Play Therapy Supervisor, Registered Art Therapist, and a licensed Marriage, Family, Child Counselor, who received her doctorate in family therapy from the California Graduate School of Family Psychology in San Rafael, California. She has served on the Board of Directors of the American Professional Society on the Abuse of Children and the National Resource Center on Child Sexual Abuse. She is also a former president of the Association for Play Therapy. She has written numerous materials on child abuse, family play therapy, culturally informed play therapy, and many related topics. There are a number of educational videotapes that feature her work that are widely used by professionals in the field of psychotherapy.

Sori: Previously we discussed your Trauma-Focused Integrated Play Therapy Model that you developed to treat children who have experienced abuse or other trauma. I understand that you

incorporate a neurosequential approach in your model. Could you say something about the neurosequential model of therapy, and how you utilize that in your integrated play therapy treatment approach?

Gil: Well, previously we were talked about the importance of remaining open and receptive to new information and to new models and then being able to evaluate them critically. We need to ask questions such as, "Does this make sense? Can I integrate pieces of this? Would I want to?" I have become a perpetual student, especially for learning things that are now available that were not when I was in school. This field is growing in so many areas, and every year I make a list of things that I really would like to learn more about. In the process of doing that I read this book, about 4 or 5 years ago, *The Boy Who was Raised as a Dog* (2006) by Bruce Perry and Maia Szalavitz.

Neurosequential Model of Bruce Perry

Sori: You recommended *The Boy Who Was Raised as a Dog* to me, and it sure was an eye-opener! I have been recommending it to all my students and colleagues.

Gil: Oh my goodness, it is a great book, and I read it going cross-country in a plane, then started reading it again, and

¹ Division of Psychology and Counseling, Governors State University, University Park, IL, USA

Corresponding Author:

Catherine Ford Sori, Division of Psychology and Counseling, Governors State University, University Park, IL, USA.
Email: csori@govst.edu

became fascinated with his work. It seemed to lend so much credence to many of the things I had thought to be true. I guess it is true that we get attracted to things that support the things that we believe to be true. I started looking into his work and joined a 2-year individual certification process that I am just now completing.

Sori: That is wonderful! It sounds like what you read validated or maybe explained some of the amazing work you have done with children who have experienced trauma and their families. How do you begin to connect what we now know about the brain to what you have already been doing in your work? What concepts did you resonate with the most?

Neurosequential Model and Dysregulation

Gil: Let me just say this about Perry's neurosequential model of therapy: What I was able to understand a whole lot better was to really pay attention to the kinds of symptoms and behaviors and symptom manifestations children were showing, as a way of understanding what part of their brains had become activated or under stimulated. What is most relevant, and Bruce [Perry] actually will say this, is that his model is not a treatment model, but an approach to better assessment that takes the child's developing brain into account. What he also says is, "I can't teach you what therapy to do because you all do the therapy and probably have all kinds of ideas. The thing that I would say to you," and this is according to Perry, "is that the *sequence* in which you deliver the interventions is the most critical piece." I will give you some examples of this concept. When children come to therapy for the very first time, the parent has told them, often right as they walk in the door, that they are coming to talk about what has happened to them. The part of the brain that is most activated at that moment is the brain stem, because the brain stem controls the regulatory system, right? So their pulse rate is probably elevated, and their breathing is probably altered at that moment in time. Some children become anxious and hold their breath; others start hyperventilating. Some children demonstrate hyperactive and acting out behavior. It is this dysregulation that often occurs. Even shutting down is a dysregulation, it is all a part of that fight/flight/freeze response.

The brain develops in this hierarchal movement from the bottom up. In the early phases of treatment, it is usually the lower part of the brain that is activated. Bruce Perry uses the model of an inverted triangle. The bottom part of the triangle represents the bottom part of the brain and the brain stem, which is the system that regulates body temperature, heart rate, and blood pressure. Then it goes up to the midbrain, or the diencephalon, which regulates appetite, sleep, and arousal. Then you move up to the limbic system, which houses emotions, reactivity, and the ability to regulate affect and actions and attachment. Next, you move up to the cortex, which is at the top of Perry's triangle model. When we do therapy, most clinicians are trained to engage the cortex, that is, have verbal dialogues. The problem is that if the brain stem is activated, and children are not breathing properly,

and their motor functioning is not in control, their cortex is also not "online." It is such a simple concept that you really have to address: What really is happening in the moment you are with the child? Being able to get the cortex online usually happens when children feel comfortable, safe, and they have a relationship with you. They are much more able to engage with you cognitively when their regulatory system is calmed down, or regulated, and it happens in the context of the relationship.

