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## The Three-Cornered Contract in Psychotherapy of the Adolescent and their parents

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### Abstract

Transactional analysis has made an indisputable contribution to thinking about the contract, its formulation, and its importance in the process of psychotherapy. The article presents the concept of contract and the process of contracting in the perspective of transactional analysis and its implications in the field of psychotherapeutic practice, with particular emphasis on individual psychotherapy of adolescent patients. Erik Berne's (1966) classic concept of the contract and Fanita English's (1975) three-cornered contract are discussed, together with a special focus on the analysis of overt and covert processes leading to success and failure in adolescent therapy from the perspective of relational transactional analysis (Hargaden, Sills, 2002). The article also describes the specific problems a psychotherapist may encounter in therapeutic work with an adolescent and their parents from the perspective of the developing tripartite relationship.

**Keywords:** contract, contracting process, contract levels, three-cornered contract, adolescent psychotherapy.

### Introduction

The inspiration to write this article came from a problem that often appears in conversations with child and adolescent psychotherapists or during group supervision. Therapists working with under-age patients repeat that the most dif-

difficult aspect of their work is in cooperation with the parents of the patient. This answer hides many difficult experiences and dilemmas experienced by therapists. These often include serious difficulties in building an alliance with parents even when the adolescent is motivated to seek help. The sources of these difficulties are very different and can be divided into three groups: 1) denial of the child's problems, 2) unrealistic expectations as to the course and effects of therapy, and 3) problems with taking into account one's participation in making changes in one's functioning, especially when they are important for the realisation of the adolescent's goals. Examples of these sources in clinical work can be as follows: inadequacy of expectations towards the psychotherapist (e.g. "my daughter needs a father"; "my son needs to have certain issues explained to him in a manly way") or questioning the competence of the psychotherapist in situations of experiencing anxiety, observing the child's developing positive alliance with the psychologist. "Taking" the patient away from therapy at important moments crucial for its success or passively destroying the beneficial changes worked out together with the adolescent are other possible sources of conflict in the psychotherapist-parent relationship (Glita, 2016, pp. 71–73). A threat in such a situation is also the loss of therapeutic neutrality, understood as remaining at an equal distance (emotional and cognitive) from all the parties participating in therapy, both at the psychological and behavioural level. The danger is "taking sides" and unconsciously playing out the internal conflict in the therapeutic relationship, e.g. focusing too much on diagnosing the parents while ignoring the patient, or unconsciously constructing a situation in which the adolescent is in a conflict of loyalties between the parents and the psychotherapist. This kind of experience on the part of both the patient and the psychotherapist and the accompanying emotional reactions may lead to a breakdown of the therapeutic alliance and, as a consequence, premature discontinuation of the adolescent's psychotherapy process (Cierpiałkowska, Frączek, 2017).

This article aims to analyse the phenomena occurring in the psychotherapist-patient-parent relationship during the conclusion of a contract according to the assumptions of transactional analysis and to propose ways of understanding the mechanisms occurring in the process of psychotherapy of an adolescent, which will allow reducing the risk of becoming entangled in an unfavourable ("three-cornered") interaction with his parents and may help maintain a professional and stable position towards the patient and his parents/legal guardians.

## **The concept of a contract in transactional analysis**

A unique concept in understanding and dealing with the dilemmas and conflicts described above, and then applying the understanding to clinical practice,

is the concept of a contract. Transactional analysis – often defined as the contract method – shows a unique understanding of the contracting process. It provides an understandable yet highly complex tool that takes into account the multilevel nature of the relationship with the adolescent patient and their parents (Rotondo, 2020, pp. 236–237). The contract for transactional analysts is considered fundamental for the proper course of treatment, especially the therapeutic relationship and alliance regardless of the form of psychotherapy proposed (Cierpiąłkowska, Frączek, 2017, p. 132).

The most quoted and best-known definition of a contract as proposed by Eric Berne in his book *Principles of Group Treatment* is: “[...] an explicit bilateral commitment to a well-defined course of action”\* (Berne, 1966 for: Stewart, Joines, 2016, p. 353). The founder of transactional analysis emphasised that one of the most important foundations of this approach is the relationship that arises between the psychotherapist and the patient, a relationship based on the capacity for autonomy, embedded in a specific context (social or cultural) that cannot be ignored, and the awareness that the patient is functioning in a system of family relationships that must be taken into account when entering into a contract with an adolescent (Rotondo, 2020, pp. 241–242).

