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Written Treatment Contracts: Their Use in Planning Treatment Programmes for In-patients

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SUMMARY The formation of a therapeutic relationship involves the negotiation of a treatment contract which conforms to the general principles of any contractual agreement. Attempts have been made to formalize the therapeutic alliance, and this paper reports the development of a written contract for psychiatric in-patients.

Introduction

Admission to hospital constitutes one of the more significant events in a person's life. The patient has to adjust himself to a change in role, to a new system of social interactions and to membership of a large organization. He will experience the reorganization of his complaints, symptoms and problems into a series of communications with therapists and other patients. These processes determine the therapeutic relationship in which treatment occurs.

This paper describes the use of treatment contracts in an attempt to give formal recognition to some of these issues in the planning of treatment programmes. Aside from these considerations, treatment contracts offer a useful way of applying a problem-oriented approach in psychiatry. The increasing use of this approach in itself alters traditional ways of viewing psychiatric disability and patient-therapist relationships (Ryback, 1974).

The Contract

The contract is a written document divided into a number of sections (see Appendix) and is framed in a legalistic manner in an attempt to emphasize its contractual component. Following admission the patient is engaged in a series of interviews with a variety of ward staff in an effort to define problem areas and treatment goals. The patient is encouraged to view these and subsequent encounters as a series of negotiations which require his active involvement. At the end of the assessment period a contract meeting involving the patient and staff members formalizes a treatment agreement between them. The contract is considered as follows:

(a) The selection of treatment goals.

It has been found necessary to satisfy certain conditions for the successful selection of treatment goals. Firstly, the parties involved should agree about the nature of the problem. This entails an examination of respective ideologies and perceptions. The goal should be defined operationally. Thus, the treatment of a goal as 'overcoming depression' is inadequate; the goal must involve some specific change in behaviour. Thirdly, the goal must be attainable as the result of specific activities on the part of both therapist and patient. Lastly, it should be attainable within a stated period of time.

(b) The setting of a time limit.

In practice this is usually one month. At the end of this time the contract is either completed or renegotiated for a further period. A decision is based on the progress achieved with the current contract.

(c) The selection of treatment methods and personnel.

Treatments are predominantly based on varieties of psychotherapy, including

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psychodynamic, behavioural and humanistic approaches. However, the contractual approach also lends itself to physical treatments and investigations and is frequently used in this way.

Several therapists may be involved in the treatment of any individual. Each has a concern with a specific goal, and each employs an appropriate modality of treatment to achieve it. Therapists include all specialties of available staff (doctors, nurses, occupational therapists, psychologists and social workers) and there is considerable blurring of traditional occupational roles.

(d) The patient's role.

The required behaviour and involvement from the patient in each aspect of his treatment is carefully explained. This necessarily involves an adequate description of treatment methods, the expected outcome and possible complications. In addition, agreement is reached about prescribed behaviours. This generally refers to maladaptive and acting-out behaviour which has previously occurred or is anticipated.

(e) Signing the contract.

The contract is signed by the patient and all the personnel directly involved in his treatment programme. The patient is instructed not to sign until he is entirely satisfied with its contents. He may delay a decision for some days and occasionally renegotiate parts of the contract.

Illustrative Cases

Two case histories are summarized here.

Case 1

This patient, a 24-year-old unmarried woman was admitted following a serious drug overdose. She was an only child, still living at home, with a background of repeated separations from her parents due to her father's enforced job moves. She had a very passive, anxious mother and a dominant father, both with difficulties in openly expressing intimate feelings. Father's relationship with his daughter was an inconsistent mixture of dominant overprotectiveness and emotional distance. The patient had a long history of repeated suicide attempts from the age of 7, when she had deliberately swallowed poisonous berries. She had been admitted to psychiatric units and had formed intense, dependent relationships with older male therapists.

During her initial admission period she withdrew to her bed, made superficial cuts on her wrists, was unable to relate to patients of her own age and formed a clinging relationship with an older female patient.

Negotiations produced four agreed problems:

(a) Too awkward to make relationships with her peer group.
(b) Unable to make decisions about herself in relationship to career and her family.
(c) Feelings of constant low self-esteem.
(d) Self-destructive behaviour.

