Agreement between Occupational Therapy Practice Framework classifications and occupational therapists' classifications

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Abstract

The American Occupational Therapy Association (AOTA) (2002) developed the *Occupational Therapy Practice Framework: Domain and Process (OTPF)* to categorize and organize concepts in the field of occupational therapy in a manner that would be understandable to practitioners within the field as well as to external readers. The current study investigates the degree to which occupational therapists' classification of terminology agrees with *OTPF*'s classification of terminology. Through mail survey format, two hundred randomly selected AOTA therapist members were asked to classify 30 randomly selected terms from *OTPF* into the six domain categories of *OTPF*: area of occupation, performance skills, performance patterns, context, activity demands, and client factors. Based upon the responses of 94 returned surveys, low levels of agreement were found between therapists' and *OTPF*'s categorizations. The median *kappa* indicating levels of agreement was .17, considered slight agreement. *Kappa* ranged from -.13 to .96, reflecting a positively skewed distribution. Therapists reported unfamiliarity with *OTPF*, as 39.4% of participants had not heard of *OTPF*, 76.6% had not read *OTPF*, and 92.6% did not use *OTPF* in their work settings. Overall, practicing therapists did not categorize terms in a manner consistent with the categorization of *OTPF*. We recommend that AOTA refrain from developing systems of categorization until a consensus develops in the field.

Agreement between *Occupational Therapy Practice Framework* Classifications and Occupational Therapists' Classifications

Terminology is important in every profession. As bodies of knowledge grow and expand, a profession requires the development of a system to categorize and organize information to provide understandable and usable concepts. For example, classifications in biology have developed so that organisms and the characteristics of organisms can be identified, compared, and contrasted in useful and meaningful ways (Christiansen, 1994).

The field of occupational therapy has undergone growth and development over the past 80 to 90 years. The methods, scientific research, and underlying knowledge base have greatly expanded. Over the years, individual scholars or groups of scholars have attempted to organize and classify the profession of occupational therapy. Kielhofner's descriptions of the foundations of the profession (2004) and Mosey's description of the profession's configuration (1981) are attempts to conceptualize occupational therapy and articulate its core constructs in a clear and consistent manner. The American Occupational Therapy Association (AOTA) also attempted to organize the concepts within the profession of occupational therapy by developing *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (1979). This document was originally developed to create a uniform system for reporting occupational therapy services for reimbursement. *Uniform Terminology* underwent two revisions (AOTA, 1989, 1994), with an expansion of objectives. *Uniform Terminology-III* (1994) aimed to depict a common and consistent terminology for clinical practice, policy making, and education.

Faced with a mandate to review *Uniform Terminology-III*, the AOTA Council on Practice found major flaws including the omission of the concept of occupation, the exclusion of

pertinent or significant occupational therapy terms, and the use of terms which were ambiguous, inaccurate, or improperly categorized (AOTA, 2002, p. 637). Evidence suggesting flaws of *Uniform Terminology* came from a study done by Borst and Nelson (1993). This study surveyed registered occupational therapists and asked them to both define and classify terms from *Uniform Terminology*. In the first part of the questionnaire, participants were given definitions of terms and then asked to match them with the correct terms, which were provided in a list format. The second portion of the questionnaire asked participants to classify terms into the appropriate *Uniform Terminology* categories, given the terms and their definitions. Results from this study showed that there was an imperfect degree of agreement between therapists and *Uniform Terminology* on definitions of terms (71.9% mean agreement, $SD = 12.4$) and a low level of agreement on classification of terms (34.9% mean agreement, $SD = 11.7$). Given the assertion that these terms and classifications are supposed to represent the "uniform" and core concepts of occupational therapy, these results suggest that *Uniform Terminology* not entirely effective in meeting its goals (Borst & Nelson, 1993).

