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This account of the origins and development of SFBT is not based on a rigorous historical analysis of key events, recovered unpublished documents, or the formal writings of de Shazer, Berg, and their colleagues at the Brief Family Therapy Center (BFTC). Rather, it is taken from the author's records of two experiences he had with de Shazer and Berg: 1) notes from a lecture de Shazer gave about the history of SFBT just one month before his death, and 2) a recorded interview with Berg in 1998 about the origins of BFTC and SF techniques. The article concludes with a few reflections by the author.

In the latter part of the summer of 2005, I (Peter De Jong) came to Milwaukee, Wisconsin from Michigan for a couple of weeks as I had done every summer since 1990. I came mainly to work with Insoo Kim Berg on our joint projects and related writings. I would, however, also sit in on the workshops Insoo and Steve conducted each summer, and stay at their home, so we could discuss the workshop content and the participants' responses to the material. These discussions helped inform Insoo's and my writing about how to make SFBT more accessible to learners. The workshops were always run by Insoo. I would sit next to Steve, both of us drinking coffee, until Insoo asked one of us to do something; such as a demo of a miracle question conversation or address a particular topic. Insoo began that 2005 summer workshop as she always did, asking the participants what they would like to have heard, seen, or done by the end of the workshop. Predictably, among the requests was the wish to hear about how Steve, Insoo, and their colleagues at BFTC developed their innovative SF techniques. So, part way through the workshop Insoo asked Steve to talk about the history of the approach, and I took notes on what he said. The version of BFTC's history contained in this article is reconstructed from those notes. It is supplemented with quoted comments from Insoo taken from a recorded interview I did with her in 1998 about the origins and development of SFBT. I conclude the article with my reflections from Steve's lecture and Insoo's comments.

Steve & Insoo's Telling of the History

The story begins in the 1970's at the Mental Research Institute (MRI) in Palo Alto,

California. There, the likes of Don Jackson, Jay Haley, and John Weakland had been developing a form of brief therapy since the inception of MRI in 1958. Steve and Insoo, both from Milwaukee but unknown to each other at the time, came to Palo Alto wanting to learn more about the ideas and practices of MRI. They learned, among other things, that MRI's practice was, in part, inspired by the work of the psychiatrist Milton Erickson. Some of MRI's therapists including Haley, would visit Erickson in Arizona and talk to him about his cases. Haley, especially, has written about Erickson's work describing many of his cases (Haley, 1986). Erickson's practice with clients was short term, sometimes included hypnosis, and always involved Erickson doing something to bring about change.

Steve became fascinated by Erickson's work. While Erickson did not develop and write about a detailed model of doing therapy, he did describe many cases and what he did with them. For example, there was the case of a twenty-one-year-old woman who came to Erickson saying she was thinking of ending her life. She said she wanted a husband and children but had never had a boyfriend and felt she was too unattractive to attract a man. She said she worked as a secretary at a construction firm and kept to herself. There was a young man at work who she found attractive, who showed up at the drinking fountain when she did, and who seemed interested in her; however, she never spoke to him. She had no friends and believed she was "too inferior to live." She decided to see a psychiatrist before ending her life, telling Erickson she would work with him for three months before carrying out her plan.

Erickson thought the woman was pretty but dressed very unattractively and her hair was stringy and unevenly cut. The woman told him her main physical defect was a gap between her two front teeth which she self-consciously covered with her hand when she talked. Erickson responded to the woman by assigning two main tasks. First, he told her that since she was going downhill anyway, she might as well have one "last fling." She was to go to an assigned store and get help selecting an attractive outfit and then to an assigned beauty shop to have her hair styled. Erickson said she accepted the task because she did not interpret doing the task as improving herself but only having a "last fling." Second, she was to go home and, in her bathroom, practice filling her mouth with water and then squirting the water through the gap in her front teeth. She was to practice until she could squirt the water up to six feet and do so with accuracy. Erickson said she thought this was a silly task, but its silliness apparently prompted her to go home and practice it conscientiously.

When the woman returned and was attractively dressed, her hair newly styled, and skillful at squirting water through the gap in her front teeth, Erickson proposed another task. This time she was to play a practical joke at the office. The next time the young man appeared at the fountain, she was to fill her mouth with water, turn, squirt it at him, run toward him a bit, and then immediately turn away and "run like hell down the corridor." At first, the woman rejected this proposal as ridiculous, but later decided it could be part of having one "last fling." So, the next day she went to the office dressed in her new outfit and looking very attractive. When she approached the water fountain the young man predictably appeared. She filled her mouth with water and squirted it at him. He yelled an expletive at her which made her laugh; she then turned and ran down the hallway. The young man chased her, caught her, and to her astonishment, kissed her. The next day, the young woman nervously approached the water fountain. The young man was hiding nearby and jumped out squirting her with a water pistol.

