Beginnings
— Steve de Shazer.

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(People often ask me questions about my story and the story of BFTC. I am neither a biographer nor an historian, so the following are somewhat random recollections of the story through the 1970s and early 80s. I will try to answer the most frequently asked questions and the more interesting ones with answers that are not already in my books.)

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I was born (1940) and grew up in Milwaukee - a city that has long been famous as a brewing city. Thus, a predominantly German culture. (When I was twelve I spent hours in the city library looking up the spelling of various words that I'd used all my life but could not find in any of our dictionaries at home. The one word in particular that started this search was "Gemütlichkeit" - which I had not realized was a German word. I had been looking in English dictionaries! This led me to begin to discover just how German or, better, Bavarian (at least my area of) Milwaukee was (and is?). Over the years the Bavarian source of the Milwaukee culture has become clearer and clearer to me. Recently my view was confirmed (again): In one of Patricia Wells' cookbooks, she talks about how "growing up German in Milwaukee" influenced her taste in food. Unknown to me, we grew up within blocks of each other.)

While growing up it was always assumed (adults believed and said) that I had "talent" when at 7 or 8 I played the clarinet (but not when I played the violin! < - I gave it up after 6 months - it was another 20 or so years before I gave up the reed instruments.) Thus, as far as the adults in my life were concerned, it was a matter of course that I study art and music and be further encouraged to go into theater, or become an architect. This was never discussed. My father thought highly of Frank Lloyd Wright and we'd make yearly visits to his headquarters in Spring Green while on camping trips. We would also go almost every year to see the Johnson Wax building in Racine with my father telling me the story about Wright's fight with the building inspectors over whether or not his columns would support the building. Wright won and they these funnel shaped columns are still holding it up 60 years later. For me, there was too much science involved in becoming an architect. "Artists," of course, cannot be expected to do well academically, particularly in such areas as math and science. This was, for me, both a blessing and a curse. Thus I had this label to hide behind whenever I did not feel like working at something like math and science.

During each and every winter I remember a growing desire to move to someplace warm, somewhere that did not get a couple of meters of snow, that did not get to -25 (F), etc. I finally achieved this goal, moving to first Victoria, British Colombia in 1970 and then to near Palo Alto, California in 1971. Within 5 years I became bored with California weather; much too predictable. Day-after-day-after-day is the same. (This is never true in Milwaukee.) Fortunately, I met Insoo - who was living in Milwaukee! (< - damn) - and when we decided to get together, I returned. Now, every day of every winter I again talk to myself (and sometimes to Insoo, now that she is starting to agree) about moving to somewhere warm < - We probably never will.

* - > Jay Haley's Strategies of Psychotherapy < - Until I read this book, as far as I can remember, I had never even heard the term "psychotherapy." Certainly this was the first book on the topic that I read. I enjoyed it perhaps more than any other "professional book" I'd read in philosophy, art history, architecture, or sociology. So, I went to the library and looked at its neighbors. I was shocked. I was unable to finish any of the others I tried to read: After Strategies - which made so much sense to me - everything else was (poorly written) nonsense until I found Advanced Techniques of Hypnosis and Therapy which is a selection of Milton H. Erickson's papers. It is not going too far to say that these two books changed my life and shaped my future. Unlike so many other "professional books," the books by Erickson and Haley were well written. They were clear. (I then read everything else they had written and I followed their references to other authors and

other articles and books.) Among other things these books implicitly and indirectly (at times) suggested many of the themes that would form my career, including the idea of "brief therapy." (My first "case" involved prescribing that a young man with a recurring nightmare force himself to have the nightmare as soon as possible after going to bed rather than keeping himself awake in order to prevent it. He was unable to force the nightmare and slept through the night.)

