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Theraputic Contracts

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Introduction

The primary aim of this review is to explore the different types of therapeutic contracts, their applications, benefits and potential limitations. The review also provides examples of relevant research that supports their use within adult mental health settings.

The therapeutic alliance is a major factor contributing to the outcome of all forms of psychotherapy (Carr, 2007). One of the hallmarks of an effective therapeutic relationship is that it is collaborative in nature (Beck, 1979). Indeed, research indicates that clients need to feel understood and experience mutual trust and respect in order for therapy to be effective (Bordin, 1994). When clinicians collaborate with clients by working towards consensually agreed goals, clients tend to engage in therapy in a co-operative way and show commitment to the therapeutic process (Carr, 2007).

Both the clinician and client must work together to solve problems and to overcome difficulties in a way that mobilises "the client's own resources and restores his [or her] sense of self-effectiveness" (Trower, 1988, p. 28). It is a state of equality where both parties occupy different roles but are collaborating on a mutual endeavour.

In order to identify the nature, roles and benefits of the therapeutic relationship, Sulzer (1962) suggests the organisation of explicit treatment contracts. Behaviour modification programmes have since developed systems of contingencies associating behaviour change with a number of conditions and rewards. These contingency contracts have become a means to ensure a client's follow-through with some aspect of psychological therapy.

However, contracts are found to be effective in the absence of rewards and incentives (Rosen, 1978). In contrast to behavioural contracts, employing reinforcement delivery systems, the therapist may instead implement therapeutic contracts as explicit agreements of the mutual exchange process between therapist and client (Menninger & Holzman, 1973).

Types of Therapeutic Contracts

Berne (1966) describes two different types of therapeutic contract depending on the theoretical orientation of therapists, their personal preferences and their experience: the administrative contract and the professional contract.

The Administrative Contract

Some clinicians draw up administrative-type contracts. These involve agreement about obvious administrative details (e.g. time and place of therapy) but also about other issues such as arrangements with referring bodies, treatment length and limits of confidentiality (Berne, 1966).

Relating to the principal of integrity, the Psychological Society of Ireland's (PSI) Code of Ethics outlines how any fee payment or benefits must be agreed contractually in advance. This also pertains to the receipt of presents that may be totally prohibited. Alternatively, there may be a limit placed on the value of acceptable presents (e.g. €5.00). If attending privately, it is ethical practice to inform clients if there are similar clinicians who may charge less (Courtois, 1999). It is also important to make clear to clients one's theoretical model of work and the professional organisation (with the associated Code of Ethics) to which one belongs, and to ensure that clients are aware of their rights and responsibilities. It is also proper ethical practice to inform clients if the clinician is on a training programme, the stage of his or her training and the training organisation to which the clinician is accountable.

An administrative contract includes agreement about treatment length or a time limit on treatment. Approximately 50% of clients can make a clinically significant recovery within about 20 appointments or about 6 months of weekly sessions (Carr, 2007). At the end of this time, the contract is either completed or renegotiated for a further period or the client is referred on, depending on the progress achieved with the current contract. Courtois (1999) also describes contract conditions surrounding scheduling, absences, and termination of therapy.

The PSI Code of Ethics outlines how it is the responsibility of clinicians to inform potential clients about the limits of confidentiality of a therapeutic relationship. They must clarify the third parties with whom information may be shared (e.g. multi-disciplinary team members, court-ordered "discovery"; White, 2002). More problematic, and despite suggestions that it should be introduced (Department of Health, 1996), mandatory reporting of (current) suspected (child) abuse (e.g. neglect, emotional or physical or sexual abuse) is not legislated for in Ireland. However, as per *Children First – National Guidelines for the Protection and Welfare of Children* (Department of Health and Children, 1999), employees of the Health Service Executive (HSE) and agencies with whom it collaborates are obligated to report same (e.g. to their line manager or Social Work Department), preferably in collaboration with clients.

