Use of Uniform Terminology by Occupational Therapists

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Uniform Terminology for Occupational Therapy — Second Edition (American Occupational Therapy Association, 1989b) was published to foster consistency in terminology among occupational therapists. In this study, agreement between occupational therapists and Uniform Terminology about the definition and categorization of 15 terms was examined. Agreement was measured on 113 responses from a randomly selected sample of 180 occupational therapists. Low levels of agreement were found on both definition of terms (71.9 mean percentage of agreement, SD = 12.4) and categorization of terms into larger conceptual categories (34.9 mean percentage of agreement, SD = 11.7). Therapists selected an alternative definition more often than the one given by Uniform Terminology on 2 of 15 terms and selected an alternative categorization more often than the one given in Uniform Terminology on 8 of 15 terms. These results indicate that therapists do not agree with many Uniform Terminology definitions and categorizations.

Occupational therapy is concerned with all occupations of the human being, whether in the area of activities of daily living, work, or play and leisure (Katz, 1985). This broad domain of concern challenges occupational therapists to assimilate a large amount of information in daily practice. One by-product of this knowledge explosion is a large and sometimes inconsistent professional vocabulary. Mosey stated that “everyone has their own definition for a particular term, has no definition at all, or uses the same term to label very different concepts” (1985, p. 507).

Given occupational therapy's broad domain of concern and the resulting lack of a common vocabulary, Mosey (1985) argued for a pluralistic approach to the profession. She stated that the embrace of monism or uniformity would lead to rigidity and the inability to adapt in a changing environment. She believed a pluralistic approach would better accommodate the various and diverse frames of reference within the profession. In contrast, Christiansen argued for more uniformity in the profession's terminology because too much diversity in terminology can impede scientific progress by making it more difficult to compare scientific findings, by providing the ammunition for endless discussions centered around semantics rather than substance, and by diluting the efficiency of our limited pool of scientists. (1990, p. 261)

As the debate about uniformity in occupational therapy terminology continues, it may be helpful to consider how this issue has been handled in similar professions. The field of psychiatry's effort toward a consistent professional terminology resulted in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition—Revised) (DSM-III-R) (American Psychiatric Association, 1987). This manual is a comprehensive listing of diagnostic categories and terms that are operationally defined. The definitions are limited to descriptions of clinical features, and categorizations are made “on the basis of shared clinical features” (American Psychiatric Association, 1987, p. xxiv). There are some differences between the DSM-III-R and occupational therapy’s Uniform Terminology: for example, the DSM-III-R is concerned with diagnosis and consists of discrete categories, whereas Uniform Terminology is concerned with evaluation and describes overlapping continua of levels of function. The DSM-III-R was designed to be compatible with the Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death (ninth revision), published by the World Health Organization in 1977.

A Uniform Terminology for Occupational Therapy has been published twice (AOTA, 1979, 1989b). The first edition (AOTA, 1979) was written in response to the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142), which called for the establishment of uniform reporting systems in all hospital departments. The systems were never adopted by the Department of Health and Human Services, however,
due to “anti-trust concerns related to price fixing” (AOTA, 1989b, p. 809). The second edition (AOTA, 1989b) had a broader purpose—to “facilitate the uniform use of terminology and definitions throughout the profession” (p. 808) and to “create a base of consistent terminology” to be used in publication, education, and practice (p. 808).

In the second edition of Uniform Terminology, two categories of function were delineated, occupational performance areas and occupational performance components. The category of performance areas was not explicitly defined but was divided into three smaller categories, activities of daily living, work, and play and leisure activities. Performance components were defined as “the functional abilities required for functional performance” (AOTA, 1989b, p. 812). Terms and definitions were given in Uniform Terminology—Second Edition for 26 performance areas and 62 performance components.

Despite these efforts, there is much diversity in the terminology used in occupational therapy publications. There are inconsistencies in the selection and definition of terms and inconsistencies in the categorization of terms into larger conceptual categories. For example, in the Bibliographic System of OT SOURCE, an online information system cosponsored by AOTA and the American Occupational Therapy Foundation (AOTF) (AOTA & AOTF, 1990), many of the hundreds of terms used to catalog the database differ sharply in definition from Uniform Terminology terms. Of the 62 terms Uniform Terminology uses to describe performance components, fewer than half were included in the OT SOURCE bibliographic system. Some of the discrepancies between Uniform Terminology and OT SOURCE resulted from the effort to make OT SOURCE compatible with other national sources, such as Index Medicus and the Cumulative Index to Nursing and Allied Health Literature.

