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ARTICLE

Steve de Shazer's Theory Development

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Abstract

This paper traces developments in Steve de Shazer's theoretical thinking from 1969 until his passing in 2005. After reviewing his definition of "theory," we organize developments in his theorizing into 4 phases, distilling from each the axioms he continued to hold until his death. For each axiom, we indicate how it is foundational to an understanding of SFBT and, therefore, contributes to distinguishing SFBT from other talk therapies. We stay close to de Shazer's writings by frequently quoting from his many articles and 6 books. We conclude with a summary of what we believe are the 6 enduring axioms of his theory of SFBT, the striking features of how he developed his theories over the years and the new lens he left us for viewing therapy interactions, and one example of research that promises to expand his theoretical legacy.

Introduction

It is common, both inside and outside the solution focused community, to hear the assertion that solution focused brief therapy (SFBT) has no theory but is simply an approach of useful practice techniques. Steve de Shazer himself contributed to this belief because he often stated in workshops and meetings that "solution focused brief therapy has no theory". His style of teaching also made discussing the topic of theory difficult. He followed Wittgenstein's advice "Anything your reader can do for himself leave to him" (Wittgenstein, 1984. p. 77), which was often unsettling if not bizarre to his audiences. For example, a workshop participant in a workshop in Germany where Kirsten Dierolf was translating asked the simple question: "What do you do with depression?" and de Shazer answered: "I don't understand that question?" (Dierolf, 2015, pp. 38-39) His response aligns with the assertion that if one answers a question, one has accepted the presupposition(s) within that question. The question, "what do you do with depression," presupposes that a therapist does something with depression, which does not fit a SFBT framework. His response "I don't understand the question" would often lead to participants asking about his theory on depression, mental illness, or whatever. De Shazer would then respond that SFBT has no theory about those things. This and similar responses may have contributed to the belief that SFBT has no theory.

If one thoroughly reviews the historical development of SFBT, especially de Shazer's writings, it is clear that he and his colleagues talked about theory on a daily basis. De Shazer wrote 6 books and about 75 papers and at least one-third of that content is about theory. Eve Lipchik, an important early contributor to the development of SFBT, wrote about the evolution of SFBT in its first ten years: "the team [at the Brief Family Therapy Center in Milwaukee (BFTC)] always tried to use theory to guide practice and to further test theory-driven practices with clients" (Lipchik et al., 2013, p. 6). Given this close relationship of theory and practice at BFTC, the authors believe it is essential to closely examine de Shazer's "theory" in his writings to more fully understand the development of SFBT.

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This paper is the result of study and reflection which began several years ago with the International Microanalysis Associates (IMA). Together with our IMA colleague Janet Bavelas,[1] we were struck by how often practitioners at conferences asserted that SFBT has no theory. So, we decided to review de Shazer's writings from beginning to end, focusing on theory development and distilling axioms of the theory Shazer developed. "An axiom is a statement accepted as true as the basis for argument or inference." (Merriam-Webster.com Dictionary, Merriam Webster, https://www.merriam-webster.com/dictionary/axiom. Accessed 28 Sep. 2020). Synonyms for axioms include postulates, principles, or tenets. As with its synonyms, axioms are foundational statements upon which theory is built. Over the years we have presented these axioms at conferences (Bavelas, De Jong, & Smock Jordan, 2014; Bavelas & Korman, 2014; De Jong & Smock Jordan, 2014; Korman, 2018) and we now offer our thoughts and conclusions in article form.

First, we address how de Shazer defined theory, attempting to clear up the confusion around his statement that "solution focused brief therapy has no theory". Next, we trace the development of de Shazer's theory through four successive phases. After summarizing and quoting from de Shazer's writings for each phase, we conclude with a statement of the axiom(s) we believe he developed during each phase. The paper concludes with a discussion of the axioms that have endured and were in place at his passing in 2005. In our conclusion, we propose the significance of de Shazer's theoretical viewpoint for practitioners in the fields of therapy and coaching.

What Did De Shazer Mean by "Theory"?

As noted earlier, about one-third of de Shazer's writing explicitly discuss theory. In order to understand his research and theory development, it is important to understand the distinction he drew between Theory (theory with a capital T) and theory (theory with lowercase T). De Shazer expressly did not attempt to explain human behavior or mental illness. Instead, his theory was deliberately and explicitly limited:

> *Certainly, I did not intend to develop nor have I developed a Theory or Grand Design, a Theory that attempts to explain everything or can be used as if it were designed to explain everything. (de Shazer, 1994, p. 274).*

Rather, he stated:

> *Ever since I began practicing brief therapy in the early 1970's, my "research" question was "What do therapists do that is useful?" In the 1980s, we changed this to "What do clients and therapists do together that is useful?" (de Shazer & Berg, 1997, p. 122).*

Steve de Shazer was rigorous. Two points remained constant in his research and theory construction projects. One addressed the phenomena he and his colleagues studied and the other the scope-conditions of their research. Said differently, the former was about what de Shazer and his colleagues were looking at and the second identified under what conditions their theories were valid and useful. One of his many statements about what he attempted to achieve was made in 1991:

> *Theory Construction.*
> *In order to construct a useful theory of doing (brief) therapy, we need to identify what is observable and repeatable about therapy sessions. We need to describe the consistencies from session to session and case to case based on what therapists and clients actually do during therapy sessions. Therefore, theory development needs to be based on the disciplined observation of therapy being done within a specific context. From this process, a description of what is done in therapy sessions can be built and then rules can be created that will enable other people to do therapy "in the same way" (Gingerich & de Shazer, 1991, pp. 241-242).*

De Shazer also clearly defined what he meant by "theory":

> *Theory, as I use the term, is not meant as an "explanation," [i.e. inferences] but rather as a coherent "description" of specific sequences of events within a specific context [i.e., a description of the therapist interacting with the client in the therapy setting] (de Shazer, 1988, p. xiv).*

He also clearly defined what his theory was not about:

> *The theory [of SFBT] has nothing whatsoever to say about "problems complaints, difficulties" etc. In fact, the theory explicitly neither includes nor excludes ideas about causation and neither includes nor excludes the various ideas about problem maintenance: it only deals with doing therapy (de Shazer, 1988, p. xix.).*

[1] This paper owes much to Dr. Janet Beavin Bavelas. Without her creative input this paper would not have been written.

Initially, de Shazer focused on descriptions of what the therapist does in the therapy room and later moved to focusing on what the therapist and client do together, that is, their interactions. In subscribing to an interactional view, he refused to theorize about behaviors or problems outside of the therapist/client interactions in which these behaviors or problems were described. He further limited his theory to the visible and audible interactions[2] in the therapy room at BFTC, saying that these were the scope-conditions for his theory. He did add, however, that the theory would be useless if it could not be applied in other settings (de Shazer, 1988, p. 67).

De Shazer's theory construction project stands apart from other theory development in the psychotherapy field. Usually, theory construction in the field starts with a set of interrelated propositions about the nature and cause of a problem. De Shazer's theory construction, by contrast, started out with trying to conceptualize the rules Milton Erickson used when he designed his unusual interventions (Erickson, 1980). De Shazer then moved on to describe what the therapist did and, thereafter, to what clients and therapists did together. All along, he kept developing theoretical descriptions of how change happens in therapy.

De Shazer's developing theory of SFBT as "… a coherent description of a sequence of events within a specific context" (1988, p. 63) can be likened to Einstein's theory of gravity. In both cases, scholars can describe what is observably happening, but they admit they do not know precisely how or why the phenomena occur that way. For example, Einstein stated that gravity bends space, but that does not say much about how or why gravity works that way. Still, with Einstein's sophisticated mathematical descriptions, scientists and engineers have been able to send people to the moon and back. Similarly, the coherent descriptions that de Shazer developed over the years about what is happening in SFBT therapist/client interactions do not depict how or why the interactions work. Nonetheless, drawing on his descriptions, many SFBT therapists aid clients in living more satisfying lives.

Historical Development or Steve de Shazer's "Phases"

Based on our reading and understanding of de Shazer's work (or perhaps one should say mis-reading and mis-understanding[3] as de Shazer preferred to call it), one can roughly divide his theory project into four different and somewhat overlapping phases: the young de Shazer, 1969-1978; early BFTC, 1978-1982; de Shazer at BFTC, 1982-1989; and the late de Shazer, 1989-2005. We encountered challenges when presenting these phases because of understandable time lapses; namely, (a) the time that elapsed between changes in practice and related theory construction, (b) the time it took de Shazer to write about these changes, and (c) the time it took for these changes to be published. These time lapses make the post-hoc reconstruction attempted in this paper challenging and somewhat arbitrary. So, this paper is our version or understanding of de Shazer's theory development project and stakes no claim of being the right or only version.

Phase 1: The Young de Shazer, 1969-1978

De Shazer was 29 years old when he started imitating what he believed Milton Erickson did with his clients. He learned Erickson's methods from reading his cases (H. Korman, personal communication, September 2002) and discovered later that he thoroughly misunderstood how Erickson worked.[4]

We find very little theory development in de Shazer's early writings. His first 4 papers are, first, about his understanding of Erickson's principles and procedures and, second, give his descriptions of his own innovative hypnotherapy techniques and strategies (de Shazer, 1974; 1975a; 1975b; 1977).

In the 4 papers that followed (de Shazer, 1978a; 1978b; 1979a; 1979b), he used other peoples' theories as lenses through which he looked at Erickson's and his own work. For example, in 1978 de Shazer wrote about his variation of

[2] De Shazer described this focus as "staying on the surface" and trying to avoid making inferences about anything going on below or underneath. We address this focus in more detail in the section of this paper called "The Late de Shazer and Wittgenstein, 1989-2005."
[3] More on this rather confusing idea further down.
[4] Many years later when de Shazer saw Milton Erickson on videotape for the first time, his spontaneous reaction was: *"Gee, he's doing it all wrong"* (McKergow & Korman, 2009, p. 44).

