Content Validity & Initial Reliability of the Rating Instrument for Therapy Contract Setting

Revised at UC (RITCS-UC)

MARCELA OSORIO THOMAS

Profesor Guía: Dr. Alex Behn Berliner, Ph.D.

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A mis padres, con mucho cariño.

To my parents, with love.
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1. Abstract

Personality Disorders (PDs) are serious, weakening and complex clinical presentations, with patients having substantially reduced life expectancy and elevated mortality of four times compared to the general population. This occurs especially in young individuals, who have 10-fold increased mortality. Often, PD patients are known as poly-consultant users of the public mental health system, increasing mental health costs and leaving patients without relief. Thus, it is important to study treatments for PDs to provide patients with appropriate care. Among PDs, Borderline Personality Disorder (BPD) has received the most scientific attention because it can be considered as a prototype for PDs in general, expressing a general factor that explains the phenotypic covariance among all them. The unique characteristic of BPD would be that it represents the impairment to maintain coherent images of self and others, a core dimension underlying the ten PDs, which include impairments in self and interpersonal functioning.

Even though evidence-based BPD treatments stem from divergent theoretical backgrounds, all of them share a common characteristic, namely they are all very structured treatments, including explicit therapeutic contracts and therapeutic frames. This is especially important for Transference Focused Psychotherapy (TFP), which hypothesis is that active work around 'treatment contract’ from the beginning of treatment is a key active ingredient driving patient improvement. However, there is no empirical evidence to demonstrate it. The main reason for this gap in the literature is a deficit in instrumentation: there are no psychometric valid instruments to measure the establishment of 'treatment contract’. So, this study aimed at developing a content & psychometric valid instrument to evaluate contracting: the Rating Instrument for Therapy Contract Setting (RITCS) revised at UC (RITCS-UC). Based on the TFP clinical guide and on an early version of the RITCS instrument, the construction of RITCS-UC included content validation through an iterative process of expert consensus among expert panels from the U.S. and Chile. The RITCS-UC includes three content dimensions of contracting: therapist’s adherence to TFP clinical guide, therapist’s competence establishing a 'treatment contract' and also, a measure of the agreement between therapist and patient.

To test reliability, four psychologists were trained to evaluate the establishment of four contracting videotaped sessions using the RITCS-UC. Then, data was analyzed using Generalizability Theory to establish inter-rater reliability estimates. A Generalizability Study (G_Study) and a Decision Study (D_Study) for each dimension were used to disentangle different sources of error and to determine the most efficient measurement design. Results of G_Studies showed relative generalizability coefficients (G_coef) of .64 for dimension adherence, with a relative standard error (SE) of 0.32. For dimension competence G_Studies showed a relative G coef of .87, with a relative SE of .25. And, for dimension agreement G_Studies showed a relative G coef of .81, with a relative SE of .25. The principal source of error in all dimensions was the interaction between dyads and raters (D x R), an expected result which confirms that the source of error didn’t come from the items but from the subjectivity of D and R. Results of D_Studies showed possible optimizations in the number of items, raters, and dyads, and showed the items for future revision.

Finally, and following the Standards for Educational and Psychological Testing, the development of the RITCS-UC has been completed and it is ready to be used in group and research contexts accounting the observations made.

Keywords: Borderline Personality Disorder, treatment contract, Transference Focused Psychotherapy, iterative process, Generalizability Theory.

2. Introduction and Project Formulation

As defined in the categorical and traditional model of the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) Personality Disorders (PDs) are enduring patterns of inner experience and behavior that deviates from the expectations of the individual’s culture. DSM-5 (2013) also establishes that subjects meet criteria for at least one of the 10 PDs when they experience any of those problems with consistency, inflexibility and causing a level of distress in their emotional and interpersonal life.
Among PDs, Borderline Personality Disorder (BPD) has received the most scientific attention and can be considered as a prototype for PDs in general, expressing a general factor that explains the phenotypic covariance among all them (Sharp et al., 2015). The unique characteristic of BPD would be that it represents the impairment to maintain coherent images of self and others. A core dimension underlying the 10 personalities theorized in the DSM-5 (2013), which includes impairments in self and interpersonal functioning.

Following Gunderson, Herpertz, Skodol, Torgersen, and Zanarini (2018) phenotypes involved in BPD are grouped in four symptom families. First, the interpersonal instability phenotype refers to BPD patients that have unstable relationships with others, but also who make big efforts to avoid abandonment. Second, the cognitive and self-disturbance phenotype refers to BPD patients who have an impoverished and unstable self-image, which associates with a chronic feeling of emptiness. Also, this phenotype refers to people that under stress can experience paranoid ideations or dissociative symptoms. Third, the affective and emotional phenotype includes BPD patients that are emotionally labile and who have mood instability. Also, this people can experience dysphoric emotions and are prone to outbursts of anger. The fourth phenotype is the behavioral deregulation one, implying behaviors that put the patient or others at risk by problems of poor impulse control.

It’s not rare that the four phenotypes of BPD mentioned can be related to the four degrees of severity of PDs theorized in the International Classification of Diseases: low, mild, moderate and severe (ICD-11, 2018). As mentioned by Tyrer, Reed & Crawford (2015), degrees of severity described in the ICD-11 can be qualified by different domain traits that show which of the main facets of personality are more prominent in the individual. The idea of Tyrer et al. (2015) is coherent with the alternative model of PDs of DSM-5 (2013), which characterizes PDs as a spectrum of personality functioning. It is also compatible with Kernberg’s formulation (1984) of PDs as a pathology of the mental representation of self and others, situating different structures through a severity continuum.

According to a recent study published in Nature, the prevalence of BPD is approximately 1.7% in the general population and of 15-28% in clinical populations (Gunderson et al., 2018). Despite the relatively small prevalence of BPD, in general, PDs are complex clinical presentations with patients having strong comorbidities between mood disorders and PDs (Friborg et al., 2014). Also, Fok et al. (2012) found in their study that BPD patients have substantially reduced life expectancy and elevated mortality of four times compared to the general population. This occurs especially in younger age groups (15-44 years old) who have 10-fold increased mortality, with life being 18.7 years shorter in females and 17.7 years shorter
in males. Although BPD patients are known for their elevated risk of suicide, a major prospective longitudinal study, the McLean Study of Adult Development (MSAD), founded that suicide is not as common as previously estimated in BPD (Gunderson et al., 2018). The MSAD study determined that the average age of non-suicidal deaths of these patients was 39 years of age, suggesting that they died up to 40 years prematurely compared with the life expectancy of 78 or 79 years of age in U.S.

There are indirect and subjective costs associated with BPD patients, like failures in social adaptation, vocational productivity (Van Asselt, Dirksen, Arntz, & Severens, 2007) or being a burden for people who love them (Bailey & Grenyer, 2013). In a community sample from the U.S., Tomko, Trull, Wood and Sher (2014) founded higher rates of BPD among people with lower family incomes, individuals under 30 years, and those separated or divorced, indicating indirect negative effects of the illness on general psychosocial functioning.

Furthermore, in the general population these patients have a substantial use of health services, and so, are costly for society. For instance, even though lifetime prevalence of BPD is 3% in Germany, the annual costs for inpatient treatment for patients with BPD accounts for approximately 20% of the total costs for psychiatric care (Bohus & Kröger, 2011). Therefore, detection and early intervention must not be viewed as futile. It is important to study treatments for PD in order to provide patients with appropriate care.

One of the first theoretical formulations of BPD was offered by Kernberg (1967) from a psychodynamic perspective. Kernberg legitimated BPD as distinguishable from schizophrenia and depression, but also from neurosis and psychosis. The hypothesis was BPD as pathology of internalized object relationships and identity diffusion. Kernberg (1975) purposed BPD to be diagnosed and treated through the experience of transference and countertransference of low defensive operations in therapy. This contributed to a significant advancement in diagnosis as well as in psychodynamic treatment possibilities. Nowadays, PDs patients can be diagnosed early in life thus sparing much clinical distress or psychosocial impairment (Newton-Howes, Clark & Chanen, 2015).

Since Kernberg’s seminal work (1975), several treatment options have been developed for BPD. There is evidence effectivity for Dialectical Behavior Therapy (DBT) which improves abilities in affect regulation (Panos, Jackson, Hasan, & Panos, 2014) and decreases activation of the amygdala (Goodman et al., 2014); for Schema Therapy (SFT), which treats dysfunctional schemas (Bamelis, Evers, Spinholven, & Arntz, 2014); for Mentalization-Based Treatment (MBT), which intervenes deficits in reflexive function (Rossouw & Fonagy, 2012); and for Transference Focused Psychotherapy (TFP), which fosters identity integration (Clarkin,
Levy, Lenzenweger & Kernberg, 2007). Even though they stem from divergent theoretical backgrounds, all evidence-based BPD treatments share a common characteristic: they are all very structured treatments, including explicit therapeutic contracts and therapeutic frames. It is thus thought that structure is an active ingredient to produce clinical significant change across all treatment modalities (Linehan, 1993; Rossouw & Fonagy, 2012; Bamelis et al., 2014; Clarkin et al., 2007).

However, the assumption that structure is a key ingredient driving therapeutic change in BPD treatments has not been empirically tested due to a lack of appropriate instrumentation to measure the establishment of treatment contracts. We think this assumption must be tested empirically given the centrality it maintains across all treatments. In order to achieve this, we aimed to develop an instrument to measure contracting according to the Standards for Educational and Psychological Testing (2014).

One central aspect of structuring treatment is the early establishment and continuous upholding of a clear and specified ‘treatment contract’. This tenet is of particular importance in TFP, which has comparatively more time allocated at the beginning of treatment to implement an explicit ‘treatment contract’ between the patient and the therapist that provides basic scaffolding for the viability of the treatment. Furthermore, TFP has the TFP clinical guide, which offers an explicit set of rules for the clinical development of a treatment contract (Yeomans, Clarkin & Kernberg, 2015). For these two reasons this treatment was selected to be a model for the construction of the rating for therapy contract-setting.

Prior research has been conducted in this area by Yeomans, Selzer & Clarkin (1993), who proposed an instrument to rate therapist adherence to the model of treatment but didn’t assess the competence of therapist either the agreement with the patient. Then Yeomans, Foelsch, Selzer, and Clarkin initially formulated an instrument to assess adherence and competence of the therapist and agreement with the patient, the Rating Instrument for Therapy Contract Setting or RITCS (n.p.). Nevertheless, Yeomans and collaborators never published or tested the psychometric properties of the RITCS. So, we revised and developed the RITCS according to the Standards for Educational and Psychological Testing (2014) of validity, reliability, and fairness.

Specifically, the content validity of the instrument and development of the items from the initial RITCS version was made through an iterative process of revision between the UC panel of experts in Santiago (Chile) and the Personality Disorders Institute (PDI) panel of experts at Cornell University (U.S.). The result was reached after three iterations, coming closer
consensus as the repetition of revision incremented (Angelo, Ryu, Pedowitz & Gallagher, 2015).

