Increasingly, domestic violence is being recognized as a major concern for children today. Hamby, Finkelhor, Turner, and Ormrod (2011) of the U.S. Department of Justice discovered that approximately 8.2 million children were exposed to some form of family violence in the past year and 18.8 million over their lifetime as reported by a national survey. Witnessing physical as well as psychological–emotional violence within the family can cause serious detrimental effects to children. Younger children respond to domestic violence by having higher levels of psychological disturbance and display lower self-esteem than do older children. Likewise, other issues related to mental and physical health may manifest. Additionally, child witnesses of familial violence are taught to maintain the secret of violence; therefore, alternative forms to verbal expression are important in supporting this population. It is imperative that these child witnesses receive interventions that are developmentally appropriate and meet their unique needs. Play therapy has been proven to be a statistically effective means of treating externalizing and internalizing problems in children. Therefore it is proposed that child-centered play therapy interventions be applied when working with children exposed to domestic violence.

**Keywords:** child-centered play therapy, domestic violence, trauma

Terr (1991) described trauma as “horrible external events” (p. 10) that occur and manifest in two distinct types. Type I traumas are a single traumatic incident that occurs in one sudden moment, whereas Type II traumas are ongoing traumatic experiences over a period of time (i.e., domestic violence). Lasting, internal changes occur within the child as a result of trauma exposure. Specifically, Terr characterized Type II traumas by the following:

1. visualized or otherwise repeated perceived memories—reexperiencing the trauma through sensations or visually; visualizations appear to be the strongest form of reexperiencing; they are usually experienced during down times such as when daydreaming or before falling asleep; (2) repetitive behaviors—frequent reenactments of the traumatic event; lack “fun”; if children have no verbal memory when the trauma occurred they may have physical sensations, play out or otherwise appear in a manner that represents how they were during the trauma; such behaviors are usually unconscious; (3) fears specific to trauma—children often harbor these fears into adulthood; fears are literal and specific to the trauma or mundane items associated with the trauma; (4) altered attitudes about people, life and the future—children’s perspective of the future is limited and reflect the belief that more traumas are inevitable.

Additionally, Terr (1991) continued to explain that memories of trauma are incomplete and spotty; children exposed to Type II traumas remember some things but not others. Children who have experienced this type of trauma also respond with emotional reactions such as lack of feeling, rage, vulnerability, hopelessness, powerlessness, and unrelenting sadness, as well as an ever-present fear (Ogawa, 2004; Terr, 1991). These children develop the ability to disassociate themselves, mentally and emotionally, to avoid feeling the emotions associated with the trauma. Denial and numbing can last momentarily or for longer periods of time. Children will present as withdrawn, of which they are unaware, because this is an unconscious
coping mechanism (Terr, 1991). Conversely, at times they become easily enraged or abnormally passive in their interactions and may fluctuate between the two. Often, they will also turn their anger toward themselves and may turn to mutilation or suicidal behaviors. Internal changes that occur within the child as a result of exposure to Type II trauma may develop into more severe symptoms, which could lead to various diagnoses including personality disorders, conduct disorders, attention-deficit disorders, depression, dissociative disorders, and anxiety disorders (Ogawa, 2004; Terr, 1991).

Others have agreed that trauma can produce hyperarousal, reexperiencing–flashbacks, repetitive behavior, and trauma-specific fear, which may inhibit self-control (Buschel & Madsen, 2006; Ogawa, 2004). It must also be considered that perception and response to trauma are dependent upon the developmental levels of the children who are exposed (Dripchak, 2007; Ogawa, 2004; Young, 2008). In children, feelings of fear, anger, and helplessness are often expressed differently from the way adults do because of developmental considerations (Ogawa, 2004). Neurological advances have found that traumatic memories in children are stored and processed in a sensory manner (somatic complaints, visual, auditory), therefore disrupting cognitive abilities to process the traumatic event (Ryan & Needham, 2001). It is believed that children affected by trauma need additional professional support to help process these sensorimotor and affective memories, which is discussed later.