Sori: It sounds similar to [John] Gottman's technique of diffuse physiological arousal, where you have agitated couples take their pulse, and if their heart rate is above 90, you can't do counseling and must take a break to calm down.

Promoting Regulation

Gil: Absolutely! It is funny that you say that, because I took Gottman's webinar, and thought that this is the exact same concept Gottman is talking about! So, when we work with children to help them calm down, we can utilize something like Biodots. The Biodots are similar to a mood ring, but we put them between the thumb and forefinger of clients' hands, and then ask children to notice what color the Biodot is, and sometimes point to the feeling they are experiencing. We might then put on some music, or we might let them do some drumming, or we might say to them, "Okay, what we would like to do now is to tell you a little story about this small animal." Then we do guided imagery and start teaching them about deep breathing. We might say, "What we are going to do is a little bit of breathing. I am going to bring out the bubbles, and what we are going to do is take a deep breath, and then we are going to make as many bubbles as we can. The slower you blow the better."

Sori: That is wonderful! So you are essentially helping the child regulate the systems located at the bottom of the triangle before activating the cortex.

Gil: What you are doing in terms of the sequence of interventions is that you are doing specific brain-based activities. What you are saying is, "The regulatory system is really activated right now, so let's work on that piece first." So, you don't sit down and ask them questions. It means that you say, "Hey, let's blow up some balloons for a few minutes, and let me show you this Biodot, and now I am going to tell you a little bit of a story." I also have some video tapes that are beautiful and very relaxing that I can play for children. There is a very soothing tape of animals that are playing in their natural environment, often water. The video has this beautiful music, and it encourages children to breath as they watch the tape. Also, I never thought technology was something that I would want to bring into the therapy office. You can get an application for the iPad that is called "Breathe to Relax." Children can choose their background and music, and then they get to set the pace for their breathing. So, for example, we ask, "How many seconds does it take you to take a deep breath?" And the kids can set the number of counts when inhaling/exhaling.

Sori: What a wonderful application to use with children!

Case Example

Gil: Let me give you a little example of why I think assessing what kids need is vital. Last month, I was meeting with teachers of a child who attended a special Ed school. He was a very dysregulated child who had a lot of exposure to domestic violence, and even saw someone get stabbed.

Sori: I'm sorry, who got stabbed?

Gil: His mom got stabbed, and he witnessed it and even tried to protect her. He had a long history of exposure to this domestic violence background. I would say about 6 years. The teachers were aware of his background. But here is what happened in his classroom. The teacher got upset. She threw a book down on the desk and started talking in a very loud tone. The minute she did that, the boy got out of his chair and walked right over to the door. She had activated his brainstem and upset him. Then she said, "Where do you think you are going? You don't have permission to get up; get back into your chair!" He just slumped over. Next, she threatened him with a visit to the office. She yelled at him because she was upset. So he just walked out the door and apparently left the school grounds. He was suspended for a week. So you go back and ask, "What the heck happened there?" When talking to the teacher and the principal, I heard the teacher describe him as "willful and disobedient" and assert that she cannot let him "misbehave" in the classroom and model this behavior to other children. So the minute you have someone perceiving the child's behavior as willful, meaning something that he does consciously, and that he has the intent of being defiant, then you have a problem, right?

Sori: The teacher in the classroom had no understanding of the reaction she provoked.

Gil: Bruce [Perry] always encourages people to go to the schools and do a presentation on the brain. So I was doing this presentation and was showing how dysregulation can occur and explaining that it is a physiological event for the child where the cortex goes offline, and he can't think of anything other than, "I am out of here, I gotta get out of here." And then they are out the door. I took this little book, which I don't know if you are familiar with, called "*Please Explain Anxiety to Me*" (Zelinger & Zelinger, 2012).

Sori: That is one I haven't heard of. What is it about, and how did you use it to teach about the brain?

