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CONCEPTUAL ARTICLES

'What Difference Will That Make?' – Contracting More Collaboratively in Solution-Focused Brief Therapy

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Solution-focused (SF) therapists often advise that if a client requests particular therapeutic processes then therapists should redirect the conversation towards outcomes. If the client hasn't yet consented to SF therapeutic processes – or has requested different processes – then controlling the conversation in such a manner could be described as an act of dominance and could be counter-therapeutic. Alternatively, responding to the request would demonstrate respect. Research suggests involving clients in decisions about their therapy has clinical benefits.

Solution-Focused Brief Therapy (SFBT) is described by Ratner, George, & Iveson (2012, p. 3) as a 'method for talking with clients' that 'holds the view that the way clients talk about their lives [...] can help them to make useful changes.' O'Connell (2001, p. 1) states it 'aims to help clients achieve their preferred outcomes by evoking and co-constructing solutions to their problems'. For Shennan (2024), SFBT sessions 'focus mainly on the person's hoped-for future, and on progress that they are making towards it'.

SF therapists therefore use this 'method for talking' to co-construct a dialogue around a client's 'preferred outcome' or 'hoped-for future', which they seek to elicit. In cases where clients talk about what therapeutic processes they want rather the outcome they would like, then solution-focused (SF) writers advise redirecting the conversation back towards outcomes. In this paper, I'll consider the position of the SF therapist following this advice and the possible position of a new client. I will then point out the therapeutic risks entailed in following standard SF practice and will then suggest how SF therapists can modify their approach to mitigate these risks. Much of this discussion will be applicable to therapists of any modality when clients have not deliberately chosen to work with their approach.

To situate myself in this discussion, I am a keen practitioner of SFBT and admire many of the SF writers that I cite here, so this is very much a friendly critique. I'm also trained in another modality of psychotherapy and have

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worked, teaching and practising therapy, with colleagues and students from a variety of modalities, so see myself as an SF therapist who is embedded in the wider therapy milieu. When I refer to 'therapy' in this paper, I am referring to individual therapy and treating 'therapy', 'psychotherapy' and 'counselling' synonymously – as clients might.

The beginning of therapy

This paper concentrates on the very earliest dialogue of two individuals; an SF therapist who is aware of the advice of the leading authors in SFBT, and a new client who may have their own expectations about what is to happen in therapy. I will consider each respectively to provide a context for my later discussion of the risks of this prevailing advice.

The SF therapist's plan of action

As I will show, SF therapists intend that they and their clients talk about outcomes at or very near the start of a session. I'll then present the advice given in SFBT for situations in which a client wants to talk about something else.

'In the first session the solution-focused practitioner seeks to make a contract around the best hopes of the client,' O'Connell (2016, p. 39) states – 'within the first five minutes,' according to Ratner et al. (2012, p. 63). Steve de Shazer, one of the founders of SFBT, believed that brief therapy should be organised around client goals (Korman et al., 2020). For example, he described the 'miracle question', an SF intervention, as 'by far the simplest way I have ever developed to help clients state goals in concrete, behavioural terms' (De Shazer, 1990, p. 96). This theme of outcome – often to be framed in concrete behavioural terms - is taken up in subsequent attempts to describe and manualise SF practice.

For example, the European Brief Therapy Association's book on Theory of SF Practice states that 'everything in the [SF] conversation aims at supporting the client's meaningful acting to make their values happen in the future' (Sundman et al., 2020, p. 40). BRIEF, an influential SF training company, state in their manual that 'follow-up sessions start by exploring what clients have done since the previous meeting that is regarded as "better", and more generally what clients have done that is useful to them' (George et al., 2020, p. 5). The Solution Focused Brief Therapy Association's treatment manual says that the setting of concrete goals is an important component of SFBT and that useful goals are 'stated in behavioural terms' (Bavelas et al., 2013, p. 9). None of this emphasis on behaviour is to claim that SF therapists never talk about emotions and feelings along the way, acknowledging them and perhaps asking about them, but that 'the therapist will not "deal" with emotions, instead moving swiftly to action talk' (Ratner et al., 2012, p. 234).

Sundman et al. (2020, p. 40) state that 'practitioners ground each speech turn towards desired change' and it seems that the very beginnings of therapy are not excepted from this. SF therapists tend to believe that it is their role to ensure clients talk about outcomes and various writers prioritise doing so over discussing whatever therapeutic processes the client brings up.