* During the second half of 72 and the first half of 73, Joseph Berger (Professor of Sociology at Stanford University) worked together on two projects. The first was what he called "research" which involved his spending whole days each week sitting behind the mirror observing my working with clients. Then we would try to bring sociological knowledge to bear upon each of the cases. Eventually we narrowed it down to describing the situation using Fritz Heider's Balance Theory. The second was to try to develop a theory based on the work of Milton H. Erickson or, perhaps, discover Erickson's theory which is implicit in the papers. We were never able to agree on which we were doing. (This eventually led to our agreeing to disagree when I started to take an "outside-observer" position including the therapist on the map.) Regardless, each paper was read and re-read and read again. Then we developed a balance theoretical model of the cases. Then we tried to sort the cases into categories or types. This latter part was never successful. There were too many cases that were unique and thus we ended up with almost as many categories as cases. Erickson, it turned out, was correct in saying that he did not have a Theory. He perhaps had many theories, but not quite one per case.

* When Insoo came to Palo Alto for a brief therapy workshop (in 74? 75? We don't remember), she asked John H. Weakland if there were any other brief therapists in the area she might watch in the afternoons, since the workshop ended at 2:00. He suggested that she contact me across town. He was sure that I would let her sit behind my mirror. As John Weakland would say, one-thing-led-to-another. We became colleagues and partners and then, to please Sarah, her daughter, then 15, who did not want us living-in-sin, we married.

* I was surprised one day in 1975 to receive a phone call from John H. Weakland inviting me to be on a panel with him, Dick Fisch, and Paul Watzlawick during the Second Don D. Jackson Memorial Conference scheduled for June of 1976. The topic was: "Techniques of Brief Therapy." We had met a year or two before and he had read what I had so far published on brief therapy and we had talked now and then. (Of course, I had read what he and his gang had published.) I was shocked and honored by this invitation and of course accepted before asking for any details. I did not want to give him a chance to change his mind. This would be my first conference presentation of any kind whatsoever. If I had known that it would involve an international audience, I probably would have scared myself into saying "no." Later that year he and I did a workshop together, "Unorthodox Techniques of Brief Therapy," for the American Association for Psychiatric Services to Children where I discovered that anything he and I might consider as "normal technique" they saw as "unorthodox." The audience thought it rather peculiar, or unorthodox, that we would ask the client about what the problem was and further that we would take their answer seriously! This sort of dissonance between what I think of as normal and ordinary and what the audience thinks unorthodox and/or bizarre has continued but the dissonance lessened over the years as I have become more used to it.

* In 1978, Insoo and I and a group of our colleagues - who had been working together (secretly) for many years - decided to set up an independent "MRI of the Midwest" where we could both study therapeutic effectiveness, train therapists to do things as efficiently as possible, and, of course, practice therapy. Due to circumstances, we had to pick a name literally overnight and thus ended up with a compromise: Brief Family Therapy Center. The word "brief" became part of the name since there were a couple of us who saw ourselves as "brief therapists" and the word "family" because some of us saw ourselves as "family therapists" who - because of method - worked briefly. (This compromise has caused me no end of trouble: I am not a family therapist.)

Prior to setting up BFTC a group of us would sit behind the mirror observing one of us work with a client. Normally, we would meet before and after to discuss the case. One day in 77, we watched while the therapist and client were trying to define and describe the problem, i.e., the client's complaint and the associated, failed attempts to resolve that complaint much in the same way that MRI would do it. The client and therapist were focused on this frame: She was depressed and, therefore, she was fat. Naturally she believed she needed to stop being depressed before she could lose weight. Behind the mirror, the group was thinking the opposite: She's fat and therefore she's depressed. Using that punctuation, interventions could be aimed at her ways of accidentally maintaining and increasing her weight. We phoned in a couple of suggestions based on this view but the therapist did not find our help helpful. This frustrated both the therapist and the group. Finally, the therapist excused himself for a couple of minutes to talk to the team. He was going to straighten us out. I don't remember the outcome of that discussion, but we soon started to routinely take a break in the session during which the team and therapist would meet, a procedural intervention that we continue to this day. It was not long before we started to take a break "to think about things" even when working alone.

Shortly after the break became routine, one day when the therapist returned to the therapyroom, the client asked him about what the team thought about her situation. The therapist clearly was stuck, not knowing what to say. We, behind-the-mirror, thought this was a reasonable request so we quickly formulated a brief statement which we phoned in. This statement was phrased as positively as we could - just to be nice and polite. We wanted to be on her side. The client beamed and thanked us. We too were pleased. In the following hour we wrote our first compliments which the therapist read to the client before he gave the homework task. The client smiled and the following session reported having done the homework. We noticed that when we gave compliments, then the clients were more likely to do the task than when we did not. Within weeks, compliments became routine. We continue to give the client some compliments when we return to the therapy room after the thinking/consultation break.

