

Family Therapy in Australia

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Written in 1998, this paper is my perspective on the history of Family Therapy in Australia. It is written from my position as one who has been privileged to be a part of that history and to have my own professional and personal development intertwined with it. The perspective I offer here is entirely my own.

In 1967 I completed my medical training in Perth, Western Australia and I looked about eagerly for training opportunities in psychiatry. I had decided somewhere in my mid to late adolescence that Freud was my ego ideal and my vision was of becoming a traditional behind-the-couch-analyst. At that time this was pretty much the only model available in Australia for someone who wanted to learn about psychotherapy. This ambition was of course part of an existential struggle that began with wanting to change me and my world and to gain social acceptability by translating (or sublimating) this into an external aim: to change others and to change their worlds.

There was not much of an Australian ethos of psychotherapy with which to identify at that time and so I looked to our cultural families of origin for guidance. Medicine in Australia had derived chiefly from a British tradition. I found three major influences: the behavioural schools, as represented by people like Eysenck; a rather biological approach to psychiatry, with people like Roth and Slater; and the British analytic schools of Freud, Klein, Fairbairn and Guntrip. All of these schools, although seemingly very different from one another, had a common element — they were individually focused. Whether psychopathology was inherent, learned or acquired, it was something that happened within an individual. The answer, if indeed there was an answer, was to find some way of changing what was going on inside that person's mind, either by modifying brain chemistry, modifying learned responses, or modifying unconscious processes.

To this blend of dogmas I was able to add a more exotic dash because of a peculiarly local factor, in that one of my consultants was a European-trained psychiatrist who had been raised in the Existential tradition. So I had a little Binswanger and Sartre for good measure.

The situation in the hospitals and clinics at that time was pretty much that psychiatrists were in charge of treatment,

psychologists did Rorschachs and MMPIs and social workers did something called 'seeing the mother' (in the case of Child Guidance Clinics); or helped find jobs, accommodation, and sorted out pension claims (in Adult Psychiatry Departments). The psychiatrists, having yet to establish an Australian identity, were offering a mixed approach of drugs and interpretations while continuing to argue about 'endogenous' versus 'neurotic'. A relatively psychogenic view of the psychoses was still popular, although these problems were also recognised as 'unanalysable'.

By 1969 I was looking further afield for postgraduate experience. I found in Melbourne an emphasis upon Klein and Winnicott and Fairbairn and Guntrip and so I steeped myself even further in psychoanalysis. The same was true in New Zealand at that time so I was well prepared to sit exams in Dunedin.

By the early 1970s American psychotherapy was having an impact here. The Human Potential Movement, which had gained ascendancy on the West Coast of the USA in the 1960s, was a particular challenge to our traditionally British biases. I was looking to expand my psychoanalytically influenced brand of psychiatry and to find other ways of working, and these new philosophies were very liberating. From the rather stern, detached and intellectual position of the psychoanalyst I was introduced to a new way of being. Now it was warmth, empathy, openness, spontaneity, positive regard, client centredness and 'You're OK'.

In Perth at that time the strongest influences were Carl Rogers and J. L. Moreno. The local Marriage Guidance Centre was operating on a Rogerian model and I became immersed in this new way of relating to people. At that same time I discovered that many of my non-medical peers had better skills than me and that I had a lot to learn about interpersonal relationships — something that is not so readily learned from behind-the-couch. I began to see people as wives and husbands rather than as neurotics.



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I began to appreciate the importance of here and now relationships, where before my focus had been on the past.

The American ethos continued to infiltrate and a Psychodrama institute (Max and Lyn Clayton) was established in Perth — the first of its kind in the country. Interestingly the Human Potential Movement had its greatest impact on the western side of the country here as in America, while on the eastern coasts of both countries a strong psychoanalytic and individualist influence persisted.

If the warmth, empathy and positive regard of Rogers had been an ideal counterbalance to the rather aloof, critical and intellectual position of Freud, then the impact of Psychodrama with its spontaneity and action, its interrelatedness and its passion, was the ideal experience for a rather self-conscious and intellectualising medical graduate.

