Advanced Systemic Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced Systemic Practice

Power, culture and the reflecting team: postmodern practice, social GGRRAAACCEEESSS and systemic work under pressure.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Advanced Systemic Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Every therapeutic conversation happens inside larger systems of power, culture and profession, and advanced systemic practice refuses to pretend otherwise. This course works at that level: the postmodern and dialogical turns, the politics of the consulting room, and systemic work under statutory pressure, for experienced practitioners.

The first module engages power and culture directly. You will work with Burnham's Social GGRRAAACCEEESSS as a discipline for noticing which aspects of identity, gender, race, class, sexuality among them, are visible and voiced in the work and which are silently organising it. You will then study the reflecting team, therapy with the wall removed, and Open Dialogue's radical transparency. The second module takes systemic practice onto hard ground: high-conflict separations, families under statutory involvement where the referral is an instruction, and the therapist's own position inside the professional network, which so often mirrors the family's dynamics precisely.

Extended written lessons with key points and practice tasks at case and network level, with a study tutor throughout. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the

conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Work systemically with complex, multi-agency and high-conflict systems
- Use narrative and dialogical practices, including externalising and re-authoring conversations
- Apply the social GRACES to power, difference and your own position in the room
- Work reflexively with teams, including reflecting-team formats
- Hold risk, safeguarding and child-focused practice within a systemic frame
- Evaluate the systemic evidence base and argue its place alongside individual modalities

PART 1

Part 1: The social GGRRAAACCEEESSS and power

Lessons 1 to 5 of the course.

CHAPTER 1

The social GGRRAAACCEEESSS and power

John Burnham's Social GGRRAAACCEEESSS framework is not merely an inventory of social dimensions but a dynamic lens through which advanced systemic practice interrogates the ever-present axes of difference and power that organise therapeutic encounters. The acronym—Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Spirituality—serves as a mnemonic for the multiplicity of identities that intersect in the room, yet its clinical potency lies not in enumeration but in Burnham's insistence on their visibility and voicing. Each grace may be visible or invisible, voiced or unvoiced, and these quadrants generate distinct relational dynamics. Visible-voiced graces, such as a client's disclosed sexuality or a therapist's openly acknowledged gender, can be directly engaged with, though even here, power asymmetries may shape whose articulation is heard. Visible-unvoiced graces, such as a Black family's silence on race when seated with a white therapist, exert a structuring influence precisely through their absence, organising the conversation by what is not said. Invisible-unvoiced graces—such as a client's hidden disability, a family's concealed class history, or an unnamed faith—operate from the margins, subtly directing the flow of dialogue without ever entering the frame. The advanced practitioner's task is to move beyond checklist practice and interrogate which grace is currently organising the conversation, recognising that silence and omission are not neutral but active forces in the therapeutic system.

Power, in this systemic frame, is not an episodic concern but a constitutive condition of the therapeutic relationship. Therapists hold positional power through their role, the institutional structures they represent, and the language they deploy, while social power is distributed unevenly across every grace they embody. A therapist's whiteness, able-bodiedness, middle-class background, or fluency in the dominant language grants them unearned privileges that shape what is sayable, what is heard, and what is dismissed. Pretending to neutrality does not dissolve this power; it merely renders it unexaminable, allowing it to operate covertly. The ethical imperative, therefore, is one of transparent self-location and proportionate

naming. Where a grace is salient to the work, the therapist may explicitly acknowledge difference early in the process: ‘We come from different places, and those differences may matter to how we understand your son’s withdrawal. I invite you to tell me how any of this lands for you.’ This stance models that power is always present and that ruptures along difference lines—whether overt or subtle—are not signs of resistance but invitations to explore the unspoken organisers of the dialogue. When such ruptures occur, the therapist’s role is to return to the question of which grace is shaping the rupture, rather than pathologising the client’s response.