O'Connell (2016, p. 40) sets out the standard SF strategy for this: 'particular challenges can arise for the SF therapist if a client's agenda is "to understand why I have these problems", or they expect the therapist to give them advice and solve their problems. The therapist may ask, "What would you hope to be different in your life once you felt you understood your problems?"' Here we can note the client's request for particular therapeutic processes framed as 'challenges' for the therapist, and the proposed solution being a question which smoothly moves the conversation away from the client's 'agenda' and towards the therapist's agenda of discussing outcome.

Ratner et al. (2012, p. 63), a.k.a. BRIEF, in their introductory book on SFBT, say:

> *'Imagine for a moment that when asked the best hopes question the client responds by saying, "My best hope from our talking is just to get it all of my chest" or "My best hope from all of this is to just to understand, to understand why all this has happened." [...] both answers relate to the therapeutic process rather than to the everyday life of day-to-day experience. [...] The client imagines that "understanding" or "getting things off my chest" will make an "in-life" difference, that it will lead the client somewhere that they want to go, and it is this that interests the solution focused practitioner, the desired destination, rather than a description of the assumed route. The key question that will lead to the disentangling of route and destination, process and outcome, is simply "so what difference will that make?"'*

The choice of words illuminates some assumptions around the relationship between therapist and client. There is a privileging of what interests the practitioner over what evidently interested the client enough for them to give it as an answer – presumably justified by the supposition that the client imagines that their chosen process will lead to a desired (and as yet unspecified) outcome. The client's answer to the best hopes question is here framed as a mere entanglement rather than a challenge, simply 'disentangled' by the therapist asking a specific question that leads the client away from discussing process and towards discussing outcome, the subject that the *practitioner* is interested in.

Shennan (2019, p. 45), also discussing potential client responses to outcome-seeking questions from the practitioner, explains that clients often think about a process that might happen in the work such as getting an explanation or advice from the worker, or just talking. 'It is therefore important to always be asking yourself if you have just heard an outcome or a

process answer,' he writes, and then offers an if-then command sequence that would fit well into a manual - 'If process, the next step is to go beyond this to outcome: If that process were to take place, how would they know that it had been useful?' Again, this is another variation on what I shall call 'the difference question'.

De Shazer cited Erickson's comment that 'therapy is about two people trying to find out what the hell one of them wants' (De Shazer, 1994, p. 15). Perhaps this task is made harder if the therapist frequently discounts clients' statements of what they want. To quote de Shazer again, 'don't let the theory get in the way. Theories will blind you' (Hoyt, 2001, p. 29).

The new client's perception of therapy

Whereas for de Shazer (1990, p. 98) 'therapy is a conversation between at least two people [...] about reaching the client's goal', the scope of therapy at large is far broader than a conversation in pursuit of outcomes. A new therapy client who has not specifically sought out SFBT may, in the British context, have looked at the UK Council for Psychotherapy's FAQs and learnt that 'psychotherapy offers a [...] space for you to reflect on any emotional difficulties with a trained therapist', 'to help you express your thoughts and feelings and explore what comes up when you do' (UKCP, n.d.). Alternatively, they may have visited the 'What is counselling?' page on the British Association for Counselling and Psychotherapy's website (BACP, n.d.) and read that:

> *'What you talk about will vary depend on what you want help with and the therapist's approach. It could include:*
>
> - *your relationships*
> - *your childhood*
> - *your feelings, emotions or thoughts*
> - *your behaviour*
> - *past and present life events*
> - *situations you find difficult'*

Ratner et al.'s (2012, p. 67) hypothetical client discussed earlier, when asked the difference question, provided the 'entangling' answers of 'getting it off my chest' and 'understanding' instead of the sought after outcome response. 'Getting it off my chest' could be appropriate in a form of therapy which prioritises the relational aspect. 'Understanding' could be a desire to use therapy to clarify one's feelings, a common process in many types of therapy. Clients may feel that such approaches are more appropriate and desirable for them than others and may also be aware of the widely publicised Dodo effect, the notion that many therapies are equally effective (Rosenzweig, 1936).

Given the variety of therapy procedures, the prevalent discourse around therapy, and the needs and preferences experienced by clients, they may legitimately have different expectations of therapy to the therapist in contexts where they have met a SF therapist without specifically requesting one. SFBT however limits its scope to a particular type of procedure – asking questions centred on outcomes, and clients may not be aware of this limitation when they arrive. What are the risks, then, of therapists going 'beyond process to outcome'? (Shennan, 2019, p. 45)

Risks of the SF approach to process discussion

I will first consider the risks of the therapist acting to bypass a discussion about therapeutic processes and then the risks that come from the power dynamics the therapist is participating in by choosing to act in such a way.