Again, I was impressed with the skills and expertise of my non-medical peers. I saw that most of psychiatry in Australia was continuing along either traditional biological or psychoanalytic pathways and that psychology too appeared to be moving along the conservative traditional mainstreams of either behavioural or psychoanalytic orientations.

So we formed a new breed of ‘therapists’ as we liked to call ourselves (eager to merge our professional differences). We were frowned upon by our conservative peers who described us as ‘fringe’. We were joined by a new group of social workers who had spent a long time in the wings ‘seeing the mother’ and sorting out pensions and were eager to put family relationships onto the main stage of treatment.

With such a predominantly non-medical peer group, we Australian ‘therapists’ of the seventies, had a rather strong anti-psychiatry bias. For most of us R. D. Laing was somewhat of a romantic hero or guru. We had seen the light: people would not be changed by finding ways to alter what happened inside their heads. They would be changed when they learnt new ways of being in the world — now; new ways of relating to their significant others — now; new ways of expressing themselves — now; new ways of thinking — now.

Whilst the 1970s in Australia did not go off with as much of a bang as the 1960s did in America, still there were enough sparks to cause some excitement. Psychotherapy in Australia was coming out of its British-based schooldays and entering a more passionate and more confused period of adolescence — to the tune of the American jukebox. The philosophies of the ME generation were irresistibly self-centred: self-actualisation, self-assertion, self-directedness, encounter, authenticity, autonomy, and intimacy. Just as we young therapists had scorned the repressive values of our progenitors, biological psychiatry, psychoanalysis and behaviourism, so we sought to liberate our clients from their repressive families. We had moved the superego out of the mind and back into the world whence it had come. We had identified the tyranny of the middle class family, the persecution of the patriarchal culture, the mystifications of the medical model. We had found an answer to all of life’s questions: therapy. Quite often the complete prescription was to leave your marriage

and join a personal growth group; or quit your mortgage and join a commune.

It was about then, the 1970s, that feminism began slowly seeping in across the Pacific. Women whose children were grown up were aspiring to education and careers and a chance at self-development. What better redirection of talents refined by 20 years of wiping noses and cleaning up messes and trying to make everyone happy, than to become a therapist? These women trooped cheerfully into universities and tertiary colleges to acquire degrees in Social Work and Psychology, to become therapists and to bring a somewhat more seasoned view to the movement.

Liberation was having its impact on men too. The traditional grey-suited ranks of psychiatry and psychology were being joined by a new generation of young men in beards and sandals and jeans. By the mid 1970s, those in the Australian therapy scene could be identified by these uniforms. The grey suit, collar and tie brigade were in hospital and private practice psychiatry, flanked by psychology, and still pretty much in charge of the treatment process. They were happy to have a large and dedicated group of predominantly female underlings — with the occasional neophyte grey suit and a sprinkling of jeans and sandals

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types with bushy beards who would no doubt settle down once they were a little older.

Outside the hospitals and clinics was a growing band of alternative therapists who were at best ‘fringe’ and at worst dangerous. Stories were told of people disintegrating into irreversible psychoses after sessions of primal scream or Rolfing or re-birthing. Worst of all, some of them had no professional training and proudly rejected all learning as intellectualism whilst pursuing the mysteries of their bodily rather than their mental experiences.

Group and couple therapies had proliferated but by now the peak of our new phase of development had been reached. Self-actualisation had failed to meet its promise. Our relationships with our families of origin had reached an all time low. We were ready for a beginning rapprochement. Blame theories, whether inwardly or outwardly directed, had offered only temporary solutions.

Upon this background we met, some 250 of us, in Melbourne in 1979 and Family Therapy as a significant force in Australian psychotherapy was born.

At our very first meeting we confronted a paradox: The blue jeans bushy beard types who had rejected the patriarchal values of the grey suit brigade, established themselves instantly as the leaders of the movement. The rank and file

were characterised by Indian cotton skirts, breast-feeding activities and blue jeans. The issue (of gender equity) subsided for a time but exploded some years later.

The new group of Family Therapists was a complex mixture of people from a variety of professional backgrounds — but there were very few psychiatrists. In 1978 Virginia Satir had visited Perth and conducted a week-long workshop. Only one psychiatrist other than me had participated.

