

THE DEVELOPMENT OF FAMILY THERAPY AND SYSTEMIC PRACTICE IN EUROPE: Some reflections and concerns

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The development of family therapy and systemic practice in Europe is sustained and far reaching. Early practice in Europe both paralleled and complemented development in North America, and innovated theory and policy in its own right. The American family therapy pioneers probably had most influence in Ireland and the UK, with their emphasis on empiricism, whilst mainland Europe spawned development of systemic practice within different philosophical traditions. Currently, we may say that integrative practice is celebrated, with a mature field wishing to incorporate ideas from other psychotherapeutic and social science traditions. Ethically, this enables more choice for families and individuals within both public sector and private sector mental health services.

Family therapy training in Europe is generally taught to Masters level, over a period of 4 years, with specified hours of practice, supervision, and study, similarly to many of the other established psychotherapies. Training standards for the modern psychological psychotherapies, including family systemic psychotherapy, are regulated both nationally and at European level within the European Association for Psychotherapy (EAP). A few countries, such as the UK, have established a research doctorate in family therapy, and also offer masters level training to systemic supervisors, eg Ireland. Training institutes have proliferated in Europe, with the majority attached to universities with validated degree programmes. Some European countries, such as the UK and Ireland, have established family therapy as a profession, with dedicated posts and associated salary scales, within their national health services. Private practice in family systemic psychotherapy and couples therapy is growing, as different European governments encourage a mixed health care economy in the face of economic cut backs to public sector mental health provision.

Europe has a long tradition of celebrating systemic practice, as distinct from family therapy, or systemic psychotherapy, as it is often called. Gianfranco Cecchin used to say that we practice systemically if we think systemically. Systemic practice has found its way into health and social care disciplines, and services, with some countries recognising the first two years of systemic training in its own right – the ‘systemic interventeur’, as the French would say. It would seem that more health and social care practitioners are interested in systemic thinking and practice, completing the first and second years of training, than wish to complete the full 4 years for the qualification of family therapist. In many ways this can be seen as the success of family systems thinking – its recognised relevance and applicability to all health and social care professionals in private, voluntary and public sector services.

The regulation of family therapy training and practice across European countries is complex. Most countries have voluntary registers of psychotherapy practitioners, held by 'umbrella organisations', with some countries having government managed statutory registers. A few countries legally require family therapists to be either trained clinical psychologists or psychiatrists for practice within national health services, for example, Italy and The Netherlands. In Germany, family therapy is not reimbursed through public sector insurance. Nearly all European countries deem family therapy training to be at post graduate level. Some countries are now establishing voluntary registers for systemic supervisors. These national umbrella associations of psychotherapy associations belong, in the main, to the European Association of Psychotherapy, which offers the EuroCertificate in Psychotherapy. In terms of family therapy, most countries have long standing regional and national associations of family therapy that support and monitor the development, training and practice of family therapists. In addition they develop and regulate ethical practice through codes of conduct and complaints procedures. These national associations of family therapy, along with the family therapy training institutes mentioned above, belong to the European Association of Family Therapy (EFTA), to which we now turn.

European Association of Family Therapy: EFTA

During the 1980's a number of leading family therapy trainers sought to establish a Europe wide association of family therapists, to promote cross cultural training, research and scholarship. For many family therapists, especially those working in countries without established national associations at that time, EFTA provided the forum for exchange and professional development, particularly through their conference programme, held in a different region of Europe every three years. The membership grew to about 1000 and was relatively stable. In 1995, the EFTA leadership made the visionary move to invite representatives from the national and regional associations of family therapy, across Europe, to discuss the possibility of the associations joining the EFTA. The move was greeted with enthusiasm and a series of meetings ensued, to debate the mutual benefits of such a partnership. Quite quickly a systemic problem emerged – the originators of EFTA wanted the national and regional associations to join an association of individual members. The national and regional associations recognised that a new structure was needed to accommodate different levels of membership, interests and goals. A working party was set up to develop a structure that enabled full participation for individual members, national and regional associations and the training institutes – who were invited to participate in the new structure. At the Budapest EFTA conference in 2000, the new structure was voted and accepted. The new EFTA had a tripartite structure: a chamber for individual members; a chamber of national associations of family therapy; and a chamber of training institutes. Countries that had regional associations were offered a period of five years to organise themselves into one federation or national association for representation at EFTA.

Each chamber of EFTA elected its own board of 7 members, with a chair person, secretary and treasurer. The three boards constituted the general board of EFTA. The overall president was elected from within the full board. A co-ordinating body, consisting of the president and two members from each chamber board, was appointed to oversee and monitor co-operation between the three boards in the general board. Thus decision making and participation was equitable across the three chambers. At present, the individual chamber has over 1200 members; the national family therapy associations chamber has 28 participating countries (every national association is represented with one vote in the chamber of national associations); and the training institutes chamber has over 120 members from 28 participating countries. Current interests and concerns are varied and complex, as we shall see next.