Retrospective disclosure of abuse by adults is not adequately addressed by *Children First*. Section 4.6.1 loosely advises clinicians to assess if there is a

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"current risk to any child who may be in contact with the alleged abuser" (p. 39). This guideline aside, clinicians typically struggle to balance a client's need to discuss freely and process his or her abuse experiences in a psychologically safe relationship with their ethical obligation to protect other children from abuse from alleged perpetrator(s). In order to maintain client engagement, some may prioritise the former over the latter (e.g. minimise the assessed risk), although they may have sufficient information to identify the alleged perpetrator(s) and have established that there are "reasonable grounds for concern" (p. 38) that other children may be at risk. Others may be fearful of litigation even though there are protections (e.g. granting of immunity from civil liability) for those who do report suspected abuse in good faith under the *Protections for Persons Reporting Child Abuse Act* (Government of Ireland, 1998). These factors most probably contribute to the variable reporting practices by clinicians across services.Clients need to be informed at first point of contact of the potential onward notification of reports of current and retrospective child abuse. If clients are unwilling, unable or not ready for such onward notification, and although it may significantly compromise the quality of the therapeutic relationship, their (verbal and/or written) therapeutic contract may have to include agreement that there is no detailed information disclosed relating to such actual or suspected abuse of children (Courtois, 1999). Additionally, freedom to express potential harm to self or others may also be curtailed if clients are not accepting of ethically appropriate onward notification of same (e.g. to family members, the client's General Practitioner).

The Professional Contract

The second type of contract is the professional contract (Berne, 1966). This defines the focus of the therapy and how it will proceed. The parties involved need to agree about the nature of the presenting concern. This involves "an assessment of respective ideologies and perceptions" (Rosen, 1978, p. 410) that necessitates agreement about what the client wants to garner from attendance.

Berne (1966) describes how he asks clients what they see as their presenting concern, what they want to change and what they want from him. He explains to them how he works, and together they decide if and how he can be of help to them in achieving what they want. The rationale behind such contracting is that the client's view of his or her presenting concern is subtly changed in the direction of mastery and away from powerlessness.

The client makes the treatment contract with him or herself as well as with the clinician, whose part in the contract is to offer skills and expert knowledge to help the client achieve his or her desired goal. Rosen (1978) also states that the client's goal needs to be defined operationally – that is, the goal must involve some specific behavioural change. Finally, it needs to be attainable within a stated period of time. For example, instead of "I will look for a new job", a goal might be defined as "I will find myself a new job within six months." Finally, the expected outcomes and potential limitations need to be explored.

According to Rosen (1978), in the professional contract the required behaviour in each aspect of the treatment needs to be carefully explained. Agreement is reached about certain behaviours. This usually refers to maladaptive behaviours that have previously occurred or are expected. Clinicians may choose to make abstinence from harmful behaviour a condition of therapy. For example, the sobriety contract described by O'Farrell and Fals-Stewert (2000) that involves total abstinence from drink and drugs is seen as a vital requirement to psychological work.

Contract Forms

Written Versus Verbal Contracts

Treatment contracts can take different forms. Some proponents advocate written contracts that are signed by both clients and therapists. Indeed, the results of a study by Molteni and Garske (1983) support the utility of signed, written contracts. Participants who signed contracts were significantly more compliant in arranging for a second appointment and in preparing for the research task while responding in a more honest and less socially desirable manner. These authors suggest that the signing of a contract appears to be perceived by clients as involving a significant commitment to fulfilling specified tasks.

However, Klier, Fein and Genero (2001) found that while clients who had negotiated written contracts were more successful in communicating actual concrete goals, more clients with verbal contacts (relative to those with written contracts) believed they would work on areas other than those agreed on in their contracts. Similarily in a study by Ribner (1974), participants who contracted in writing for increased frequency of self-disclosure did disclose more often, but did not increase in mutual attraction or trust toward the recipients of the disclosure as expected.

Written contracts may, therefore, be less useful in producing complex behavioral change. Other studies have documented similar instances in which clients who

comply with the specified behaviors of the written contract do not show significantly superior gains on associated behavioral measures (Franzini & Grimes, 1980; Stuart, 1971). Clients may feel that only those areas defined by the contract are open to examination.

