
The Therapeutic Contract in Work with Groups: A Formal Analysis

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An appreciation of the complexity of the therapeutic contract is essential for effective social work practice with groups. In essence, the group contract is a dynamic instrument which changes over time in relation to the number of persons engaged, the configurations involved (one to one through group as a whole), and the nature of member interpersonal connection. A theoretical matrix is developed which provides prescriptive as well as analytic utility for social work role performance. Contract-form alteration is matched to stage of group maturation, and implications are elaborated upon with respect to the use of the contracts as conceptualized here. Brief examples from group practice are cited to illuminate the relevance of a more formal understanding of the contract in work with groups for social work practice.

References to the importance of contracted therapeutic goal statements have been present in the literatures of virtually all the helping professions.¹ Contemporary emphasis on professional accountability—especially accountability to and with clients—and on client participation in the sequencing and focusing of social work treatment appears to be fostering recognition of the contract as a central dynamic in the therapeutic process. Garvin has sharpened the ethical considerations inherent in the therapeutic relationship by claiming for the contract that it “has roots in social work’s commitments to the self-determination of the client so that he is not manipulated toward ends he does not seek through means he does not accept.”²

In discussions of the contract in the social work literature, the impression is too often created that the therapeutic contract is negotiated early in the worker/client relationship, as a way of begin-

ning, and is not subject to ongoing review and reformulation. Schwartz, for example, in referring to its use with groups, called it "an initial working agreement, a frame of reference from which to choose one's first responses."³ Other group theorists have dealt with the concept less formally in their discussions of the helping process.⁴

We suggest, rather, that the shifting dynamic of the therapeutic relationship mitigates against assuming that an agreement, once made, should remain unchanged over the long term. Given the nature of interaction over time, the persons involved in a relationship change, the quality and direction of the interaction change, and the relationship itself changes. To borrow from the terminology of cybernetics, if information fed back as outcome measures reveals that a situation which initially existed remains unchanged over time, the experience essentially has been that of a holding action. From our perspective, it is questionable whether a mere holding action is legitimate social work activity; instead, we suggest that regular renegotiation and reformulation of the therapeutic contract must be viewed as an essential element of skillful professional practice.

This article describes an analytical framework which can be applied to assess the quality of group movement over time. In particular, we suggest that a more purposeful use of the therapeutic contract can result in increased group effectiveness while, at the same time, contributing to increased worker sensitivity to the unique needs of individual group members. From our perspective, the contract negotiation process is open ended and moves through a series of increasingly complex stages, in the end resulting in not one therapeutic contract but a series of contracts which reflect changing individual and group-as-a-whole priorities over time. Knowledge of these stages, we believe, will aid workers in helping to direct group behavior toward considerations which reflect shared therapeutic interests without concomitant loss of essential member individuation. In our discussion, we will seek to identify those stages at which the therapeutic contract might be more appropriately negotiated in a written rather than verbal form.

Theoretical Development of the Therapeutic Contract

The simplified schema presented in table 1 summarizes our notions concerning the conceptual evolution of individual and group contracts over time. The matrix identifies the four major types of therapeutic contracts to be considered in this paper and contains

Table 1
STAGES OF INDIVIDUAL AND GROUP CONTRACT DEVELOPMENT OVER TIME

TIME PHASES	STAGES OF GROUP CONTRACT DEVELOPMENT			
	1. Independent	2. Reciprocal	3. Mutual	4. Interdependent
Pregroup	a_1	$a_1+b_1+c_1=d_1$	Pregroup	Pregroup
Beginning	a_1	$a_1+b_1+c_1=d_1$	$d_{n_1}+B_1+C_1=F_1$	$a_{n_1}+d_{n_1}+F_1=F_1$
Beginning+ $\frac{1}{3}$	a_2	$a_2+b_2+c_2=d_2$	$d_{n_2}+B_2+C_2=F_2$	$a_{n_2}+d_{n_2}+F_2=F_2$
Beginning+ $\frac{2}{3}$	a_3	$a_3+b_3+c_3=d_3$	$d_{n_3}+B_3+C_3=F_3$	$a_{n_3}+d_{n_3}+F_3=F_3$
Termination	a_4

NOTE.— a =client's private objectives; b =client's objectives shared with worker; c =worker's objectives for individual clients; d =worker and client contracted objectives; B =individual client objectives for group as a whole; C =worker objectives for group as a whole; E =initial group-as-a-whole objectives; F =worker and client integrated objectives for group as a whole; n =all individual contracts.

further specification as to the changes which occur to them in achieving increased levels of individual and group goal clarity, explicitness, and specificity.

