

ORIGINAL ARTICLE

The Malaysian Occupational Therapist Perspective on the Use of Play in Children With Disabilities

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ABSTRACT

Introduction: Play is an important milestone that contributes to children's development in various ways, and play deficits seem to be acutely apparent in some children with disabilities. Commonly, play is used by an occupational therapist as a modality, reward, or outcome. Play may improve behaviour skills and metacognitions among children with learning disabilities. Currently, there is still insufficient and inconclusive information on current play practice patterns and purpose of using play among occupational therapist in Malaysia. Hence there is a need for this study to be conducted. This paper aims to investigate the use of play from the perspectives of Malaysian occupational therapists who are working with children with disabilities. **Methods:** An online survey was conducted using a convenience sampling strategy. There was 225 occupational therapist participated in this study. The inclusion criteria were occupational therapists now practicing for at least two months in the pediatric setting. The questionnaire from a prior study was employed. **Results:** Most participants characterized their primary use of play as a modality (92.00%, n=207). The majority of the participants stated they assessed play (67.10%, n=151) and perceived as moderate to very competent in the use of play therapy (92.90%, n=209). There is a significant difference between the levels of competency with years of practice with children ($p \leq 0.05$). **Conclusion:** Play as an occupation warrants further attention to develop occupation-centered practice, particularly in the Malaysian occupational therapy setting. *Malaysian Journal of Medicine and Health Sciences* (2022) 18(8):322-332. doi:10.47836/mjmhs18.8.41

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INTRODUCTION

The definition of play is diverse, and recent scholars address play as variable and ambiguous (1), making it difficult to define (2). Many theories heavily influence a description of the play. American Occupational Therapy Association (3) and Parham and Fazio (4) define play as any spontaneous or scheduled event that provides fun, amusement, entertainment, or enjoyment from an occupational therapy view. Core elements characterize it: intrinsic motivation, where the child is free to engage; controlled by the player; freedom from external rules or direction; with attention on the play process rather than on the product of play.

Four well-known classical theories prior 1920s justify the existence of play and its role (as cited in Parham & Fazio, 4): (1) surplus energy theory, (2) recreation or relaxation theory, (3) pre-exercise theory, and (4) recapitulation theory while contemporary theories developed later, emphasize the psychological relevance of a child's social, cognitive, and emotional development. These theories are grouped into the following categories (as cited in Parham & Fazio, 4): (1) biological, (2) psychodynamic, (3) cognitive development, and (4) sociocultural. Since theories commonly attribute play to the developmental nature, play is considered essential to bodily health development because it supports children's emotional, cognitive, physical, and social well-being. Recent studies show that play has a strong predictor toward a child's optimum growth (5), providing significant benefits on motor development (6), social and emotional development (7), language skills and creativity (8), language and cognitive development (9).

Drawing on the previous research, there were 14 types of play which are construction play, rough-and-tumble play, large-motor play, dramatic play, exploration play, role play, language/ communication play, socio-dramatic play, social play, small-motor play, symbolic play, mastery play, recapitulative play, and digital/ technology play, and children may participate in more than one at a time (10). A recent study shows that children in Turkey prefer modern plays (11). Another research discovered that girls favored pretend play over boys, who preferred constructive play (12).

Play is an important milestone that contributes to children's development in various ways, and play deficits seem to be acutely apparent in some children with disabilities. According to Knox (13), children with physical disabilities' generally show impaired play characteristics, including fear of moving, decreased vigorous play, and a preference. The child could also have issues with toys and show minimal exploration. Social play opportunities are often restricted due to hospitalization or schedules that do not permit personal interaction. Pfeifer (14) discovers that cerebral palsy children with more significant motor limitations had diminished play ability. Play pattern in children with cognitive deficits typically manifests a play preference for play materials, limited or restricting play repertoires, decreased motivation, distracting or inappropriate use of objects, diminished imagination, and reduced social contact (13). The previous study also found the autistic child had restricted interest in play tools and required specific information about the tool to comprehend their context (15).

Occupational therapy for children is regarded as one of the most important fields of practice globally (16). Lynch and Moore (17) suggested that occupational therapy prioritizes play among children with disabilities. American Occupational Therapy Association (3) stated play is one of the occupational therapy core roles and has a fascinating viewpoint on a play as an occupation (18). Nestor and Moser (19) stated that play had been the most common child occupation that inspires them to participate in meaningful and personal experiences. Therefore, occupational therapists can bridge the challenges to permit a child to participate in the play.