Family Therapy was to prove an area where social workers could demonstrate their skill in dealing with families. It was an opportunity for the non-medical therapists to establish their special expertise and to achieve a new identity not only as primary therapists but also as teachers and supervisors. Perhaps for that reason psychiatry was slow to show interest. ‘Seeing the family’ was traditionally an incidental task and was delegated by the treating psychiatrist, whose focus was the individual patient. Those to whom this job had been delegated over the years were not to be readily accepted as peers, even less as teachers or supervisors.

Our theoretical interests at that first meeting in Melbourne were varied. Most of us had been following communication models and were most familiar with Satir, Bateson, Jackson, with neurolinguistics, social learning, role theory, some beginning notions of systems theory (I still could not spell Bertalanffy), even a little cybernetics. From

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our more traditional bases we had a strong grounding in psychodynamics, behaviourism, biology and sociology. The social workers talked about ‘epistemologies’ and I wondered what they meant. Some people talked about a ‘Milan influence’ and I thought they meant David Malan. We had some ideas about Minuchin and structure and we knew about boundaries.

Over the next three or four years the group settled down to some serious work. We established a communication network and a journal; we formulated ideas and integrated our reading until we were sufficiently sophisticated to identify the particular models we employed. The original emphasis upon communication and structural models was quickly expanded and people became familiar with systemic and strategic approaches.

For many of us the humanist movement with its emphasis upon openness and equality had taught us to be suspicious of hierarchy and structure. But now we found ourselves *imposing* hierarchy and structure. This created a dilemma and we began to question the notion of hierarchy in different ways. We looked at our group leaders in Canberra in 1984. They were entirely male. Resentment ran deep and the group fractured.

There were now clearly delineated ‘schools’ of family therapy. In Melbourne, Moshe Lang and Brian Stagoll had been prominent from the first days. Both were thoroughly trained and widely experienced in their background disciplines of psychology and psychiatry and they had developed a somewhat systemic style of family therapy. Moshe’s charm came from his gentle worldliness, Brian’s appeal from a more brash social reformism.

In Sydney, the late Margaret Topham was the first Australian to be trained in family therapy. She had returned from Palo Alto in 1968 and later established the Australian Institute of Family Therapy. Beginning with the communications model approach she had learned from Satir and Jackson, Margaret continued to develop her style of therapy as new ideas took over. Beginning as a social worker, she was very much before her time and the traditional hierarchies of biological psychiatry and psychoanalysis were slow to accord her due status.

In Adelaide, there had long been an adventurous group of psychotherapists who had pursued different paths from their colleagues in Melbourne and Sydney. It was in Adelaide, after all, that the Western Institute for Group and Family Therapy (California, USA), in the form of Bob and Mary Goulding, had first taken hold in 1974. After meeting the Gouldings in Adelaide, I hotly pursued them back to Mt Madonna, California. Ellyn Bader was a member of that Institute and whilst much of the Goulding’s work was TA and Gestalt, we were introduced to a new style of family therapy — a style which remains simply ‘Ellyn Bader’, rather than one which can be categorised.

From that background in Adelaide, Michael White emerged to demonstrate his skill and creativity and his mastery of complicated concepts from cybernetics. In Sydney Kerrie James began to formulate the feminist dilemma of the family and along with Laurie MacKinnon bravely challenged the patriarchal biases in the organisation of the Australian family therapy group.

In Perth, family therapy struggled more slowly. Lois Achimovich and I had attended the first conference in Melbourne and for a while we formed a small group of two with no other psychiatrists in Perth showing any interest. Locally, the non-medical psychotherapists had become firmly committed to the humanist psychotherapies but there was also a continuing commitment to the psychoanalytic tradition (from which I had never separated myself). Over the next few years I teetered between a commitment to both traditions, a hybrid who was regarded with extreme suspicion by both analysts and family therapists.

Brisbane and Hobart had yet to develop an identifiable school of family therapy, although people from both Queensland and Tasmania came to be seen at annual conferences. Paddy Burges-Watson from Hobart was, like me, a traditionally trained psychiatrist struggling with the integration of the intrapsychic and the intrafamilial. Another psychiatrist, Aija Wilson, returned from the Nathan Ackerman Institute in New York and moved from Melbourne to Brisbane where, like Paddy and me, she

continued to struggle with the dialectic of the individual and the family.