The clinical consequences of avoiding process discussion

The act of bypassing a discussion about therapeutic processes could lead to missed clinical benefits and the risk of premature termination of therapy.

To begin with the obvious (though potentially overlooked), one problem with bypassing the client's preferences is that the client simply does not get what they came to therapy for. De Smet et al.'s (2021, p. 167) study on clients with good outcome scores but low therapy satisfaction analyses the case of a CBT client who reported several positive behavioural changes after therapy for her 'depressive complaints' though 'could not pinpoint what had helped' and stated 'she would have liked to find a "real cause" for being depressed, like a severe trauma, but she had not found one yet and also the therapy/therapist did not aid her in that'. Such a client may have sought therapy to clarify feelings and instead been given therapy that modified thoughts and behaviour, with the success of the latter not negating the dissatisfaction of not receiving the former. This is speculation but the case illustrates a potential pitfall in not acknowledging or accommodating a client's preferences.

Research in healthcare shows that shared decision-making increases patients' satisfaction and active involvement in care and reduces dropout (Ahmad et al., 2014; Makoul & Clayman, 2006). Specifically for therapy, Cooper and Norcross, drawing on two meta-analyses, state 'research suggests that eliciting—and accommodating—clients' psychotherapy preferences make valuable contribution to outcomes. It is associated with large reductions in dropout rates and medium improvements in clinical change' (www.c-nip.net, 2019, p. 1). SF recommendations, however, do the opposite - not only not eliciting or accommodating, but deliberately ignoring the client's requested process and redirecting the conversation towards outcome.

It is possible then, that proceeding with SF questioning without having responded to a client's discussion of therapy process could curtail clinical improvement and perhaps contribute to dropouts. Beyebach et al. (1996, pp. 303–304) observe that for most SF therapists 'dropout is not considered a problem' and that 'research shows that quite often "dropout" is not equivalent to "therapeutic failure"' and can be caused by clients feeling like

they have improved enough not to come back. While this can be true, they opine that it can still have negative consequences; the financial and administrative effects on professionals, the lack of fit suggested by the therapist believing the client will want another session whilst the client does not, and the subsequent inability for therapists and researchers to learn about the client's outcome.

However, it is also quite plausible that a client's non-attendance *could* be caused by therapeutic failure, which seems an increased risk if the client feels disappointed that their preferences for therapeutic processes were not taken seriously. Sommerfield's (2023) research into clients' moments of disappointment with their therapist found that leaving or thinking about leaving therapy was the predominant client response and that 34% of the studied participants reported ending therapy following a 'disappointment event'. Knox et al.'s research into psychotherapy failure found that one cause was when 'participants felt that psychotherapists were overly invested in a technique/approach or were inflexible' (2023, p. 307) and another was when therapy 'did not address participants' concerns', with a participant asserting 'I did not get help for why I was in therapy' (p. 305). A concerning consequence of therapy failure was that 'typically, participants became disinterested in or had difficulty seeking other mental health services' (p. 306). This is uncomfortable reading and it can be appealing to brush these issues aside as not applying to us, so it's worth remembering that 'clinicians often underestimate the extent of client dissatisfaction with psychotherapy or the psychotherapist' (Hunsley et al., 1999; Knox et al., 2023, p. 229; Westmacott & Hunsley, 2010) 'and overestimate their own clinical effectiveness' (Knox et al., 2023, p. 229; Walfish et al., 2012).

Regarding satisfaction, qualitative research suggests that clients perceive value in having their feedback on therapy heard and acknowledged in dialogue with their therapists (Cooper et al., 2015; Li et al., 2024). Cooper (2020), a pluralistic therapist, elaborates:

> *That's something we've seen in our qualitative research, talking to clients about the experience of being in pluralistic therapy. They don't always say that preference accommodation was the key to their psychological change, but what they do seem to say is that they appreciate the therapist trying: asking them what they want and then trying to meet their preferences. It's experienced as a sign of good will, of respect, of trying: even if they don't get it right.*

Clients experience being asked what their therapeutic preferences are as a sign of respect, yet as we've seen earlier, SF writers' advice when the client brings up their preferences is to change the subject through employing the difference question. Deliberately digressing from the client's statement is perhaps a missed opportunity to show respect, or worse, could be perceived by the client as a sign of disrespect. I would argue, even more strongly, that taking the position that the therapist has the right to control the conversation

in this way at this point is an expression of power over the client which can have negative consequences in itself, as well as being inherently problematic on point of principle.