Gil: It is about a dinosaur that is living in a dangerous environment. He has this little switch that gets turned to freeze, flight, fight modes. The problem is that after there is no more danger, that switch is still going off. The whole book is about how children need to have control of when the switch gets flipped. It is really a great book. Anyway, I was explaining to the teachers that we have to make sure that the behaviors are being seen in the context of trauma. The teacher said that if he had not left the building, he would have been placed in isolation. I thought to myself, that is the worst thing! Do you put a dysregulated child whose brain stem and midbrain and

limbic system are all aroused somewhere all alone? Attachment theorists would say the best thing would be for someone to actually reach out and touch him, so he could feel the connection to another human being. Someone who could begin to say to him, "Take a deep breath for a few minutes. I'd like us to go back and think about something that feels nice, like maybe the ocean, and how the ocean waves come in and out rhythmically" . . . and get him into a calm state so his brain stem gets somewhat balanced again. And then you can start a therapy dialogue.

Neurosequence-Informed Interventions

Gil: So this is the lesson of the neurosequential model of treatment: That most of us are out of sequence in our interventions. The interventions are fine, as Bruce [Perry] says, and he is receptive to all kinds of therapies. At the same time, when I am listening to him it becomes clear there are parts of the brain that respond to different activities, and that these activities are better to do if a specific part of the brain is dysregulated. Bruce Perry does suggest some therapies that are better for the brain, provided in the context of an empathic relationship. I will summarize them: animal-assisted therapy, music therapy, massage therapy, and therapies emphasizing relationships and touch. In addition, he actually suggests occupational therapy, having some kind of physiological differences occur, and a lot of repetition of sensory motor stimulation that is patterned. He also says that if you have a child who is online in terms of the cortex, you can enhance that if you can walk and talk simultaneously.

Sori: How interesting! So it is important to assess what part of the brain is engaged at any given time and to choose activities that are repetitive and patterned, to enhance that part of the brain.

Gil: Then when you start stimulating other parts of the brain that are functioning with the part that is online, you are promoting health and integration of the brain. These are just really important things to know. Perry believes that touch is critical. I heard Gary Landreth, a nondirective play therapist, say that somehow we have come to the conclusion that psychotherapy is just 50 min or an hour once a week. He always asks, "Who invented that? Where does that come from? Why did we all agree that this is what everybody does?" Bruce Perry says, and I think Gary [Landreth] says this too, that many of our clients need more. Bruce Perry always encourages us to get the caretaker or the parent to invest time in the child, for example, rocking the child in place for 10 min every night, because that would go a lot further than any kind of psychotherapy. That is because it is a patterned, repetitive, sensorimotor stimulation in the context of their relationship. This all lines up perfectly with Daniel Siegel's work. Bruce (Perry) explains these concepts clearly. So I thought, "Well, it seems like animal-assisted therapy, especially equine therapy, is really an important thing for children to do." So in the last year, I attended a couple of equine therapy workshops, got around horses, and even referred a couple of children to it. And I thought, "Oh my

Lord! This animal-assisted therapy has all kinds of dimensions of healing that would never occur in a therapy setting!” Then I start wondering if there is any way we can incorporate this type of therapy into our clinical setting.

Sori: This is so exciting! I think more and more people, like me, are getting interested in animal-assisted therapy, as well as other new approaches.

Gil: You know when I first came here from California and I would do something like art or sand therapy, people would think anything different was “new wave.” But we really have to be open to new things. For example, Dr. van der Kolk is now doing research on yoga for the treatment of PTSD, and that is awesome! But I have heard that he has received negative feedback from the psychiatric community for even being interested in massage therapy, yoga, or other holistic approaches. People often get rigidly invested in one type of therapy, and it is safe to say there is no one model that will work for all clients.

There are so many different ways of beginning to think about supplementing what we do, and being more holistic. I want to make sure that I have mentioned most of the things that Bruce talked about. For example, the importance of occupational therapy, and he talks about play therapy, and attachment-based approaches, like Theraplay, and how important those are. He is very open and is not invested in any one particular kind of therapy. What he is invested in is making sure that the treatment is provided in the context of brain functioning observed in child clients.

This coincides with the whole notion of what Daniel Siegel and other people have presented about the plasticity of the brain. I remember conversations 20 years ago where people would say if children have been that severely traumatized under the age of 6 you might as well give up on them and understand there is little hope. But, it turns out that the plasticity issue is much more optimistic, particularly in the context of a relationship. That is one of Siegel’s glorious contributions, and this information can be made available to people in a clinical setting. Thus, clinicians promote clients’ relationships outside of therapy, and also ensure that therapy includes a positive relationship, and opportunities for children to explore the dimensions of a positive relationship.