Another example of divergent terminology is Christiansen’s listing of 52 “ability categories,” defined as “general traits which are a product of genetic makeup and learning” (1991, pp. 21–23). He further listed six types of “intrinsic enablers of performance” (p. 24) that underlie and support the ability categories and that are roughly analogous to Uniform Terminology performance components. However, the concept of ability categories was not clearly distinguished from the concept of intrinsic enablers of performance or from Uniform Terminology performance components. It seems that the ability categories, the intrinsic enablers of performance, and the Uniform Terminology performance components were all meant to define the functional abilities required to engage in occupational performance. Indeed, most of these ability categories overlap in some way with Uniform Terminology performance components. For example, Uniform Terminology listed a performance component called “strength” (AOTA, 1989b, p. 813), and Christiansen listed the similar ability categories of “static strength,” “explosive strength,” “dynamic strength,” and “trunk strength” (1991, p. 22). In another example, Uniform Terminology listed a component called “range of motion” (AOTA, 1989b, p. 813), whereas Christiansen listed the similar ability categories of “extent flexibility” and “dynamic flexibility” (1991, p. 22).

Just as there are differences in the selection and definition of terms in occupational therapy literature, there is also much diversity in the categorization of terms. The OT SOURCE Thesaurus of Occupational Therapy Subject Headings (AOTA, 1989a) is based on a hierarchical classification scheme that presents completely different categories from those used in Uniform Terminology. This situation resulted largely from an attempt to conform to already established national indexes. Many theorists present categories of performance areas and performance components that differ both from each other and from Uniform Terminology. Christiansen (1991), Hopkins and Tiffany (1988), Katz (1985), Kielhofner and Burke (1980), Llorens (1991), Llorens and Donaldson (1983), Mosey (1986), Nelson (1984, 1988), and Reed and Sanderson (1980) all named and categorized the performance areas and performance components in slightly, although significantly, differing ways. For example, Mosey (1986, pp. 326–327) categorized the performance areas of meal preparation and cleanup, household maintenance, shopping, and money management as activities of daily living, but Uniform Terminology categorized these areas as work (AOTA, 1989b, p. 811).

In another example, Hopkins and Tiffany (1988, pp. 96–97) proposed an activity analysis form listing activity characteristics, which are analogous to Uniform Terminology performance components. However, Hopkins and Tiffany listed “proprioception” and “vestibular” as perceptual components, whereas Uniform Terminology listed these under the heading of “sensory processing” (AOTA, 1989b, p. 811). Another discrepancy is seen in that Uniform Terminology contained a category called “neuromuscular,” which Hopkins and Tiffany omitted altogether. They either placed those terms that Uniform Terminology labels “neuromuscular” in other categories or did not include them at all.

In a final example, Townsend, Ryan, and Law (1990) proposed using the World Health Organization’s International Classification of Impairments, Disabilities, and Handicaps (1980) in occupational therapy. Instead of distinguishing between performance areas and performance components, this classification is based on a hierarchy of three system levels: impairments, which occur at the level of tissues and organs; disabilities, which occur at the level of the person; and handicaps, which occur at the social level (Christiansen, 1991). From all these examples, it is clear that conceptual categorization schemes in occupational therapy literature vary greatly.

In the ongoing process of revising the profession’s terminology, data that describe how occupational therapists actually use terms would be helpful to the profes-
The purpose of this study was to determine to what extent occupational therapists agree with *Uniform Terminology* in their use and categorization of terms. The hypotheses were as follows:

1. There would be a low degree of agreement between occupational therapists and *Uniform Terminology* in the selection of terms used to describe specific deficits.
2. There would be a low degree of agreement between occupational therapists and *Uniform Terminology* in the categorization of terms.

**Method**

**Subjects**

The study sample consisted of 180 registered occupational therapists, selected at random by the AOTA direct mail service. Of 135 responses, 6 were returned blank and 16 respondents were not working as occupational therapists, leaving 113 valid questionnaires for analysis. The demographic characteristics of the sample are described in Table 1; the categories listed were patterned after those used in the 1990 Member Data Survey (AOTA, 1991, June 6).

**Instrumentation**

A questionnaire was designed to sample (a) selection of *Uniform Terminology* terms to describe certain performance components, given the *Uniform Terminology* definition of the performance component, and (b) categorization of terms (both performance areas and performance components) into conceptual categories, given the *Uniform Terminology* term and definition. Several versions of the questionnaire were field-tested on occupational therapy graduate students before the one used in this study was developed.

