1 Contracts and Contract Making

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The model in this chapter seeks to shed light on the different facets of the contract in therapy. It is based on the work of Berne (1966), originator of transactional analysis and one of the earliest therapists to write in detail about contracting. He defined a contract as: 'An explicit bilateral commitment to a well defined course of action' (1966: 362).

Berne identifies three forms of contract in the therapeutic world: the *administrative,* the *professional* and the *psychological contracts.* This chapter explores the model at the interpersonal level of the practitioner and the client. In Chapter 10, the same model is applied at the institutional and social levels.

The administrative contract

Sometimes also referred to as the business contract, this type of contract deals with all the practical arrangements such as time, place, duration, fees (if any), agreements with referring bodies or agencies, confidentiality and its limits. These are all apparently straightforward but it is surprising how often practitioners, with their eyes firmly fixed on the therapeutic work to come, can be unclear about them or overlook their importance. This importance is fundamental. Not only is clarity about administrative agreements an ethical (BACP 2000) and respectful necessity; the creation of this structure significantly contributes to the provision of the 'stable system boundary' (see Introduction) – the 'safe space' in Winnicott's (1960) terms or Lang's 'therapeutic frame' (see Jacobs in Chapter 2).

The administrative contract covers the following areas:

The venue, the time, the frequency of the therapy sessions

Some therapists offer as a matter of course and as a vital part of providing the containing structure, a regular unvarying time each week (or more than once per week), for example Smith (1991). There is no doubt that this structure does provide the sort of constant holding which allows people to feel safe to explore their deeper feelings. However, there are many other arrangements that can suit both parties. Sometimes a more flexible structure is appropriate. For example, Parkes, in his work with bereaved people, sets up an arrangement whereby sessions are organised for the following visit according to need, the space between the sessions being very

variable (Parkes and Sills 1994). It is helpful if the counselling room remains unchanged, as this provides continuity and security, but this may not always be possible. The important factor is that whatever the arrangements, it is stated clearly and agreed at the start of counselling.

The duration of the commitment

Many counsellors work within a limited time-frame (Elton Wilson 1996, 2000 and see Chapter 11; Feltham 1997), either because of their work setting, or because of other considerations such as their particular approach or the needs of the client. Some (e.g. Talmon 1990) practise single-session therapy. Whatever the case, the contract needs to be clear, including arrangements for review and whether there is the possibility of extending the contract or referring on. If the practitioner offers an open-ended agreement, he or she may suggest a procedure for ending which may include a period of time for evaluation and closure.

Fees

The BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* (2000: 8) states that 'Practitioners are responsible for clarifying the terms on which their services are being offered in advance of the client incurring any financial obligation or other reasonably foreseeable costs or liabilities'. Any fee payment agreement must be made clear, including the possibility of fee increase over the course of a long counselling commitment; also what the policy is for cancellations, holidays and so on. Fees vary greatly between practitioners. It is quite common to charge more for short-term work (which protects the livelihood of the therapist), and also to take experience into account. Many practitioners operate a sliding scale which they negotiate with the individual client according to their circumstances. It is ethical practice to inform clients of the range of fees charged in the area and let them know if there are similar practitioners who may charge less. Often, counsellors who work for an agency which provides counselling at no cost make a point of acknowledging the commitment required from the client in terms of time, energy and, where relevant, the National Insurance contribution they make, in order to stress that the endeavour involves mutual engagement. For further discussion on the setting, changing and payment of fees see Tudor (1998) and Tudor and Worrall (2002).

Changes to the contract and how they will be negotiated

Either client or practitioner may at some time want to change the agreed contract. This may be unforeseen or it may be planned according to the needs of the client or the practitioner. Where possible changes in frequency, duration or fees can be predicted at the initial stage of counselling so that they are part of both people's expectations.

The involvement of other parties

Any involvement of an agency or other body is clearly agreed upon (see Tudor in Chapter 10). This may be relevant where the counsellor's fees are being paid by a third party, or where there is a procedure for accountability.

Confidentiality

The issue of confidentiality is so important and so sensitive that it takes a place in the *administrative contract* section, although arguably it is also part of the *professional contract.* Clients are being asked to come and share (usually unilaterally) their thoughts and feelings, their problematic behaviour, their perhaps embarrassing fears and sense of failure. They may sometimes need to give details of criminal or antisocial past or present behaviour. To provide a safe container it is important that they know they can do so in private and can trust their counsellor to respect their privacy. However, therapists may not feel able to commit themselves to total confidentiality. They may be required to liaise with other health professionals involved in the client's care or obliged by a contract with their employer to disclose certain information. They may wish to discuss the work with supervisors or to quote clients in written material (albeit with disguised identity). They may have ethical and moral principles relating to certain situations (such as the risk of harm to the client or another person, the mistreatment of children, the involvement of Class A drugs or other illegal activities) which cause them to consider breaking confidentiality. Practitioners should make any limits clear to clients from the start. This is not only ethical towards clients but self-protective with regard to the law (see Chapter 9). If an occasion arises during the course of the counselling which has not been predicted, the matter can be discussed and negotiated at the time, in order to obtain client consent where possible, taking into account that the client might agree in order to please a valued counsellor or through ignorance of the significance of what might be revealed in the counsellor's disclosure.

