Therapist – Client Congruity in Therapeutic Contracting

Therapists may identify clinical issues or "problems" that the client him or herself does not recognize as such. The attitude a client has about a given situation or issue qualifies their *motivation state.* True therapeutic motivation requires that the following criteria must be met:

1. The client comprehends the situation or condition the therapist has identified;
2. The client identifies that situation as a "problem" (ego dystonic);
3. The client regards that problem as being amenable to change;
4. The client views him/herself as the agent of change (i.e., internal locus of control *vis a vis* the problem).
5. The client wants to do something about this problem;
6. The client wants to do something about this problem now, in the therapy.

A client's attitude about a given problem may be quite fluid. Yesterday's "catastrophe" may be today's run-of-the-mill annoyance, and what I committed to work on last week may—this week—be insoluble, someone else's issue to change, or simply not worth the effort. Similarly, a client may adopt different motivations for different problems, have ambivalent motivation toward a given problem, or, in the case of tertiary dissociation (ego fragmentation), have one or more ego states invested in maintaining the problem.

Because a client must satisfy all six criteria above before s/he can be considered accountable for his or her behavior vis a vis the problem, it is premature to "problem solve" or entertain solutions until these criteria have been met. Table 1 below identifies five states of motivation and their characteristic presentation, or *verbal report,* and the client's coping style associated with each state. The verbal report represents statements a client may actually make about a problem, or may simply characterize the client's attitude.

Table 1. TYPOLOGY OF MOTIVATION STATES (Not a progressive or immutable sequence)

State #	Verbal Report	Coping Style
1.	"*What problem?"*	Denial; dissociation; avoidance
2.	"*Oh, that problem. That' s life!"*	Helplessness, Victim role;
3.	"*I hate that problem; I wish someone else would so something about it."*	Blame; external locus of controlMoratorium; fear/avoidance
4.	"*It's my problem, but I do not want to do anything about it (now, at all, with you)."*	Moratorium; Fear/avoidance
5.	*It's my problem; how do I solve it?*	Responsibility

Motivation, contracts, and mutuality

The dialectic nature of relationship implies that every encounter is a negotiation, each interaction is implicitly contractual. To speak is to implicitly request another to listen; to listen is to implicitly invite speaking, and so on. Each motivation state informs the type of *therapeutic contract* that unfolds. The therapeutic contract is an understanding of what the client wants from the therapist and what the therapist will provide in response. The contract has both tacit (or *de facto)* and explicit (nominal) elements that inform the purpose for the therapy in general, and the session in particular. A nominal contract that is congruent with the de facto contract is a signal of mutuality and forms the basis for a trustworthy therapeutic relationship.

However, elements of the contract are often incongruent, and/or therapists mistake the true nature of the client's *de facto* contract. Some therapists may assume that a client's complaint about a family member is an implicit request for *advice,* when what the client truly wants is *support, or validation*. Like motivation states, contracts are often fluid. This week I want *support* around issue X; last week I wanted *advice* around Issue Y, and so forth.

Table 2 lists the types of contracts that can characterize most therapeutic encounters, followed by a sample chief complaint and a brief description. Using the table as a guide, the therapist can conceptualize the client's motivation and match it to the appropriate treatment plan. Similarly, the supervisor can evaluate the client's motivation, either through audio or careful interview of the therapist. Supervisor and therapist can then evaluate the type of *de facto* treatment contract being offered to determine the mutuality of the therapy being delivered.

Table 2. A Typology of Therapeutic Contracts

Type	Chief Complaint/ Description
Ulterior motive/ HiddenAgenda	*My wife said she'd leave me if I didn't come. The court ordered me to be here.* This client is complying with some external pressure to attend treatment, but doe not really want help or think there's a problem. When the client conceals the external pressure, this qualifies as a "Hidden Agenda."
Consult/Advise	*We're here to find out if we need therapy. What do I do about my child's acting-out at dinner?* These are straightforward requests for an assessment or opinion about a specific problem.
Crisis Stabilization	*I'm going to kill myself! My brother thinks he's a banana and he's about to unpeel!* These are emergencies that require case management, crisis intervention, and support.
Supportive Counseling	*I just need someone to talk to. This is the only place I can unload... .* Seldom so clearly requested, this is a basic claim for empathic listening and validation, and probably constitutes the most common type of therapeutic interaction.
Problem Solving	*How do I get my kids to listen to me? How can we deal with the in-laws without fighting?* This is a straightforward request for the therapist's help in solving a specific problem.
Growth/Healing/ Differentiation	*I don't want to be anybody's victim anymore. I want to build self-esteem...become more assertive.* This is a request, perhaps by the more insightful or psychologically aware client, for personal growth. This contract implies a willingness to "work" on issues that transcend today's problems.

Table 3 outlines the contract types above along with the motivation state most likely associated with that contract, the therapist's role in the contract, and the length of time executing the contract might entail. The table serves to guide trainees as to what they might reasonably expect from the current treatment episode. This method helps the supervisor assess the therapist's progress at assessing motivation and delivering treatment congruent with the appropriate contract.

Table 3. The Relationship Between Therapeutic Contract and Motivation State

Contract Type	Motivation State #	Therapeutic Activity	Treatment Length
Ulterior Motive	1	Re contract	1-2 sessions
Consult/Advise	1 – 5	Advise; refer	1–2 sessions
Crisis Stabilization	2 – 5	Problem solve/ Case management	Brief
Supportive Counseling	2,3,4	Empathic Listening; Cultivate motivation	Ongoing,
Growth/Healing Differentiation	5	Family-of-origin work; problem solving; Skills development	long term

Conclusions:

The typology of motivation states guides the clinician toward a clearer understanding of the client's needs and coping style. Congruence along the various elements: de facto motivation, nominal motivation, therapeutic contract, and therapist activity ensures that the therapy is client-centered, mutually agreeable, and anchored in trust. In addition, this model suggests clues that may reveal the source of therapeutic impasse.