The questionnaire consisted of two cases, the first of which described deficits in performance components in an elderly woman with a right cerebrovascular accident (see Figure 1). This case sampled the subject’s selection of *Uniform Terminology* terms for these deficits. Fifteen deficits in performance components were described with the definitions given in *Uniform Terminology*. All 62 performance components from *Uniform Terminology* were listed in alphabetical order to the right of the case narrative. The subject was then asked to select the term from the list of performance components that best matched each of the 15 deficits described in the case narrative. The subject was instructed to go on to the next case only when completely done with the first one, and not to return to the first one at a later time.

The second case described both performance area and performance component deficits in a man with a closed head injury (see Figure 2). This case sampled the categorization of these deficits into larger conceptual categories. Fifteen *Uniform Terminology* terms and definitions were given in random order in the case narrative, 5 performance areas and 10 performance components. These terms and definitions were listed with an answer blank before each of them. A key listed the three performance area categories and the eight performance component categories given in *Uniform Terminology*. The three performance categories were activities of daily living, work, and play and leisure. The eight performance component categories were sensory processing, perceptual skills, neuromotor, motor, cognitive integration and cognitive components, psychological, social, and self-management. These eight categories were chosen because they represent the lowest level of categorization given in *Uniform Terminology*. The *Uniform Terminology* descriptions of a performance area and a performance component were given in the instructions. The subject was asked to decide whether each term was more a performance area or a performance component, and also to decide into which category of performance area or performance component the term best fit. The subject indicated his or her choice by writing the number corresponding to the category in the answer blank before each term and definition. Space was provided for comments on either of the cases or for any other comments.

**Procedure and Analysis**

The survey was mailed according to the total design method (Dillman, 1978). This method involved an initial mailing and a follow-up postcard. Second and third mailings (the third via certified mail) were sent to nonrespondents.

Agreement between subjects and *Uniform Terminology* was calculated as a percentage score. An overall mean percentage of agreement score was calculated for each case; a percentage of agreement score was also calculated for each item.

**Results**

**Agreement Between Therapists and Uniform Terminology**

The mean percentage of agreement between subjects and *Uniform Terminology* for the first case (matching *Uniform Terminology* terms to their definitions) was 71.9% (SD = 12.4). The percentage of agreement score for each item is shown in Table 2). The term given by *Uniform Terminology* was the most popular match to its definition unless otherwise noted.

The mean percentage of agreement between subjects and *Uniform Terminology* for the second case (categorizing *Uniform Terminology* terms, given the definition) was 54.9% (SD = 11.7). The percentage of agreement score for each item is shown in Table 3). Only
CASE ONE

There are fifteen sentences below with blanks before them. Each of these sentences describes a deficit found during an occupational therapy assessment. For each of these sentences, decide what term listed on the opposite page best matches the deficit described, and write the number corresponding to that term in the blank in front of the sentence. You may change your answers, but please make your final answers clear.

June is a 78 year old female diagnosed with a right cerebrovascular accident and chronic obstructive pulmonary disease. An occupational therapy assessment yielded the following information about June's deficits.

___ She could not reliably describe or draw the relationship of the body parts to each other.

___ She could not identify the excursion and direction of movement in her left upper extremity.

___ June did not consistently interact using manners, personal space, active listening, and self-expression appropriate to her environment.

___ June was frequently unable to identify familiar faces or objects.

___ Identifying forms and objects from incomplete presentations was difficult for her.

___ She expressed an underdeveloped value of her physical and emotional self.

___ June had difficulty determining the location of objects and settings and the route to the location.

___ She had difficulty recalling events from the immediate past.

___ She was unable to differentiate between foreground and background objects.

___ She could not identify objects through the sense of touch.

___ June had difficulty interpreting stimuli through the eyes, including peripheral vision and acuity, awareness of color, depth, and figure-ground.

___ She also had difficulty mentally manipulating spatial relationships.

___ She also did not demonstrate an appropriate degree of tension or resistance in the muscles of her left upper extremity.

___ June was unable to sustain a purposeful activity over time.

___ She also could not identify and manage stress and related factors.

Figure 1. Case 1 in the questionnaire: matching Uniform Terminology terms and definitions.

