

A Play-Based Treatment Paradigm for Nonoffending Caretakers: Evidence-Informed Secondary Trauma Treatment

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Despite the growing clinical literature aimed at assisting children affected by potentially traumatizing events, little exists about individual treatment for nonoffending parents. Nonoffending parents' reactions to their children's traumatic events can be extensive and long-lasting and frequently include complex feelings about themselves, their children, the offender, and the judicial system. Furthermore, these feelings and reactions can impact their children's own healing. This article aims to provide an individual play therapy treatment paradigm designed for nonoffending parents. Additionally, this article will describe posttraumatic reactions of nonoffending parents and their effects on traumatized children.

Keywords: childhood trauma, sexual abuse, non-offending parents, treatment

The prevalence of children who experience potentially traumatic events has led clinicians to develop assessment and treatment plans to reduce negative posttraumatic responses, including empirically validated treatment protocols such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). Some of the newest research on assessment of childhood interpersonal trauma involves clinicians broadening current diagnostic conceptualizations for victimized children. The term *potentially traumatic event* is now used to highlight the variability of reactions and responses to disparaging events and crises (Ogle, Rubin, Berntsen, & Siegler, 2013), and treatments are focusing on symptoms related to affective and behavioral dysregulation, cognitive distortions, and interpersonal discord (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Furthermore, responsive treatment protocols involve integrating nonoffending caretakers (Tavkar & Hansen, 2011).

Despite the current clinical focus on assisting children affected by trauma, little exists in the literature about individual treatments designed specifically for nonoffending parents, the secondary survivors of childhood trauma (Costas & Landreth, 1999). Research suggests that parents are often traumatized by their children's

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potentially traumatic event (Landolt, Vollrath, Ribi, Gnehm, & Sennhauser, 2003), yet their experiences may be minimized by professionals, or parents themselves, in a misguided effort to serve the immediate emotional needs of the child. Furthermore, caretakers consider effective parenting to be a challenging task after trauma (Alisic, Boeije, Jongmans, & Kleber, 2012) and may vary in their abilities to adapt to their family's new psychological realities (Cohen, 2009).

Understanding the various mechanisms in which parents react to a child's trauma and meet needs for emotional/physical safety and acceptance is an important function of the play therapist. Thus, the objectives of this article are to (1) describe posttraumatic reactions of nonoffending parents of child trauma survivors, (2) identify ways in which parents' reactions affect children posttrauma, and (3) introduce a treatment paradigm for play therapists who work with nonoffending parents. Case examples will be used to demonstrate the use of this paradigm in the authors' clinical work with nonoffending caretakers. In these cases, all clients' identifying information has been altered to protect confidentiality.

NONOFFENDING PARENTS, REACTIONS TO CHILDREN'S TRAUMA

Like their children, nonoffending parents range in their responses to trauma and may present with psychosocial difficulties (Tavkar & Hansen, 2011). These reactions typically include affect and cognitions directed toward the self, the child, and the offender. Additionally, parents may have complex thoughts and feelings related to the judicial system (Turner et al., 2012).

Caretaker's Feelings About Self

Nonoffending parents of child abuse survivors report significant emotional distress as well as posttraumatic and grief symptomatology (e.g., Elliott & Carnes, 2001; Manion et al., 1996) for an average two years postdisclosure (Stauffer & Deblinger, 1996). The most commonly reported feeling toward oneself is guilt. Parents may hold themselves to unrealistic standards, believing they should have had prescient knowledge that the perpetrator was dangerous. For example, Tina, after learning that her child had been touched sexually by a peer during nap time at day care, stated that she should have known that the staff was not vigilant. She told her play therapist, "When I was dropping [my daughter] off, one of the kids had thrown his lunch on the floor and none of the staff had done anything." The distorted belief that she should have known her daughter was not safe, after witnessing the staff's response to a nonabuse event, highlights the complicated guilt Tina experienced.

