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The Development of My Personal Solution-Focused Working Model: From 1978 and Continuing

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Abstract

I had the privilege and good fortune to be one of the founding members of the Brief Family Therapy Center (BFTC) in Milwaukee, which was started by Steve de Shazer and Insoo Kim Berg in l978. I left BFTC in l988, and have been practicing at ICF Consultants, Inc. in Milwaukee, a mental health agency that I own and operate with Marilyn J. Bonjean, Ed.D. In this article, I share some of the history of BFTC; the development of the original model we developed there, *brief family therapy*; and how the model changed to *solution-focused therapy*. I also share my own clinical and theoretical reactions to our developing model and other developments in the field of therapy, as well as how these reactions influenced my personal way of practicing and teaching solution-focused therapy.

Keywords: BFTC, solution-focused history, de Shazer, Berg, working model, Summation Message

I am about to share with you conversations I have had with myself for more than 35 years about the therapy that I practice. My hope is that these conversations will give you a historical glance at the development of solution-focused therapy and also my personal path as a therapist and colleague. Before I begin, I just want to tell you how sad it makes me to have to be the last practicing therapist of the core group that started the Brief Family Therapy Center in Milwaukee (commonly known as BFTC). Unfortunately, Steve de Shazer, Insoo Kim Berg, Jim Derks, and Elam Nunnally have all passed away. Marilyn LaCourt retired from the field over a decade ago.

I also want to honor the memory of Lyman Wynn, a father in the field of family therapy, who was Chief of Psychiatry at Strong Memorial Hospital in Rochester, New York when we first met him. In l981, our team (from BFTC) went to a small meeting in Connecticut where the most distinguished family therapists at the time gathered for a weekend of show and tell. We were not sure how we had even gotten on their mailing list and felt a bit anxious about participating, but decided to take a chance. Lyman, a great proponent of positive communication for families, responded to our videotape with immediate interest, and from that time on was a frequent visitor at BFTC and our staunchest advocate and supporter.

The Birth of Brief Family Therapy

It was l978. I was a student in a family therapy training program approved by the American Association of Marriage and Family Therapy (AAMFT) at Family Service of Milwaukee. Insoo Kim Berg was my supervisor. Insoo and Steve de Shazer were newlyweds. They first met in Palo Alto when Insoo and Jim Derks, a colleague from Family Service, went to the Mental Research Institute (MRI) in Palo Alto for a workshop about the brief therapy model they developed there. Steve was living and working in Palo Alto and hung out at MRI whenever he could. Jim, who witnessed Steve and Insoo's meeting, said they fell in love instantly. Steve moved back to Milwaukee, his hometown, to marry Insoo and took a job as a therapist at Family Service.

Steve had a dream and Insoo, who was able to accomplish anything once she set her mind to it, was determined to help him realize it. He wanted to start his own institute—a think tank for developing a *brief family therapy* approach. In preparation for this, he and Insoo met one night a week in their home with a group of like-minded people, mostly from Family Service, to experiment with different ideas. In those days, before Wisconsin licensed therapists, they could only see clients at a state-certified mental health

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clinic, so they beat the bushes for relatives, friends, and friends of friends who would volunteer to present a problem or dilemma for which they wanted help. The group explained its goals and procedure to the volunteers and sought written permission for videotaping. The volunteers seemed to be kind of amused by this unusual process, but they took it in stride. During the interview, the group would observe from a staircase in the house while a therapist worked with a volunteer in the living room. Much like the MRI Brief Therapy Center approach (Fisch, Weakland, & Segal, l982) and Selvini-Palazzoli's Milan model (Selvini-Palazzoli, Cecchin, Prata, & Boscolo, l978), the group then took a break to develop hypotheses about the problem and to construct a message for the interviewer to deliver to the volunteer subjects. After the clients left, the group would watch the videotape of the session and discuss it. One day, Insoo invited Marilyn LaCourt, another trainee, and me to attend one of these evening meetings. I was really intrigued by what I saw there. I had left behind psychodynamic play therapy because it seemed too slow and lacked family involvement. However, I wasn't totally convinced, nor was I comfortable, with the strategic interventions I had observed.

Not too much later, Steve and Jim Derks left Family Service and rented a small office. A number of people in the evening group, including Marilyn LaCourt and I, were invited to make a modest financial contribution toward the start-up costs of BFTC. Signing on meant an indefinite time without an income, and only those of us who were not breadwinners could do so. For this reason, Insoo stayed at Family Service for a while longer. One of the unfortunate people who really wanted to join, but could not, was a man named Don Norum, a therapist at Family Service, who wrote a paper in l978 titled "The Family has the Solution." He could not get it published at the time, but it was finally given its due in 2000 in the *Journal of Systemic Therapies* (Norum, 2000).

The final core group was quite diverse.

