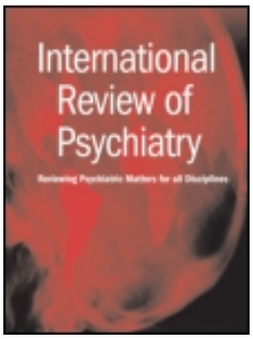

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Family and family therapy in the Netherlands

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Abstract
This article describes how families are functioning in the Netherlands, and how family therapy is used in mental healthcare. In the open Dutch society, new ideas are easily incorporated, as exemplified by the rapid introduction and growth of family therapy in the 1980s. In recent decades, however, family therapy has lost ground to other treatment models that are more individually orientated, and adhere to stricter protocols. This decline of family therapy has been exacerbated by recent budget cuts in mental healthcare. In regular healthcare institutes family therapy now has a marginal position at best, although family treatment models are used in specific areas such as forensic treatments. In addition, the higher trained family therapists have found their own niches to work with couples and families. We argue that a stronger position of family therapy would be beneficial for patients and for families, in order to counteract the strong individualization of Dutch society.

Introduction

This paper will discuss the position and role of the family and of family therapy in the Netherlands, a country of 16.5 million inhabitants in western Europe. Following local conventions in the Netherlands, we consider as a family a household of persons including children, who may or may not be related, who have enduring affective relations, and who support and care for each other (Encyclo, 2011). In spite of popular belief, the family continues to play an important role in Dutch society, albeit in a wider variety of forms.

Structure of the family

In the last few decades families in the Netherlands have diversified in colour and type. The traditional nuclear family (mother and father living together with two or more children) is no longer the prototypical family type. People in the Netherlands have considerable freedom whether or not to marry, whether or not to have children, or to divorce and remarry, and whether or not to have children with a new partner. As a result, families have become more complex.

About 2.1 million households (28%) in the Netherlands consist of two parents with children (E-Quality, 2011). However, there are some remarkable trends with regard to this type of family. Firstly, a considerable proportion of two-parent families consists of unmarried parents, which is widely accepted in the Netherlands. Secondly, parents in the Netherlands tend to be relatively old: the age at which women have their firstborn (at 28.6 years) is among the highest worldwide (NationMaster, 2011). This delay in women having their first child is usually ascribed to economic and career motives, as women are catching up on their relatively low participation in the work force in comparison to other western countries. Interestingly, 7% of Dutch women choose to have no children at all (Brinkgreve, 2008).

Each year, between 31,000 and 35,000 marriages end in divorce (about 0.9% of marriages per year (CBS, 2011)), involving about 33,000 children. In many cases the result is a one-parent family (at least temporarily), of which there are about 486,000 (7% of households, in 2010). This type of family has increased considerably over the last decades. There are also large differences by ethnic groups of the single parent: 18% of native Dutch families with children have one parent, whereas this proportion is 44% for families of Surinam descent and 48% for families of Netherlands Antillian descent (E-Quality, 2011). The one-parent family may be caused by divorce, but it may also result from a deliberate choice of the single parent. As a large proportion of divorcees choose to remarry, many children are nowadays raised in remarried or 'patchwork' families (149,000 households, in 2010), consisting of stepparents, half-siblings, etc.

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There are 2.2 million households (30%) of couples living without children (E-Quality, 2011). In recent decades, homosexual couples – and parents – have emerged as a new type of household and family. Gay and lesbian marriages have been accepted since 2001, and homosexual relationships and parenthood are widely accepted. In 2010, 25,000 lesbian couples were living together, 20% of whom with children. There were 31,000 gay couples living together, 3% of whom with children. In addition, there are 2.7 million households (36%) of single people (E-Quality, 2011). The number of single-person households has increased over recent decades, because more elderly people tend to live independently, and they tend to live longer.

In addition, the Netherlands has become ethnically and culturally very diverse as a result of immigration by various groups, for example Moluccans, Turks, Moroccans, immigrants from Surinam and the Netherlands Antilles and from former Yugoslavia. As an illustration of this diversification, the number of different family names has increased from about 100,000 in 1947 (for 10.5 million inhabitants) to over 300,000 in 2007 (for 16.5 million inhabitants; G. Bloothooft, personal communication). In 2010 about 154 000 immigrants arrived in the Netherlands (CBS, 2011).

Incidence of mental illness

The number of people with any form of mood disorders in 2009 was 643,800 and the number of people with an anxiety disorder was 1,057,800. The incidence of a psychological problem in 2009 was estimated at about 1.9 million (18% of the normal population) (Trimbos Instituut, 2010). Personality disorders could be diagnosed in about 14% of the normal population (Verheul et al., 2007). Of the psychiatric population, about 60% has a personality disorder (Verheul et al., 2007), and of patients with an addiction, 57% could be diagnosed as having at least one personality disorder (Verheul et al., 2007). The incidence of schizophrenia is about 15 to 20 per 100,000 inhabitants.