An interesting aspect of this area is that of *client* confidentiality. Is it reasonable for a practitioner to ask a client to respect any self-disclosure she may make? On the face of it, there would seem to be nothing against this. It could be said to fall into the area of mutual respect. Some therapists do suggest that their clients should not use the content of their sessions as the subject of social small talk, as this has the effect of diluting the power of the work. However, the practitioner needs to be careful in her approach. A blanket request for confidentiality might be experienced by the client as if he was being enjoined to secrecy, much in the same way as many abused children are urged 'not to tell'. Thus, what at first felt like a safe container might begin to feel like a hermetically sealed box.

Paradoxically, even in the area of therapist confidentiality, it could be argued that the issue of confidentiality can be overstressed. Emphasis on the boundaries of privacy could become confused with secrecy and might subtly give the client the impression that there is something shameful, abnormal and strange about their feelings or experiences – or indeed about their coming to therapy – and that it must at all costs be kept hidden. It may be valid to remember how a 'senior devil' coached his nephew Wormwood to torment people in C.S. Lewis' *The Screwtape*

Letters by urging them to keep their fears secret because 'shame does best in the dark' (Lewis 1942). Such issues may need to be addressed in therapy in order to avoid the reinforcement of shameful feelings.

Ethical code

Most counsellors and psychotherapists believe that it is necessary to make clear to the client the professional organisations to which they belong, and the ethical codes to which they adhere. Some advocate informing the client of the salient points of the code, for example that there can be no social or sexual contact, and so on. It is proper ethical practice to inform a client if the practitioner is a trainee, their stage of training and the training organisation to which the practitioner is accountable.

Written contracts

Some practitioners draw up written contracts which detail the agreements between them and their clients in order to ensure clarity. Appendix 1 and Appendix 2 contain two examples of such contracts, offered by Joanna Purdie and Graham Colbourne.

The professional contract

The professional contract defines the purpose and focus of the counselling/psychotherapy and how it will proceed. Usually clients seek help because of some specific area of stress or discomfort. This may be expressed in behavioural terms, as in compulsive behaviour, or in affective terms, as with depression or anxiety. Client and therapist agree on what the problem is and what the focus of their work will be. Sometimes the client is not clear about what he wants and a preparatory contract to explore is agreed upon.

It is useful to take Bordin's (1979, 1994) model of *goals*, *tasks and bonds* to elucidate the professional contract. The *goal* is the shared articulation of the desired outcome of the therapy. The *tasks* are the 'specific activities that the partnership will engage in to investigate or facilitate change' (1979: 15) and the *bond* 'is likely to be expressed and felt in terms of liking, trusting, respect for each other and a sense of common commitment and a shared understanding in the activity' (1979: 16). Goals and tasks are both within the remit of the professional contract. Bonds are addressed under the *psychological contract.*

Setting the goal – the 'therapy contract'

Bordin (1994: 21) says 'Reaching an understood and mutually agreed-on change goal is the key process in building an initial, viable alliance.' Transactional analysts often make very specific change contracts in accordance with the spirit of Berne's (1961, 1966, 1982) idea of self-responsibility and equality in the relationship. Berne wanted to move away from the 'medical model' of therapist as expert and

client as passive patient. He would ask his patients what they saw as the problem, what they wanted to change in their lives and what they wanted from him. He would explain to them how he worked and together they would decide if and how he could be helpful to them in achieving what they wanted for themselves. Then they would make an agreement – a mutual commitment not only concerning times, duration and so on but also about the specific goal of the therapeutic work. The philosophy behind this sort of contracting is that clients know and are able to say what they want to change in their lives. The client makes the therapy contract with him or herself as well as with the therapist, whose part in the contract is to offer skills and expertise to help the client to achieve the desired goal. What was then an innovative approach to therapy has since been validated by much outcome research. Berne's method of contract making is strikingly reminiscent of the client-directed approach proposed by Duncan and Miller (2000) whose ideas were built on powerful research evidence as well as experience.

Therapy contracts are traditionally defined as 'hard' or 'soft'. In a hard contract the goal is clearly defined in behavioural terms: for example, 'I will find myself a new job within six months', 'I will go somewhere away from my home once a day' or 'I will make three new friends by the end of the year'. Soft contracts are more subjective and less specific: for example, 'I will start enjoying my life', 'I want to reconcile my desire for closeness with my need for independence' or 'I want to get to know myself'. If, in the opinion of the therapist, any goal chosen by the client will involve other work that the client has not envisaged, then this too will be discussed. This process can be thought of in contrast to Goldberg's (1977) notion of the therapist meeting the 'present client' and gearing her work to her vision of the 'future client', in the hope that when the client gets there he will be pleased with the result. Goldberg explores this situation – where the therapist can envisage an outcome that is not imagined by the client – but concludes that it is still 'best practice' for the practitioner to be open about her intentions.