Current interests and concerns within European systemic practice

While at an EFTA Board meeting held in Paris during January 2013 we collected opinions both via a short questionnaire and by talking to participants about their concerns with regard to the future of family therapy in Europe. The EFTA Board members are all experienced and senior family therapists and trainers, with national and international recognition, and registered with EFTA. There was considerable interest in this question, and not only because most countries in Europe are experiencing considerable economic difficulties at present.

The questionnaire comprised of 3 short questions:

- 1) What, in your view, are the current concerns of trainers in your country, region or area?
- 2) Do you think people will come forward for training in family therapy during the next 5 years? Will there be: More training, the same training, or less training?
- 3) How much do you think each of the areas below will change? (No change; little change; much change)
 - a) The length of training?
 - b) The theory of family therapy?
 - c) The practice of family therapy?

Responses to this brief pilot survey came from 7 European countries. During discussions at board meetings, a very similar picture emerged. A number of board members took the questionnaire away and promised to send a reply. The interest was considerable and we may plan a larger participation survey later.

The responses to our first question centred mostly on the economic difficulties people experienced in their countries. Comments such as: 'if nothing changes economically during the next few years, a decrease of interest amongst students

specialising in family therapy will be inevitable'. A repeated phrase was: 'reduction in resources devoted to training ... is expected to result in less training'; also 'students will not be released by employers from employment to undertake training'; 'the economics prevent students from being able to pay for their studies'. Participants were also wondering: 'whether there will be clients who would attend to their relational issues in the wider context of socio-political and economic crises'.

These were common concerns. One board member replied: 'CBT is becoming the favoured treatment and believed by policy makers to be shorter'. Comments like: 'there is a loss of hope that systemic therapy is seen as an important factor in training', and 'In our country the economic and social crisis makes many families suffer the consequences, and our democratic model is in danger' illustrated the concerns about power, social policy and resource allocation. Yet another participant predicted: 'The decrease in the number of students because of the economic crisis is inevitable' and 'short term therapy will be the one that will be practised'.

One set of responses to the first question was different from the others in terms of how the concerns centred on 'the dilemmas of evidence based practice and practice based evidence'. Here the concerns concentrated on 'the pursuit of conformity of education and training' and that 'there are multicultural challenges which need to be tackled.'

The majority of responses to our second question indicated that board members thought that there would be fewer students coming for systemic therapy and systemic family therapy training. Some thought it might be the same or less but none indicated that more students would be enrolling for training. However 'there is a stable number of interested professionals' was one position articulated. Whereas another respondent pointed out that: 'because of economic issues some trainings had already been "diluted" by attempting to incorporate systemic training in other shorter modalities of training. There are advantages as well as disadvantages to this tendency'. Another person suggested: 'I think there will be a different approach to training in the future – shorter and less intensive'. Another offered a more positive response: 'The number of students applying for training is already very high, (in our country) and it has been like this for many years. Each year almost 1/3 of the applicants are being rejected. Many want to become family therapists, or to be trained in systemic practice for use in their current work, and many who are already trained want to develop further'. This last comment was unusual but may relate to the fact that the economic difficulties in that country are not the same as in some of the others.

Question 3 produced interesting discussions and varied from those who pointed out that the length of training was enshrined in laws and rules in a number of countries while others, for whom this was not the case, predicted that the training would be shorter in the future. The attempts made by EFTA to standardise requirements in a way that brings the less rigorous trainings up to a higher level, consistent with the

specifications of the European Association for Psychotherapy, is creating a concentrated discussion in EFTA. (for further information see Training Standards on the EFTA website)

There was more agreement with regard to whether the theories would change. No one thought they would stay the same; some thought there would be little change, but some others thought, because of the need for shorter training, theories had to change. 'Basic principles and theory will stay the same'; 'theory and practice should change a little'; 'change takes time and will progress slowly. Theory will not change much, but interpretation and emphasis will change', illustrates the range of positions.

As to whether the practice of family therapy will change the views were clearer. No one thought that there would be "no change". One board member said; 'Practice is hopefully always experiential and in change.....'. Yet another pointed out that: 'the practice will be more individual but orientated in a systemic perspective....'

Overall this brief enquiry into board members' thinking was a useful exercise. The anxiety expressed across all of the questions was an expectation of external pressure to reduce the length and quality of training with a corresponding pressure to reduce the length and depth of therapy. The risk is that a reduction in the quality of the systemic therapy being offered will result in it losing its current claims to effectiveness and will accelerate the move to other modalities of treatment that require less training, and to shorter therapies, and which are thereby cheaper.

A final word from the chair of the National Associations chamber of the EFTA

One of the responsibilities of the chair of the National Associations chamber of EFTA is to regularly summarise and review the traditions and developments in family therapy and systemic practice in the different European member countries. Recently, colleagues from EFTA¹ responded to the following questions:

1. Which models of family therapy and systemic practice are preferentially implemented in your country, based on your professional knowledge?
2. What do you think are the reasons for this preference over other models (or, in the case of no preferences, why not)?
3. Is there a correspondence between single models and the structures of national institutions which offer therapeutic help?