In general, the weaker groups in Dutch society tend to have more psychiatric problems: women, elderly people, people with low education and/or low income, physically unhealthy people, unemployed people, non-western immigrants, people living in highly urbanized areas, and people living alone.

Family therapy

Historical overview

Family therapy was introduced in the Netherlands in the 1970s, and grew rapidly throughout the 1980s. It became an officially recognized form of psychotherapy in the Netherlands. Consequently, many psychotherapists and psychologists were trained in family therapy, and family therapy became more widely available. The outpatient institutes treated clients more often as part of the client's system, and one-way screens were used abundantly. Family therapy strengthened treatment of eating disorders, adolescent problems, addiction, psycho-education and expressed-emotion movements, and it was the treatment of choice in that area. However, expansion halted in the early 1990s. The field of family therapy was looking for a theoretical basis. Although several concepts were adopted (autopoiesis, radical constructivism, social constructionism, etc.), this did not add to a unifying theoretical framework (Rijnders & Nicolai, 1992). Family therapy was renamed 'systems therapy', in view of the demographic changes described above. The focus of family therapy was broadened to include culture, ecology, gender, and larger systems. Due to the lack of scientific evidence of its effectiveness, family therapy lost its prime position. Research in family therapy is difficult, because of the complexity of the client's environment and the large number of relevant variables involved (Buysse et al., 2008). Luckily this lack of evidence is currently being addressed by researchers and clinicians, and effectiveness research is currently being performed.

Training and education

The professional organization for family therapists in the Netherlands is the Dutch Association for Relational and Family Therapy (NVRG, www.nvrg.nl). The NVRG has about 1,600 fully registered members, plus members in training. The NVRG issues a quarterly professional journal in Dutch, entitled *Systeemtherapie*, and organizes annual conferences, master classes, etc.

Training in family therapy is done by trainers licensed by the NVRG, in order to guarantee that the training meets high professional standards. Training is accessible for therapists holding a university degree or having an equivalent level of education. Most of the trainees in family therapy are clinical psychologists or psychotherapists, with a few psychiatrists who wish to specialize in family therapy. After 212 h of theoretical training (including 12 h of research methodology) the trainees must receive 75 h of supervision. They are also obliged to undergo their own therapy as a patient for at least 50 sessions. After meeting these requirements, the trainee may become a registered member of the NVRG.

After 5 years of membership and practising family therapy, a family therapist may apply to become a supervisor. Next, in order to become a trainer in family therapy, the candidate must design a course

syllabus, which is evaluated by the NVRG, and the candidate is screened on his/her didactical qualities. A recent Dutch handbook on systems therapy (Savenije et al., 2008) is used widely as a basic manual for teaching and training in family therapy. In our own experience as trainers we emphasize that therapists need to develop their own personal style of family therapy, which means using your own resources and your inner dialogue in order to attune to the clients' needs (Rober, 1999).

Methods and models

The prevalent models in family therapy in the 1970s and 1980s were the structural and strategic models (e.g. Haley, 1976; Minuchin & Nichols, 1993) and later the cybernetic model (Palazzoli, 1979), as well as the insights from the MRI Institute (e.g. Watzlawick, 1978). It is part of Dutch culture to be open to new developments, which has also applied to developments in family therapy in past decades.

Narrative therapy (White & Epston, 1990) quickly became popular in the Netherlands. The non-pathologizing perspective influenced many therapists, especially those working with families and small children. Externalizing a problem and putting it in a different context – outside oneself – makes new solutions possible, and it gives the family members a sense of joint agency in how to live their lives (van Hennik, 2011). Following the non-pathologizing perspective, the work of the Finnish 'open dialogue' group (Seikkula, 2002) is adopted in some Dutch institutes. Patients with a first-time psychosis are being treated in an open dialogue, where patients, family members and therapists try to assign a shared meaning to the symptom. Instead of inviting people to the office, this is a communal practice organized in social networks.

Since the 1990s there has been increased focus on violence in couples and in families. After political action, legislature was changed in order to protect the victims of domestic violence. Until recently, the victims (usually women) used to go into shelter, whereas nowadays the perpetrator is legally forced to stay away from home for a certain time, and police and mental health professionals nowadays work in tight cooperation (Groen & Van Lawick, 2009). Multisystemic therapy (MST) is used widely in forensic institutes in the Netherlands. For example, De Waag, a forensic institute in Utrecht has a big MST programme. De Viersprong, a mental health institute in Halsteren, has an MST programme for juvenile offenders. In this programme the family is treated for 5 months by outreaching family therapists. Functional family therapy is also implemented in the Netherlands in various institutes.

The method of non-violent resistance (Omer, 2007) has been implemented by some family therapists working with youths and adolescents. This method is based on the idea that violent behaviour should be treated in a non-violent way. A child with violent behaviour is enveloped in a social network of people who care about him or her. The network functions as a safe haven, and parents are supported to refrain from violence and to connect with the larger network of supportive people. Omer's work has been translated into Dutch (Omer, 2007), and Omer regularly visits the Netherlands to train therapists.

