

Comments by Clinical Editor

Author offers understanding for the need of rough play in child development and play therapy.

By Enrico Gnaulati Ph.D.

The Therapeutic Use of **ROUGH- AND-TUMBLE PLAY**





Children's rough-and-tumble play (R&TP) is easy to identify when witnessed—chasing and fleeing, mock fighting, or pretend wrestling—often involving pouncing, climbing, tumbling, grappling, and rolling around on the ground. Historically, play scholars have disregarded R&TP as a legitimate area of study (Scott & Panksepp, 2003). However, there is a growing body of anthropological research pinpointing how essential R&TP is during early childhood for picking up valuable social and emotional competencies (Pellegrini, 2009; Smith, 2010). Indeed, we play therapists have much to learn about how children's naturally occurring in-session R&TP can be capitalized on to fortify bonds with clients and expand their expressive know-how. For play therapists wishing to incorporate an interpersonal/experiential approach (Altman, Briggs, Frankel, Gensler, & Pantone, 2002; Gnaulati, 2008; Norton & Norton, 2011) R&TP can represent dramatic occasions for interpersonal learning and render the expressive outlets nested in the play more emotionally enlivening and potent.

One of the main functions of R&TP is social bonding (Scott & Panksepp, 2003). The sheer delight on the faces of children as they participate in classic R&TP, such as fleeing and chasing, or using mock wrestling moves to overpower, or be overpowered by each other conveys how they are in the process of cementing a personal relationship. Adults often assume that R&TP necessarily leads to relationship conflicts and they try to thwart it on the playground (Logue & Harvey, 2010). However, when children themselves are polled, the overriding conclusion is that R&TP mostly represents a pleasurable way to connect with peers (Reed & Brown, 2000). A Dutch research team (Trezza, Baarendse, & Vanderschuren, 2010) has shown how in the mammalian brain that the same pleasure centers that regulate appetite and food intake light up during R&TP activity, and interview data reveals how up to 85% of play-fighting partners are friends (Smith, Smees, & Pellegrini, 2004).

The social bonding function of R&TP has implications for how we conceive of basic rapport building and relationship formation in child therapy. If R&TP is a core way in which young children establish social bonds, to engage children effectively emotionally, we therapists may need to get better at responding in kind to their subtle and not-so-

subtle attempts to lure us into mock fights, fleeing, and chasing games, and the likes. The obvious enjoyment most children derive from such play scenarios should clue us into the unique potential R&TP represents for emotionally reaching our child clients, enabling us to provide the optimal level of arousal they need, thereby leaving them feeling that we “get them” and are fully present in the room with them. In my experience, an eagerness and willingness on the part of the therapist to respond to children's R&TP overtures can speed up a child's comfort level being in therapy and lay the groundwork for a positive and productive therapy relationship.

R&TP may also be the primary, time-honored way in which children safely experiment with and acquire mastery at handling their own and others' aggression, as well as deal with power dynamics in relationships (Pellegrini, 1987). Observational studies have established clear distinctions between R&TP and real aggressive conflicts (Fry, 2005). First, children involved in R&TP commonly smile and laugh, or exhibit a “play face”; their implicit awareness and conveyance of the fact that what they are enacting is for playful purposes, and that they intend or expect no real harm. When real aggression is occurring, children commonly frown, engage in “stare downs,” bare their teeth, or have a puckered look—all manifesting intent to do harm (Pellegrini, 1987). Second, R&TP typically incorporates mutual role reversals, and what play researchers call “self-handicapping,” by older, or more mature participants (Pellis & Pellis, 1996). For example, in a mock wrestling match, where there is much contagious grunting and giggling, a younger boy might gleefully announce, “now it's my turn to be on top,” only to find the older boy willingly allowing this to occur, even “self-handicapping” himself by going limp to allow the younger boy to more capably pretend to pin him down. With R&TP, there is restrained aggression and playful posturing. There is a mutual desire to hold back from inflicting any real harm and to trade dominator and dominated, or chaser and flier roles, to ensure that the enjoyable nature of the play persists. The vast majority of children grasp the essential difference between R&TP and real aggressive conflict. By age 10, about 96% of children are able to distinguish between play fighting and real fighting (Smith, 2010).