To establish psychometric stability of the instrument, four raters were trained to evaluate the establishment of four videotaped contracting sessions using the RITCS-UC. Then, data were analyzed using Generalizability Theory (GT) (Brennan, 1992) to establish inter-rater reliability estimates of dimensions adherence, competence and agreement. A generalizability study (G_Study) was used to disentangle different sources of error and a decision study (D_Study) was used to determine the most efficient measurement design for each dimension and to determine which items have to be review to minimize measurement error (Cronbach, Rajaratnam & Gleser, 1963).

To address fairness in testing, we provide trainings to the researchers and raters to learn about the theoretical bases of the instrument where researchers and raters could answer about unclear issues. Also, we addressed fairness by constructing the instrument in English, which is the universal language of science, ensuring the raters had a certificate in ALTE-2 and a Psychology.

Finally, we developed a content-valid instrument, which is reliable in group investigation contexts to evaluate the establishment of treatment contracts based in TFP. We wish this be a contribution to the study of structuring in treatments for BPD.

3. Theoretical Framework

3.1. Structured Treatments for Borderline Personality Disorders

So far, research has shown that evidence-based psychotherapy for PD strongly emphasizes structured treatments. For instance, structured components are a key part of Dialectical Behavior Therapy (DBT), a treatment that understands BPD as a deficit of affect regulation, especially in patients with suicidal behavior (Linehan, 1993). Another evidence-based treatment, Mentalization Based Therapy (MBT), regards BPD as driven by deficits in the capacity to mentalize (i.e., to understand the internal affective states of oneself and others) and considers therapy structure as a vital component of the treatment (Rossouw & Fonagy, 2012). Similarly, structuring treatment is also important in Schema-Focused Therapy (SFT) that treats dysfunctional schemes conceptualized as drivers of BPD pathology (Bamelis et al., 2014). But structure objectivized on ‘treatment contract’ is understood as a key part of Transference-Focused Psychotherapy (TFP). This treatment proposal for BPD is an evidence-based
treatment, which considers identity diffusion syndrome as the cause of this pathology. In treatment, diffuseness of identity is confronted with the concreteness of treatment structure (Clarkin et al., 2007). In TFP contracting is introduced at the beginning of treatment and clinical strategies converge around working-through patient’s reactions to ‘treatment contract’ throughout the process.

3.2. Common and Specific Active Ingredients
Researchers have hypothesized two different types of “active ingredients” that may be responsible for therapeutic improvement: common and specific factors (Castonguay, 1993). Common factors refer to those elements that are shared across therapeutic relationships, whereas specific factors refer to theory-specified techniques that are prescribed for a given treatment modality (Castonguay & Holtforth, 2005). The structuring of personality treatments is arranged differently for each type of therapy. Sometimes establishing a structured therapeutic setting is considered a prior element, "external" to the therapy, or pre-therapeutic. However, there is no good treatment without good structuring of the setting in TFP because interventions are precisely related to the breaking of therapeutic contracts (Yeomans et al., 2015). Therefore, the structure of this psychotherapy becomes more relevant than for other treatments, and that makes it a good therapeutic model for studying the active ingredient of the treatment contract. Although the therapeutic structure is a common active ingredient across evidence-based treatments for BPD, the specific use of contracting strategies at the beginning and throughout the treatment emerges as a potential specific active ingredient in TFP.

3.3. Content of Transference Focused Psychotherapy Contract Setting
On TFP, the contract is a verbal agreement reached between the therapist and the patient prior to commencing treatment. The content of TFP contracts consist of patient and therapist responsibilities. Some of the universal patient responsibilities are to attend sessions on a regular basis, pay the session fee, make free associations and reflect on their own recount, on the therapist’s comments, and on the patient-therapist interaction. At the same time, the therapist responsibilities are to observe the schedule, pay close attention to the patient’s recounts, strive to help the patient gain understanding of the deepest aspects of their personality and difficulties, and explain the limits of the therapist’s involvement. Additionally, the contract considers individualized aspects, including possible behavioral forms of resistance to the
treatment and assessment of specific threats to treatment and to the life of the patient or of others (Yeomans et al., 2015).

3.4. Importance of Interpreting Challenges to Therapeutic Contracts in TFP

Establishing a structured treatment frame in TFP is achieved by drafting a clear treatment contract at the onset (Yeomans et al., 2015). This is especially important because TFP is based on the premise that clarification, confrontation, and interpretation of the patient’s reactions to framing restrictions will be therapeutic to compensate for the patient’s internal structural deficits (Yeomans et al., 2015). In fact, the treatment frame is essential throughout the treatment in order to diagnose transference markers and make pertinent interventions in response to the patient’s reactions to the frame. In TFP, frame or contract interventions involve three different aspects:

(1) Contract non-compliance by the patient (e.g., late arrival to the session or late payment).
(2) An explicit confrontation by the therapist regarding the patient’s non-compliance with the contract.
(3) A technical intervention designed to connect non-compliance with hypothetical vulnerabilities in the underlying structure of personality, and its transference expression.

This process is conceptualized to be a main component of TFP and thus, contracting is possibly an active treatment ingredient, a specific factor rather than a pre-therapeutic setting of treatment rules.

3.5. Need for Developing an Instrument to Rate the Establishment of Therapeutic Contract

Although there is research showing TFP is an effective treatment for BPD (Cho-Kain, Finch, Masland, Jenkins & Unruh, 2017; Clarkin et al., 2007), not much is known about the active ingredients that may explain the patient’s improvement. The sole study in this area was conducted by Yeomans and collaborators (1993), who proposed an initial version of an instrument to rate the contract-setting phase of treatment, the Contract Rating Scale (CRS). The CRS rated therapist adherence to the treatment manual of BPD proposed by Kernberg and Clarkin (1992). Also, the CRS rated therapist skill or competence in presenting the framework to the patient, and consensus or agreement between therapist and patient regarding conditions of treatment. Researchers highlighted the drafting of the treatment contract as a critical moment
in treatment, associating the quality of contract setting with dropouts. But, Yeomans and collaborators didn’t assess the psychometric stability of the CRS.

An instrument to measure contracting in its detailed ingredients and disentangle possible sources of error is essential to advance in the scientific agenda for capturing the specific contribution of the establishment of the ‘treatment contract’ to therapy outcomes. Therefore, we proposed develop the RITCS at UC to capture relevant components of contracting regarding TFP clinical guide (Yeomans et al. 2015). Such instrument will provide a measure of the therapist’s *adherence* to TFP clinical guide (Yeomans et al. 2015), the therapist’s *competence* establishing a ‘treatment contract’ and also, a measure of the *agreement* between therapist and patient. This particular segmentation of active ingredients of contracting may provide researchers a nuanced, disaggregated estimation of the importance of its components.

### 3.6. Generalizability Theory to establish coniability of the RITCS-UC

Following Brennan (1992) Generalizability Theory is conceptual framework and a methodology to disentangle multiple sources of error that contribute random error term in a measurement procedure. Also, this methodology is useful to determine universes of admissible observations through Generalizability Studies (G_Studies) and to determine universes of generalization through Decision Studies (D_Studies). So, we used Generalizability Theory to determine psychometric properties of the RITCS-UC and made G_Studies and D_Studies for each dimension using the EduG 6.1 software.

### 4. Objective

To develop a content valid versión of the RITCS-UC to evaluate contract-setting in BPD treatments based on TFP, according to the Standards for Educational and Psychological Testing of validity, reliability and fairness.

#### 4.1. Specific Objectives for developing a content valid instrument using expert consensus

1. Define the experts for the two panels on Chile and U.S.
2. Train UC panel of experts on the RITCS theoretical basis.
3. Conduct iterations of the RITCS between the UC and Cornell University experts until a consensus is reached on content validity.
4. Adapt the RITCS rating guidelines and scoring rubric to the new version revised at UC.

4.2. Specific Objectives for estimating the psychometric properties for the instrument through Generalizability Theory

1. Rate how much the therapist adheres to the TFP clinical guide setting areas.
2. Rate the therapist’s competence establishing relevant treatment contract areas.
3. Rate the level of agreement reached between BPD patient and TFP therapist on the establishment of the contract.
4. Disentangle different error sources contributing to the undifferentiated random error term.
5. Establish the items that must be reviewed to minimize measurement error.
6. Calculate the most efficient measurement design and universe of generalization for each dimension

4.3. Specific Objectives to address fairness in testing

1. Generate training for the UC panel of experts, on the theoretical bases of the RITCS.
2. Train the raters on the theoretical bases of the RITCS-UC.
3. Review the English language of the RITCS-UC to be accessible for people with the ALTE-2 certificate.

5. Method

The threefold objectives of this project were: to develop a content valid instrument that assesses the establishment of TFP contracts in treatments for BPD, to explore its psychometric properties testing it through a G_Study for each dimension, and address fairness across all the process.

5.1. Content Validity

Content validity will be understood as a rational analysis of the content of a test, based on subjective judgment until it achieves its suitability (Allen & Yen, 2001). Also, content validity will refer to the extent to which an instrument measures what it is supposed to be measuring (Cronbach & Meehl, 1955).
Two resources were taken into account to develop the content-valid instrument: the TFP clinical guide (Yeomans et al., 2015), and an earlier version of the Rating Instrument for Therapy Contract Setting or RITCS (Yeomans et al., n.p.).

The content of the instrument was established through experts’ consensus through a four-round iterative process. Following Angelo and collaborators (2015), an iterative process is progress toward a desired result through repeated deliberations. Also, authors purposed it comes closer to the expected result as the number of iterations increase. In this case, three iterations between panels of experts at Cornell University and UC were necessary to reach a consensus.

5.1.1. Transference Focused Psychotherapy Clinical Guide

The TFP clinical guide (Yeomans et al., 2015) provided explicit parameters of content validity to develop a TFP-based contracting measurement. The RITCS-UC covers the principal contracting components prescribed on the clinical guide in its three sections: universal patient responsibilities, therapist responsibilities and individualized patient responsibilities.

5.1.2. Rating Instrument for Therapy Contract Setting revised at UC (RITCS-UC)

The initial version if the instrument, the RITCS (Yeomans et al., n.p.), was used as the basis to develop a contracting measurement. It constitutes an earlier attempt to construct a valid TFP-based instrument to assess the establishment of contracting strategies. Thus, the instrument developed and rated at UC –the RITCS-UC– covered content areas mapped out first by the RITCS (Yeomans et al., n.p.). The three content dimensions covered were adherence and competence of the therapist and agreement with the patient. Adherence refers to the degree to which the therapists apply the theory-specified techniques of the intervention. Competence refers to the therapist’s skills with which these techniques are implemented (Webb, Derubeis, & Barber, 2010). And finally, agreement refers to the extent to which the psychotherapist and the patient reach an agreement regarding the treatment contract components (Yeomans et al., 2015).

5.1.3. Panel of Experts

The panel consisted of two groups of experts, from the UC and from the Personality Disorders Institute (PDI) at Cornell U. Following Waltz, Strickland and Lenz (2010) experts were selected to review and discuss the content of the instrument based on their expertise about the content area measured (PDs), and structural aspects of instrument construction. Including both types of expertise maximized the likelihood of developing a content-valid and a well-
constructed instrument (Davis, 1992) regarding TFP theory, and stability of its psychometric properties.