The power dynamics behind the difference question

The power dynamics behind the act of controlling the conversation in this manner before the client has consented to the therapist's way of working could be considered an act of dominance. It could be counter-therapeutic but, even if not, may still best be avoided on principle. To consider this fully, I will examine models of power and how they intersect with this interactional manoeuvre.

When a client, in response to an SF therapist asking them about their hoped-for therapy outcome, instead states the therapeutic process that they hope for, the question 'what difference would it make?' (and its variants) enables the therapist to divert the client to their preferred topic of therapeutic outcome in a way so smooth that it can be hard to notice such a change of topic is occurring. It is a slick manoeuvre and a gift to the fledgling SF therapist. When I trained in SFBT, I practised this technique, and in various groups watched experienced therapists demonstrating it (confidentiality prevents me providing transcripts of this). Despite my grounding in another therapy modality I would even find myself swept up in a collective sense of frustration at the clients that didn't easily yield, with therapists repeating variants of the question, until, at last, they gave what the SF therapist considered an acceptable answer: an 'in-life' (Ratner et al., 2012, p. 67) outcome. After years of practice, an SF therapist's ability to make this transition becomes very well-honed, and the client new to therapy and in a state of psychological distress is at a considerable disadvantage if they'd initially rather discuss therapeutic process than outcome. I felt increasingly uncomfortable about the ease with which I could move the conversation along in this way.

In Knox et al.'s (2023, pp. 309–310) study on psychotherapy failure, the clients interviewed 'variantly advised mental health professionals to attend to the power differential in the psychotherapy relationship'. For me, that power differential was particularly evident in the difference question. Proctor's (2002) wide-ranging discussion of power in psychotherapy can help us to attend to this differential by helping us conceptualise it, so I will summarise two theories that she describes.

Firstly, following De Varis (1994), Proctor discusses three *aspects of power*:

- *Role power*: 'the power inherent in the roles of therapist and client that results from the authority given to the therapist to define the client's problem and the power the therapist has within the organisation and institutions where they work. [...]. Whatever the context of a therapist's work, power is still given by society to those identified as therapists.' (Proctor, 2002, p. 12)

- *Societal power*: 'the power arising from the respective structural positions in society of the therapist and client, with reference to gender, age, ethnicity etc.' (p. 12) Proctor notes that 'therapists are more likely to be White and middle class, whereas clients are generally poorer, more disabled mentally and physically, older, younger, more dependent and with less social support.' (p. 19)
- *Historical power*: 'the power resulting from the personal histories of the therapist and client and their experiences of power and powerlessness. [...] The personal histories and experiences will affect, and to some extent determine, how individuals are in relationships and how they think, feel and sometimes behave with respect to the power in the relationship.' (p. 12) Clients, for example, may have become habitual 'people pleasers', may believe their wants have little worth, or may never have been listened to, including by professionals. Therapists' experience of role power will contribute to their own personal history.

Of course, power cannot always be adequately described in unidirectional structural terms, and clients are not necessarily passive - but they often exercise their power by leaving therapy, which can produce the deleterious effects previously discussed.

Proctor (2002) also adapts Cromwell and Olson's (1975) *domains* of family power to the context of therapy. These are:

- *Bases* (the economic and personal assets of power entailed in the above three aspects of power)
- *Processes* ('interactional techniques, such as persuasion, problem-solving or demandingness, that individuals use in their attempts to gain control over aspects of the relationship'; Proctor, 2002, p. 94)
- *Outcomes* (through which the therapist controls what is acceptable).

(The processes and outcomes discussed in this context of domains of power should not be confused with the processes and outcomes previously discussed in the context of therapy, e.g. the therapeutic process of clarifying feelings or the client's desired outcome from the therapy.)

Let's apply Proctor, De Varis, Cromwell and Olson's terminology around power to the difference question: the application of a well-rehearsed formula to divert a client from their hope for a therapeutic process towards instead identifying a therapeutic outcome. It is a case of a therapist, from their *power bases* (comprising their *role, societal and historical power)*, using a *power process*

(the interactional technique of the difference question) towards the *power outcome* of controlling the conversation so that the client gives an answer acceptable to the therapist.