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Milton Erickson's crystal ball technique[5] using "Expectation States Theory" (Webster & Sobieszek, 1974) to look at his own work:

> *…The crystal ball technique as described in the two case examples is not, in any formal sense, an application of Expectation States Theory, nor is the case material offered as further proof of the theory. Simply, this theory will be used to look at the therapy from a different point of view (de Shazer, 1978a, p. 204; our emphasis added).*

Between 1971-1976, de Shazer worked with Jerry Talley and Joseph Berger from Stanford University's sociology department applying Heider's balance theory (Heider, 1946). They were trying to understand the rules Erickson used in his therapy sessions and, because de Shazer was imitating Erickson, also trying to understand what de Shazer was doing in his sessions.

As with other theories de Shazer examined over the years, he used Heider's balance theory as a lens through which to look at and describe what happens in the therapy room. It was as if he was trying to answer the question: How does what I did in this session fit or make sense within this theory?

The young de Shazer seemed to be searching for a theory that could be used to describe and, perhaps, explain his work. In a retrospective unpublished paper originally taken from the BFTC-website, de Shazer wrote about the work with Berger and described two research projects:

> [writing about the first project] …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 [project] 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 (de Shazer, 1999. p. 7).

De Shazer's work using Heider's balance theory in therapy and theory development is explored and described in great detail in his first book (de Shazer, 1982a). We do not see that balance theory had a lasting impact on SFBT theory.

Precursors of what will come. We found the first inkling of what will emerge later in de Shazer's theory construction projects when he described his disagreement with Berger in 1972 as they were mapping cases using Heider's balance theoretical model. The disagreement was about including the therapist in the balance-theoretical maps they were working on together. Berger wanted to stay with mapping the family while Steve wanted to map the whole system in the therapy-room which, as he saw it, included the therapist: "This eventually led to our agreeing to disagree when I started to take an 'outside-observer' position including the therapist on the map" (de Shazer, 1999, p. 7).

When de Shazer wrote "Beginnings" in 1999, it is clear that he felt that, already in 1972, he was starting to entertain the idea of investigating "therapy-as-a-system" (de Shazer 1981, p. 56) rather than looking at "the family-as-a-system" (de Shazer 1981, p. 56), even if this crucial distinction was not fully clear to himself at the time.[6] This shift is noteworthy for at least two reasons. First, de Shazer's method of investigation was observing therapy sessions and then trying to describe what he observed. Second, the disagreement with Berger may well have been the beginning of de Shazer's shift from primarily observing and describing the client's problematic system and what the therapist did with that, to focusing instead on the interaction between the client and therapist. "Including the therapist on the map" (de Shazer 1999. p. 7) became a fundamental principle in everything that emerged later at BFTC. We have conceptualized this principle of de Shazer's developing theory in our first two axioms:

- **Axiom 1: Therapy is an observable interactional process, that is, a conversation.**
  Axiom 1 captures how de Shazer, so early in his theorizing, moves toward focusing on what is observably happening in the therapy room, namely, clients and therapists are interacting in the sense of having a conversation together. Thus, he begins to clearly distinguish his theoretical focus from that of therapies that focus on what is happening inside the client which is not observable and not focused on client-therapist interaction.

[5] In 1987 he had come to see the crystal ball technique as "… an early attempt to systematically focus the client on solutions rather than on problems" (Molnar & de Shazer 1987, p. 350).

[6] In a paper published in the late 1970's de Shazer still talked about "resistance" and "homeostasis" not yet questioning these concepts or metaphors (de Shazer, 1979b, pp. 83-95). It is noteworthy, as we explain later, that the concepts homeostasis and resistance disappeared (or stopped being useful) once the distinction between family-therapy-as-a-system and family-as-a-system became clearly articulated.

- **Axiom 2: The minimum unit of analysis is the therapist interacting with the client in the therapy setting. This unit cannot be subdivided further.**
  With this axiom a clear boundary was set towards basically all other theories in the field. If you cannot subdivide "the unit of therapist interacting with the client in the therapy setting" you can no longer theorize or speculate about what's going on with the client, inside the client or in the client's family. In order to describe pathology or dysfunction in the client or in the family system you have to subdivide the unit into its components. Steve de Shazer's theory is a theory about therapy – it's not a theory about the people that are in therapy.

Before proceeding, we want to note that it soon became apparent to us in our study of de Shazer's writings that it is not possible to pinpoint exactly when and in which manuscript de Shazer's different ideas appeared. Some of his ideas were hinted at in early writings but then only fully described 10 to 20 years later. For example, consider the concept of exceptions. Harry Korman once asked de Shazer where his "weird" (Harry's word) way of listening came from. De Shazer answered that he had "always heard the holes" in the story. When he started to do therapy, he said people would tell him about their problems, but what always stood out for him were the holes. Holes were the parts of the client's story that did not fit with the complaint. De Shazer said that these holes were always there and had always interested him most. He also said that he had always worked the same way (personal communication, mid-90's). Traces of this are in the papers he wrote. In 1975a, he published a paper where one can see that he was actively searching for what was later named exceptions:[7]

> *I tried to get exact data about the pattern of the boy's accidents. It happened at home, at his friend's, at kindergarten, morning or afternoon. Nor could they (the family) discover any behavior pattern common to the days when there were no messes. (de Shazer, 1975a, p. 86 emphasis added).*

Phase 2: Early BFTC, 1978-1982

In 1978, de Shazer and a group of colleagues with different orientations to therapy from the agency, Family Services of Milwaukee, started the Brief Family Therapy Center (BFTC). Their expressed intent was to try to make therapy briefer and more effective. One of their main goals was to address an omission in the MRI-model (Mental Research Institute of Palo Alto):

> *Nowhere does the group [MRI] explicitly deal with the brief therapy approach used with people who have mutually exclusive goals or with people who have vague, ill-formed goals that they are unable to articulate (de Shazer, 1982a, p. 29).*

Attempting to solve the puzzles posed by these families,[8] while merging the different ideas at BFTC led to the development of the "ecosystemic brief family therapy" model (de Shazer, 1982a).[9]

It was during these years that de Shazer articulated the distinction between the study of the family-as-a-system and the study of family-therapy-as-a-system. He argued that studying the family-as-a-system in the context of therapy sessions makes little sense because in therapy there is also a therapist and sometimes a team with all these sub-systems working together with either the explicit or, at least, implicit goal of change (de Shazer, 1982a, pp. 1-3, 5-6). He began to write about what he called fundamental flaws in the theories about family therapy. He exposed the "muddles" (de Shazer, 1982a, p. 3; de Shazer 1982b) created by concepts like "homeostasis," "resistance," "linear versus circular thinking," and "continuous versus discontinuous change". He also questioned the usefulness of other popular concepts like "paradox" and "power" (de Shazer, 1981; 1982a, pp. 15-18; 1982b). He concluded that these concepts are not useful if one wants to understand how family therapy works as a "change-promoting" system. The concepts resistance and homeostasis were being used to make sense of what caused and/or maintained problems in the family-as-a-system. In order to understand the change process, one must make use of other concepts. Motivating de Shazer's conceptual conclusions during this period was what he and his colleagues saw happening in the therapy rooms at BFTC. Rather

[7] An exception is "what happens when the complaint does not happen" (de Shazer et al., 1986, p. 215).
[8] Actually, de Shazer had already published a paper in 1975 (de Shazer, 1975b) where he suggested one way to work with families having conflicting goals.
[9] In August 1980, de Shazer wrote that he was putting the "final touches" on his first book *Patterns of Brief Family Therapy: An Ecosystemic Approach* (Underground Railroad, Vol • 1 • No. 2, p. 2). So, there was a two-year lag between the final touches and the book's publication. By that time (1982), with therapy innovations at BFTC developing so rapidly, de Shazer and his colleagues were no longer working as described in this book (H. Korman, personal communication, 1988).

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than families and couples showing homeostatic reactions or resistance, the team observed families and therapists collaborating to produce client change (de Shazer, 1982a, pp. 9-15). The challenge for de Shazer became describing this collaborative process in more useful ways.

The importance of the shift from describing the family-as-a-system to describing family-therapy-as-a-system cannot be overemphasized. Taking an interactional view among the family therapy sub-systems opened up a whole new world of theoretical description, clinical practice, and investigation (research). With the new focus of family-therapy-as-a-system, de Shazer and the team at BFTC removed the artificial conceptual barrier between the therapist and the family. Among other conceptual shifts, they replaced homeostasis with "morphogenesis." Homeostasis is a concept that leads to a relatively closed-system, static description of the client system (i.e., the couple or family). Employing the concept of morphogenesis, on the other hand, leads to a more open-system, "ecosystemic" description of the client system as a sub-system in interaction with other sub-systems (i.e. the therapist and consulting team) in the therapy context. Therefore, morphogenesis can be used to more clearly and accurately describe client system change (de Shazer, 1982a, pp. 3-5).