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In looking at the responses we should highlight the European commonalities as well as the national specifics.

1. Our European colleagues said that alongside the traditional route of the Milan approach to systemic therapy, the structural and narrative models originating from other continents are finding application in practice and in vocational training. The multiply voiced reasons for these developments are that it is about the respective possibilities of these models and/or the predilections of leading trainers and therapists of a country to learn and to pass on these methods via workshops and from conferences. So this suggests that the meaning of single family therapy schools in education and practice is defined partly via single personalities and their 'legacy'.

This knowledge has frequently led to further developments closely entwined with national practices. It seems there are many concomitant influences, for example, in France, the great significance of psychodynamic and psychoanalytical approaches make distinct their influence on the process of further development, with the re-importing of postmodern philosophies hardly playing a role there (see also Le Goff in: Ng 2003). Greece is another example of the emergence of its own synthesised model (the 'systemic-dialectic approach' according to V. and G. Vassiliou, who themselves were early disciples of Virginia Satir; see also Softas-Nall in Ng: 2003 and the Contribution of XY in this Special Issue). Eastern European countries, on the other hand, have been able to participate in this discourse only since the lifting of the iron curtain, so that their history of updating is still developing. Norway, in contrast, emphasises the fact that the high level of prosperity in the country over the past decades has enabled them to extend invitations to foreign colleagues to their national events as well as being able to attend numerous international symposia.

Political positioning and tradition also manifests itself here as a determining factor in another form: for example, the reflecting team approach developed by Tom Andersen seems congruently embedded into the Norwegian social-democratic state model. The Finnish Dialogical Model of Jaakko Seikkula and Tom Arnkil (himself originally a socio-political spokesperson) also intertwines ethico-political dimensions with the theory and practice of psychotherapeutic care. In another example, in Italy it has also been emphasized (Bertrando in: Ng 2003) that the origins of the Milan model can be traced back to socio-political criticism (for example, the psychiatric clinic as a Total Institution) as much as to an epistemological one.

2. Spanish colleagues point out that besides the capability of single pioneers like Minuchin, Sluzki or Watzlawick to master the Spanish language and thus to be able to be directly and efficiently active in the country, cultural analogies also play a great role. It seems that here, as is also emphasized in Greek practice, that the structural approach fits in with the self-conception of many families, which define themselves as child-centred.

As has been mentioned above, the socio-political system and its discourses also influence individual self-concepts as well as those of families and their therapists. Thus in (“pragmatic”) Great Britain, for instance, the plurality (of approaches) seems to be taken as a matter of course, not requiring any further substantiation. So the respective conceptualizations of ‘family’ and ‘individual’ (traditional vs. postmodern) are thought to partly determine the use of family therapy concepts and methods. An interesting variation on this is to be found in Latvia: according to a professional inner perspective on family therapy development, the easy blending-in of narrative approaches could be traced back to the high degree of folklore roots in the everyday life of this country.

Thus single model approaches can be seen to cross the boundaries of family/individual conceptualizations and extend themselves into the direction of cultural customs in a process of mutual influence. All in all, the social constructions of national traditions and current social practices seem to exert a certain influence on the choice of models which perhaps should not be underestimated - a conclusion that is socio-politically congruent with the endeavours of systemic colleagues geared towards creating "custom-made" packages for their clients. It has to be emphasized though that this does not occur through ignorance of other methods, but rather through the choice of knowledge relevant to practice.

3. Development seems to be going in the direction of conceptual and practical eclecticism. Our European colleagues stressed the point that in training and in practice a large number of methods and concepts are absorbed in order to have at our disposal a broad repertoire of action possibilities for our different working contexts. Both historically and for now, our colleagues have emphasised the profound importance of practical knowledge and its development for the future of systemic training and practice. This recognition of 'practice-based evidence' provides for the continuity of different models, which retain their cultural sensitivity and socio-historical relevance. Systemic models in their diversity provide a solid offering in the psychotherapeutic landscape which is consistent with progressive European thinking.

References:

Bertrando P. The Effects of Family Therapy in Italy. In: Ng K S (Ed.): Global Perspectives in Family Therapy - Development, Practice and Trends. New York: Brunner-Routledge, 2003: 83–105.

Le Goff J F. Family Therapy in France: A Brief Overview. In: Ng, K S (Ed.): Global Perspectives in Family Therapy - Development, Practice and Trends. New York: Brunner-Routledge, 2003: 115–124.

Ng, K S (Ed.): Global Perspectives in Family Therapy - Development, Practice and Trends. New York: Brunner-Routledge, 2003.

Softas-Nall B. Reflections on Forty Years of Family Therapy, Research, and Systemic Thinking in Greece. In: Ng, K S (Ed.): Global Perspectives in Family Therapy - Development, Practice and Trends. New York: Brunner-Routledge, 2003: 125–143.