- *Steve de Shazer*, born and raised in Milwaukee, was a shy, multi-talented man. He was an accomplished musician, painter, cook, and beer brewer, and a student of sociology.
- *Insoo Kim Berg* was born and raised in Korea and had studied pharmacology before coming to the United States, where she studied social work. She was willing to tackle anything new, and when she did, she did it extraordinarily well—like cooking, sewing, gardening, and other activities.
- *Jim Derks*, raised on a large pig farm in Iowa, was a man who spoke his mind—more often using metaphors than directly. He was a talented carpenter and wood carver. He went home each night to his farm outside of Milwaukee, where he raised animals and grew fruit and vegetables.
- *Elam Nunnally* was a professor of family studies at the University of Wisconsin–Milwaukee (UWM). He was a warm and gentle man. He was married to a woman from Finland and was highly devoted to his family. Elam spent many summers with his family in Finland, where he later taught solution-focused therapy to a large segment of the therapeutic community.
- *Marilyn LaCourt* was a former teacher with a master's degree in communications and a particular drive to think outside the box. She was also a wonderful cook.
- Finally, I, *Eve Lipchik*, a child of the holocaust, was born in Vienna and raised in New York City. I was an aspiring playwright in college. I was formerly a psychodynamic play therapist, and then became a family therapist. I enjoy a bit of painting as well, and yes, like the others, I love to cook and eat!

Steve and Jim accepted a few master's degree field placement students from the UWM School of Social Work as soon as they opened the first office. Among them was Alex Molnar, a professor of education at UWM, who was interested in family therapy and was studying for a master's degree in social work. After he graduated, he continued to participate in our activities. He was a very supportive research partner to Steve, who valued his thinking greatly (de Shazer & Molnar, l984).

Our modus operandi was conversation. We had conversations about subjects like the *Möbius strip*,[1] *strange* and *charmed loops*,[2] or just about anything that might fit within our goals. But most of all, we talked about what seemed to work or not work.

To Join or Not To Join BFTC?

Accepting the offer to join BFTC was not as easy a decision as it may seem, in spite of my interest. It required that I have an extensive conversation with myself about my professional identity. Did I want to change my orientation and commit to a yet-to-be-developed way of working and thinking? I had just spent 2 years getting comfortable doing systemic family therapy. Was it wise to continue treading on uncertain ground? People I respected had told me one of my strengths as a therapist was that I could tune into people's emotions. The brief therapy we had been experimenting with was much more about the head than the heart. A lot of the thinking was based on paradox, and that seemed manipulative to me. Could I be genuine practicing this way? Did I want to?

For some reason—which I still do not quite understand—I decided to see some of the great family therapists work in order to make my decision. So I took

[1] A *Möbius strip* "is a surface with only one side and only one boundary component. . . . [It] has the mathematical property of being non-orientable. It can be realized as a ruled surface. It was discovered independently by the German mathematicians August Ferdinand Möbius and Johann Benedict Listing in 1858" ("Möbius Strip," n.d., para. 1).

[2] A *strange loop* is a "repetitive interactional pattern that alternates between contradictory meanings" ("Coordinated Management," n.d., Strange Loop section, para. 1). "In the example below, the alcoholic identifies that he is an alcoholic and then quits drinking. Since he has quit drinking, he convinces himself that he is not really an alcoholic and so he starts drinking again, which makes him an alcoholic. He alternates between contradictory perceptions of being an alcoholic and not being an alcoholic. A second variation is the 'charmed' loop. In this interaction, each person's perceptions and actions help to reinforce the other's perceptions and actions" ("Coordinated Management," n.d., Strange Loop section, para. 1–2).

some time to go to 2- and 3-day workshops by famous family therapists, like Salvador Minuchin, Carl Whitaker, Jay Haley, and Lynn Hoffman. Though I had studied family therapy intensely, I had had few opportunities to observe it in actual practice. In retrospect, I may have thought that if I had watched family therapists with different approaches, I would have gotten a better understanding of Steve and Insoo's work, thus making it easier for me to make a decision. As I began to notice the differences in the work of the masters, I came away thinking that what really mattered was *not* personal style, but rather, theoretical stance. All the distinguished therapists I saw seemed to be good therapists, but I personally was attracted to the theoretical stance of BFTC and the developmental aspect of the work there. What stood out for me about all of these masters was that they were more similar than different, especially in one very important way: They had a palpable desire to help their clients. That underlying commonality somehow made me decide that I was doing the right thing by joining BFTC.

To this day, I have never regretted my decision, and I am so grateful to have been a part of BFTC. Those early days of camaraderie and creativity were fantastic! I cannot say enough about them. The first few months we had very few clients, so every day was one long conversation about the many different ideas we derived from reading, thinking, and observing the few clients we had. Above all, we were accountable to no one but ourselves and our clients, had no financial ties, and were free to spend our time any way we liked. I believe now that the freedom served as the foundation for creativity. We never worked alone or without the support of the team. The underpinnings for what became known as the *binocular theory of change* (de Shazer, l982) based on Bateson's (l978, l979) work on "the difference that makes a difference" and Milton Erickson's work on hypnotherapy (Erickson, l954; Erickson, Rossi, & Rossi, l976) was developed. According to the theory, the family system and the therapist/team system form a *suprasystem*, the interactions of which result in changed perceptions, and further, changed behaviors in clients. The intervention message that we read to the clients at the end of the session had to be *isomorphic*[3] with their view of the problem in order to produce what was called "the bonus," which according to de Shazer (l982), was something much like the depth perception resulting from a binocular as opposed to monocular view. An important part of this theory was the concept of *cooperating* (de Shazer, l982), an Ericksonian concept in which the therapist meets the client where he or she is to circumvent resistance. We at BFTC defined this as "cooperating with how the client cooperates." While this was really just another way of being strategic (meaning it was inspired by strategic family therapy), it allowed me to feel more comfortable in my therapeutic skin because it was so client-centered.

That first BFTC office had a unique setup (see Figure 1).