The team at BFTC also replaced the concept of client resistance with "clients as cooperating". The study of family-as-a-system, and the notions of homeostasis, and client systems being resistant to change all went hand in hand. As de Shazer wrote in his ground-breaking paper, "The Death of Resistance":

> *The idea [of client resistance] was that the family-as-a-system seemed to maintain the status quo through deviation-counteracting processes. The changes in the family-as-a-system were seen as mutual, causal, negative feedback loops that kept the changes within certain limits and constraints…. Systemic changes that go beyond the homeostatic plateau either destroy the system or restructure it (de Shazer, 1984, p. 12).*

And, a bit further on he continues:

> *The concept of resistance locks many family-systems-based therapies into the prevailing epistemology of linear causation, "force", or "power", because it implies a separation between the therapist and the family system. When homeostasis is used as the organizing concept on this more complex level, the "resistance" is seen as located in the family and is described as something the family is doing. It is not seen as a product of therapist-family interaction. (de Shazer, 1984, p. 13)*

Later, in the same paper, he explained that adopting a view of the family-therapy-as-a-system with its ecosystemic view of sub-systems (i.e. family, therapist, and team) in interaction within an open supra-system (i.e., the therapy context) puts the concept of client resistance to "death"[10] (de Shazer, 1984). In its place, he turned to the notion of clients cooperating and wrote the following about the clinical significance of re-describing the therapy system with different metaphors:

> *If these distinctions [family therapy-as-a-system versus family-as-a-system and morphogenesis versus homeostasis] are to be useful clinically, then behavior that is commonly labelled "resistance" can be usefully re-described. One way of doing so is to conceptualize or think in terms of "cooperating":* [and then quoting from his earlier book *Patterns of Brief Family Therapy*]
>
> *'Each family (individual or couple) shows a unique way of attempting to cooperate, and the therapist's job becomes, first, to describe that particular manner to himself that the family shows and, then, to cooperate with the family's way and, thus to promote change (de Shazer, 1982a, pp. 9-10)'*
>
> *(The term "cooperating" is used in an attempt to avoid reification, because the "ing" helps to keep the therapist thinking in terms of processes of continuing interaction between the subsystems, rather than the condition that*

[10] De Shazer's paper on "The Death of Resistance" was not published until 1984. However, as he explained later in a 1989 paper entitled "Resistance Revisited," the paper had been conceptualized and essentially written several years earlier. He wrote in that later paper: "In 1978, after sitting behind the mirror and seeing our team … work with clients advertised as 'highly resistant' by the referring therapists and seeing these clients cooperate readily with us, we decided that a little conceptual violence was called for and thus we murdered resistance" (p. 227). Soon after, in 1979, de Shazer submitted the paper for the first time. He recounts it took 6 revisions without changing the title or thesis of the paper and 17 rejections before the paper was accepted and published in 1984. Apparently, resistance can be very difficult to overcome.

There is a story in SFBT circles that in July 1979, after the team at BFTC had killed resistance, they buried it and built a shrine. Some say the burial was at BFTC, others say it took place at de Shazer and Berg's home. While widely circulated, this story has never been confirmed and, as of yet, we have never heard anyone say that they saw the shrine. Perhaps the burial was metaphorical as was the "murdering".

The paper was accepted for publication on the 3'd May1984. This date was chosen as the Solution Focused world day in honour of what some people see as one of de Shazer's most groundbreaking publications.

> *might be implied by the use of cooperation, which might describe a principle rather than a process. 'Cooperation' tends to disconnect a 'something' from its ground and makes it 'thing like': a likely process given the dominance of the old epistemology.) (de Shazer, 1984, p. 13)*

While we do not know which came first, the change in metaphors for therapy or the way the BFTC team was working with clients (probably it was different on different days until their re-descriptions crystallized), we do know that these conceptual shifts meant a very different way of thinking about therapy interactions and responding to what clients were saying. For example, if a family or client now showed "resistance," this no longer meant that they were resisting change – the old concept. Instead, the apparent resistance was now understood as a collaborating attempt from the family or client trying to let the therapist know that he or she had expressed a less than useful idea (knowingly or un-knowingly), about what the problem was, or what the therapist thought would be good for the family, or what the family should do to solve the problem. By labelling this "collaborating," the behavior was now understood – and responded to – as a communicative signal from the family indicating that the therapist was off track in his work and that the therapist needed to change his behavior, that is, to continue responding to the family in the direction of finding a way to cooperate with the family. The apparent resistance, therefore, was no longer seen as a sign of pathology in a family needing to preserve the problem and the status quo.

Once the therapists at BFTC began discarding homeostasis and resistance as useful ways to understand and decide on what to do in therapy and, instead, saw the family's responses as attempts at cooperating, this change in viewpoint reinforced changing therapists' behaviors toward clients and, therefore, changed the interactional patterns in the therapy ecosystem (i.e. family-therapy-as-a-system). So, practice at BFTC had now changed: new patterns of interactions had emerged that required new concepts and theories for the new interactional patterns to be described more accurately. This, in turn, influenced the design of new research projects that, in turn, influenced ongoing theory and practice. This was how practice, theory, and research were recursively related in the theory development project at BFTC.

It was also during this period that de Shazer developed his binocular theory of change in the therapy ecosystem which drew directly on Maruyama's (1963, p. 166) concept of morphogenesis in interacting systems. Maruyama defined morphogenesis this way:

> *Once a system is kicked in a right direction and with sufficient initial push, the deviation-amplifying mutual positive feedbacks take over the process, and the resulting development will be disproportionately large as compared with the initial kick (as quoted in De Shazer, 1982a, p. 96)*.

De Shazer theorized that the therapist and the team at BFTC were initiating change in client systems by harnessing morphogenesis through the design and delivery of the "intervention" at the end of the therapy session (de Shazer, 1982a. pp. 7-15). The idea was that the family had one view of "the problem" and of what happens in the family. The therapist and team would develop another view that was different, yet related enough to be in cooperation with the family's view. The team would then give their view in the feedback to the family at the end of the session. A bonus would emerge in the difference between the two views. This bonus, according to de Shazer, was the same kind of bonus that happens with the merging of the different visions of the world when the picture in the left eye is merged with the picture of the right eye; namely, depth appears. He called this the binocular theory of change.[11] For a long time, this was the main concept that organized the therapy sessions at BFTC. The therapist's or "conductor's" job was to interview the family and create a detailed description of what happened when the problem was present. The conductor and the team would then meet and create an intervention message for the family that was as close as possible to the family's description but with some differences. The goal was to create a "matching" description of the family's trouble, close enough and called "isomorphic" by de Shazer, to be recognized and accepted by the family as their own, and yet different enough to create a meaningful, change initiating difference when merged with the family's slightly different view. The concepts of "isomorphism" and "match" were the organizing principles in how to do the interviews and create these matching, isomorphic intervention messages. At the time, de Shazer's theory was that it was the intervention message with their incorporated tasks, and more specifically, the families' responses to the tasks that promoted change. The team at BFTC called these tasks "clues". The clue could be anything from specific behavioral tasks and experiments to indirect

[11] De Shazer drew on Bateson's concept of "news of the difference" and the notion of "second order changes" in systems when explicating his concept of "bonus" in the binocular theory of change (1982a, pp. 7-9; 1984, p. 12).

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Ericksonian "interspersing techniques," or simply telling a story about how other families with similar problems had solved their problems, or simply being pessimistic about the outcome of the therapy.[12]

We think it is important to emphasize that the model developed during these first four years at BFTC was a problem-solving model solidly built on systems thinking and interspersed with Ericksonian ideas. Detailed descriptions of the problem and the interactional patterns around the problem were thought to be necessary to create purposeful tasks that would change the problematic patterns of interaction in the families and solve their problems.

Even though there are hints earlier in de Shazer's writings, our belief is that a new axiom about change crystallized during this 1978-1982 phase and remained prominent ever after in de Shazer's work:

- **Axiom 3: Change is the purpose of the therapist and client meeting.**
  Axiom 3 may seem simplistic and obvious to everyone. It's not. By emphasizing therapy as a change-promoting system, de Shazer is distinguishing his focus from all the therapies that focus on the nature and assessment of client difficulties as the precursor to treatment. As he himself put it:

  What the early conceptualizers and therapists since then have failed to realize is that "the study of the family" and "the study of family therapy" are studies of different logical types. The former is a study of stability while the latter is a study of changing (de Shazer, 1982a, p.4).

  This axiom also clarifies why solution focused therapists are not interested in the problem or the causes of the problem and the enormous differences this leads to in practice compared to almost everything else in the world of psychology and psychiatry.
- **Axiom 4: Client change via therapy occurs through observable interactions in which the therapist finds ways to cooperate with the client.**
  As we described earlier in this section, de Shazer and his colleagues noticed that in the therapy rooms at BFTC -- instead of resisting -- clients seemed to be collaborating with their therapists in order to produce client change. This observation, coupled with his already developing interactional focus on the client-therapist system, led de Shazer to question and dismiss many established concepts in the family therapy field and, thereby, continued to differentiate how therapy was being done at BFTC compared to many other family therapy clinics both then and today.

Phase 3: de Shazer at BFTC 1982-1989: The Emergence of Solution Focused Brief Therapy

From problem resolution to solution development, How It Began. In 1982 a family with 27 problems came to therapy (as described in Hopwood & de Shazer, 1994). At the end of the session, when it was time to take a break and construct an intervention message, none of the problems had been described in enough detail for an isomorphic message to be constructed.

So, following de Shazer's and the BFTC's team understanding of Ericksonian principles,[13] the therapist and team constructed a vague task later to be named the "formula first session task" (FFST)[14] and delivered it to the family at the end of the session:

> *Between now and next time we meet, we [I] want you to observe, so that you can tell us (me) next time, what happens in your [pick one: family, life, marriage, relationship] that you want to continue to have happen (Hopwood & de Shazer, 1994, p. 558, quoting de Shazer, 1985, p. 137).*

[12] The reader can find many examples of client cases and the related clues that the BFTC team designed during this period in de Shazer (1982a).
[13] See Haley's (1967) description of these principles including that which says problems which are vaguely described should lead to vague end-of-session feedback and a vague homework task.
[14] De Shazer had started developing standard (or formula) tasks as early as 1969 for use with cases involving similar problems (de Shazer, 1985, pp. 122-125). In 1985 he renamed them "skeleton keys" (de Shazer 1985, pp. 119-136). Many SFBT practitioners continue to use these tasks today.