The craft of working with Social GGRRAAACCEEESSS extends to the use of cultural genograms, a method developed by Monica McGoldrick and expanded further by Monica Hardy and Anthony Laszloffy. Unlike standard genograms, which map biological and relational patterns across three generations, cultural genograms layer in the lived inheritance of migration, language loss and retention, faith practices, experiences of racism, and senses of belonging. These are not static demographic labels but dynamic narratives that shape identity and relational patterns. For example, a family’s migration journey from Nigeria to the UK may have involved the loss of a mother tongue, the adoption of English as a lingua franca, and the negotiation of religious practices between traditional Yoruba spirituality and British Christianity. Drawing these as family architecture converts culture from an abstract category into a lived, embodied history that the therapist can engage with directly. The cultural genogram also becomes a tool for the therapist’s own self-location, where they judiciously place themselves within the system they are mapping. A therapist might say, ‘I notice I’m asking about faith practices, and I should share that I was raised outside any religious tradition. There will be things I won’t automatically understand, and I’d welcome you helping me see what those are.’ This act of open positioning models the systemic claim that the therapist’s subjectivity shapes what is missable, while also inviting the client to co-create the therapeutic frame.

Consider the case of the Adeyemi family, a Nigerian-British household referred for their 16-year-old son’s social withdrawal. The therapist, a white, middle-class woman, had conducted three sessions of what she described as ‘competent circular questioning’—mapping interactions between the son, his parents, and his older sister without apparent impasse. Yet the work remained static, with polite exchanges masking underlying tensions. Supervision, employing the Social GGRRAAACCEEESSS lens, asked which

grace was organising the conversation. The therapist reflected on the visible graces: the family's Nigerian-British identity, her own whiteness, and the son's withdrawal as a potential cultural or generational misfit. Yet what was unvoiced was the elephant in the room: the family's assumption that the therapist, as a white professional in a British service, would inherently pathologise their parenting or cultural practices. This invisible-unvoiced grace—race as an organiser of the therapeutic encounter—had been exerting a structuring influence precisely through its silence. In the fourth session, the therapist named it directly: 'I realise I've been asking about home and school, but I haven't asked what it's like bringing your family's trouble to a white British service, and to me.' The silence that followed was not resistance but recognition; the father replied, carefully, 'We assumed you would think our discipline was the problem. Everyone does.' Once voiced, the organiser of the conversation shifted from the unspoken assumption to the explicit exploration of racialised power dynamics. The therapy, previously stalled, now had a live focus: the intersection of race, parenting norms, and institutional power. The question 'Which grace is organising this conversation right now?' thus became the catalyst for movement, demonstrating how the Social GGRRAAACCEEESSS framework transforms static encounters into dynamic, power-sensitive dialogues.

The discipline of the framework lies in its relentless interrogation of the present tense. The advanced practitioner does not merely catalogue graces but asks, in every moment, which axis is currently shaping the dialogue. This question must be asked not only of the client system but of the professional system, including supervision. A supervisor might ask a therapist, 'Which grace are you privileging in your formulation? Whose voice does your report amplify—the articulate father's, the English-fluent daughter's, or the grandmother's, whose words you summarise?' The reflexive turn is critical: the therapist's own position, including their class, race, ability, and education, shapes what they can perceive and what they risk missing. For instance, a therapist raised in a working-class context might overlook the subtle class cues in a middle-class family's language, while a therapist with a visible disability might not notice the ways their client's unspoken assumptions about ability are organising the room. The ethical stance, therefore, is one of humility and curiosity, where the therapist remains attuned to the possibility that their blind spots are the very graces that are organising the conversation.

Working with Social GGRRAAACCEEESSS also requires an understanding of how graces intersect to produce unique forms of privilege or marginalisation. Kimberlé Crenshaw's concept of intersectionality reminds us that no grace operates in isolation; a Black woman's experience of racism is shaped by her gender, while a disabled gay man's experience of ableism is inflected by his sexuality. In systemic practice, this means that the therapist must listen for the compounded effects of multiple graces. For example, a young Muslim woman might experience her therapist's questions about her faith as both supportive and intrusive, depending on whether the therapist's own secular background allows them to hold the complexity of her spiritual identity without collapsing it into a diagnostic category. The advanced practitioner must therefore hold the tension between naming graces and avoiding reductionism, recognising that each client's relationship to their graces is idiosyncratic and co-constructed in the therapeutic relationship.