The classical assumptions formulated by Berne find far-reaching additions, taking into account yet other aspects and elements. Some authors focus more on the conditions a person has to fulfil to enter into a contract (i.e. which Ego states should participate in the formation of the contract), others on its usefulness and significance for the involvement of the patient and therapist in the therapy process or the assessment of its progress, others on various problems and difficulties in the process of entering into a contract. However, with time the classical definition has been extended by adding other elements, thus complementing the understanding of the contract with additional dimensions. Muriel James and Dorothy Jongeward (1994, p. 313) define a contract as: “an Adult commitment to one’s self and/or someone else to make a change” or “a clearly expressed commitment made by an individual to a therapist, a therapy group, or himself, and concerning the achievement of a specific goal representing a certain stage of therapy” (1994, s. 354). Ian Stewart and Vann Joines (2016, pp. 353–355) define a contract as a situation in which “the client sets out the changes they want to make and specifies what they can do to make those changes happen. The practitioner states whether he or she will undertake to work with the client towards achieving his or her dream change, and specifies what his or her contribution to this process will be.” In conclusion, the therapist using different theoretical assumptions and clinical experiences concerning the contract encourages the patient to make a transparent, bilateral commitment,

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\* All translations – A. Machnia.

clearly and precisely defining the aim, tasks, and tools to be used for its implementation. Making a contract encourages the patient to take joint responsibility for the outcomes of the psychotherapy process (Berne, 1966, p. 362).

Steiner (1994) specified and described four conditions of a contract adequate to the patient's expectations and needs, the inclusion of which during the contractual process protects the patient and therapist from the realisation of hidden (scripted) expectations and resistance to change:

- 1) mutual consent (voluntary; both parties agree to the contract),
- 2) fair exchange (the type of remuneration must be clearly defined and agreed upon by both parties: the therapist receives a fee, the patient receives professional help),
- 3) competence (of the therapist to provide diagnosis and psychotherapy, of the patient to understand the meaning and sense of the contract),
- 4) legality (conformity of the contract with the cultural, ethical, and legal norms in force in the given country and described in the association the psychotherapist belongs to).

Other transactional analysts add a condition to the proposed list, namely the reality of the contract – i.e. a goal formulated in such a way that it is achievable from the perspective of the patient and therapist (Frączek, Smelkowska, 2016).

In summary, the contract is an agreement between the Adult ( $A_2$ ) and the Parent ( $P_2$ ) of the psychotherapist and the Adult ( $A_2$ ) and Parent ( $P_2$ ) of the patient, supported by the Child ( $C_2$ ), formulated in a language adapted to the patient's capacity, in which the decision is clear and realistic. The contract allows for the disclosure of contradictions between the patient's expectations and the limitations of the psychotherapy process, for the analysis of the complaints made and the formulation of the problem, for the clarification of the nature of the relationship (the goals become visible to all parties to the contract), for the mobilization and motivation by clarifying specific goals, for protection against sabotage and resistance (Cardon, Mermet, Thiriet-Tailhardat, 1995).

Berne distinguished three levels of the contract: administrative, professional, and psychological. Analysing the contract from the perspective of all these levels helps to create a safe and transparent space between therapist and patient, which allows the psychotherapy process to be conducted effectively and ethically in the direction desired and agreed upon with the patient (Sills, 2006, p. 9; cf. Table 1). If the patient is an adolescent, it is important to discuss the various levels also with the parents of the adolescent. In the event of the professional level, it is important to agree with the adolescent in what form and when the parents will be introduced to the objectives set during the consultation meetings. Conducting psychotherapy of a teenager in the TA trend leaves the therapist free to decide whether to discuss the goals of therapy with parents. I implement this stage of work in such a way that I first establish and dis-

cuss it with the teenager and then invite parents to a joint consultation, during which the teenager presents the established goals to the parents. See Table 1 for a description of the contract levels.