Sori: To me, that positive relationship speaks to the recent research on common factors across models of therapy and how important the relationship is (Sprenkle & Blow, 2004). I would bet that many of us wish we had known all this years ago.

Gil: Absolutely.

Attachment-Based Approaches: Circle of Security and Theraplay

Gil: For whatever reason, fields of study have been compartmentalized from one another, such as the study of domestic violence, or trauma, or attachment. There are attachment conferences that occur in isolation. Neuroscience has also been fairly isolated, but now we have a number of people

who are starting to really bring those threads of data together, which is exciting. You have to credit people for having the wherewithal to stay current on these themes. For us as practitioners, it is important to explore this information and initiate constructive assessments of it, but not taking guidance without appropriate evaluation. Really looking at what a new intervention is about and assessing the merits and usefulness. There are two attachment models that I have been studying over the last 5 years or so, which are attachment-based therapies. They are Theraplay and the Circle of Security.

Sori: Okay! Can you tell me more about the Circle of Security (COS) approach?

Gil: The Circle of Security is a wonderful attachment-based model based on 50 years of research on attachment. The model uses a grid to show how the family creates a secure base and safe haven for the child. Once the secure base exists, it creates an opportunity for the child to explore away from the parent. When they come back to the parent, they are welcomed into a safe haven. The developers of COS designed a graphic that is a circle with hands, and the children are going on the top of the circle when they are exploring, and they are on the bottom of the circle when they are coming back to their safe haven. All relevant attachment issues occur within the concept of this Circle of Security. Parents are taught these basic principles. I recently took a weeklong training on “Circle of Security Parenting Program,” which I believe will be a great service to provide to high-risk parents.

Sori: That is so exciting! Can you talk about how the principles of the Circle of Security help parents understand the behaviors of children who experience trauma or lack regulation skills?

Gil: Basically, parents are taught the principles of attachment. They are given a videotape that demonstrates these basic principles. This is very accessible and easy to understand. The Circle of Security model traditionally is based on the Strange Situation experiment developed by Mary Ainsworth. The interview is conducted where the stranger enters the room, then the parent leaves, then the parent comes back. So the coming and going sets up these attachment reactions. You watch to see if the parent warmly welcomes the child back, and if the child can tolerate the parent leaving again, knowing that the parent will return. This is based on the idea of ruptures and repairs. One of the things they talk about is the concept of cues and miscues.

I’ll give you a perfect example of this. We have a mother who has adopted a child, and the child has an anxious attachment to her. The child goes to her individual sessions and the parents attend their own therapy. The child is usually out first and waits for her parent. Sometimes that child actually turns away from her mother, sometimes goes under a chair, and if the mom tries to hug her, she kicks her mom. What we explain to parents is that these are all missed cues. We told this mother, “The reality is your child is really excited to see you. She has been sitting there asking, ‘When is my mom coming? When is my mom coming?’ Then she sees you and she gets overwrought with emotion, she dysregulates, and then she miscues you. It seems to you that she is saying, ‘Get

away from me!’ But in reality she really, really wants to see you, but she just cannot negotiate that.” Thus, parents are taught to override the miscue and do what the child needs at that moment. Parents have to trust themselves to know what their children need and they have to be available to them.

Sori: That is really huge! That is such a huge reframe you gave the parent. The parents learn not to take the miscues personally.

Gil: Yes. That is a huge concept, and it coincides with what parents watch on their own tapes. Then you can say, “See what happens here? Look at how much the child needs you.” There is a lot of reframing going on. For example saying, “Here’s a place where maybe you could have done this. I wonder what would have happened then.”

I had a mother I was working with who would go to school to pick up her child. The child would run right by her as mom watched all the other parents being greeted with hugs and kisses from their children. She felt inadequate, and that other people were judging her because her child did not want to say hello to her. But the child was so activated by seeing mom that many of her attachment issues would come up, and she could not regulate herself. What we taught the parent to do was to go to the car and, before getting in, take her child into her arms, give her a huge body hug, look into her eyes and say, “I am so happy! Look, I am seeing those beautiful eyes, and look at your beautiful smile. I missed you today. I thought about you, and I am so happy to see you.” So we plan that kind of reunion, which is more exaggerated and extreme, to help the child become regulated.