The practical application of the framework extends to the language of the setting itself. Institutional language—whether diagnostic categories, assessment tools like the PHQ-9 or GAD-7, or even the terminology of 'treatment plans'—carries implicit assumptions about normality, pathology, and power. A therapist working with a family from a collectivist culture might find that the individualised language of cognitive-behavioural interventions clashes with the family's relational understanding of distress. Here, the Social GGRRAAACCEEESSS lens invites the therapist to ask which institutional graces are organising the therapeutic encounter. Are the assessment tools being used in a way that privileges certain narratives of distress over others? Does the language of the service inadvertently pathologise cultural practices that fall outside the dominant norm? The therapist's role is not to reject institutional language outright but to interrogate its fit with the client's lived experience and to adapt accordingly.

In supervision, the Social GGRRAAACCEEESSS framework becomes a tool for examining the therapist's blind spots. A supervisor might ask, 'What did you miss in the room today? Which grace were you not attuned to, and how might that have shaped the client's experience of safety or threat?' This reflexive practice extends to the therapist's own training and cultural background. For example, a therapist trained in a Western, individualistic model might struggle to recognise the relational nature of distress in a family from a more collectivist background. The supervisor's role is to help the therapist locate themselves within these epistemological tensions,

recognising that their training has equipped them with certain ways of knowing while rendering others invisible.

The ethical stance of the advanced practitioner is one of transparency, proportion, and curiosity. Transparency does not mean exhaustive self-disclosure but judicious self-location where it serves the work. Proportion requires the therapist to assess when naming a grace is clinically relevant and when it risks becoming a performative act. Curiosity involves maintaining an openness to the client's experience of the therapist's graces, recognising that even well-intentioned questions can land as intrusive or dismissive. For instance, a therapist might ask about a client's faith practices not out of genuine curiosity but because they are attempting to demonstrate cultural competence—a move that risks reducing the client's spirituality to a tick-box exercise. The advanced practitioner, by contrast, approaches such questions with humility, acknowledging their own limitations and inviting the client to educate them.

The Social GGRRAAACCEEESSS framework thus transforms the therapeutic encounter from a dyadic interaction into a polyphonic dialogue, where multiple voices, histories, and power dynamics are held in tension. The advanced practitioner's discipline lies in their ability to listen for the organiser of the conversation, to name it when it is salient, and to hold the space for its exploration without collapsing into premature resolution. This work is not for the faint-hearted; it demands a willingness to sit with discomfort, to interrogate one's own complicity in power structures, and to tolerate the uncertainty of not knowing which grace will emerge as the organiser in any given moment. Yet it is precisely this discipline that transforms therapy from a technical exercise into a liberatory practice, where the unspoken organisers of the room are brought into the light and made workable.

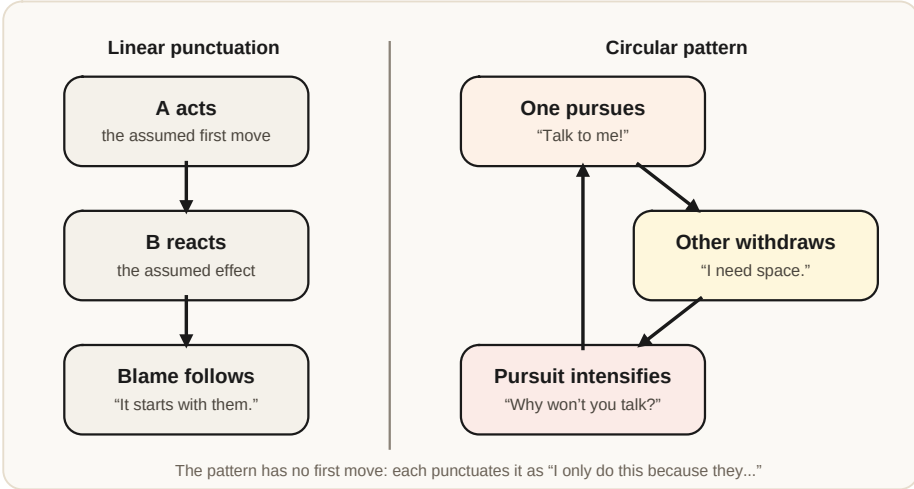


FIGURE 1.1 Linear versus circular causality
Linear thinking asks which person is the cause; systemic thinking sees a pattern with no first move: each behaviour is both response and provocation. The classic pursue–withdraw cycle shows why blaming either party misses the point, and why the pattern itself is the client.