5.1.4 Content-validity of the RITCS-UC

Although Yeomans et al. (n.p.), at the PDI at Cornell U., had created an initial version of the RITCS to measure contracting, that version has not been used or validated yet. Therefore, both, the initial version of RITCS and the expert’ visit from the U.S. to Chile for training, served as an appropriate starting point to develop a contracting measurement.

At the beginning of the process to develop a measuring instrument Eric Fertuck, member of the PDI at Cornell U., visited Chile and gave us, the UC panel of experts, a two-day training on the RITCS (Yeomans et al., n.p.). The workshop familiarized the UC experts with the conceptual underpinnings and the measurement model of the instrument, as proposed by Grant and Davis (1997) and by Waltz and collaborators (2010) as a good practice in the content validation stage through the judgment of experts.

Afterwards, the UC panel of experts, accompanied by Fertuck, rated a videotaped mock contracting session using the earlier RITCS instrument. This activity helped us to identify problems in Likert scales, anchor scales, and to identify non-suitable content. Next, the UC panel and Fertuck created a new version of the RITCS revised at UC (RITCS-UC) and then used it to rate another videotaped mock contracting session. The assessment of this session allowed experts to identify new problems and to develop a second version of the RITCS-UC.

Later, this second version of the instrument was sent by Alex Behn, from UC, to the panel of experts at Cornell U. The experts at U.S. reviewed the second version of the RITCS-UC and returned it to Behn with comments and suggestions. The UC panel revised comments from Cornell U. and proposed changes to solve the observations made. I collected the information and developed the third version of the RITCS-UC. This version was used in another videotaped mock contracting session allowing identify additional issues. Again, I collected the suggestions, and sent it through Behn to Cornell U. Cornell’s experts reviewed the third version of the instrument and returned it with further comments. The panel of experts from UC reviewed these last comments and made suggestions collected by me. Finally, we proposed a fourth and final version of the instrument. Thus, the iteration and review process for the RITCS-UC took place three times. After the iteration and review process, both panels of experts agreed on the content validity of the instrument.
5.1.5 Review of the RITCS-UC rating guidelines and scoring rubric

I adapted the initial version of the rating guidelines and the scoring rubric of the RITCS to the revised RITCS-UC (see Appendix 9.2 and Appendix 9.3). Once the scoring rubric and the rating guidelines were adapted, the RITCS-UC was ready to be tested by a generalizability analysis and to prove its psychometric stability.

5.2. Rating and psychometric validity of the RITCS-UC

Once both panels of experts approved the content validity of the instrument, the RITCS-UC was ready to be tested for its psychometric stability. For that purpose, four psychologists were trained to rate four videotaped contracting sessions with the RITCS-UC. Then a generalizability analysis of the first use of the instrument was estimated. The analysis included G_Studies as well as D_Studies, and data was analyzed using the EduG 6.1 software.

5.2.1. Training Raters

Four young psychologists were selected for us and hired to be raters of four videotaped contracting sessions using the RITCS-UC. Before scoring sessions, raters underwent a two-day workshop with me as a member of the UC panel of experts that attended Prof. Eric Fertuck’s workshop. Each day consisted on two-and-a-half-hour training. During the workshop, participants learned about the theoretical principles of TFP, the sections, the dimensions and the rating guidelines (see Appendix 9.2) of the RITCS-UC. The goal was for raters to learn about the contents and sections of the instrument so they could rate different aspects of the contracting sessions with six-point Likert scales.
In training, raters were informed that in contracting therapists had to explain to the patient about the universal patient responsibilities, therapist responsibilities and individualized patient responsibilities. First, in training, raters learned that therapists had to explain to the patient about universal patient responsibilities regarding attendance, fees, and the patient’s role. In the sub-section universal patient responsibilities on attendance, raters learned that therapists would have to explain to the patient that, in therapy, patients should attend each session (indicating how often), arrive on time (explaining the consequences of late arrivals), stay for the duration of the session, and notify the absences in advance. In universal patient responsibilities regarding fees, raters learned that therapists should set a fee, explain the financial consequences for missed sessions, and establish procedures for payments due and payment methods to the patient. In universal patient responsibilities about the patient’s role, raters learned that therapists had to explain the tasks for treatment according to their own therapeutic model. As videotaped sessions therapeutic model was TFP, the workshop taught that in TFP one of the patient’s roles is to keep honesty about thoughts, feelings, and behavior. Another patient’s role addressed and taught in training was that TFP patients should avoid life events that negatively impact the treatment.

Second, in training raters learned that therapists should explain to the patient the therapist's responsibilities regarding scheduling, establish therapist treatment tasks, clarify the limits of therapist involvement, and determine the policy of confidentiality. In the sub-section therapist responsibilities about scheduling, raters learned that therapists should schedule, be on time, facilitate the entire session, and notify the patient about absences and vacations. Also, in the workshop, it was taught that the therapist should explain to the patient the therapist's responsibilities about therapist treatment tasks depending on his/her own specific therapeutic model. In this case, in TFP the therapists should keep floating attention and contribute in case it is pertinent. In the sub-section therapist responsibilities about clarifying the limits of therapist involvement, raters learned that therapists should clarify the type of interaction permitted outside of sessions regarding the therapeutic model, and also about the limits to what therapists can do to help patients during the session regarding the therapeutic model. Finally, in therapist responsibilities about explaining the policy of confidentiality, the workshop taught that therapists should explain how requests for information would be handled, except when talking about suicidal and homicidal ideas.

Third, the training taught raters that the therapist should explain to the patient about individualized patient responsibilities regarding threats for the patient’s life and regarding threats to treatment. In the sub-section individualized patient responsibilities regarding threats
to the patient’s life (like suicidability), raters learned that therapists should talk about individualized patient responsibilities and state why he/she has chosen those particular areas based on the patient’s history revealed upon its presentation. Also, raters were taught to outline threats to the patient’s life that would be expected from him/her to deal with. About treatment, raters were taught that therapists should address areas that are considered as threats to treatment and state why these areas were chosen based on the patient’s history. Also, raters were taught to outline threats to the patient’s life that would be expected from him/her to deal with.

Afterward, the training continued with the raters evaluating with the RITCS-UC two mock videotaped contracting sessions that had been brought to Chile by Prof. Eric Fertuck when he facilitated the training to the Chilean panel of experts. With the mock-videotaped sessions, raters could practice and test the lessons learned during the workshop. That allowed clarification for questions from raters. They were also able to compare answers between them and discuss differences.

5.2.2. Videotaped contracting Sessions

The raters watched videotaped preliminary interviews and rated the respective videotaped contracting session. The videos were facilitated by the Chilean Personality Disorders Institute as part of the collaboration with them. Psychotherapists from the Institute taped the videos at sessions, and I collected the videos from the different consults. In total, raters watched 14.5 hours of video, spread over seven sessions of two-and-a-half-hour per day at UC. They simultaneously watched the videotaped sessions but scored individually the contracting sessions of four dyads of a psychotherapist and a patient with the RITCS-UC. All patients had previously given their consent to be taped, and having been assured that the session could stop if they so requested it.

5.2.3. Data Collection Instrument

The data collection instrument was the Rating Instrument for Therapy Contract Setting revised at UC (RITCS-UC), which is attached in Appendix 9.1. In general terms, the instrument is based on a six-point Likert Scale, with the anchors “Not applicable” (rating of 0), “Totally disagree” (rating of 1) and “Totally agree” (rating of 5).

5.2.4. Statistical Analysis

To disentangle different sources of variance through G_Studies, data was analyzed using the G_Study statistical function on the EduG 6.1 software. The three facets involved in the measurement design were: dyads (D), raters (R) and items (I); with four levels and infinite
universe of generalization for facets D and R, but the facet I was fixed on different number of items depending on dimension (see Figure 1). Analysis was made regarding the design D/RI, which means that D was considered the differentiation facet in a two-way mixed effects model, with I as a fixed facet.

To calculate the most efficient measurement design and universe of generalization through D_Studies, the statistical functions Optimization and Generalizability Facet (G_Facet) were used on EduG 6.1 software.

5.2.5. Anchor “not applicable”

For data analysis, a score of 0 was assigned to statements that were not rated. In the RITCS-UC Likert scale the number cero represents the anchor “not applicable”. This is, for example, the case when a rater did not rate a statement and the rate for the statement is not available to assess the applicable statement. For that, we interpreted as cero, or not applicable, when some statement wasn’t rated.

Figure 2:
Venn Diagram for the measurement design D/RI.

Note. Variance partition diagram for the estimation design D/RI where D, R & I represent the facets Dyads, Raters & Items, respectively, and Item is a fixed facet.
6. Results

The project developed the RITCS-UC as a content and psychometric valid instrument that rates the establishment of TFP-based psychotherapeutic contracts in investigation contexts for groups. Its difference from the RITCS (Yeomans et al., n.p.) resides in the integration of the assessment of dimensions competence and agreement besides adherence. For content validation, the instrument was developed through expert consensus on an iterative process between a panel of experts from the U.S. and one from Chile. After three iterations, the RITCS-UC was accepted as a content valid instrument to rate psychotherapeutic contracting. Then, the scoring rubric and the rating guidelines of the RITCS-UC were adjusted to the new version of the RITCS-UC (see Appendix 9.1, Appendix 9.2 and Appendix 9.3).

In general terms, this instrument can evaluate contracting in investigation contexts for groups in three dimensions: therapist adherence, therapist competence and agreement with the patient. At the same time, the instrument rates each dimension as related to the establishment of the three content sections of the RITCS-UC, which are universal patient responsibilities, therapist responsibilities and individualized patient responsibilities.

For the psychometric validity, four trained raters scored four-videotaped TFP contracting sessions with the RITCS-UC to test the properties of the items. The observation design consisted of three facets, being the facet dyad the differentiation one, with four levels and an infinite universe of generalization. The measurement objects were the facet rater, also with four levels and an infinite universe of generalization, and the facet item with a fixed model of different number of items for each dimension: adherence has 9 items; competence has 20 items; and agreement has 18 items. Data was analyzed in the EduG 6.1 software for a generalizability analysis, which principal results can be seen at the RITCS-UC abbreviate scoring rubric (see Table 1).

Following Brennan (1992) we can think of the G_coef as the analog of a reliability coefficient in classical theory. So, results went from 0 to 1 to expressing generalizability coefficients.

In this study, results from the raters’ evaluations on the four dyads show a relative G_coef of .64 for adherence, of .87 for competence, and a .81 for agreement (see Table 1). Results are concentrated in scores for each dimension of the instrument: adherence, competence and agreement. No comments were made about the analysis of G_coef of the interaction of sections crossed with dimensions. Some facets became composed of very few items, making it difficult to treat it as an instrument and not as a measure of a specific question. Also, crossing dimensions with sections generates low relative G_coef or even null (see Appendix 9.4 for
Instead, when all items composing each of the three sections of each dimension were joined, the numbers became reasonable.

Disentangling sources of error with G_Studies allows identifying the interaction between facets dyad and rater (D x R) as the principal source of error with a 100% influence on relative error for the three dimensions of the RITCS-UC.

