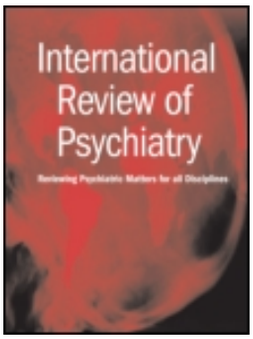

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Family therapy in the Czech Republic

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Abstract
Political, economic and cultural transformations in the Czech Republic after 1989 were reflected in a number of demographic indicators, including those that characterize family behaviour. The main features of these changes are declining birth and marriage rates, postponement of first marriage and first birth ages, and a growing proportion of children born outside of marriage. These changes are comparable to those that have taken place in western Europe since the 1960s; however, some of them are abrupt and cause rapid shift in the family structure. Over the last two decades, significant changes have also occurred in the organization of family therapy. Earlier less coordinated activities underwent institutionalization, and guidelines for training and supervision were established. Family therapy in the Czech Republic is covered by a national organization, the Society of Family Therapy (SOFT). Standards of training and supervision correspond to European standards. The problem remains the lack of support for family therapy from state institutions, especially in the health service. There are only a few healthcare facilities providing family therapy for the treatment of psychiatric disorders or chronic somatic diseases. The capacity of these centres is substantially inadequate.

Introduction

In the post-war years, the development of psychotherapy in the former Czechoslovakia was for ideological reasons greatly restricted. The totalitarian regime had originally planned to weaken the family influence by supporting and building facilities to raise children collectively (Matějćek, 2001). In the 1960s, the political liberation led to a quick but, unfortunately temporary, development of psychotherapy. The later invasion of the Warsaw Pact troops in 1968 saw official development stop for the next 20 years. Psychotherapy and family therapy were promoted as a voluntary activity of psychologists and psychiatrists and were not allowed to interfere with state recognized structures in the health system.

Family therapy ideas penetrated from the western European literature among staff in departments of child psychiatry, and in marital and educational and psychological counselling, thanks to child psychiatrist Peter Boš. Largely due to his foreign contacts and translations in the *Context* newsletter in the early 1980s, systemic family therapy was gradually promoted in addition to officially required psychological diagnostics and pharmacotherapy.

The first World Congress of Family Therapy, with the participation of many colleagues from western countries, took place in 1987 in Prague and contributed significantly to the popularization of family therapy in the former Czechoslovakia. After 1989 there were significant changes in the organization of family therapy. Earlier less coordinated activity underwent institutionalization, rules were originated and training supervision developed.

The Society for Psychotherapy and Family Therapy (CPS), a part of J.E. Purkyne´s Medical Association, was founded as well as the Association of Marriage and Family Counsellors (AMRP), comprising mainly psychologists and family therapists in marital counselling (counselling for family and interpersonal relationships). Besides the Family Therapy Institute in Prague (P. Boš, J. Špitz) there were other independent family therapy institutes formed including the Systemic Experience Institute in Prague (V. Strnad) and the Institute for Family Therapy and Psychosomatic Medicine in Liberec (V. Chvála, L. Trapková, J. Knop). The latter is the only medical facility with a clinical outpatient department focusing on psychosomatic problems. The end

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of the 1990s witnessed the accreditations of training programmes in psychotherapy for healthcare, four of them in family therapy.

Structure of family

Political, economic and social changes in the Czech Republic after 1989 were reflected in a number of demographic indicators, including those that characterize family behaviour. These connections led to the onset of the second phase of demographic transition, which took place in the Czech Republic with a twenty-year delay compared to western Europe. This transformation is, however, in some indicators abrupt, and led to rapid changes of the internal structure of the family.

The main features of these changes are declining birth and marriage rates, while first marriage and first birth ages increased. Between 1990 and 1996 the birth rate in the Czech Republic fell sharply from 12.6 births per 1000 people in 1990 to 8.7 in 1996. The period of low birth rates continued between 1996 and 2001, however, the birth rate then gradually increased to 11.3 births per 1000 people in 2009. The total fertility rate in the Czech Republic was 1.89 in 1990; the lowest level (1.13) was reached in 1999 and the current rate is around 1.5 (Český statistický úřad, 2012). In the international context, this level is one of the lowest in Europe and in the world (Council of Europe, 2004). The main reason for the sharp decline in birth rate and fertility rate in the 1990s is the delay in starting a family to a later age in individuals born in the demographically strong 1970s. This phenomenon is caused above all by extension of possibilities for the self-realization of young people outside the family sphere (longer period of study, professional career, international internships, travelling, etc.) after the fall of the totalitarian regime. While the mean age of women at first childbirth in 1990 was 22.5 years and the mean age of women at childbirth was 24.8 years, this increased to 27.4 years, respectively 29.4 years in 2009 (Český statistický úřad, 2012).

