

South Australia's First Family Therapist — Jeff Gerrard Remembers: An Interview

Lorraine Read

Jeff Gerrard can claim the distinction of being the first family therapist in South Australia. Early on in his career as a psychiatrist he explored the growing field of psychotherapy overseas and observed, studied, and trained with some of the historical greats in the area. When he returned to South Australia in the early 70s, it seems to have been a natural step for him to begin practising family therapy and training other health professionals in the theory and practice of family therapy. The early training that Jeff led at the South Australian Children's Hospital enabled a cooperation between a number of early family therapists, such as Michael White and Anne Sved Williams, to train the first cohort of people who would later go on to become significant contributors to the family therapy field in Australia. In this interview, Lorraine Read invites Jeff to explore his early contributions to the field and to discuss the training and supervision experiences which were/are important in his development as a family therapist.

Lorraine: When did your interest in family therapy begin?

Jeff: I went to Montreal, Canada, for two years. I was really doing the psychiatric training, but began my interest in family therapy by attending a two-week course in family therapy with Nathan Epstein, who was the Professor of Psychiatry at McMaster University in Ontario. He'd previously been at the Jewish General Hospital in Montreal where he developed family therapy in Montreal and in Canada. So I did a two-week course there at the Jewish General with some of his team members. One of our staff psychiatrists at the Montreal General ran a session focusing on couples and looking at family therapy theory, and at times we extended that to look at children's issues.

Lorraine: Do you remember what attracted you to family therapy at that time? Was there a particular thought or case that intrigued you?



Jeff: No, I think I was drawn to family therapy because it was an approach that was different from psychoanalysis. It was like real life in progress, talking with people within their important relationships and setting them homework tasks, and really we had very positive, hopeful interventions to work with, which were different to psychiatric interventions. That's what attracted me to it. It offered the opportunity for intervention. Perhaps also I became interested because family therapy was on the crest of the wave — it was a new time, family therapy was



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something that was not available in Australia when I left.

Lorraine: What did psychiatry think of family therapy at that time?

Jeff: I think it was still very much on the outer in some areas of psychiatry, but both the people I mentioned are psychiatrists. Epstein originated the McMaster model. At the beginning of the McMaster model, Epstein's thinking was that you could do a family interview in an hour, and ascertain how that family worked. Yeah, I think he was probably teaching the beginnings of the McMaster model when I was there — focusing on the style of communication, behaviour control, whether the family was functional or dysfunctional, they're the parts that I usually remember of the McMaster model.

Then I went down to Boston. I initially looked at a Harvard child psychiatry program, which just didn't seem satisfactory. The clients were kids on remand and, as I remember it, were locked up behind bars and I didn't fancy a program which was largely based on that sort of clientele. So I rang up Boston State Hospital. Two family therapists from the Boston Family Institute, Fred Duhl and David Kantor, were running a family therapy training program if you worked at Boston State. So I was recruited there and went there the following year and did the whole of their program. They were using some psychodrama concepts for exploring things, and designing experiences which allowed us to explore issues and different family structures in their seminars, which became an action-style of learning. Fred Duhl then developed this into family sculpture which he taught us in these seminars. And I joined a program of live-in research with David Kantor, who was their research psychologist. He was looking into schizophrenia. They published a book called *Inside the Family*, describing how they put observers in the family for up to six weeks to observe the interactions. When I came along, they asked me to do some psychiatric interviews with these families, and record them. They took over that information; I have no idea what happened to it, but presume that was incorporated into their ideas. And they were looking at different family forms, families where there was a black-white marriage, or a schizophrenic member, or other unusual family structures.

Lorraine: So there was quite a feeling of new things and exciting things happening in family therapy research?

Jeff: Yes, but another thing that I also explored was the T-group movement and I did a two-week workshop in Maine, which I really enjoyed, and that was an experience! I didn't offer a lot, I sat back and lis-

tened and saw what was going on and I was really challenged for doing that in a group setting, and challenged to become more active. I got in touch with a lot of other ideas that were around at the time, for example Maslow's hierarchy of needs. Psychiatry was willing to have a look at many different theories, many different approaches.

Lorraine: And when you came back to Australia, did you come back to the Children's Hospital?