In order to minimize measurement error, the following items must be reviewed: for adherence item I.C.1 or II.B.1, or II.C.1, or III.B.1 (see Table 9); for competence I.C.2, or item II.A.4, or item III.A.6, or item III.B.6 (see Table 16); for agreement I.A.5, or item I.B.3, or item I.B.5, or item II.D.3, or item III.B.5 (see Table 23).

Finally, we calculated the most efficient measurement design and universe of generalization for each dimension. The most important dimension to analyze was adherence, because it showed an initial relative G_coef of .64. So, for adherence, D_Studies showed that the most efficient measurement design to evaluate four dyads could have six raters and eighteen items (see Figure 3). For competence, D_Studies showed that the most efficient measurement design to evaluate four dyads with four raters could have until six items (see Figure 4). For agreement, D_Studies showed that the actual measurement design to evaluate four dyads with four raters could have up to nine items (see Figure 5). But, for reducing items in competence and adherence, content validity would have to be review especially on items suggested before.

### Table 1:
The RITCS-UC G_coef Abbreviate Scoring Rubric.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>G_coef</th>
<th>Relative SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence</td>
<td>0.64</td>
<td>0.32</td>
</tr>
<tr>
<td>Competence</td>
<td>0.87</td>
<td>0.25</td>
</tr>
<tr>
<td>Agreement</td>
<td>0.81</td>
<td>0.25</td>
</tr>
</tbody>
</table>

### 6.1. Results for Adherence

To analyze the generalizability for adherence dimension Table 2 shows the 9 items that compose the construct. The G_Study showed a relative G_coef of .64 among the four raters on items that make up this dimension, with a relative standard error of .32 (see Table 4). The interaction between facets D and R (D x R) was the principal source of error with a 100% of influence on relative error and results for differentiation variance was .18 for facet dyad.
D_Studies through the G_Facet function suggest reviewing the following items to minimize measurement error, item I.C.1 or II.B.1, or II.C.1, or III.B.1 (see Table 9). Also, the function Optimization showed that the most efficient measurement design to evaluate four dyads could have six raters and eighteen items (see Figure 3).

Table 2: Items and Statements for Adherence

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.A.1.</td>
<td>Therapist thoroughly addresses patient responsibilities regarding attendance.</td>
</tr>
<tr>
<td>I.B.1.</td>
<td>Therapist thoroughly addresses patient responsibilities regarding fees.</td>
</tr>
<tr>
<td>I.C.1.</td>
<td>Therapist thoroughly addresses patient responsibilities regarding patient’s role.</td>
</tr>
<tr>
<td>II.A.1.</td>
<td>Therapist thoroughly addresses his/her own responsibilities regarding scheduling.</td>
</tr>
<tr>
<td>II.B.1.</td>
<td>Therapist thoroughly addresses therapist responsibilities regarding therapist treatment tasks.</td>
</tr>
<tr>
<td>II.C.1.</td>
<td>Therapist thoroughly addresses therapist responsibilities regarding clarifying the limits of his/her own involvement.</td>
</tr>
<tr>
<td>II.D.1.</td>
<td>Therapist thoroughly addresses therapist responsibilities regarding explaining policy of confidentiality.</td>
</tr>
<tr>
<td>III.A.1.</td>
<td>Therapist thoroughly addresses individualized patient responsibilities regarding threats to patient’s life.</td>
</tr>
</tbody>
</table>

6.1.1. Measurement Design and G_Study for Adherence

The observation design to test the psychometric validity for adherence (see Table 3) consisted on three facets, where dyad was the differentiation one, four levels and an infinite universe of generalization (INF). The measurement objects were facet rater, also with four levels and an infinite universe of generalization; and facet item, a fixed model of 9 statements.
Table 3:
Observation Design for Adherence.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Label</th>
<th>Levels</th>
<th>Universe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyad</td>
<td>D</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Rater</td>
<td>R</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Item</td>
<td>I</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 4:
G_Study for Adherence.

<table>
<thead>
<tr>
<th>Source of variance</th>
<th>Differentiation variance</th>
<th>Source of variance</th>
<th>Relative error variance</th>
<th>% relative</th>
<th>Absolute error variance</th>
<th>% absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>0.18</td>
<td>R</td>
<td>0.00370</td>
<td>0.0</td>
<td>0.00370</td>
<td>0.0</td>
</tr>
<tr>
<td>.....</td>
<td></td>
<td>I</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td>.....</td>
<td></td>
<td>DR</td>
<td>0.1</td>
<td>100.0</td>
<td>0.1</td>
<td>100.6</td>
</tr>
<tr>
<td>.....</td>
<td></td>
<td>DI</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td>.....</td>
<td></td>
<td>RI</td>
<td>.....</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
</tr>
<tr>
<td>.....</td>
<td></td>
<td>DRI</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Sum of variances: 0.18
Standard deviation: 0.42

Coef_G relative: 0.64
Coef_G absolute: 0.64
Grand mean for levels used: 3.38
Variance error of the grand mean: 0.07
Standard error of the grand mean: 0.27

Figure 3:
Optimization for Adherence.

Note. Estimated Generalizability coefficients for the D/RI design and an infinite universe of generalization, with the number of raters ranging from 2 to 9, and the number of items ranging from 9 to 63.
6.1.2. Decision Study for Adherence: Optimization of Raters

After running the G_Study, the D_Study begun with an optimization plan of raters for adherence, showing a relative G_coeff of .75 when increasing number of raters to seven and maintaining items on nine (see Figure 3). Additionally, increasing raters to seven would diminish relative standard error of measurement from .32 to .24 with a relative error variance of .06 (see Table 5).

Table 5: Optimization of Raters for Adherence, Increasing raters.

<table>
<thead>
<tr>
<th>Lev.</th>
<th>Univ.</th>
<th>G-study</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>INF.</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>R</td>
<td>INF.</td>
<td>4</td>
<td>5</td>
<td>INF.</td>
<td>6</td>
<td>INF.</td>
<td>7</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Observ.</td>
<td>144</td>
<td>180</td>
<td>216</td>
<td>252</td>
<td>288</td>
<td>324</td>
<td></td>
</tr>
<tr>
<td>Coef_G relative</td>
<td></td>
<td>0.64</td>
<td>0.69</td>
<td>0.72</td>
<td>0.75</td>
<td>0.78</td>
<td>0.80</td>
</tr>
<tr>
<td>Coef_G absolute</td>
<td></td>
<td>0.64</td>
<td>0.69</td>
<td>0.72</td>
<td>0.75</td>
<td>0.78</td>
<td>0.80</td>
</tr>
<tr>
<td>Rel. Err. Var.</td>
<td></td>
<td>0.1</td>
<td>0.08</td>
<td>0.07</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Rel. Std. Err. of M.</td>
<td></td>
<td>0.32</td>
<td>0.29</td>
<td>0.26</td>
<td>0.24</td>
<td>0.23</td>
<td>0.21</td>
</tr>
<tr>
<td>Abs. Err. Var.</td>
<td></td>
<td>0.1</td>
<td>0.08</td>
<td>0.07</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Abs. Std. Err. of M.</td>
<td></td>
<td>0.32</td>
<td>0.29</td>
<td>0.26</td>
<td>0.24</td>
<td>0.23</td>
<td>0.21</td>
</tr>
</tbody>
</table>

6.1.3. D_Study for Adherence: G_Facet analysis of Raters

G_Facet analysis of raters for adherence dimension show eliminating rater three would turn reliability good and better than the obtained .64, indicating a relative Coef_G of .7 (see Table 6). Also, results show that eliminating rater four would turn reliability excellent, indicating a relative Coef_G of .8 (see Table 6). Nevertheless, eliminating a rater in this case will not be theoretically positive to the testing of the RITCS-UC because eliminating one rater would increase relative standard error (see Table 7) and then not methodologically favorable.
On the other hand, reducing raters to three increases relative standard error from .32 to .37, and to .45 with two raters (see Table 7); and relative error variances turns from 0.1 to 0.14 and 0.21 for three or two raters respectively. So, it is not methodologically positive to eliminate any rater.

Table 7: Optimization of Raters for Adherence, decreasing raters.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef_G Relative</th>
<th>Coef_G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>1</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>.70</td>
<td>.70</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>.80</td>
<td>.80</td>
</tr>
</tbody>
</table>

6.1.4. D_Study: Optimization of Items for Adherence

Afterwards, the optimization plan of items for adherence dimension show a relative G_coef of .75 if the number of raters is maintained at four, and the number of items is increased from nine to fifty-five. Additionally, it diminishes relative standard error of measurement, in this case from .32 to 0.23 with a relative error variance of .05 (see Table 8).
Table 8:
Optimization of Items for Adherence

<table>
<thead>
<tr>
<th>G-study</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
</tr>
<tr>
<td>R</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
</tr>
<tr>
<td>I</td>
<td>9</td>
<td>9</td>
<td>45</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Observ.</td>
<td>144</td>
<td>720</td>
<td>800</td>
<td>880</td>
<td>960</td>
</tr>
<tr>
<td>Coef_G</td>
<td>0.64</td>
<td>0.74</td>
<td>0.74</td>
<td>0.75</td>
<td>0.75</td>
</tr>
<tr>
<td>Coef_G</td>
<td>0.64</td>
<td>0.74</td>
<td>0.74</td>
<td>0.75</td>
<td>0.75</td>
</tr>
<tr>
<td>Rel. Err. Var.</td>
<td>0.1</td>
<td>0.06</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Rel. Std. Err. of M.</td>
<td>0.32</td>
<td>0.24</td>
<td>0.24</td>
<td>0.23</td>
<td>0.23</td>
</tr>
<tr>
<td>Abs. Err. Var.</td>
<td>0.1</td>
<td>0.06</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Abs. Std. Err. of M.</td>
<td>0.32</td>
<td>0.24</td>
<td>0.24</td>
<td>0.23</td>
<td>0.23</td>
</tr>
</tbody>
</table>

6.1.5. D_Study: G_Facet analysis of Items for Adherence

G_Facet analysis of items for adherence shows that eliminating item I.C.1 or II.B.1, or II.C.1, or III.B.1 turns reliability to a better good reliability than .64 indicating a relative Coef_G of .65, .67, .71 or .72 respectively (see Table 9). But, eliminating any item diminishes the power of content validity as was established by panel of experts in the U.S. and Chile.

Table 9:
G_Facet analysis of Items for Adherence

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef_G Relative</th>
<th>Coef_G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>I.A.1.</td>
<td>.58</td>
<td>.58</td>
</tr>
<tr>
<td></td>
<td>I.B.1.</td>
<td>.42</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>I.C.1.</td>
<td>.65</td>
<td>.65</td>
</tr>
<tr>
<td></td>
<td>II.A.1.</td>
<td>.63</td>
<td>.63</td>
</tr>
<tr>
<td></td>
<td>II.B.1.</td>
<td>.67</td>
<td>.67</td>
</tr>
<tr>
<td></td>
<td>II.C.1.</td>
<td>.71</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td>II.D.1.</td>
<td>.36</td>
<td>.36</td>
</tr>
<tr>
<td></td>
<td>III.A.1.</td>
<td>.59</td>
<td>.59</td>
</tr>
<tr>
<td></td>
<td>III.B.1.</td>
<td>.72</td>
<td>.72</td>
</tr>
</tbody>
</table>
6.2. Results for Competence

To analyze generalizability of competence, Table 10 shows the 20 items that compose construct. A relative Coef_G of .87 was found, with a relative standard error of .25 (see Table 12). The interaction between facets D and R (D x R) was the principal source of error with a 100% of influence on relative error and a differentiation variance of .42 for the facet dyad.