Disadvantages of 'hard' contracts

There are some significant disadvantages and caveats to the concept of 'hard' contracts for change. The first of these is that if a client and practitioner are agreeing that a change is desired, the client may at some level feel unacceptable the way he or she is. When many clients come to counselling with a poor self-image, it can be more important that they learn to understand and accept themselves rather than aim immediately for change. It is interesting to remember the paradoxical theory of change, which states that 'change occurs when one becomes what he is, not when he tries to become what he is not' (Beisser 1970: 88).

A possible related danger is that a contract may invite practitioner and client to be too task-focused, to the detriment of the relationship between them. Since the establishment of a *bond* (Bordin 1979) between therapist and client, involving mutual respect and trust, is an essential part of the working alliance (see Introduction) it is vital that the relationship not be ignored.

Clients may feel that only certain areas – that is, those defined by the contract – are open to examination. They may feel unseen and unheard in fundamental ways. Or they may feel that they cannot talk about deeper feelings and thoughts which

might emerge in the counselling process. While there are some forms of therapy that work in a tightly structured way, most practitioners would believe that it is vital to provide a space where the client can feel free to bring anything at all to the session and not feel limited by the overall contract; also that the contract be constantly available for review and renegotiation – not set in stone but part of the clarifying process of the work. The exception would be when the contract is specifically for short-term, outcome-focused work when it is normally appropriate to limit the content of the sessions to the defined and agreed area – an approach which is summed up rather deftly by a colleague, Angus Igwe, who says 'The main thing … is to let the main thing … be the main thing!'

Clients may adapt to what they think the practitioner wants in order to win approval (see Kapur's 1987, work on the 'bargain relationship'). Alternatively, if they have a strong pattern in their lives of constant achievement, they may turn their contract into yet another performance hurdle to overcome. The counsellor needs to take the personality (see Chapter 8) and the patterns of the client into account when deciding whether a precise contract is appropriate. For some, simply to be in the room would be the contract of choice.

Clients who genuinely 'don't know' what they want may feel inadequate. This is particularly important: whilst many clients come to counselling with a clear idea of what their difficulty is and what in their lives they want to be different, many others do not. They come simply aware of a generalised malaise or anxiety: 'I have been feeling miserable for months and I don't know why' or, as one client put it, 'I want to know who I am.' Lapworth et al. (1993), discussing contracts, refer to another book by C.S. Lewis in which he says 'How can we come face to face with the gods until we have faces?' (Lewis 1978). In the same way, how can we come face to face with our potential self until we know the face of our present self? For these clients it could be almost abusive to ask them to state their goals clearly. An appropriate initial (soft) contract would be simply 'to explore'.

Even those clients who do seem to know what they want may not know the full significance of the change they are seeking. We human beings do not remain stuck in our difficulties for no reason. They have seemed to us like the only way of coping with life. As one eloquent man said of his mother, 'Her tears kept her company.' We need to understand fully the meaning of our choice before we can carry it through. Consequently many practitioners, as a matter of course, agree an initial contract to explore the client's situation, or to make a very small behavioural change. Then at a later stage, after the relationship is established and the client knows herself more fully, a contract for greater change is negotiated.

Clients who have been 'sent' to therapy – for example the man whose wife will leave him if he does not stop gambling – or who have unrealistic goals – such as the terminally ill client who is seeking a cure – may hurry to make contracts which are doomed to failure.

Finally, there is another caveat in relation to clients who come to therapy without a particular aim in view. It concerns first and second order change (see Introduction). Clients can make specific contracts for desired changes initially, but by definition, if they are capable of imagining them, they come from the current frame of reference and are therefore first order changes. The fundamental shift will be made only when they have risked entering that area of bounded instability between order and chaos (see Introduction), and embarked on the process of

'reflexivity' – the capacity to reflect upon themselves and their assumptions. It is essential that the contract be non-restrictive and extremely flexible, so that the client is available to his or her creativity. This is particularly true of longer term therapy, which aims at structural change, and which may lead the client into that area of bounded instability from which an unknowable outcome may arise.

Advantages of 'hard' contracts

Despite these limitations and pitfalls, there are some powerful advantages to making clear change contracts of this kind. They are as follows.