In recent years, there has been a steady transformation in the practice patterns of occupational therapy, including expanded service venues and an increasing importance placed on the therapeutic value of occupation in human life (Youngstrom, 2002). According to Youngstrom, the *Uniform Terminology* documents did not speak to this expanding arena of occupational therapy, and as a result a new framework was devised to "reaffirm and clarify what occupational therapy is all about" (Youngstrom, 2002, p. 607). The *Occupational Therapy Practice Framework: Domain and Process (OTPF)* was the product of this endeavor, developed to "describe the domain that centers and grounds the profession's focus and actions" (AOTA, 2002, p. 609).

The newly formed *OTPF* was designed to categorize and organize the field of occupational therapy in a logically consistent manner that would be understandable and accessible to persons within the field as well as to external or outside readers (AOTA, 2002). *OTPF* is divided into two components: the *Domain*, which explains the profession's purpose, focus, and areas in which it assists people, and the *Process*, which explains the methods by which occupational therapy treatment takes place. There are six main categories in the domain portion of the document: areas of occupation, performance skills, performance patterns, context, activity demands, and client factors. These main categories are then divided into subcategories, sub-subcategories, and sub-sub-subcategories and so forth, with terms explained by either definitions or examples. For example, the category *Areas of Occupation* is divided into seven sub-categories: activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation. Within each sub-category there are lower level terms. For example, *Social Participation* has sub-categories of *Community*, *Family*, and *Peer/friend*, with definitions given. The hierarchy of the process portion of *OTPF* is similarly organized into categories of *Evaluation*, *Intervention*, and *Outcomes*, with subcategories, definitions, and explanations given.

There are some basic principles that underlie the formation of a system of classification. One principle is that all entries in a given category must share a similar characteristic or characteristics. For example, polar bear, cheetah, and whale are all in the taxonomic classification of "mammal"; common characteristics include warm-bloodedness and milk nourishment for newborns. Second, all entries in the same category must be unique, without overlap with other entries in the category or with entries in other categories. Therefore, "whale" cannot be classified both in the mammals and the fish categories. If there are situations in which

an entry fits into two categories and overlap occurs, these exceptions must be clearly explained. Third, all possible entries for each category must be included—there should not be incompleteness in the categories. For example, all animals in the "mammals" category should be listed within that category (Nelson, in press).

According to Nelson (in press), *OTPF* has many discrepancies that do not follow the general principles required in a system of classification. For example, the category *Context* overlaps with entries from other categories. The entry *tools* is listed under both the category *Context* and the category *Activity Demands*. Similarly, in the category *Areas of Occupation*, sub-category *Social Participation*, the term *community* lists examples of "neighborhood, organizations, work, and school" (AOTA, 2002, p. 621). However, *Work* and *Education* are two separate sub-categories within *Areas of Occupation*. This leads to the question: When do you classify a work or school occupation under *Work* or *Education* and when do you classify the occupation under *Social Participation* in the *Community*? These two examples show how there is overlap among terms in separate categories. Other flaws in *OTPF*, according to Nelson, include the incompleteness of the *Domain* in addressing the subjective meanings of individuals. The only items that address the subjective sense of individuals are the *Spiritual* and *Cultural* sub-categories of *Context*, and these are incomplete and little-described. According to Nelson, *OTPF* has not met the criteria necessary for a systematic and complete classification of the profession of occupational therapy, and he predicts a lack of reliability among occupational therapists attempting to classify and use terms in *OTPF* (Nelson, in press).

A vital feature of professional terminology is the degree of agreement that constituents of the profession maintain about the nature of the concepts. Indeed, the chief task in developing a classification system of a profession's terminology is to select appropriate terms with precise and

usable definitions upon which the majority of professionals agree (Bloom, 1956). A high degree of agreement is necessary for common understanding as well as the ability to pass on the information to future learners (Reynolds, 1971). *OTPF* was developed as a model of how occupational therapy occurs out in the field. In order for *OTPF* to be a valid reference and guide for the field of occupational therapy, it must be representative of practice occurring in the field and must be agreed upon and recognized by clinicians in the field. If it is not, then the utility of this document in describing occupational therapy practice must be questioned.