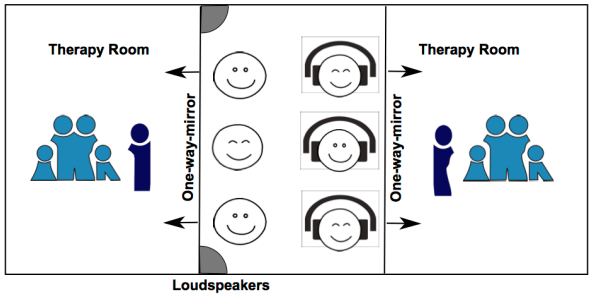

Figure 1. Setup of BTFC office. The therapy room was divided by a viewing room that had one-way mirrors facing both ways.

One team could observe by listening directly through the sound system and the other team had to listen with headphones. But what actually happened—when we were lucky and had two cases—was that we would watch both of them by intermittently switching to headphones. We could not bear to miss anything about a case that came our way!

The interviewing therapist was called the *conductor*. After the interview, he or she took a consultation break to talk with the team and to construct an intervention message.

A Conversation With Myself About Brief Family Therapy

When I initially took my turn as the conductor, I felt uncomfortable in the role. I understood that I had to focus on information about the *problem* (at this time we asked about the problem in detail) so the team behind the mirror could compose an intervention message. But the team did not make it easy! It had a heavy hand on the buzzer that connected them to the interviewing room, always reminding me to get back to problem talk. They were somewhat impatient with me when I wanted to discuss that this made it difficult for me to focus on the conversation with clients in the interview room. So what was my problem? Well, to be isomorphic, we had to concentrate on the client's description of the problem. Perhaps my inexperience with this format hampered me a bit, but I felt this role made it really hard to connect with clients. So I asked myself, if we, the family and the team, create a suprasystem (in accordance with the binocular theory of change) (de Shazer, l982), then could not all the interactions lead to change to some degree, even those not so clearly related to the problem for which the clients sought help? As I watched the videotapes (we still had time to watch most of them), it looked to me as if a lot more went on in the interview that could indirectly relate to the problem. I asked myself if one should really ignore clients' tangents, emotions, or body language. I wondered about how clients felt when we did not seem to respect what they wanted to tell us or understand how they felt, but instead, kept asking about the problem. I told the group that I believed that the interview in itself may be as important as

[3] "The word 'isomorphic' applies when two complex structures can be mapped onto each other, in such a way that to each part of one structure there is a corresponding part in the other structure, where 'corresponding' means that the two parts play similar roles in their respective structures. This usage of the word 'isomorphic' is derived from a more precise notion in mathematics (43, p. 49). Hofstadter strongly suggests 'that it is such perceptions of isomorphism which create meanings in the minds of people' (43, p. 50)" (de Shazer, 1982, p. 8).

the intervention message for change. The team, in the spirit of research, or maybe to appease me, went lighter on the buzzer when I was the conductor. The importance of the interview for solutions did not become a point of interest for the team as a whole until l982, when we accidentally discovered that the client's focus on exceptions to his or her problem can lead to solutions.

By the way, I was not alone in my thinking at that time. Carl Tomm was also beginning to think of the interview as an intervention, and I remember discussing this with him. When I think back, that may have been the point at which I became aware of the issue of inductive versus deductive reasoning[4] in our work. In our discussion, I became more aware than ever that the assumption that the intervention message is the vehicle for change is too reductionistic, and that random information clients offer on their own can be as, or more, valuable to resolving the problem. Carl, too, had discovered at the time that focusing on the problem alone was limiting and spoke about the interview as a series of continuous interventions (Tomm, l987a, 1987b).

Soon, BFTC received national and international attention by means of a publication started by Steve in 1981, the *Underground Railroad*. It was sent out to people who were working on the cutting edge of the field. Among the contributors, in addition to our group, were people like Bill O'Hanlon, Brian Cade, Tony Heath, Bradford Keeney, and Cheryl Storm, many of whom continue to contribute to the therapy field to this day. By late l981, we had more clients and students and moved to a larger office space with more rooms with one-way mirrors. Many colleagues with whom we had forged connections began to visit our center. BFTC was the first place Michael White visited on his first trip to the United States. The *Underground Railroad* also attracted students like Yvonne Dolan, Michele Weiner Davis, John Walter, Jane Peller, among others who later made valuable contributions to solution-focused therapy.

The Birth of Solution-Focused Therapy

As a result of the next development, which started with the question "Why don't we ask them what they don't want to change?", the interview became our main focus and interest. It was late l982. Overall, our therapy was a loose and creative process. We often went in the direction of randomness, with the belief that it could lead to different and unexpected patterns of change. Sometimes we even went as far as to consult the *I Ching*.[5] Every session was a research project. We were still problem focused and had begun to develop some standardized tasks which were similar to Selvini-Palazzoli and Prata's (l980) invariant prescription. One of those tasks, particularly with vague clients, was to ask them to bring a list of what they want to change the next time they come. One day when the team was discussing whether to assign this particular task someone (and there are now many versions of who that actually was) said, "Why don't we ask them what they don't want to change?" In keeping with our "anything goes" attitude, we did. This question eventually grew into the formula first session task[6] (de Shazer, l985, p. 137) and the rest is history! Our problem-focused approach had become solution-focused!