Steve studied scores upon scores of Erickson's cases trying to figure out his way of working with clients. Insoo had this to say about Steve's study of Erickson's work:

> He (Steve) is the type that when he's interested in something he just reads and reads and reads …. That's what he did with Erickson's work; he just immersed himself. And he's always looking for patterns that connect. So, he looked a lot really into Ericksonian patterns – what is it about his way, how can he describe the patterns – that seem so out of nowhere.

Steve came to see at least two patterns that connected in Erickson's way of treating cases. First, Erickson heard and tied his tasks and proposals for the client to the client's goal. In the case of the young woman, he heard that she wanted a husband, a family, and friendships. Second, he creatively drew on qualities and skills that the client possessed and could be put to use in reaching the client's goal(s) (the principle of utilization). In the case of the young woman, she had a space between her two front teeth and she mastered squirting water through that space.

Steve also noticed that Erickson's brief way of doing therapy -- often in just a few sessions -- was radical because it came at a time when therapy was indefinite. Many therapists believed clients regularly needed one-hundred or more sessions. When research studies at the time showed the average number of sessions for clients was about four sessions, therapists would bemoan this and say things like: "the client's progress is only a temporary flight into health," or "the client's quick progress did not address the real or underlying problems," or "leaving therapy so soon is a defense mechanism; it is a sign of client resistance to getting better."

In thinking about these common therapist explanations in the 1970's for the average few number of sessions, Steve and his colleagues saw a "big disconnect" between these explanations and what their clients were telling them. As Insoo described it:

> In that time (early to mid-1970's), families kept dropping out and dropping out of treatment. Families don't tend to stay in treatment very long. Couples don't tend to stay in treatment very long. And I didn't know that at the time. So, I kept getting this uncomfortable feeling that this isn't right, this isn't right. The clinical phenomenon and what the theory says didn't go together. So, I was in search for something – there must be an answer for this …. And I think that another thing that was interesting was that these 'failure cases' because by their (most therapists') criteria – anything less than people who stay in treatment for less than a year – was a failure case -- because they are dropouts. Yeah, (but) dropout cases were sending their best friends, their family members … I only saw them three times and they must have thought that I helped ... because they are

sending their sister, their mother – so I thought something isn't right, something isn't right, but I didn't know what.

As a consequence of this "disconnect," Steve and Insoo began looking more carefully at the existing data about number of sessions. They saw that mental health facilities at the time were taking as many as six sessions to do extensive assessments before they began treating the assessed problems. Clients often "dropped out" before the assessments were completed. Nevertheless, clients said coming to the sessions had been helpful. Other data indicated 80 to 90 percent of therapy was less than 20 sessions; yet, most clients said therapy was useful. Steve then realized that clients were using therapy differently than most therapists thought they should. With Erickson's work and the data about client number of sessions as background, Steve thought: Let's build a brief therapy around the client goals; they obviously are using therapy that way anyway. So, he decided to listen more intentionally to and believe what clients say they want and say is useful for them. Meanwhile, by this time which was in the later 1970's, Steve had returned to Milwaukee and joined the large family service agency where Insoo worked. Insoo had put a one-way mirror into her large office so she and colleagues could observe practitioners working with clients. They and their colleagues soon discovered that they could not simply ask the client: "What is your goal?" When they did that, the client would respond "to stop drinking," or "to stop fighting with my teenage son," or "to be less depressed." These client responses were more like problem statements rather than goals. Accepting these responses as goal statements was not useful because practitioners know the hardest way to change is to try to stop something. Soon, Steve and Insoo observed and recognized that the clients who were making progress had discovered something else to do instead of the problem behaviors. So they began experimenting with questions like: "What are you going to do instead of the drinking?" "When you are not drinking, what will be there instead?" "What will be happening when you are not drinking anymore?" "What will others notice you doing when you are not drinking anymore?"