Table 1  
*Contralateral levels according to E. Berne*

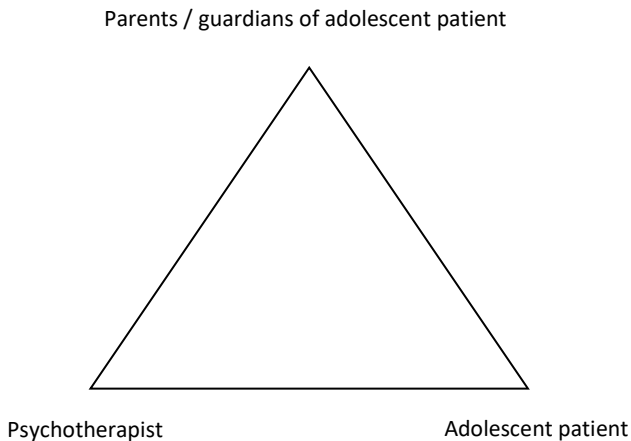
Contract level	Summary
ADMINISTRATIVE	<p>It defines the scope of work, creates a safe space for further psychotherapeutic work, i.e., time and place of psychotherapy; amount and payment for sessions; audio and video recordings, participation or access to information of third parties, i.e., observers, parents, guardian, teacher; ways to renegotiate the contract; describes the principle of discretion and exceptions to it, and the process of supervision of the psychotherapist.</p> <p>In the event of short-term work, the number of sessions, the conditions of termination, and the ways of renegotiation/renewal of the contract.</p> <p>The rules of the institution where the therapist works (office, counselling centre, hospital, school, etc.), i.e. the regulations of the institution, internal arrangements.</p>
PROFESSIONAL	<p>Commonly agreed psychotherapy goals with the patient and his parents, often preceded by a phase of listening to the patient's complaints and problem definition.</p> <p>Description of the approach, tools, and working methods. Guidelines on how to conduct psychotherapy (e.g. disclosure of free associations, homework).</p> <p>Explanation of what psychotherapy is and what it consists of, some therapists describe the methods they use. If bodywork techniques are used, a thorough discussion and explanation of the method.</p>
PSYCHOLOGICAL	<p>The relationship between the contracting parties and the psychological processes involved. Unspoken and often unconscious expectations of the patient and his parents towards the therapist and the therapist towards the patient and parents.</p> <p>Analysis of possible sources of psychological coercion and their influence on the relationship and the psychotherapy process.</p> <p>Checking whether the patient does not come to therapy to confirm scriptural beliefs – analysis of psychological games, elements of the script (especially elements inaccessible to the patient's awareness), the consciousness of the occurrence of hidden double transactions, and the third principle of communication, roles in Karpman's drama triangle, analysis of transference and counter-transference.</p> <p>Analysis of observed defence mechanisms based on splitting, e.g. projective identification, various forms of idealization, devaluation, and fantasies about the psychotherapist.</p>

Source: own elaboration based on Terlato, 2017; Hargaden, Sills, 2002; Sills, 2006; Frączek, Smelkowska, 2016; Hay, 2009; Grzegółowska-Klarkowska, 1986.

Over the last few decades, the concept of contracts has been developed by many transactional analysts. An interesting perspective is offered by Holloway and Holloway (1973; Rotondo, 2020, pp. 241–242). They describe and explain two types of contracts: the autonomy contract, which is concerned with working at the level of the script, the structural model and the process of re-decision, and the social change contract, which is concerned with working at the level of ego states, the functional model and the economy of recognition signs. Another example of contracts i.e. “hard” and “soft” contracts and the contract matrix is exhaustively described by Charlotte Sills (2006, pp. 19–26).

### The three-cornered contract and therapeutic alliance

Two people can enter into a contract whose subject matter relates solely to the relationship between them (a bilateral contract). However, if their arrangements involve the participation of third parties e.g. parents, guardian ad litem, school psychologist, they must ensure that the three-cornered contract (between three parties) or multipartite (more than three parties) contract is formulated and is known to all parties involved.



*Figure 1*  
Three-cornered contract

Source: own elaboration based on English (1975).