After running the G_Study, the D_Study begun with an optimization plan for competence, showing a relative G_coef of .75 when maintaining number of raters on four and decreasing items to nine (see Figure 4). D_Studies through the function G_Facet suggest reviewing the following items to minimize measurement error: I.C.2, II.A.4, III.A.6, or III.B.6 (see Table 16). Optimization showed that the most efficient measurement design for competence to evaluate four dyads could have four raters and six items (see Figure 4).

Table 10: Items and Statements for Competence.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.A.2</td>
<td>Therapist thoroughly explains to the patient his/her responsibilities regarding attendance, showing clinical benefits and being pedagogical, patient and empathic.</td>
</tr>
<tr>
<td>I.A.4</td>
<td>Therapist’s reaction to patient’s response is fully adequate (consider only the elements of attendance that were presented on item I. A.1.).</td>
</tr>
<tr>
<td>I.B.2</td>
<td>Therapist thoroughly explains to the patient his/her responsibilities regarding fees, showing clinical benefits and being pedagogical, patient and empathic</td>
</tr>
<tr>
<td>I.B.4</td>
<td>Therapist’s reaction to patient’s response is fully adequate (consider only the elements of fees that were presented on item I. B.1.).</td>
</tr>
<tr>
<td>I.C.2</td>
<td>Therapist explains to the patient his/her responsibilities regarding patient’s role, showing clinical benefits and being pedagogical, patient and empathic</td>
</tr>
<tr>
<td>I.C.4</td>
<td>Therapist’s reaction to patient’s response is fully adequate (consider only the elements of patient’s role that were presented on item I. C. 1.).</td>
</tr>
<tr>
<td>II.A.2</td>
<td>Therapist thoroughly explains to the patient his/her own responsibilities regarding scheduling, showing clinical benefits and being pedagogical, patient and empathic</td>
</tr>
<tr>
<td>II.A.4</td>
<td>Therapist’s reaction to patient’s response is fully adequate (consider only the elements of scheduling that were presented on item II. A.1.).</td>
</tr>
<tr>
<td>II.B.2</td>
<td>Therapist thoroughly explains to patient his/her own responsibilities regarding therapist treatment tasks, showing clinical benefits and being pedagogical, patient and empathic.</td>
</tr>
</tbody>
</table>
II.B.4. **Therapist’s reaction to patient’s response is fully adequate (consider only the elements of therapist treatment tasks that were presented on item II. B. 1.).**

II.C.2. **Therapist thoroughly explains to patient his/her own responsibilities regarding clarifying limits of his/her own involvement in treatment, showing clinical benefits and being pedagogical, patient and empathic.**

II.C.4 **Therapist’s reaction to patient’s response is fully adequate (consider only the elements of clarifying the limits of therapist’s involvement that were presented on item II. C. 1.).**

II.D.2. **Therapist thoroughly explains to patient his/her own responsibilities regarding explaining policy of confidentiality, showing clinical benefits and being pedagogical, patient and empathic.**

II.D.4. **Therapist’s reaction to patient’s response is fully adequate (consider only the elements of policy of confidentiality that were presented on item II. D. 1.).**

III.A.2. **Therapist thoroughly explains to patient his/her individualized responsibilities regarding threats to his/her life, showing clinical benefits and being pedagogical, patient and empathic.**

III.A.4. **Therapist’s reaction to patient’s response is fully adequate (consider only the elements of threats to patient’s life that were presented on item III. A. 1.).**

III.A.6. **This content area selected by therapist corresponds to crucial areas that represent threats for patient’s life.**

III.B.2. **Therapist thoroughly explains to patient his/her individualized responsibilities regarding threats to treatment, showing clinical benefits and being pedagogical, patient and empathic.**

III.B.4. **Therapist’s reaction to patient’s response is fully adequate (consider only the elements of threats to treatment that were presented on item III. B. 1.).**

III.B.6. **Content area selected by therapist corresponds to crucial areas that represent threats to treatment.**

6.2.1. **G_Study for Competence**

The observation design to test the psychometric validity for *competence* (see Table 11) consisted of three facets. Dyad was the differentiation facet, with four levels and an infinite universe of generalization (INF). The measurement objects were the facet rater, also with four levels and an infinite universe of generalization (INF), and the facet item with a fixed model of twenty statements.
Table 11:
Observation and Estimation Design for Competence.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Label</th>
<th>Levels</th>
<th>Universe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyad</td>
<td>D</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Rater</td>
<td>R</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Item</td>
<td>I</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 12:
G_Study for Competence.

<table>
<thead>
<tr>
<th>Source of variance</th>
<th>Differentiation variance</th>
<th>Source of variance</th>
<th>Relative error variance</th>
<th>% relative</th>
<th>Absolute error variance</th>
<th>% absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>0.42</td>
<td>R</td>
<td>.....</td>
<td>0.00370</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>.....</td>
<td>I</td>
<td>.....</td>
<td>(0.00000)</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>.....</td>
<td>DR</td>
<td>0.06</td>
<td>100.0</td>
<td>0.06</td>
<td>94.6</td>
</tr>
<tr>
<td>D</td>
<td>.....</td>
<td>DI</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td>D</td>
<td>.....</td>
<td>RI</td>
<td>.....</td>
<td>(0.00000)</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>.....</td>
<td>DRI</td>
<td>(0.00000)</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td>Sum of variances</td>
<td>0.42</td>
<td></td>
<td>0.06</td>
<td>100%</td>
<td>0.07</td>
<td>100%</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0.65</td>
<td></td>
<td>Relative SE: 0.25</td>
<td>Absolute SE: 0.26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coef_G relative 0.87
Coef_G absolute 0.86

Grand mean for levels used 3.26
Variance error of the mean for levels used 0.13
Standard error of the grand mean 0.35

Figure 4:
Optimization for Competence.

Note. Estimated Generalizability coefficients for the D/RI design and an infinite universe of generalization, with the number of raters ranging from 2 to 9, and the number of items ranging from 6 to 30.
6.2.2 D_Study: Optimization of Raters for Competence

Afterwards G_Study, optimization plan of raters for competence showed that a relative G_coef of .77 (relative Coef_G) could be obtained even if the number of raters is decreased to three (see Table 13).

Nevertheless, reducing any rater in this case will not be methodologically positive to test the psychometric validity of the RITCS-UC, because there are only four raters, a small number. In this case, reducing one rater would increase relative standard error from .25 to .29 with a relative error variance of .09 (see Table 13). So, it is not methodologically positive to eliminate any rater.

<table>
<thead>
<tr>
<th></th>
<th>G-study</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
<td>INF.</td>
<td>4</td>
<td>INF.</td>
</tr>
<tr>
<td>R</td>
<td>4</td>
<td>INF.</td>
<td>6</td>
<td>INF.</td>
<td>5</td>
<td>INF.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
<td>20</td>
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<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>400</td>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>240</td>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>320</td>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Coef_G</td>
<td>0.87</td>
<td>0.91</td>
<td>0.89</td>
<td>0.83</td>
<td>0.77</td>
<td>0.62</td>
</tr>
<tr>
<td>Coef_G</td>
<td>relative</td>
<td>0.86</td>
<td>0.9</td>
<td>0.89</td>
<td>0.82</td>
<td>0.76</td>
</tr>
<tr>
<td>Rel. Err. Var.</td>
<td>0.06</td>
<td>0.04</td>
<td>0.05</td>
<td>0.09</td>
<td>0.13</td>
<td>0.26</td>
</tr>
<tr>
<td>Rel. Std. Err. of M.</td>
<td>0.25</td>
<td>0.21</td>
<td>0.23</td>
<td>0.29</td>
<td>0.36</td>
<td>0.51</td>
</tr>
<tr>
<td>Abs. Err. Var.</td>
<td>0.07</td>
<td>0.05</td>
<td>0.05</td>
<td>0.09</td>
<td>0.14</td>
<td>0.27</td>
</tr>
<tr>
<td>Abs. Std. Err. of M.</td>
<td>0.26</td>
<td>0.21</td>
<td>0.23</td>
<td>0.30</td>
<td>0.37</td>
<td>0.52</td>
</tr>
</tbody>
</table>

6.2.3. D_Study: G_Facet analysis of Raters for Competence

Analysis of G_Facet of raters for competence indicates that eliminating any rater would not indicate better G_coef than the obtained .87 (see Table 14). The assumption made on optimization analysis of raters for competence, which stipulates that eliminating any rater will not be methodologically positive to test psychometric validity of the RITCS-UC, is thus upheld. Eliminating rater 1, rater 2, rater 3 o rater 4, diminishes relative Coef_G to .86, .8, .85 and .82 respectively.
### Table 14:

*G_Facet analysis of Raters for Competence.*

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef G Relative</th>
<th>Coef G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>1</td>
<td>0.86</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>0.80</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0.85</td>
<td>0.83</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>0.82</td>
<td>0.82</td>
</tr>
</tbody>
</table>

6.2.4. D_Study: Optimization of Items for Competence

Afterwards, the optimization plan of items for *competence* dimension show us a relative G_coef of .76 when the number of items is decreased from twenty to six (see Table 15). But, eliminating any item diminishes the power of content validity as established by the panel of experts in the U.S. and Chile. Additionally, decreasing the number of items from twenty to six increases the relative standard error of measurement, in this case from .25 to 0.36 with a relative error variance of .13.

### Table 15:

*Optimization of Items for Competence.*

<table>
<thead>
<tr>
<th>G-study</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
</tr>
<tr>
<td>R</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
</tr>
<tr>
<td>I</td>
<td>20</td>
<td>20</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Observ.</td>
<td>320</td>
<td>128</td>
<td>112</td>
<td>96</td>
<td>80</td>
</tr>
<tr>
<td>Coef_G relative</td>
<td>0.87</td>
<td>0.79</td>
<td>0.78</td>
<td>0.76</td>
<td>0.73</td>
</tr>
<tr>
<td>Coef_G absolute</td>
<td>0.86</td>
<td>0.76</td>
<td>0.74</td>
<td>0.71</td>
<td>0.67</td>
</tr>
<tr>
<td>Rel. Err. Var.</td>
<td>0.06</td>
<td>0.11</td>
<td>0.12</td>
<td>0.13</td>
<td>0.15</td>
</tr>
<tr>
<td>Rel. Std. Err. of M.</td>
<td>0.25</td>
<td>0.33</td>
<td>0.34</td>
<td>0.36</td>
<td>0.39</td>
</tr>
<tr>
<td>Abs. Err. Var.</td>
<td>0.07</td>
<td>0.13</td>
<td>0.15</td>
<td>0.17</td>
<td>0.20</td>
</tr>
<tr>
<td>Abs. Std. Err. of M.</td>
<td>0.26</td>
<td>0.36</td>
<td>0.38</td>
<td>0.41</td>
<td>0.44</td>
</tr>
</tbody>
</table>

6.2.5. D_Study: G_Facet analysis of Items for Competence

Results of G_Facet analysis of items for *competence* (see Table 16) shows that removing item I.C.2, item II.A.4, item III.A.6, or item III.B.6, increases relative Coef_G from .81 to .89, .9, .88, and .88 respectively. But as mentioned before, reducing any item would diminish the
power of content validity as was established by panels of experts in the U.S. and Chile, so, it would not be methodologically recommended.