Hopwood and de Shazer (1994) described what happened next:

> *Two weeks later when the family returned, my [de Shazer's] colleagues and I were surprised when the family described 27 different things that had happened that they wanted to continue to have happen. 25 of the 27 were directly related to the 27 concerns listed during session one. When asked, the family members said that they thought the problem that brought them to therapy was solved and therefore no more sessions were needed (p. 558).*

In the ensuing discussions at BFTC, someone remarked that this was a very interesting case because the family did the task and the task was useful; that is, change happened and most important and interesting was that the therapist and the team had no idea which one of the 27 problems had been addressed by the task. This fact would eventually lead to a radical new question: Is it possible to solve a problem without knowing what the problem is? Another very important and interesting thing was that this family with vague problems had reported concrete things happening.

> *This prompted us to start using the formula intervention with other cases in which the clients described vague goals and complaints. Case after case, concrete and specific changes in the week interval between the first and second session were reported. This prompted the development of a more organized study, …. (de Shazer 1985. p. 138).*

In the more organized exploratory study that followed, the therapists at BFTC were instructed to give the FFST task to all the clients and families at the end of the first session regardless of what had happened in the interview, unless the therapist had a very good reason not to. If the therapist did not give the FFST, he or she had to describe why. Sixty-four percent of new cases got the task. Eighty-nine percent of these cases reported noticing something worthwhile happening in the interval between the first and second session and two-thirds said that things were better (de Shazer, 1985, p. 155).

The results of this research created a major theoretical problem. The binocular theory of change in the ecosystemic model of brief therapy (de Shazer, 1982a) required that the team produce an isomorphic description of the family's problem that matched the family's view. This was necessary in order to open the lock of the closed door of the problem and solve it. It was inconceivable that the FFST could match and be isomorphic with two-thirds of the clients' and families' descriptions of their problems and complaints. Identifying this as an anomaly, that is, an occurrence when the data do not fit the theory, de Shazer stated:

> *As Kuhn (1970) [in The Structure of Scientific Revolutions] pointed out, anomalies develop and either they need to be re-described within a current theory or the theory needs to change so that a description is possible (1988, p. xiv).*

So, faced with a choice between re-describing the observations from the BFTC study of the FFST within their current ecosystemic theory of problem-solving, isomorphism, and match, versus needing to change the current theory, de Shazer chose the latter. He started doubting the theories he had developed for 15 years and began to develop new concepts and theoretical descriptions.

From isomorphism and match to fit. The shift that started in 1982 did not appear in print until 3 years later. It took until the 1985 publication of Keys to Solution in Brief Therapy for de Shazer to offer a very different description of what he now saw happening in the therapy rooms at BFTC:

> *As the BFTC team continued to work together and a distinct, unique philosophy developed, a shift occurred from our being interested in 'problems/complaints and how to solve them' to 'solutions and how they work'. We looked at what is on the other side of the locked doors and started to figure out how the clients and we got there (de Shazer, 1985, pp. 44-45).*

The locked door metaphor was central in de Shazer's 1985 book. The client's problem was metaphorically described as a room with a number of locked doors, where all the doors might lead to a solution. Before the shift began in 1982, therapy focused on understanding the lock (the problem) in such a way that one of the doors could be opened. The therapist needed to create an isomorphic description of the problem, matching the one the family already had, but with small differences so that new possibilities might come out of the merging of the two (the binocular theory of change). With the results from the study on the FFST, the concepts of match and isomorphism had to be abandoned. Interventions no longer needed to be isomorphic and matching. They just needed to fit:

> *We had been looking at "Problems: Complaints and how to solve them," while the concept of fit suggests rather that we need to look at "solutions and how they work". And we do not need to know how a particular lock (complaint) is constructed in order to find a skeleton key-like intervention that fits in such a way that it opens the door to a "better," more satisfactory future for the client (Nunnally et al., 1986, p. 95).*

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Changing the interviewing process. Changing the theoretical focus from problems and how to solve them to solutions and how they work led to fundamental changes over time in the interviewing process and what kinds of information were sought and amplified in the interviews. This process had begun with the invention of the FFST because once this task was given at the end of a session, the team at BFTC followed up at the next session with questions about what clients had discovered that they wanted to continue to have happen in their lives. These questions were new. De Shazer wrote the following about this change:

> *As my colleagues and I at the Brief Family Therapy Center (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. Clearly, there are solution related things that the client and therapist do during the session. (de Shazer, 1988, p. xiii).*

He continued a bit further on:

> *For several reasons, I did not (and still do not) like this shift in focus, but our investigation of solution development forced it on me. This is the second time that one of our investigations has forced a major shift in our approach (see de Shazer, 1985). Such shifts are normal parts of any exploration process: one follows where the data lead (De Shazer, 1988, p. xiv).*

De Shazer was not explicit about what it was about the change of focus to "solution related things that the client and therapist do during the sessions" that he did not like. Perhaps he was still enamored of the elegant summaries and ingenious tasks that he had been offering families at the end of sessions. Perhaps he felt that it was a daunting task to make sense of the chaos and complexity that is the therapy session and take on describing and theorizing about how these "solution related things" actually happen in the interaction in the therapy room. Regardless, he decided to follow where the data led. Consequently, at BFTC, the team now started looking for patterns of interactions around successful solution development. As the team focused more on the interviewing process, they saw things happening that they had not noticed before. In addition to inventing and continuing to incorporate the FFST and its follow up interviewing, they invented interviewing for exceptions and pre-session change. These three phenomena shared being descriptions of better things happening in clients' lives. In other words, they were all descriptions of when seemingly locked doors of the problem were open or partially open. The simplest way to begin opening the locked doors and, therefore, to promote change became building on when things were already better, that is, finding out how clients made exceptions and pre-session change happen and suggesting that they do more of what they were already doing that was working for them.

Exceptions. De Shazer mentions "exceptions" for the first time in 1985:

> *Although the child is seen as always wetting the bed, there are probably some dry nights now and then - exceptions to the rule (an important concept developed jointly by the author, Wallace Gingerich and Michele Weiner-Davis to describe what the therapist is after during the first session). However, these exceptions frequently slip by unnoticed because these differences are not seen as differences that make any difference: The difference is too small or too slow.*
>
> *These exceptions to the rules of the pattern are exactly the kind of information the therapist needs to know. It is important for the therapist, the child, and the parent(s) to know that the child in some (perhaps unconscious?) way knows how to have a dry bed (de Shazer 1985, p. 34).*[15]

De Shazer later created the distinction between spontaneous and deliberate exceptions:

> *…many clients reported exceptions to the rule that the complaint always happens. Some of these exceptions the client described as spontaneous – "it just happened" – while others they described as the result of a deliberate shift in behavior. In either case, their description can be seen as including a difference that had not yet made a difference to them (de Shazer, 1988, p. 4).*

[15] One of the authors (PDJ) interviewed Insoo Kim Berg in 1996 about the development of solution focused brief therapy at BFTC and where, in particular, the concept of exceptions came from. She said she thought it came soon after and directly from the development of the FFST. Her view was that asking clients to pay attention for what they wanted to continue to have happen in their lives (i.e. FFST) was similar to asking them about what was happening in their lives when the problem times were not happening (i.e. exceptions). The interview with Berg is available on request from PDJ; if interested, email him for a copy at pdejongsft@gmail.com.

Creating descriptions of exceptions in the therapy interview, and being clear about whether they were spontaneous or deliberate, eventually came to be viewed by de Shazer and the BFTC team as one very useful way to promote solution development. Every exception was thought to be a difference in the client's life that potentially could be made into a difference that creates the more satisfying life desired by the client. For clients who could describe deliberate exceptions to their problems, de Shazer and his colleagues suggested that they do more of the exception behavior because they were already doing that and thus knew how to do it. For those clients who described spontaneous exceptions, the team recommended for clients to: (a) pay attention to when the exceptions happened, (b) how they might be contributing to them happening, and (c) report back to the therapist/team at the next session what they discovered.

Pre-session change. The shift from problem resolution to solution development began with the invention of the FFST. The team at BFTC used the FFST and other formula tasks[16] as the primary interventions in client solution development and by the mid-1980's they had described these tasks in detail (de Shazer, 1985; de Shazer & Molnar, 1984). For a long time, de Shazer and his colleagues thought the end-of-session tasks were the key initiators of client change. However, ongoing careful observation of therapy sessions kept leading to new discoveries of how the interview itself might be promoting solution development.

Weiner-Davis, de Shazer, and Gingerich (1987) gave a detailed description of the chance event that led to the discovery and description of pre-session change:

> *She (the mother) postulated that her divorce of several years ago had had a lasting effect on him (the 12-year old son) and that perhaps he was experiencing a deeply rooted depression. Just as the therapist was about to consult with the team behind the mirror, the mother nonchalantly mentioned that for the 3 days prior to coming for therapy, her son "had been trying in school." The therapist stopped for a moment, expressed great surprise, and asked the boy why he decided to "turn over a new leaf."*
>
> *At first the boy appeared perplexed by this idea but quickly affirmed that, indeed, he had turned over a new leaf because he was "tired of always getting into trouble." The remainder of the session was devoted to helping the boy determine what he needed to do to stick to his resolution. Therapy goals were accomplished within three sessions. (p. 359)*.

The team at BFTC then recalled other clients who had reported improvements between the call for an appointment and the first session. These findings once again led to a research project, this time at Weiner-Davis's clinic. In this study, 30 families were asked the following question by their therapists at the beginning of the session:

> *Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation? (Weiner-Davis et al., 1987, p. 360)*.

In 20 of the 30 cases, the parent present in the session answered that things had already started to be better in the direction of what they wanted to get out of therapy. Consequently, as with the discovery of exceptions in the first session, therapy in these cases turned to working on maintaining change instead of trying to start it. De Shazer and his colleagues wrote the following about when clients reported exceptions, pre-session change, or any useful changes in first sessions:

> *We noted that we then worked to keep these changes going and that this approach led to increased client satisfaction and fewer sessions per client (Nunnally et al., 1986, p. 90)*.