Jeff: When I was thinking about coming back, I actually arranged an affiliation with the Boston Children's Hospital, because there was no family therapy in Australia at the time. I was heading headlong down the family therapy path, and the only way I could see back into Australia was really by child psychiatry, so I started this affiliation with Boston Child Guidance Clinic and with the Boston Children's Hospital across the road. Then I started to pick up some family therapy from the children's perspective. A psychiatrist called Ernest Bergell supervised me, and showed me an article that a colleague Jaqui Zilbach had written on the use of play equipment with children. I started to do family therapy with younger children and had supervision for that and that was great. I began doing this in the second year of my stay in Boston. I had a friend, Paul Zimmet, looking for jobs for me. He sent me the advertisement for the position of Director of Psychiatry at the Adelaide Children's Hospital, so I applied and became Director. That's how I came back, and started work around August '71.

Lorraine: You were the first family therapist?

Jeff: Certainly the first in South Australia. However, I didn't feel fully formed as a family therapist, but I had enough confidence to demonstrate it to staff at the Children's and see a family at one end of the office, as the one-way screen wasn't big enough. I did several workshops over a number of years with Margaret Topham, and eventually she visited for a week as a guest family therapist.

Lorraine: Were there particular cases you were interested in?

Jeff: No, I was a bit of a generalist. I didn't specify the sort of families I wanted to see. Probably I mostly saw the behaviour disorders. School refusal was also pretty common, and abdominal pains, and various other issues such as epilepsy. Sometimes I saw the kids with things like epilepsy and I wanted to track what was happening to their families.

Lorraine: Did you have a favourite approach?

Jeff: Early in the piece, I liked the structural approach of Minuchin. I think we were all enamoured a bit by Minuchin, reading his books and

trying some of the structural moves — I guess, particularly, if there was a child in between the two parents, I'd move the child out from between the two parents and explore what change happened with the parental communication as a result of that.

Lorraine: Is there anything that strikes you about family therapy back then that still holds quite true today, when you look down the passage of time?

Jeff: You're looking at the present with family therapy and you're observing the interactions and that is the power of family therapy, that it's happening right in front of you. You're not viewing the history, you're actually seeing things happen, and you have the opportunity to be the observer of what is happening, and I think that's the strength of it. How you do that or whatever theory you be guided by, is additional to the experience of watching the family interaction unfold before your eyes. I think most approaches have to observe what's happening. So, I'm still very much an observer of the interactions. I still see myself as rather direct, really. I usually try speaking directly.

When I get some inkling that the family is not responding to my directness, I'll then go to speaking differently, I'll start to become a little bit restraining, or paradoxical.

Lorraine: One of the things that you began was the Family Therapy Training at the Children's Hospital in Adelaide. What year was that?

Jeff: Well, from memory that was about 1977. I think by that time Michael White was on the staff at the Children's Hospital as a senior social worker, and Anne Sved Williams was a part-time medical officer. Anne had just come back from New York; she studied with Nathan Ackerman. So the three of us set up the three parts of the training course. We designed the content of the first part, mainly focusing on theory, and moving into the practical areas of family therapy in parts 2 and 3, and that worked really very well for the next five years, until Michael decided to leave the Children's.

Lorraine: And Graham Martin?

Jeff: Graham was in that first group. He was one of the students. He had come to work with us at the Hospital — and he was one of the first people in the training group, along with Judith Cross. I think, Lorraine, you and Andrew Wood were in the second training group. Well there were about eight in the first group: Ray Hawkes, Liz Mackenzie, Graham Martin, Maria Scicchitano, Di Gilbert and Geraldine Slattery. I look back at it, and we probably wouldn't have been able to do that now, setting

up a training course, devoting half a day a week to teaching people from outside the hospital, but all those people now hold responsible positions.

Lorraine: Was there a lot of support for doing that at that particular time?

Jeff: By virtue of being the director of the psychiatric department, I had quite a degree of autonomy at the time, the hospital political mandate prioritised teaching and research, as part of our teaching of medical students. In that climate, we were able to set up the family therapy course, and I don't remember how much permission I had to do this. I think I developed it and taught in the course; it was like a departmental project.

Lorraine: You wouldn't have thought twice about how much of an issue it was. You just did it. But you would have to fight these days.

Jeff: We had to fight then if we wanted money, but we didn't need money as such to run this course; we had the trainers on staff.

Lorraine: If you had a message for the beginning family therapist, given the wisdom that family therapy has taught you, what would you say? What advice would you give?