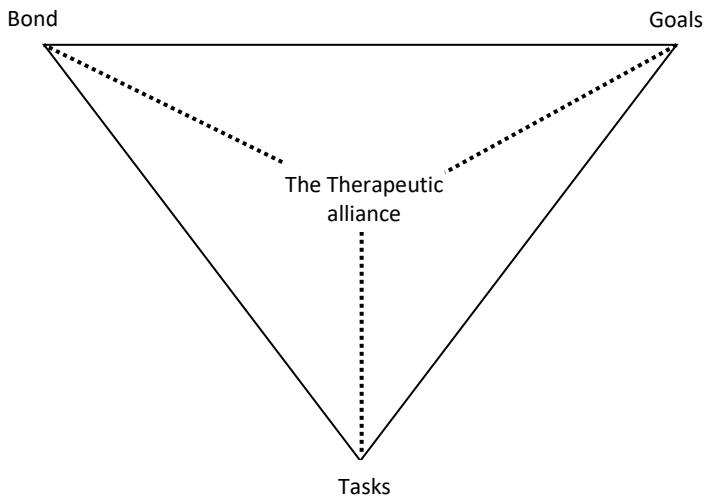
Three-cornered contracts are an integral part of psychotherapeutic work with adolescents (English, 1975). The psychological distance between the parties involved in the contract is represented by an equilateral triangle (cf. Figure 1) – this is an illustration of a three-cornered contract in which the goals of the work

are transparent and realistic and the decision of each party is conscious and voluntary. In other situations, there may be an imbalance between the parties involved, which can be represented by the isosceles triangle, which illustrates a shortening of the distance with one party to the contract and an increase with the other (Rotondo, 2020, p. 247). This usually occurs when, in the contracting process, the clinician omits to analyse any of the levels of the contract (cf. Table 1) or any of the conditions for a good contract described by Steiner (1994). The transactional analysis does not propose the only valid procedure for building a relationship with an adolescent patient, rather it focuses on analysing the consequences for the therapeutic alliance depending on whether the initial consultation took place first with the adolescent's caregivers or with the adolescent himself (Frączek, 2020, pp. 881–882).

The three-cornered contract between the psychotherapist, the adolescent, and their parents should take into account not only the principles and rules of a bilateral contract but also the relevant issues and specifics of a multilateral one. Usually, after an initial consultation conducted separately with the parents and the adolescent, the psychotherapist proposes a joint meeting for all parties involved in the treatment process. This is the time set aside to present the established goals and to discuss the degree of commitment of each party in achieving them. Three issues specific to the three-cornered contract deserve special attention. Firstly, the psychotherapist in the joint consultation must reveal the emerging mutual expectations of all parties to the contract: parents towards the adolescent, adolescent towards the parents, parents towards the psychotherapist, psychotherapist towards the parents, adolescent towards the psychotherapist, and psychotherapist towards the adolescent. Secondly, it is important to establish clear and distinct boundaries for communication between psychotherapists, adolescents, and parents, with particular attention to the transfer of content from the relationship with the adolescent to the relationship with the patient's parents. The principle of discretion has a significant impact on building and maintaining the strength of the therapeutic alliance with the adolescent, so it is extremely important to establish what information, under what circumstances, and in what way will be communicated directly to the parents (e.g. situations threatening the life or health of the patient or others) and what will be discussed during the session with the adolescent and only then communicated to the carers as agreed. This dilemma also relates to placing boundaries on parents who inquire about their child's progress towards goals while omitting their participation in obtaining feedback (Frączek, 2020, pp. 883–884). The third point concerns the situation of modifying or changing a pre-established contract. Discussing and naming possible ways of modifying the contract gives the parents an understanding of the procedure according to which the work of the adolescent and the psychotherapist proceeds without involving them in the content of

the individual sessions. For example, a specific number of sessions can be agreed upon with the parents to exchange feedback on the implementation of the therapy plan at the beginning, middle, and end. This allows the caregivers to adjust their expectations and, above all, to be an ally in the adolescent's process of change, which is also a change of the whole family system (Rotondo, 2020, p. 245).