Therefore, if using a written contract, it is important that clinicians provide a place where the client can feel free to bring anything he or she wants to their appointments, and not feel constrained by the overall contract. They also need the freedom of a flexible contract that is available for ongoing re-negotiation. Otherwise clients may remain resistant to change beyond the requirements of the contract.

Co-Operation Versus Therapist-Directed Contracts

Contracts help the client to provide a clear and public statement. This affects the probability of executing the required behavior due to the weight of potential aversive consequences for not fulfilling the stated intention (Kanfer, Cox, Greiner & Karoly, 1974). According to social-psychological research, adherence is further enhanced if the client's commitment is consistent with his or her opinion (Kiesler, 1971). Therefore, by minimising his or her role in contract negotiations, the therapist can maximise assent and potential motivation to meet the terms of the contract.

Indeed, in a study by Hansson, Berglund and Ohman (1984), clients who actively co-operated in the development of their contract showed a significantly larger reduction of anxiety compared with the other clients whose contracts were developed primarily by staff.

Another study by Hansson, Berglund, Liljencrantz, Andersson and Ohman (1985) found that having clients who were actively involved in planning their therapeutic contracts resulted in more positive expectations of the importance of their own efforts, the social network, and the group activities and structure of the ward they were on. Similar results were found in studies of treatment for alcohol abuse (Vanicelli, 1979), suggesting that the less the therapist is involved in developing the contract, the better the treatment outcome.

Potential Limitations of Contracts

Arguments against therapeutic contracts include the possibility that the very act of a client and clinician agreeing that a change is desired may lead some clients to feel unacceptable the way they are. Sills (1997) suggested that it may be more important that clients learn to understand and accept themselves rather than aspire for immediate change. Conditions about the client's role run the risk of being met with dishonesty regarding the relevant behaviours (Sills, 1997), and may result in clients thinking that their most agonising parts are not acceptable to the clinician. In addition, clients who genuinely "don't know" what they want may feel inadequate. Failure to maintain behavioural changes may also lead to client guilt or resentment.

Benefits of Therapeutic Contracts

Enhanced Client Empowerment

The formation of a treatment contract is the product of important client–clinician negotiation. Even when clients only have a limited freedom to negotiate (e.g. when admitted compulsorily to hospital), the process still occurs. Such negotiation necessitates the assumption of (pseudo-) egalitarian roles in that clients are encouraged to behave as consumers (Menninger, 1958) seeking a service and who have to make a series of choices and decisions about the treatment they are offered.

Clinicians, therefore, must not regard clients as unequal and must be prepared to "sell" their service in exchange for the desired client behaviour and fee payment (if any). Both need to engage in a reciprocal "give and take" and they have to respect each other's role. In addition, by substituting a consumer role for a client one, the process of contract-making can also have the effect of instilling in clients a sense of personal power. Indeed, it has been found that providing such role expectations and clear responsibilities to clients increases their treatment adherence and motivation (Molteni & Garske, 1983).

By customising the therapeutic relationship to take account of a client's need, the therapeutic alliance can be maintained (Carr, 2007). Indeed, Lash (1998) demonstrated a therapy contract to be effective in increasing the initiation of substance abuse aftercare group therapy and attendance frequency. Similarly, in a study of a training program for obese individuals, Korman (1972) found that the contract group was more effective both in terms of initial weight loss and maintenance of reduced weight over time.

Clarified Expectations

Nelson and Mowry (1976) suggest that, along with defining role relationships, contracts benefit the

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client–therapist relationship by clarifying the purpose of treatment. They facilitate an atmosphere of hope. They also clarify expectations and may, therefore, have an impact on the premature discontinuance of therapy. Relevant research reviewed by Goldberg (1977) suggests that failed or discontinued treatment is largely caused by unrealistic expectations and misunderstandings between clients' needs on the one hand and the therapist's way of conducting therapy on the other.

Reduced Number of Appointments

Contracts also facilitate case planning and the limitation of the duration of a therapeutic relationship. For example, Cook and Skeldon (1980) found that the length of in-patient stay for clients with mental health presentations was reduced for the group with whom contracts were used.