The current study investigates how practicing occupational therapists conceptualize occupational therapy. Given the broad classification headings and the sub-terms of *OTPF*, do therapists in the field categorize the sub-terms in the same manner that *OTPF* does? What is the level of agreement between *OTPF* and therapists in terms of categorization of *OTPF* terminology?

This study is somewhat similar to Borst and Nelson's (1993) evaluation of *Uniform Terminology*. However, the current study exclusively focuses on the categorization of terms in a one-step method rather than using a two-step process that considers definitions and categorizations separately. In this study, participants are given one task of classifying terms into the proper categories, instead of two separate tasks (one of matching terms to their individual definitions, and then a second task of classifying terms into their categories). The ability to classify terminology requires knowledge of (a) definitions and (b) relationships to other terms. In other words, defining terms is a precursor ability to categorizing terms, and successful categorization depends upon understanding the meaning of the term as well as on understanding where it fits in relationship to other terms. Therefore, studying participants' responses to the categorization task adequately assesses participants' knowledge of the terms as well as their

place within the categorization structure. Also, it is important that terms and concepts in a document defining the basic concepts of occupational therapy be easily recognizable and understandable to occupational therapists. Therefore, terms should not require definitions in order to be usable by occupational therapists. A document describing the core of a profession must be written in language its professionals understand.

Method

Participants

Participants were 200 registered occupational therapists, selected at random from the American Occupational Therapy Association (AOTA) database of registered occupational therapists and retrieved for research use through AOTA's List Rental Service. The participant information was received from AOTA through email transfer and then printed on the survey envelopes. A 60% response rate was predicted based upon Borst and Nelson (1993).

Instrumentation

A two-page questionnaire was designed. Participants were asked to complete the pages in order (Page A first, then Page B) and to refrain from looking at the second page of the questionnaire until they had finished the first page. As a reminder, the second page was stapled to the back of the first on all four sides so that it could not be seen. The first page listed 30 randomly selected terms from *OTPF* along the left side of the page, and the six main categories of *OTPF* along the right side (see Appendix A). Terms in *OTPF* included in the randomization were the lowest level terms with definitions. For example, the category *Client Factors* has a fairly extensive hierarchical categorization. *Client Factors* is subdivided into *Body Function Categories* and *Body Structure Categories*. The next level of categorization (using *Body Function Categories* as the example) divides *Body Function Categories* into *Mental functions,*

Sensory functions, Neuromuscular and Movement-related functions, etc. From there, the category *Mental Functions* is further divided into *Global mental functions* and *Specific mental functions*. Below this level are the lowest level terms in this category, such as *Consciousness functions*, *Orientation functions*, *Sleep*, etc. These lowest level terms have definitions and are therefore included in the randomization list for the study. The *Domain* category with the fewest levels of subcategories is *Performance Patterns*. This category is divided into three subcategories—*Habits*, *Routines*, and *Roles*. *Habits* is further divided into three sub-terms—*Useful habits*, *Impoverished habits*, and *Dominating habits*—which have definitions and are the lowest level terms included in randomization. However, *Routines* and *Roles* have no further subdivisions, and those two terms are the lowest level terms with definitions in their line of development; therefore, they were included in randomization.

Terms were randomized in a stratified way, with five terms per major domain category, so that each category had equal representation. Randomization was done using a random numbers table, randomized both for terms selected from *OTPF* as well as the order in which terms appeared on the questionnaire. Participants were asked to choose the proper category for each term and mark the blank beside each term with the corresponding category.

In order to increase the response rate, the task was developed to be as simple as possible and require the least amount of time as possible. Only 30 items were selected for categorization, and there was only a categorization task instead of two separate tasks, one of defining terms and one of categorizing terms. By limiting the number of questions as well as the number of question forms, one can expect a higher response rate from participants (Fowler, 1993).