Points worth keeping

- GGRRAAACCEEESSS: the ever-present axes of difference and power
- Ask: which axis organises this conversation now
- Self-location: the therapist’s position shapes what is missable

PRACTICE TASK

Choose two GRACES most invisible in your own practice and write one question each that would voice them in session.

CHAPTER 2

Reflecting teams and open dialogue

The reflecting team and Open Dialogue are not merely techniques but ethical configurations that re-orient the relational geometry of therapeutic work. They embody a shift from a hierarchical, expert-driven stance to a polyphonic stance in which multiple voices are invited to speak, listen, and be heard. This lesson unpacks the theoretical lineage, the procedural mechanics, and the clinical implications of these practices for the advanced systemic practitioner, with a particular focus on power, culture, and dialogue. It also provides a worked example that demonstrates how the principles can be instantiated in a real-world session.

The origins of the reflecting team can be traced to Tom Andersen's pioneering work in Norway in the mid-1980s. Andersen inverted the traditional one-way mirror that had long symbolised the distance between therapist and client. In the classic arrangement, a team of clinicians observed a family from a darkened room, intervening only through a speaker or a telephone, their expertise concealed and delivered in a top-down fashion. Andersen's innovation was to turn the lights around, allowing the family to hear the professionals speak directly about the family's narrative while the professionals remained visible. The family then reflects on those reflections, thereby disrupting the observation hierarchy that the mirror had entrenched. The team members speak tentatively, using the subjunctive mood – "I wonder whether…", "Perhaps we might consider…", – offering ideas as gifts rather than definitive findings. They also speak appreciatively, acknowledging strengths alongside questions, and they openly disagree with one another. This open disagreement models multiplicity for the family, providing a lived illustration of polyphony that counters the family's own either-or battles. The family is invited to select which reflections resonate, which miss, and which they wish to carry forward, thereby reclaiming agency over the meanings that shape their relational world.

The philosophical underpinnings of the reflecting team are rooted in the dialogical traditions of Michael White and David Epston, whose narrative therapy foregrounds the co-construction of meaning. Andersen's team extends this dialogical stance by making the process of co-construction

audible to the family. The practice also aligns with the concept of Social GGRRAAACCEEESSS, which emphasises the need for clinicians to be transparent about their own interpretive lenses, thereby reducing the power differential that often obscures the therapeutic encounter. By speaking in a tentative, provisional manner, clinicians acknowledge the provisional nature of their understandings and invite the family to participate in the ongoing negotiation of meaning.

Jaakko Seikkula's Open Dialogue, developed in the early 1990s in Western Lapland, builds on the same ethical foundation but applies it to the treatment of psychosis, a context where hierarchical structures are especially entrenched. Open Dialogue is characterised by five core principles: immediacy, network orientation, transparency, tolerance of uncertainty, and dialogism. Immediacy requires that a network meeting be convened within twenty-four hours of a crisis, ensuring that the family's experience is addressed before the crisis solidifies into a medicalised narrative. The network orientation expands the therapeutic space to include not only the individual experiencing psychosis but also family members, friends, and any other significant others, thereby recognising that the crisis is embedded within a relational system. Transparency mandates that all participants hear what is said about them; clinicians articulate their thoughts aloud, avoiding private case conferences that would otherwise conceal professional deliberations. Tolerance of uncertainty involves resisting the urge to rush to a diagnostic label or pharmacological intervention, instead holding space for the crisis to unfold and for the meanings to emerge organically. Finally, dialogism frames the interaction as a continuous conversation in which every utterance is answered, and the psychotic speech is treated as a form of communication rather than a symptom to be eliminated.

The empirical evidence for Open Dialogue, while not without limitations, is compelling. Long-term follow-up studies in Western Lapland have reported lower rates of antipsychotic medication, reduced hospitalisation, and improved functional outcomes compared with conventional services. Critics have noted the non-randomised design, the homogeneity of the Finnish population, and the potential challenges of transporting the model to health systems with different funding structures and professional cultures. Nonetheless, the central claim that a polyphonic, network-oriented service can produce better outcomes remains robust, and the model has inspired adaptations in the United Kingdom, Italy, and the United States, where

practitioners have experimented with network meetings and transparent decision-making.