Table 16:  
*D_Study: G_Facet analysis of Items for Competence.*

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef_G Relative</th>
<th>Coef_G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>I.A.2.</td>
<td>.85</td>
<td>.84</td>
</tr>
<tr>
<td>I</td>
<td>I.A.4.</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>I</td>
<td>I.B.2.</td>
<td>.87</td>
<td>.87</td>
</tr>
<tr>
<td>I</td>
<td>I.B.4.</td>
<td>.87</td>
<td>.87</td>
</tr>
<tr>
<td>I</td>
<td>I.C.2.</td>
<td>.89</td>
<td>.86</td>
</tr>
<tr>
<td>I</td>
<td>I.C.4.</td>
<td>.87</td>
<td>.86</td>
</tr>
<tr>
<td>II</td>
<td>II.A.2.</td>
<td>.86</td>
<td>.84</td>
</tr>
<tr>
<td>II</td>
<td>II.A.4.</td>
<td>.90</td>
<td>.87</td>
</tr>
<tr>
<td>II</td>
<td>II.B.2.</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>II</td>
<td>II.B.4.</td>
<td>.86</td>
<td>.85</td>
</tr>
<tr>
<td>II</td>
<td>II.C.2.</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>II</td>
<td>II.C.4.</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>II</td>
<td>II.D.2.</td>
<td>.86</td>
<td>.84</td>
</tr>
<tr>
<td>II</td>
<td>II.D.4.</td>
<td>.86</td>
<td>.84</td>
</tr>
<tr>
<td>III</td>
<td>III.A.2.</td>
<td>.86</td>
<td>.83</td>
</tr>
<tr>
<td>III</td>
<td>III.A.4.</td>
<td>.85</td>
<td>.84</td>
</tr>
<tr>
<td>III</td>
<td>III.A.6.</td>
<td>.88</td>
<td>.87</td>
</tr>
<tr>
<td>III</td>
<td>III.B.2.</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>III</td>
<td>III.B.4.</td>
<td>.84</td>
<td>.84</td>
</tr>
<tr>
<td>III</td>
<td>III.B.6.</td>
<td>.88</td>
<td>.88</td>
</tr>
</tbody>
</table>

6.3. Results for Agreement

To analyze the generalizability for *agreement*, Table 17 shows the 18 items and statements that compose the construct (see Table 17). A relative G_coef of .81 was obtained with a relative standard error of .25 (see Table 19). The interaction between facets D and R (D x R) was the principal source of error with a 100% of influence on relative error, and a differentiation variance of .27 for dyads.

D_Studies through the function G_Facet suggest reviewing the following items to minimize measurement error, item I.A.5 or I.B.3, or I.B.5, or II.D.3 or III.B.5 (see Table 20).
The optimization function showed that the most efficient measurement design to evaluate four dyads could increase raters to five raters and decrease items to nine (see Figure 5).

**Table 17:**
*Statements and Items for Agreement.*

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.A.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of his or her own responsibilities regarding attendance.</em></td>
</tr>
<tr>
<td>I.A.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her responsibilities regarding attendance (consider only the elements of attendance that were presented on item I. A. 1.).</em></td>
</tr>
<tr>
<td>I.B.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of his or her responsibilities regarding fees.</em></td>
</tr>
<tr>
<td>I.B.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her responsibilities regarding fees (consider only the elements of fees that were presented on item I. B. 1.).</em></td>
</tr>
<tr>
<td>I.C.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of his/her own responsibilities regarding patient’s role.</em></td>
</tr>
<tr>
<td>I.C.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her own responsibilities regarding patients’ role (consider only the elements of patient’s role that were presented on item I. C. 1.).</em></td>
</tr>
<tr>
<td>II.A.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding scheduling.</em></td>
</tr>
<tr>
<td>II.A.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding scheduling (consider only the elements of scheduling that were presented on item II. A. 1.).</em></td>
</tr>
<tr>
<td>II.B.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding therapist treatment tasks</em></td>
</tr>
<tr>
<td>II.B.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding therapist treatment tasks (consider only the elements of therapist treatment tasks that were presented on item II. B. 1.).</em></td>
</tr>
<tr>
<td>II.C.3.</td>
<td><em>Patient thoroughly agrees with therapist presentation of limits of his/her own involvement.</em></td>
</tr>
<tr>
<td>II.C.5.</td>
<td><em>Consensus between patient and therapist is reached and considers patient’s</em></td>
</tr>
</tbody>
</table>
understanding and acceptance of therapist responsibilities of clarifying the limits of therapist’s involvement (consider only the elements of clarifying the limits of therapist’s involvement that were presented in item II. C. 1.).

II.D.3. Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding explaining policy of confidentiality

II.D.5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding policy of confidentiality (consider only the elements of patient’s role that were presented on item II. D. 1.).

III.A.3. Patient thoroughly agrees with therapist’s presentation of his/her own individualized responsibilities regarding threats to his/her own life.

III.A.5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her own individualized responsibilities regarding threats to his/her own life (consider only the elements of threats to patient’s life that were presented on item III. A. 1.).

III.B.3. Patient thoroughly agrees with therapist’s presentation of his/her own individualized responsibilities regarding threats to treatment.

III.B.5. Consensus between patient and therapist is achieved and considers patient’s understanding and acceptance of individualized patient responsibilities regarding threats to treatment (consider only the elements of threats to treatment that were presented on item III. B. 1.).

6.3.1. G_Study for Agreement

The observation design to test psychometric validity for agreement (see Table 18) consisted of three facets, being dyad the differentiation one, four levels and an infinite universe of generalization (INF). The measurement objects were facet rater, also with four levels and an infinite universe of generalization (INF); and facet item with a fixed model of 18 statements.

**Table 18:**
*Observation and Estimation Design for Agreement.*

<table>
<thead>
<tr>
<th>Facet</th>
<th>Label</th>
<th>Levels</th>
<th>Universe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyad</td>
<td>D</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Rater</td>
<td>R</td>
<td>4</td>
<td>INF</td>
</tr>
<tr>
<td>Item</td>
<td>I</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 19:  
**G_Study for Agreement.**

<table>
<thead>
<tr>
<th>Source of variance</th>
<th>Differentiation variance</th>
<th>Source of variance</th>
<th>Relative error variance</th>
<th>% relative</th>
<th>Absolute error variance</th>
<th>% absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>0.27</td>
<td>R</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DR</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DI</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RI</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DRI</td>
<td>0.00000</td>
<td>0.0</td>
<td>(0.00000)</td>
<td>0.0</td>
</tr>
<tr>
<td>Sum of variances</td>
<td>0.27</td>
<td></td>
<td>0.07</td>
<td>100.0</td>
<td>0.07</td>
<td>100.0</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0.52</td>
<td></td>
<td>Relative SE: 0.25</td>
<td>Absolute SE: 0.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coef_G relative 0.81  
Coef_G absolute 0.81  

Grand mean for levels used 3.35  
Variance error of the mean for levels used 0.08  
Standard error of the grand mean 0.29

Figure 5:  
**Optimization for Agreement.**

Note. Estimated Generalizability coefficients for the D/RI design and an infinite universe of generalization, with the number of raters ranging from 2 to 9, and the number of items ranging from 6 to 30.

### 6.3.2. Optimization of Raters for Agreement

Afterwards, the optimization plan of raters for agreement show us that a relative G_coef of .76 that could be obtained even if the number of raters decreased to three (see Table 20). Nevertheless, eliminating any rater in this case will not be theoretically positive to test the psychometric validity of the RITCS-UC because there are only four raters. In this case, reducing one rater would increase relative standard error from .25 to .29, so it is not methodologically recommended.
Table 20: 
Optimization of Raters for Agreement.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef G Relative</th>
<th>Coef G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Option 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.3.3. G_Facet analysis of Raters for Agreement

Results of G_Facet analysis of raters for agreement shows that if rater 3 or rater 4 could be eliminated, relative G_coefs would rate from .81 to .76 or .87 respectively (see Table 21). But, it would not be recommendable reducing any rater because there are only four and this increases relative standard error as mentioned before in optimization of Raters for agreement.

Table 21: 
G_Facet analysis of Raters for Agreement.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef G Relative</th>
<th>Coef G absolute</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>1</td>
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<td>0.68</td>
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<tr>
<td></td>
<td>2</td>
<td>0.62</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0.76</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>0.87</td>
<td>0.87</td>
</tr>
</tbody>
</table>

6.3.4. Optimization of Items for Agreement

Afterwards, the optimization plan of items for agreement dimension show us that a relative G_coef of .77 can be obtained, even if the number of items decreased from eighteen to twelve (see Table 22). But, eliminating any item diminishes the power of content validity as was established by panel of experts in the U.S. and Chile. Additionally, it increases relative standard error or measurement, in this case from .25 to .28.
Table 22:
Optimization of Items for Agreement.

<table>
<thead>
<tr>
<th></th>
<th>G-study</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Univ.</td>
<td>Univ.</td>
<td>Univ.</td>
<td>Univ.</td>
<td>Univ.</td>
</tr>
<tr>
<td>D</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
</tr>
<tr>
<td>R</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
<td>4 INF.</td>
</tr>
<tr>
<td>I</td>
<td>18 15</td>
<td>15 12</td>
<td>12 9</td>
<td>9 6</td>
<td>6 6</td>
</tr>
<tr>
<td>Observ.</td>
<td>288</td>
<td>240</td>
<td>192</td>
<td>144</td>
<td>96</td>
</tr>
<tr>
<td>Coef_G</td>
<td>0.81</td>
<td>0.79</td>
<td>0.77</td>
<td>0.74</td>
<td>0.69</td>
</tr>
<tr>
<td>relative</td>
<td>Coef_G</td>
<td>0.81</td>
<td>0.79</td>
<td>0.77</td>
<td>0.73</td>
</tr>
<tr>
<td>absolute</td>
<td>Rel. Err. Var.</td>
<td>0.06</td>
<td>0.07</td>
<td>0.08</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>Rel. Std. Err.</td>
<td>0.25</td>
<td>0.27</td>
<td>0.28</td>
<td>0.31</td>
</tr>
<tr>
<td>of M.</td>
<td>Abs. Err. Var.</td>
<td>0.06</td>
<td>0.07</td>
<td>0.08</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>Abs. Std. Err.</td>
<td>0.25</td>
<td>0.27</td>
<td>0.28</td>
<td>0.32</td>
</tr>
</tbody>
</table>

6.3.5. G_Facet analysis of Items for Agreement

Results of G_Facet analysis of items for agreement shows (see Table 23) that if item I.A.5, or item I.B.3, or item I.B.5, or item II.D.3, or item III.B.5 could be eliminated, the obtained relative Coef_G of .81 would increase to .84, .83, .82, .83 and .84 respectively. But as mentioned before in optimization of items for agreement, reducing any item would diminish the power of content validity as was established by panel of experts in the U.S. and Chile.