Jeff: I don't think family therapy is something that I'd suggest you learn on your own. I think you need to learn in a group, have group support, and I also think you need some sort of mentor or supervisor-type person, because there are a few hard knocks in working with families, and you can get disillusioned, and you can get over-involved at times. I think that we all went through the videotaping stages, and I still think that's very necessary. I don't do it myself now, but I think it's very necessary to review what you're doing, but you've got to get informed consent. Also you need to learn more than one approach. You may learn one approach at a time, but over a number of years explore different approaches. And, I think in family therapy you do have permission to use yourself and develop your own confidence in things, to use more of yourself even to the extent of sharing, discreetly, parts of your own thinking or your own life. I think that has to be done carefully and I think I'd say parsimoniously, but at times I think it is helpful to share.

Lorraine: Any comments about family therapy now and the way it's evolved?

Jeff: It was always thought that when family therapy moved from being a new and radical therapy and to being taught by universities and teaching institutions, it would lose some of its popularity. Well, I'm not sure if that's happened. You can now do a

Ph.D, or some lesser degree in family therapy, but it's probably not quite as popular as it was when I started doing family therapy. I still think it's a very valid, useful therapy. But I also think that there are variations, like seeing a key member of a family, and still be working with different aspect of the family issue with that particular person. That's going back to Murray Bowen's style of working with a family.

Lorraine: You were doing quite radical things at that time. Did you realise you were being so radical?

Jeff: No, no — that's only in hindsight. Moving from seeing an individual client to working with numerous people, that was a big change. Various therapists including myself have invited in a co-therapist, but to work alone with the whole family was really quite a big challenge. And then people saw the chance to work with young children and families, allowing children to play with the toys available, so they could be comfortable in the situation.

Lorraine: Family therapy seems to have almost forgotten the children. So I wondered if you'd noticed that change as well?

Jeff: Well, certainly working the way I used to at the Children's Hospital, or in your case at CAMHS, addressing the children's problem is our bread and butter, so working with the children is the way we've come to view family therapy. Just an interesting aside, while I was at the Children's and doing my family therapy, I was asked by the Professor of Psychiatry to see an adult family. One adult member had manic depressive disorder, and another one had severe diabetes, and I actually refused to take the offer up. I just thought it was such an established medical/psychiatric diagnosis that I wouldn't take that sort of family on. So that might just also say something about a lot of my family experience being child-orientated and not particularly adult-orientated whilst I worked at the children's hospital.

Lorraine: Any other family therapy training experiences that stands out for you?

Jeff: Well, I went back to the States on a post-graduate trip to update myself — I actually spent a month doing various workshops. I worked with various people there, and that was really interesting. I looked at MRI, and got interested in their stuff. I was really quite a fan of Carl Whittaker, I read his books, and was quite excited by *The Family*

Crucible, bought some of his videotapes. I liked his work. The three generational sessions that he did, bringing in grandparents, were very interesting. He invited them to come in to help him to help their children, not as patients.

I enjoyed doing a workshop with Chloe Mandanes and her husband, Jay Haley. Haley was very interesting too. He was almost laconic, he'd sit back and analyse things. And he and Whittaker looked at psychotic adolescents when he was presenting, and looking at the craziness of the family system.

Just recently, I thought, 'If I'm going to continue working, I should get some supervision'. But maybe I survive on having several peer supervision groups going, I've have one going in hypnosis, one in psychiatry, and one with a marital/family therapist.

Lorraine: It's still important even after all that time in the field to have peer supervision. Is there a particular thing that attracts you about peer supervision?

Jeff: Well, I think it's become very important — this is the current emphasis on quality assurance. If you've got a peer group you can review the latest developments, but you also have the support of your colleagues. Well, for example, I've been through a completed suicide in my practice, and I had plenty of support from my peer group. Then more recently, one of the other members of the peer group has had a client complete suicide and we've been able to support him, both in the group and over the phone and have met with him directly over a meal.

Lorraine: It's interesting that you talk about the peer support of your colleagues, is there something personal in that, it's not just about the professional level?

Jeff: It's almost like a family, because the colleagues I'm working with, four out of five I've known for decades. So, yes, it's like a family, we meet roughly every month, have a meal together, share our cases, and then we also raise questions. Preparing and then presenting one's family work to the group is a learning experience par excellence. Just reviewing your data new insights hit you and in addition the group may focus on system, developmental and multigenerational issues as well as counter transference feelings which need to be dealt with, to continue working effectively with the family. ©