Terms
1. Activity Tolerance
2. Attention Span
3. Auditory Sensory Processing
4. Bilateral Integration
5. Body Scheme
6. Categorization
7. Concept Formation
8. Conversation
9. Coping Skills
10. Crossing the Midline
11. Depth Perception
12. Endurance
13. Figure-Ground
14. Fine Motor Coordination/Dexterity
15. Form Constancy
16. Generalization of Learning
17. Gross Motor Coordination
18. Gustatory Sensory Processing
19. Initiation of Activity
20. Integration of Learning
21. Intellectual Operations in Space
22. Interests
23. Kinesthesia
24. Laterality
25. Level of Arousal
26. Long-Term Memory
27. Muscle Tone
28. Olfactory Sensory Processing
29. Oral-Motor Control
30. Orientation
31. Position in Space
32. Postural Control
33. Praxis
34. Problem Solving
35. Proprioceptive Sensory Processing
36. Range of Motion
37. Recent Memory
38. Recognition
39. Reflex
40. Remote Memory
41. Right-Left Discrimination
42. Roles
43. Self-Concept
44. Self-Control
45. Self-Expression
46. Sensory Awareness
47. Sequencing
48. Short-Term Memory
49. Social Conduct
50. Soft Tissue Integrity
51. Stereognosis
52. Strength
53. Synthesis of Learning
54. Tactile Sensory Processing
55. Termination of Activity
56. Time Management
57. Topographical Orientation
58. Values
59. Vestibular Sensory Processing
60. Visual Closure
61. Visual-Motor Integration
62. Visual Sensory Processing

STOP PLEASE MAKE SURE YOU HAVE WRITTEN ONE NUMBER BEFORE EACH SENTENCE. PROCEED TO THE NEXT SECTION ONLY WHEN YOU ARE COMPLETELY DONE WITH THIS SECTION. DO NOT RETURN TO THIS SECTION AT A LATER TIME.
CASE TWO
The following narrative describes several deficits found during an occupational therapy assessment. Please read the narrative carefully and then follow the instructions at the top of the next page.

Brad is a thirty-five-year-old man with a closed head injury who is presently in a rehabilitation center. An occupational therapy assessment yielded the following information about Brad's deficits.

_ Brad has trouble with praxis (conceiving and planning a new motor act in response to an environmental demand).
_ He has difficulty with socialization (interacting in appropriate contextual and cultural ways).
_ He has problems with self-control (modulating and modifying one's own behavior in response to environmental needs, demands, and constraints).
_ He also has difficulty with visual-motor integration (coordinating the interaction of visual information with body movement during activity).
_ Brad has deficits in self-expression (using a variety of styles and skills to express thoughts, feelings, and needs).
_ He has deficits in proprioception (interpreting stimuli originating in muscles, joints, and other internal tissues to give information about the position of one body part in relationship to another).
_ Brad has an impaired ability to cross the midline (moving limbs and eyes across the sagittal plane of the body).
_ He has difficulty with shopping (selecting and purchasing items and performing money transactions).
_ He does not use a satisfying method of sexual expression (recognizing, communicating, and performing desired sexual activities).
_ He has difficulty with roles (identifying functions one assumes or acquires in society).
_ In his left upper extremity, he has limited range of motion (moving body parts through an arc).
_ He is unable to do meal preparation and cleanup (planning nutritious meals and preparing food; opening and closing containers, cabinets, and drawers; using kitchen utensils and appliances; and cleaning up and storing food).
_ He has deficits in concept formation (organizing a variety of information to form thoughts and ideas).
_ He also needs to improve his play or leisure exploration (identifying interests, skills, opportunities, and appropriate play or leisure activities).
_ He has problems with right-left discrimination (differentiating one side of the body from the other).

Each of the fifteen underlined boldfaced terms in the narrative on the opposite page can be seen as either an occupational performance area or an occupational performance component. Performance areas include activities of daily living, work activities, and play/leisure activities. Performance components refer to the functional abilities required for occupational performance. Each term can be further categorized under one of the eleven sub-headings listed in the key below.

For each term, decide first whether you think it is more a performance area or more a performance component. Then decide which sub-heading (found in the key below) best categorizes that term. Write the number corresponding to the subheading that best categorizes the term in the space before the sentence that contains the term. Write only one number before each sentence. You may change your answers, but please make your final answers clear.