Some therapists may wish to reconsider this habit in order to claim less power over the client because they find that an inherently more ethical approach. They may also consider the potential consequence that the client becomes further disempowered by the interaction, thus contributing negatively to their experience of power. Given that individuals may turn to therapy because of previous powerlessness, and may hope therapy leaves them feeling more empowered, there is the need in such cases to consider the 'internal consistency of the means and the end', as Proctor (2002, p. 93) puts it.

Contracting reconsidered

I believe that the issues I have attempted to highlight can be mitigated by SF therapists' taking a power-aware, pluralistic perspective on therapy and making small changes to how they begin their work with clients. I will discuss these in turn.

Therapist attitudes

There are two particular attitudes that can help therapists navigate these pitfalls; a commitment not to disempower clients and a pluralistic perspective towards therapy.

On the subject of power, given that many people may become therapy clients because of their experiences of powerlessness, therapists should commit not to further entrench such powerlessness as far as possible. To do this they need to be aware of their own power, and the above models of aspects and domains of power are useful ways to conceptualise this and in so doing bring their power into their awareness. A therapist who rejects such a conception of power may prefer to formulate this more positively, such as a commitment to encouraging the client's self-efficacy during all stages of the therapy process.

Further, given that there is a range of therapeutic procedures, not all centred on outcome, that the Dodo effect tells us that there is little significant difference between modalities and that research suggests clients having their psychotherapy preferences accommodated is beneficial, therapists of any stripe should be able to acknowledge a client's expressed preferences and discuss the matter securely and non-defensively. The therapist need not be able (or willing) to offer what the client asks in order to discuss the matter; after an honest discussion, the client can make an informed decision about proceeding with an SF therapist or going elsewhere. This requires what Cooper and McLeod (2011, p. 219) describe as a pluralistic perspective - 'believing that there are many different ways of helping clients, even though they choose to specialize in just one'.

Such attitudes accord with all but one of BACP's (2018) ethical principles: being trustworthy, autonomy, beneficence, non-maleficence and self-respect. (Many SF therapists won't be BACP members; I make this point simply because they are good principles.)

Recommendations for practice

Stemming from such attitudes, I propose small changes to how SF therapists begin their work with clients in order to mitigate the risks I have outlined. These suggestions are based on the conclusions from the previously mentioned research base, though of course, further research could be undertaken to validate them with clients from varying contexts (e.g. culture, gender, presenting issue, clinical setting, and so on).

Therapists in private practice can easily choose to describe their approach in promotional material to facilitate prospective clients making an informed choice. If they had a conversation about working together before the therapy begins, the therapist can ask about the clients' expectations of therapy. If there is a significant lack of fit, there's then the opportunity for the therapist to signpost elsewhere, or offer a single session to see if the client finds SFBT useful anyway.

This is not unusual but things get more complicated in situations where clients have not deliberately chosen SFBT in particular. George writes that 'therapeutic focus is the therapist's responsibility. Of course the answer to the "best hopes" will come from the client however from then on shaping the conversation is the therapist's job' (BRIEF, 2021). I propose instead that therapists take that responsibility a turn or two later in the conversation.

If, when the therapist asks for the client's hoped-for outcome from the work, the client provides such an asked-for outcome, then, before launching into SF questions I recommend very briefly explaining what happens in SFBT and checking for informed consent. For example, in my work at a university counselling service, I usually say something like this:

> *Client: 'I want to be able to get on with my work instead of procrastinating all the time.'*
>
> *Therapist: 'The method of therapy we often use tends to help people who want to see changes in their lives like that. It basically involves me asking people questions about how they'd like things to be and in what's helping with that already. When people answer these kinds of questions they tend to notice positive changes happening in their lives. Do you want to give it a go?'*
>
> *Client: 'OK, sure.'*

At this point, the client has given informed consent for, not only SF-style questions, but also for the therapist to take the lead by repeatedly asking questions (not all therapies do this - consider free association in psychoanalysis or 'following the client' in person-centred therapy). While I

would still check in occasionally on the client's experience of the session, I think it is now legitimate for the therapist to take the 'job' of shaping the conversation. Anecdotally, I have also found that clients can be more expansive in answering SF questions (particularly about interaction) as a result of my offering this kind of rationale. Alternatively, practitioners in some contexts may arrange for this kind of dialogue and consent to take place before the first session and back this up with content such as web pages, handouts and video.