In recent years, the increased focus on attachment, on emotion regulation and on mentalization has been fruitful for our profession. These concepts gave us a new way of integrating the inner world of the client with the interactional world of the family.

The work of Susan Johnson (2004) on emotionally focused therapy (EFT) has had a strong influence on the international field of couples therapy. Johnson was one of the proponents to apply the attachment theory of Bowlby (1988) to adult relationships, and she emphasized the interdependency among people (Mikulincer & Shaver, 2007). Effective dependency is regarded as the glue between families and couples and it does not need to be pathologized. EFT has earned its place in the Netherlands as a couple therapy model, and expansion to emotionally focused family therapy (EFFT) is in progress.

Also based on Bowlby's (1988) attachment theory, mentalization-based treatment (MBT) was developed in London by Bateman & Fonagy (2004); this method has been implemented by De Viersprong (Halsteren), which also provides training in MBT. For the treatment of borderline personality disorders, MBT is currently regarded as one of the two treatments of choice, next to schema focused therapy. In addition, development of mentalization-based family therapy is currently under way.

Challenges and solutions

The present Dutch society is strongly based on the neo-liberal concept of self-reliance, where social success and happiness have become almost synonymous. People are encouraged to improve themselves, and to manage their body, their brain and their whole life like an enterprise. This has led to many more patients seeking psychiatric or psychological help, which is generally accepted in Dutch society. In chronic psychiatric patients, having a mental problem may serve as a justification for failures in life (Dehue, 2008). At the same time, the biological perspective has become prevalent in the past decades, so that, for example, medication is currently preferred over long-term therapy.

The high influx of patients seeking treatment has overwhelmed the mental healthcare institutes. In

order to regulate the costs of general healthcare, the Dutch government decided in 2008 to decentralize and commercialize the entire healthcare system. Additional regulations prevent healthcare institutes from having long waiting lists, and limit the maximum number of sessions. Complicated psychiatric treatments are more and more delegated to the least trained professionals, e.g. psychiatric nurses.

These trends have conspired to create the main challenge for family therapy in the Netherlands: family therapy is presently not the treatment of choice in mental healthcare. It is considered too expensive, and too complicated because multiple therapists are usually involved. In addition, there is insufficient scientific evidence to support or warrant family therapy. Institutes are therefore focused on individual protocols, and clients are treated individually, initially with cognitive behavioural therapy and medication. These therapies are mostly provided by young, relatively inexperienced psychologists, in order to keep treatments affordable, with psychiatrists being responsible for medication. In line with these developments, treatment of relational problems is no longer being reimbursed as of January 2012.

Current Dutch professional guidelines for treatment of depressive illness do not mention family therapy. Although Dutch guidelines for treatment of personality disorders do mention the family perspective, family therapy is not mentioned. For the treatment of borderline personality disorders, a model arrangement recommends involving family members, but in practice this is seldom done. In spite of these challenges, individual family therapists still continue to offer family therapy in mental health institutes, albeit on a small scale. In some units this has resulted in a well defined policy for family therapy. In children's psychiatry, parents and siblings are routinely involved in treatment. Likewise, in elderly psychiatry, attention for parents, children and other caregivers has grown, due to the increasing age of the general population, and the tendency for elderly people to live independently.

Some private clinics in the Netherlands focus on systemic treatment and treat individual clients as part of a system (e.g. Molemann Mental Health, Lorentzhuis, and Amsterdams Instituut voor Relatie en Gezinstherapie). Couples therapy is also regularly provided by a large number of private practices, either based on EFT (Johnson, 2004) or on their own integrated model. This is only possible, however, for those therapists that have an official licence to practise as a psychotherapist, clinical psychologist, or psychiatrist. In addition, a few institutes (e.g. Altrecht, ProPersona) offer individual therapy in conjunction with couples therapy using EFT (Johnson, 2004). The underlying idea is that all these individual treatments will have greater effectiveness when the system is involved, thus improving attendance and preventing relapse.

Presently, the most urgent task is to convince opinion leaders, politicians and healthcare insurance companies that family therapy is indeed beneficial for patients, for families and for Dutch society at large. For example, improvements in parents' relations correlate with reductions in delinquent symptoms in adolescent children (Mann et al., 1990).

Conclusions

In Dutch society, with its strong individualism and flexible and changing family ties, family therapy is needed more than ever to weave a connecting fabric between people. The high incidence of anxiety and depression (see section 3) may be related to the dissipation of traditional family structures. Living alone and being lonely deteriorates one's physical and mental health: humans are social animals who need each other to regulate their emotions (Mikulincer & Shaver, 2007; Snyder et al., 2006). Family therapy is necessary to counteract the effects of individualization in Dutch society, and to forge strong and reliable ties.

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