Effective Contract-Making

In order to overcome potential limitations, Sills (1997) describes a number of conditions for effective contract-making.

First, care needs to be taken that the contract is achievable, taking the client's age and current skill set into consideration. Second, the achievement of a therapy contract may lead to a possible interruption of established patterns of behaviour. Hence, the clinician needs to ensure that it does not pose a risk to the well-being or survival of the client. In these situations an appropriate initial soft contract would be simply "to explore". Third, the contract needs to be positively worded to facilitate client motivation to follow through on the specifics of the contract. Fourth, the achievement of the contract needs to be open to checking by one of the five senses (i.e. externally observable). Fifth, the contract needs to be directed towards a goal as this allows both the clinician and the client to state unambiguously when their work together is complete. Finally, the contract must be placed in clear context (i.e. where the contract will be carried out, when and with whom).

In relation to "no self-harm" agreements, Sills (1997) likens their use to salt in cooking, stating that their "overuse means the power to enhance is lost" (p. 117). While such agreements exclude references to "not to stop feeling a certain way", they do detail how "not to behave" and they need to specify desired alternative behaviours. For example, along with a written contract, Öst (1980) provided clients with a summary of clear and accessible cues for action. Applied with such care, they provide the client with a reminder of strategies, that may not be otherwise salient at times of need. It is also useful to consider the personality type of the client in order to design a contract that not only addresses the identified problem but also has the right "feel" to the client.

Conclusion

Therapeutic contracts are explicit agreements of the mutual exchange process between therapist and client (Menninger & Holzman, 1973). There are two different types of contracts.

An administrative contract includes details such as time, place, fees, presents, duration and arrangements with referring bodies. This type of contract also needs to inform clients of the potential onward notification of reports of current and retrospective abuse. Otherwise, the administrative contract may have to include agreement that there be no detailed information disclosed relating to such (actual or suspected) abuse of children (Courtois, 1999). Most clinicians believe that it is important to make clear to clients the professional organisation to which they belong and their stage of training.

The second type of contract is the professional contract that defines the focus of the therapy and how it will proceed (Berne, 1966). This necessitates agreement about what the client wants to garner from attendance and goals are operationally defined. In such a contract, the required client behaviour in each aspect of treatment needs to be carefully explained.

Treatment contracts can take a written or verbal form. Clients who negotiate written contracts may be more successful in communicating actual concrete goals (Klier et al., 2001). However, when using a written treatment contract, it is important that clinicians provide a place where the client can feel free to bring anything he or she wants to their appointment, and not feel limited by the overall contract.

Treatment contracts can also be either co-operation or therapist-directed. Research supports the former type of contract. By minimising his or her role in contract negotiations, a clinician can maximise the potential for client assent and motivation to meet the terms of the contract (Hansson et al., 1985).

Many clinicians feel uncomfortable about using therapy contracts, believing that they are overly constricting. Indeed, a potential limitation of treatment contracts is that client guilt or resentment may manifest itself if they fail to maintain behavioural change (Sills, 1997). In addition, the very act of agreeing that a change is needed may lead some clients to feel unacceptable the way they are.

However, the limited existing research suggests that therapy contracts are useful for a number of reasons. They help clinicians to work ethically with clients. They provide a useful measure for assessing the effectiveness of therapy as behaviour may be compared with initial goals. If, as Beck (1979) suggests, the role of the clinician is to assist in the empowerment of his or her clients, then it is essential to invite them to be active in moulding the therapeutic relationship, deciding their therapeutic goals and meaningfully pursuing

To summarise, the essential components for effective contract-making include:

- Arrangements surrounding time and place of therapy;
- Details of fee payment and policy regarding receiving gifts;
- Rights of clients;
- Length of therapy/number of appointments;
- Conditions surrounding absences, scheduling and

termination of therapy;
- Limits to confidentiality (including disclosures of current & retrospective abuse);
- Focus and model of therapy and how it will proceed;
- Required behaviour (of both client and clinician);
- Expected outcomes and potential limitations.

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