We offered her a contract to overcome these problems, which involved regular twice weekly discussions with a female nurse of her own age to explore problem (a) and weekly meetings with a male doctor of her own generation to explore problems (b) and (c). A social worker and her doctor were to meet on a weekly basis with her parents to help problem (b).

Her part of the contract involved:

(a) Not going to bed during the day.
(b) Attending groups regularly.
(c) Desisting from attacks on her body.

During the negotiation she felt unable to accept part (a) of her contract, and a compromize involved a two-hour bed-rest period.

The contract lasted one month, at the end of which it was renegotiated and attendance at a social skills group was added to help problems (a) and (c).

During her admission she developed more confidence; she became infatuated with a male charge nurse but coped with her feelings and ultimately enrolled in a beautician course. Her suicidal and self-destructive behaviour ceased. Subsequently, after her discharge, she made some close friends of her own age. She has been followed up for 18 months and during this time has maintained her friendships, although she does not yet have a boyfriend. There have been

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no further suicide attempts and she coped when her father suddenly left home with a 20-year-old girlfriend two months after her discharge.

Case 2

A 45-year-old housewife was referred from the Neurology Department, where her 14-year-old daughter had been diagnosed two years previously as suffering from grand mal epilepsy. The patient had subsequently manifested severe free-floating anxiety and had developed agoraphobia. Her daughter had had to miss progressively more school to stay with her mother. There was no previous psychiatric history, but her mother had suffered with symptoms of anxiety for many years, and especially since her son had left home to marry six years previously. In the past two years the patient had suffered three significant bereavements. At further family interviews, the patient's husband, an initially quiet, taciturn man, became tearful when discussing his ineffective role in the family. The daughter was immature for her age and still sat on her father's lap; she talked with a babyish lisp and shared secretive glances with her mother. The patient's problems were listed as:

(i) Difficulty in coping with recent bereavements and loss in general.
(ii) Difficulty in travelling alone.
(iii) Over-identification with daughter and conflicts over allowing her to gain independence.

She was offered a contract involving thrice weekly individual psychotherapy with her male doctor for problem (i), a daily desensitization programme for problem (ii) organized by a ward sister, and six sessions of conjoint family therapy for problem (iii) given by her doctor and a social worker. The contract was signed for three weeks.

At the end of treatment she was travelling alone and her anxiety symptoms had been reduced though she was not entirely free of anxiety. She spent two weekends at home and for the first time allowed here daughter to go out unaccompanied to a youth club. It was felt that her husband had become more assertive. He and the patient had arranged to go for dancing lessons together.

Interestingly, this patient suffered a further bereavement one week after discharge and had to cope with the funeral arrangements herself. She phoned one month later to report that she was now feeling much better and had delayed her phone call until she had got over the death. She had maintained her improvement at six months. At one year after discharge she had obtained a part-time job and was now symptom-free.

Discussion

The treatment contract described in this paper differs from the model applied to some behaviour modification programmes. In the latter it has been used in a variety of clinical situations (Aragona *et al*, 1975; Davidson *et al*, 1973; Liberman, 1970; Miller *et al*, 1974; Rosenstock, 1975; Skuja, 1976; Stabler and Warren, 1974; Stern and Marks, 1973; Stuart, 1969), in which the contract is based on a system of contingencies associating behaviour change with a number of conditions and rewards.

In the setting described here, however, the contract can be seen as a written statement of the elements of a therapeutic alliance. Menninger (1958) analysed this in depth and used the term 'treatment contract' to emphasize its relationship to other transactions, especially those involving goods or services.

Menninger's thesis was that the therapist traded his skills and time to the patient in exchange for the presentation of a problem, submission to the therapist's expertise, and payment (at least in private medicine). The nature of the psychotherapy contract differed from other contracts in several ways; one of the most important was that the relationship between the parties came close to being the goal of treatment, whereas in other situations it was merely a means to an end.

The formation of a treatment contract is the result of negotiation between patient and therapist, a negotiation which is itself affected by a number of important variables. One of these is the degree to which the patient can be a willing voluntary partner to a contract. Thus, a psychotic patient admitted compulsorily to hospital has only a limited freedom to negotiate,

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although there can be little doubt that even in this situation the process occurs. Another variable concerns the therapist's approach to treatment; Cooklin (1973) has described some of the implied contracts based on differing models of the patient-therapist relationship. Poor treatment outcomes can often result when the therapist fails to communicate his treatment approach to the patient or when the patient expects something quite different from the treatment he actually receives.