Sori: The mother can now interpret the interaction differently and have a different response. The daughter’s needs are met. It is really amazing!

Gil: The “Circle of Security” model is just amazing and that is just one of the principles. There are five or six of them. In a way this method depersonalizes interactions so parents can focus on the child’s developmental needs by focusing on the circle, and what traditionally happens as children travel the circle. And low and behold, the parents start depersonalizing things when their child is behaving poorly or causing parents to feel inadequate. It is really, really a great model.

Sori: I can see how, without intervention, those behaviors in a child can elicit negative reactions from parents; it can become that reciprocating, vicious cycle that gets worse and worse.

Gil: Yes, and if the parents perceive that their child is hostile toward them, eventually they get hostile toward the child. If they have rewarding interactions, they are more likely to feel kind towards them. I love this model and find it incredibly compatible with Theraplay.

Sori: Okay. I love that! The two methods are based on the same attachment principles. Can you tell us more about what that combination looks like?

Gil: It is a beautiful combination, in fact, because both models are based on attachment theory. Theraplay is relational, active, physical, nurturing, and overall, a wonderful model.

I wish I would have integrated these concepts more fully earlier in my career because they are so useful to clients. It is also compatible with the recent information about neuroscience. If people really want to do brain-based activities, Theraplay is probably the best bet, to be honest with you. I mean it just hits all the basic variables of increasing brain plasticity.

Sori: It is really important to know how much you value Theraplay.

Brain-Based Therapy

Gil: Do you know Bonnie Badenoch’s book on brain-based therapy? I think we are going to see more and more of these books coming out, because I think that is where we are all headed. You cannot go to a conference and not hear about the brain and neuroscience, you just can’t. Do you know about the book, “*The Whole-brain Child* (Siegel & Bryson, 2012)?”

Sori: Yes, I have that. Actually, I bought that for my children. For my adult children.

Gil: That’s wonderful! I know, me too! This material is important, and is not exclusively for clinical use, parents can learn it too. So the model that we use is that whatever we learn, we share with parents. The wonderful thing about Bruce Perry’s materials is that many of them are written for parents, who need to understand why their children act the way they do. Parents need to have this brain-based background in order for them to be less reactive and more responsive.

One of the things we also do is to have children teach the parents whatever we teach the child, and the other way, too. Theraplay really fits in here—the parents always receive Theraplay, as well as the children, so we process with them what that felt like. Then, we explain what happened in their brain that caused them to get to that place.

Sori: That is wonderful. In the program I directed at a cancer support center, we also had the children teach their parents relaxation training, and both parents and children loved it—especially the children.

Gil: As a family therapist, I think there are many more systemic ideas to inform others about. There should be no mystifying therapy; you want to demystify therapy. You want to convey clarity so it is useful to clients. That is why I recommend and do these things; there is a health benefit it produces, and you want clients to incorporate them at home. That is the beautiful thing about Theraplay, that all of the exercises are so simple that anyone can do them, and they are always shown and repeated in sessions so they can be integrated successfully.

Sori: It is important to demystify therapy. Can you speak to how you demystify some of the more complicated brain concepts we have discussed. How do you teach children about the brain?

Gil: Yes. We love the concepts of the *Whole-Brain Child*, especially about “flipping your lid,” based on Daniel Siegel’s work. We demonstrate Siegel’s hand model of the brain

to explain how the different parts of the brain work at different times. And the children understand these easily. I've seen 4-year-olds coming out of sessions and say, "Mom! My amygdala is all worked up!" Or they will say, "My cortex made a good decision." It is just so great to see children really incorporate what they have learned. They are all speaking the same language, and they have a context for understanding. I think *The Whole-Brain Child* is an incredible book. This kind of approach is so important: making sure that you are bringing in the important people in the child's life, and that you are providing real help. You know that secure attachment is a necessary component to their healing process. It is all interactive. It is all like . . .

Sori: Interpersonal?

Gil: Yes I think that you really begin to see these concepts coming together. Ok, well this is an exciting conversation

Sori: Before we end, I wonder if you could mention some specific interventions counselors might use? I remember you describing coregulation, where the parent would hold their upset child, and specifically focus on the adult slowing down his or her own breathing and respiration. For example, rocking the child gently, the child would coregulate and attune to the adult?