The horizontal axis of the matrix outlines the stages of group development vis-à-vis the group contract negotiation process. The reader will note that the contract negotiation process begins with the independent contract of stage 1, moves forward to the more complex reciprocal and mutual contracts of stages 2 and 3 and, as group members identify with the major organizing purposes of the group as well as their own needs and those of other group members, the contract finally develops into the more involved, but most desirable, interdependent agreement of stage 4. The vertical axis of the matrix reflects modifications to the original contracts as the group process unfolds through time, that is, beginnings, middles, and endings. The assumption underlying these changes is that increased maturation occurs as individual group members and the group as a whole move toward fuller achievement of their stated and unstated objectives for the shared group experience. The letters and symbols used in each of the matrix's fifteen cells refer to the saliency of the role assumed by each of the contract participants, as individuals and as group members, at various points along the contract continuum. Lowercase letters refer to individual client-worker negotiations, and capital letters are used to symbolize the contractual process with the group as a whole as the referent. The passage of time, with its subsequent contract renegotiation, is symbolized by numerical subscripts.

The Independent Contract

The independent contract of stage 1 is made up entirely of the private and personal concerns of individual clients (a_1). These contracts exist apart from any external worker influence and, as such, constitute the client's own private therapeutic agreement with himself vis-à-vis the group process.

Some clients may feel, for example, that certain problems are too embarrassing or threatening to share with workers initially (such as those of a sexual or criminal nature) and may withhold such data until the client's confidence in the worker has been realized. In such situations, clients typically share problems of a less threatening nature and await the appropriate point in treatment before entering the heretofore unmentioned concerns into the therapeutic process. Other clients may feel that some problems of a personal nature are too trivial to make the subject of formal intervention (e.g., loneliness, boredom, preoccupation with personal fantasies) and, as a result, simply choose not to share them with the worker. Whether shared or not, however, problems designated by clients as either trivial or embarrassing are important to the therapeutic process inasmuch as they are central areas of concern to the client and do form part of the cognitive and affective structure used by clients for understanding and resolving problems which are formally considered. Ideally, all relevant concerns are shared by clients with workers as early in treatment as possible but, pragmatically, workers must be alert to probe problem areas which have been specified by clients through vague and only partially complete statements.

Like other contracts which make up the total group experience, the substance of the independent contracts can be expected to change over time as the client's needs reach a higher level of clarification or understanding. In table 1, this movement is symbolized vertically as the independent contract of stage 1 (a_1) is revised during the middle phase of treatment (a_2) and once again, just prior to termination (a_3). The substance of these changes, of course, is influenced by the individual's subsequent growth and maturation. Unlike other group-based contracts, however, the independent contract continues to develop and unfold even after the formal therapeutic relationship with the worker and other group members has terminated (a_4), since individuals do not stop revising their own goals and personal expectations for themselves simply because a formal intervention experience has stopped. In other words, independent contracts exist within the mind of the individual client. They are not directly part of the group experience, but they are influenced by any personal maturation which occurs as a result of the group experience.

Necessarily, independent client contracts are not the property of the group and, therefore, do not require validating approval from either the worker or other group members in order for them to

become part of the client's personal treatment experience. These contracts form an important part of the client's initial interactions with the worker and other group members and are part of the total group experience.

The Reciprocal Contract

In stage 2 of group contract development, client and worker must achieve a reciprocal agreement concerning those central issues, problems, or concerns which both agree should form the client's major problem-solving activity in the group. Typically, these therapeutic objectives are specified through private dyadic interviews between worker and client during which the client shares with the worker his formulation of the problems (b_1) which compelled him to seek professional help. The resulting problem list is always shorter than that contained in the client's independent contract and, to a large extent, is focused on those special problems which the client understands, whether correctly or not, to be the appropriate content for treatment. Responding to the client's understanding of his own problems, the worker, in turn, reinterprets the client's statements in light of the worker's diagnostic perspective, shares his tentative conclusions or areas of agreement with the client (c_1) and, if reasonably together, client and worker arrive at an agreement (d_1) as to the major therapeutic objectives which each will pursue on behalf of the client in the course of treatment.