Noticing the presence of and then inventing the concepts of exceptions and pre-session change, changed how the interviews were conducted at BFTC. Therapists began exploring change in the form of exceptions and pre-session change earlier and earlier in the first session. Moreover, since this search could begin right away in the first session, it meant that:

> *… the therapist and client are constructing a therapeutic reality based on continuing transformation or change (as evidenced by any exceptions), rather than on initiating change. When exceptions are identified, the homework task will usually include the idea that the client should do more of what they are already doing rather than suggesting that they do something new (de Shazer, 1988, p. 5)*.

An interesting aside here that again reveals how revolutionary BFTC's developing ideas and practices were in the 1980's, is that already in 1978 Don Norum, who worked at Family Services in Milwaukee at the same time as de Shazer and Berg, wrote and presented a paper titled: "The Family has the Solution". The paper was about how pre-session

[16] Several other formula tasks had their origins in the earlier work of mainly de Shazer and Erickson (de Shazer, 1985, pp. 119-136).

change can be used to create a sustainable solution. It was rejected as nonsense by the reviewers for the journal Family Process (Kiser 1995, pp. 263-264). The paper was finally published 22 years later (Norum, 2000).

The crystal ball technique and the miracle question. Like Milton Erickson, de Shazer believed that brief therapy should be organized around client goals. And, although de Shazer's concept of "goals" evolved along with his therapy practices and theoretical descriptions, he also believed client goals should be as specific, concrete, behavioral, and realistic as possible (de Shazer, 1985, p. 9; 1990, p. 97). However, as he wrote in 1985:

> *The reality is that clients often come with vague and/or mutually exclusive goals or goals which they cannot describe. In fact, the most difficult and confusing version of this is that some people do not know how they will know when their problem is solved. Without realistic goals, without a way to measure success, people can go around in this world mired in the muck of past mistakes and bad luck.*

Erickson's crystal ball technique and BFTC's miracle question were therapy practices intended to help clients develop and describe more useful goals than they had at the outset of therapy.

The crystal ball technique was the precursor to the miracle question. Erickson described using the crystal ball technique with a variety of problems (Erickson, 1954, pp. 261-283). De Shazer started using his version of the crystal ball technique in the mid-1970's (de Shazer, 1978a) and his version involved having the client in a trance imagine and peer into several different crystal balls and describe what they were seeing (1985, pp. 81-83). Two of the balls were about memories of the past, "a pleasant memory that was forgotten long ago" and a memory of "a recent but surprisingly forgotten event". In both cases, the client was asked to (and thereby taught to) observe her or his own behavior and how others responded. Two other crystal balls were oriented to the future, one to the successful resolution of the client's problem and another to how the problem was solved. De Shazer summarized the significance of this technique:

> *The crystal ball technique is used to project the client into a future that is successful: The complaint is gone. I have found that simply having the client, while in a trance, view his or her future in a crystal ball or a series of crystal balls can be enough to prompt different behavior, thereby leading to a solution (de Shazer, 1978a). The ideas behind the technique can also be used in clinical situations that do not involve formal trance. Either way, the client constructs his own solution, which can then be used to guide therapy. As I see it, the principles behind this technique form the foundation for therapy based on solutions rather than problems (1985, p. 81).*

Most notably, two of the crystal balls were brought forward into the new solution development interviews. They morphed into asking clients to remember "some success in life, particularly one that is an exception to the rules surrounding the complaint," and asking clients "what will things be like for you and others when the problem is solved?" (de Shazer, 1985, pp. 82 -83).

In theoretically reflecting on how using the crystal ball technique in therapy sessions might be promoting client change, de Shazer drew on two different theories: 1) Berger's expectation states theory (Berger et al., 1977) and 2) Axelrod's theory of cooperation (1984). Both of these theories had the backing of experimental research. Regarding expectation states theory, de Shazer (1985, p. 74) wrote that it "is concerned with both how interactional situations develop and maintain patterns and also how the expectation-maintaining behaviors change". De Shazer stated that when clients come to therapy, they come because their attempts to solve their problems have failed and they have developed expectations for the future which say only more of the same "damn thing" is going to keep happening. He then noted that therapy can change these negative expectations:

> *Change in the structure of these [problem saturated] expectations will occur when the conditions change in some way, …. Feedback or evaluation from an authoritative source such as a therapist can undermine these expectations and thus promote changes in behavior, different outcomes, and the development of new expectations (Berger et al., 1977). Of course, these new expectations will also be self-maintaining and the clients stand a chance of a more satisfactory life (de Shazer, 1985, p. 75).*

De Shazer, then, viewed the crystal ball technique as a way to get clients to describe new and different sets of expectations for the future, expectations of having successfully resolved the problems that brought them to therapy.

The usefulness of Axelrod's theory and research to de Shazer's project of describing how therapy more broadly and the crystal ball technique in particular seem to work, can best be appreciated by considering de Shazer's definition of therapy in the mid-1980's. At this time, he defined therapy in these words: "At BFTC, clinical practice defines therapy as cooperative, as oriented toward change and solutions, and as focused on the present and future" (de Shazer, 1985,

p. 79). At the same time, then, that de Shazer was describing therapy as an interactive process in which the therapy system of therapist, client, and team work collaboratively toward the client's goals, Axelrod was busy researching under which conditions cooperation among interacting participants was advantageous. As described earlier in phase 2, de Shazer had replaced the concept of client resistance with the idea of clients attempting to cooperate. Axelrod's experiments provided strong evidence that cooperation is the strategy that leads to the best outcomes in the long run, even in the competitive game situations he was researching. De Shazer (1985, 73), noting the relevance of Axelrod's findings to the therapy situation, quoted Axelrod who stated: "… mutual cooperation can be stable if the future is sufficiently important relative to the present" (Axelrod, 1984, p. 126). In the crystal ball technique, de Shazer saw the therapist and team cooperating with the client to construct a description and an experience of a desired future. The desired future, of course, was directly relevant and important to the client's problem-saturated present which the client presumably came to therapy to change.

The miracle question, similar in purpose to the crystal ball technique, was invented in 1984 by Insoo Kim Berg (De Jong & Berg, 2013, p. 90-91; Korman, personal communication with Steve de Shazer, 1990). Berg was trying to get a woman with many complex complaints to describe how she would know that she did not need therapy any longer. The client was working hard with the questions but could not find answers. About 20-25 minutes into the session, the woman sighed deeply and said, "My problems are so serious it would take a miracle to solve them." Berg, picking up the words the client had used, then asked: "So suppose this miracle happens, but it happens while you're sleeping, so you can't know it happened. How will you discover it happened after you wake up? What will be different?" The woman then went on to describe 16 behaviors that would be signs to her that the miracle had happened and, therefore, indications that she no longer needed therapy.[17] Members of the team at BFTC felt that the miracle question was significant and all the therapists were asked to use it. Lipchik et al. (2012, p. 15), in reviewing how SFBT developed, wrote: "… soon it became evident that the miracle question added a new dimension to therapy: a future orientation and an opportunity for people to build on their hopes and dreams for solutions, not only past and present strengths and resources."

In summary, then, by the mid-1980's, de Shazer was describing the client's problem as a room with locked doors, and the role of the crystal ball technique (and by extension the miracle question) as a useful way out:

> *… the most useful way to decide which door can be opened to get a solution is by getting a description of what the client will be doing differently and/or what sorts of things will be happening that are different when the problem is solved, and thus, creating the expectation of beneficial change. The client's language while describing some alternative futures and the details of the differences after solution seem more important than the details about the locked room of the complaint. With possible alternative futures in mind, the client can join the therapist in constructing a viable set of solutions (1985, p. 46).*

Again and again, when talking about goals, the crystal ball technique, and the miracle question, de Shazer came back to Berger's theories. He believed that it was the expectation of change happening that made change happen:

> *When a goal is defined, the expectation of a different, more satisfactory future starts to develop and behavior changes in the present become possible. The future is made salient to the present; thus, the goal and the consequences of its achievement can "determine" or shape what happens next (de Shazer, 1985, p. 94).*

It is interesting to note that at the same time de Shazer was developing his thinking around the crystal ball technique and miracle question as a way for clients to construct and experience a desired (changed) future, he was also writing about homework tasks ("interventions") given at the end of a session as being a useful way to help clients experience change:

> *Our efforts to understand how the interventions described above worked [the authors had described "A useful interventions" in their paper] revealed that they have one quality in common: each attempts, in some way, to help the clients experience changing (de Shazer & Molnar, 1984, p. 303).*

So, according to de Shazer in the mid-1980's, therapy practices that allowed clients to experience changes seemed to contribute to solution development by changing the problem-saturated expectations they held at the beginning of therapy into expectations of more satisfying lives.

[17] Another version of the invention of the miracle question has Jim Wilk, a resident at BFTC, observing Steve de Shazer using it for the first time in the mid 1980's (Lipchik et al., 2012).

Developing a theory about solution-developing interviews, the briefer maps. By 1988 and the publication of his third book, Clues: Investigating Solutions in Brief Therapy, de Shazer was continuing his shift of focus to the increased importance of the interviewing process itself in solution development. Based on ongoing observation of therapy sessions in the mid to later 1980's, he had realized even more persuasively that therapeutic change cannot all be put to the interventions in the end-of-session message. This realization complicated his theory development project. As he stated, "Let's face it, interviews are a mess and therefore studying them is equally messy" (1988, p. xiv). Nonetheless, he set about studying what the various team members shared in their solution development interviewing. He wrote: "Each member of the BFTC team has a different style and a different way of implementing the model. And yet each member of the team will say we are 'doing the same thing!'" (1988, pp. xiv-xv).