KEY TO CATEGORIES:

PERFORMANCE AREA CATEGORIES
1. Activities of Daily Living
2. Work
3. Play/Leisure

PERFORMANCE COMPONENT CATEGORIES
4. Sensory Processing
5. Perceptual Skills
6. Neuromuscular
7. Motor
8. Cognitive Integration and Cognitive Components
9. Psychological
10. Social
11. Self-Management

STOP PLEASE MAKE SURE YOU HAVE WRITTEN ONE NUMBER BEFORE EACH SENTENCE. PROCEED TO THE NEXT SECTION ONLY WHEN YOU ARE COMPLETELY DONE WITH THIS SECTION. DO NOT RETURN TO THIS SECTION AT A LATER TIME.

Figure 2. Case 2 in the questionnaire: categorizing Uniform Terminology terms, given the term and definition.
Table 1
Demographic Characteristics of the Sample (n = 113)

<table>
<thead>
<tr>
<th>Demographic Descriptor</th>
<th>Frequency</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years worked as an occupational therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>1-3</td>
<td>19</td>
<td>16.8</td>
</tr>
<tr>
<td>3-5</td>
<td>18</td>
<td>15.9</td>
</tr>
<tr>
<td>5-7</td>
<td>22</td>
<td>19.5</td>
</tr>
<tr>
<td>7-10</td>
<td>18</td>
<td>15.9</td>
</tr>
<tr>
<td>10-15</td>
<td>15</td>
<td>13.3</td>
</tr>
<tr>
<td>&gt; 15</td>
<td>17</td>
<td>15.0</td>
</tr>
<tr>
<td>Hours per week currently working as an</td>
<td></td>
<td></td>
</tr>
<tr>
<td>occupational therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time (30-40)</td>
<td>95</td>
<td>84.1</td>
</tr>
<tr>
<td>Part time (0-30)</td>
<td>18</td>
<td>15.9</td>
</tr>
<tr>
<td>Primary area of interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration and management</td>
<td>8</td>
<td>7.1</td>
</tr>
<tr>
<td>Developmental disabilities</td>
<td>12</td>
<td>10.6</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Gerontology</td>
<td>9</td>
<td>8.0</td>
</tr>
<tr>
<td>Mental health</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>36</td>
<td>31.9</td>
</tr>
<tr>
<td>Sensory integration</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Multiple areas including physical disabilities</td>
<td>13</td>
<td>11.5</td>
</tr>
<tr>
<td>Other or multiple, but not physical</td>
<td>20</td>
<td>17.7</td>
</tr>
<tr>
<td>Primary employment setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct service</td>
<td>76</td>
<td>67.3</td>
</tr>
<tr>
<td>Administration</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Consultation</td>
<td>9</td>
<td>8.0</td>
</tr>
<tr>
<td>Supervision</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Classroom teaching</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Other or multiple functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient acute care</td>
<td>12</td>
<td>10.6</td>
</tr>
<tr>
<td>Inpatient rehabilitation unit</td>
<td>18</td>
<td>15.9</td>
</tr>
<tr>
<td>Nursing home</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Private practice/consultant</td>
<td>11</td>
<td>9.7</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>School</td>
<td>12</td>
<td>10.6</td>
</tr>
<tr>
<td>Other or multiple settings</td>
<td>51</td>
<td>45.1</td>
</tr>
</tbody>
</table>

*Due to rounding, not all percentages add up to 100.

6 respondents agreed with the Uniform Terminology categorization on more than one half of the items. The categorization given by Uniform Terminology was the most popular match to the term and definition unless otherwise noted.

Respondent Comments
Of the 113 valid responses, 28 included comments. Regarding case 1, 5 respondents specified other terms that they would prefer to those listed, 7 respondents thought that the terms listed were not mutually exclusive, and 6 wanted more information to decide which term went with which deficit. Regarding case 2, 3 respondents specified other categories that they would prefer listed, 11 respondents thought that the categories listed were not mutually exclusive, and 3 wanted more information to decide how to categorize the terms. Three respondents—one in mental health, one in hand therapy, and one in pediatrics—indicated that they thought that the cases fell outside of their practice area and that a practitioner in physical disabilities might be better able to com-

Table 2
Case 1: Percentage of Therapist Agreement with Uniform Terminology in Selecting Terms, Given the Definition