Table 23:
G_Facet analysis of Items for Agreement.

<table>
<thead>
<tr>
<th>Facet</th>
<th>Level</th>
<th>Coef _G Relative</th>
<th>Coef_G absolute</th>
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</thead>
<tbody>
<tr>
<td>I</td>
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<td>.79</td>
</tr>
<tr>
<td></td>
<td>I.A.5</td>
<td>.84</td>
<td>.84</td>
</tr>
<tr>
<td></td>
<td>I.B.3</td>
<td>.83</td>
<td>.83</td>
</tr>
<tr>
<td></td>
<td>I.B.5</td>
<td>.82</td>
<td>.82</td>
</tr>
<tr>
<td></td>
<td>I.C.3</td>
<td>.72</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td>I.C.5</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td></td>
<td>II.A.3</td>
<td>.78</td>
<td>.78</td>
</tr>
<tr>
<td></td>
<td>II.A.5</td>
<td>.81</td>
<td>.81</td>
</tr>
<tr>
<td></td>
<td>II.B.3</td>
<td>.78</td>
<td>.78</td>
</tr>
<tr>
<td></td>
<td>II.B.5</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td></td>
<td>II.C.3</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td>Section</td>
<td>Value1</td>
<td>Value2</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>II.C.5</td>
<td>.78</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>II.D.3</td>
<td>.83</td>
<td>.83</td>
<td></td>
</tr>
<tr>
<td>II.D.5</td>
<td>.81</td>
<td>.81</td>
<td></td>
</tr>
<tr>
<td>III.A.3</td>
<td>.81</td>
<td>.8</td>
<td></td>
</tr>
<tr>
<td>III.A.5</td>
<td>.8</td>
<td>.8</td>
<td></td>
</tr>
<tr>
<td>III.B.3</td>
<td>.79</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>III.B.5</td>
<td>.84</td>
<td>.84</td>
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</tr>
</tbody>
</table>
7. Conclusions and Discussion

This thesis developed a content-valid instrument based on the early proposal by Yeomans and collaborators (n.p.) through an iterative process of expert consensus to evaluate the establishment of TFP-based psychotherapeutic contracts in treatments for BPD patients, in investigation contexts. Also, this project confirmed the confiability of the RITCS-UC in terms of its generalizability properties, to be use in future investigations. The development of the RITCS-UC protects fairness for raters who have a Bachelor’s Degree in Psychology and level of English ALTE-2.

Raters were not experienced clinicians, so they may not be the most suited to determine the emerging components of the treatment framework and rate videotaped contracting session. We suggest replicating this study with experienced clinicians as raters, especially experts in TFP with BPD patients.

Results are concentrated in scores for each dimension of the instrument: adherence, competence or agreement. But, no comments were made about the analysis of the interaction of sections crossed with dimensions because some facets were composed of very few items making it difficult to treat it as an instrument and not as a measure of particular statements. To do this analysis we suggest improving the number of statements composing each section without compromising the practical aspects to the use of the instrument, such as length.

G_ Studies showed the interaction between dyads and raters (D x R) as the principal source of error, accounting for 100 % of relative error for the three dimensions of the RITCS-UC. This was an expected result because this means that the subjectivity of raters and dyads is being captured, but items remained stable.

Decision studies about items were also made with the EduG 6.1 software with the functions optimization and G_Facet. Results of G_Facets for adherence showed eliminating item I.C.1 or II.B.1, or II.C.1, or III.B.1 turns reliability to relative Coef_G better than the obtained .64. But, eliminating any item diminishes the power of content validity as was established by panel of experts in the U.S. and Chile. So we suggest future investigations examine the content of those items and try to improve the formulation of the statement. It is the same suggestion for the items of competence I.C.2, item II.A.4, item III.A.6, or item III.B.6; and for the items of agreement I.A.5, item I.B.3, item I.B.5, item II.D.3, or item III.B.5.

To improve fairness, we can suggest translating the RITCS-UC to the Spanish language to extend the accessibility to Latin researchers.
Nevertheless, an instrument based on TFP, that it’s also a psychometrically reliable measure of the process of the establishment of therapeutic frames, is available to researchers interested in the study about contracting and its active ingredients.
8. References


9. Appendix

9.1. Rating Instrument for Therapy Contract Setting revised at UC (RITCS-UC)

Rating Instrument for Therapy Contract Setting (RITCS-UC)
Frank Yeomans, M.D., Pamela A. Foelsch, Ph.D.
Michael Selzer, M.D. and John F. Clarkin, Ph.D.
REVISED AT UC

Patient: _______________________
Rater: _______________________
Therapist: _____________________
Session #____ Date: _______
SECTION I: Universal Patient Responsibilities

I. A. Universal Patient Responsibilities: Attendance

- Attend every session (state how often)
- Arrive on time & consequences for late arrivals
- Stay for the entire session
- Notify absences in advance

I. A. 1. Therapist thoroughly addresses patient responsibilities regarding attendance.

<table>
<thead>
<tr>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

* If 0 or 1, proceed to item I. B. Universal patient responsibilities: Fees.

I. A. 2. Therapist thoroughly explains to the patient his/her responsibilities regarding attendance, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

I. A. 3. Patient thoroughly agrees with therapist presentation of his/her own responsibilities regarding attendance.

<table>
<thead>
<tr>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

I. A. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of attendance that were presented on item I. A. 1).

<table>
<thead>
<tr>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
I. A. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her responsibilities regarding attendance (Consider only the elements of attendance that were presented on item I. A. 1).

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I. B. Universal Patient Responsibilities: Fees

- Set fee
- Financial consequences for missed sessions
- Procedures for payments due
- Payment methods

I. B. 1. Therapist thoroughly addresses patient responsibilities regarding fees.

<table>
<thead>
<tr>
<th>Rating</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If 0 or 1, proceed to item I. C. Universal patient responsibilities: Patient’s Role.

I. B. 2. Therapist thoroughly explains to the patient his/her responsibilities regarding fees, showing clinical benefits and being pedagogical, patient and empathic

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I. B. 3. Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding fees.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. B. 4. Therapist’s reaction to patient’s response is fully adequate (consider only the elements of fees that were presented on item I. B.1).

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

I. B. 5. Consensus between patient and therapist is complete and considers patient’s understanding and acceptance of his/her responsibilities regarding fees (Consider only the elements of fees that were presented on item I. B. 1).

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

I. C. Universal Patient Responsibilities: Patient’s Role

- Tasks of treatment: This depends on the specific treatment tasks for your therapeutic model.
- Honesty about thoughts, feelings and behavior.
- Avoid life events that negatively impact treatment.

I. C. 1. Therapist thoroughly addresses patient responsibilities regarding patient’s role.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

*If 0 or 1, proceed to item II. Therapist Responsibilities

I. C. 2. Therapist thoroughly explains to the patient his/her responsibilities regarding patient’s role, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>
I. C. 3. Patient thoroughly agrees with therapist presentation of his/her own responsibilities regarding patient’s role.

Rating

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
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<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

I. C 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of patient’s role that were presented on item I. C. 1).

Rating

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

I. C. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her own responsibilities regarding patient’s role (Consider only the elements of patient’s role that were presented on item I. C. 1).

Rating

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

SECTION II: Therapist Responsibilities

II. A. Therapist Responsibilities: Scheduling

- Will be on time and stay duration
- Notification of absence
- Vacations

II. A. 1. Therapist thoroughly addresses his/her own responsibilities regarding scheduling.

Rating

<table>
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<tr>
<th>0</th>
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<th>4</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

* If 0 or 1 proceed to item II. B. Therapist Responsibilities: Describes the treatment tasks
II. A. 2. Therapist thoroughly explains to the patient his/her own responsibilities regarding scheduling, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</tbody>
</table>

II. A. 3. Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding scheduling.

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<thead>
<tr>
<th>Rating</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</table>

II. A. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of scheduling that were presented on item II. A.1).

<table>
<thead>
<tr>
<th>Rating</th>
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<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
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</tbody>
</table>

II. A. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding scheduling (Consider only the elements of scheduling that were presented on item II. A. 1).

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
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</tbody>
</table>
II. B. Therapist Responsibilities: Therapist treatment tasks

- Depends on the specific treatment tasks for your therapeutic model.

II. B. 1. Therapist thoroughly addresses therapist responsibilities regarding therapist treatment tasks.

II. B. 2. Therapist thoroughly explains to patient his own responsibilities regarding therapist treatment tasks, showing clinical benefits and being pedagogical, patient and empathic.

II. B. 3. Patient thoroughly agrees with therapist presentation of his/her responsibilities regarding therapist treatment tasks

II. B. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of therapist treatment tasks that were presented on item II. B. 1.).
II. B. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding therapist treatment tasks (Consider only the elements of therapist treatment tasks that were presented on item II. B.1.).

<table>
<thead>
<tr>
<th>Rating</th>
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<tbody>
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<td>3</td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

II. C. Therapist Responsibilities: Clarifying limits of therapist’s involvement

- Type of interaction permitted outside of sessions regarding your therapeutic model
- Limits to what therapist will do to help patient during session regarding your therapeutic model.

II. C. 1. Therapist thoroughly addresses therapist responsibilities regarding clarifying limits of his/her own involvement.

<table>
<thead>
<tr>
<th>Rating</th>
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<tbody>
<tr>
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<tr>
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<td>4</td>
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<tr>
<td>5</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

*If 0 or 1, proceed to item II. D. 1. Therapist Responsibilities: explains policy of confidentiality

II. C. 2. Therapist thoroughly explains to patient responsibilities regarding clarifying limits of his/her own involvement in treatment, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
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<tbody>
<tr>
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<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

II. C. 3. Patient thoroughly agrees with therapist presentation of limits of his/her own involvement.

<table>
<thead>
<tr>
<th>Rating</th>
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<tbody>
<tr>
<td>0</td>
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<tr>
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<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
II. C. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of clarifying the limit’s of therapist’s involvement that were presented in item II. C. 1.).

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</tr>
</tbody>
</table>

II. C. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding clarifying limits of therapist’s involvement (Consider only the elements of clarifying the limits of therapist’s involvement that were presented in item II. C. 1.).

<table>
<thead>
<tr>
<th>Rating</th>
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</thead>
<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

II. D. Therapist Responsibilities: Explaining policy of confidentiality

- Handling of requests for information, exception - suicidal/homicidal

II. D. 1. Therapist thoroughly addresses therapist responsibilities regarding explaining policy of confidentiality.

<table>
<thead>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*If 0 or 1, then proceed to item III: Individualized patient responsibilities.

II. D. 2. Therapist thoroughly explains to patient his/her own responsibilities regarding explaining policy of confidentiality, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
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<th>5</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
II. D. 3. Patient thoroughly agrees with therapist presentation of his/her own responsibilities regarding explaining policy of confidentiality.

Rating

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

II. D. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of policy of confidentiality that were presented in item II. D. 1.).