In the past 20 years the number of marriages has declined from 91,000 in 1990 to 48,000 in 2009 (Český statistický úřad, 2012). The rate of remarriage of the divorced and widowed also declined. At the same time the mean age at first marriage significantly increased for both sexes. While in 1990 the mean age of women entering into marriage was 21.4 years and men 24.0 years, in 2009 the mean age of women was 29.2 years and men 32.0 years (Český statistický úřad, 2012). The number of divorces in the last 20 years has remained relatively stable (around 30, 000 divorces per year). Due to the decline in marriage, however, the total divorce rate in this period rose from 38.0% to 49.6% and is one of the highest in Europe (Council of Europe, 2004).

The duration of marriage was slightly extended from 10.3 to 12.5 years and the proportion of divorces of shorter duration (up to 5 years) and the proportion of divorces with minor children decreased (Český statistický úřad, 2012).

A new feature of the last two decades is the dramatic increase in the number and proportion of children born outside marriage. While 8.6% of children were born out of wedlock in 1990, in 2009 there were 38.8% (Český statistický úřad, 2012). Most children born outside marriage are to women with primary education ($>60\%$ of children of women) and the least to women with university education ($<10\%$) (Ministerstvo práce a sociálních věcí, 2004). These children are born to women without a stable partner as well as to women with a partner with whom they do not share a common household, and also to women with a partner in a common household without marriage (so-called 'de facto marriage' or cohabitation). Czech society is tolerant of unmarried cohabitation and sees it as a normal and common life cycle or a possible alternative to marriage (Ministerstvo, 2004). This form of coexistence is captured in statistics from the personal statement in the census, and the actual situation and trends can only be described indicatively.

Very little information exists about the stability of this form of cohabitation. The increasing proportion of unmarried people in Czech society is probably not accompanied by an equivalent rise in the number of unmarried cohabitation, except for categories of men and women aged 25–29 years (Ministerstvo práce a sociálních věcí, 2004).

Family structure and its changes can best be described by the regular census, which is carried out every ten years. According to statistical data between 1991 and 2001 (results from Census 2011 are not yet published) the proportion of two-parent families (i.e. consisting of partnering parents, married or unmarried, and their chidren) declined. This was mainly due to the decline in two-parent families with dependent children. The vast majority of two-parent families live as a so-called nuclear family, i.e. without other people. According to the last census (2001) two-parent families with dependent children formed a quarter of all households and less than one half of all two-parent families. One-parent families with children account for, on average, fewer children (average 1.7 children in 2001) and at the same time an increased proportion of couples without children. Two-child families are still the most common model, but even here the proportion of such families declined between 1991 and 2001 from 63% to 45%. In the same period the proportion of single-parent families (single parent household and their children)

increased, primarily families with dependent children; 27% of dependent children lived in incomplete families in 2001. The vast majority of incomplete families are formed by women (single or divorced) with children, which also reflects the ongoing practice to entrust the care of minor children after divorce to their mothers (Ministerstvo práce a sociálních věcí, 2004).

Social, economic and cultural relationship changes in the past 20 years have inevitably had a major impact on the family structure. Primarily this is a result of the relationship between men and women gradually becoming more equal. Education and high employment among women reduced their dependence on a partner and increased the demand for reconciling family and professional interests. The marriage of equal partners provides both equal opportunities and emphasizes the quality of the relationship. However, it places high demands on communication and creation of a mutually acceptable lifestyle.

Another important change is that of the parent-child relationship. Child-rearing has seen the focus shift from the area of adaptation to social order to the development of individual skills and success in independent life. Education focused on the overall development of the child requires greater involvement of both parents as well as financial costs. The results of both processes are higher demands on quality partnerships and a smaller number of children in families or voluntary childlessness. The past two decades have witnessed the mostly secular Czech society, and families quickly approach, in both a positive and negative point of view, the societies of western Europe, where development has taken place continuously over a longer period of time.

Family therapies

Family therapy in the Czech Republic, covered by the national organization the Society of Family Therapy (SOFT), is part of the European Family Therapy Association (EFTA). Standards of teaching and supervision correspond to European standards. SOFT has about 150 members, publishes its own online magazine (www.softforum.cz), which continues the 15-year tradition of the *Context* magazine of Peter Boš. The professional advice of SOFT is relayed through organized expert meetings and conferences. Education in family therapy and systemic family therapy (systemic therapy) is available in four professional institutes. It contains at least 500 hours of theory, practice and self-experience and subsequently at least 100 hours of case work supervision. Comprehensive training in family therapy lasts 6–7 years with specific traits within the individual institutes.

The training capacity is about 230–250 people for every 4-year cycle, followed by work under supervision, of which an estimated third to a half of the participants applied family therapy in their practice.

The problem remains the lack of support for family therapy from state institutions, especially in medicine. The Czech Republic lacks an Act on psychotherapy which would define the profession of psychotherapist or family therapist. Psychotherapy is currently tied to a number of different professions and the organization is scattered in different government sectors (health, education, social services). The health sector still pays heed to an outdated law that regulates the conditions for treatment (Public Health Act of 1960), in which therapy can only be performed in healthcare. However, this healthcare fails due to backward education and poor legislation to adequately promote and exploit the possibilities of family therapy in various medical disciplines such as paediatrics, psychiatry, and certainly not in such somatic disciplines such as neurology, internal medicine, gynaecology and others. Many psychologists and special pedagogues work with families in counselling outside the healthcare system. Disputes continue as to whether these experts are authorized to work outside the health sector. In addition to the traditional counselling network for family and interpersonal relations, and educational and psychological counselling, new specialized units for families with problematic children or for drug users were created in the frame of social services. These facilities are only partially funded by government money and their existence depends on subsidies from domestic or European sources. Every major city has a similar service available. However, high-quality family therapy cannot be found everywhere. Systemic therapy is also used for coaching teams in various professions in the commercial world.