Consequently, de Shazer embarked on mapping the "same thing" the team members at BFTC were doing in their solution development interviews. He saw this project as a theory development project because: "Theory, as I use the term, is not meant as an 'explanation,' but rather as a coherent 'description' of specific sequences of events within a specific context" (1988, p. xiv). The sequences of events he wished to describe were "the various (interviewing) pathways from 'complaint' to 'goal achievement' and 'solution' that cases predictably tend to follow" (1988, p. xviii). De Shazer also realized he had to be rigorous in this effort: "Theory construction demands that the resulting map, have a high degree of rigor. It is not enough that one step logically follows another: these steps need to follow each other predictably" (1988, p. 15).

It was apparent upon observation that different therapists at BFTC were often making similar decisions. For instance, if a client described at the beginning of a session that things were already better, there was a high probability that the therapist would follow-up with questions about what was different, what the client had done to make the change happen, and what the client needed to do to maintain the progress. These types of decisions can be mapped:

IF: exception or pre-session change is described,

THEN: there exists a high probability that the therapist will ask: "How did you do that?"

Many cases were found to follow a similar pathway: Problem talk → Interviewing for Exceptions → Asking the Miracle Question → Asking about Pieces of the Client's Miracle Already Happening → Consultation Break → Feedback and often a Homework Task suggesting that the client(s) continue to do what they were doing, and/or observing further progress, and/or observing for what the client did to maintain the progress already made.

Other cases proceeded along different pathways. For example, one could be a session where the client would start by saying that there was no problem and, despite efforts by the therapist all through the session to get some sense of what the client wanted, nothing would emerge. In this pattern, it was highly predictable that the therapist would end the session with "compliments" only (de Shazer, 1988, pp. 87-88). It was also predictable that during this type of session the therapist would inquire if someone else had sent the client to therapy, who that was, and what that person wanted to see happen as a result of therapy.

The central map (i.e., the theory) changed as practice at BFTC changed. For example, once pre-session change had been discovered and described, it changed the pattern of first sessions because therapists now tended to start sessions searching for change that had already happened. The previous talking about the problem at the beginning of the session fell more into the background as the therapists at BFTC started trying to develop descriptions of progress and change already at the beginning of the session, and then working to keep the changes already happening going.

In reflecting on the "CENTRAL MAP," de Shazer wrote:

> *As a result, the structure or family tree that we have developed for looking at interviews has given us a tool for disciplined observation and description of the resemblances among interviews in spite of their apparent diversity. This has helped me in my theory construction project which, in turn, has helped us to understand what it is we do (1988, p. xvii).*

As the clinical work at BFTC changed and became simpler, the central map and the accompanying computer program changed. The different iterations of the computer program were named "BRIEFER I" and "BRIEFER II" (de Shazer, 1988, pp. 14-19, 41-45). A third version Briefer III was never published and has survived only on a few peoples' computers that still run Windows XP. In Briefer III, between 80 and 90 per cent of de Shazer's task suggestions could be predicted by the program. The program itself contains only 16 rules (de Shazer, personal communication and demonstration of the program, Sept 1988). The version showed to Harry Korman was for research and demonstration purposes only. When Harry asked de Shazer if he had thought about commercializing the program,

de Shazer answered that it was to much hassle and that if the program was to be used clinically the questions about legal responsibility were unsolvable.

Theories about therapeutic change. What is change? This question looks simple enough until one tries to answer it. Is change just doing something in a different way? Or, is it thinking differently about a situation which then prompts different behavior? Or, is it being able to do something today that one could not do yesterday which then leads to feeling successful and telling someone about the success and then being able to do it again? Or, is change all of these things and possibly many more?

Nunnally et al. (1986), in an article about therapeutic change, described how they tried to apply different theoretical models of understanding to their observations of client change at BFTC. They considered: (a) the notions of first and second order change proposed by MRI (Watzlawick et al., 1974), (b) the continuous change/discontinuous change frame suggested by Prigogine et al., (1972) and by Dell & Goolishian (1979), (c) the distinction between homeostasis and morphogenesis (Maruyama 1963; Wilden, 1980), and d) the concepts of catastrophe theory (Thom, 1975). The BFTC authors indicated that none of these theories fit their experience or observations very well. Instead, they preferred to stay with the basic understanding that they had held for several years: "For us as brief therapists, influenced by Milton Erickson, it is perhaps easiest to think about 'change' as … whatever happens that makes the client's life more satisfactory and to let it go at that" (Nunnally et al., 1986, p. 88). In addition, many of the therapists at BFTC long held a Buddhist view of change "…that change is constant and that stability is an illusion". This Buddhist view did fit their observations of clients reporting pre-session change, exceptions to problems, and progress between sessions. As they wrote: "we … worked to keep these changes going and … this approach led to increased client satisfaction and fewer sessions per client" (Nunnally et al., 1986, p. 90).

So, regardless of all the different theories about change; change is either satisfactory to the client or it is not. In the end, therefore, the BFTC authors concluded the following about change:

> *Any behavior that is seen as new or different can be used as part of the therapeutic construction of a solution. It does not need to be a bit of behavior that is seen as part of the complaint pattern. Even if the new behavior first occurred before the first therapy session, it can be labeled as the start of the solution. Thus, any difference can be developed into a difference that makes a difference as long as the new behavior (or newly perceived behavior) is „sacramental", i.e., is perceived [by the client] as an "outward and visible sign of change."*
>
> *Clearly, any theory of clinical change needs to include the influence of the observer, i.e., the Heisenberg hook. Although the process of change can be seen as constant, the therapist/observer's influence is part of what makes for the distinction between a) differences that make a difference and b) those differences which make no difference (Nunally et al., 1986, p. 90).*

How does brief therapy create change? Scanning de Shazer's writings for his answers to this question soon becomes confusing and overwhelming because he developed so many theories about the topic. In 1988 he wrote the following about his attempts to develop answers to how brief therapy creates change:

> *During the past 20 years of doing, studying, thinking about, and observing brief therapy, I have devised about 1,000 different descriptions [theories] of how brief therapy works. That is roughly one construction for every 10 cases. Along the way, I have found out that I never know what I think until I see what I write and how I write it. This has allowed me to throw away some of the more obviously stupid answers.*
>
> *The answers that I thought held up best (the ones that more closely approximated a good answer!) I have used as material for articles, books, and more recently, expert systems (e.g., de Shazer, 1975a, 1978a, 1979a, 1985). But just when I have one that I think is the best, the clearest, the most comprehensive and most general, something happens that leads me in another direction. Therefore, today's answer is only for today; tomorrow it might change, or it might not (de Shazer 1990, p. 92).*

While the above quotation is from a 1990 publication, that publication is a reprinting of an address given by de Shazer in 1988 at the Fourth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy in San Francisco, California. It was in that address that he gave his most detailed description to date of how he thought brief therapy creates client change. He began this description by reviewing ideas he had introduced earlier in the 1980's,

namely, creating an expectation of change through BFTC's new interviewing techniques and having clients experience change through home-work tasks or experiments suggested in the end of session interventions. However, as he continued his description in the address, by 1988 he had expanded these ideas in ways that anticipated where he would take his theory development project in the 1990's and beyond.

As we described in our previous section on the crystal ball technique and miracle question, the complaints clients bring brief therapists seem to be constructed on a simple premise: whatever it is they are complaining about "always happens." By 1988, de Shazer was beginning to develop this point more fully by focusing on the language clients use when they describe their own and others' problems: Couples often will say "we always fight," or parents say "our children are always misbehaving," or the individual client so often uses language like "I am depressed," or "I am an anorexic," or "she is a schizophrenic." As de Shazer wrote: "Regardless, clients have had the bad luck of talking about things in a way that leads them into constructing the complaint as a situation involving a steady state. It is locked into the words they use, i.e., 'I am' and/or 'It is' and/or always" (1990, p. 94). Then, drawing on Wittgenstein (1958; 1968), he pointed out that this way of talking leads one to equate whatever follows the "I am" with "something immutable or unchangeable, such as, 'I am a male,' or 'I am a Swede. … [and in using] analogous grammar in different sentences ['I am anorexic' and 'I am a Swede'], we (perhaps unconsciously) expect them to have analogous meanings" (pp. 94-95). In other words, the grammar clients regularly use plays a major role in rigidifying their perception of their problems.

De Shazer (1990) then made an argument for exceptions as poking a hole in the client's "it always happens" frame of reference:

> *As I see it, inventing exceptions pokes holes in the clients' frame ('I am this' or 'It always happens') so that they can see through it: The complaint rule is deconstructed so that its immutability is undecidable: The 'I am a flasher' rule changes into something else, perhaps: 'I sometimes expose myself.' The 'sometimes' in this sentence is very strong. It is difficult to even unconsciously hear the sentence as analogous to 'I am a male.' This deconstruction prompts clients to at least begin to doubt their 'it always happens' rule. Once doubt is developed, what is really going on becomes undecidable and a new reality can be constructed (de Shazer 1990, p. 96).*

De Shazer by now (1988) was also stating that exceptions leading to client change are not objective phenomena:

> *It is important to remember that exceptions do not exist out there in the 'real world'; they are cooperatively invented or constructed by the therapist and client talking together. Before the therapist and client talk about exceptions, these times are simply seen as 'flukes' or differences that do not make a difference. It is the therapist's task to help clients make flukes into differences that make a difference. I am continually surprised by exceptions and frequently I let the client see this. Client stories about times when the complaint is unexpectedly absent frequently 'knock my socks off' (de Shazer 1988, p. 96).*

In the conclusion of this important paper de Shazer summarized his thinking this way:

> *Most simply put, therapy is a conversation between at least two people (minimally one therapist and one client) about reaching the client's goal. When as a result of this conversation clients begin to have doubts about their immutable framing of their troublesome situation, the door to change and solution has been opened. This is the essence of brief therapy (de Shazer 1990, p 98).*

Thus, de Shazer's theory in the late 1980's about how change happens in brief therapy was that the therapist gets the client to doubt the frame "it always happens" through the construction of exceptions that amount to differences that make a difference for clients.