There is significant research evidence to show that they lead to success in counselling and psychotherapy outcome (see Introduction and also Sutton 1979, 1989; Rosenhan and Seligman 1984; Orlinsky et al. 1994; Asay and Lambert 1999). Clients are encouraged by the contract-making process to believe not only that they have the right to say what they want and to 'own' that want, but that they have some control over their lives, that they have options and that the power for change is in their own hands. This can have the effect of instilling hope in the client, along with the sense of personal power, both of which are identified as being factors involved in successful therapy outcome (Asay and Lambert 1999; Duncan and Miller 2000). The achievement of a contract forms a foundation for future changes. It is likely these experiences of satisfaction are associated with what Panksepp (1998) calls 'the seeking system' of the brain and actually produce biochemical rewards. Some practitioners choose to work with a broad overall goal, then use smaller, achievable 'hard' contracts as stepping stones along the way. Dryden (1989) calls these 'outcome goals' and 'mediating goals' (cf. Parloff 1967).

'Hard' contracts provide a useful yardstick for assessing the effectiveness of the work, which is essential if practitioners are to work ethically with their clients (Sutton 1989). If contracts are not being achieved this should be explored: perhaps something significant has been missed; perhaps the wrong contract has been chosen, in which case it should be renegotiated. Possibly the counsellor and client are not suited or the issues are outside the practitioner's competence. Then the counselling should be brought to a close, particularly if there is an alternative counsellor available.

'Hard' contracts also provide clarity of focus, which gives both practitioner and client something to aim for. The work of clarifying the contract is an important part of the overall work and leads to economy of time and expense in the long run. They use the power of the envisaged potential so that the client not only works consciously towards the goal but at a deeper level has already accepted the possibility of the outcome in his mind. Hard contracts also help to avoid misunderstandings and unrealistic expectations on the part of both client and practitioner, for instance that the psychotherapist actually has a magic wand which, if the client behaves well, will be miraculously waved over his head so that his life will be transformed. Contracts help to reinforce the notion that change happens because we make it happen, even if we cannot always predict all the consequences.

At the highest level a contract might describe a long-term life change. At the simplest level, it involves the client saying what she wants and the practitioner agreeing to it – or a practitioner making a suggestion which a client accepts, as in 'do you want to say more about that?', 'Yes, I have been worrying about … etc'. Contracts

help to ensure that the vulnerable client does not feel pressurised or controlled. They highlight the client's 'readiness, willingness and choice' (Mahrer 1989: 32).

The contracting matrix

The contracting matrix seeks to address some of these issues regarding the limitations of goal-led therapy, while retaining the benefits of clear contracts. It brings together different types of contract appropriate for different situations, and it invites the practitioner to hold them flexibly and lightly. The practitioner makes a contract with a client which takes account of his needs and wants, the time-frame in which they are working, his level of self-awareness and so on. The contracting matrix (see Figure 1.1) is another way of thinking about different types of contract. It is a way of organising some of these parameters into four types of agreement for the work's direction, each of which has implications for what might be required from the practitioner in terms of relationship and approach. It also addresses some of the contract-making caveats that were mentioned earlier in the chapter.

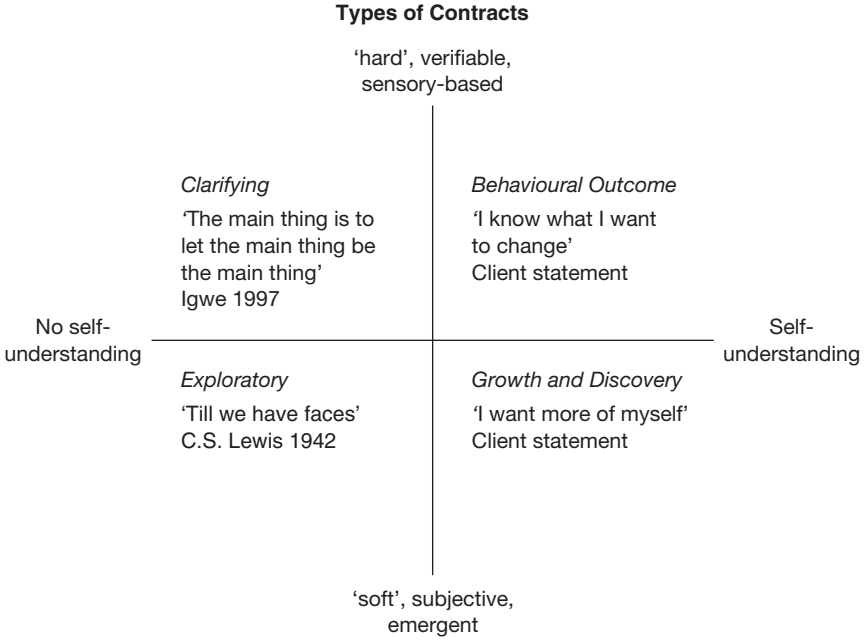


Figure 1.1 The contracting matrix

The vertical axis describes the continuum between the 'hard' contract, which is observable, verifiable, and sensory-based (see Chapter 5) and the 'soft' contract, which allows the unknown to emerge, is subjective and intangible. The horizontal axis reflects the degree to which the client does or does not understand what changes he needs to make. The resulting matrix offers four types of contract that allow the practitioner to respond to the client where he is – according to his perceived and experienced needs and wants, according to his personality type and according to his level of psychological awareness.