These questions, too, were difficult for clients to answer. Clients would often first respond, "I don't know." So, Steve, Insoo, and their colleagues (who by now had formed BFTC in 1978) kept working at ways to ask questions about client goals in order to give clients maximum opportunity to construct useful goals for themselves. And then, in the early 1980's, Insoo had the case of a woman who came to her saying she was depressed and was contemplating killing herself. She had several children with many problems themselves and a husband who drank too much alcohol and was out of work. Insoo began goal work with the woman asking questions like: "so what needs to happen here for you to say our meeting was useful?" And, "what do you want different by the end of our work together?" To these and several similar questions, the client responded "I don't know" and she continued to give more details about the problems of her family and herself. Then, at one point the woman added the words "unless a miracle happens" to her "I don't know's." Insoo, by this time intentionally attendant to client words, picked up the phrase and asked: "Okay, so suppose a miracle happens and all these problems are over, what would be happening instead?" The woman then began to answer, "my husband would stop drinking and have a job," and "I would have more energy." Insoo continued with "what else would be different?" The woman responded with "my kids would be doing better in school." As Insoo continued following up on each client answer and getting more details, she and the team noticed the woman became more animated and seemed less depressed and more hopeful. The differences in the woman from the beginning of the session to the end impressed the observing team so much that they decided, as they had been doing with each promising new technique, to ask the "miracle question" of all clients for the next several months and see what difference that made in the rates of client progress. The "miracle question" turned out to be so useful that BFTC made asking it a standard practice of their developing new form of brief therapy. Insoo has commented that the observing team at BFTC did not invent the miracle question; instead, it came from listening carefully to what clients say and then using that:

> You know, I think clients say that stuff all the time: "do you have a magic pill?" Or, "do you have an answer to this?" "I need an answer from you." "I need a miracle from you." "Or a magic wand from you." I think clients say that all the time… But sometimes when the event, the case, and the circumstances come together, *you hear them*! (italics added) And I think that out of desperation (laughing), when the case seems so hopeless; out of desperation you hear them. That's what happens a lot; and you get new ideas. It comes from that, not that we are so brilliant or so smart. But I think that, "oh my gosh, what do we do now?" creates that kind of crossroad, and then something opens up I think.

Steve says the same sort of careful listening to the client and then building on what he heard led to the use of scaling questions in SFBT. Steve had a case shortly after the release of the American film "10" starring Bo Derek as a beautiful young woman and Dudley Moore as a middle-aged composer. Moore's character, experiencing a mid-life crisis, becomes infatuated with the young woman whom he rates as "11" on a scale that only goes up to 10. The film was very popular and the practice of rating things on a 10 point scale was finding its way into popular culture. Steve's case was a man who was returning for a later session and Steve asked him how he was doing. The man said: "I'm doing better." Steve asked: "How much better?" The man replied, "Well, I'm not a perfect 10; but I'm about an 8.5." Then Steve asked: "So what tells you it's 'about an 8.5'?" The client went on to describe the progress he had been making. After that case, and through discussion and reflection with Insoo and his colleagues, Steve came to realize scaling was so useful because the client had to be scaling himself relative to his own goal(s), not some professional, supposedly objective, criterion of success. And, in asking the client to provide the details for the number he gave, the client and Steve became clearer about what it is the client wanted different in his life which, in turn, made deciding what to do next easier.

Once it dawned on Steve that the client's goal was implicit in the scaling numbers for

progress, he also began to notice that many clients who were making progress came into later sessions already describing what was better. Implicit in these descriptions was what clients wanted different in their lives, i.e. their developing goals. So, Steve and his colleagues began asking "what's better?" at the beginning of follow-up sessions and then lots of follow-up questions to get the details of what was better. This began in the early 1980's and was a new direction because in the late 1970's and into the early 1980's, BFTC practitioners were still influenced by practice at MRI and would give clients tasks intended to bring change. As the tasks were intended to change clients and/or their situations, it was natural to begin later sessions by asking clients whether they had done the tasks and what the results were. In shifting toward conversations about what was better and away from asking whether clients completed their tasks, Steve and his colleagues discovered most clients, if asked, could identify something better. As BFTC practitioners pursued this new line of questioning, figuring out more and more ways to keep the conversation about what was better going, even when some clients would start out by saying "nothing," they found over 90 percent could identify something better. The more they stayed with the "what's better" opening in their follow-up sessions, the less they focused on asking about tasks and designing intricate tasks based on family systems thinking as they had been doing earlier. Steve says a bonus to shifting toward asking "what's better" was the discovery that what clients described as "better" often had nothing to do with the original problem(s) that brought them to therapy. The bottom line here, Steve says, is that clients define success differently than most practitioners who try to help clients by assessing and solving their problems. He came to realize that in listening ever more intentionally to what clients want and inventing with them more and more ways to invite them to describe in detail what they want and the progress they are making, clients were teaching the practitioners at BFTC to move away from problem solving in favor of building solutions in partnership with them.