**Domestic Violence and Children**

A national survey conducted by Hamby et al. (2011) of the U.S. Department of Justice reported that 90% of children exposed to some form of family violence in the past year were exposed to physical violence and visually witnessed the attack, whereas 72.7% were visual witnesses to psychological–emotional violence over their lifetime. Of these children who witnessed attacks, 6.6% were exposed to physical assault of their parents and 5.7% were exposed to psychological–emotional violence. Additionally, the survey found that one in nine (11%) of children were exposed to some form of violence (physical and/or psychological) in their family in the past year and one in 15 (6.6%) experienced violence between parents or between a parent and partner. Similarly, McCloskey, Figueredo, and Koss (1995) conducted a study of 375 women who were in domestic violence situations. Women in the study reported the co-occurrence of verbal, physical, and escalated aggression in families with violence. Of the participants, 75% of the women reported being choked by their partner, with 50% of children stating they witnessed it. Also, about 50% of the women reported that they were threatened with a weapon. Child witnesses of domestic violence begin to expect adult aggression as part of everyday life despite their fear of it (Lieberman & Van Horn, 1998). Their intense need to help, yet being helpless in the situation, leads to an inability to maintain emotional relationships that are fulfilling (Lieberman & Van Horn, 1998). As exposure to the cycle of domestic violence occurs, children continue to have the experience of conflicting emotions such as love and terror and mixed messages about who is safe and unsafe. Kot, Landreth, and Giordano (1998) stated that “these children are often confused and negatively impacted by their parents’ cyclical expression of love and violence towards each other. Violence in domestic households creates environments that are unstable, inconsistent, and model aggression as a means of conflict resolution” (p. 19). In a similar way, children can experience confusing and conflicting emotions such as happiness and fear regarding seeing the abusive parent (Buschel & Madsen, 2006). Children who are exposed to domestic violence are forced into the paradox of wanting to continue connectedness with their abusive parent but also protecting themselves emotionally (Young, 2008). As these contradictory feelings become integrated, children begin to externalize their emotions. These confusing and overwhelming feelings lead to school phobia, separation anxiety, learning disorders, enuresis, digestive disorders, depression, and difficulties with peers (Kot et al., 1998). Younger children respond to domestic violence by having higher levels of psychological disturbance and displaying lower self-esteem than do older children (Lieberman & Van Horn, 1998).

Children who have been exposed to domestic violence take on responsibility for the parental conflict they see, as well as feel helpless in their daily lives (Kot et al., 1998). It therefore makes sense that witnessing such violent offenses and
experiencing feelings of powerlessness lead to behavioral manifestations. Literature on domestic violence and children has emphasized that children not exposed to such trauma (Graham-Bermann, Castor, Miller & Howell, 2012; Kot et al., 1998; Lieberman, Van Horn, & Ozer, 2005; Tyndall-Lind, 1999; Tyndall-Lind, Landreth, & Giordano, 2001). Children from violent homes often display internalizing and externalizing behaviors simultaneously. Additionally, significant differences in separation anxiety, obsessive–compulsive, and conduct disorders were found between children who were exposed to domestic violence and those who were not (McCloskey et al., 1995). The most recent study, done by Graham-Bermann et al. (2012), demonstrated that trauma symptoms were found in 92% of children exposed to domestic violence whose symptoms lasted longer than one month. Of these children, 69% displayed increased aggression, 65% demonstrated separation anxiety, 45% had development of new fears, and 27% showed regressed developmental gains. In the study, significant relationships were found regarding diagnostic trauma symptoms and internalizing (p < .001) and externalizing (p < .01) behaviors as measured by the Child Behavior Checklist (CBCL). It should be noted that 62% of the participants did not experience additional traumatic events besides domestic violence. Additionally, a 1-month follow-up that was conducted found that 71% of participants still displayed symptoms and 17% met diagnostic criteria for posttraumatic stress disorder.

In a similar way, a study conducted by Lieberman et al. (2005) showed that child functioning is negatively impacted by marital violence. The study included 85 preschoolers and their mothers who were exposed to domestic violence. Mothers’ rated their children’s behaviors on the CBCL: 28% scored in the clinical range and 7% scored in the borderline range for the total problems score. It was also demonstrated that the amount of violence witnessed by the children was significantly correlated to their behavior problems (p < .01). In 1998, Lieberman and Van Horn used the CBCL to evaluate behaviors seen in preschoolers who had experienced domestic violence. The researchers found comparative results to earlier studies; 70% of the 26 participants demonstrated borderline or clinical range scores on externalizing behaviors (aggressive–destructive), and 56% had scores in the borderline or clinical rage for internalizing behaviors (anxiety, depression, withdrawn). Elevated externalizing behavior scores as well as elevated internalizing behavior scores were seen in 80% of children who participated in the study. They noted that study results confirm the belief that being a witness to domestic violence is a traumatizing experience for young children.

