In the Right Place at The Right Time:
An Interview with Brian Stagoll

Max Cornwell

Few in Australia have done more than Brian Stagoll to develop and critique a local family therapy within an international context, to define its political and intellectual challenges, and to give the field organisational substance. He has been at the centre of Australian family therapy for more than two decades, as both creator and iconoclast. Brian is a psychiatrist who has always pursued social justice and community health initiatives along with a busy life as a therapist, and is a keen reader of history, politics, philosophy and literature. He was a co-founder of our annual conferences. He co-founded and organised the Williams Road Summer Schools in the 1980s. He was a co-founder of this journal, its first Associate Editor and book review editor. He has contributed some of our most significant papers, as well as publishing elsewhere nationally and internationally. He was influential as a Board member and later as President. He is an Honorary Life Member of VAFT, which he co-founded, and in 2001 he received — in his home city of Melbourne — the Journal Award for outstanding contributions to family therapy.

Max: You have been in family therapy for well over a quarter of a century — what got you started?

Brian: I started medical school in 1963, 40 years ago! 1962 was the year Family Process was launched — so I began in medicine around the same time family therapy first raised its institutional voice. I see family therapy as part of my larger life’s work in medicine and psychiatry, particularly social psychiatry. My formal engagement with something called ‘family therapy’? When did I first hear the term? Probably in the late 1960s, in conjunction with R. D. Laing. Anti-psychiatry was thrilling and shocking and I was very interested in Laing, Cooper and all that. But even as a young man I was much more of a temperament to be prudentially reformist rather than ecstatically ultra-leftist. My politics were then, as now, much more a gentle Fabianism than a confronting Trotskyism, although we have had our lapses! Of course, over the last 40 years what was a moderate and centre position seems now to be more extreme, but I haven’t changed much in my politics.

But the story goes back earlier for me. I was lucky enough to be born in 1944 as a first son in suburban Melbourne. It was a very fortunate time and place to be born. I was a rather nerdy student who found himself in medical school, where I was first confronted with the realities of class and hierarchy. I gravitated towards that minority of medical students who were Jewish and/or migrant (as was my wife-to-be). Melbourne University medical school was very hierarchical and traditional, and took itself extremely seriously. We forget. We are still attuned to medical dominance but medical dominance had a much stronger presence then. I was walking through Melbourne University the other day and drifted past the lecture theatre where on early Saturday mornings we had to attend an obligatory lecture. The roll was marked and the Professor insisted that the gentlemen all wore suits and ties. (And for the very few women, dresses not slacks.) You would be put out of the theatre if you

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Institute returned the interest. The official bodies leaned, but I don't think the Psychoanalytic it. I was very interested in analysis despite my social when I started. All ambitious residents wanted to do Psychoanalysis was the preferred treatment Brian: psychiatry reflected this. I picked up the mood. was in the air in the early 6O's, and the new social ing that they worked in the same place. So change ever met Bateson or Jackson, but I think it fascinat- Max: Max: These changes led to different treatments? Brian: Yes. Before the 1950s there were really only two kinds of treatment. There was psycho-analysis, largely for the professional upper classes, and for everyone else there was a fairly crude form of biological psychiatry available in the public asylums and based on ECT, psycho-surgery (already waning then) and the recently introduced tranquillizers, which were a major advance. But by 1960 social psychiatry was advancing. I've just finished writing a reappraisal of Ken Kesey's 1962 book One Flew over the Cuckoo's Nest. The book is quite different from the 1976 film and caught the rising mood of rebellion and resistance to the system. It became a sort of bible of anti-psychiatry, written around the same time that the work of Laing, Goffman, Szasz and Foucault's Madness and Civilisation surfaced. An interesting historical link picked up in my review is that Kesey worked as an aide in the very same hospital (Palo Alto Veterans Administration) as Gregory Bateson and his team, during their research on double binds and the communicational contexts of schizophrenia. This work was one of the theoretical foundations of family therapy. I haven't been able to find whether Kesey ever met Bateson or Jackson, but I think it fascinating that they worked in the same place. So change was in the air in the early 60's, and the new social psychiatry reflected this. I picked up the mood. Max: What about psychoanalysis? Brian: Psychoanalysis was the preferred treatment when I started. All ambitious residents wanted to do it. I was very interested in analysis despite my social leanings, but I don't think the Psychoanalytic Institute returned the interest. The official bodies were elitist, authoritarian and reductionist. After medical school I got married to Onella and we went to New York. Onella did a social work degree in community organising at Columbia and I started my psychiatry residency in the Bronx, at Einstein Medical School. Einstein had a very strong psychoanalytic base but also a group doing fundamental research in psycho-biology and another group around community mental health. For me it was the best of all worlds. The key ideas of community mental health were about taking a population rather than an individual as the unit of study, thinking about ways of intervening in the community outside hospitals, and thinking preventively. Family therapy was a clinical expression of the ideas of community mental health. Social psychiatry in post-War United States was a declaration that pathology was not just in the individual, but that there is real oppression and violence out there, that can be measured and quantified — and challenged. This was a big change from the psychoanalytic and biological ways we looked at the world. Anti-psychiatrists of course were saying that psychiatry itself was part of the problem. I think they went a bit hard on that, but certainly the dominant forms of psychiatry and psychoanalysis supported deeply entrenched conservative positions.