Play-based occupational therapy intervention uses play to accomplish treatment goals and develop skills and abilities to perform daily life activities (4). Play intervention proved the positive result in improving play behavior of children with Down syndrome (20), effective on metacognitive and behavioral skills of executive function in students with specific learning disabilities (21), improve social skills of ADHD children's (22), promoting more role-pretending behaviors and a sense of environmental control towards children with cerebral palsy (23), and effective for autism children problems (24). However, despite the promotion of occupational

therapy role in the field and the suggestion that play is one of the most critical of childhood occupations (4,13,17), there is evidence that practitioners appear to have little emphasis on this where clinicians do not consider play as the primary goal for children's functional outcome (18,25–28).

Kuhaneck et al. (18) describe the trends of play used by an occupational therapist as 1) modality (the use of play as a means to achieve a result not directly related to playing, such as the use of play activity to work on attaining a goal of increased fine motor coordination), 2) reward (using play during or at the end of an intervention to incentive the child for performing a requested task), and 3) outcome (play as the goal of intervention).

Several studies conducted in Western countries discover consistent results where occupational therapists' primary use of play during the session is as a modality to accomplish other goals linked to the sensory, motor, and cognitive elements of task (18,26,28). In Canada, neither occupational nor physical therapist focuses on play among cerebral palsy children under five years old (29). In the United Kingdom, play interventions were not identified as unique among pediatric occupational therapists (30). In Sweden, the play was not the primary goal for an occupational therapist (27). These studies show practitioners continue to report limited focus on play as an occupation. Lynch et al. (28) highlighted that play as an occupation deserves further attention to strengthen occupation-centered practice, particularly play-centered practice in the pediatric context. The occupational therapist may experience difficulties focusing on play occupation based on this past research.

Previous literature identified factors that enable practitioners to or prevent them from focusing on play occupation are, 1) perceived lack of education on play (research, theory, and interventions), 2) pressures in the workplace (26,28), 3) limitations of insurance reimbursement and the confines of practicing in a hospital-based setting (31), 4) constrained access to formal assessment tools (28). The recent systematic review indicates the current development of play instruments in the occupational therapy field is immature and constantly evolving (32). Common determinants to encourage play as interventions are 1) culture, 2) play materials, 3) resources (33), 4) improving competence in assessment and intervention (18). Further study is required to ensure that 'play for the sake of play' is not forgotten (17).

To date, no published study on the existing perspective of play in Malaysia's occupational therapists has been conducted, and hence there is a definite gap in knowledge in this area. To address this, the aim of this research is to investigate the use of play from the perspectives of Malaysian occupational therapists who deal with children with disabilities.

MATERIALS AND METHODS

This is a quantitative cross-sectional study using a questionnaire from the previous research by Kuhaneck et al. (18) to investigate the use of play from the perspectives of Malaysian occupational therapists who are working with children with disabilities. A cross-sectional design is best suited to study the prevalence of a phenomenon, situation, problem, attitude, or issue by examining the population's cross-section (34).

Participants were sampled using non-probability convenience sampling among occupational therapists. The inclusion criteria include an occupational therapist who is now practicing in paediatrics setting for at least two months or currently is practicing in other areas but has been working in the paediatric setting for at least two months, as suggested in the previous study (18). There is no updated census regarding the total number of occupational therapists in Malaysia. The Malaysian Occupational Therapy Association (MOTA) identified 1914 as an approximate number of registered memberships until December 2020. It is estimated that only 50% (957) of them worked with children (Nurul Jannah Binti Rahim, Secretary of MOTA, personal communication, January 27, 2021). However, many Malaysian occupational therapists are still not registered as a member of MOTA. Besides, the issue reported by Kadar, McDonald and Lentin (35) was service areas or specialties (such as whether they work in the pediatric field or any other specialization area) not known. The total number of Malaysian occupational therapists stated in the secondary data is 1400 (36,37) and 1800 (38). Snowball sampling methods were also used, inviting participants to ask peers to participate in the study.