If, instead, the client expresses a hoped-for process, I propose acknowledging this instead of ignoring it. Shennan (2019) observes that one reason clients bring up a process is that they think it might be necessary, so, if in doubt, I suggest checking if this is genuinely a preference rather than what they think *should* happen in therapy. If it *is* a preference, there are two broad options that can be used instead of changing the subject.

One, which will depend on the therapist's desired way of working, is to try to accommodate the client. Sometimes this could be done within a broadly SF framework. For example, if a client wishes to 'talk out' their problems, this is not incompatible with SFBT and the therapist could simply be mindful not to rush them into 'solution talk' (Berg & De Shazer, 1993). Another example, if a client wants advice, could be to ask them questions to help them give themselves advice, or failing that, to state what other people have found helpful while encouraging the client to find out what's right for them (as suggested by George, 2019). Some therapists may wish to extend beyond the boundaries of SFBT and integrate approaches from elsewhere, perhaps before returning to SFBT, for example teaching skills, giving information or suggesting coping strategies from cognitive behavioural therapy (such approaches were adopted by counsellors at Leeds Metropolitan University - White, 2003 - and similar approaches are used where I work, at Oxford Brookes University). Going further beyond SFBT, some therapists may wish to learn another therapy modality or practice one they already know. For example, if a client expressed a strong desire to clarify a feeling that is puzzling them, a therapist familiar with psychodynamic or person-centred therapy may wish to offer that instead of SFBT, offering the client's desired process instead of trying to convert the client's answer into an SF-compatible outcome in order to fit in with the therapist. The opportunity to sometimes work in another modality may also be attractive to some SF therapists, though not all.

The other broad option is to be honest about the fact that the therapist will not be able to accommodate the preference (which is entirely legitimate). If, for example, the client is keen for a therapist to offer interpretations on what is going on for them psychologically in their relationships, a SF therapist could non-judgementally say, 'I know a lot of therapists work like that but that's not the kind of approach I use. Rather than offering explanations about psychology, I tend to ask questions geared towards helping people make changes in their lives. Is that something you'd like to try, or would you prefer I help you find a therapist that works in the kind of way you mentioned?'

The therapist can then accordingly either signpost or proceed with SFBT. If the client is willing to give SFBT a go, the next step for the therapist may be now to ask the difference question, having been granted permission to 'shape the conversation' in such a way. The therapist might ask, for example, 'if this therapy was useful to you, just like explanations about psychology would have been, what differences would you be noticing in your life?'

It's possible that experienced SF therapists may already work in ways similar to this, despite the directive approach to process discussion outlined in the literature. Those who do not may still be quite happy, for all that I've said, to use the difference question to divert clients from process to outcome. They may have had much success with it, appreciate its efficiency in their pursuit of brevity, and feel that the risks and potentially missed benefits that I've outlined are low in probability or small in impact. However, my proposed mitigations are also small. In most cases, SFBT would be able to proceed as usual, but with the potential benefit of increasing clients' positive expectations about therapy and enhancing the likelihood of better outcomes (Lindhiem et al., 2014), at the cost of a few minutes and the risk of a therapist losing a client to another therapist better suited to them (which we should welcome on the principles of autonomy and beneficence).

Depending on a therapist's ethical stance on these matters, this way of working could also provide a welcome opportunity to stop taking power from the client in this particular way, by giving up a well-rehearsed interactional technique and by surrendering an effort to control the conversation before the client has given informed consent to the SF approach. While I have highlighted potential consequences of the usual approach, there are also deontological considerations - therapists may (or not) feel that this is a better way to behave on principle, even if it were to have no discernible impact on a particular session. Many of these principles may of course apply equally to therapists of other modalities in situations where clients have not chosen their way of working.

Conclusion

In this paper I have discussed the standard SF advice on beginning therapy - to divert clients from their mention of therapy processes with a canny question on what difference such processes would make in order to have the conversation instead focused on therapy outcomes; all before explicit consent has been granted for an SF approach to therapy. I have discussed how this behaviour contradicts emerging evidence supporting a more collaborative approach and have attempted to problematise it on the basis of power dynamics. I've proposed a mind-set and a tweak to the conversational process that will mitigate these concerns. To respond directly to a client's request is a small way to show respect and avoid disempowering them. SF practitioners, perhaps more than anyone, know that a small change can make a big difference.

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