In trying accurately to summarize phase three of de Shazer's theory development project, one cannot do much better than to point out that with the publication of Keys to Solution in Brief Therapy (1985), Clues: Investigating Solutions in Brief Therapy (1988), and some 25 articles between 1982 and 1989, de Shazer and his colleagues at BFTC had moved dramatically away from a problem-focused brief therapy based on ecosystemic thinking. In the latter's place, he had created a detailed theoretical description for how a solution-developing interview was conducted at BFTC. His publications included session maps for what to do in interviews and guidelines for how to use what had emerged during the session to develop end-of-session messages that included compliments, affirmations of the clients' goals, and standard interventions or tasks designed to prompt clients to look for and/or continue the changes they wanted more of in their lives. If one wanted to learn how to conduct SFBT with clients, one could not do much better than reading de Shazer's books and articles from this phase carefully and then working to put their content into practice.

These sources from the 1980's contain a theoretical description of client change through solution development and, thereby, incorporated one more groundbreaking axiom into de Shazer's theory development project:

- **Axiom 5: Brief therapy is about developing solutions with clients.**
  This axiom is meant to capture solution development involving the therapist and client working cooperatively to continue changes already occurring in the client's life, specifically those changes in the direction of the more positive future the client wants. It also involves inviting clients to expand and construct the details of their definitions of a more satisfying future. This axiom reaffirms de Shazer's interactional stance because solution development occurs through the client, therapist, and team (when present) acting as a single system focused on promoting client change. In contrast, solution development is not about viewing clients as having problems conceptualized as puzzles to be assessed and solved. In this respect, de Shazer clearly distinguished SFBT from most other therapies.

Phase 4: The Late de Shazer and Wittgenstein 1989-2005: Co-constructing Client Change through Language Interaction

The nymphomania case. Some would call this the period "after the nymphomania case" and some would call it the "post-structural phase of SFBT". By 1989, de Shazer and his colleagues had mapped how solution developing interviews were done. They had a clear view of how solution developing tasks were created and they had described the connections between the information created in the interview and the tasks they suggested to clients. BFTC was crowded with students and practitioners wanting to learn how to do this new form of brief therapy focused on developing solutions, not resolving or solving problems. De Shazer and Berg were getting more and more well-known and were teaching all over the world. Then, in 1989, a woman and her husband came to BFTC complaining about her being a "nymphomaniac". In the woman's view her condition – having an insatiable need for sex – was a symptom of an underlying, very serious problem rooted in her infancy that would require long-term "deep therapy" to solve. When she and her husband left the session, the problem was re-named "insomnia" which was resolved during the two weeks that followed the interview. De Shazer and his colleagues recognized that the change that had happened in the therapy session and the results reported by the clients could not be understood from inside the then current theory of SFBT; that is, the case could not be charted on the maps they had developed between 1982 and 1989. Once again, an "anomaly" had occurred and de Shazer turned to his "hobby" of philosophy and the sociology of knowledge to begin re-describing SFBT, this time through the lens of "post-structural" thinking.

> *Within a structuralist framework, "nymphomania" certainly cannot slip over into "insomnia. " However, within the more recently developed post-structural view of language (Harland, 1987), this is exactly the way words are seen to work (de Shazer & Berg, 1992, p. 73)*.

And, in the same paper, de Shazer and Berg wrote:

> *While the predominant structuralist view sees meaning and truth as being behind or within a person, a system, or a structure, another view, called post-structuralism (see, e.g., Harland, 1987), stresses the interaction of people as an activity through which meaning is constructed. Basically, structuralism and post-structuralism involve discontinuous ways of thinking about words, concepts, and meaning (p. 73)*.

So, in what sense are these two views discontinuous? In the predominant structural view, meaning making is understood as a process happening in the mind of the person. How people interpret and understand what they perceive is an activity that happens in the brain. What people say and how they behave – the "surface" behaviors – are determined by what is going on beneath the surface, inside them. Understanding meaning making this way leads to research about what goes on inside the head of a person.

In the post-structural view – what today is more often known as "social constructionism" (Gergen, 2015) – meaning making is interactional; it happens in the communication between people. Meaning making is a visible process on the surface (i.e. visible and audible communicative actions) and it is going on continuously as people communicate with each other. Understanding meaning-making this way leads to research on the visible and audible interactions between people. Researchers here observe the micro-sequences of what happens in a conversation when people agree or disagree about what to do or think in a particular situation, or how to interpret and describe some experience. In other words, researchers here investigate the many ways the participants in the dialogue reciprocally influence one another.

These phenomena are thought to all play a role in how meaning emerges in the dialogue. De Shazer and Berg call these interactional phenomena the "negotiation" of meanings:

> *As an example of using language, the therapist-conversation-client unit can be approached in a broad way because whatever the conversation is going to mean to both therapist and client depends on their negotiations (1992, p. 77).*

The couple in the nymphomania case, for example, described at the outset of therapy what they saw as their problem. The words they used carried certain meanings to them at the time. The wife said she had an insatiable sexual desire and she could not sleep without having had intercourse. To her, at that moment in the conversation, her desire and difficulties with sleep were signs of being a nymphomaniac. Further, in her view, nymphomania was a symptom of deep underlying problems rooted in her childhood which would require long-term therapy to resolve. The description on the surface; "an insatiable need for sex that prevents her from sleeping" was, to her, the sign on the surface of a deeper reality, namely, "nymphomania". As the session continued, however, an alternative description with its associated meanings emerged. De Shazer and Berg wrote:

> *The conversation about what is going on here switched to her husband who described her [the wife's] agony about the nymphomania and his tiredness. As he saw it, he was being robbed of the opportunity to be romantic toward her; rather than her lover, he had become just a stud, a sex machine.*
> *Husband: "But for me, it's more of a sleep problem for both of us."*
> *Therapist: "I wonder about that. Maybe we've been looking at this the wrong way."*
> *Wife: "Do you have any cures for insomnia? I'm game."*
> *Therapist: "I don't know. We've been looking at this as a sex disturbance, but it's beginning to look more like a sleep disturbance" (p. 75).*

The husband suggested that it was more of a sleeping problem for the two of them. The therapist said that maybe we have been looking at this the wrong way and thus suggested that perhaps the husband was right. Perhaps the need for sex before sleeping was a way to deal with a sleeping disturbance. The wife then asked for a cure for insomnia. On the surface, that is, from how the three people in the therapy room were now talking, the meaning of the daily sexual activities before falling asleep had begun to shift from a clear-cut symptom of nymphomania to possibly being a symptom of a sleep disturbance, or simply a way to handle difficulty falling asleep.

De Shazer and Berg continued about the case:

> *Throughout the remainder of the session, the therapist kept the conversation strictly on a behavioral level and avoided any further discussion of thoughts, feelings, and meanings. The sleep-disturbance-complaint became solely a "behavioral" or "technical" difficulty around which a solution could be constructed through technical means (p. 77).*

So, from this point in the session, the therapist and the couple talked about a problem of insomnia (not nymphomania) and, at the end of the session, the woman received technical advice from the team behind the see-through mirror on some things she might try to "cure" her insomnia.

> *After consulting with the team behind the see-through mirror, the therapist told the woman about two options:*
> 1. *Perhaps as an experiment, she could quit exercising for now. This idea was immediately rejected by the woman; or*
> 2. *(a) if she found herself awake one hour after going to bed, she was to get up and do hateful household chores like oven cleaning; or (b) if she found herself awake one hour after going to bed, she was to continue to lie there but with her eyes wide open, concentrating on keeping her tongue from touching the roof of her mouth until she fell asleep.*
>
> *The second idea was accepted with good humor: Both the woman and her husband burst out laughing. In response, the team called in an additional element: After the evening meal, sometime before he went to bed, her husband was to toss a coin to decide which option she was to use on any particular night" (p. 77-78).*

De Shazer and Berg, in reflecting on the case, commented:

> *What is going on here? The husband offered a different view, a different word/concept that was immediately accepted by his wife and the therapist. We thought we were on safe grounds; language seemed to be behaving itself quite well, but now the woman is saying that she is willing to consider calling her complaint by a different name (p. 76)!*

De Shazer and Berg, of course, are joking when they say that "language seemed to be behaving itself quite well". If language behaved well, which is the usual structuralist view, "nymphomania" cannot slip over to "insomnia". Thus, the question remains: "What is going on here?"