Children who demonstrate these elevated aggressive and maladaptive behaviors due to domestic violence are more likely to exhibit violent patterns as adults, known as intergenerational transmission of violence, which should be dealt with early on from a developmental perspective (Kot et al., 1998; Tyndall-Lind, 1999; Tyndall-Lind et al., 2001). Some children may be developmentally unable to directly discuss the traumatic event (Ogawa, 2004). In addition, children exposed to domestic violence have been conditioned to be silent about the abuse; therefore alternatives to verbal processing and expression are important (Kot et al., 1998; Tyndall-Lind, 1999). Interventions with these children should emphasize trusting and healthy, positive relationships (Tyndall-Lind et al., 2001). Likewise, it is thought that communicating symbolically may lessen externalizing behaviors (Buschel & Madsen, 2006).

It is therefore imperative that children exposed to domestic violence be provided with interventions that address all of these needs, such as child-centered play therapy (CCPT), which is discussed next.

**Conceptual Background**

Child-centered play therapy (CCPT) was birthed out of the client-centered theory posed by Carl Rogers (1949), which is not based on a method or set of techniques but rather on a deeply embedded set of personal attitudes and beliefs regarding the worth and significance of individuals. Counselors remain consistent in their beliefs and interactions of acceptance and competency of clients’ self-direction, thus freeing the client to explore experiences, self, and life in a new way with new goals and meaning in a safe environment (Rogers, 1949).

Counselors began examining client-centered theory as applied to children, understanding them and how they relate to the world, their
experiences, and their development (Ray, 2011).

Children are generally less verbal, less insightful, and less able to identify and express their emotions than are adults due to lower cognitive development; therefore, play is their natural means of communication (Bratton, Ray, Rhine, & Jones, 2005; Fall, Balvanz, Johnson, & Nelson, 1999; Landreth, 2002; Landreth, Ray, & Bratton, 2009; Phillips & Mullen, 1999; Ray, 2011). Children typically struggle to bridge the gap between concrete experience and abstract thought. Play therapy helps children process these abstract experiences through concrete means (Landreth et al., 2009; Ray, 2004; Ray, 2011). Therefore, children often use inanimate objects rather than words to project their feelings, beliefs, and perceptions about themselves and the world (Bratton et al., 2005; Landreth, 2002).

Play Therapy

Play is a natural way for children to communicate and to increase self-awareness as well as communicate this awareness to others (Landreth et al., 2009; Ray, 2011). Materials and toys are therefore used to directly or symbolically play out emotions, thoughts, or experiences that occur in their concrete and active world. Play provides an opportunity for the counselor to enter the world of children and for children to communicate at their level of understanding (Landreth et al., 2009).

Play therapy has been proven to be a statistically effective means of treating externalizing and internalizing problems in children (Bratton et al., 2005; Ray, 2011). A meta-analysis conducted by Bratton et al. (2005) revealed that on average a child receiving play therapy services performed more than .75 SD better on given behavioral–emotional outcomes compared to those who did not participate in play therapy. The review indicated that play therapy, regardless of therapeutic approach, is considered effective; however, humanistic interventions produced larger effect sizes. Those considered nonhumanistic are more directive in nature and include behavioral-, cognitive-, and solution-focused play interventions. Humanistic, nondirective approaches to play therapy such as CCPT produced higher treatment outcomes when compared with other modalities of play therapy (previously referenced).

Child-Centered Play Therapy

Child-centered play therapists model acceptance of and attend to the whole child, including cognitions, behaviors, and emotions, through an accepting, genuine, and empathetic relationship based on Rogers’ client-centered theory (Fall et al., 1999; Landreth, 2002; Post, 2001). This relationship is the basis for change and is a way of being with children rather than a technique that is applied to them and their problems (Landreth, 2002; Landreth et al., 2009). CCPT employs interactions with children such as tracking (reflecting play behavior), reflecting content–meaning, reflecting feeling, returning responsibility (facilitating decision-making), encouraging (esteem building), unconditional positive regard and acceptance, and limit setting (Landreth, 2002; Landreth et al., 2009; Ray, 2011). Through these principles, CCPT creates a safe environment for children to explore and express their emotions, master tasks, and practice coping skills, which lead to increasing feelings of empowerment and self-acceptance (Blanco & Ray, 2011; Landreth, 2002; Post, 2001). In a similar way, the freedom and control experienced by children involved in CCPT provides them with encouragement and development of positive coping skills, experimentation, decision-making, and problem-solving in a non-threatening manner (Cochran, 1996; Johnson, McLeod, & Fall, 1997).