Bordin (1994), after conducting numerous studies on the effectiveness of psychotherapy, described a model in which he assumes that the effectiveness of psychotherapy depends largely on the quality of the therapeutic alliance, which includes: 1) the patient's level of participation in negotiating the key goals of therapy (the cognitive component), 2) the tasks relevant to achieving the goals set, specific to a particular school of psychotherapy, and 3) the strength of the bond, i.e. the feeling of being accepted, respected and liked (affective component; cf. Fig. 2). In other words, the psychotherapist and the adolescent patient (and his/her parents) have a clear common agreement about the purpose of their work – the direction and the desired outcome. They have clarity and understanding of how the therapy will work and what each party's role will be in this endeavour (tasks) and that the psychotherapy process will be conducted in an atmosphere of mutual respect and empathy. For transactional analysts, the first two points are the significant and main focus of the contract. The third concerns the empathic relationship which, according to Helena Hargaden and Charlotte Sills, is the “heart and cornerstone” of the psychotherapy process in relational transactional analysis terms (2002, p. 55).



*Figure 2*

The therapeutic alliance

Source: compiled from Cierpiałkowska Frączek, 2017.



Transparent and understandable contracting on each of the levels described above (cf. Table 1) with every person involved in bringing up the adolescent (cf. Figure 1) protects against conflicts and misunderstandings and limits attempts to sabotage the changes made in the therapy room in the psychotherapist-patient-parent relationship. Therapy with the adolescent is always a three-cornered (and sometimes multilateral) contract, thanks to which it is sometimes easier to come to an agreement with the parents/legal guardians/school about the intended purpose of the work, but not always with the adolescent – work in a psychologically forced situation often fails (Pierini, 2014, pp. 109–111).

In summary, traditionally in transactional analysis, the focus on the contract emphasises the responsibility of the patient and therapist to define and achieve the desired change. The three-cornered contract clarifies and describes the mutual commitment regarding what the contralateral parties are doing and that each has different roles and responsibilities. It takes into account the active participation of the patient in achieving the agreed goal. At the same time, it is a dynamic tool, evolving with the development of the psychotherapist-patient-parent relationship and each stage of the adolescent psychotherapy process implemented (Rotondo, 2020, pp. 241–242). However, regardless of the form of psychotherapy, the therapist and the patient (and his/her parents) must have a common understanding of why they are together in the office, what rules and principles they commit themselves to, that they can name the problem they are presenting and the goal they are going to pursue together, and that they have an agreement on the course of therapy (Hargaden, Sills, 2002, p. 56–57).

### **Non-recognitions and recognitions and their significance for the contract**

No matter how precisely the contract (goals) is defined and the contractual framework (principles and rules) is discussed, and no matter how much the therapist is aware of the benefits and losses of the contract, in every process of psychotherapy, there are issues related to its ambiguity (i.e. the psychological level of the contract, hidden double transactions, situations of renegotiation of a previously agreed contract, nonrecognitions, scripting, transference, and countertransference, etc.). Attempts to control these unconscious processes and phenomena in the patient and the relationship between the patient and the therapist may cause the very essence of psychotherapy to be lost. The relational approach analyses with greater attentiveness the unconscious processes that emerge in the therapeutic relationship as the healing process unfolds (Hargaden, Sills, 2002, pp. 27–30).