Contracts have been employed in crisis intervention settings. Nelson and Mowry (1976) developed five themes which characterize their benefits for the client-therapist relationship. They suggest that contracts aid (a) the definition of role relationships, (b) the definition of problems, responsibilities, alternatives and decisions, (c) limitation of the time of the relationship, (d) elimination or control of symptoms and (e) avoidance of the stigmatizing labels usually associated with deviance. In short, the intentions of contracts in the treatment situation are to provide a sense of structure to the patient-therapist relationship and thus to avoid or minimize ambiguities, to engender an atmosphere of hope through de-emphasizing symptoms and feelings of failure, and to provide limits to patient and therapist behaviour.

A formal contract subtly changes the nature of the therapeutic relationship. In the course of negotiating an agreement about treatment, the participants perform roles that are more equal than is general in the early phase of a therapeutic encounter. Because they are engaged in a common task which demands responsibilities from each, the process conforms to many of the principles of consumerism. That is, the patient is encouraged to behave as someone who has rights, is seeking a service and has to make a series of choices and decisions about the treatment he is offered. The therapist, likewise, must cease to regard the patient as a passive, or at least unequal, participant in treatment and must be prepared to 'sell' his service to the patient for a reasonable return—usually called co-operation, or agreement—for suitable behaviour on the part of the patient. Neither partner should give or receive unequally from the other, and each is expected to respect the other's role within the transaction.

Clearly, the contract represents more than a mere business agreement. The process of contract negotiation is frequently the major therapeutic event in itself for reasons that are not difficult to see. The most important involves a change in self-perception and hence in interpersonal function as a result of substituting a consumer role for a patient one. This is particularly important in a hospital setting, where the disadvantages of patienthood are most apparent. It is also evident that a discussion of problems when defined in an operational manner subtly changes the patient's view of these problems in the direction of mastery and away from helplessness.

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Appendix

THE TREATMENT CONTRACT

This contract is an agreement between you, the patient, and the staff who will be involved in your treatment. It is not legally binding, but you and the staff are making a very firm undertaking to each other which all concerned are expected to respect.

The object of this contract is to lay down the treatment goals for your problems and to describe the techniques that will be used to achieve them. It includes the staff who will be involved in treatment and how long the contract will last.

It is very important that you fully understand the terms of the contract and in particular what is expected of you. Please do not sign the contract until you are satisfied with the terms and conditions of it. If you are not, you are strongly advised to discuss the matter with the therapists. Once you have signed, however, you will have agreed to fully participate in the programme described herein.

* * * * *

This contract is between ....

and the following staff members: 1. ....

2. ....

3. ....

4. ....

5. ....

and has been negotiated to achieve the following identified goals of treatment:

goal 1 ....
....

goal 2 ....
....

goal 3 ....
....

goal 4 ....
....

goal 5 ....
....

The contract is valid for..........weeks, between .... and ....

To the Therapists

1. We, the therapists, agree to provide the following treatments for the goals as described above:—

Treatment for goal 1............................
to be given by................

" " goal 2............................
to be given by................

" " goal 3............................
to be given by................

" " goal 4............................
to be given by................

" " goal 5............................
....

2. We intend the treatments to have the following beneficial effects:

....
....
....
....

3. We recognize that the following unintended effects of treatment may also occur:

....
....
....
....

To the patient

1. I, the patient, agree to take part in the treatment programme as follows:

For goal 1 ....

" " 2 ....

" " 3 ....

" " 4 ....

" " 5 ....

2. I understand the objectives of treatment, the techniques to be used and the possible unintended effects.
3. I agree to participate fully in the programme as outlined above and to play my full part in the life of the ward.
4. I agree to keep all scheduled appointments.
5. Other agreements:

....
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....
....

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To the patient and therapists

We agree to abide by the terms and conditions of the contract and that no part of it can be changed without the agreement of the parties concerned.

Signed .... Date............
....
....

....
....

....
....
....
....
....

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