<table>
<thead>
<tr>
<th>Uniform Terminology Term</th>
<th>Agreement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body scheme</td>
<td>98.2</td>
</tr>
<tr>
<td>Kinesthesia</td>
<td>53.1</td>
</tr>
<tr>
<td>Social conduct</td>
<td>83.2</td>
</tr>
<tr>
<td>Recognition</td>
<td>61.9</td>
</tr>
<tr>
<td>Visual closure</td>
<td>66.4</td>
</tr>
<tr>
<td>Self-concept</td>
<td>94.7</td>
</tr>
<tr>
<td>Topographical orientation</td>
<td>74.3</td>
</tr>
<tr>
<td>Recent memory</td>
<td>41.6*</td>
</tr>
<tr>
<td>Figure-ground</td>
<td>86.7</td>
</tr>
<tr>
<td>Stereognosis</td>
<td>75.2</td>
</tr>
<tr>
<td>Visual sensory processing</td>
<td>96.5</td>
</tr>
<tr>
<td>Intelectual operations in space</td>
<td>42.5</td>
</tr>
<tr>
<td>Muscle tone</td>
<td>85.0</td>
</tr>
<tr>
<td>Activity tolerance</td>
<td>53.6*</td>
</tr>
<tr>
<td>Coping skills</td>
<td>85.0</td>
</tr>
</tbody>
</table>

*More popular match to the definition of Recent memory was Short-term memory (53.1%).

Table 3
Case 2: Percentage of Therapist Agreement With Uniform Terminology in Categorizing Terms, Given the Term and Definition

<table>
<thead>
<tr>
<th>Uniform Terminology Term (Category)</th>
<th>Agreement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praxis (Motor)</td>
<td>28.3</td>
</tr>
<tr>
<td>Socialization (Activities of daily living)</td>
<td>0.0*</td>
</tr>
<tr>
<td>Self-control (Self-management)</td>
<td>58.4</td>
</tr>
<tr>
<td>Visual-motor integration (Motor)</td>
<td>8.0*</td>
</tr>
<tr>
<td>Self-expression (Social)</td>
<td>38.9</td>
</tr>
<tr>
<td>Proprioception (Sensory processing)</td>
<td>63.7</td>
</tr>
<tr>
<td>Crossing the midline (Motor)</td>
<td>13.3*</td>
</tr>
<tr>
<td>Shopping (Work)</td>
<td>6.2*</td>
</tr>
<tr>
<td>Sexual expression (Activities of daily living)</td>
<td>2.7*</td>
</tr>
<tr>
<td>Roles (Psychological)</td>
<td>7.1*</td>
</tr>
<tr>
<td>Range of motion (Neuromuscular)</td>
<td>38.8</td>
</tr>
<tr>
<td>Meal preparation and cleanup (Work)</td>
<td>5.4*</td>
</tr>
<tr>
<td>Concept formation (Cognitive integration and cognitive components)</td>
<td>93.8</td>
</tr>
<tr>
<td>Play or leisure exploration (Play/Leisure)</td>
<td>87.6</td>
</tr>
<tr>
<td>Right-left discrimination (Perceptual skills)</td>
<td>71.7</td>
</tr>
</tbody>
</table>

*More popular categorization for Socialization were Social (83.2%), Play/Leisure (12.4%), Cognitive integration and cognitive components (7.1%), and Psychological (15.0%).

Table 3
Case 2: Percentage of Therapist Agreement With Uniform Terminology in Categorizing Terms, Given the Term and Definition

More popular categorizations for Visual-motor integration were Perceptual skills (47.8%), Sensory processing (31.0%), and Neuromuscular (11.5%).

More popular categorizations for Crossing the midline were Perceptual skills (53.0%), Neuromuscular (23.0%), and Sensory processing (17.7%).

More popular categorizations for Shopping were Activities of daily living (53.2%), and Cognitive integration and cognitive components (5.4%).

More popular categorizations for Sexual expression were Psychological (35.4%), Social (30.1%), Self-management (15.9%), and Play/Leisure (15.0%).

More popular categorizations for Roles were Social (69.0%), Work (8.8%), and Cognitive integration and cognitive components (8.0%).

More popular categorization for Range of motion was Motor (69.2%).