Research data were collected using the adopted and adapted version of the questionnaire developed by Kuhaneck et al. (18) with permission from the primary author. The test-retest reliability of the questionnaire was conducted by the main author within a 2 – to 3 weeks period and yielded a good *r* value ($r=0.86$) (18). The survey then structured as an online survey. The online survey was chosen because it is beneficial for a large and geographically diverse sample (34). Therefore, the survey questionnaire was pilot-tested with 30 occupational therapists to determine the face validity of the questions and to identify the online operational issues. Each occupational therapist evaluated their comprehension, doubt, and the item's clarity and brevity using a 4-points Likert scale: (i) not clear, (ii) need major modifications, (iii) need some modifications, (iv) clear. Items rated with one or two were counted as disagreement, while three or four were counted as agreement. Data were calculated through the Face Validity Index (FVI) and the Average Face Validity Index (Ave-FVI). The results indicate that the items' comprehension achieved an almost perfect agreement with I-FVI ranging from 0.85- to 0.95. Additionally, the items' clarity, brevity, and

doubt achieved an agreement with I-FVI ranging from 0.85- to 0.95. After subsequent amendments are made, Google Doc links are disseminated via social media channels (e.g., WhatsApp, Telegram, etc.). The data was collected from July – to September 2021. The final survey questionnaire then consisted of 22 questions. Ten were the demographic section, while the remaining section was regarding how occupational therapists use play in their practice, the use of play in various settings, assess play, and new questions regarding competency in applying play in clinical practice. The inclusion criteria were stated at the beginning of the Goggle Doc link. Participants who did not fit into the inclusion criteria do not have to answer the questions. In addition, the researcher examines every participant's answer to ensure they fit into the inclusion criteria.

Ethical approval was granted from University Technology Mara (UiTM) Research Ethics Committee (Ref. Number: REC/05/2021 (MR/311)). The study followed the recommendation flowchart by Strengthening the Reporting of Observation studies in Epidemiology (STROBE). Data from Google Doc were then imported into the Statistical Package for the Social Sciences (SPSS) version 25 and analysed according to the research objectives.

RESULT

The demographic information of the participants is presented in Table I. The age of most of the participants (45.30%, $n=102$) ranges from 23 to 28 years old. Fifty-three (23.60%) are males, and 172 (76.40%) are females. Malay-ethnic made up 67.10% ($n=151$) of the participation. Most participants had five to seven years of experience (41.30%, $n=93$). Meanwhile, for the years of working experience with children, 97 participants (43.10%, $n=97$) stated they had 2 to 4 years of experience. The majority of participants are diploma holders (68.00 %, $n=153$), and 152 (67.60%) stated they had pediatric occupational therapy courses. In the previous two years, 164 participants (72.90%) did not attend any play-related course. For the practice as an occupational therapist, mostly the participants are from the government health clinic (34.70%, $n=78$), followed by the government general hospital (32.90%, $n=74$).

Table II shows the descriptive analysis of the results of the study measures, i.e., The Role of Play in Pediatric Occupational Therapy (18). According to the data, most participants characterized their primary use of play in current practice as a modality to elicit motor, sensory, or psychosocial outcomes in their clients (92.00%, $n=207$). In contrast, the same total number of participants, nine (4.00 %), defined their primary use of play as a reward and outcome in current practice.

Participants were asked about the duration of play usage within one typical occupational therapy session. The

Table I: Descriptive analysis of the demographic variable.

Variables/ Question no.	N	%
1. Age (Years)		
• 23–28	102	45.30
• 29–35	99	44.00
• 36 years old and above	24	10.70
Mean (SD) = 29.97 (4.74)		
2. Gender		
• Male	53	23.60
• Female	172	76.40
3. Ethnicity		
• Malay	151	67.10
• Chinese	11	4.90
• Bumiputera Sabah	43	19.10
• Bumiputera Sarawak	20	8.90
4. Years practicing as an Occupational Therapist		
• 0 to 1 year	8	3.60
• 2 to 4 years	49	21.80
• 5 to 7 years	93	41.30
• 8 to 10 years	39	17.30
• Over 10 years	36	16.00
Mean (SD) = 7.44 (4.45)		
5. Years of working with children's		
• 0 to 1 year	38	16.90
• 2 to 4 years	97	43.10
• 5 to 7 years	57	25.30
• 8 to 10 years	22	9.80
• Over 10 years	11	4.90
Mean (SD) = 2.43 (1.03)		
6. Education level		
• Diploma	153	68.00
• Bachelor's	61	27.10
• Master	11	4.90
7. Did you have a pediatric occupational therapy course?		
• Yes	152	67.60
• No	73	32.40
8. Have you gone to any course specifically on play in the last 2 years?		
• Yes	61	27.10
• No	164	72.90
9. Where do you currently practice as an OT?		
• Government General Hospital (E.g. Hospital Kuala Lumpur)	74	32.90
• Government District Hospitals (E.g. Hospital Kuala Pilah)	45	20.00
• Private Hospitals (E.g. Hospital Tawakal)	5	2.20
• Government Health Clinic	78	34.70