The *outcome-focused contract* (top right) requires of the client a high level of clarity about his problem and desired goals as well as an ability to describe those goals in behavioural terms. Clients who come to therapy, to counselling or to coaching with a clear aim – and perhaps a time-limited frame – may find these contracts most useful. For example, a newly appointed manager realised that her job involved making presentations to clients: she saw a counsellor to help her overcome her shyness and learn some communication skills; her work focused on building her confidence and working through her anxieties; she decided also to enrol on a public speaking course.

The *clarifying contract* (top left) is one offered to the client when he knows broadly what he wants, or at least that he wants clearly definable change, but he does not understand what the problem is and what he needs to do. Here the contract may be to identify the key issues and then review the direction. It fits with Igwe's guiding slogan – let the main thing be the main thing. An example of this kind of contract is the man who referred himself to a therapist in despair about his failure in relationships. His experience was that although women usually agreed to date him when he first asked them, after a couple of meetings they stopped wanting to see him. He very much wanted a long-term relationship and this was his stated contract. First he wanted to find out what he was doing to sabotage his possibilities.

At the bottom of the matrix lie two types of contract which do not articulate an observable outcome. They are for clients whose need is for a subjective internal change or development, not an externally defined one. The *exploratory contract* may be suitable for someone who can identify internal distress, such as depression or anxiety, but has neither understanding nor clarity other than a need to 'feel better'. They hardly know themselves; they may have little sense of self and therefore are certainly not capable of identifying a behavioural goal. Hence 'till we have faces'. How can we face the challenges of our lives, and decide who and how we want to be until we know who we are now? This client needs to go on an inner journey in a relationship with a trusted other, to explore the territory of her distress and her identity. The completion of this contract may possibly be followed by a behavioural, outcome-focused contract, or it may not.

Finally, there is what in TA may be called the *autonomy contract* (with the particular meaning that 'autonomy' has in TA). More widely, it might be called a *discovery contract* or perhaps an *engagement contract*. The signature phrase for this type of contract is 'I want more of myself'. This was said by a client who had been in therapy for anxiety at some time in the past. She returned to see the therapist saying that she had discovered all sorts of previously unknown aspects of herself during her last course of therapy. She had come back, not because she was in distress and discomfort but because she wanted 'more of herself'. It would have been completely inappropriate to pin her down to a contract for change. On the contrary, she wanted more of who she already was; so that was the agreement.

The process of making contracts

Various writers have described different types of contract and ways of making them (for example Holloway and Holloway 1973; Clark 1975; Goulding and Goulding 1979; Allen and Allen 1984; Bordin 1994; Stewart 1989, 1996 and Chapter 5).

The questions in Box 1.1, based on the work of James (1977) then expanded by Clarkson and Ward (personal communication) in Lapworth et al. (1993) are designed to clarify a contract for change and represent a formal style of contract making. They are therefore most suitable for making behavioural change contracts and can be explored in the course of one session or spread over a longer time. The eight stages are in themselves a form of protocol. However, the therapist will feel free to adapt them as appropriate.

Box 1.1 Making the contract for change

1 What do you want that would enhance your life?
2 How would you need to change to get what you want?
(These are deceptively simple questions, and time is needed to explore them properly and uncover the self-damaging patterns of a person's way of living. They may need to be preceded by a much wider exploration of how life would look once the desired outcome had been achieved. It is important that the client is not expecting someone else, or life, to change but is willing to look at how they are living at present and what they are doing to maintain the status quo.)
3 What would you be willing to do to effect this change?
(This must be couched in positive terms – i.e. to start doing something rather than to stop as in 'I will phone my friends when I am feeling lonely' rather than 'I will stop sitting at home feeling lonely.' 'I will feel and express my feelings' instead of 'I will stop smoking'. This is enormously important according to extensive research evidence that people make happen what they imagine and envisage.)
4 How would other people know when change has been made?
(This ensures a verifiable outcome and also increases the chances of getting support and encouragement from other people.)
5 How might you sabotage yourself?
(This addresses the client's normal ways of avoiding change and it is surprising how easily most clients can answer the question.)
6 How will you prevent the sabotage?
(An invitation to another behavioural commitment.)
7 How will you reward yourself on completion and how will you make sure that you maintain the level of stimulus and attention that you were accustomed to getting from the old behaviour?
(This addresses the fact that people's maladaptive patterns normally have some secondary gain in that they provide a way – albeit unsatisfactory – of getting some of their needs met.)
8 How will you spend your time when you have changed?
(Nature abhors a vacuum. Frequently people revert to old patterns – negative self-talk, obsessing, or some other form of behaviour – because of a sense of emptiness or even loss. It is important to build in a plan for new ways of structuring the time.)