Rating

<table>
<thead>
<tr>
<th>0</th>
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<th>2</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

II. D. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of therapist responsibilities regarding policy of confidentiality (Consider only the elements of patient’s role that were presented in item II. D.1.).

Rating

<table>
<thead>
<tr>
<th>0</th>
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<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>
SECTION III: Individualized Patient Responsibilities

III. A. Individualized patient responsibilities: Threats for patient’s life (like suicidability).

- Therapist’s statement of why he/she has chosen these areas, based on what the patient’s history and presentation has revealed.
- Therapist’s outline of the steps that the patient will be expected to take in order to deal with the threats to the treatment specific to his/her case.

III.A. 1. Therapist thoroughly addresses individualized patient responsibilities regarding threats to patient’s life.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

* If rating is 0 or 1, then stop coding.

III.A. 2. Therapist thoroughly explains to patient his/her individualized responsibilities regarding threats to his/her life, showing clinical benefits and being pedagogical, patient and empathic.

<table>
<thead>
<tr>
<th>Rating</th>
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<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

III. A. 3. Patient thoroughly agrees with therapist's presentation of his/her own individualized responsibilities regarding threats to his/her own life.

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
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<td>Totally disagree</td>
<td></td>
<td></td>
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<td>Totally agree</td>
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</tbody>
</table>

III. A. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of threats to patient’s life that were presented in item III. A. 1.).

<table>
<thead>
<tr>
<th>Rating</th>
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<th>1</th>
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<th>5</th>
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</thead>
<tbody>
<tr>
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<td>Totally disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Totally agree</td>
</tr>
</tbody>
</table>

III. A. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of his/her own individualized
responsibilities regarding threats to his/her own life (Consider only the elements of threats to patient’s life that were presented in item III. A. 1.).

III. A. 6. Content area selected by therapist corresponds to crucial areas that represent threats to patient’s life.


- Therapist’s statement of why he/she has chosen these areas, based on what the patient’s history and presentation has revealed.
- Therapist’s outline of the steps, which the patient will be expected to take in order to address the threats to the treatment specific to his/her case.


III. B. 2. Therapist thoroughly explains to patient his/her individualized responsibilities regarding threats to treatment, showing clinical benefits and being pedagogical, patient and empathic.

*If rating is 0 or 1, then stop coding.

Rating

<table>
<thead>
<tr>
<th>0</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</table>

III. B. 4. Therapist’s reaction to patient’s response is fully adequate (Consider only the elements of threats to treatment that were presented on item III. B. 1.).

Rating

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</table>

III. B. 5. Consensus between patient and therapist is reached and considers patient’s understanding and acceptance of individualized patient responsibilities regarding threats to treatment (Consider only the elements of threats to treatment that were presented on item III. B.1.).

Rating

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
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</table>

III. B. 6. Content area selected by therapist corresponds to crucial areas that represent threats to treatment.

Rating

<table>
<thead>
<tr>
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<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
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<td>Totally disagree</td>
<td>Totally agree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
List content areas that YOU (rater) consider crucial threats for treatment of this patient, only if not selected by therapist (threats to patient’s life or threats to treatment).

<table>
<thead>
<tr>
<th></th>
<th>Content area (Threats to patient’s life or threats to the treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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</table>
9.2. Rating guidelines RITCS-UC

Description
Rating Instrument for Therapy Contract Setting – revised at UC (RITCS-UC) is a coding system designed to rate adherence and competence of therapists in establishing a therapeutic contract with the patient. It also provides a rating to the agreement reached between the patient and the therapist as to the therapeutic contract stipulations.

This instrument is based on TFP clinical theory, but in this current version it is tailored to analyze the contract setting used in different treatment models, including TFP.

*RITCS-UC* is organized in three sections (represented with Roman numerals) referring to the main areas of the contract: patient responsibilities, therapist responsibilities, and individualized patient responsibilities. Each section is composed of series of dimensions (represented by letters), which are composed of five or six statements (represented by Arabic numerals) that can be rated using a five-point Likert Scale.

Statements are used to collect information about the content and process of establishing a contract: presentation of the responsibilities, patient’s response, therapist’s reaction and degree of reached consensus. An additional statement is presented for the two dimensions of the individualized patient responsibilities section, which measures the degree in which the content risk selected by the therapist is indeed a crucial threat.

The scores of each section and the global scores (i.e., the three sections together) are calculated in terms of three scales: Adherence, Competence and Agreement. The first two categories purport to be a measure of the therapist’s contracting abilities.

General Guidelines
*RITCS-UC* rating unit is a psychotherapy session. The use of video-recorded sessions is recommended, although verbatim transcriptions may also be an option.

Before coding, *raters* were highly encouraged to consider specific suggestions. First, become familiar with the patient's diagnosis and history. Reviewing the evaluation phase of video-recorded sessions is the ideal scenario, but sometimes reading a case formulation may be enough. Second, *raters* should watch the entire session before coding. While watching the session, they are asked to take notes of all verbal and non-verbal markers on which they could base their ratings. These notes may serve as a basis to reach inter-rater consensus.

When rating the adherence Scale (Statement 1), *raters* should only consider whether a therapist covers a particular content area, despite whatever finesse may be lacking.
When rating the Competence Scale (Statements 2 and 4), *raters* should consider the quality of how the therapist manages the situation. Anchors “Totally disagree” (1 point on the Likert Scale) and “Totally agree” (5 points on the Likert Scale) are described as follows:

- **“Totally disagree”:** *rater* totally disagrees with the therapist’s explanation or reaction to the patient’s response (e.g., apologizing, withdrawing, abdicating or modifying the contract).
- **“Totally agree”:** *rater* totally agrees with the therapist’s explanation or reaction to the patient’s response (e.g., probing, clarifying and/or confronting the patient when necessary. Confrontation can be directed towards resistances, confusions, avoidances and, if appropriate, refers to past behaviors that contrast the oral agreement).

When rating Competence Scale (Statement 6), *raters* should consider the importance of the content areas selected by the therapist for the patient, given his/her background, specific pathologies and potential threats to the treatment. Anchors “Totally disagree” (1 point on the Likert Scale) and “Totally agree” (5 points on the Likert Scale) are described as follows:

- **“Totally disagree”:** the *rater* totally disagrees with the therapist’s selection of content area(s) when no past or present situation shows (a) the possible threat that the behavior represents, and/or (b) the presence—or possible presence—of the behavior in the patient.
- **“Totally agree”:** the *rater* totally agrees with the therapist’s selection of content area(s) when it represents a crucial threat to the treatment, as evidenced by (a) the persistence and pervasiveness of the behavior addressed, (b) the relation of the behavior addressed to previous failures (in therapy, work or school), and/or (c) a visible risk of the behavior to the capacity of the patient or the therapist to work in therapy.

If *rater* has no information about the patient’s diagnosis and history, Statement 6 must not be rated.

When rating the Agreement Scale (Statements 3 and 5), *raters* should consider the degree of agreement reached by the patient and the therapist for the therapeutic contract stipulations.

### 9.3 Scoring Rubric of RITCS-UC

Scores for *adherence, competence* and *agreement* on each Section, and Global Score for *dimensions*.
<table>
<thead>
<tr>
<th>Section</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Patient Responsibilities</td>
<td></td>
</tr>
<tr>
<td>a. Attendance</td>
<td>Dichotomize Dimension A, Statement 1</td>
</tr>
<tr>
<td>b. Fees</td>
<td>Dichotomize Dimension B, Statement 1</td>
</tr>
<tr>
<td>c. Patient’s Role</td>
<td>Dichotomize Dimension C, Statement 1</td>
</tr>
<tr>
<td>II. Therapist Responsibilities</td>
<td></td>
</tr>
<tr>
<td>d. Scheduling</td>
<td>Dichotomize Dimension A, Statement 1</td>
</tr>
<tr>
<td>e. Treatment Tasks</td>
<td>Dichotomize Dimension B, Statement 1</td>
</tr>
<tr>
<td>f. Involvement Limits</td>
<td>Dichotomize Dimension C, Statement 1</td>
</tr>
<tr>
<td>g. Confidentiality</td>
<td>Dichotomize Dimension D, Statement 1</td>
</tr>
<tr>
<td>III. Individualized Patient</td>
<td></td>
</tr>
<tr>
<td>Responsibilities</td>
<td></td>
</tr>
<tr>
<td>a. Threats to Patient’s Life</td>
<td>Present if listed as one of the content areas selected by the therapist (Dimension A and B).</td>
</tr>
<tr>
<td>b. Threats to the Treatment</td>
<td>Present if listed as one of the content areas selected by the therapist (Dimension A and B).</td>
</tr>
</tbody>
</table>

Additionally, the instrument may help to identify which specific contents within the sections were presented by dichotomizing ratings for statement 1 (1 recoded as 0: Not present; 2-5 recoded as 1: Present).
List content areas that YOU (Rater) consider crucial threats to the treatment of this patient, only if not selected by therapist (Threats to patient’s life or threats to the treatment).

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B</td>
<td>Lying (as reported by family members and previous therapist)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A</td>
<td>Bulimia</td>
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</tbody>
</table>

Content area: A) Threats to patient’s life or B) Threats to the treatment.
## Scale Scores

<table>
<thead>
<tr>
<th></th>
<th>Patient Responsibilities</th>
<th>Therapist Responsibilities</th>
<th>Individualized patient Responsibilities</th>
<th>Global Score</th>
</tr>
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<tbody>
<tr>
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<td>3,83</td>
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<tr>
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<td>3,17</td>
<td>3,97</td>
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<tr>
<td>AGREEMENT</td>
<td>4,3</td>
<td>4,75</td>
<td>4</td>
<td>4,35</td>
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</tbody>
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## Presence of contract contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Aspect</th>
<th>Is present</th>
<th>Section</th>
<th>Aspect</th>
<th>Is present</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Patient</td>
<td>Attendance</td>
<td>Yes</td>
<td>III. Individualized Patient Responsibilities</td>
<td>A) Threats to Patient’s Life</td>
<td>Yes</td>
</tr>
<tr>
<td>Responsibilities</td>
<td></td>
<td></td>
<td></td>
<td>B) Threats to the Treatment</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>B) Fees</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C) Patient’s Role</td>
<td>Yes</td>
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<td></td>
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</tr>
<tr>
<td>II. Therapist</td>
<td>A) Scheduling</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibilities</td>
<td>B) Treatment Tasks</td>
<td>Yes</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>C) Involvement Limits</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D) Confidentiality</td>
<td>Yes</td>
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### 9.4 The RITCS-UC Coef_Scoring Rubric

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<tr>
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<th>Universal Patient Responsibilities</th>
<th>Therapist Responsibilities</th>
<th>Individualized Patient Responsibilities</th>
<th>Coef_G for dimension</th>
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<tbody>
<tr>
<td>Adherence</td>
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<td>0.42</td>
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<td>Competence</td>
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<tr>
<td>Agreement</td>
<td>0.00</td>
<td>0.34</td>
<td>0.61</td>
<td>0.81</td>
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</tbody>
</table>

*Note.* Table 1 shows the scoring rubric for the results of G_Study of the RITCS-UC for dimensions and sections.