We realized that change occurs when clients focus on positives and exceptions. The challenge now became to use the interview to help clients discover what worked for them; gradually, the now famous techniques were developed: exception question, miracle question (which had its origins in Erickson's, 1954, crystal ball technique), coping questions, and scaling questions. It all worked amazingly well! Decision trees were developed to clarify and simplify the technique, and to make it easily teachable and reproducible.

A number of years later, in his introduction to his l988 book, *Clues: Investigating Solutions in Brief Therapy*, de Shazer wrote

> As my colleagues and I at BFTC continue to study solution development we have been forced by our analyses to look more and more at the process of the interview. We found it was no longer enough to use our perhaps overly simple idea that the interview led to the intervention strategy and therefore the task (p. xiii).

Our underlying theoretical objective remained reductionism, or minimalism, which suited my need to help clients as quickly and effectively as possible.

The Emotional Climate of the Therapeutic Process

In l981, I was asked to consult with a women's shelter in Milwaukee. This led to 25 years of interest and development of ideas about how to use solution-focused therapy to treat spouse abuse (Lipchik, 1991; Lipchik & Kubicki, l996). The team joined me in treating cases referred by the Milwaukee District Attorney's office and by men's and women's groups; however, unfortunately, we did not do any formal research in this area. It became very clear though that our approach—a couples treatment (implemented after careful assessment) that made both partners responsible for their own behavior—was very effective with less severe cases in which there was some mutuality in the relationship. It

[4] Two broad methods of reasoning in logic are the deductive and inductive approaches to investigation. Deductive reasoning works from the more general to the more specific. Sometimes this is informally called a "top-down" approach. Inductive reasoning works the other way, moving from specific observations to broader generalizations and theories. Informally, this is sometimes called a "bottom up" approach.

[5] At least 5,000 years old, the *I Ching* is a mystical text or a book of oracles; through the symbolism of its hexagrams, the person asking a question is believed to be guided toward the solution of difficult problems and life situations. It can also be read as a book of wisdom, revealing the laws of life to which all humans must attune in order to live in peace and harmony (Wilhelm, 1989).

[6] Between now and next time we meet, we would like you to observe, so that you can describe to us next time, what happens in your (life, family, relationship) that you want to continue to have happen.

helped to preserve the family unit as opposed to separating it for months, which was the general policy in the United States and in other countries at the time. These cases were part of our general outcome studies and fared as well as all our other cases. Although there have been few changes in policy in the United States regarding the treatment of couples without separating men from their families, I still hope that those years of national and international presentations made some difference for couples and families in different parts of the world. My ongoing work on spouse abuse was a powerful contributor to my feelings about the need to attend to emotions in our work. It was one reason that I tried to develop a visual concept of the therapist–client relationship and the context in which techniques are applied (see Figure 2).

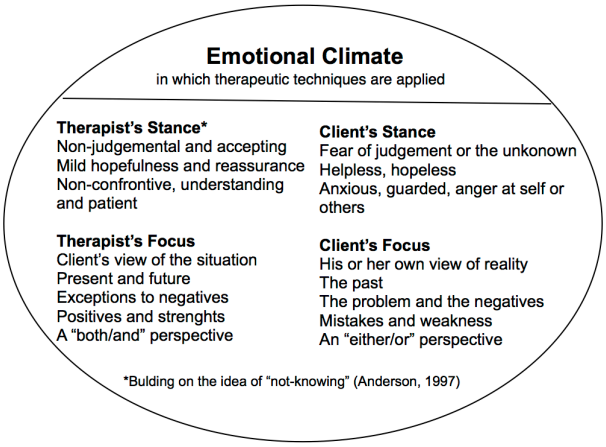

Figure 2. The emotional climate in which therapeutic techniques are applied.

"BRIEFER" – A Task-Generating Computer Program

Around l984, one of our research associates, Wally Gingerich, a professor at the School of Social Work in Milwaukee, suggested that we try to see if an expert computer system could be developed to determine which task a therapist should give at the end of the first session. This idea was very appealing to Steve, who was also interested in computers and always ready for new research. To accomplish this, we brought in a master's degree student, Hannah Goodman, who was looking to do a project on artificial intelligence for her dissertation (Goodman l986; Goodman, Gingerich, & de Shazer, l989). In order to write the program, she interviewed each of us in great detail about our interactions with clients. When I went through this process, it became clear to me that in spite of the effectiveness of our techniques, things happen with clients that simply cannot be described concretely. I seriously questioned whether the therapeutic process could be computerized. Again, I asked myself, what about the client's emotional state? What about the role of body language? But my colleagues always reminded me that we had a model based on cognitive–behavioral ideas, and emotion had no place in it (cognitive and behavioral theories at this point in time did not include emotions or body language). How could this be reconciled theoretically? When I discussed this with my colleagues, they listened respectfully, but were again not about to go there with me. As it happened, the BRIEFER computer system turned out to be fairly accurate in matching the task given to clients at the end of the first session by a live therapist or team.