Central to the rise of family therapy and advanced research in social psychiatry were the new technologies of recording and, later on, videotaping. The very idea of seeing families, or thinking about larger social groups as units for intervention, broke down certain barriers. It led to an account of social reality before we could decide who was 'sick'. The audio-visual and epidemiologic technologies revealed a reality to evil, and the workings of malignant social forces, never quite seen before. Oppressive realities were exposed to public view, not hidden privately. The treatment of whole families, and the ability to review this by video, was a revolution. It not only attacked the restrictions of individual therapy, it led to a shift in our sense of responsibility for the whole social climate. Restrictions ascribed to reality were loosened. Remember Freud's famous line: 'Much will be gained if we succeed in transforming your hysterical misery into common unhappiness'.

Max: That was Studies in Hysteria, wasn't it?

Brian: Yeah. The very last paragraph of a very important book. But why couldn't we do anything about 'common human unhappiness'? Well, we could! We could start by questioning racism, sexism and other malignant interactions (although we didn't use those terms then). We could open
things up to public scrutiny, and expand the context and the agenda. That was the promise of community psychiatry, and I came to family therapy through this. We could challenge the dominant and fixed world views of psychiatry and psychoanalysis, and soften harsh realities. Family therapy was the light and the way. It was extremely exciting, a moment of epistemological exhilaration. We young male psychiatrists vainly thought this was a revolution, and rather pretentiously talked of ‘a new epistemology’ and a paradigm shift. We conveniently bracketed out other traditions such as social work, that had also been coming closer to these ideas.

I'd started my psychiatric residencies in 1970, first at Royal Melbourne Hospital, and then a superb psychiatric residency in the Bronx in New York. I had wonderful experiences with some of the older European psychoanalysts who had come out of a radical refugee tradition, before I moved to community psychiatry. In the last years of my residency I moved over to the community family therapy group around Bronx State — Chris Beels, Andy and Jane Ferber, Al Scheflen, Phil Guerin. I was a fellow with Bill McFarlane and co-therapist with Virginia Goldner, among many others.

Max: Your life in family therapy has a twin axis. There is the enquiring doctor looking for new ways of working or expressing medicine (and psychiatry in particular), and there is that very strong orientation (with persistence rather than zeal) to what you called an ‘ecstatic radical political view of the world’.

Brian: I never thought I was particularly radical. But if you want, I was part of the quest for social justice without fanaticism. That’s certainly a tradition in medicine, in social and public health. My heroes were the old TB physicians who eradicated tuberculosis, and going back to the 19th Century, the great public health reformers.

Max: You were able to find a tradition within medicine on which to found, to express the quest. There were some radicals at the time who were just busily hacking down medicine as they understood medicine to be. Did you see yourself more as an insider or an outsider?

Brian: When I was younger I saw myself as a bit of an outsider wanting to get in. But the route to the higher specialities was blocked. Most of my friends in medical school became psychiatrists or epidemiologists. We were, by dint of class and the way we spoke, excluded from the inner sanctums of surgical training. I probably exaggerated that more then than I do now! A while ago I gave up the conceit that (the old joke) I couldn’t work out whether I was a professional marginal or a marginal professional. The notion of there being a fixed centre of power, an inner sanctum of the elect, is problematic. Sometimes I’m an insider and sometimes I’m not. Now I’m more of an insider. How more ‘inside’ can you be than being interviewed! I suppose the question of inside/outside is one of the key questions that we must grapple with. I never saw myself belonging to the dominant tradition of biomedicine but there’s the social tradition of medicine too, which is quite inspiring.