Misunderstanding. In the same article about a post-structural revision of doing therapy, de Shazer and Berg offered this theoretical description of what happens in therapy sessions:

> *Clients describe their situation from their own particular, unique point of view. The therapist listens, always seeing things differently, always having different meanings for the words the clients use, and thus redescribes what the clients describe from a different point of view. The possibilities of new meanings open up from these two different descriptions, these two different meanings, when they are juxtaposed. (This is metaphorically similar to the process involved in depth perception (see, "Binocular theory of change" in de Shazer, 1982a). The result is not the clients' views and meanings and it is not the therapist's view and meaning but something different from both (p. 77).*

In a related publication, de Shazer called this interactional process around client meanings and therapist attempts to understand, "creative misunderstanding" (de Shazer, 1991, pp. 68-69). He proposed that because the participants in a conversation, including clients and therapists, come from different backgrounds and experiences, they can, in a real sense, only misunderstand each other. It is through their language negotiations to reduce the misunderstandings that new meanings and related new pathways to solutions may emerge. So, again, in the "nymphomania case", the husband misunderstood the wife's "nymphomania" as a "sleep problem" and the therapist misunderstood the wife's "sex disturbance" as a "sleep disturbance". Then, as stated earlier, the therapist's subsequent work with the couple in that initial session focused on the creative misunderstanding of them experiencing a sleep disturbance and how a solution to this technical difficulty could be constructed including giving a classic BFTC session-ending task. Thereafter, and extraordinarily:

> *Two weeks after this session, the woman sent a note thanking the therapist and team for seeing that her "insatiable need for sex" was but a "a symptom of my insomnia". She wrote that "immediately my sleep patterns and my libido returned to normal". She did not say whether she and her husband ever tried the intervention task (de Shazer & Berg, 1992, p. 78).*

Ludwig Wittgenstein. From the early 1990's until his death in 2005, de Shazer continued to think and write about how the meanings of words in therapy sessions are not fixed and the implications of these shifting meanings for client change. He drew on the work of several philosophers, most notably Ludwig Wittgenstein, to develop his own theoretical descriptions. De Shazer appreciated Wittgenstein's view of how language works. Wittgenstein did not believe words have essential meanings; instead, de Shazer stated: "Wittgenstein … points out that the meaning of words is determined by how they are used by the various participants within a specific context" (1991, p. 71). Closely associated to the contextual meaning of words is that meaning is established in interactive dialogue: "… language and speech originate and develop through use, through social interaction and communication" (de Shazer, 1994, p. 51). De Shazer expressed this contextual and interactive character of therapy sessions this way:

> *For instance, a therapist's utterance during a particular session is related to all of his previous utterances (during that session), all of his future utterances (during that session), and all of the client's utterances on a particular subject during that session as well – a situation … Wittgenstein called a "language game" (de Shazer, 1994, p. 51).*

By his use of the term "language game" Wittgenstein was proposing the view that language is better viewed as an interactive activity than an abstract set of essential meanings (de Shazer et al., 2007, p. 109). A bit further on in the same source, de Shazer writes: "What Wittgenstein calls 'language-games' can be simply described as slices of everyday life, the home base of words and concepts (p. 110). In the 1990's and right up until the end of his life, de Shazer came to view and talk about solution-focused conversations as language games which are context specific and where the language interactions can open up new possibilities for clients to create more satisfying lives for themselves. After 1990, it is noteworthy that de Shazer and his colleagues did not add new solution focused techniques to the ones they had invented during the 1980's. However, drawing especially on Wittgenstein and beginning with the "nymphomania" case, he came to describe what he saw happening through the use of solution focused techniques in a very different way. For example, de Shazer stated about the use of scaling in SFBT:

> *Unlike most scales used to measure something based on normative standards (i.e., a scale that measures and compares the client's functioning with that of the general population along the bell curve), our scales are designed primarily to facilitate treatment. Our scales are used not only to "measure" the client's own perception but also to motivate and encourage, and to elucidate goals, solutions, and anything else that is important to each individual client. … Scales allow both therapist and client to use the way dialogue works naturally by developing an agreed upon term (i.e., "6") and a concept (i.e., on a scale where "10" stands for the solution and "0" for the starting point, "6" is clearly better than "5") that is obviously multiple and flexible. Since you cannot be absolutely certain what another person meant by his or her use of a word or concept, scaling questions allow both therapist and client to jointly construct a bridge, a way of talking about things that are hard to describe – including progress toward the client's solution (1994, p. 92).*

Like scaling conversations, de Shazer theorized that conversations around the miracle question, what's better questions, exception questions, and coping questions similarly all draw on "the way dialogue works naturally". That is, these solution focused techniques invite clients to construct, in their own language, the alternative futures they want, what already is happening that is better relative to those preferred futures, times when more of what they want is already happening in their lives, and how they see themselves coping when they have all but lost hope of a better future. De Shazer called his theoretical description of solution focused sessions and the shifts in meaning that so often accompany solutions "interactional constructivism" (de Shazer, 1991, p. 48; 76-80). In addition to continuing the use of solution focused techniques invented in the 1980's, de Shazer's interactional constructivism continued to respect what clients said they wanted from therapy, not what the profession was saying clients needed. His interactional constructivism, with its focus on the shifting meaning of words through dialogic interaction, also made very clear the importance of attending to and working with client's everyday language. In this regard, de Shazer regularly reminded those who wanted to be SF therapists and coaches that, in their conversations with clients, they must "stay at the surface" of client words and not hypothesize about what might be going on inside clients' heads or their situations. Finally, his *interactional* constructivism continued the change already begun during the 1980's of viewing the content of the interview as more important in initiating client change than the end-of-session intervention or task. The focus of interactional constructivism is squarely on the language[18] interactions of therapist and client in the sessions—on the solution-focused language game. Tasks, while still offered after 1990, receded into the background and functioned more as session ending summaries of what was interactionally constructed in the therapy session.

Returning to our initial purpose of extracting the axioms in de Shazer's theory development project, we believe he added one more axiom in his 1989-2005 phase:

- **Axiom 6: Therapy is a visible interactional, dialogic process negotiating the meanings of the client's language.**
  This axiom is meant to capture de Shazer's view that client change occurs through the negotiation of the meanings that clients bring to the client-therapist system. Words clients use are not essential or fixed in meaning, but negotiable through therapist-client conversations about what clients might want, positive client change already happening in clients' lives, and what additional progress toward more satisfying client lives might look like. While some other post-modern therapies may share this theoretical view, most therapies in the field are not post-modern and function as though words describing client difficulties and their solutions have essential meanings (i.e., depression, anxiety, nymphomania, sleeping problems etc.). That is, for most therapies in the field, client problems and their related treatments are largely thought to have a definable existence separate from clients and what clients might say about them.

  This axiom is also consistent with the axioms identified with de Shazer's earlier theoretical phases. The negotiation of meanings is a visible process and continues his emphasis on describing the construction of solutions from what can be directly observed in the therapy room. Shifts in meaning occur in the language interactions of the therapist-client system as they cooperatively work to construct solutions around the client's goal(s) for a more satisfying life.

[18] Language is not only words. Shrugging your shoulders, rolling your eyes, facial expressions etc. are all part of language.

Conclusion

We hope that this paper has challenged the myth that SFBT has no theory. If so, our purpose in writing it has been achieved. In reflecting on our attempt to condense de Shazer's writing we are amazed at the creativity and richness in his theory construction. He began by viewing Erickson's, and then later BFTC's, therapy sessions through the lens of several existing theories in the field. When these theories could no longer capture what he and his colleagues were observing in their therapy sessions, he set aside those conceptualizations and developed other theoretical descriptions. In the process, he deconstructed many entrenched theoretical constructs in the family therapy and broader psychotherapy field and several times reformulated his own descriptions of client change and what clients and therapists do together that is useful in promoting client change. At the time of his death in 2005, his descriptions were clearly postmodern, focusing on the language interactions between therapists and clients. In our view, he left a legacy of 6 enduring theoretical axioms of inviting client change through the practice of SFBT developed over more than 40 years of thinking and writing. In the time order in which they were developed, these axioms of SFBT are:

- **Axiom 1: Therapy is an observable interactional process, that is, a conversation.**
- **Axiom 2: The minimum unit of analysis is the therapist interacting with the client in the therapy setting. This unit cannot be subdivided further.**
- **Axiom 3: Change is the purpose of the therapist and client's meeting.**
- **Axiom 4: Client change via therapy occurs through observable interactions in which the therapist finds ways to cooperate with the client.**
- **Axiom 5: Brief therapy is about developing solutions with the client.**
- **Axiom 6: Therapy is a visible interactional, dialogic process negotiating the meanings of the client's language.**

In reflecting on what we have conceptualized as de Shazer's four phases of theory development, we are especially struck by two things. The first is his method of theory construction. We have written about his and the BFTC team's view of the recursive relationship between practice, research, and theory. It is obvious in his writings that de Shazer never strayed from this approach to knowledge development, and it is noteworthy that he privileged the direct observation of practice as the source of discoveries that led to the descriptions of the innovative and distinctive SFBT techniques of doing solution focused brief therapy that we have today. Time and again, throughout his four phases, it was a direct observation of something that happened in the therapy room between the therapist and the client that got the team thinking differently and developing a new research project to test the usefulness of the new discovery. The theory, then, followed from that.

The second thing about de Shazer's theory development project that jumps out for us is that he developed an interactional theory of what is happening between therapists and clients. In this regard, he is clearly in the minority among practitioners and theorists in the psychotherapy field. The field generally remains a problem solving one; that is, focused on assessing client problems and developing related interventions. Enormous energy and other resources are devoted to developing typologies of problems, clients, and families. These typologies are meant to give direction to therapists in their interviewing and development of interventions. It is striking that de Shazer's theory development project and the resulting SFBT have added no typologies or categories of clients or problems to the field. De Shazer did not even attempt to categorize client strengths or types of solutions. SFBT is solely focused on what is jointly constructed in the interactions of therapists and clients that is useful for client change. At the time of his death, he was continuing to theoretically describe what is happening in the language interactions of therapist and clients.

Since de Shazer's passing, new research in the microanalysis of therapy conversations is continuing de Shazer's interactional focus and expanding it to other aspects of therapist/client interactions (Bavelas, De Jong, and Smock Jordan et al., 2014; De Jong, Smock Jordan, Healing, & Gerwing, 2020; Korman et al., 2013; Smock Jordan et al., 2013). These studies which are based on direct observation of client/therapist interaction offer empirical support to de Shazer's interactional constructivism. They also indicate that the co-constructing of meaning is a feature of all therapies, not only post-modern ones. Although the meanings co-constructed by therapists using different models are different, all therapists employ the same, directly observable interactional processes to influence the direction of their sessions consistent with what they believe is most helpful to clients.

So, we believe de Shazer made significant theoretical contributions throughout his career. We also believe both his recursive method of developing theory and his interactional constructivism will endure. If we continue to follow the example he set in these regards, we believe our field will be the stronger for it.

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