Both reflecting teams and Open Dialogue operationalise the principle that change emerges from polyphony rather than from an expert monologue. For the advanced practitioner, the challenge is to integrate these principles into everyday practice, even when the broader organisational context does not fully support them. The internalised reflecting team is one such integration: the therapist pauses mid-session, voices two or three tentative interpretations aloud, and invites the family to choose which resonate. This practice cultivates a habit of thinking aloud, thereby reducing the distance between internal cognition and external communication. Transparency, another transferable habit, involves narrating one's clinical reasoning in real time, allowing the family to hear the rationale behind interventions. The network reflex asks the therapist, at each impasse, "Who else is part of this system, and should they be invited into the room?" This question foregrounds the cultural and relational context, ensuring that power is not inadvertently concentrated in the therapist's chair.

Cultural considerations are paramount when applying these practices. In collectivist cultures, the network orientation of Open Dialogue may align naturally with existing communal decision-making processes, whereas in more individualistic societies, the invitation to involve extended family or community members may require careful negotiation to respect privacy and autonomy. Reflecting teams must also be attuned to cultural scripts that dictate who is permitted to speak and whose voice is valued. By modelling disagreement and multiplicity, the team can challenge culturally embedded hierarchies, but it must do so with cultural humility, acknowledging that the very act of speaking tentatively may be perceived differently across cultural contexts.

Power dynamics are further illuminated when the reflecting team includes professionals from diverse disciplines. When a social worker, a psychiatrist, and a family therapist sit together, their differing epistemic lenses become audible to the family. The family's ability to hear these divergent perspectives without a single voice dominating demonstrates a redistribution of epistemic authority. This redistribution is not merely symbolic; it has concrete implications for treatment planning. For instance, a psychiatrist's inclination towards medication can be balanced by a

therapist’s focus on relational processes, and the family can weigh these options in a transparent dialogue, thereby exercising agency over the therapeutic trajectory.

A concrete worked example illustrates how these principles can be woven together in a session with a family navigating adolescent self-harm. The therapist, Maya, has been working with the Patel family for several weeks. The adolescent, Arjun, has presented with repeated episodes of cutting, and the parents, Priya and Raj, are caught in a pattern of blame and rescue. Maya decides to employ an internalised reflecting team. After a brief pause, she says, “I’m going to think aloud about what I’m hearing, and I’d like you to tell me which of these ideas feels most accurate for you.” She then offers three tentative reflections: “One possibility is that the cutting is a way for Arjun to signal that he feels unheard in the family; another possibility is that the cutting is a symptom of underlying anxiety that has been amplified by the family’s conflict; a third possibility is that the cutting is a form of communication that is trying to negotiate new boundaries within the family.” She frames each reflection with the subjunctive, using phrases such as “I wonder whether” and “perhaps”. Priya, after a moment of contemplation, responds, “The first one resonates – we do often feel that Arjun disappears when we try to talk about his feelings.” Raj adds, “The second one also makes sense; we’ve been so caught up in the arguments that we haven’t noticed his anxiety.” Arjun, who has been sitting quietly, looks up and says, “I think the third one is right – I’m trying to tell you that I need space, but I don’t know how.” Maya then acknowledges each contribution, noting the multiplicity of meanings and inviting the family to explore how these perspectives might inform a shared plan. The session proceeds with a network meeting that includes Arjun’s aunt, who lives nearby, and a school counsellor. Maya narrates her thinking aloud throughout, explaining why she suggests a safety plan that incorporates both emotional expression and concrete boundaries, while also postponing any decision about medication until the family has had time to reflect on the multiple meanings of the self-harm. This transparent, polyphonic approach reduces the sense of authority, invites cultural and relational resources, and tolerates the uncertainty inherent in a crisis.

The worked example demonstrates several core competencies of advanced systemic practice. First, the therapist models tentative language, thereby reducing the power differential and inviting the family to co-construct

meaning. Second, the therapist expands the system by inviting additional network members, embodying the Open Dialogue principle of network orientation. Third, the therapist practices transparency by thinking aloud, allowing the family to hear the professional reasoning that would otherwise be concealed. Fourth, the therapist tolerates uncertainty by postponing a definitive diagnostic label and medication decision, thereby respecting the family's need to process the crisis in their own time. Finally, the therapist facilitates polyphony by presenting multiple reflections and allowing the family to select those that resonate, thereby reinforcing the family's agency.