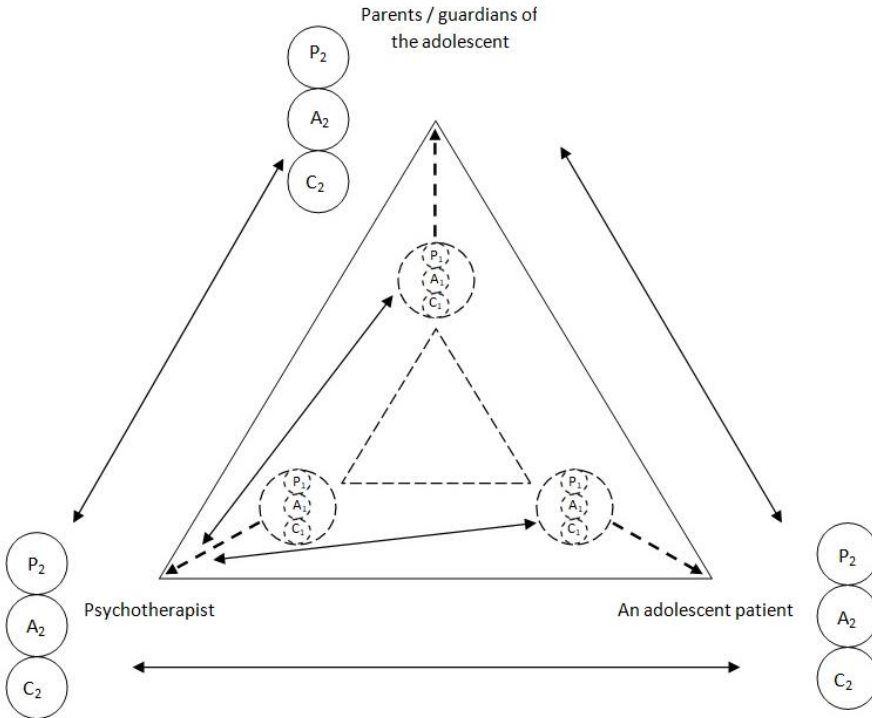


Figure 3

Three-cornered contract and contract levels – integration of concepts

Source: own elaboration.

In Fig. 3 and attempt was made to graphically present the dependencies which we observe in the process of psychotherapy of a teenager, taking into consideration: 1) the persons involved in the treatment process, i.e. the adolescent, the parents, and the therapist (cf. Fig. 1), 2) the levels of the contract described by Berne (cf. Table 1) and 3) the Ego states in the structural model, which are activated both at the conscious level (I present this employing a continuous line) and at the unconscious level (dashed line) during contracting. The figure shows a slice (as if frozen in a frame) of the contracting process, which in its nature is a dynamic and changing process during psychotherapy. The contracting process presented above is a very complex and complicated activity, which is certainly subject to further analysis in subsequent stages of therapy. Monitoring the processes that the transactional analyst should take into account to maintain the balance between the work with the conscious and the unconscious part is important both in the process of contracting, which is the result of the consultation and in the changes of the contract (concerning the goal and tasks) during the process of psychotherapy.

When the therapist concentrates too much of the contract setting mainly on the conscious level i.e. between Ego states ( $P_2$ ,  $A_2$ , and  $C_2$ ) more accessible to the patient, parent, and psychotherapist by focusing on the analysis of the administrative and professional level of the contract, there is a risk of overlooking the processes present on the unconscious level i.e. the Ego states  $P_1$ ,  $A_1$ , and  $C_1$  and not taking sufficient account of the psychological level. In a three-cornered contract, there may be an additional danger that at one time the psychotherapist has to take into account what is happening at the unconscious level (i.e.  $P_1$ ,  $A_1$ , and  $C_1$ ) in the adolescent, at another time in the parents/legal guardians. Each party may unconsciously play out their hidden desires and conflicted expectations in the relationship, thereby boycotting or hindering (persisting in resistance) by activating defence mechanisms the achievement of change in psychotherapy.

The sense of security and predictability that the contract provides does not exempt the psychotherapist and the patient (and parents) from the fears and uncertainties that are part of the change process in psychotherapy. The transactional analysis emphasises that the most important function of the contract is to give structure in the often unclear (to the patient) psychotherapeutic process (Terlato, 2017, pp. 12–13; Sills, 2006, p. 9). This carries both a risk of loss and a potential gain. On the one hand, it may lead the therapist to focus so strongly on the conscious aspect of the contract that he/she activates unconscious defences against the complexity of what may arise in the relationship and the psychotherapy process. The therapist's defences may consequently lead to a limitation of creativity and competence (access to the Adult) on both the patient's and the therapist's side and to sustain the illusion of control and predictability (Terlato, 2017, pp. 12–13). On the other hand, it is an opportunity to build a stable therapeutic alliance with the patient, which will be the basis for achieving the established goals of psychotherapy (Cierpiąłowska, Frączek, 2017).