Sometimes a more organic, emergent style of contract making is more appropriate. Bordin (1994) offers a less formalised method of identifying the goal, which is particularly suitable for clients who need a period of exploration (clarifying or exploratory contracts). He stresses the importance to the therapeutic alliance of a

slow and sensitive exploration of the client's situation, in which the client has the feeling of being respected and heard both for herself and in terms of her understanding of the problems and what is needed. The practitioner contributes to this with his ideas, questions and so on. Finally the practitioner suggests a goal which most fully captures the person's 'struggle' and addresses it (Bordin 1994: 15).

There are also here-and-now 'instant' contracts in order to clarify something or find a way forward in a session. Those might include such questions as: 'I have a suggestion for you, do you want to hear it?' or 'Do you want some information about that?'.

It is important to listen to the client's answer and make sure a contract is agreed before continuing. It is not necessary to make that sort of contract every time an intervention is made which diverts the process. Permission to do this is normally implicit in the positive *psychological contract.* However, it can be very useful in helping the practitioner find his way in the process or in ensuring that a client does not feel pushed or even re-abused. This sort of contract is also valuable for heightening here-and-now awareness and self-responsibility. For a deeper discussion of these 'process orientated contracts' see Chapter 6.

Tasks

The second element of the professional contract is the agreement about role or 'tasks' (Bordin 1994). Berne (1966: 20) says that the therapist describes clearly 'the limitations and potentialities of what his treatment has to offer'. This may include a description of the theory and method used, the way the therapy may proceed, and something about the practitioner's philosophy of therapy and human growth as well as its relevance to what the client wants to get from therapy. Again, practitioners vary enormously in how much they choose to make explicit. However, it should be remembered that there is considerable evidence to suggest that failed or discontinued treatment is largely caused by an unaddressed difference in expectations between practitioner and client (see Introduction and Goldberg 1977). Furthermore, Asay and Lambert, reviewing the 'working alliance', which has been shown by overwhelming research evidence to be an extremely important predictor of positive therapy outcome, state 'the element of collaboration between therapist and client including the consensual endorsement of therapeutic procedures, has been shown to be an essential part of the development of a strong therapeutic alliance' (1999: 44).

It may be especially important to give a fairly detailed explanation of the approach when proposing to work cross-culturally. The role of the counsellor or psychotherapist can vary enormously between different cultures – from advice-giving community leader in one culture, to spiritual guide in another, to awareness facilitator in a third (Grant 1994). For example, clients from some Asian and other oriental backgrounds may need a logical and rational approach while those from Western cultures may expect to address their feelings (d'Ardenne and Mahtani 1989). In therapy, the client, as well as ideally feeling a greater degree of safety, is likely to feel increased vulnerability to the power and influence of the practitioner. This may make him easily swayed by the practitioner's ideological, moral or religious viewpoint (Feltham and Dryden 1994). Clear contracting about such things helps to avoid undue influence by seeking to develop an equality of relationship while not ignoring the real or perceived power differential that exists. Another

significant factor could be the different language interpretations when client and practitioner are from different cultures. The meaning of the words of a contract, the words used to describe the practitioner's roles, even the word 'contract' itself might be full of subtle shades of meaning. Clarifying them can be part of the process of interested enquiry and contact that is so necessary in a cross-cultural engagement.

In describing their role, and depending on their theoretical orientation, practitioners may say something like 'I believe that you are getting stuck in these areas because you are not bringing all of yourself to the situation and have got into fixed patterns of responding. I see my job as helping you raise your awareness of yourself and increase your options', or: 'My view is that we get into difficulties because of what we believe about ourselves and the world. My job is to help you think about your thinking and change the unhelpful patterns', or 'I believe that we get into problems when we block out natural growth processes and that given the right conditions we can rediscover those processes and allow them to develop'. Some practitioners might describe the methods they use: 'Every session we will agree together on what the focus of the session will be'; 'Each week you will make a diary of how much and when you are eating'. Some lay down very explicit guidelines for how the therapy will be conducted, for example, 'Your job is to talk about whatever is on your mind. You will find that I don't say very much; I will occasionally comment to highlight an emerging theme or issue, but mainly this is a space for you to explore'.

On the other hand, many practitioners feel that to explain the process in detail is like describing the film before you get to the cinema. For these practitioners, the client's reaction to the therapist's manner and interventions will form an important part of the work. In that case the therapist must weigh up the balance between an ethical obligation to make sure that the client is well informed about what he is 'letting himself in for', and the desire to keep the field open to surprise and spontaneity. If the practitioner chooses not to go into details about her way of working she can expect more to emerge in the *psychological contract* (see p. 21). This may be appropriate if the approach focuses largely on looking at issues of transference. If the approach seeks to minimise transference issues, one way of doing so is to be as explicit as possible about what the therapy will involve. Many practitioners choose to offer a series of three to six sessions ending with a review before offering a longer contract (Elton Wilson 1996, 2000; Chapter 11). This gives the client experience of the method of counselling and allows for a more informed commitment to further work.