The health sector only contains a limited number of places that offer family therapy for the treatment of psychiatric disorders in children or adults, or chronic somatic diseases in psychosomatic medicine. The capacity of these centres is totally inadequate. None are bound to an academic department of a faculty of medicine. In medical research, biological orientation prevails, the psychosocial aspects of diseases are formally mentioned, but are not practically taken into account.

If the physician (psychiatrist, sexologist or other practitioner) or a clinical psychologist meets the conditions for the operation of a medical practice as a psychotherapist and family therapist in state or non-state healthcare facilities they can obtain contracts with health insurers which enable family therapy to be covered by compulsory health insurance. A growing awareness of the possibilities of family therapy amongst the population is increasing demand. More

and more patients are interested in the possibility of such treatment. Experts from various medical fields still have great respect for the possibilities of family therapy, especially in difficult to treat chronic cases (Chvála & Glos, 1985; Komárek, 2005; Poněšický, 2004). Overall, the importance of family therapy is slowly increasing. This is evidenced by the fact that a newly published textbook on psychotherapy contains chapters on family therapy (Vybíral & Roubal, 2010). Textbooks focused on family therapy (Gjuričová & Kubička, 2009), and also books with the original concepts of family therapy (Rieger & Vyhnálková, 1996; Trapková & Chvála, 2004) have also been published.

In our institution, the Centre for Complex Therapy of Psychosomatic Disorders in Liberec, we register about 900 new patients a year (Chvála, 2009). The concept of family therapy was present at the birth of the institute, which was based on the principle of brief therapy according to the model of the Milan team and Steve DeShazer more than two decades ago (DeShazer, 1982). Orientation to solve difficult cases, regardless of the age or sex of patients, allowed us to develop a range of techniques that are far from just family therapy, which were adopted from the outset by the centre's team of doctors and psychologists. The current team consists of 13 people – psychiatrists, sexologists, physiotherapists and clinical psychologists. We have individual psychotherapy of various schools and also group techniques and physiotherapy available for our patients. Treatment is largely funded from general health insurance. During the 1990s, we extended family therapy techniques with narrative therapy that we not only use in children with somatic problems or behavioural disorders, but also in adults (Marner, 2000; White & Epston, 1990). We have achieved outstanding success and created our own concept, especially in cases with eating disorders, which facilitates the treatment of these and other complicated cases (Trapková & Chvála, 2000) where the formation of symptoms is directly related to the stagnation of the process of adolescent separation from the family. A third to half of our patients undergo family therapy with one or two therapists.

The workplace forms a clinical basis for the Institute of Family Therapy and Psychosomatic Medicine in Liberec (LIRTAPS), which organizes training for family therapy of psychosomatic disorders accredited in healthcare. Fourteen years of comprehensively training more than 100 colleagues in family therapy has passed, and they now work in different places throughout the country, half of which are formed by physicians, while the other half represents psychologists and further care professions. The method in which we combine family therapy with other techniques, for example, with body techniques, has been published in a separate monograph (Chvála & Trapková, 2008). More than 20 years of experience has been given to new workplaces which have gradually been established. We provide teams and case supervision.

Other workplaces use family therapy predominantly in psychiatric disorders of children and youths (Center for Family Therapy University Hospital Motol, Prague), or in pre-delinquent youths experimenting with drugs (Prev-Centrum, Prague). Family therapy is used to a smaller extent in the Ondrejov Psychiatric Centre in Prague, which is dedicated to the rehabilitation of post-psychotic and psychotic patients. Family therapy-based graduate training in the workplace takes place wherever there is good will, such as in Hradec Kralove, in Rychnov nad Kneznou, in Plzen, and in Prague. We expect that this trend will continue and family therapy in medical facilities will become more common and an affordable method of treatment.

Conclusions

Political, economic and social changes in the Czech Republic after 1989 were reflected in a number of demographic indicators, including those that characterize family behaviour. The main features of these changes are declining birth and marriage rates, increased first marriage and first birth ages, a growing number and proportion of children born outside of marriage, and a decline in the proportion of two-parent families.

Family therapy in the Czech Republic is covered by the national organization SOFT. Standards of teaching and supervision correspond to European standards. The problem remains the lack of support for family therapy from state institutions, especially in medicine. The Czech Republic lacks an Act on psychotherapy, which would define the profession of a psychotherapist or family therapist. There are still only a few workplaces within the health sector where family therapy for the treatment of psychiatric disorders in children or adults, or chronic somatic diseases in psychosomatic medicine, is fully utilized. The capacity of these centres is totally inadequate; however, a growing awareness of the possibilities of family therapy among the population is increasing demand.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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