Solution-Focused Therapy Takes Off

By the mid-1980s solution-focused therapy had arrived. We had students, as well as requests for workshops and training, from all over the world. Some members of the original group had left and new members, usually ex-students, like Kate Kowalski and Ron Kral, took their place. Jim Derks left for a well-paying job in a large health organization when he and his wife had a child. Marilyn LaCourt left soon to join Jim to get medical insurance for her family. BFTC could not afford medical insurance for its staff members yet and large organizations were able to supply generous benefits. The close bonds that had made the original group so fruitful began to gradually loosen. There was also less opportunity for teamwork. Our private practices had grown and our training program required our attention as supervisors. Steve concentrated on the research group and his writing. Insoo began to do trainings at university counseling programs all over the state and also became active in the AAMFT, both locally and nationally. More and more invitations, particularly to Insoo and Steve, arrived from all over the world to do workshops and lectures. All of us who had been part of the development from the start were both proud and a little amazed that we had accomplished more than we had ever expected. I have to confess that we had also developed a considerable amount of hubris about the efficacy of solution-focused therapy.

With less focus on developing the model and increasing contacts with other therapists at conferences and workshops, I became more aware of and interested in concurrent developments in the field, like the work of Lynn Hoffman, who was moving toward a constructivist approach; Harry Goolishian and Harlene Anderson, who were exploring language systems; and Michael White who was laying down the foundation of narrative therapy. I noticed that while we shared a desire to move away from cybernetics toward constructivism, unlike us, they were gradually moving away from specific techniques. They were using conversations with clients that had no specific goals and just allowed clients to find new ways of thinking about their situation.

By this time, I was following the clients more than I followed the general solution-focused model by the book, and was less bound to a specific order for applying the techniques. I also began to change my way of teaching. When we started training, we gave the trainees 4 to 6 weeks of seminars before putting them in a room with clients. Most of them became increasingly anxious about meeting clients face-to-face, and when they finally did, their anxiety often

made for awkward sessions with too many phone calls to the room. After a while, Insoo, as Director of Training, with agreement from the team, suggested that we change this procedure and put students in the room with clients as soon as they started; students were given just a brief outline of the questions to ask. This was not an ideal situation either, as students often looked down at the paper more than at the clients. At the time, we really were not expecting "one-session miracle cures" from students at the beginning of their training (this was more an expectation that we had of ourselves). Students, of course, got to watch us work too. I had a big problem with students not developing a good connection with clients right away. Without it, I felt clients could not fully focus on thinking about the answers to questions about exceptions and the future. So with my students, I instituted a method where I asked them first and foremost to listen. I asked them to make sure that they understood what clients were feeling and wanting, and to make sure that the clients knew that they were being understood. I told them not to worry if they had not defined goals clearly in the first session. More clients came back for a second session than before, reporting that they felt better even if they had not found a solution. This relaxed the therapists in training, who were encouraged by these reports, and subsequently led to quicker solutions for clients. While our team created the theory and techniques together, we had very different styles of putting them into action, and that was true for how we taught as well. I believe that this was very isomorphic with our belief that the client's worldview must be respected and utilized in order to be helpful.

I also developed a model of dual track thinking to help students orient themselves in the therapeutic conversation. *Dual track thinking* (Lipchik, 2002) is the process of interacting with clients while simultaneously monitoring one's own thoughts and feelings. It is a tool that I found very helpful for making choices about how to respond to clients. For example, in a situation when the therapist feels overwhelmed by the client's story and begins to feel helpless, he or she can refer to one of the solution-focused assumption, such as *nothing is all-negative*, or *clients have strengths and resources*. These and other assumptions serve as reminders to keep probing for small exceptions or coping skills, and reduce unnecessary anxiety that cannot help but be transmitted to the client in some manner.

Around the same time I was thinking about all this, John Weakland came for one of his almost annual visits to BFTC. He and Steve had become very close friends by that time. John was Steve's role model to such a degree that they even drove the same type of car. John usually conducted a session with a client in front of the mirror for our trainees. These demonstrations reflected the MRI brief therapy model very precisely and succinctly. But during this particular visit, John stayed in Milwaukee a bit longer and asked us if we would like to see some of the tapes from his private practice. Of course we wanted to see them! Who would not want to observe the master at work? What a surprise that was! John was quite a different person in his private practice tapes compared to his demonstrations. He engaged much more with clients, responded more empathically, and wove technique into conversation so seamlessly. It was beautiful to see. What I saw him do in his private practice clearly reflected some of the ideas that I was trying to develop and describe. If I needed any further encouragement to stay on my course, he had given it to me.

Individuation

Some of you may recall the early 1980s when everyone became very interested in the work of Humberto Maturana. I remember going to an American Family Therapy Academy meeting and listening to presentations by Carl Tomm about Maturana and Varela's theory of autopoesis and cognition.[7] Afterwards, audience members hesitatingly asked each other, "Do you know what this has to do with family therapy?" Well, it did not take too long for family therapists everywhere to "get it." As the years passed, the field gradually became enriched with postmodern ideas inspired by Wittgenstein, among others, and propelled by thinkers like von Glaserfelds, Gergen, and Derrida, to mention only a few. I appreciated this new direction. It held so much promise for new and interesting ways of thinking about therapy and also resonated with my ideas about human connection. But I have to admit, I hit that snag of uncertainty again. I really had a hard time with Steve de Shazer's pronouncement in those days that "there is no such thing as theory." What he meant by this was that every linguistic interaction is unique and occurs in the moment. It was his way of saying that the course of the solution construction must not be planned or predictable, but spontaneous. But, I thought, isn't that a theoretical stance in itself? And what does that actually mean for the therapist and for teachers of therapists? Once again, the conversations began in my head about how to reconcile all this. I began to realize that I needed a "both/and" solution, one that was biological as well as philosophical. I searched the literature for past theories that fit a constructivist lens, but that also incorporated cognitive and emotional aspects of the therapeutic process. This search resulted in my rediscovery of Harry Stack Sullivan's interpersonal model,[8] and an increased appreciation for Maturana and Varela (l987). The work of these men had a biological foundation that considered human relationships as fundamental for human development, change, and survival. They denied objective reality in favor of experience in the moment, which is driven by emotions. Sullivan (1953) considered the basis of all problems presented by patients as emotional discomfort with