During CCPT, children are validated in their feelings and actions, which therefore decreases anxiety and self-defeating coping mechanisms (Fall et al., 1999). This environment of acceptance without contingency of competence excludes a message that adults care just as much about children’s feelings as about their performance. Respect and relationship are believed to be the prerequisite for change and learning (Axline, 1947; Landreth, 2002).

Child-Centered Play Therapy and Trauma

Trauma at preverbal and nonverbal developmental stages does exist, but at a subconscious level, which impacts emotions and behaviors that may be evident in play (Young, 2008). Play is a cathartic way for children to express their whole experience of the trauma (Ogawa, 2004).
Trauma is seen to be unconsciously created, and there is usefulness in play as a medium to access this trauma and associated emotions (Ryan & Needham, 2001). Play allows children to access their feelings in a way that incorporates affective, fantasy, and kinesthetic modalities. Ogawa (2004) stated, “Fantasy in play allows children to change the story, so that they become empowered and strong enough to overcome their feelings of helplessness and lack of autonomy” (p. 24). Trauma affects the development of sense of self in younger children and the authentic self in older children (Young, 2008). A sense of self-control may be regained in play that represents nurturing, rescuing, revenge, and fantasy play as children begin to feel empowered (Ogawa, 2004). CCPT allows children to regain a sense of self-control as they move toward self-actualization due to the self-directed nature of the sessions.

Symbolic play allows children to experience mastery over traumatic events and work toward a more integrated self (Green, Crenshaw, & Kolos, 2010). Play therapy desensitizes children naturally, because it is a safe environment for processing trauma. Children have the ability to regulate their distance to traumatic events during play therapy sessions through use of materials and symbolism. CCPT provides children with the opportunity to control how and when they will decide to confront their trauma, if they choose to do so (Green et al., 2010). Play therapy is a means for them to regain control over emotions, confusion, and anxiety at a subconscious level (Young, 2008). Traumatized children can use toys to work through these emotions and distance the self as needed emotionally. CCPT offers children a healthy model of consistency, predictability, and control, as well as the opportunity to alter the outcome of the trauma on their terms. Young (2008) stated that “play therapy enables preverbal and nonverbal traumatic components to be visited, manipulated, controlled, and integrated into a tolerable and manageable experience” (p. 21).

Mastery over the trauma is gained when the child feels safe and secure in the therapeutic relationship (Young, 2008). Upon feeling safe and secure within the therapeutic relationship, children will begin to explore the materials in the playroom and use them symbolically (Buschel & Madsen, 2006). Therapists wishing to use CCPT must be aware that the nature of the traumatic experience will affect the therapeutic and healing process (Ogawa, 2004). Attachment issues may be present due to the trauma, which can complicate relationship building, taking longer for it to be built (Terr, 2013). Multiple exposures to traumatic events can increase feelings of vulnerability, hopelessness, powerlessness, and lack of control. Trauma should be treated with three principles in mind: abreaction, context, and correction (Terr, 2013). These three cannot all occur at once, but play can facilitate their presence. Terr (2013) explained that abreaction is a therapeutic release that helps children who have never learned verbal expression for emotions to play out their feelings. Context, according to Terr is a “child’s understanding, clarification, and perspective of trauma” (p. 55) that he or she is able to play out. Correction is a way of doing or pretending to change what happened in the trauma.

Dripchak (2007) defined posttraumatic play (PTP), in which the same materials are used, as being ritualistic in nature. Repetitive themes that are traumatic in nature are also observed. Both positive and negative PTP can occur during sessions. Positive PTP allows for children to change negative components of the trauma into positive ones and allows the child to gain mastery and feelings of empowerment. Negative PTP may worsen the traumatic effects in that the anxiety and internal conflicts are perpetuated and play is restricted as well. The child is unable to come to mastery over the event, failing to gain acceptance and resolve. Children engaging in negative post traumatic play may appear “stuck” in the trauma or associated feelings. Therapists need to carefully monitor behavioral reenactments that are obsessively repetitive and sometimes dangerous, because children may play out terror, loneliness, or helplessness in overcoming the trauma (Green et al., 2010). When negative posttraumatic play is evident, it is important for the therapist to use a softer and slower tone of voice to create a sense of safety and add to the child’s focus (Dripchak, 2007). Therapists should also incorporate reflective statements that help the child make meaning of the play, emphasizing possibilities of a new direction and control—choices. Esteem-building statements such as “you’re working hard to figure out a way” may be helpful as well. A shift toward less traumatic play and
reduction in problem behaviors takes place as healing begins (Young, 2008).