The second page of the questionnaire inquired about demographics and level of familiarity with *OTPF* (see Appendix B). Before completing the categorization task, participants

were not informed that their categorization responses were going to be compared to *OTPF*. This second page revealed the study's purpose of comparing therapists' responses with *OTPF*. After learning that the study was based upon *OTPF*, participants were asked not to change their answers. Rather, a pure assessment of occupational therapists' conceptualization of occupational therapy was elicited. Also, participants were asked not to record their responses on the categorization task and not to save the record.

Procedure

The survey materials were pilot-tested with 13 occupational therapy graduate students and three occupational therapy program faculty to test for clarity, ease of use, and time. Surveys were mailed to participants in July 2005 according to the total survey design method (Dillman, 1978). The mailing included a cover letter, the two inter-stapled questionnaire sheets, and a stamped return envelope. The cover letter asked for the therapists' assistance, relayed what was being requested of them, told about how long their participation would take, and stated that there were no right or wrong answers—just a request for their informed opinions. The letter also stated that identifying information would be destroyed after completion of the study.

Follow-up reminder postcards were sent to participants whose responses were not received within two weeks. Upon return of survey, blocks of three were formed according to the order in which surveys were received, and one participant from every block was randomly selected for re-administration of the same categorization task in order to test for stability of responses. The retest survey was sent out 14 days after receipt of the initial survey. The same procedure was used, with follow-up reminder postcards sent after two weeks without receiving a response.

After implementation of the procedure, there was a low return rate for survey completion ($N = 72$, 36%). Therefore, with IRB approval, a second mailing was conducted to increase the response rate. The survey forms and a cover letter asking for participation were sent to those therapists on the original participant list who had not yet returned a survey. The mailing also included a mint in each envelope. This mailing took place approximately three months after the original surveys were sent. The retest survey for stability was not administered to this group because additional requests would potentially become burdensome for participants. In summary, all data were collected between July 2005 and December 2005.

Analysis

To determine the level of agreement between each therapist and *OTPF*, a 7 x 7 grid was formed and a *kappa* was computed. If all thirty terms were classified by the therapist in the same way as in the *OTPF* classification, *kappa* was equal to 1. Disagreements occurred when the therapist classified a term in a different category from *OTPF*; the more disagreements, the lower the *kappa*. See a hypothetical example of how *kappa* can analyze a single therapist's 30 responses in Figure 1. In the example, *kappa* would equal .96, indicating nearly perfect agreement. The only disagreement was that the therapist classified one term as a "C" whereas *OTPF* classified it as a "D."

A *kappa* was computed for each participant's grid, and *kappas* indicating central tendency and range across all participants were computed as the best overall description of level of agreement. Percentages of agreement were computed to supplement the *kappas*. Percentages of agreement are easier to understand but do not account for chance agreement, as does *kappa*. Stability was assessed in a parallel way. See Figure 2.

Results

All returned surveys with 28 or more of the 30 responses filled out were included in data analysis. One hundred surveys were returned, 94 of which had at least 28 responses. This resulted in a 47% (94/200) response rate. Six of the 94 usable surveys were not complete with all 30 responses and had one or two items blank. These surveys were not penalized for blank answers; analysis was based solely upon the responses that were given.

Participants' mean number of years of practice was 11.5 (SD = 3.8). Mean number of work hours per week was 28.4 (SD = 15.3). Twenty-two percent of participants classified their area of practice as physical disabilities, 13% as school systems, and 12% each as gerontology or sensory integration. The remainder varied across thirteen practice areas. Participants were also asked questions concerning their level of familiarity with *OTPF* (see Table 1).

See Table 2 for main results of the study. The median agreement between therapists and *OTPF* categorizations was .17. This is slight agreement, according to Landis and Koch (1977). The median was selected as the best measure of central tendency because the data were positively skewed, with means greater than medians and with large ranges in fourth quartiles, indicating a few higher scoring outliers. Of thirty possible responses, the median number of agreements was only 9; hence the median percentage of disagreement was 70%.