Max: In terms of getting into family therapy, did you see yourself as linking up with other like-minded doctors, or more with other related disciplines?

Brian: I think it was both. I had great colleagues, medical and non-medical. I never put much emphasis on the status of being a doctor. I certainly had connections with social work through Onella and Columbia to the fantastic work that happened in the 1960s around community organising and the ‘War on Poverty’. Onella has a book signed by Saul Alinsky that says ‘You’ve heard it, Aussie, now go and do it’. So that was all part of our talk. We were committed to social change and we believed that we could carry it off, and family therapy gave us a set of myths that really encouraged us.

Max: What were the myths that attracted you?

Brian: Now that’s interesting. I can remember my great excitement reading Steps to an Ecology of Mind when it came out in 1972. I was spending a lot of time with Al Scheflen, who knew Bateson well. We thought systems theory derived from Bateson — or ‘the epistemology’, as we used to say — was the map that led us to do so well clinically, because there is no doubt we were getting results beyond what we had experienced in a more individual psycho-dynamic frame. We credited the theory for our successes, but now I don’t think that was the complete story.

Max: What do you think it might have been?

Brian: The person who I’ve been reading on this lately, and who was also an important mentor, is Chris Beels. He argues that the successful effects of family therapy were due to our optimism and energy, and our attunement to certain folk and political traditions which he traces back to the 19th Century in America. Beels lists progressive education, utopian and spiritual movements, philosophical pragmatism, hypnotic/healing rituals, social work and community organising. These connections, not always explicit, enabled a freedom to imaginatively embrace alternatives, an eagerness to
actively participate in a democratic rather than a hierarchical way with people, and a willingness to put ourselves in risky situations of crisis in community settings, where of necessity you got very pragmatic and did what worked.

This is still the important question and the good news is that the results are in (with the usual caveats and next set of doubts!) We have the evidence! I still have, out of my medical and epidemiological background, a soft spot for empirically supported treatments. I'd rather have evidence-based treatments than charisma-based treatments or faith-based treatments, both of which have afflicted family therapy! There is now a very significant body of empirical psychotherapy research, and it shows robustly that the major factors of why therapy works are related to the so-called 'common factors'. It is the quality of the therapeutic engagement that counts, the quality of the relationship. That can be broken down into the factors of empathy, congruence, the degrees of activity that are encouraged in the patient, and the role of hope. Psychotherapy research has shown that all therapies have successes. The family therapy literature is replete with unorthodox and unconventional therapies getting good short term results. We suffer from a pull towards a kind of wistful inductivism, where on the basis of a few dramatic case successes we develop a whole theory of how to do therapy. We can do better than that. We now have a general idea of what works in therapy but we still seem to ascribe effectiveness to our 'scientific' theory, rather than our optimism and skill at engagement and relationship. So take, for example, the current fashion for cognitive behaviour therapy (CBT). Or for that matter, narrative therapy which is basically a form of social behaviourism, that externalises behaviour rather than symptoms, and then applies cognitive strategies. CBT is increasingly influential because the people involved have marketed it very well and it has a research strategy which catches the temper of the times. You know, John Howard's infamous remark, 'The times will suit me? Well, for CBT, the times have suited it. I'm not averse to cognitive therapy. Patients like it, because it actively engages them, it gives them a model they can understand and work with, and it's optimistic. To a degree it works, if you limit the context in which it is applied. (The positive results of CBT are clearest for the less complex 'pure' cases.) But the explanations for its efficiency are tilted towards its scientific and theoretical rationale, rather than the relational common factors.

In the early 70s we thought family therapy was effective because of the 'interactional view', 'systems theory', the 'new cybernetic epistemology', etc. Now I think it was something else, of a more general nature, about healing relationships. Relationships come first, the specific techniques second. But our institutional success led to entrenching our theoretical dogma, as it always does, and the dogma of systems still haunts us (and sometimes still exhilarates us!). Alas it was not the revolution, but something valuable nonetheless. The systems view has expanded our view of the puzzle.

Max: You came back from the States very full of these currents, which were some years ahead of what was happening in Australia.