The reciprocal contract is a more complex instrument than the independent contract of stage 1, inasmuch as both client and worker must reach some measure of agreement as to its terms and conditions. In order to arrive at such an agreement, the client must modify his private independent contracts so that they conform more closely to the professional interests and skills of the worker ($a_1 \rightarrow b_1$), and the worker in turn must be sensitive to the individualized needs of each client, as well as to his functional responsibilities as a group therapist, agency employee, or whatever frame of reference is appropriate to the offering of his service. This process is a dynamic one, and through it client and worker achieve a level of individualization which is not possible in either the mutual or interdependent contracts of stages 3 or 4, both of which emphasize group goals and group development.

The reciprocal contractual process is illustrated in the following clinical situation. The client, a twenty-seven-year-old university graduate student with problems of generalized chronic anxiety, was asked to state his therapeutic objectives in written form following two preliminary pregroup interviews with the worker.

Miller Contract 1 (b_1).—In his initial statement of his goals, the client said,

As I thought about our conversations and as I started trying to clarify my needs, I began to see a pattern in my behavior. It is this pattern I wish to

clarify: I block myself in everything—in physical competitions, in comprehension of school subjects, in communicating with others (by asking endless questions and not saying anything about myself), in not accepting my own worth (I have very little self-confidence). . . . What I want from you is aid in my process of exploration, to help me keep my objective—my rigidity—in view. From other members I want support in my effort.

Accepting the client's initial formulation of his difficulties and agreeing with his stated objectives, the worker, also in writing, responded supportively and emphasized that the group experience could be used to further these objectives.

Worker's comments on Miller Contract I (c₁). The worker replied:

Your objectives feel solid and real but convey some sense of premature closure to me. During the next several weeks let's both try to keep these objectives in mind as all of us (you, me, and other group members) struggle with how we can use one another to achieve these goals. You've made a fine beginning and I encourage you to use this new understanding as you try to work out relationships with other group members. In the meantime, I'll be available to you as you need help in using the group to achieve these objectives.

During a brief meeting prior to group, the client verbally expressed approval of the worker's clarifications and agreed to add these concerns to his own objectives. As a result of this pregroup process, an initial reciprocal contract (*d₁*) was arrived at by worker and client.

Because of the importance of establishing individual therapeutic objectives for each client, the reciprocal contract negotiation process should never be curtailed. The process performs an essential function in group treatment in that it provides the opportunity for establishing both the content of treatment (e.g., problems or needs) and clarification of the contextual elements which serve as the conditions on which the treatment may proceed, for example, the time, place, frequency, and cost of treatment. Failure to negotiate these terms successfully at the outset of intervention very often results in premature failure of treatment or at best leaves open a wide variety of contextual questions which interfere with its real substance, the reduction of personal problems and concomitant increases in individual problem-solving ability.

Because of their essentially dyadic nature, reciprocal contracts must be considered the private property of individual clients and the worker. They are not the property of the group as a whole and, like the independent contract, do not require group validation or approval for their effectiveness. Only worker and client must agree on its conditions. The terms of these reciprocal agreements may be stated either formally or informally and are subject to change in response to a fuller understanding of the client's difficulty (*d₁ → d₂ → d₃*). Indeed, one expects that such changes will occur as

the group process unfolds and, through periodic private meetings with the worker, clients can affirm their agreement to pursue essentially unchanged, modified, or entirely new sets of therapeutic objectives. Only the individual client and the worker must agree to pursue these revised objectives, thereby further promoting a process wherein individual group members are helped to achieve the high level of individuation essential to effective therapeutic intervention.

The Mutual Contract

Having already agreed to the terms of the independent and reciprocal contracts upon entering the group situation, the worker and client once again negotiate a new and entirely different contract between themselves and other group members.

The mutual contract of stage 3 requires that individuals, including the worker, reorganize or otherwise reintegrate their personal therapeutic objectives with those stated for the group as a whole. That is to say, clients must find some suitable means for redefining their idiosyncratic needs so that they are consistent with therapeutic objectives of the group process as a collective experience ($b_1 \rightarrow B_1$). Clients achieve this integration by weighing carefully the stated purposes for the group and, to the extent possible, making known the strength of their identification with the group purposes as therapeutic objectives which are consistent with their own sought-after goals. Similarly, the worker must integrate his personalized objectives for each individual client (c_1) into those for the group as a whole; in doing so he establishes a new set of therapeutic objectives for the group experience itself (C_1). As a result of this fairly complex process, worker and clients are helped to achieve a new, albeit tentative, mutual contract which contains the early objectives and *raison d'être* for the collective experience.