The original BFTC team was quite interesting and, I suspect, unique. (I joined this group when I moved back to Milwaukee.) Unlike most groups who start an institute, this group was very heterogeneous which I think greatly contributed to its creativity. (For further information on this group see: Nunnally, de Shazer, Lipchik, and Berg, 1986.) In some ways we were very naive: We began this institute with no outside funds. It was just a private-practice group of workaholics. We used whatever money we made in the first years to buy chairs, tables, videocameras, videotapes, one-way windows, and to pay the secretary (who never missed a paycheck). If then we had any money left over, we first repaid the loans each of us had made to start the institute. Until the third year, pay checks for the team were rare. Frequently we would arrive at the center before 9 in the morning and not leave until after the last clients were finished after 9 in the evening. Saturday was a short day; usually we closed up shop around 3:00.

BFTC's first official act was to get a sign painted and business cards made for Jim Derks and I who were to be the only full time "public members" of the group. (The third, very part-time "public member" was Marvin Wiener who moonlighted as a therapist although his regular work was as a family physician. Like me, he was a brief therapist who had no official training as a therapist. Jim Derks had trained as a structural-family-therapist in Philadelphia.) The second official act was to do a 3-hour presentation at the state family therapy association conference. We did not even have an office yet. We were seeing clients in our living room. The team, usually just one person, sat on the stairs working the video camera. When we took a break, we would go upstairs to the bedroom level. This worked well as far as the actual doing of therapy, but Insoo and I soon found out that this meant there was no way to leave the office. We went looking.
* In our first office suite we had two therapy rooms with a viewing room in between and a little business office. This little office, where my first book and the early BFTC papers were written, was

barely big enough for the furniture, the videotaping equipment, and four people standing. Nonetheless, we would gather there to watch sessions on the monitor and to watch videotapes < - Sardines.

In the main viewing room the team could watch two cases at once. (There was more room in this viewingroom, but when the two therapy rooms were in use and the whole team, students, visitors, and guests were all in there, it would get pretty warm. During the years we worked this way, only one person ever fainted.) However, one team had to use headsets and thus they could not talk while observing a case. The other team listened over loudspeakers and thus were free to move about and talk. Thus the second team would often get too loud and irritate the team handicapped by headsets. Surprisingly, there was little or no difference between the messages the two teams invented. This puzzled some of us so we started a little research project to find out how what the team behind the mirror did related to what was happening in front of the mirror.

* We audiotaped the hours when there was only one session and therefore the team members in the viewing room could talk. Eve Lipchik (originally trained as a child-therapist) was rather surprised one day when she listened to the tape from behind-the-mirror made while she was in-front. Everything had been fine. When she took the break and came behind the mirror, the team (Alex Molnar - a professor in the School of Education - and I) had worked with her to design an intervention message that she thought fit quite well. She became puzzled when she listened to our tape because Alex and I had spent the time talking about our reading of Schopenhauer! How, we all wondered, did this correlate with the talk of the therapy session? How were we able to talk about philosophy and simultaneously observe the therapy session well enough to be helpful to the therapist? Although this was an extreme example, it was not unique. Frequently, behind the mirror there was no conversation relevant to the therapy session on the other side < - What was going on here?

We began experimenting with having two teams for a single therapy session. The "official" team would be in the viewing room while the "research" team would be watching the monitor in the office. After the client left, the two groups would get together and compare. Most often the two teams had the same idea for a homework task and usually the compliments were similar and sometimes the same. Even when the research team cheated and based their intervention message on the I-Ching, the messages turned out to be similar. We would frequently split up workshops and training groups into two or more units to design messages and usually these messages were very similar. Ever since I have used this as a tool for teaching therapists how to design these intervention messages. (Now I will show the videotape of first part of a first therapy session, up until the intermission and then stop the tape so that the seminar participants, in small groups, can spend 10 to 15 minutes designing an intervention message. Then I play the message on the tape after hearing from each group of participants about their ideas. No matter where in the world I have done this, the various teams will almost always come up with acceptable alternatives or with messages that are so similar that I am tempted to say they are "the same." Upon occasion, a team will come up with one that I think is superior to mine!) My (mis)understanding of this is that everything therapists need to know to design useful and successful intervention messages is readily available and easily identifiable because it is right on the surface - the actual conversation between therapist and client. Nothing more is needed! (The trick, so to speak, is knowing how to organize this stuff.)