More popular categorization for Meal preparation and cleanup was Activities of daily living (90.3%).
plete the questionnaire. Because of these concerns, comparisons were done to determine whether those who indicated physical disabilities as their primary area of interest scored differently from those who indicated other interests. Note that those who indicated both the area of physical disabilities and another area as their primary interest were not included in these comparisons. In the first case, which involved matching terms to definitions, the percentage of agreement with Uniform Terminology of the 36 subjects that indicated physical disabilities as their primary area of interest (M = 74.8%, SD = 12.3) was not significantly different from that of the 62 therapists who indicated other primary areas of interest (M = 70.2%, SD = 12.7; two-tailed t(98) = 1.76, p = .082). In the second case, the percentage of agreement distribution was positively skewed and leptokurtic; therefore, a Mann Whitney U test was used to compare the two groups. This test indicated that the percentage of agreement with Uniform Terminology of the therapists whose interest was in physical disabilities (M = 33.7%, SD = 14.9) was not significantly different from the percentage of agreement of those in other areas (M = 36.0%, SD = 10.4; two-tailed U = 956.5, p = .152).

Discussion

The results support both hypotheses. The first hypothesis predicted a low percentage of agreement between therapists and Uniform Terminology in case 1. In case 1, the only choices offered for matching with the Uniform Terminology definitions were the 62 Uniform Terminology performance components, which are assumed to be mutually exclusive. No other terms were offered as competing choices. These terms represent the profession’s most basic concepts. This presents a strong argument for judging the mean 71.9 percentage of agreement as very low.

This low overall percentage of agreement in case 1 could be due to inadequate definitions as given in Uniform Terminology, overlap in the performance components themselves, or inadequate therapist awareness of the Uniform Terminology terms. Table 2 indicates that there was much variation in the percentage of agreement with individual Uniform Terminology terms; it ranged from 98.2% to 33.6%. On two items, the term most frequently matched to the definition given in the case was not the Uniform Terminology term that was being defined. On these two items, there was more agreement among therapists than there was between therapists and Uniform Terminology. The variation between items in percentage of agreement with Uniform Terminology signifies a low degree of internal consistency among the items in the case; therefore, the overall mean percentage of agreement score reported above is not necessarily a valid representation of therapists’ agreement with Uniform Terminology terms and definitions in general. The reader is cautioned against using this overall score as a generalizable measure.

The second hypothesis predicted a low percentage of agreement between therapists and Uniform Terminology in case 2. In case 2, the only choices offered for categorizing the 15 Uniform Terminology terms and definitions were the 11 Uniform Terminology categories. No other categories were offered as competing choices. Therefore, the mean 34.9 percentage of agreement that was found is judged to be extremely low.

This low overall percentage of agreement in case 2 could be due to inadequate definitions for the terms as given in Uniform Terminology, the absence of definitions for the categories given in Uniform Terminology, overlap in the categories themselves, or inadequate therapist awareness of the Uniform Terminology terms and categories. Table 3 indicates that there was much variation in the percentage of agreement with individual Uniform Terminology categories; it ranged from 93.8% to 0.0%. On eight items, there were categorizations that the respondents selected more frequently than the categorization given by Uniform Terminology. Thus, there was more agreement among therapists on these eight items than there was between therapists and Uniform Terminology. The variation between items in percentage of agreement with Uniform Terminology signifies a low degree of internal consistency among the items in the case, just as there was in case 1; therefore, the overall mean percentage of agreement score reported is not necessarily a valid representation of therapists’ agreement with Uniform Terminology categorizations in general. The reader is cautioned against using this overall score as a generalizable measure.

There are several implications for occupational therapy research and practice. Several occupational therapy terms are not being used in a manner congruent with Uniform Terminology. This may be the result of inadequacies in Uniform Terminology, a lack of awareness of Uniform Terminology among therapists, the rejection of Uniform Terminology by therapists, or the existence of multiple terminologies. Research could be done to determine the causes of the low agreement between therapists and Uniform Terminology found in this study. More research remains to be done to explore the actual use of terms by therapists, as this study only sampled a small portion of Uniform Terminology.

We believe that the profession of occupational therapy should continue to strive for a commonly understood terminology, while recognizing the need for exclusive terminologies when concepts are unique to a particular frame of reference. This common terminology would naturally be revised over time, as usage and logic dictated. A commonly understood terminology would facilitate communication and discussion among occupational therapists and between occupational therapists and other professionals. This common terminology should be used...
for those core concepts that are shared between two or more frames of reference in occupational therapy. Consideration should also be given to terminologies already established in other professions, such as psychology and physiology. Those terms that are unique to one frame of reference would naturally be selected and defined by the author(s) of that frame of reference. Without this common terminology for core items, there is less chance of efficient and meaningful discussion in occupational therapy.

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References


Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142). (1977), 42 u.s.c. 1305.