Twenty-five retest surveys to investigate stability were sent, and 18 surveys were returned with 28 or more responses (one returned survey had 23 responses and was not used in data analysis), resulting in a return rate of 72%. The median *kappa* agreement between participants' first and second tests was .30, considered fair agreement according to Landis and Koch (1977). Still, only a median of 13.5 of 30 items were classified the same way at a later date by these 18 participants (see Table 3).

Discussion

The level of agreement comparing *OTPF* classifications to classifications by the surveyed practicing therapists is slight, with a median *kappa* across all participants of .17. To be considered a substantial level of agreement, *kappa* would have to be in the range of .60 - .80. No participant agreed with *OTPF* classifications in 30 of 30 items. The median percentage of agreement was only 30%, indicating much more disagreement than agreement.

Some disagreements might have been due to participants having different viewpoints on how terms should be classified, and other disagreements might have been due to unfamiliarity with the terms altogether. One participant commented, "I was trying to help you but I know my responses are not accurate." Another commented, "Most of these were guesses—I have no idea what these terms are in reference to." Multiple participants placed question marks beside terms, including *benefits*, *flows*, *contexts*, *expresses*, and *bends*, indicating that they were unfamiliar or unclear about these *OTPF* terms. The survey participants were experienced therapists, with an average of 11.5 years of experience. Even then, they were unfamiliar with certain terms. It should be noted that the terms included in the survey were selected randomly. No attempt was made to deliberately select *OTPF* terms that might be especially obscure to participants. This is in contrast to the Borst and Nelson (1993) study, which selectively chose the *Uniform Terminology* terms perceived to be most problematic for inclusion on the survey.

As shown in Table 1, 39.4% of participants had not heard of *OTPF*, and 76.6% of participants had not read *OTPF*. Only 7 participants (7.4%) reported use of *OTPF* at work. This reveals an astonishingly high number of therapists who are unfamiliar with a document that is supposed to "describe the domain that centers and grounds the profession's focus and actions"

(AOTA, 2002, p. 609). This survey took place over three years after the official approval of *OTPF.*

It should be noted that those therapists who listed their main area of practice as education ($N = 4$) had especially high levels of agreement with *OTPF*, with a median of 22.5 (out of 30) agreements, or 75%. The educator's median *kappa* score was .70, which was much higher than the overall median *kappa* score of .17. We speculate that educators in academia have more regular exposure to *OTPF* because of their teaching responsibilities. Interestingly, though, their categorizations still varied from *OTPF*'s 25% of the time.

The test for stability involving the random selection of participants for retest indicated that therapists frequently disagreed even with themselves in the classification of these terms. The median *kappa* was .30, and there was 45% median agreement (see Table 3). Why were approximately half of the items classified differently on the second mailing? The reasons might be the same as those explaining the slight agreement between therapists and *OTPF.* Since terms might have been unfamiliar, participants might not have had a strong basis for their selections, and multiple categories might have seemed appropriate for categorization. It is also possible that the format of the survey itself did not make sense to participants. However, participant comments pertained to the terms and concepts of the survey rather than to the layout or format of the survey itself. Also, the survey instrument underwent pilot-testing, and the survey instrument was designed and modified to be understandable and user-friendly. Results concerning instability should be interpreted with caution, given the small sample of 18.

A limitation of the study is a lower than optimal return rate. Although we were hoping for a higher response rate, a 47% response rate is not uncommon (Kerlinger, 1986). All efforts were made to ensure that participants would complete and return surveys, including reminder

postcards and a follow-up mailing (Dillman, 1978). Due to the comments received from participants, we perceived a general sense of uncertainty from many participants concerning the "correctness" of their responses, even though they were told repeatedly that there were no correct or incorrect responses. We reason that if participants did not feel confident in how they categorized the terms, this reduced their motivation to complete the survey, as they may have felt it would reflect poorly upon their abilities as occupational therapists. This general sense was particularly conveyed in one participant's comment on a blank survey, "I'm sorry—I can't complete this questionnaire because I am not familiar with much of the terminology." There is no reason to think that the therapists who did not participate in the study would have agreed with *OTPF* at a higher rate than those who did participate.