The following process recording illustrates the development of a mutual contract as part of an initial meeting of parents who sought help from a community mental health center "to learn better ways of responding to, and rearing, their children":

I began by reminding everyone that we were going to work this evening on a beginning statement of goals that would speak to their separate interests and our functioning as a whole group, as well.

After some time I asked if I could try putting into words what we had been talking about. With an okay from them, I tried: "We are going to meet and, by talking and listening and trying out some ideas with each other, see if we can understand our children and ourselves better and thereby be able to control our own and our children's behavior better." After repeating the statement a couple of times and giving them a chance to write it down, I asked if they thought that was enough to give us a start toward learning more successful methods of child rearing. They did; we suggested trying this out with a review in a few weeks. On that, the session broke up.

Table 1 shows that the mutual contract negotiation process involves consideration of all of the previously agreed-to reciprocal contracts with individual clients (d_n); an additional set of objectives maintained by the individual clients for themselves as group members ($b_1 \rightarrow B_1$) and, for the worker, an additional set of therapeutic objectives which reflect both individual client needs and those for the clients viewed as a collectivity ($c_1 \rightarrow C_1$). This process results in newer and more globally stated therapeutic objectives (E_1) which, if the experience is to be an effective one, reflect both individual and group-as-a-whole needs. Neither client individuation nor group-as-a-whole purposes need suffer losses to their essential integrity as a result of this process; on the contrary, the total experience should be enriched by the pursuit of individual and shared therapeutic diversity within the common framework of a mutually acknowledged and agreed-to set of objectives for the group as a whole.

A major responsibility for the worker at this stage of group development is to help clients retain their enthusiasm for pursuing personal objectives while also fostering their identity with the more collective objectives which must be achieved if the group experience is to help individuals attain their personal goals in the context of a group experience. The worker's initial attempt at defining the nature of help given and taken in the preceding recording is illustrative of worker behavior at this point.

Obviously, the mutual contract is the common property of all group members. No member may alter the terms of this agreement without the prior consent and approval of all other group members, including that of the worker. Similarly, the worker may not impose a new set of objectives on the group without their prior consent and approval.

Modifications to the mutual contract are expected to occur from time to time ($E_1 \rightarrow E_2$), a process which is intended to be deliberate, conscious, and purposeful in furthering the therapeutic ends of the group as a whole. When used in this way, renegotiation of the contract provides workers and clients with another opportunity for affirming their own similarities and differences as well as their common support for both the means and the ends of professional intervention. In the preceding example, the initial formulation of such goals was accepted by the parents as tentative and provisional and open to review and renegotiation. The members' sense of beginning investment in the goal statement may be seen in their suggestion of a definitive time for review.

The Interdependent Contract

The ideal contract in group treatment is the agreement arrived at during stage 4 of group development. The interdependent contract which is formed here (F_1) takes cognizance of the individual's private

concerns (a_1), those which he and the worker have already agreed to pursue together in the interest of the individual (c_1) and as a group member (d_1), those which other group members have also agreed to help the individual pursue with them in the context of group (B_1), those objectives which the individual and group hold for themselves in common as group members (E_1), and, finally, the individual's integration of the preceding independent, reciprocal, and mutual contracts within the common goals and purposes held by the various group members for the group as a whole (F_1). The interdependent contract reflects clients and worker functioning together as a common entity in pursuit of fully integrated individual, group, and group-as-a-whole therapeutic objectives.

The interdependent contract differs from the mutual contract of stage 3 in that, at stage 4, clients have resolved their preoccupation with personal rather than group objective conflicts and also feel less need to force their commitment to group-as-a-whole objectives. Member participation is more spontaneous, areas of interpersonal and intrapsychic conflict are more conscious, and in general clients feel themselves to be more fully engaged with others in the process of achieving significant areas of conflict resolution. The group possesses a special rhythm recognizable to individual participants who, together, are able to find an appropriate level of participation which furthers achievement of self and other therapeutic objectives. The defensive mechanisms which previously functioned as sources of problem perpetuation tend to be judiciously relaxed, and most group members feel themselves to be moving toward the realization of both separate and shared therapeutic objectives.

An excerpt from the worker's monthly summary of the parents' group referred to above illustrates the interdependent contract in action as a therapeutic instrument: "At a previously agreed-upon contract renegotiation point, six weeks after the initial meeting, the parents reviewed their understanding of the group's purpose and their progress to date. They recognized that each member had achieved some part of his personal objectives and that their development as a group had made individual progress possible. The members then agreed to continue to work toward achievement of their initial purposes as a group using the same approach taken during earlier meetings. . . ." When the contract can be cast in a form such as is suggested, it contains reference to the group as a whole, to the intended outcome, to group content, and to means of treatment. Member roles and worker roles are implied, if not explicit, thus suggesting something of group structure, as well.