[7] "'Autopoiesis' (from Greek αὐτο- [auto-], meaning 'self,' and ποίησις [poiesis], meaning 'creation, production') refers to a system capable of reproducing and maintaining itself. The term was introduced in 1972 by Chilean biologists Humberto Maturana and Francisco Varela to define the self-maintaining chemistry of living cells. Since then, the concept has been also applied to the fields of systems theory and sociology" ("Autopoiesis," n.d., para. 1)

[8] Harry Stack Sullivan was one of the most important innovators and seminal thinkers in American psychiatry. He lived during the first half of the 20th century. Sullivan was a synthesizer, bringing the contemporary ideas of psychiatry and social science together to form what has been called "social psychiatry." The intellectual roots of the community mental health movement are found in Dr. Sullivan's work and writings.

self and others, which he called *anxiety*. He defined his role as therapist as being a *participating observer* of the relationship between the therapist and client (Chapman, l953). Maturana and Varela (1987) considered emotions to underpin all action described as "languaging" (p. 234), "a phenomenon that takes place in the recursion of linguistic interactions—linguistic coordinations of linguistic coordinations of action" (p. 211). So essentially, therapy is an emotionally-based interaction, both for Sullivan and Maturana and Varela. Moreover, Maturana and Varela's notion that an organism's conservation of basic resources is necessary for change and survival is highly congruent with solution-focused thinking. These ideas encompassed how I was trying to explain a solution-focused process that included emotions. But still, all this information and ideas collectively caused me to struggle with my loyalty to the solution-focused model that I, too, had helped to shape. Biology, cognition, and emotion did not seem to have a place in the minimalistic solution-focused model that we had developed. I asked myself, "Can I preserve and advance the philosophy and basic concepts of the solution-focused model if my thinking veers too far from the party line?" After a while, I decided that there does not have to be a right or wrong. There can be multiple descriptions of some basic principles. I believed that I needed to choose a way of thinking about therapy that was comfortable for me in the sense that it was congruent with my observations and clients' responses in therapy. This was absolutely necessary if I was going to be helpful to people.

Based on all of my experience and the current ideas I have described, I created my own theory and assumptions.

My Theory of Change and Assumptions

My theory of change. Human beings are individual, biological entities that are unique in terms of their genetic make-up and social development. They have the capacity to change to the degree determined by these factors. They construct meaning about their world, themselves and their relationships through language. Problems are what they experience as distressing life situations they feel incapable of changing. Solutions become possible through conversations during which they discover resources within themselves to achieve what they define as solutions.

Assumptions to facilitate the therapeutic work.

1. Every client is unique.
2. Clients have the inherent strength and resources to help themselves.
3. Therapists cannot change clients: they can only cooperate with how clients cooperate.
4. Every human being strives for emotional security.
5. Emotions can override cognition.
6. One cannot change the past; only exchange of language in the present can change the future.
7. The quickest solutions are arrived at slowly.
8. Nothing is all negative.
9. Change is a constant and inevitable; a small change can lead to bigger changes.
10. Best solutions are arrived at slowly.
11. If it works don't fix it: if it doesn't work do something different.

I have always found theory and assumptions to be important guideposts for therapists. Many years ago I used the following metaphor about learning how to ride a bicycle when teaching. It is difficult at first not to keep falling over with the bicycle until one learns how to balance it. As one gets more and more competent one becomes more and more aware of the subtle movements one has to make to stay upright. In the same way, it is difficult to keep the therapy moving forward at the beginning without moments of faltering. Just as one does not always have someone running behind the bicycle to steady it one does not always have a team behind the mirror to call in a question or thought at that moment. A list of assumptions can help one keep the rhythm and direction of the therapy going. This is not only true for the beginner but for the experienced therapist, as well. There are always decision points we reach at which theory and assumptions are helpful guideposts.

Another thing that came to my mind as constructivism guided our thinking at BFTC was an inconsistency between the session and the message we gave to clients at the end. In 1986, we had come up with the idea that clients really fall into three categories: visitors, complainants, and customers (de Shazer, 1988). *Visitors* do not think they have a problem, *complainants* just want to complain and not change, and *customers* are motivated clients who make our lives so easy. The purpose of these categories was to decide whether to assign a task at the end of the session. The formula for the message had been standard for years: Start with compliments; reframe something or normalize it; make a comment or psychoeducation point; end with the statement, "What we want you to do for next time . . . "; and give a homework assignment.

The categorizing of clients did not seem consistent with our philosophy of not labeling people. It caused me to ask myself whether these categories could really be considered collaborative.