Brian: I'm not sure we were that far ahead. During the time away I missed the great stories in Australian life around Whitlam. There had been enormous social changes. I left Australia in late 1970, thinking 'I don't know if I'd ever want to go back'. I came back partly because I had worked out stuff about my family of origin, courtesy of the Bowenites — a very useful piece of therapy for me. When I returned, Australia had changed — or I had! Those radical currents stirring in Australia were just settling down. There had been enormous anxiety in Australia at the end of '75, and the boundaries were up, but there was still great energy in the country. That energy translated over the next few years into the Hawke Labor Governments which, whatever we thought of them then, are in retrospect models of very good government. So I came back early in '76, carrying lots of ideas, lots of energy, as did Onella.

We set to work and I was lucky. I was always lucky. I was in the right time at the right place. When I came back to Australia I got a job at Bouverie Clinic, led by Geoff Goding. I was part of the first systematising and organising of family therapy courses, and I was the founding Secretary of the Victorian Association of Family Therapists, now an enormous organisation. That was in 1979, and the Journal and Conference started in 1980/81. Then I moved from Bouverie into Community Mental Health, the high point of my professional life. I worked with a number of very gifted people in a part of Melbourne that was both old and new Australia. We developed a vision and a whole range of programs for organising psychiatric services that were widely-defined and community based: Melville Clinic, in Brunswick. We had a catchment area and crisis service with the lowest hospitalisation rate and lowest medication rate in the mental health system. We had a highly energetic and committed staff and did a number of wonderful and sometimes wild things.
Max: So this was an age of exuberance, of achievement?

Brian: Also, later, of defeat and retreat. Eventually we got too big for our boots. Parkinson's Third Law says that super competence in a bureaucracy is much more offensive than incompetence. We were unnecessarily in-your-face, although our models for mental health got adopted ten years later. But change in systems occurs slowly if it is to happen at all in a lasting way. This is something I've learnt about both families and larger systems. At the same time there was another version of family therapy in Victoria which was much more clinically based, office based practice that didn't take the next step up into a community frame. It was technically innovative but relatively inaccessible and not willing to engage the public health service delivery concerns as I thought it should. Struggles around the relocation of Bouverie in the early 1980s, in which I was very painfully involved, were about the place of family therapy in the mental health system — about whether family therapy could become the model for psychotherapy and psycho-social approaches within the larger mental health system or whether it remained on the margin as a specialised research and training exercise. I was on one side, and there was a group of people on the other side, and the debate got rather personal.

Max: That would have been when there was a lot of debate about whether family therapy was just another therapy to be used differentially or whether it was an umbrella that subsumed a range of approaches.

Brian: Yes. I always took a strong position that family therapy was continuous with psychotherapy/psychiatry and was part of the larger treatment package. But there was another view that such ideas were a heresy. One was committed to family therapy, as an epistemology, which meant one couldn't mix with infidels. So, for example, psycho educational approaches to schizophrenia — which is now one of the really positive long-term achievements of family therapy — were regarded as 'not proper family therapy'. There was a purity and narrowness of vision that I thought was constraining, a not-so-splendid isolation. It was technically centred on the movement around Palazzoli, after the split in the Milan group. In retrospect, it was a surgical model evolved by master technicians, that proposed that if we come up with the particular paradox or message or something, this will crack open the family system and cure anorexia or schizophrenia or whatever. It was a most attractive fantasy, and like all fantasies it didn't stand up to the cruel actualities of the world. I think Boscolo now makes the same critique.

Max: There was still that dream of the '70s that you could transform schizophrenic behaviour through non-biological means.

Brian: Yes, the remnants of that Laingian odyssey. Madness as breakthrough, psychosis as 'liberation' — a kind of rueful romanticism, which I was never really attracted to that much. Perhaps I didn't smoke enough dope because I was asthmatic!

Max: You would have also had the chance to use the new psychotropic drugs and to see what they could do in terms of immediate symptom relief.

Brian: Yes. I always used medication, but I never underestimated the heaviness of the side effects of the earlier drugs. Medication has become less toxic. Psychopharmacology moved to a much more dominant position after 1980 along with the rise of DSM III and DSM IV, and their categorical Kraepelinian approach, away from dimensional relational models of diagnosis. But the disease model has its uses, and we have become more subtle in our understanding of biological and social factors. Perhaps systems thinking has modified the rigid medical model. I would like to think so!