CONTINUE

Table I: Descriptive analysis of the demographic variable. (cont.)

Variables/ Question no.	N	%
• At community centre (PDK/CBR)	1	0.40
• National Referral Centre (Private or Public, e.g. IJN, IPR)	2	0.90
• Government Institutions (E.g. HBUK, Permai, RSK)	6	2.70
• Private home care services	2	0.90
• Others	12	5.30
1. Disciplines that are currently being practiced		
• Medical	29	12.90
• Surgical	8	3.60
• Orthopedic	21	9.30
• Pediatric	81	36.00
• Neuro	5	2.20
• Psychiatry	13	5.80
• Others	68	30.20

Table II: Descriptive analysis of the study measure.

Question no.	N	%
11. Which best describes your predominant use of play in your current practice with children ages 3 to 7?		
• I use play as a MODALITY to elicit motor, sensory, or psychosocial outcomes in my client.	207	92.00
• I use play as a REWARD during or at the end of an intervention session.	9	4.00
• I use play as an OUTCOME.	9	4.00
12. In a typical pediatric occupational therapy session, what percentage of time would you spend on play in each of the following ways?		
As a modality :		
• 0% - 40%	58	25.80
• 50% - 100%	167	74.20
Mean (SD) = 1.74 (0.44)		
As a reward :		
• 0% - 40%	126	56.00
• 50% - 100%	99	44.00
Mean (SD) = 1.44 (0.50)		
As an outcome :		
• 0% - 40%	109	48.40
• 50% - 100%	116	51.60
Mean (SD) = 1.51 (0.50)		
13. With what percentage of your total pediatric client caseloads do you use play in the ways listed below?		
As a modality :		
• 0% - 40%	59	26.20
• 50% - 100%	166	73.80
Mean (SD) = 1.73 (0.44)		

CONTINUE

Table II: Descriptive analysis of the study measure. (cont.)

Question no.	N	%
As a reward :		
• 0% - 40%	120	53.30
• 50% - 100%	105	46.70
Mean (SD) = 1.47 (0.50)		
As an outcome :		
• 0% - 40%	113	50.20
• 50% - 100%	112	49.80
Mean (SD) = 1.50 (0.50)		
14. Out of all of your pediatric occupational therapy sessions in a week, what percentage of total occupational therapy sessions per week do you use play?		
As a modality :		
• 0% - 40%	59	26.20
• 50% - 100%	166	73.80
Mean (SD) = 1.74 (0.44)		
As a reward :		
• 0% - 40%	122	54.20
• 50% - 100%	103	45.80
Mean (SD) = 1.46 (0.50)		
As an outcome :		
• 0% - 40%	107	47.60
• 50% - 100%	118	52.40
Mean (SD) = 1.52 (0.50)		
15. What percentage of your total pediatric client caseload has documented goals including play as the primary desired outcome?		
• 0% - 40%	45	20.00
• 50% - 100%	180	80.00
Mean (SD) = 1.80 (0.40)		
16. Rate the importance in your setting of the following factors in developing therapy goals focusing on play as an outcome. (1: Important, 5: Not Important)		
a) My frame of reference		
• 1	80	35.60
• 2	40	17.80
• 3	43	19.10
• 4	39	17.30
• 5	23	10.20
Mean (SD) = 2.49 (1.38)		
b) The role of the OT in my setting		
• 1	88	39.10
• 2	49	21.80
• 3	19	8.40
• 4	37	16.40
• 5	32	14.20
Mean (SD) = 2.45 (1.49)		

CONTINUE

Table II: Descriptive analysis of the study measure.(cont.)