Parents' difficulty managing daily situations can further reinforce this guilt. A qualitative study that examined effects of child abuse on nonoffending parents (McCourt, Peel, & O'Carroll, 1998) found that learning of the trauma affected parents' health, finances, housing, career, and marital relationships. Accruing debt after moving away from an abusive person, giving up jobs that required less out-of-home child care, and impaired communication between spouses are among

the stressors mentioned by parents (e.g., Bronk, 2006; McCourt et al., 1998) and those that play therapists frequently hear from parents. One father told his son's therapist that he judged himself for even "wasting session time" mentioning these stressors. Reactions from others can also play a role in parents' guilt (Heflin, Deblinger, & Fisher, 2000; Regehr, 1990). Parents in McCourt et al.'s (1998) study reported that in some cases, initially supportive individuals became critical over time, blaming either the parent or child, and became frustrated when parents failed to return to previous levels of functioning quickly.

Alternatively, denial is an additional response that may occur in the wake of children's abuse disclosures (Manion et al., 1996). Parents may deny that the abuse happened, or, as noted in incest literature, fail to take any responsibility for family dysfunction that may have contributed to abuse (DePo & Koontz, 1991). In both scenarios, denial serves as an unconscious defense mechanism, aimed at protecting the parent from the overwhelming feelings associated with their child's trauma. Refusal to participate in treatment also falls under this category. McCourt and colleagues (1998) found that it was particularly difficult for protective males in traumatized children's lives to engage in treatment. Little exists in the literature for assisting these nonoffending fathers with treatment, largely because many opt not to partake in treatment or related research (Grosz, Kempe, & Kelly, 2000).

Caretakers' Feelings About the Child

Parents experience a wide range of feelings toward traumatized children, one of which is often anger. With younger children, parents are usually aware that their anger at the child for failing to prevent the abuse or tell them about it is inappropriate. In these cases, an aspect of treatment may be helping parents to take displaced anger and redirect it toward a more appropriate recipient (Turner et al., 2012). Perhaps more challenging for parents are the feelings of anger directed at older children and teenagers, particularly when the breaking of a rule precipitated the abuse. Carolyn, the mother of a female high-school student who was raped at an after-prom party told her daughter, "I told you that you were too young to go to an after-prom sleepover." Research on blame attribution has found that individuals, especially males, are more likely to blame sexual abuse victims who do not physically resist an assault (Rogers, Davies, & Cottam, 2010). Parents of adolescents may also wonder whether their child consented to the sexual activity (Regehr, 1990), or experience a decrease in trust of their adolescents (Davies, 1995).

Parents may fear that their children will be permanently and psychologically changed, particularly when children demonstrate unfamiliar and sometimes frightening posttraumatic behaviors (Cohen, 2009). Lisa, who entered treatment after her daughter was abducted from a playground, feared that her daughter would never feel safe or be as carefree again. Her feelings deepened when her daughter began attempting to flee in public places, a manifestation of posttraumatic avoidance. These attributional fears may also mirror those of their children; interpersonally traumatized children will often report that they feel different from their psychologically adjusted and nontraumatized peers (Mannarino, Cohen, & Berman, 1994), or fear that they are beyond help and damaged (Meiser-Stedman et al., 2009).

Caretaker's Cognitions and Affect Regarding the Offender

Many parents feel malice toward the perpetrator that disrupted and adversely affected their children's lives. Particularly in situations where the perpetrator was a trusted friend, partner, or other family member, parents feel betrayed and unable to trust their own judgment or their relationships (Grosz et al., 2000). Five months into treatment after being sexually molested by a friend's father, one client reported that his mother, Jill, was unsupportive of his new friendships. Jill later shared in an individual session with the therapist that she had fears related to her son visiting a friend's house for a play date. She was apprehensive of becoming involved at her son's school again, scared that she would misread another parent. Jill's anxieties over allowing her child to experience positive life experiences, coupled with disinterest or avoidance of social activities, are typical affective reactions shared by many parents with children posttrauma (McCourt et al., 1998).