Max: I don't want to go too far away from family therapy but I've got to ask you, what is a nice socialist boy like you doing, in the early 80s, going into private practice?

Brian: I'm happy to be called 'socialist', but a 'nice boy'! There is a tradition of democratic socialism that is within the public health tradition of medicine, and I identify with it. It was always going out of fashion but there is still part of me that is a linear, Old Leftist first-order Welfare Statist. I left Melville Clinic for private practice in 1982 because I was exhausted. I didn't understand that you can't run a marathon by sprinting, or change a system by charging barricades. Heroism and love wear out. You need support from larger structures. At Melville Clinic the work we were doing was prominent enough by then to encounter significant opposition from the mental health establishment: 'Psychiatry shouldn't meddle with politics' — that sort of thing. But maybe we pushed de-institutionalisation too hard. There are still some mental health bureaucrats who avoid me. But we learn.

Around 1981, Moshe Lang left Bouverie to set up Williams Road Family Therapy Centre. Moshe and I met at Bouverie when I got back from New York in 1976. We had talked for years of having an independent family therapy institute away from the constraints of bureaucracies. I would speak to Moshe at least once a week and he would say, 'When are you coming across? You're exhausted; you can't do it any longer'. I followed Moshe in
building Williams Road. This was a wonderful place, a community of self-styled ‘refugees’ from academia or mental health or isolated practice. We had large training programs, large practices — the Summer Schools, the Journal, the Conferences, VAFT. All up and running by the mid 1980s. That’s what we did.

Max: You were very active around the organisation of VAFT.

Brian: That was a good era, in the time from the 1976 Minuchin visit, which was a key event in the history of Australian family therapy.

Max: Which you revisited the year before last?

Brian: Yes. One of the great moments, interviewing Minuchin 25 years later. I was also very actively involved in health policy through the Health Policy Committee of the ALP. The Victorian government of John Cain from 1982 was progressive and forward thinking. Having left the bureaucracy, I had time and freedom to be involved in health policy initiatives from outside the system. We were deeply involved in policy change, e.g. the Mental Health Act in 1986, which reformed the systems of certification and confinement and put the emphasis on care rather than control. I was one of the authors of the legislation, which I’d like to say has held up over time.

Max: I remember you mentioning to me once that you were one of the people responsible for putting limits on psychosurgery. Was it that legislation?

Brian: Yes. There was a wide community consultation and then some very detailed and complex negotiations with all the interested parties until we finally had a strong Bill. By that time I was taking more seriously Max Weber’s dictum that ‘Politics is the slow boring of hard Boards’! That activity was parallel to my involvement in family therapy. The other thing I became more involved in was the community health movement (as distinct from community mental health). From the late ’80s, first of all in Fitzroy and then in the larger City of Yarra, I’ve played a part in building excellent systems of care that are community-controlled and certainly very community responsive.

For years I’ve chaired the Community Liaison Committee of North Yarra Community Health. One feature is regular public meetings conducted in ten languages, with 150 participants. We have kept that going since 1995, a great challenge to our skills of chairing. The Community Liaison Committee recently was given an award for excellence by the Victorian Multicultural Commission. It represents the kind of democratic accountability I have always believed in and been able to find in my life in Fitzroy. I was lucky again to be in the right place at the right time and connect with people who, although we didn’t know it then, were to instigate some major social reforms in Australian life, in welfare, housing and health care. I am very proud to be part of that movement. One of my most recent projects has been to record an oral history of some of those stories, and organise walks about the history of Social Justice in Fitzroy.

Max: That touches on something that has been a recurring issue for you — the tension between the ‘local specific on the ground’ and the broader internationalist views that you have.

Brian: Are you calling me a rootless cosmopolitan now! But, yes, there was a period where I was quite involved in international family therapy and then I left that — I didn’t want to get on that particular talk circuit. My energy has been more local. I found my way back to a more national thing in the ’90s, particularly through the Journal. I had had a short period when I was a visiting Fellow at Deakin University, when I hung around with real intellectuals, but I had to earn a living as well. The six months off were wonderful. That’s the only significant period of time off I’ve had. But one of the questions I ask is ‘How come I didn’t get into academic psychiatry’?

Max: Well, how come? I know you were a medallist in the College.

Brian: Yeah, I had offers, but I found a spot first of all at Melville and later at Williams Road and then I was influencing health policy. That was enough.