* During the 70s and perhaps before, at least among family therapists there was the idea that first sessions needed to be longer than the traditional (50 minute) hour because there was so much information to be had when seeing a family unit. Their idea was that it was impossible to find out everything the therapist needed to know from all those people in only 50 minutes! Taking an intermission in the session, as we did to design an intervention message, meant that 10 minutes or more might be lost from the already inadequate 50. In 1979 or so, Elam Nunnally - a family

sociologist, whose sessions were the longest of anybody's in the group - and I decided to do an experiment. We imposed a 30 minute limit on ourselves. That is, we automatically took the intermission after just 30 minutes regardless of how large the client unit might be and regardless of whether or not we thought we had "enough" information. In none of the 40 or so cases did we have trouble designing an intervention message. We always found that we had "enough" information. Furthermore, this arbitrary time limit had no effect on outcomes, task performance, or on whether or not the client would return for the subsequent session. At that point it became clear that the intervention message could be built around anything that therapist and client had talked about as long as it fit for the client. Over the years since my sessions have continued to be closer to 30 minutes than to 50 and Elam's sessions started to be less than one hour for the first time in his career.

* During the 70s and into the 80s the practice of brief therapy continued to focus upon the (hopefully useful) homework tasks given at the end of the therapy session. Of course, Erickson's work provided the model or prototype. A cleverly designed task was thought to be necessary for effective brief therapy and, therefore, the team would agonize over tasks for our clients in each and every session. With some frequency, the tasks were so clever that they need to be called "paradoxical." (We quickly discovered that learning how to design clever, paradoxical tasks is very difficult indeed. Many potential brief therapists never did figure it out, gave up and continued to practice in traditional ways.)

Since in the 70s these tasks were seen as the engines of change, it was important to us, the therapists, that the clients did their homework. Of course clients, being human beings, sometimes did the task, sometimes modified it, sometimes did the opposite of it, sometimes did not do it, and sometimes did something that they thought was the assigned task but what they did actually bore little or no resemblance to the given task. Puzzling - > Frequently, the clients would get better regardless. It seemed to us that they got better more quickly when we simply accepted whatever they did as perfectly ok. For example, if they reported doing the opposite of an assigned task, we took this as a message and thus we would follow with a task we wanted them to do the opposite of! This seemed to work quite well. We quickly discovered that if a client reported not doing the assigned task, this was a very strong message that meant the client would probably never do an assigned task, so we learned to stop assigning them tasks. Contrary to our ideas about the place of tasks in the change process these clients would still (often) get better. A puzzle indeed - > but one that got solved in the 1980s and 90s.

* We did a little project in which we would show videotapes of the clients receiving the intervention message to groups of therapists (and graduate students in social work) who knew little or nothing of our way of working. We played the tapes with the sound off and asked the audience to predict whether or not these clients would do the task that was being given. Then, they were to tell us what they used to help them make a prediction. It turned out that fairly accurate predictions could be made in most cases: 1) The therapists were better predictors than the graduate students and 2) No single non-verbal sign was the key to predicting but any combination of non-verbals might be. That is, a simple nod was not enough. But if the client also shifted in the chair, or smiled, or took a deep breath, crossed or uncross his legs, then prediction was possible. Interestingly, none of the students or therapists wrongly predicted that the "noncompliant client" (one who did not do the assigned task) would do the task. * In the early eighties we moved to larger quarters when Insoo's membership in BFTC became public. Each of the full-time staff had an office which doubled, when necessary, as a therapy room. In the new suite of offices we had four mirrors! This changed things, a lot. All of which has been covered in my various articles and books.

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