From over the Tasman we heard of innovative work by David Epston and he and Michael White managed across the thousands of miles that separated them to establish a productive working relationship and to integrate also the work of Karl Tomm in Calgary.

By 1984, people were returning from training institutes overseas and Max Cornwell had persuaded Brian Cade to leave Cardiff and join him in Sydney. Both widely experienced in the Milan approach and both working with Margaret Topham's family therapy institute, they began consulting, teaching and supervising strategic therapy. By

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now I was part of that group too. I had left Perth and moved to Sydney to immerse myself once more in the mysteries of psychoanalysis and to explore the new ideas of Self Psychology. My input to the (Family Therapy) Institute was to integrate the psychodynamic with the systemic — an indication that in seven short years family therapy had come full circle.

Jim Crawley had taken up a position in Perth and was beginning to develop a family therapy training program with a structural and systemic orientation. It was Jim who had promoted the idea that the 1986 Family Therapy Conference would have as its theme the integration of individual and systemic perspectives. Some people were not ready for this. Moshe talked of a rapprochement with our families of origin and I talked of the need for integration rather than polarisation. Some regarded us as reverting to old and conservative habits. Others reflected that we were showing our true colours at last — we had been closet analysts all along.

From the time of the Canberra conference in 1984 when Kerrie's talk 'Breaking the Chains of Gender' had challenged the group process, a separate Women's Conference had developed. This met in the two days before the annual Family Therapy Conference and became a quite separate and independent group, although generally comprised of women who were also attending the Family Therapy Conference. This forming of a separate group was viewed by some as hostile, by others as indispensable to the adequate development of women within the family therapy group itself. By 1986, there was less friction between the groups and Moshe's reference to rapprochement seemed not inappropriate.

By 1987, formal training groups were established in Sydney, Melbourne and Adelaide. Catherine Sanders

and Malcolm Robinson had formed another influential group in Adelaide. Anita Morawetz had been active for several years in Melbourne, along with Jeff Gerrard and Geoff Goding.

From all of this, it seems that no particular practice can be identified as Australian Family Therapy. Rather, we do what is peculiarly Australian: we struggle towards integrating into an originally British-derived culture of a variety of influences, both American and European; we have conservative elements who work to preserve the old traditions; we have adventurous pioneers who rush out to explore new places; we have spirited entrepreneurs who import the latest fashions; and we have, somewhere in the future, a way of being that is uniquely Australian.

Commentary 2004

Revisiting this paper some sixteen years on, I observe that the family therapy field in Australia remains as diverse now as it was then. Unfortunately the status of family therapy has not improved, and for this my professional group — psychiatry — can take some credit. It has continued to marginalise family therapy and to promulgate the biogenetic and cognitive behavioural paradigms. Only lip service is paid to the role of family therapy in major mental illness, despite adequate research evidence of its value. There seems little likelihood that this will change — in spite of decades of rhetoric about the biopsychosocial model.

Recognition of the high prevalence of child abuse and domestic violence has also had a powerful — and chiefly negative — impact on family therapy. We are less adventurous now in prescribing family interventions, knowing that we may be dealing with undisclosed abuse. Restoring hierarchy in a family is a tricky business if a parent is sexually abusing a child. Similarly, ensuring safety rather than promoting authentic dialogue is the priority if a spouse is being physically assaulted.

More positively, perhaps, the issue of gender equity has been dealt with reasonably well within our professional ranks. At least, we certainly talk the talk these days. For the families we deal with, however, domestic inequality persists — nowhere more apparent than with respect to the care of family members with mental health problems. More salient now are cultural/racial and socio-economic inequality; and the problems of indigenous people, of refugees and of an emerging underclass of underemployed poor remain largely unsolved. In the face of social oppression, prevailing notions of family dysfunction may be distinctly unhelpful. At the same time, I would say that one of the great strengths of family therapy is and continues to be its concern with social context. The importance of working with neurotransmitters and with cognitive schemata must be acknowledged, but so long as these (micro) phenomena are embedded within interpersonal, family and social relationships, then systemic and family interventions will remain powerful. ©