Parents of traumatized children also report fears about seeing their children's perpetrator again (McCourt et al., 1998). The notion that most perpetrators are known to their victims intensifies this fear for many parents and can result in parents' increased social withdrawal (Brestan & Payne, 2004). Gutner, Rizvi, Monson, and Resick (2006) found that social withdrawal was elevated in both primary and secondary victims who knew their perpetrator. Finally, parents may struggle with guilt, as they realize that their children's disclosure has disrupted another family as well as their own. Jill stated, "No one wins here," when discussing the perpetrator's family and the impact of the upcoming trial on them.

Caretakers' Appraisal of "the System"

The same feelings that parents experience toward the perpetrator can be directed toward the multiple systems involved in a child abuse case, including police, court, social services, and treatment facilities. Immediately after a disclosure, parents are faced with the decision of whether or not to report the trauma. Although to some this may seem like an obvious decision, parents sometimes struggle with fears of retraumatizing their child, reporting the crime only to have the perpetrator left uncharged or found not guilty, or being blamed by reporting agencies (Regehr, 1990). Ashley spent several weeks discussing the intense rage that she felt toward the police officers who mishandled her sexually abused daughter's case. Ashley described being verbally assaulted by one of the officers when she hesitated to allow her 5-year-old daughter to be interviewed alone. Another mother-father dyad regretted their decision to follow through with charges after their adolescent daughter's perpetrator pleaded his case down from a felony to a misdemeanor, effectively denying their daughter the right to face her abuser.

When parents file charges with the police regarding sexual trauma, other child-protection departments and social service agencies become involved. Child Advocacy Centers, one such child-based social service organization, will often conduct forensic interviews with both the child and parents, followed by referrals for mental health treatment. Social Services Agencies (SSA) that receive and make decisions based on allegations of child abuse are also a frequent target of anger and

frustration in the wake of a trauma. SSA can make any number of decisions in the interest of children at risk, with the most extreme being removal from the home. Their involvement can become a stressor for parents, particularly if the parent perceives the SSA workers as uncaring, meddling, or accusatory (DePo & Koontz, 1991).

Although all of these systems are necessary parts of the legal process and designed to be helpful to the family from a judicial standpoint, many parents report that SSA's involvement is intrusive or, in the previously mentioned case of Ashley, even psychologically harmful (Manion et al., 1996). Therefore, it is important to note that parents who feel supported by SSA workers view this help as a valuable form of social support during the investigative process (McCourt et al., 1998). Other systems that can offer such assistance may include support groups, victim advocates, treatment providers, and/or school staff and personnel.

EFFECTS OF PARENTAL RESPONSES ON CHILDREN WITH TRAUMA DISCLOSURES

The way in which parents respond to and support their children after learning of their traumas largely impacts children's mental health (Davies, 1995; Valentino, Berkowitz, & Stover, 2010). Research indicates that parental distress predicts children's posttraumatic stress responses (e.g., Deblinger, Stauffer, & Steer, 2001), perhaps even more than the potentially traumatic event itself (Scheeringa & Zeanah, 2001). Furthermore, dysfunctional parenting styles can exacerbate children's symptoms. The model of *relational PTSD* (Scheeringa & Zeanah, 2001) describes three parenting patterns that can be impairing for a traumatized child: withdrawn, overprotective, and frightening.

Withdrawn parents, also referred to as unresponsive or unavailable parents, are unable to attend to their children's needs because of their own impairment (Valentino et al., 2010). These parents may have a personal trauma history that is triggered, or a preexisting mental health problem that limits their ability to accurately perceive and address their children's needs. Children's symptoms may become exacerbated as they attribute their parents' unavailability to being psychologically damaged and increase attention-seeking behaviors in an effort to elicit a response from their parents (Caffery & Erdman, 2000). *Overprotective* or constricting parents are cognitively preoccupied with the notion that their children will be traumatized again. These parents may have difficulty remembering the importance of children experiencing mastery and independence in the wake of a trauma (Valentino et al., 2010); they may also struggle to redevelop trusting and caring relationships with others. Scheeringa and Zeanah (2001) note that this type of parenting style may occur when a parent is present at the trauma but unable to protect the child. It may also occur when the parent believes his or her absence caused the child's traumatization. Leslie told her play therapist that she ruminated about her daughter being molested while she was away at work. Her feelings of helplessness manifested themselves in Leslie demanding her daughter be in her line of sight at all times. Parents may also worry that their children will blame the parent for failing to protect them (McCourt et al., 1998).