**Child-Centered Play Therapy and Domestic Violence**

Children witnessing domestic violence are at greater risk for developing adjustment issues (Tyndall-Lind et al., 2001). Social skills between child witnesses of domestic violence and their families and peers are impaired as well and are directly related to the amount of violence they have been exposed to. Inadequate problem-solving skills are often an issue for children in a shelter from domestic violence, and aggression is usually their initial coping method for resolving issues, as is exhibiting immature and regressive behaviors. According to Tyndall-Lind (1999), “Children who are constantly exposed to negative environmental stimuli, consistently reinforce the development of a negative self-identify and rarely receive information that contradicts negative environmental messages” (p. 12), which creates an external locus of control and self-concept. Negativity from the family begins to become integrated into the self and perpetuates feelings of blame and guilt. Therefore, maladaptive behaviors manifest as a coping mechanism and further support their distorted belief system (Tyndall-Lind, 1999). Through play therapy children are given the opportunity to express themselves and experience themselves in many new and different ways, therefore creating new beliefs about themselves, their potential, and their capabilities (Kot & Tyndall-Lind, 2005; Tyndall-Lind et al., 2001). During these new experiences, children begin to change their self-concept by challenging negative messages they may have received within their families and violent homes (Tyndall-Lind et al., 2001). Improvement seen in self-concept has a great impact on coping, because it is the core of social-emotional development (Kot & Tyndall-Lind, 2005). Tyndall-Lind et al. (2001) further endorsed addressing the self-concept by saying that “positive self-concept has been listed as a protective factor associated with improved ability to cope with parental violence” (p. 68).

Kot and Tyndall-Lind (2005) emphasized that “a primary goal of play therapy with child witnesses of domestic violence is to help establish a corrective therapeutic relationship that optimizes trust, safety, and mutual respect, thereby enhancing the child’s opportunity to accurately integrate denied and distorted traumatic material” (p. 33). Empathy and acceptance toward self and others are cultivated over the course of therapeutic play in which the child is engaged in a genuine, warm, accepting relationship with the therapist (Green et al., 2010). Within the therapeutic relationship, children begin to understand the dynamics present in healthy relationships and feel a sense of control over their vulnerability (Tyndall-Lind, 1999). Mastery and personal awareness are increased through the use of CCPT skills such as allowing the child to lead, returning responsibility, effective and empathetic reflection of emotion, and limit setting (Tyndall-Lind, 1999). Limit setting conveys to children that they have the ability and potential to make positive behavioral choices and exercise self-control, as well as take responsibility for their choices. Limits help to model boundaries within a genuine and caring relationship in a healthy manner, which is extremely important for children exposed to domestic violence. One of the more essential factors in the therapy session is to create a sense of security by offering consistency, predictability, and enforcing limits, because children exposed to domestic violence view the world in a fearful, unpredictable manner (Ogawa, 2004). Green et al. (2010) described the therapeutic environment in CCPT as a unique environment in which children can “practice corrective, empowering actions, and release blocked energy related to a sense of powerlessness anxiety” (p. 98). It is common for children exposed to domestic violence to play out themes related to safety, control, conflict, protection, mastery, and control (Kot & Tyndall-Lind, 2005). Play allows for children to symbolically deal with emotions related to the domestic violence and allows for psychic distance, which reduces anxiety enough for them to effectively work through those emotions. Therapeutic progress can be observed in the children’s play as they are able to manipulate the toys and move from a victim role toward one of mastery over the traumatic events. Many children begin to view the family violence from a variety of perspectives and gain understanding about how the events occurred as well as increase objectivity. Kot and Tyndall-Lind (2005) recommended that toys in the playroom should include police and emergency vehicles and personnel dolls—
puppets, handcuffs, weapons, and doctor kits. Ryan and Needham (2001) added that it is important to have symbolically meaningful materials consistently available in the playroom for each session; however, the therapist must be mindful of those that may trigger memories of personal trauma in a negative, harmful way.

