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RELEVANT TARGET POPULATIONS AND EXCEPTIONS

Contracts have proven to be appropriate for clients
with a wide range of behavioral goals. Behavioral contracts can be adapted or created to fit any number of different needs; whenever there is a need for a behavior to be more consistently performed, a contract may be useful. Research has shown that contracts have been especially effective with substance abuse, schizophrenia, obesity, anorexia, and student performance.

Contracting has been used extensively and successfully with substance-abusing clients. It has been used to increase attendance to appointments, compliance with treatment, and relapse prevention. Behavioral contracts with family members of substance-abusing clients also increase client compliance and produce better outcomes. Outcomes for dually diagnosed clients (with both substance abuse and mental health issues) have also been more favorable when behavioral contracting was used. Contracts with these clients have been successful in improving compliance to medical, psychiatric, and substance abuse treatment.

Contracts using negative reinforcement or "consequences" are often used with substance-abusing clients. Negative reinforcers are aversive consequences that are removed when the target behavior is performed. Negative reinforcers for substance-abusing clients often include job loss or a probation violation with the threat of returning to jail. Contracts using negative reinforcement have been especially effective with substance-abusing clients who hold positions of responsibility (e.g., medical doctors, psychologists, nurses, etc.). In these cases, the negative reinforcer is often a detailed letter addressed to the licensing board describing the client's substance abuse and surrendering his or her professional license; during treatment, the letter is held by the clinician. If the client is noncompliant with the contract (i.e., the client drinks or uses drugs), the clinician will send the letter to the board of registration.

Positive reinforcers are often used for clients on methadone. Clients with consistent clinic attendance are trusted to take home methadone doses for the following day rather than having to come into the clinic every day. For other substance-abusing clients, positive reinforcers often include simple things clients can give themselves or receive from friends or family members (e.g., free babysitting, rides to therapy and meetings, buying something special, etc.). Positive reinforcers are not effective for abstinence in the short term, but they give clients something to work for while they are developing new habits and finding new ways of spending time.

With schizophrenics and dually diagnosed clients (those with mental illness in addition to substance abuse), behavior contracts have been particularly helpful in compliance and monitoring of psychiatric and medical treatments.

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Behavioral contracts are used to increase compliance with weight loss. Behavior contracts may include when, where, or what foods to eat. Reinforcers may include rewards from the client or the client's family. Behavioral contracts are also used to increase weight gain (see example above).

Suicide (or safety) contracts should be used carefully and must not be the primary intervention. It is generally agreed that suicide contracts provide more false reassurance to the clinician than prevention for the patient. With suicidal patients, detailed safety plans, an infusion of hopefulness, alleviation of depression, identification of triggers, and rehearsal of coping skills are more effective. A behavioral contract can be built around one or more of these interventions.

Behavioral contracting is also used extensively for decreasing juvenile probation violations, increasing prosocial behavior in conduct-disordered youth, ameliorating behavior problems in children, and enhancing student performance.

COMPLICATIONS

Several complications can arise when a contract is implemented. First of all, if a contract is developed before there is enough rapport between therapist and client, that contract may become a source of resistance in the therapy. The client may not yet have enough trust in the therapist and may experience the contract as a punishment by the therapist rather than an aid to treatment. This is often a risk in substance abuse treatment, since there is generally a good deal of shame about substance use, and the client may be unable to trust easily.

Contracts can be ineffective and damage the therapy if the tone of the contract becomes angry, punitive, or paternalistic. This may be due either to lack of training or underlying feelings on the part of the therapist. This s especially a risk in mandated treatment or when the therapist (rather than the client, the family, the probation officer, judge, etc.) is in control of the contingency.

Contracts may not be effective if the client is not included in creating the contract. Contracts are most effective if the client chooses the target behavior and wants the behavior change. However, in the case of clients mandated to substance abuse treatment, the client does not often share the same goal. However, it is important to identify something the client is motivated to do (to maintain a job, for example). This goal is clearly related to substance abuse recovery, and the contract will be more effective if this goal is incorporated into the contract.

Just as clients should be included in choosing target behaviors, clients should also be included in choosing reinforcers. The range of items that is reinforcing or motivating varies greatly from person to person. Money and food are primary reinforcers and

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are reinforcing to almost everyone. However, these reinforcers are not always available, and their use as contingencies is not ethical in many situations. Other, secondary reinforcers vary among individuals. A contract will not be effective if the client is not interested in obtaining the reinforcer.

Neither can contracts be effective if the client does not yet have the skills to perform the behavior. If this is true, then no amount of motivation and no type of contingency will be effective in getting the client to perform the behavior. If the client cannot yet exhibit the behavior at will, then skills training is indicated. Often, clients merely agree to the contract and are not really invested in the contract or the treatment.

In these cases, it is important to thoroughly question clients about their motivation to change. Sometimes when clients appear unmotivated, they are actually experiencing hopelessness; the client does not actually believe the contract will help. In these cases, the therapist must impart confidence that the treatment can work and hopefulness that the client will be able to change.

It is common for spouses and other adult family members to be involved in a client's substance abuse treatment. However, the role of the spouse in the therapy must be clearly defined. It is not the role of the spouse to enforce the contract or to remind the client to behave in a certain way; that is an impossible task, since the spouse does not have control over the client's behaviors. More important, it will create more stress in the relationship and may reinforce an existing dysfunctional pattern. However, the spouse can and should report to the therapist what he or she observes about the client's behaviors.

As noted above, "contracts for safety" (contracts implemented to prevent the client from attempting suicide) are not contraindicated, but they must be used carefully and in conjunction with other intervention in order to be most effective.

CASE ILLUSTRATION (INCLUDING BEHAVIORAL ASSESSMENT)

"Tiffany" was in a psychiatric day program. She had lost more than one job due to her angry outbursts at coworkers. In the past, she had yelled at others, using profane language, and once damaged a cash register by punching it. Tiffany said that she was not sure why she had the outbursts and that they came on quickly. She genuinely wanted to be successful at holding a job and to be better able to provide for her two boys. When Tiffany and her therapist, "Dr. Kim," examined the behavior together, they concluded that it happened almost daily on the first week of a job and lasted about a minute. After the first weeks of the job (if she was still employed), Tiffany's outbursts diminished to about once a week, but were at a higher intensity and lasted up to 5 minutes. Dr. Kim did a behavioral analysis of the antecedents and found out that criticism (be it real or imagined) triggered these inappropriate expressions of anger. The two of them defined some appropriate, assertive responses to criticism, and Tiffany

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practiced these with Dr. Kim. Tiffany contracted that over the next week, she would practice the skills in the group therapy sessions, practice an assertiveness script with friends, and in addition, she would go into the community twice that week and practice assertiveness exercises.

Tiffany came back to therapy and had met the contracting goals. Dr. Kim expressed warm approval. Tiffany thought she still had a long way to go, but she was proud of herself and more hopeful that she might actually be able to change her behavior after all these years. At this meeting, she and Dr. Kim contracted that she would continue practicing the assertiveness skills in the community; in addition, she would apply for a job in a preemployment workshop.

Once Tiffany had obtained a job in a preemployment workshop, she would be contracting to practice her new skills at the workshop. Her behavioral contract would continue to change weekly, to reflect new goals. The contracting would continue until she was successfully maintaining a job. The therapy would then focus on relapse prevention skills. Tiffany would be contracting to practice skills to prevent her from sliding backward. When that was accomplished, therapy would decrease in frequency until she proved to be stable after 3- and 6-month checkup visits. *—Anne F. Philips*