Finally, the *frightening*, reenacting, or endangering parental style mimics the intrusive symptoms many adults experience posttrauma. Parents may actually retraumatize their children by consistently probing for more information related to the potentially traumatic event. In the previously mentioned case of Jill, she thought she was promoting open communication by frequently asking her son about his trauma; however, he reported to his play therapist that he felt fixated in his trauma whenever Jill discussed it. He found it difficult to discuss but continued to do so as he believed it was helpful for Jill. Increased questioning by the parent can lead the child to attempt to set rigid personal and psychological boundaries in an effort at self-preservation (Scheeringa & Zeanah, 2001). In the case of adolescent trauma survivors, this may lead to more secretive behavior, which puts them at risk for danger or even revictimization (Davies, 1995).

TREATMENT FOR NONOFFENDING PARENTS

Parents are not only secondary victims of their children's traumas but also vitally important to their children's posttraumatic adjustment and recovery as their greatest potential "natural resource" (Heflin et al., 2000; p. 170). Thus, their treatment must also be prioritized. Parents report that they generally benefit from having a therapist available to listen objectively and without blame (McCourt et al., 1998). They may need support and assistance from the play therapist throughout specific posttraumatic stages, such as immediately after disclosure, throughout the reporting and investigation process, during their children's treatments, and, depending on the case, for the duration of any court proceedings. Unfortunately, there are few treatments that directly address parental needs, and distress often persists (Davies, 1995).

Child-focused treatments may include a parental or relational component. TF-CBT (Cohen et al., 2006) is the current "gold standard" in empirically supported childhood trauma treatment. The included parenting sessions have demonstrated usefulness in decreasing parental distress (Deblinger, Steer, & Lippmann, 1999). However, these sessions are largely skills-based. Moreover, TF-CBT requires completion of rigorous therapist training and has the same limitations of other cognitive-behavioral treatments, including strict adherence to the manualized treatment approach and focus on skills-building and exposure exercises. Parents may be impaired by mental health issues that limit their capacity to participate actively (Cohen et al., 2006). Lastly, parents and children may prefer unstructured sessions as they attempt to regain feelings of control over their worlds (American Academy of Child and Adolescent Psychiatry [AACAP], 2010).

Other treatments focus on strengthening the parent-child relationship, such as Parent-Child Interaction Therapy (PCIT; Eyberg & Calzada, 1998), filial therapy (VanFleet, 2011), and child-parent relationship therapy (CPRT; Bratton, Landreth, Kellam, & Blackard, 2006). PCIT aims to improve parent-child attachment, decrease child behavior problems, and improve parenting skills and related stress. PCIT is supported with more than 100 randomized controlled trials utilizing a variety of childhood populations (Herschell, Calzada, Eyberg, & McNeil, 2002). However, at the time that this article was written, there were no published studies

using PCIT with nonoffending parents and their traumatized children. Limitations to this model include its young target population, contraindications for parents with significant psychopathology, implementation requirements (i.e., mirror observation and/or video monitoring, complex coding system; Goldfine, Wagner, Bransetter, & McNeil, 2008), and failure to address posttraumatic responses or symptoms.