Child-centered play therapy (CCPT) can act as an effective intervention in that it is a means for children to regain a sense of control and empowerment in their lives and is developmentally appropriate (Kot et al., 1998). The most recent study on effects of CCPT on children exposed to domestic violence was conducted by Kot and Tyndall-Lind (2005), in which individual CCPT was compared to sibling group CCPT and a control group. Participants were between the ages of 4 and 10 years old, resided in the domestic violence shelter, and were composed of similar-gender distributions. Ethnicities between the treatment groups were almost identical, whereas the control group contained a larger percentage of African American children. Twelve intensive CCPT sessions were held over the course of 2–3 weeks, each 30–60 min long. No significant differences were found between the two interventions, although individual CCPT produced a trend toward a somewhat more positive change. Improvement was demonstrated by increases in self-concept and decreases in externalizing behaviors and total behavior problems. In a similar way, a study done by Tyndall-Lind et al. (2001) examined the effectiveness of intensive CCPT sibling groups for children living in a domestic violence shelter. Twelve 45-min sessions were conducted over 12 days and consisted of two siblings at a time. The study found that intensive sibling group play therapy was as effective as was intensive individual play therapy, because there were no significant differences. The experimental group demonstrated significant \( p < .001 \) increases in self-concept measures, whereas the control group scores declined. As measured by the CBCL, mothers of participants reported significant \( p < .05 \) decreases in total behavior problems and an increase in their children’s overall well-being, which was also confirmed by shelter staff. Significant decreases \( p < .01 \) were also reported for externalizing behaviors, aggressive, and delinquent behaviors (e.g., lying, cheating, swearing, hurting others, destroying property), whereas children in the control group showed an increase in aggressive behaviors. Participants in the group demonstrated a positive \( (p = .058) \) trend toward decreasing internalizing behaviors (e.g., withdrawal, somatic complaints, anxiety, depression). Therefore, this study supports the idea that individual play therapy is an intervention with positive results for child witnesses of domestic violence.

The earliest study found regarding CCPT and children exposed to domestic violence was done by Kot et al. (1998), in which twelve 45-min individual sessions were conducted over the course of 12 days (3 weeks). Participants demonstrated significantly higher self-concept scores and significantly fewer externalizing behavior problems as well as fewer overall behavior problems. They demonstrated increased feelings of empowerment as measured by the Joseph Pre-School and Primary Self-Concept Screening Test but also through mother’s perceptions. It was proposed that stronger self-concepts would lead to less ownership of parental violence and also lessen the likelihood that they would continue the domestic violence cycle. Additionally, mothers reported less aggression and other behaviors such as lying, swearing, and cheating. Although no significant reduction in internalizing behaviors was noted, fewer were observed by the mothers (e.g., less withdrawal, somatic complaints, anxiety, depression, nightmares). They also observed development of self-nurturing strategies in their children. Reduction in such behaviors would indicate CCPT as an effective treatment, because children exposed to domestic violence demonstrate elevated levels of externalizing and internalizing problems in general. The control group in the Kot et al. study demonstrated a consistent increase in observed behavior issues, as noted by mothers. The researchers highlighted that significant increases in proximity of play with the therapist indicate higher levels of security and comfort within the therapeutic relationship. Additionally, they noted that play themes also significantly shifted from conflictual to nurturing, constructive, and creative. Children who participated in the CCPT sessions also demonstrated less aggression than did the control group in a follow-up assessment after sessions were terminated.
Conclusion

It is clear that exposure to domestic violence is an issue that many children face in today’s society and that this exposure has long-lasting impacts if left untreated. Children exposed to such violence need to feel safe, supported, and understood within the therapeutic environment, while also experiencing a model for healthy relationships. Play is the natural language of children and allows for deep, meaningful expression of emotions associated with trauma that may be otherwise left silent. Child-centered play therapy (CCPT) is a developmentally appropriate approach to therapy that has been demonstrated to be an effective intervention to support healing from domestic violence exposure throughout the literature over that past several decades.

Therapists wishing to work with children impacted by domestic violence should be well trained in CCPT and trauma and have access to competent supervision due to risks related to client welfare. Therapists expertly trained in CCPT are able to reflect feelings and meaning in play, which provide an avenue for understanding and connection with the child. Additionally, the use of esteem building and returning-responsibility responses may help to repair damage that occurred to the child’s self-concept. Limit setting through the CCPT process also provides modeling of healthy relationships and boundaries for children exposed to domestic violence. Therefore, therapists working with this population need to be well trained in CCPT and well versed in trauma to best address children’s therapeutic needs.

References