Another approach to the research question would be to separate the classification task into two components, definition and categorization, as was done in Borst and Nelson (1993). The current study evaluated therapists' thoughts on definition and categorization in one step. It could be possible, however, that the large degree of variability and low agreement rate with *OTPF* is due to therapists not being clear on the meanings of the terms (definition), which then impaired their ability to categorize the terms as precisely as they would have liked. On the other hand, definitions should not be necessary to understand essential terminology among members of a profession. Terminology that is not readily understandable to therapists should not form the basis of the framework. Also, dividing the classification task into two steps would make the survey instrument longer, and this tends to decrease the response rate (Fowler, 1993). Because the response rate was already problematic in the current study, this may not be beneficial. A possibly better method to use for future research would be to administer the survey face-to-face

to increase the response rate; however, this method is expensive and time-consuming and would require special funding.

Overall, the results from this study show that occupational therapists tended to be unfamiliar with the *OTPF* document and that occupational therapists did not categorize terms from *OTPF* in the same manner that they are categorized in *OTPF*. It is unclear whether differences in categorization were due to practicing therapists having different viewpoints on how terms should be classified or due to unfamiliarity with the terms altogether. The findings of this study should be investigated further to determine the causes for low agreement levels.

Nelson (in press) found that there are many logical errors of definition and classification in *OTPF*, based upon logical reasoning. The current study presents empirical data that are consistent with Nelson's analysis that the terminology and categorization of *OTPF* are not useful for practice, education, and research. We recommend that AOTA refrain from developing systems of categorization until a consensus develops in the field.

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Appendix A
Page A of Survey Instrument

Instructions: Please classify each term below (the list from 1-30 on the left) into the most appropriate category (the list of A, B, C, D, E, F, X on the right) by marking each blank ____ with the corresponding category letter. Please classify the terms as you think would be most appropriate rather than classifying them as others might. Please do not consult with others or with reading material prior to filling out this page. There are no correct or incorrect answers.

EXAMPLE:

Terms to Categorize:	***Categories:***
C 1. My Husband the Alien	A. Action movie
B 2. Catsup and Cucumbers	B. Drama movie
X 3. Mi Vida Morada	C. Comedy movie
B 4. Death of a Cuticle	X. Does not fit A, B, or C
A 5. Fighting Pilots	

Terms to Categorize:

____ 1. Social demands
____ 2. Eating
____ 3. Focuses
____ 4. Expresses
____ 5. Required body functions
____ 6. Meal preparation and cleanup
____ 7. Benefits
____ 8. Personal device care
____ 9. Sequence and timing
____ 10. Bends
____ 11. Memory functions
____ 12. Roles
____ 13. Flows
____ 14. Dominating habits
____ 15. Feeding
____ 16. Personal
____ 17. Temporal
____ 18. Orientations functions
____ 19. Safety procedures and emergency responses
____ 20. Impoverished habits
____ 21. Useful habits
____ 22. Touch functions
____ 23. Social
____ 24. Mobility of joint functions
____ 25. Psychomotor functions
____ 26. Cultural
____ 27. Required body structures
____ 28. Routines
____ 29. Required actions
____ 30. Virtual

Categories:

A. Areas of occupation
B. Performance skills
C. Performance patterns
D. Context or contexts
E. Activity demands
F. Client factors
X. Mark if the term does not fit into A, B, C, D, E, or F

Please make sure to put a letter (A, B, C, D, E, F, X) in all 30 blanks. After filling in all blanks, please undo the staples and complete the next page. Please do not come back to this page and modify any responses after you finish this page.

Please: Fill in a letter for all blanks.

Appendix B
Page B of Survey Instrument

Please provide us with background information.

How many years have you worked as an occupational therapist? Please count half-time work for one year as ½. _____

How many hours per week are you currently working as an occupational therapist? _____

What is your primary area of interest/practice? Please mark only one (1).