Question no.	N	%
c) Physician prescription		
• 1	53	23.60
• 2	60	26.70
• 3	58	25.80
• 4	38	16.90
• 5	16	7.10
Mean (SD) = 2.57 (1.21)		
d) Reimbursement issues		
• 1	42	18.70
• 2	53	23.60
• 3	77	34.20
• 4	33	14.70
• 5	20	8.90
Mean (SD) = 2.72 (1.18)		
e) Availability of play assessments		
• 1	56	24.90
• 2	74	32.90
• 3	41	18.20
• 4	32	14.20
• 5	22	9.80
Mean (SD) = 2.51 (1.27)		
f) Practice setting philosophy		
• 1	49	21.80
• 2	70	31.10
• 3	57	25.30
• 4	27	12.00
• 5	22	9.80
Mean (SD) = 2.57 (1.23)		
17. Which frame of references do you use?		
a) Neurodevelopmental		
• Yes	142	63.10
• No	83	36.90
b) Sensory Integration		
• Yes	217	96.40
• No	8	3.60
c) Model of Human Occupation		
• Yes	70	31.10
• No	155	68.90
d) Developmental		
• Yes	170	75.60
• No	55	24.40
e) Biomechanical		
• Yes	39	17.30
• No	186	82.70

CONTINUE

Table II: Descriptive analysis of the study measure. (cont.)

Question no.	N	%
f) Rehabilitative		
• Yes	78	34.70
• No	147	65.30
a) Others		
• Yes	4	1.80
• No	221	98.20
18. Which ONE frame of reference do you use MOST often?		
• Neurodevelopmental	16	7.10
• Sensory Integration	131	58.20
• Model of Human Occupation	12	5.30
• Developmental	51	22.70
• Biomechanical	1	0.40
• Rehabilitative	11	4.90
• Other	3	1.30
19. Do you assess play behaviors in your practice with children ages 3 through 7?		
• Yes	151	67.10
• No	74	32.90
20. Which play assessment(s) do you use?		
Preschool Play Scale (Knox: Bledsoe and Shepard)		
• Yes	24	10.70
• No	81	36.00
The Play History Interview (Takata)		
• Yes	13	5.80
• No	92	40.90
Parten Peer Interaction Scale (Parten)		
• Yes	4	1.80
• No	101	44.90
A Play Agenda (Michelman)		
• Yes	2	0.90
• No	103	45.80
Growth Gradient (Michelman)		
• Yes	3	1.30
• No	102	45.30
Guide to Play Observation (Florey)		
• Yes	11	4.90
• No	94	41.80
Specification for a Play Milieu (Takata)		
• Yes	3	1.30
• No	102	45.30
Guide to Status of Imitation (deRenne-Stephen)		
• Yes	2	0.90
• No	103	45.80
Vineland Adaptive Behavior Scales (Sparrow, Balla & Cicchetti)		
• Yes	10	4.40
• No	95	42.20

CONTINUE

Table II: Descriptive analysis of the study measure. (cont.)

Question no.	N	%
Batelle Developmental Inventory (Newborg, Stock, Wnek, Guidbali & Svinicki)		
• Yes	3	1.30
• No	102	45.30
Transdisciplinary Play-Based Assessment (Linder)		
• Yes	3	1.30
• No	102	45.30
Playground Skills Test (Butcher)		
• Yes	5	2.20
• No	100	44.40
The Assessment of Ludic Behavior (Fernand)		
• Yes	3	1.30
• No	102	45.30
The Test of Playfulness (Bundy)		
• Yes	18	8.00
• No	87	38.70
The Pediatric Volitional Questionnaire (Geist & Kielhofner)		
• Yes	2	0.90
• No	103	45.80
Test of Environmental Supportiveness (Bundy)		
• Yes	4	1.80
• No	101	44.90
Penn Interactive Peer Play Scale (PIPPS) (Hamptom)		
• Yes	1	0.40
• No	104	46.20
The Developmental Play Assessment (Lifter)		
• Yes	15	6.70
• No	90	40.00
The Symbolic Play Test (Power & Radcliffe)		
• Yes	6	2.70
• No	99	44.00
Parent Child Interaction Play Assessment Method (Holigrocki, Kaminski & Frieswyk)		
• Yes	5	2.20
• No	100	44.40
The Play Observation Kit (POKIT) (Mogford-Bevan)		
• Yes	7	3.10
• No	98	43.60
Play Observation Scale (Rubin)		
• Yes	30	13.30
• No	75	33.30
Children's Playfulness Scale (Trevlas, Grammatikopoulos, Tsigilis & Zachopoulou)		
• Yes	3	1.30
• No	102	45.30

CONTINUE

Table II: Descriptive analysis of the study measure. (cont.)