In contemporary relational approaches, alongside the classical understanding of the controlling function of the contract, greater therapeutic significance is attributed to the analysis and understanding of the complexity and multidimensionality of the therapeutic relationship at both conscious and unconscious levels (Hargaden, Sills, 2002, p. 55; Terlato, 2017, pp. 8–9). Focusing on one aspect of these complex processes causes various problems. A therapist who focuses excessively on the conscious aspects of the contract, i.e. the patient's conscious decision to participate in psychotherapy, may fail to take into account the unconscious aspects that emerge as the relationship develops. In the opposite situation, when the therapist focuses exclusively on the unconscious aspects of the contract it can lead to a disregard for what has been established at the conscious level (administrative and professional level). In other words, omitting to explain to the patient that what happens at the unconscious level (psychological

level) is related to what is established at the conscious level can lead to additional confusion and ambiguity for the patient. Whatever the source, the therapist may lose attention to the vital information flowing from the relationship that develops between them and the patient. A relationship of which the therapeutic alliance is an important element, being complex, ambiguous, and subject to constant natural and continuity-threatening fluctuations in therapy (Cierpiąłkowska, Frączek, 2017, pp. 131–133). In other words, the desire to control and include the patient into the contracting process plan may impede the development of the transference and countertransference process, thus blocking the possibility of the patient's unconscious relational needs to emerge (Hargaden, Sills, 2002).

The dynamics of the activation of transference reactions related to the obstruction of contractual goals can be observed both on the part of the adolescent and the parents. This requires the therapist to be particularly attentive to the most significant processes that are already set in motion during the initial consultation with both the adolescent and the parents, with particular attention to when the parent may step in and try to change the goals of the therapy, which are related to the activation of their unconscious processes, e.g. denying the experience of anxiety, observing the developing positive alliance between the child and the therapist may become a source of aggression (e.g. the parent forgets to provide the child with money or to inform about a planned departure at the time of the meeting) and, as a result, interrupt the process of the adolescent's therapy. The balance between working on the conscious aspects of the contract and taking into account the emerging competing goals that emerge on an unconscious level in the adolescent and parents is a very important competence not only relevant during the contract with the patient, but also during the whole process of psychotherapy.

## **Conclusion**

The presented issues show that the most important thing is to maintain the balance between the analysis of conscious and unconscious processes that appear in the relationship during the contract with the patient and his parents. The psychotherapist's ability to observe clinically significant indicators of unconscious mechanisms on the part of the parent is a helpful process in sustaining effective psychotherapy of the adolescent. It seems, however, that this is a state to which, like autonomy, we are constantly striving and that it seems impossible to achieve a constant and unchanging level, especially when we treat each patient as a conscious, spontaneous, and capable of intimacy individual who realizes being autonomous in many different ways.

In conclusion, a very important skill for every therapist working with adolescent patients is to establish a transparent, understandable, and feasible contract in the initial phase of work with the patient, taking also into account the context and expectations of his parents. It is helpful in this respect to improve one's qualifications, to have one's work regularly supervised, and to have one's psychotherapy. In other words, a constant search for one's professional path and increased awareness of oneself and one's relations.

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## Specyfika kontraktu trójstronnego w pracy psychoterapeutycznej z adolescentem i jego rodzicami

### Streszczenie

Analiza transakcyjna wniosła niepodważalny wkład w myślenie o kontrakcie, jego formule i znaczeniu w procesie psychoterapii. W artykule przedstawiono koncepcję kontraktu i procesu kontraktowania w ujęciu analizy transakcyjnej oraz jej implikacje w obszarze praktyki psychoterapeutycznej, ze szczególnym uwzględnieniem psychoterapii indywidualnej pacjentów nastoletnich. Omówiona została klasyczna koncepcja kontraktu Erica Berne'a (1966) oraz kontraktu trójstronnego Fanity English (1975) wraz ze szczególnym uwzględnieniem analizy jawnych i ukrytych procesów prowadzących do sukcesu i porażki w terapii adolescenta z perspektywy relacyjnej analizy transakcyjnej (Hargaden, Sills, 2002). W artykule zostały opisane także specyficzne problemy, na jakie może natrafić psychoterapeuta w pracy terapeutycznej z nastolatkiem i jego rodzicami z perspektywy rozwijającej się relacji trójstronnej.

**Słowa kluczowe:** kontrakt, proces kontraktowania, poziomy kontrakt, kontrakt trójstronny, psychoterapia nastolatka.