____ Developmental disabilities
____ Mental health
____ Gerontology
____ Physical disability
____ Education
____ Sensory integration
____ Administration/management
____ Work programs
____ School systems
____ Home/community health
____ Technology
____ Other (please specify)_____

I will be comparing your responses to categorizations in the Occupational Therapy Practice Framework (OTPF), recently developed by the American Occupational Therapy Association. Remember, there are no right or wrong responses to the exercise you completed on ***PAGE A***. However, I would like to gauge your level of familiarity with OTPF.

Prior to reviewing this form, had you heard of the Occupational Therapy Practice Framework (OTPF)?
____ Yes ____ No

Did you know that Uniform Terminology-III was rescinded and that OTPF is the ensuing document?
____ Yes ____ No

Have you read the OTPF? ..... ____ Yes ____ No

Did you participate in the OTPF development process? ..... ____ Yes ____ No

Do you use the OTPF in your work setting? ..... ____ Yes ____ No

While filling out ***PAGE A***, did you realize that the 30 terms and 6 categories were drawn from OTPF?
____ Yes ____ No

I certify I have not talked with anyone about the survey items and I certify that I have not used reference material (including the OTPF) when filling out ***PAGE A***..... ____Yes ____ No

I certify I have not gone back and changed my responses to ***PAGE A*** at any point after completing it.
____ Yes ____ No

*Upon completion of this page, please mail **PAGE A** and **PAGE B** in the enclosed return envelope.*

Please do not keep a record of your responses.

Thank you so much! Your thoughts are important!

Table 1

Prior Familiarity with OTPF

Question	Yes	No
Heard of *OTPF*?	57 (60.6%)	37 (39.4%)
Knew *OTPF* replaced *Uniform Terminology-III*?	36 (38.3%)	58 (61.7%)
Read *OTPF*?	22 (23.4%)	72 (76.6%)
Part of development process for *OTPF*?	3 (3.2%)	91 (96.8%)
Use *OTPF* at work?	7 (7.4%)	87 (92.6%)
When completing categorization task, realize terms were from *OTPF*?	21 (22.3%)	73 (77.7%)

Note. These questions were asked only after the participants completed the categorization task.

Table 2

Degree of Agreement Between Therapists' Categorizations and OTPF *Categorizations (N=94)*

	M	*SD*	Skewness	*Mdn*	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
Total Agreement[1]	10.3	6.3	1.3	9	1 - 6	6 - 9	9 - 13	13 - 29
Percentage of Agreement[1]	34.3	20.9	1.3	30	3.3 - 20.0	20.0 - 30.0	30.0 - 43.3	43.3 - 96.7
Kappa	.23	.24	1.3	.17	-.13 - .06	.06 - .17	.17 - .32	.32 - .96

[1]For 88 participants, 30 agreements were possible. For five participants, 29 were possible, and for one participant, 28 were possible.

Table 3

Degree of Agreement Between Therapists' First Categorizations and Second Categorizations (N=18)

	M	*SD*	Skewness	*Mdn*	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
Total Agreement	14.8	5.0	0.1	13.5	6 - 10.5	10.5 - 13	14 - 18.5	18.5 - 23
Percentage of Agreement	49.6	17.1	0.1	45	20.0 - 35.0	35.0 - 43.3	46.7 - 62.8	62.8 - 79.3
Kappa	.40	.20	0.2	.30	.10 - .23	.23 - .33	.37 - .54	.54 - .75

Figure Captions

Figure 1. Example of data analysis grid between each therapist and *OTPF*.

Figure 2. Example of data analysis grid between a therapist's first and second ratings.

Figure 1

One therapist's rating

OTPF

	A	B	C	D	E	F	X
A	5						
B		5					
C			5				
D			1	4			
E					5		
F						5	
X	0	0	0	0	0	0	0

Figure 2

One therapist's first rating

Same therapist's second rating

	A	B	C	D	E	F	X
A							
B							
C							
D							
E							
F							
X							