Filial therapy (VanFleet, 2011) and CPRT (Bratton et al., 2006) are empirically supported, parent-child therapies wherein counselors train parents to conduct child-centered play therapy with their children. Parents are trained to facilitate a positive relationship with their children using skills such as unconditional acceptance and positive regard. Filial therapy and CPRT have demonstrated effectiveness in treating families with high levels of stress (e.g., Smith & Landreth, 2003). These studies have found that parent-child relationships are strengthened, negative child behaviors and parental stress decrease, and parental empathy and acceptance increases after treatment. Filial therapy and CPRT are less complicated to execute than PCIT when a therapist has limited time, funding, and training (Nadkarni & Leonard, 2007; Smith & Landreth, 2003). They have also been used effectively with nonoffending parents and their children (Bratton, Ceballos, Landreth, & Costas, 2011; Costas & Landreth, 1999; West, 2010).

The fact that PCIT, filial therapy, and CPRT have broad contexts under which they can be used is among their strengths. However, assuming that parents of traumatized children need the same type of treatment as parents with other presenting issues may be misguided. Finally, focusing on the parent-child relationship and the measurement of child outcomes sometimes means less time spent on parents' individual posttraumatic reactions and needs. The Directive-Analytic-Systemic model (DAS) is a treatment paradigm designed by the authors to address nonoffending caretakers' needs in individual play therapy. At this time, no empirical research has been conducted on DAS; therefore, case examples are used to demonstrate the application of this treatment.

DAS

DAS is an empirically informed treatment paradigm designed to address the extensive needs of nonoffending parents through the multimodal use of *directive, analytical, and systemic* interventions. DAS is loosely designed around the notion that trauma treatment occurs in three phases, a concept discussed at length in the adult complex trauma literature (e.g., Courtois, 1997; Herman, 1992) and, more recently, in the child complex trauma literature as well (e.g., Cohen, Mannarino, Kliethermes, & Murray, 2012; Green & Myrick, submitted). This approach suggests that treatment first involves a period of stabilization, followed by processing of the trauma, and finally, a focus on reconnection and moving forward. Thus, in DAS, directive interventions correspond with increasing safety and stability, analytical interventions assist clients with trauma processing, and systemic interventions target positive changes in relationships as individuals integrate healing into their lives.

Directive Interventions

Treatment often begins with psychoeducation. Explaining common psychological reactions after a potentially traumatic event may decrease fear and anxiety, as well as provide a more accurate cognitive framework for appraising past and current experiences (Phoenix, 2007). Many nonoffending parents attempt to modulate their own reactions to observe their children's responses and are overwhelmed with information from various service and legal agencies. In the beginning, play therapists may be most helpful by simply normalizing affective responses and providing accurate answers to questions. Bibliotherapy can provide information to parents of diverse educational and cultural backgrounds in a straightforward, nonthreatening way. *When Your Child's Been Molested* (Brohl & Potter, 2004) and *Helping Your Child Recover From Sexual Abuse* (Adams & Fay, 1992) are two books used often by the authors in their early treatment with parents.

Optimizing parenting skills, including limit-setting and mutual respect, is also recommended during this early stage of treatment (Cohen et al., 2012). A simple game such as "Simon Says" enables parents to practice giving instructions and provide positively reinforcing statements to the play therapist, the one following instructions in the game. Through a warm, nonjudgmental relationship, play therapists model how to accept behaviors and feelings within themselves and their children. Parents also learn how to implement, appropriate, nonviolent consequences when instructions are ignored (Saunders, Berliner, & Hanson, 2004).

For some parents, psychoeducation and related skills-building will be the focus for only a couple of sessions. For others, treatment will address stabilization for some time. It is important for play therapists to remember that trauma-related treatment rarely occurs in a perfectly, linear fashion, and the need for stabilization-focused interventions may arise more than once (e.g., Courtois, 1997). For example, many parents will need to revisit directive interventions as a court date draws near. Despite being stable and feeling "ready," parents often benefit from a review of skills before the date. Some parents leave court feeling retraumatized, so play therapists are wise to prepare for this potentiality by openly discussing parents' thoughts and feelings, as well as educating parents on what to expect. Furthermore, depending on the experience parents have during trial, a processing of what they said, heard, and felt may also be incorporated into their trauma narrative later in treatment.