Max: Was it during Williams Road that the writing began to flow?

Brian: No, it was actually at the end of Melville that I was the most productive.

Max: That’s when you wrote the compensation paper.

Brian: The compensation paper and the stuff on Greek families. I had a lot going. After that, the Journal had the Refrains series, and I kept being invited to give plenaries. I’ve had four plenaries at our National Conference. Adelaide, 1981, Brisbane, 1983, Adelaide again in 1990 and then Wellington in 1995. It’s interesting to re-read them. They say more or less the same things as I’m saying today. I pushed it a little bit here or there but I haven’t really changed my position very much at all. Some people would say I’m still the disgraceful, patriarchal psychiatrist I always was. Maybe they’re right!
Max: Maybe some would say that, but a lot wouldn’t. Come back to the Journal.

Brian: The Journal has been a lasting achievement and very important in the development and support of education of many, many therapists in Australia and New Zealand. I’m extremely proud to have been a contributor. One of the privileges I had was working with outstanding Editors of the Journal. The first one of course was Michael White. I still have a personal fondness for Michael although he’s gone off on his own trajectory and it’s one which I don’t find a great deal of sympathy for. Then later on I worked with you, who were, as they say, ‘a fellow traveller’. You brought a wonderful flair and colour but also great substance during those years. The transitions of Editors have always tended to be a headache, and we had another difficult transition when Hugh and Maureen Crago took over. I strongly advocated for their appointment and I am very pleased that everybody agrees the years since have been successful for the Journal. Family therapy may not be as fashionable as it once was, but there is still a very strong and flourishing movement in Australia, reached through the Journal.

Max: On the surface, you are a bit of a contradiction. At times you have felt quite marginalised in family therapy or unhappy about major currents within it. You have also had a very central and important role. You’re one of family therapy’s strongest critics and one of its strongest supporters.

Brian: It’s like A.J.P. Taylor’s line about how being a loyal life-long member of the British Labor Party meant he generally disagreed with what it did. My loyalty took the form of being a reasonably effective manager/administrator who promoted orderly processes and inclusion — and that is not a skill to be devalued. As for conceptual stuff, I’ve always liked playing with ideas, and linking the right words together. I never lost the vision of social psychiatry. I never lost the vision of a democratic free republic, despite the times suiting Howard.

Max: Since those early days do you see yourself as having simply, with growing maturity and experience and perhaps wisdom, continued on the same trajectory or have there been any other really significant turning points in how you positioned yourself or saw yourself?

Brian: I suppose it’s been more about continuity and evolution and gradual change, the old Fabianism. Were there any shocks to my system? I’m actually fairly well insulated by dint of my privileged medical position, strong family support and general optimism. But I think that as for all us blokes, feminism had profound effect. I tried to express my struggles in a review I wrote for the Family Networker in 1989. It was one of the pieces I found hardest to write, but one of my favourites. I reviewed Deborah Leupnitz’s *The Family Interpreted*, alongside the book about the Women’s Project in Family Therapy. I compared the effects of feminism on family therapy with the fall of the Berlin Wall. Both events shook me up. I said in the review, even a Victorian male psychiatrist can change!

Max: Who’s now looking from a position maybe approaching retirement. You have watched your daughters grow up and on their way, probably where you were 30–35 years ago.

Brian: My eldest daughter is a refugee lawyer who works next door to the office her mother worked in as a social worker in the Brotherhood of St. Lawrence in 1969. She is in that same block of Brunswick Street, Fitzroy, which I’ve written about as one spring of social reform in Australia. My youngest daughter has just started work as a paediatric nurse, and my middle daughter is an industrial relations solicitor. There are resonances there, and also great relief that the younger generation is taking over.

Max: What other shocks have disturbed the continuity?

Brian: The last few years in Australia. In my 1995 plenary I talked about Mabo. I really thought Australia was moving out of the old settlement of White Australia.

Max: Out of darkness.

Brian: Out of Whiteness. The last few years have been dispiriting in that sense; to see the projects of reconciliation and human rights wound back so much is despairing, but I’m still optimistic.

Max: Apart from the positive effects of the feminists and your dismay at the political wind-back, you’ve continued to persist and, as someone who knows you well, in some respects I could argue that you’ve been more consistent than family therapy itself. I would like you, if you can, to characterise in a few phrases each of the decades with which you have been involved with family therapy. We’ll leave the ‘60s because we gave that a fair burst. You characterised the ‘70s as ‘the time of energy’.