My experience had taught me that clients do not necessarily maintain the same position they come in with. The level of motivation can change considerably by the end of the first session, and thereafter, depending on how the sessions progress. For instance, when I would invite a client's reluctant/resistant partner to come in to see me by him- or herself—to tell me his or her side of the story—more often than not, the partner ended up becoming a participating so-called customer. I also often found this to be true with families, or with parents who just planned to have their child in therapy. As far as I remember, my opinions about using this labels did not get much of a response from the others. Later, Steve stopped using them in teaching and in the most recent editions of the basic textbook on solution focused therapy, *Interviewing for Solutions* (De Jong & Berg, 2008, 2013), the labels were not included; and the descriptions were more nuanced in later years. But at the time, in the 1980s, either the lack of time together or divergent interests kept group members from responding to ideas as they had in the first few years. Even if we touched

on the subject briefly, it typically did not go any further. So I asked myself, what would be more congruent with our collaborative philosophy? I came up with the idea of mirroring the interviewing process in the intervention message, that is, the recursive process of questions and answers. Eventually, I reconfigured this message to what I now call a *summation message*.

The summation message. Instead of coming back like an expert after the in-session break and giving the client the message from the team, I would say "What I heard you say today . . ." and then ask the client if I heard them accurately or if they wanted to correct something I said. Then, I would reply with a message about my reactions to the interview with the usual reframes and comments, but instead of assigning a task, I would casually say, "Sometimes, we have found that people in your situation find it helpful to do . . ." and explain a task that the client could chose to do (or not do) until our next meeting.

The Steps of the Summation Message

A. Reflection of client's input. This statement should include the following:

1. the complaint,
2. the goals,
3. any progress that has already been made, and
4. what the client said about how the situation is affecting him or her (including emotionally).

B. Response to client's input. This statement should include the following:

1. the therapist's reaction to the situation;
2. reinforcement of positives and changes;
3. normalizations, reframes, or new information; and
4. acknowledgement of clients' feelings.

C. Task. The task should always be stated as a suggestion rather than an assignment; clients can choose to do it (or not).

My experience with this process has been very positive. Repeating what you heard the client say appears to result in the therapist having an increased attention. Further, for the clients it typically resulted in an even more deliberate "yes-set" reaction (i.e., a nodding of the client's head that signals agreement or attentiveness; de Shazer, l982; Erickson, Rossi & Rossi, l976), which we had always observed for the standard intervention message. Clients seem to appreciate being asked whether they were understood. Once clients agree that I heard them correctly, my comments that follow are nowadays typically far less strategic than in the past. They tend to be as positive as possible in order to maintain hope and motivation, and at a minimum, not to suggest things are hopeless or worse. Tasks are fitted to the clients. Some clients, like those who tend to be a bit compulsive, need a behavioral task, while others who are on the more creative spectrum do better with a "thinking" or "noticing" task. I do not always give a task or suggestion. In some cases, it may be sufficient to say, "You seem to be doing the right things to progress, so keep doing what you think is best for you. I'll look forward to hearing what that is." While this is not a "task," it is a definite message, and I think it is useful to end every session by saying something regarding the time between sessions.

Is There a Right Way to Do Solution-Focused Therapy?

In l987, I began to notice that, Steve de Shazer seemed to be conducting interviews as though he were testing what task might fit at the end of the session rather than first trying to understand where the client was coming from. It felt to me like a throwback to the early days when we thought the intervention made the difference. After watching for a few weeks, I told Steve, "You are hypothesizing about which task to give at the end." He disagreed. Although we had come a long way from the early think tank in which every new thought was food for a group discussion, Steve and I were not beyond a research challenge. So we decided that we would watch a videotape together and stop it after every exchange in order to share what we were thinking. This proved to be very interesting. Our process, or idea of co-construction, was really very different at the time. Steve's process seemed to me to be one of working backwards. If the client's information was not useful for the intervention that occurred to him early on in the session, he would direct the interview toward another possibility until he found a good fit. My process was, and still is, forward driven—step by step along a straight line from beginning to end. But, at the end of the session, we both came up with almost identical messages and tasks. We arrived at nearly the same results from both inductive and deductive reasoning. Since Steve was a man of few words, I do not know what conclusions he drew from this exercise, but to me this was evidence that there are different ways to be solution-focused.

As the years went by at BFTC, the graduates and next generation of trainers began to develop their own styles. Some increasingly emphasized the use of techniques, while others became more relaxed. We also gradually modified our initial belief that the solution-focused process worked, regardless of what specific problem or situation was at hand. As early as l982, we had to accept this when treating spouse abuse cases, as I discussed above. It was critical to assure the safety of victims above and beyond the application of our theoretical concepts. However, it was not until the late 1980s that it was acknowledged in publications that certain problems had particular complexities that needed to be considered. So it became necessary to take a "both/and" stance: Solution-focused therapy did not need a problem description to be applied, but at the same time, some contextualization was needed for areas such as alcohol treatment (Berg & Miller, 1992), geriatric dementia (Bonjean, 1989), school problems (Molnar & Lindquist, l989), and issues in social service systems (Berg, l994).

I Began a New Chapter

In l988, I left BFTC for various reasons. One of the main ones was that I wanted more time for my family. I have to say, Insoo and Steve tried to accommodate me so that my workload and time commitment would allow me to stay, but I had also been having a conversation with myself for some time about independence. After 8 years with BFTC, my reputation was primarily based on my affiliation with the center. There were times when I was with Insoo and Steve when people asked, "Who are you?" I wondered whether I could ever establish myself on my own as a creative practitioner in their shadow. The process of convincing myself that I should take a chance took over a year.