The issue of touch merits particular attention. The area is complex and it is not possible to enter into a discussion here about when the use of touch may be useful and when counterproductive. Certainly, clearly negotiated contracts are essential in order to protect both parties. If a practitioner uses bodywork as part of his or her method, this must be explained and explored carefully at the outset. Some practitioners have found it useful to make an explicit, written contract about the use of touch. I am grateful to James Kepner, author (1993, 2001) and renowned body psychotherapist, for permission to include as Appendix III, his own written consent form. However, he stresses (personal communication):

> The informed consent document for body-oriented psychotherapy (Gestalt Body Process Psychotherapy) is just one part of a true informed consent process for body and touch related work and should not be presented in isolation. Touch work must be done within an existing therapeutic relationship, and the consent form and its contents has to be a part of a dialogue about the rationale, use and understanding

of body-oriented work as psychotherapeutic. This form should not be copied as stated and used, since its tenets are based on a particular orientation to body psychotherapy, and particular intent for the use of touch. Other therapies may use touch for different purposes and in different ways.

Breaches of contract

Whatever the practitioner's approach, the professional contract is made, along with the administrative contract, as a formal offer and acceptance of a therapy commitment. The practitioner needs to think about how to respond if the contract is broken – by either party. It is important that he is clear from the outset which agreements are part of a contract and which are simply ground rules (see Chapter 10). A breach of contract on either side is likely to be symbolic of psychological processes that must be addressed (see Chapter 2).

In theory either side has recourse to the courts if a legal contract is broken but in practice it is very unlikely that a therapist would take a client to court, even for such clear breaches as non-payment of fees. Indeed, Hans Cohn (personal communication), in somewhat humorous vein, said that the reason that therapists use the word 'contract' at all is 'because it gives them the feeling that they are in charge'. What is important is that any broken contract be addressed and sensitively explored for its implications and significance. An overemphasis on contracts may point to an excessive desire for control – a denial of human changeability. However, impatience with, or abhorrence of, contracts may imply avoidance of boundaries, of commitment and of the responsibility of choice.

Steiner (1974: 243) said that 'contracts in treatment should be regarded with as much respect as contracts are regarded within the law'. He identified four elements that he said should be common to both a legal and therapeutic contract (see Chapter 10). In fact, there are important legal dimensions to contracts in counselling and psychotherapy. These are addressed separately by Peter Jenkins in Chapter 9 (also Jenkins 1997; 2002).

The psychological contract

The third type of contract consists of the unspoken, and often unconscious, expectations that are brought to the counselling room by practitioner and client, resulting in a sort of implicit agreement which can have positive or negative consequences. It is paradoxical to use the word 'contract' in this context; it implies conscious agreements. The psychological contract, on the contrary, is usually not even in awareness. However, Berne's use of the word reminds us powerfully of the strength of such unspoken and unchosen pacts, which are at best empathic connections and at worst the enmeshment of an unrecognised transference and counter-transference symbiosis.

The 'positive' psychological contract

This is the area of the third of Bordin's (1979, 1994) elements of the working alliance: the *bonds.* From the start of the therapy, the practitioner puts a high priority on the

establishment of a relationship of mutual respect and trust in which the client will feel free to share his concerns, and experience being heard and attended to. If the administrative and professional contracts are made carefully and appropriately, practitioner and client are ready to embark on whatever journey they have agreed. At the psychological level, the client may already be feeling hopeful and optimistic about what he can achieve. If the practitioner feels similarly confident, has assessed the client correctly for the course of counselling that she intends to give, and believes that she is able to offer help, an unspoken bond is developed which is likely to affect the positive outcome of the therapy. Clarkson (1992), building on the work of Winnicott (1958), refers to a 'facilitative' transference and counter-transference relationship which develops between therapist and client and involves both people's temperament, styles and preferences based on past experiences. Of obvious relevance here are the subtleties of variables in this form of relationship. This is also the realism of the right brain connection described by Schore (2003) or the 'limbic resonance' of Lewis Amini and Lannon described by Lee in Chapter 6.

The 'negative' psychological contract

There are two major ways in which the psychological contract, if not recognised, can influence the counselling in an adverse way and have unwanted consequences. The first of these is the hidden agenda: the unvoiced fears, fantasies or hopes that find a haven in the consulting room. One client may come to counselling with the unexpressed goal that it will stop her husband from leaving her. Another client appears to have come voluntarily but has actually been 'sent' by a spouse or boss (Mearns 1994). Practitioner and client may unconsciously collude to avoid some existential reality which is part of their mutual field – for example death, choice or uncertainty. Surprisingly frequently, a hidden agenda on both sides of the relationship concerns unrealistic expectations of what the therapist could and should do. If the professional contract has not been clarified with sufficient care, this hidden agenda becomes built into the therapy matrix, and both parties end up disappointed.