Brian: Epistemological exhilaration and great hope

Max: Then you started to say something about the ‘80s.

Brian: The balls we had in the air were coming down. I associated the 1980s with Thatcher and Reagan and the winding back of the social view, of sociability, socialism, and solidarity, with a rising sense of ironic self consciousness, which can be both positively and negatively deconstructive. The
negative form withdraws into a self-referential haze while an oppressive social system goes on with business as usual. But there is a positive form of deconstruction too. It recognises that the endless cycle of interpretations can still be paused, and a passionate critique launched. Private irony can go with public hope, as my favourite philosopher Richard Rorty has made clear. We can self-subvert without folding.

In the 90s there was a renewal of the importance of the need to be attentive to all voices. The voice of the consumer rose in health care. Family therapy was a bit outside this. For example, in the end it was the parent/consumer voices in mental health that made us give up our theories about the 'family' aetiology of schizophrenia. We had drifted along with this idea for too long. Without the outside consumer challenge we could let it drift, rather than acknowledge that we had been caught in a posture of blame and avoidance. In the early 90s there was this mood of reconciliation, but for reconciliation that meant acknowledgement of unfortunate involvements in the past. There is no social change or understanding without mourning. There is no personal growth without grief. There is no change without us coming to terms with resolving our ambivalences. I think that the whole movement around Stolen Children was something larger, that showed us this. Colleen Brown and the way she embodied that was very important to me. That was the '90s: reconciliation, mourning and acknowledgement.

**Max:** How would you characterise the New Millennium, so called?

**Brian:** It's a particularly worrying time: the spectre of war and terrorism and not just the spectre, the actuality. And the response of limiting our civil freedoms, and retreating to the hard old 'realities'. But I’m also given hope by the movement for peace.

**Max:** And in family therapy? That's a backdrop to family therapy.

**Brian:** I suppose so, but sometimes ‘family therapy’ doesn't seem so relevant. I wonder now if the term ‘family therapy’ as such has lost its usefulness or the excitement it once had. The term says less than it used to, about changing the world. It is now a technical term in the panoply of psychotherapeutic technologies.

**Max:** Is there a better term?

**Brian:** Well, the Journal made its subtitle ‘Innovative and contextual approaches to human problems’. I supported that, and I still deeply believe in therapy. Therapy makes a contribution to individual lives, and it also contributes to public issues, by proposing certain values to civil society: reflectiveness, patience, hope, and an insistence on finding a level and setting where everyone can find their voice, and be acknowledged. And questioning, rather than declarations of privileged knowledge. One of the singular contributions of family therapy has been its pursuit of questions that empower participation and collaboration: those questions — circular, future, miracle and so on — that bring out connections or introduce possibilities of change. My friend, Michael Madden, gave a paper last year in Hobart about the best questions to ask in couple therapy, and the worst. I am very excited by these ideas. Couples therapy is now probably the main form of family therapy. The family therapy literature distorts what family therapists actually do. For many psychiatrists and family therapists, a lot of their work is with couples. Couple therapy has never been particularly well theorised by family therapy yet as a day-to-day practice it's much closer to what practitioners do. It is also interesting that couple work never missed recognition of the individual, or a recognition of individual psychiatric disorder in the couple. Clinically, couple therapy is proving very useful in approaching depression. The work of Leff et al. and Asen is very important here.

**Max:** There is a lag between the descriptive power of the theory and the different ways therapists find to engage people.

**Brian:** Theory is a minimal guide in the zones of uncertainty we meet. When you are a practising therapist it's very hard to maintain purity for too long. What is my vision for the 21st Century? I like this, from Jeremy Holmes: ‘Patients in this new century deserve therapies that transcend old rivalries and concentrate on effectiveness, common factors and the search for active ingredients that go beyond brand names and instead concentrate on the development of skills needed to deliver them’. I would add we need methods of community accountability that can call into question dichotomies like consumers/providers without reducing our expertise or ability to help change.

**Max:** Now here you are in your own rooms where you've been for some years with some colleagues, you've worked hard. Would you do it all again or would you do it differently now, and what for you now is giving you most joy in what you're doing?
Brian: Would I do it all again? I shared a recent conversation with Peter Churven. We graduated in psychiatry at the same time. I said, 'We could have done anything in psychiatry. Would we take the family therapy path again?' We both decided we would. But I really don't know if you can consciously plan such things. We stand in a chain of narrators, and go where the conversation takes us.