Gil: Yes. There are many coregulating activities based on mirror-neurobiology. You want the children to follow you, not for you to mirror them. Even in a school setting, doing something as simple as the teacher saying, "I am going to do one, two, three," and tapping the desk. "And now I want you to do one, two, three."

Sori: So you use little rhythm games!

Gil: Yes. You really get them into a little rhythm game and that is coregulation. You might say to a child, "Clap. I am going to be the director, and when I raise my hand you clap loudly, and when I bring my hand down you clap softly." Even something like that is coregulation. Coregulation is, for children, really the acceptance that we all have times that we are excited, and times when we are calm or quiet. There are always these rhythms and fluctuations that we get. We tell the child we can all go outside to reset when you get all wound up, and then you can come back into the classroom. So anytime you can do something like that with the child, even that little simple "hot potato, cold potato" game, where you have a little something and you can say, "Well this is a really cold potato," and then you pass it to them and it is cold. Then you say, "You activate it," and then it is hot. But you always want to end it on the cold. Then your coregulation is occurring, and you are ending up in a place where everybody is relaxed.

Music and the Brain

Sori: Earlier you mentioned that Bruce Perry recommends music therapy. I remember learning years ago that music integrates both sides of the brain. I believe it is the only art that does. It is interesting to me, having been a music teacher

for years, that many of the skills that I learned were so beneficial for my brain!

Gil: Absolutely.

Sori: How wonderful that we can use music, rhythms, and simple games to help regulate children.

Gil: Actually, remember that I told you Bruce Perry puts a very, very high emphasis on music therapy? We had one recent web seminar that was all about music, so he sent out these articles, such as "Using Brain-Friendly Music in the Classroom," the "Rewards of Music Listening: Response and Physiological Connectivity of the Mesolimbic System," and "Musicians Have Enhanced Subcortical Auditory and Audiovisual Processing of Speech and Music."

So everywhere now, people are talking about the positive effects of music. Perry also sent articles on the brain and empathy, and on physical activity.

Sori: That is interesting because even when I taught piano, I was always looking for creative ways to engage different parts of the children's brain to help them integrate the music into themselves. It is exciting now to hear that there is research behind it.

Gil: Yes, it is really exciting.

Sori: In addition to music and all we have talked about, can you suggest another play therapy technique that you use with these families?

Gil: Yes, play genograms (Gil, 2003) are really useful, and people can do them very easily without having to buy a lot of materials. A tube of fish or animals, limiting the selection to one category, is enough. I also use buttons, rocks, crystals, and minerals. I even do a nature genogram, where I tell people to go outside and find things that represent your thoughts and feelings about people in your family, including yourself. They use broken things, sharp things, dead things . . . it is a fascinating activity to do. A lot of counselors resist buying more materials, so we need to find a way to make this easier. A collage—they could cut out pictures from magazines and use the pictures in a genogram. There are lots of ways to do it.

Sori: I know our time is about up, but may I ask one final question that is on my mind? How does Perry, or how do you actually do the grid brain assessment shown on his website? Is it based solely on observations, or are medical tests involved?

Gil: Unfortunately, unless you have participated in NMT training, you really can't. Now I think in the next 5 to 10 years, his hope is to standardize it enough that anyone will be able to use it. The assessment is based on observations and historical data. There is a form where you rate each item as something in which you have high, low, or moderate confidence. Let's say a child has been adopted under the age of 1; with very little information prior to the adoption. You would rate that as low confidence. What Perry looks at is epigenetic factors, genetic factors, a lot of material on early development, ages 0 to 5, and then of course later years. He is looking at the basic functioning of the parents during those times, what kind of caretaking children received, or what traumatic stressors there may be. That's the first part, on adverse events.

Then Perry looks at relational health. He thinks that those things balance each other out; when adverse events are high, but you eventually begin to have high relational health. Eventually the impact of the adverse event will lessen. But if you have high adverse events and low relational health, that child will probably get worse. So the second phase is all on adverse effects on the relational health for the child. What is available for the child? Even if it is not a parent, it could be a community system, or external family system, and Perry looks at rating all that.