The second, and inevitable, unspoken expectation that the client brings will not be in his or her conscious awareness and will be based on past experience of life and relationships. Berne (1966) says that at one level people come to therapy in order to confirm their 'script'. The man who is afraid of closeness expects his psychotherapist to dominate and intrude upon him. The woman who has always allowed others to decide things for her expects to be told what to do. The friendless man who was abandoned in a children's home as a baby expects at some level not to be seen and heard. The frightened woman expects to be attacked. Clients bring their transference reactions to their counsellor or therapist and this can form part of the psychological contract. The practitioner is invited into a counter-transference which will bring about the expected outcome. If she responds to the invitation, the therapy can then be founded on this destructive bond, repeating what Wachtel (1977) calls the 'cyclical dynamics' rather than changing them. The client who fears closeness intellectualises and withholds and the therapist becomes demanding and interrogative. The passive woman is so helpless and unable to think for herself that the counsellor begins to think for her and give her

instructions. The abandoned man mumbles in a monotone and talks about himself from a distance and the practitioner feels bored and switches off during sessions. The frightened woman's counsellor scares herself by feeling unaccountably murderous towards that woman. In all these situations, patterns repeat and are perhaps entrenched so that no change occurs.

Transference and counter-transference *will* happen in counselling and psychotherapy, and probably all practitioners are familiar with the phenomena. Luborsky et al. (1986) demonstrate that the relationship with the therapist or counsellor reflects the client's relationships in his everyday life. The task of the practitioner is to try and work with this without falling into a negative psychological contract. How practitioners choose to approach the issue again varies between theoretical orientations. Psychodynamic practitioners and some transactional analysts will choose to allow the transference to develop and work carefully within it. Other humanistic practitioners will see it as their task to encourage a real, 'here and now' relationship as far as possible and will therefore work to show how the transference interferes with that relationship. Some practitioners, for example cognitive–behavioural practitioners, will do everything possible to minimise the transference and if it emerges, might use it to examine patterns of thinking. And so on. What is normally true is that the more detailed and explicit the *professional contract*, the less the transference will occur. This is also true of the unconscious, unrealistic hopes of a magical cure that clients sometimes bring. What is essential is that the therapist and client address and seek to dispel the transference if it is putting what Bordin calls a 'strain in the therapeutic alliance' (1994: 18).

It goes almost without saying that practitioners too will bring some transference to the consulting room, to which clients will respond. This will inevitably contribute to the co-created psychological contract, which can be explored together with the client as appropriate and also examined carefully in supervision.

The contractual context

There are many levels to the contractual context. Administrative, professional and psychological aspects can be considered at any of the levels. First there is the level of the therapist's contract with society in whichever way he understands that; then with the organisation or agency involved (both these are discussed in Chapter 10). When these are in place, the therapist is free to negotiate the overall therapeutic goal or development contract with the client himself. He may also, depending on the nature of the work, make an explicit sessional contract at each meeting, or this may be implicit within the overall contract. And finally there are those moment-to-moment contracts known as 'process contracts', which Stummer (2002) describes as requesting permission to proceed and again can be explicit (see Chapter 5) or implicit.

Box 1.2 shows the levels of contract in the form of a list. When Brigid Proctor teaches about them she uses, with her usual flair for the spatial as well as the visual, a set of Russian dolls. Each one nestles safely inside the container of the previous one – each separate but contributing to a whole. The dolls capture the idea that the contract, at best, acts as a safe container for the creative work in the area of bounded

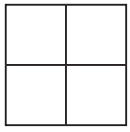
Box 1.2 Levels of Contracts

… with the world, society, the environment, etc.

… with the organisation and individuals in it – *the administrative contract*

… with the client regarding the desired 'developmental outcome' – *the professional contract*

The Contracting Matrix



… with the client for a session

… with the client 'moment by moment'

Contracts are to be reviewed regularly and updated as appropriate.

instability (see p. 6) and that it can do that best if it itself is 'contained' by the clarity and safety of the previous level of contract.

Conclusion

This chapter has provided an overview of the different elements, types and levels of contracts which can and do occur in the therapy situation. The aim has been to

offer an exploration of the range of contractual agreements which therapists and their clients make together, without being prescriptive. Whether we, as practitioners, opt for making only *administrative contracts* or whether we make an explicit contract for behavioural change, there is a common factor in our contracting. Both explicitly, and implicitly as part of the *psychological contract,* therapist and client make a mutual commitment to a relationship which will be in the service of the client's growth and development.

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