Question no.	N	%
Child-initiated Pretend Play Assessment (ChiP-PA) (Stagnitti)		
• Yes	3	1.30
• No	102	45.30
Others		
• Yes	20	8.90
• No	85	37.80
21. Where did you learn how to assess play, or to use specific play assessments?		
Occupational therapy entry-level curriculum or fieldwork		
• Yes	93	41.30
• No	49	21.80
Graduate school coursework or practicums		
• Yes	34	15.10
• No	108	48.00
Continuing education		
• Yes	67	29.80
• No	75	33.30
On the job training		
• Yes	61	27.10
• No	81	36.00
Other		
• Yes	4	1.80
• No	138	61.30
22. How competence you are applying play therapy. (1: Not very competence, 5: Moderately competence, 10: Very competence)		
• 0-4	16	7.1
• 5-10	209	92.9
Mean (SD): 1.93 (0.26)		

results show that 167 (74.20%) participants stated they spent 50% to 100% of their time on a play as a modality, and 126 (56.00 %) participants stated they spent 0% to 40% of their time on a play as a reward. The play was the primary outcome of interest is 50% to 100% of their time on play session for 116 (51.60%) of participants.

Participants were also asked about the percentage of their total caseload of pediatric clients, emphasizing play intervention. The result revealed that most participants use play as a modality 50% to 100% of their total caseloads (73.80%, n=166). Besides, the participants stated that play was used as a reward (53.30%, n=120) and as an outcome for 0% to 40% of their total caseload (50.20%, n=113).

For the percentage of their total number of occupational therapy sessions in a week that incorporated play, the

majority of the participants stated that 50% to 100% of their total sessions incorporated play as a modality (73.80%, n=166). The participants also revealed 50% to 100% of their total occupational therapy sessions per week using play as an outcome (52.40%, n=122). In comparison, 54.20% (n=118) of the participants stated 0% to 40% of their total number of occupational therapy sessions in a week that incorporated play as a reward.

In terms of the percentage of total pediatric client caseloads with documented goals that include play as the primary desired outcome, the majority of the participants reported 50%-100% (80.00%, n=180). In comparison, 45 (20.00%) participants reported for 0%-40%.

The participants were asked to rate the importance of six different items in developing therapy goals focusing on the play as an outcome. The six items were rated on a 5-point scale from not important to important. The two items most frequently selected as important were the occupational therapists' frame of reference (35.60%, n=80) and the role of occupational therapy in their practice setting (39.10%, n=88).

Participants also reported on their use frames of reference. The top frames of references selected were sensory integration (SI) (96.40%, n=217), followed by developmental (75.60%, n=170), and neurodevelopmental (63.10%, n=142). When asked which frame of reference they used most often, SI was the most frequently used frame of reference, with 131 (58.20%) participants reporting it, followed by developmental (22.70%, n=51) and neurodevelopmental (7.10%, n=16).

The majority of the participants stated they assessed play behaviors in practice with children (67.10%, n=151), and the most play assessment being used are Play Observation Scale (13.30%, n=30) and Preschool Play Scale (10.70%, n=24). The participants also reported learning how to assess play or use specific play assessments mainly through occupational therapy entry-level curriculum or fieldwork (41.30%, n=93) and continuing education (29.80%, n=67).

The participants were asked to rate their competency in using play therapy on a 10-point scale ranging from not very competent to very competent. The majority of participants gave scores ranging from 5 to 10 (92.90%, n=209). A one-way between-groups analysis of variance is also being conducted to the significant differences between the years of practice with children with the level of competency. The result shows a significant difference between the levels of competency with years of practice with children, as shown in Table III.