Then he looks at assessing all of the parts of the brain, following his hierarchical brain model. For example, if you are looking at the brain stem you will ask questions like, "Does this child have a normal heart rate? Does he have any breathing dysfunction? How good has his appetite been? Is his swallowing, gagging, and sucking okay?" You get the best responses about all of those issues, including motor activity. Actually, that is the hardest for families to fill out. There are even questions regarding the endocrine system, the thyroid, like does the child sweat a lot? There are children who have ocular eye movement, whose eye is wandering a lot. You don't intend to notice every specific thing, but you do somehow, amazingly, notice a lot.

What Perry comes up with is a report that gives you a map of the brain, showing parts that are understimulated and/or overstimulated, according to all of the information obtained. Then based on the assessment, he gives recommendations for treatment in all of those categories.

Sori: Yes! That is the fascinating part, isn't it? The assessment then leads to specific treatment recommendations.

Gil: It is really amazing. This is an approach that can really guide you towards appropriate interventions. The Child Trauma Academy is currently working on a graphic depiction of brain functioning, based on information provided, that I believe eventually people will be able to access online.

Sori: That will be great. And people can check Perry's website for information on his model.

Gil: Bruce (Perry) does a lot of these teachings on each one of his webinars. So my suggestion is for people to participate in these webinars. That is the way to go because it is really interesting to listen to him, especially since his whole model is based on repetition. He has a wonderful voice and he repeats the most critical pieces over and over and over again. I really enjoyed it.

Sori: That is what good teachers do. They repeat the important things, and especially so, given he is teaching a model based on repetition and patterns.

Gil: Exactly, and he is a very good teacher. When you join, he requires you to read many materials. Overall, it is very tough, requiring much investment, but very rewarding. It was a very intense educational experience.

Sori: And one that was also exciting, as is your work integrating this model with abused and traumatized children. You offer trainings on your model, Trauma-Focused Integrated Play Therapy. You are such a prolific writer and trainer. I believe people are going to be quoting Eliana Gil for generations to come, because your contributions to the field have been groundbreaking. They start with your work in merging

the fields of play and family therapy, your writings on treating abused children and adolescents, and understanding cultural issues in play therapy that impact our work with children. Your work has had a tremendous impact on me both personally and professionally.

Gil: I appreciate that. I think what Bruce Perry needs to do now is to go one step further and write a book for clinicians who are thinking, "Now that I have heard what you have to say, how do I change my practice?" He could give some practical examples of how to do it, and what to do in specific cases.

Sori: I hope that happens. But perhaps you should do the book with him! I am always eagerly anticipating your next publication. I understand you and Jennifer Shaw have just finished a new book on working with children with problem sexual behaviors, and that you are doing a revised edition of *Play in Family Therapy* (Gil, 1994), which I use every semester in my child therapy class.

Gil: Yes, that is correct.

Sori: Eliana, I want to thank you for being so generous with your time. It has been wonderful and I have a much deeper understanding of the neurosequential approach and your integrative model for the treatment of traumatized children.

Appendix

Resources

- Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: Norton.
- Gil, E. (2010). *Working with children to heal interpersonal trauma: The power of play*. New York, NY: Guilford.
- Gil, E. (2011). *Helping abused and traumatized children: Integrating directive and nondirective approaches*. New York, NY: Guilford.
- Gil, E. (2012). *The healing power of play: Therapy with abused children*. New York, NY: Guilford.
- Siegel, D. J. (2011). *Mindsight: The new science of personal transformation*. New York, NY: Bantam Books.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

- Gil, E. (1994). *Play in family therapy*. New York, NY: Guilford.
- Gil, E. (2003). Play genograms. In C. F. Sori, L. L. Hecker, & Associates (Eds.), *The therapist's notebook for children and adolescents: Homework, handouts, and activities for use in psychotherapy* (pp. 49–56). Binghamton, NY: Haworth.

- Perry, B. D., & Szalavitz, M. (2006). *The boy who was raised as a dog*. New York, NY: Basic Books.
- Siegel, D. J., & Bryson, T. P. (2012). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*. New York, NY: Bantam.
- Sprenkle, D., & Blow, A. (2004). Common factors and our sacred models. *Journal of Marital & Family Therapy*, 30, 113–129.
- Zelinger, L., & Zelinger, J. (2012). *Please explain anxiety to me! Simple biology and solutions for children and parents*. London, England: Loving Healing Press.