As such, when invited into R&TP exchanges by their clients, child therapists need not be overly concerned that, should they respond in kind, their clients will misconstrue their actions as aggressive in nature. The more relevant concern is for therapists to use their imagination actively to steer and shepherd the play in ways that free clients up to more thoroughly, flexibly, and safely actualize any latent desires to show and cope with aggression. Other social and emotional lessons embedded in the play and coaxed along by the therapist include: the importance of self-restraint when agitated, especially in the face of provocation; the sharing of power without adverse reactions, or playfully and smoothly trading off who gets to be in charge; when and how to proudly show off one's strengths or face-savily admit to personal limitations; and honoring one's own and other's personal space and touch sensitivity.

This is all notwithstanding how R&TP interactions can have cathartic effects, creating calm moments and openings for clients to make candid disclosures and arrive at important insights.

A Case Example

Nine-year-old Frank was referred for therapy due to being socially reserved, mildly depressed, and prone to either avoid competitive situations with male peers, or be obsessively preoccupied with winning, to the point of blatantly cheating to gain the upper hand. During a session a few months into therapy, he grabbed a hold of one of my leather couch cushions as if to use as a weapon, and with a devilish grin on his face, playfully marched toward me as I was sitting on an adjacent chair. I got on my feet speedily, but not in time to prevent myself from being pushed back onto my rear end by Frank wielding the cushion. I ruefully declared: "Ah, ha, the almighty Frank wants to feel like he's da boss, and push me around." Frank laughed loudly and rebutted, "yeh wimpy dude you don't stand a chance." I put my left hand behind my back and told Frank that would make things even because I was a grown-up. He

insisted this was unnecessary. He then came at me using the cushion as a battering ram. I used both hands to push him back vigorously. He lost his balance and fell on the carpet uttering, "I changed my mind. Get that left hand behind your back." I complied with his wishes and stated, "I have a wise enemy who knows what to say and do so he can stay competitive."

I began pretend-taunting him, "For a minute there, I thought you were Frank the tank. But you ain't no tank." Using a moderate amount of force, he repeatedly rammed into my raised knees as I was sitting, slumped back in my soft chair.

I commented: "My opponent is wiser than I thought. He remains strong. Even though I'm trash talking him he does not completely lose his cool."

The interaction segued into me being the dominant one and he trying to counter my force. I picked up a cushion couch to use as a blocker and with a faux dictator-like voice announced: "The police have been called in to hold the protestors back. The world leaders are meeting inside the auditorium and it is my job to hold the line." I then pushed him back with my cushion, as he used the full force of his body to prevent me. This scenario repeated itself about 10 times, until on the 11th time, as we both were in a fit



“... we play therapists have much to learn about how children’s naturally occurring in-session R&TP can be capitalized on to fortify bonds with clients and expand their expressive know-how.”

of contagious laughter, I playfully lifted him and lowered him down on the couch, pretending my cushion was a hamburger bun and his body the hamburger saying, "Well, I believe I'm about to make the biggest hamburger ever. Heck, I might even enter it into the Guinness Book of Records." I then jovially claimed that my fingers were ketchup containers poking and tickling him while asking him where he wanted the ketchup to go. Frank laughed uproariously, screeching at me to not to put ketchup under his arm because it tickled, but that it was fine to put it on his elbow. I quickly complied.

Things then mellowed out considerably. Frank asked me to get him a juice-box and as we sat on the couch side-by-side, he drank his juice while candidly and elaborately disclosing to me all the

details of a recent soccer match where a friend of his had scored an “awesome goal,” and he had provided the assist. I stated, “See, you can be important and strong, without having to be the center of attention.”

Risk Management

It goes without saying that risk management issues urgently need addressing before engaging in R&TP interventions with children. In my experience, most parents have an innate, global, awareness of the positive aspects of R&TP for bonding with children, as well as helping them experiment with and master aggression. Once provided with some education as to its specific social and emotional benefits, parents I deal with are often quick to gain trust in its applicability. For example, I may make explicit mention to parents of the greater range and intensity of feelings that animated R&TP interactions can evoke, affording their child with opportunities to acquire expressive mastery while in a heightened state of emotion. Parents often realize that minor scuffs and scratches might occur during R&TP, but that this is a small price to pay for seeing their children more fully embrace and engage in therapy. Safety proofing the office is a must. Having an open play space, with a thick carpet, void of hard or sharp edged furniture reduces the potential for physical harm. So too does constant vigilance on the part of the therapist during R&TP to implement conditions of safety rapidly and effectively when necessary, such as bracing a child’s fall, pausing the play to require that a hard toy be replaced with a soft one, or deftly pushing nearby objects out of harm’s way.