For the advanced practitioner, the integration of reflecting teams and Open Dialogue requires a shift in professional identity. The therapist moves from the role of expert who possesses the final word to that of a facilitator of conversation, a steward of multiple voices. This shift is underpinned by a commitment to humility, curiosity, and the belief that meaning is co-created rather than transmitted. It also demands a willingness to sit with discomfort, as the tolerance of uncertainty can feel unsettling for clinicians trained in diagnostic certainty. Supervision and peer support become essential, as the practitioner must navigate the emotional terrain of hearing divergent professional opinions and the potential for conflict within the team.

Ethical considerations are inseparable from the practice of reflecting teams and Open Dialogue. Informed consent must encompass the possibility that the family will hear the therapist's provisional thoughts and that other professionals may be present and speak openly. Confidentiality is maintained, but the boundaries of what is shared are negotiated in a transparent manner. The practitioner must also be vigilant about power imbalances that may arise when certain family members dominate the conversation, ensuring that each voice is afforded equal weight. Cultural competence is required to recognise when certain topics are taboo or when particular relational hierarchies are deeply embedded; the therapist must negotiate these sensitivities with respect and flexibility.

In summary, reflecting teams and Open Dialogue offer a robust framework for advanced systemic practitioners seeking to re-balance power, honour cultural diversity, and foster genuine dialogue. By embracing tentative language, inviting network participation, practising transparency, and tolerating uncertainty, clinicians can create a therapeutic space where polyphony thrives and change emerges from the collective wisdom of the

system rather than from a singular expert voice. The internalised reflecting team, the network reflex, and the habit of thinking aloud are concrete tools that can be deployed in any clinical setting, regardless of organisational constraints. As the field continues to evolve, the challenge will be to sustain these practices amidst the pressures of service demands, while continuing to generate evidence that demonstrates their efficacy across diverse populations and settings. The commitment to polyphony over monologue is not merely a methodological choice; it is an ethical stance that recognises the inherent dignity and agency of every participant in the therapeutic conversation.

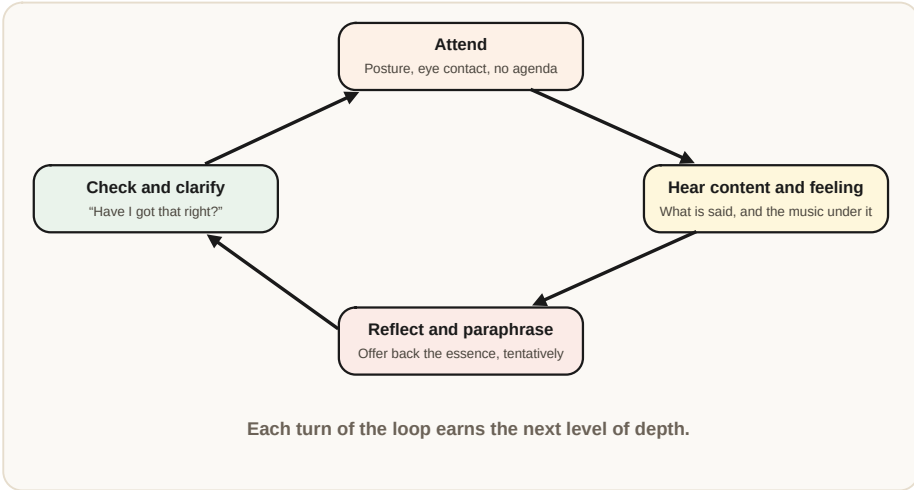


FIGURE 2.1 The active listening loop

Listening is a discipline with a shape: attend fully, take in both content and feeling, reflect back what was heard, and check the reflection. Each accurate reflection invites the client one level deeper; each check repairs the small misses before they become ruptures.

Points worth keeping

- Reflecting team: tentative professional talk, family reflects on it
- Open Dialogue: network, transparency, tolerance of uncertainty
- Polyphony over expert monologue

PRACTICE TASK

Write two sentences a reflecting-team member might say about a stuck session, modelling tentativeness and difference.