When I finally made the decision, the plan was to rent a room somewhere and work part-time. Well, it did not quite work out that way. Marilyn Bonjean—a family therapist specialized in working with geriatric and the chronically ill patients, who had been in private practice part-time at BFTC—happened to leave her job as clinical director of a nursing home. I left BFTC at about the same time because of a change in management. Marilyn also wanted to try full-time private practice, so we decided to share a space. The idea of renting one or two rooms mushroomed when we fell in love with an old Victorian building, the first floor of which had particular warmth and charm. We founded ICF Consultants Inc.,[9] in l988, where we practiced independently but shared the administrational tasks and occasional projects. We were happy and proud to celebrate 25 years of harmonious and successful partnership last year.

In keeping with my continuing curiosity about what really makes the difference for clients in SFBT, one of the first things we did at ICF was to set up a protocol to study this question. We developed two sets of questionnaires, one for the therapist and one for the clients. At the end of each session, the therapist filled out a form predicting the outcome for the next session, and noted potential reasons for the prediction of such an outcome, for example a particular conversation, a response by the client, or a particular intervention that was considered potentially useful for the client. Before each session, clients were asked to fill out a questionnaire asking them if they had experienced any change, and if so, how they accounted for it. For instance, if the therapist had said, done, or assigned something last time that the client thought had made a difference?

We ended up with about 65 cases. What was absolutely astounding was that the therapists' predictions and the clients' reports never matched. Not one client ever credited a particular technique or homework task as having made a difference to them. Instead, they reported things like "the therapist accepted me," "she understood what I was saying," "she made me feel I wasn't crazy," and "she made me feel better about myself." This affirmed for us the importance of the relationship, or the emotional climate in therapy. It demonstrated that the techniques do not work by themselves. Their effectiveness depends on the context in which they are used. We did not publish this study but it guided us in our development as therapists.

In the years after I left BFTC, I had time to focus more whole-heartedly on my teaching and writing. I did not feel in any way constrained to write before I left, but I was busy with administrative tasks and had become the Director of Training because Insoo and Steve were traveling so much. Once on my own, I again began reflecting on how I was practicing the solution-focused model and also began to write about it. I also began to present more nationally and internationally. Developing presentations and receiving feedback from audiences stimulated my thinking.

Those years at BFTC from l978 to l988 will always count as some of the best years of my life. I gained so much! Steve's knowledge and thought process served to help expand my own like nothing else before. Insoo's mentoring transformed me from a fearful to confident presenter, a role I never expected to fulfill. I will always be thankful for having had the opportunity to be part of BFTC and its creative developments.

An Entirely New Perspective

In the mid-1990s, I was invited by Francine Shapiro to participate in training in eye movement desensitization and reprocessing (EMDR; Shapiro, 1995). This was the result of a casual conversation in which I mentioned my interest in the new neuroscientific research that was coming out at the time as a result of improved imaging techniques.

Up to that point, what I knew about EMDR was that it was in essence the opposite of a solution-focused way of practicing. However, I had not taken any training of my own in years, and it seemed like fun to do something totally different. Well, I was blown away by what my fellow trainees and I experienced! I saw how we produced amazingly rapid results in a totally different way than any therapy I had ever read about. I was also attracted to the fact that EMDR attempted to deal with cognition *and* emotions. So I had to ask myself, how can I integrate this work with my solution-focused way of thinking? It seemed at first that the stance of the therapist is totally different, but with more training and practice, I recognized that the EMDR process was also very client-centered. I now utilize EMDR in situations where solution construction seems to be at an impasse because the client cannot get past a negative belief about him- or herself in relation to something that happened in the past.

More recently, I adopted techniques to help clients regulate their emotions and stop obsessive thinking. Also, thanks to Michael White's externalization technique, I often provide relief to clients by externalizing their inability to regulate emotions. I explain that the emotional systems in the brain are much more extensive and powerful than the cognitive systems, and that they shut down rational thinking and control when they get too aroused. I usually get sighs of relief and statements such as "so it isn't my fault?" or "I'm not crazy?" The clients are then in a better state of mind to focus on techniques that utilize their own resources, such as

[9] ICF stand for Individuals, Couples and Families.

thinking about times when they have been able to regulate their emotions in the past or ways in which they do so already.

I don't know how other solution-focused therapists would describe me today. I am sure that I would not be considered orthodox. By the way, "orthodox" is a word that Steve de Shazer abhorred. He always said he never wanted solution-focused therapy to become an orthodoxy. In developing my views, I often struggled in deciding whether to follow my gut feelings or my colleagues, for whose thinking I have the utmost respect. However I now feel confident about identifying myself as a solution-focused therapist because I feel grounded in the philosophy that therapy is a collaborative process; problems are not pathology, but rather the ups and downs of life. I have a systemic, interpersonal perspective and I believe people have inherent resources that will lead to solutions. Moreover, I think it is more important to move forward than to explore why things happened in the past. This is a framework with which I integrate other methods or techniques when necessary, with the rationalization that I have to help the best way I know how, rather than according to specific guidelines. Perhaps my impatiences to help clients in the best and quickest way possible has driven me to expand my solution-focused framework? Perhaps no one can keep doing something for 30 or more years without evolving? Perhaps one shouldn't even try to stay the same? But, on the other hand, if it works, should one fix it? I don't know the answer to all of these questions because I really believe that every human being is unique.

So that is the development of my solution-focused working model to date. I hope I will be able to continue my journey just a little way longer.

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