Reflections

I (the author) am struck by three things in Steve's brief telling of the history of BFTC and SFBT. The first is his focus on just a few years of that history; namely, from the mid-1970s to the mid-1980s. I wonder if this was the period, in his mind, when the key discoveries were made at BFTC. It was the period when BFTC began abandoning the theories and practices of the field of psychotherapy in general and differentiated itself in practice and thinking from MRI. It is also the brief period during which the unique solution-focused questions and practices were invented at BFTC that have endured to the present as heart of SFBT.

Second, I am struck by Steve's emphasis throughout that the team at BFTC learned to listen to clients in a different way. While the rest of the field was using professionally constructed categories to assess client problems and then move to helping clients with related interventions, BFTC practitioners were learning to listen to clients on their terms versus the lens of the field. Steve and Insoo first noticed the "big disconnect" between the field's view about how much therapy clients needed and how clients were using just a few therapy sessions and finding that useful. BFTC believed the clients about the usefulness of just a few sessions and began listening more intentionally to what clients said they wanted and what progress they were making. In a sense, BFTC closed the textbooks about how to do therapy in favor of listening to their clients. And, as Insoo said, "…sometimes when the event, the case, and the circumstances come together, *you hear them* (the clients)!" The increasing BFTC capacity to hear clients on their terms rather than through professional categories, led to the signature SF questions and practices.

Third, I am impressed by the approach to investigation and knowing that BFTC adopted. While early on Steve and Insoo experimented with practices drawn from family systems theory, they soon set that approach aside in favor of direct observation of therapy sessions. Insoo put a one-way mirror in her office at the family service agency in the 1970's. One-way mirrors and direct observation and review of recorded sessions remained a central feature of practice, research, and learning at BFTC until Steve and Insoo's passing. The colleagues at BFTC consistently observed for which clients were making progress and what those clients and their practitioners were doing together that might be contributing to that progress. When they noticed a client and practitioner collaborating in a new and potentially useful way (such as Insoo picking up on her client saying "unless a miracle happens"), they incorporated the innovation into their practice and formed a research study to measure its usefulness. Employing rigorous observation of real time and recorded sessions is what contributed most to listening to clients in a new way and the invention of SF techniques. Steve, in a book published in the 1990's reaffirms the importance of such observation:

> Therapists are interested in the doing of therapy and, at least in a certain sense, only the observation of sessions or watching videotapes of therapy sessions can give them the 'data' they need [to learn SF and improve their practice skills] (de Shazer, 1994, p. 65).

Reviewing these notes from Steve's 2005 lecture and the 1998 interview with Insoo has gotten me thinking that we may have more to learn from this version of the history of SFBT than I first realized. Many of us who teach workshops and write about SF practices, tell our learners that SF is "simple but not easy." That is to say, it is simpler to describe, understand, and teach the SF approach in concept than it is to actually conduct a SF conversation. On reflecting once again on Steve and Insoo's history described in this article I wonder if we have ignored some of their genius in our teaching. I know that for the nearly thirty years that I have been teaching and practicing the SF approach, I have focused mainly on teaching the SF questions invented at BFTC together with the outlook about clients and practice embedded in those questions. This question-based approach largely ignores how SF questions were invented. In contrast, Steve, Insoo, and their colleagues themselves first "learned" the SF approach through direct observation of therapy sessions and listening to and learning to hear clients on their own terms. Having recorded sessions allowed them to revisit the words of what clients said and stay close to those words so as to reduce the natural tendency (often

unintentional and below the level of awareness) to transform what clients say into the practitioner's preferred or professional categories. Perhaps, I am thinking more and more, SF learning would be enhanced by consistently having our learners record their SF interactions from the outset of their learning. That is easier than ever to do with smart phones, laptop computers, and role playing. The teaching can then be organized around inviting learners to observe for what their "clients" are saying and what they and their clients are doing together that contributes to clients constructing detailed visions of what they want and measuring progress toward these goals as the clients define progress. In organizing SF learning around learners becoming keen observers of their own SF conversations, they will be reinventing the SF model for themselves. Doing it this way originally worked well for the BFTC team; perhaps shifting our teaching in that direction will produce similar results for today's SF learners.

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