Clearly, the interdependent contract is the common property of the group as a whole, since it contains all the purposes, goals, and objectives of the clients as individuals and as a collectivity. The contract also

incorporates the therapeutic objectives of the worker for each individual (d_n), those which he holds for the group as a separate entity (C_1), and those new goals or objectives which have emerged either from him or other group members as the group has progressed through various stages of group development ($B_1 \rightarrow B_3$; $C_1 \rightarrow C_3$; $E_1 \rightarrow E_3$). Like the reciprocal and mutual contracts, the interdependent contract should not be thought of as either immutable or rigid; on the contrary, the interdependent contract is subject to renegotiation at various points in time as client needs become further defined or as individual or shared purposes in using the group become clearer ($F_1 \rightarrow F_3$). This interdependent agreement is a dynamic one which can be used by both worker and clients to further self- and shared interests. Like the reciprocal and mutual contracts, the interdependent contract also dissolves once the group disbands, as its essential properties no longer exist apart from the individual member purposes which have gone into its construction.

Written versus Verbal Contracts

While specific reference was not made to the form of the contract, the uniqueness of each of the four contracts described above leads to considering casting one or more of them in written form. The private independent objectives of each group member would almost certainly not be written, inasmuch as they exist only within the individual client. At the other end of the group-relatedness continuum, the shared interdependent contract need not be committed to writing since the maturity of performance and functioning achieved at this level of group development would obviate the need for writing down the common understanding.

In the two middle stages of group contract negotiation, however, written contracts are useful in furthering both client understanding and group development. As we noted earlier, assurance of individuation is the hallmark of the reciprocal contract. Almost certainly the nature of the negotiation which is occurring at the reciprocal contract stage suggests the efficacy of a written rather than verbal contract. A major attraction at this point of group development for a written contract is the opportunity it presents both worker and client for achieving greater therapeutic clarity, specificity, and explicitness. The case of the graduate student was used to illustrate this point.

Written contractual revisions at appropriate points in the group's process increase worker sensitivity to the specialized needs of individual clients and, in so doing, contribute to the overall effectiveness of the group as it moves through time toward the achievement of stated communal purposes and goals. The use of a written instrument to effect this process will help to assure higher levels of individual and group goal attainment.

As the group qua group proceeds toward maturity as its own unique entity, the written contract will facilitate that process as the mutual contract is struck. The use of a written contract at this stage of group development has validity as a structure which enhances the existence of the group as a self-aware therapeutic milieu. In the act of capturing essential ideas in a form satisfactory to the several persons comprising the group, deeper treatment issues will be revealed as persons strive for phrasing which embodies their common concerns. Likewise in this negotiation process, as members accommodate to the demands and needs of others which can be met in this group experience, group norms begin to emerge and group cohesion begins to occur as members identify with each others' strengths and weaknesses. Where progress toward this end can be aided by casting agreements and understandings in written form, that activity between worker and clients is suggested.

In making the decision to use written or verbal forms of the therapeutic contract, the overriding consideration should be the anticipated therapeutic effect either form will have on individual group members and the group as a whole. We believe that there is nothing necessarily superior about either approach, with the sole exception that the use of written contracts during the reciprocal and mutual contract stages will contribute to an earlier identification of client problems and, with this, a firmer commitment to pursue more strongly focused therapeutic goals and priorities. In situations where workers seek to achieve these preidentified goals, such as in socioeducational and task-oriented groups, the use of written contracts is especially indicated.

Conclusions

The authors have sought to further refine the concept of the therapeutic contract in work with groups. We have suggested an analytic framework for use in understanding the complex nature of the contract as it evolves and changes over time. In the application of this framework, several distinct but interrelated individual and group-as-a-whole contracts have emerged. We have suggested that increased worker sensitivity to the contract in its various forms must exist if optimal levels of group goal achievement are to occur and if sought-after group member individuation is to be assured. Further, we have suggested that, because of its changing nature, the therapeutic contract is a central dynamic in the therapeutic process which, when used purposefully, furthers individual and group conflict res-

olution and contributes to increased client participation in both the means and ends of professional social work intervention.

Notes

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