Max: Are you pleased you did it?

Brian: Oh, yes! I got on certain buses at the right time and they took me to great spots. Of course there are things I regret and looking back wished I'd handled better. I had tendencies when I was younger to be impatient, to confront unnecessarily, to stir things up. Now I think I'd be more moderate. I would, wouldn't I! Remember the old joke about having extreme opinions expressed moderately? Sometimes I had extreme opinions, expressed extremely! I've been fortunate to be part of an international movement for social change and to belong to a particular part of Australian history that represents the best that this country has to offer the world. The stuff that I've written, and that you've written too, of the things we like about Australia and the ways they were expressed in family therapy ... well, hopefully we helped to add something. A patriot? In the sense of Camus' line about how he loved his country too much to be a patriot, sure!

Max: You're in your practice.

Brian: Yes, the practice! For all the fancy talk that we've been having, I wouldn't like to miss that. The main thing I've done over the last twenty years, 30 hours a week, is have quiet conversations at varying levels, week after week, year after year. This is the privileged, private, intimate space of the craft of therapy with Rosie de Young and Michael Madden. I've been doing that for many years. That's very important. But one hopes to get oracular! ... Yeah, and think about the next generation and the world they are going to live in.

Max: Is there anything in particular that is important to you that we haven't had a chance to cover?

Brian: I'm still dissatisfied with the way family therapy has stayed marginal to psychiatry. Psychosocial interventions have gone out of fashion, yet there is very strong evidence now of how effective the formulary of psychosocial interventions are. For example, Bill McFarlane has shown in his work on psycho-education with chronic schizophrenia, that psycho-educational approaches had equal and, importantly, complementary effects to medication in preventing relapse rate. What family therapy is at its best (and we now have a corpus of knowledge that's encoded in fine text books, like Glick et al., something that I never had as a student) is that repertoire of techniques for establishing partnerships and developing coalitions that allow work in tricky and entangled situations. I once spoke of the gloom of interactions, the terror of entanglements and the beauty of their release. We need that more than ever. Psychopharmacology comes into that equation. We need to teach how all the bits of the puzzle can be put together, including drugs. Even though we certainly have adequate knowledge, we still haven't put that into the mainstream. If anything we're going backwards on that. I have fears for psychiatry, but also great hopes. Maybe the advances will come out of really good neuro-science that can get down to specificities and start linking up brain states and brain changes with psycho-social interventions. That would expand our ways of thinking! And I hope we can again turn to a social view of health - one that values a community of tolerance, co-operation and accountability. That's certainly not the temper of the times. It's important to recognise the contributions of psychopharmacology in the reduction of human misery, but we can also add so much more.

Max: One of the things I find unsurprising but interesting about our conversation is we keep coming back to philosophical, political, social positions, attitudes, and values and keep away from technique.

Brian: Yes. I think we have an obligation to learn the techniques. We must put great effort into learning those skills, but psychotherapy is a bit like jazz: the best bits come out of a tradition, and are improvised on the spot. I'm still mindful of tuning up my techniques. I have weekly sessions around the craft of therapy with Rosie de Young and Michael Madden. I've been doing that for many years. That's very important. But one hopes to get
to a position where the technique is not applied too consciously. Then you are also in a position to self-critique. But if you self-critique it’s generally in terms of a philosophical and moral frame, not a technical one. Values and cultures come first, techniques second. We must avoid being what Max Weber called ‘specialists without spirit, sensualists without heart ... ’

(Interviewed March 14, 2003)

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Thanks to Neil Phillips for the portrait of Brian Stagoll.

Selected Publications of Brian Stagoll
A Model for Family Therapy Training, *ANZJFT*, 1979, 1, 1: 35–42. (With M. Lang & G. Goding.)


Look. I admire your colleague’s skills at helping couples to re-story their lives, but I am somewhat concerned that his love of nineteenth-century literature might be having an undue influence over his clinical outcomes.”

This cartoon was printed alongside an article about helping couples improve (the authors called it “re-story”) their relationship through reading excerpts from great literature. It is reproduced here with the kind permission of Brian Cade and of John Hills, *Context*’s General Editor.
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