Table III: The significant difference between the levels of competency with years of practice with children.

Items	Mean	Standard Deviation	F	df	Sig.
Years of practice with children's					
0 to 1 year	6.45	1.81	2.54	4	0.04
2 to 4 years	7.10	1.59			
5 to 7 years	7.09	1.75			
8 to 10 years	7.41	1.79			
Over 10 years	8.09	1.51			

DISCUSSION

As far as our knowledge, this study is the first study to investigate the use of play from the perspectives of Malaysian occupational therapists. The results shows that play were identified primarily as a modality rather than as an outcome. This is similar to the existing findings from Western Countries (18,26–28,31). When play is used as a modality, from the occupation therapy perspective, this is not actually play (28). Hence, facilitating play for the sake of play was a low priority for most Malaysian occupational therapists, even though it is a crucial issue for children. This result might be primarily explained by increased referrals for functional concerns other than play, which influences occupational therapists to focus solely on functional issues rather than play as an occupation. Mani and Velan (39) stating that a lack of awareness of the profession's area of practice, OT role in specific areas of expertise, and practice contexts in which OT services are provided among medical practitioners can lead to missed referrals, which could affect the therapist actions. Because doctors are higher in the health professional hierarchy, occupational therapists in Malaysia rigorously adhere to their referrals, causing their treatment priority to remedy impairments without addressing other concerns (40).

The two most important factors related to developing therapy goals focusing on the play as an outcome were the occupational therapists' frame of reference and the role of occupational therapy in their practice setting. This findings similar with Kuhaneck et al. (18). Occupational therapy is differs from other professions in that it offers fascinating perspectives on the play as an occupation, which is their primary role (3,18). This is because occupational therapists can consider various factors to encourage participation, such as the environment, promoting the crucial objects to encourage play, and the structuring of the playgroup itself to encourage playfulness within the group (41). Furthermore, even though the frame of reference influences occupational therapy to develop goals centering on the play as an outcome, further study into these findings is required to validate this Malaysian occupational therapist

perspective. This is because most frames of reference, such as the SI frame of reference, are impairment-focused rather than occupation-focused (42), such as play.

Participants also provided information on how they utilise frames of reference. SI was chosen as the top frame of reference, and it was also found that this frame of reference was the most commonly implemented. Similarly to previous studies, the majority of occupational therapists in the United States, Ireland, and Switzerland are using the SI frame of reference (18,26,28). This is because the prominence of a biomedical approach in pediatric occupational therapy has emphasized skill remediation rather than participation. These are stressed by Page (49) where the need to look into the lack of focus on occupation-centered strategies. Furthermore, this rationale may be directly related to client groups and reasons for referral, which significantly influence frame of reference preferences. As shown in a study that was conducted in Switzerland (28), where DCD and ADHD were the most prevalent client groups, the SI frame of reference was one of the most commonly applied. However, Kuhaneck et al. (18) stated that the SI frame of reference continued to place a limited emphasis on play as an outcome of therapy.

The majority of the participants stated they assessed the play behaviors with children. In contrast to prior research by Kuhaneck et al. (18), only a few participants reported assessing play in their practice with children aged three to seven. This finding might be driven by the type of intervention widely used in clinical settings. A 2015 article by Kadar, McDonald and Lentin (35) asserted that play therapy is the most commonly utilised intervention for children with Autism in Malaysian occupational therapists practices. However, sensory-based interventions were widely used by occupational therapists worldwide to treat children with ASD (43). As a result, it's not unexpected that most Malaysian occupational therapists evaluated children's play behaviors.

The participants' preferred to use the Play Observation Scale and Preschool Play Scale as the assessments to evaluate play behaviour among the children. However, the Batelle Developmental Inventory and the Vineland Adaptive Behavior Scales are selected as the most assessment frequently used by the occupational therapists in the United States (18). The Preferences for Activities of Children (PAC) was frequently used among occupational therapist in Ireland (26). In comparison, participants in each of the three nations chose the Vineland Adaptive Behavior Scales as their preferred evaluation instrument (Ireland, Sweden, and Switzerland) (28). Because of the finding from previous studies are varied, it is challenging to discern justification from this result. Occupational therapists should exercise good clinical reasoning when selecting a play instrument to

use in practice (32). Therefore, these evaluations may be chosen by Malaysian occupational therapists due to their ease of administration. Besides, both assessments did not require specialized training to utilize it as it is not addressed in its manual (44,45). Many occupational therapists choose an evaluation instrument based on the availability and the ease of administration of the assessment (46).