Once parents begin to demonstrate an increased understanding and mastery of their affective and cognitive experiences, play therapists may start challenging them to discuss the traumatic event. For parents to sensitively and adequately make sense of and integrate their children's traumas, they must develop the capacity to speak about it both metaphorically and directly. Kate and Mike struggled to discuss their son's sexual assault. To help them manage anxiety, they played a game of therapeutic "hot potato," where the person holding the potato when the music stopped read one statement written with trauma-specific terms. By replacing terms such as "the incident" with "our son's sexual assault" and "that man" with the name of the perpetrator in a playful, yet supportive way, both parents began feeling less triggered when their son spoke of the trauma. Additionally, they reportedly felt more comfortable answering questions from their son's lawyer and more prepared

for the upcoming trial. They also used “hot potato” as a metaphor for “passing on” the responsibility of talking about the trauma to one another when needed.

The need for and duration of this level of intervention will vary. For Kate and Mike, approximately five to seven sessions over two months were spent gaining mastery over the difficult emotions evoked by the traumatic material. Once this area of difficulty improved, the play therapist initiated a discussion about beginning to processing the trauma. Play therapists might also consider using standardized measures to gauge parents’ readiness to begin analytical interventions and trauma processing. The Parental Support Questionnaire (PSQ; Mannarino & Cohen, 1996), the Parental Emotional Reaction Questionnaire (PERQ; Cohen & Mannarino, 1996), and the Parental Stress Index (PSI; Abidin, 1995) are reliable and valid measures of posttraumatic, parental responses. Play therapists can give these as pre- and posttest measures or throughout treatment to assess any changes. Additionally, any relevant symptom checklists may assist with tracking comorbid symptomatology.

Analytical Interventions

Processing the traumatic experience and developing a coherent narrative of the experience is important for parents, just as it is for their children. Trauma narratives serve to (1) detach neutral stimuli from danger/trauma, (2) challenge and correct any distorted or inaccurate thoughts about the trauma, and (3) contextualize the details of the event(s) within the family’s life (Cohen & Mannarino, 2008). Thus, the therapeutic rationale for utilizing Jungian sandplay therapy (Kalff, 1980) in trauma processing is that individuals make meaningful links between internal and external experiences and develop the story of their experience. Parents use miniatures to express complex experiences encompassed within the trauma. After concretizing the experiences through pictures in the sand tray, parents can then begin making meaningful links and developing mastery over the material. The process of expressing oneself through sand play is inherently therapeutic (e.g., Bradway & McCoard, 1997) and allows for the connection of conscious mind’s understanding of the traumatic experiences with the unconscious mind’s interpretations (e.g., Carey, 1999).

Jungian sandplay was used with two parents whose son, James, witnessed another child being beaten to death by his inebriated step-father (Green & Connolly, 2009). The parents were having difficulties understanding why their son was engaging in maladaptive coping mechanisms, such as wetting his pants and refusing to fall asleep at night after the trauma. Sandplay was employed for the parents to increase collaboration, understanding, and communication. They cocreated, without any direction from the therapist, multiple scenes over many months. Through these various sand pictures and the symbolic stories they told, the parents developed increased empathy for James and developed acceptance of his posttraumatic, behavioral reactions. Furthermore, they reported that the sandplay intervention assisted them in reestablishing lines of communication with each other that had been temporarily severed after James’ traumatic experience.

Pacing is important during this phase of treatment to avoid flooding of emotions or destabilization. Preparing parents for the intensity of this phase of treatment is also useful, as it allows parents to be in the mindset necessary to be helped

by the intervention. Because length of trauma processing will depend on the complexity and chronicity of the trauma, the analytical phase of treatment will also vary in length. In the authors' experiences, trauma processing using sandplay takes approximately four to six months, with sessions occurring at least weekly.