Perhaps the most thorny risk management issue is that of physical contact during R&TP and its possible misconstrual as inappropriate, unwanted touch, or even sexual abuse. My way around this is to have parents be present in the room during the early phase of therapy with young children and for me to act on opportunities for R&TP that arise that might be precedent setting in terms of substantiating my intentionality to do no harm during physical contact while playing. Over the years I have noticed that parents are inclined to take their child’s lead on matters relating to inappropriate physical contact such that when they directly witness the glee and zest manifested by their child being playfully strong-armed by me, concerns about malice quickly become a non-issue. Additionally, during adjunctive parent meetings, I have found that productive discussions about the therapeutic benefits of the R&TP interventions they previously directly observed often results in parents believing that I am both informed and resolute in my commitment to helping their child. This perception gives me credibility when that I maintain need to be talk out, talk through, and learn from the occasional mishap and misunderstanding occur during R&TP exchanges with their children.

In no uncertain terms, if therapists are to make therapeutic use of R&TP interactions they need to be highly proactive around creating conditions of safety in the office. They also need to be extremely conscientious about honoring a child’s moment-to-moment touch sensitivities and be poised to handle sensitively and transparently any concerns parents might have regarding

physical contact occurring between the therapist and their child.

To be sure, risks arise when employing R&TP interventions, but in my experience, they are vastly outweighed by the therapeutic gains.

References

- Altman, N., Briggs, R., Frankel, J., Gensler, D., & Pantone, P. (2002). *Relational child psychotherapy*. New York, NY: Other Press.
- Fry, D. P. (2005). Rough-and-tumble social play in humans. In A. D. Pellegrini & P. K. Smith (Eds.), *The nature of play: Great apes and humans*. (pp. 54-88). New York, NY: Guilford.
- Gnaulati, E. (2008). *Emotion-regulating play therapy with ADHD children: Staying with playing*. Lanham, MD: Jason Aronson.
- Logue, M. E., & Harvey, H. (2010). Preschool teachers’ views of active play, *Journal of Research in Childhood Education*, 24, 32-49. doi: 10.1080/02568540903439375
- Norton, C. C., & Norton, B. E. (2011). Experiential play therapy. In C. E. Schaefer (Ed.), *Foundations of play therapy* (2nd ed., pp. 187-203). Hoboken, NJ: John Wiley & Sons.
- Pellegrini, A. D. (1987). Rough-and-tumble play: Developmental and educational significance. *Educational Psychologist*, 22, 23-43. doi: 10.1207/s15326985ep2201_2
- Pellegrini, A. D. (2009). *The role of play in human development*. New York, NY: Oxford University Press.
- Pellis, S. M., & Pellis, V. C. (1996). On knowing it’s only play: The role of play signals in play-fighting. *Aggressive Behavior*, 1, 249-268. doi: 10.1016/1359-1789(95)00016-X
- Reed, T. L., & Brown, M. H. (2000). The expression of care in the tough-and-tumble play of boys. *Journal of Research in Childhood Education*, 15, 104-116. doi: 10.1080/02568540009594779
- Scott, E., & Panksepp, J. (2003). Rough-and-tumble play in human children. *Aggressive Behavior*, 29, 539-551. doi: 10.1002/ab.10062.
- Smith, P. K. (2010). *Children and play*. West Sussex, UK: Wiley-Blackwell.
- Smith, P. K., Smees, R., & Pellegrini, A. D. (2004). Play fighting and real fighting: Using video playback methodology with young children. *Aggressive Behavior*, 30, 164-173. doi: 10.1002/ab.20013.
- Trezza, V., Baarendse, P. J., & Vanderschuren, L. J. (2010). The pleasures of play: Pharmacological insights into social reward mechanisms. *Trends in Pharmacological Sciences*, 31, 463-469. doi: 10.1016/j.tips.2010.06.008.

About the Author

Enrico Gnaulati, Ph.D. has practiced as a licensed child psychologist for more than 15 years in in Pasadena, California. He has published two books and a host of articles in academic journals and popular magazines about the uses of play therapy with ADHD children and the medicalization of normal childhood developmental struggles leading to the over-diagnosis of as ADHD, Bi-polar Disorder, and Autism. enrico@gnaulati.net