Participants also stated that they learned how to evaluate play or utilise particular play assessments mainly through occupational therapy entry-level curriculum or fieldwork. Moore and Lynch (26) also indicated that their majority of participants learned to evaluate play during their education or training. One study was previously undertaken in the United States to describe the emphasis on play in the curricula of entry-level occupational therapy programs (47). According to the study, students are only given limited practice with specific play evaluations, and most programs prioritize clinical observation for measuring play abilities. Furthermore, a minority of programs reported teaching any play evaluations to competence (47). Although this is uncertain, the same may be true in these Malaysian contexts. Because there is no information about this finding in Malaysian settings, it is urged that Mitchell et al. (47) study be replicated to offer an updated picture of the situation.

These data also suggest that most Malaysian occupational therapists are perceived as moderate to very competent in the use of play therapy. The result also indicates that there is a significant difference between the levels of competence with years of practice with children. This might be due to the therapist's greater exposure, contributing to more knowledgeable, expertise and confidence in administering the assessment in the area of play among children. According to Unsworth (48), experience provides practitioners with a bank of knowledge and allows them to deal with several clients with related issues. Consequently, they comprehend what kind of assessments and interventions to employ and when to use them (48). Supported by previous research (49), occupational therapists with more years of clinical experience perceive their competency level to be adequate or greater for the central role of an expert in facilitating occupation.

Implications

The current level of research knowledge will benefit occupational therapy professions, including clinical and educational settings and clients. To begin, the findings of this study will increase the credibility of occupational therapists in clinical practice if the play-centred occupation is highlighted in paediatric practice. Second, promoting the requirements of various training and certificate programs concerned with play will aid in the expansion of occupational therapy, particularly paediatric occupational therapy in Malaysia. Third, the

study's findings will assist in strengthening occupational therapy's professional identity by allowing for the development of unique expertise or specialized abilities. Due to this area of expertise, occupational therapists will have greater job opportunities, particularly in private centres where paediatric occupational therapists are in high demand. Furthermore, this study will help occupational therapists broaden their area of practice in the play occupation, allowing them to focus more on evidence-based therapy. It will also affect the requirement for certain authorities to develop clinical practice guidelines specific to play for occupational therapists to use in clinical practice.

In terms of education, this study will determine the need to extend and establish educational resources for play occupations at undergraduate and postgraduate levels and further investigate how play occupations are presented in occupational therapy curricula in Malaysia. Moreover, the findings may warrant more research into play occupation in Malaysian's context to advise evidence-based practice.

This study's findings will also substantially influence the client, such as increasing the effectiveness of their occupational therapy intervention sessions. The intervention will also help them perform better in their daily activities, as we know from the literature that play has significant developmental advantages for children.

Limitations

One limitation of this study was the response rate. There are still fewer occupational therapists who are willing to participate in this study, and hence the findings may not give an accurate overview in the Malaysian context. Another potential source of bias is the sample population. Because there is no information about the service areas or specialisations such as whether they serve in the pediatric field or any other specialist area, the occupational therapist from a discipline other than pediatric may interpret play incorrectly. Thirdly, the occupational therapists were practising in settings with fewer experiences dealing with developmental disabilities, such as national referral centres, government institutions, and private home care services, might inflate the data because it is unclear how this may have influenced their response since difference with their primary work settings.

CONCLUSION

This study successfully investigated the use of play from Malaysian occupational therapists perspectives. In addition, this study replicated a survey done in the United States (18) and Europe (26,28) to understand play occupation in Malaysian occupational therapy perspective. Most Malaysian occupational therapists characterized their primary use of play in their current

practice as a modality, which is consistent with previous findings (18,26,28). This issue appears to be consistent throughout decades of research, which established that play is undervalued as an authentic form of occupation-centered practice. As a result, it is proposed that more future studies be conducted to determine whether there are criteria that permit or prohibit practitioners from focusing on play occupation. Hence, play as an occupation warrants further attention to develop occupation-centered practice, particularly in the Malaysian occupational therapy setting.

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