Systemic/Family Interventions

Once the trauma has been processed, parents will report less individual impairment and later sessions will likely address posttraumatic functioning in the family system. Specifically, (a) traumatized children may feel less capable of contributing to the family's goal of returning to preabuse functioning, (b) parents may struggle with their nontraumatized children, and (c) other family members may have faulty or irrational thinking about trauma. Incorporating family-based work into parents' treatment facilitates the process of sharing feelings and collaborating to make healthy decisions for the family as a whole (e.g., Scheinberg & Fraenkel, 2001). Any number of family issues may be addressed during this final phase of treatment.

Systemic/Family Intervention Case Example

Ed expressed disproportionate feelings of guilt after punishing his daughter for failing to complete her chores. His 15-year-old daughter, Susan, had disclosed repeated sexual abuse by a neighbor. Susan had become angry, withdrawn, and depressed in the months after the disclosure. Ed reported that her mood improved or appeared slightly elevated when she participated in structured activities such as family game night, weekday family dinners, and group household chores. He also reported feeling relief when she was productive, as it removed some of the burden of extra household responsibilities from him. Similar to other nonoffending parents, he struggled to balance compassion with reasonable expectations for Susan. He had previously felt responsible for the trauma, as he believed he should have known what was happening to Susan. These thoughts and feelings were processed and were no longer impairing him; however, he still felt that his family was operating less effectively than it could be.

Before inviting Susan to join a session, Ed and his therapist discussed chores that Ed felt were reasonable for Susan to complete. Using sand pails and stones, the play therapist encouraged Ed to use one pail to represent him and one pail to represent Susan. Ed put stones in each pail; stones in his pail represented his responsibilities in the family, and stones in Susan's pail represented hers. The play therapist encouraged Ed to notice what happened when too many stones were in his pail. He remarked that it became too heavy to carry, a symbol of how difficult it was for him to manage all responsibilities on his own. Alternatively, Susan's pail was light, and Ed remarked that it was "unstable," just as he believed Susan was when she had nothing productive to keep her active and emotionally present at home.

In a family session, Ed candidly shared his conflicted feelings to Susan. He expressed worry about her well-being, guilt over his expectations, sadness, anger at the abuser, and finally frustration. Susan shared her own feelings of guilt over

failing to help at home, anger when Ed pushed her to be active, worry about her own well-being, and fear that she would never again be “normal.” She also expressed feeling emotionally damaged and unworthy of love from others. Ed and Susan identified ways Susan could contribute to the household and practiced using “I statements” (e.g., “I feel frustrated when you have not emptied the dishwasher”) to communicate feelings without assigning blame. Ed also shared how proud he was of Susan for disclosing the abuse, how much he loved her, and that he did not blame her for the abuse. In individual treatment, Ed and his therapist continued to discuss the ways in which Ed’s lingering feelings of guilt were affecting his ability to set and reevaluate reasonable expectations for Susan.

The goals of later trauma treatment are less specific, so the length of remaining therapy will vary. Play therapists may recommend ongoing family therapy, general counseling, or decide with parents to terminate treatment altogether. Despite the uniqueness of this population, therapists can utilize similar processes to determine readiness for termination as they would with nontraumatized clients.

CONCLUSION

Although the interventions with empirical support for treating primary child trauma survivors have demonstrated effectiveness (e.g., Cohen et al., 2006; Saunders et al., 2004), the application to individual treatment of nonoffending caretakers is less well-developed. The DAS treatment paradigm combines directive interventions aimed at reducing specific maladaptive behaviors, cognitions, and emotions with analytical processing of traumatic material, and an awareness of the renovation that occurs as trauma survivors incorporate their recovery into their present and future. Its structured, yet flexible, approach to disseminating skills, processing traumatic experiences, and reconnecting parents to daily life complements the treatments available to traumatized children and allows parents a way to heal as their children do the same. Future research in this area needs to focus on the validation of treatment paradigms like DAS to increase awareness among the therapy community and accessibility among nonoffending parents.

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Received May 22, 2013

Revision received August 14, 2013

Accepted August 26, 2013 ■

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