Systemic & Family Approaches

THE TALKING THERAPIES UK PRACTITIONER SERIES



Systemic & Family Approaches

The complete practitioner pathway, from foundation through to advanced practice

Advanced level · 60 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

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

Revision 5. This printing was set on 10 November 2026 from the course as it stood that day.

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

This volume gathers the whole of the Talking Therapies UK pathway in Systemic & Family Approaches into a single book. Each of its parts is a complete course from the practice's training library, and each chapter is a lesson from that course, so the volume covers the subject in the order in which it is taught, from foundation through to advanced practice. It is written for psychotherapists, psychologists and other qualified psychological therapists, and it assumes a caseload and access to supervision.

The constituent courses are: Systemic Thinking Foundations; Working Systemically; Multisystemic Therapy: Theory, Principles and Practice with Young People and Families; Advanced Systemic Practice.

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 60 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

- Think in systems: describe circular causality and how it differs from linear blame
- Map a family system, including alliances, boundaries and hierarchies, with a genogram
- Describe homeostasis and why systems resist change even when members suffer
- Recognise repeating interaction patterns, such as pursue–withdraw, in couples and families
- Ask simple circular questions that reveal pattern rather than fault
- Describe the major schools of family therapy and their shared foundations
- Conduct systemic sessions with couples and families, balancing alliance across members
- Use circular, reflexive and scaling questions to interview for pattern and possibility
- Formulate systemically, including the problem's function and the system's punctuations
- Work with enactments in session rather than reports about home
- Apply structural and strategic techniques, including reframing and boundary-making
- Attend to your own position in the system, including triangulation pulls
- Explain the origins, purpose and social ecological foundations of Multisystemic Therapy and its status as a licensed programme.
- Summarise the evidence for MST with balance, including US trials, meta-analyses, the London trial and the START trial and its five-year follow-up.
- Describe the nine treatment principles and the analytic process, and apply them to the formulation of a young person's behaviour.
- Engage caregivers and families, assess strengths and needs across systems, and combine the desired outcomes of key participants into measurable overarching goals.
- Develop specific, testable hypotheses about the drivers of behaviour, prioritise them and link them to intermediary goals while guarding against confirmation bias.

- Describe interventions with parenting and monitoring, family relationships, peers, school, and individual and caregiver difficulties, integrated within the principles.
- Explain in general terms how MST has been adapted for substance misuse, child abuse and neglect, problem sexual behaviour, psychiatric crisis, health care, transitions and emerging adults.
- Apply safety planning and safeguarding duties in home-based work, including responses to exploitation, domestic abuse and risk to the practitioner.
- Practise in a culturally responsive way that recognises disparities, uses interpreters properly and avoids deficit framing.
- Evaluate outcomes honestly, plan for discharge and sustainability, borrow ideas from MST ethically and identify the route to training in a licensed team.
- 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

Systemic Thinking Foundations

From the individual to the pattern: circularity, context and the family as a system.

CHAPTER 1

From linear to circular causality

Systemic therapy begins with a shift in the fundamental question that guides clinical enquiry. Where an individual therapist asks, “What is wrong with this person?” and then searches for a history, a cognitive schema, or a biological substrate, the systemic therapist asks, “What pattern is this behaviour part of, and between whom?” This seemingly modest re-orientation opens a vista onto relational dynamics that are invisible when the focus remains on a single person. The change is not merely semantic; it reconfigures the clinical unit from the individual to the relational system, and it demands a different logic of causality. Linear causality, the familiar notion that A causes B in a one-way chain, is replaced by circular causality, the idea that behaviours are mutually reinforcing within a pattern that sustains itself. In this lesson we will explore the theoretical underpinnings of circular causality, the role of punctuation in the construction of each participant’s story, and the way symptoms function as communications and, paradoxically, as solutions within a system. A worked example will illustrate how these concepts operate in practice, and we will reference the seminal contributions of Paul Watzlawick, Gregory Bateson, Salvador Minuchin, and Virginia Satir, among others, to ground the discussion in the evidence base of systemic thinking.

The notion of circular causality draws upon cybernetic and systems theory, prominently developed through the work of Gregory Bateson, who argued that human interaction is best understood as a feedback loop rather than a linear chain of cause and effect. In his classic formulation, “the pattern that connects” replaces the simple question of “who did what to whom?” This perspective was further refined by Paul Watzlawick and his colleagues at the Mental Research Institute, who articulated the five axioms of communication that underpin systemic therapy. The second axiom – that one cannot not communicate – and the third axiom – that the nature of a relationship is determined by the punctuation of the communication sequence – together illuminate why each party in a dyad can be simultaneously right about the origin of a problem. Punctuation, in this context, refers to the point at which each participant draws a line around the ongoing interaction and declares that the sequence begins there. When two partners each punctuate the same

loop at opposite ends, their narratives become mutually exclusive, and the conflict appears insoluble because each side is convinced that the other is the initiator of the problem.

Circular causality therefore replaces the linear formulation “A causes B” with a bidirectional, self-maintaining loop: “A and B cause each other.” Consider a couple in which one partner, Emma, withdraws from intimacy, and the other, Liam, pursues her more aggressively. Emma’s withdrawal is interpreted as a reaction to Liam’s pressure, while Liam’s pressure is interpreted as a reaction to Emma’s withdrawal. Each behaviour becomes the stimulus for the other, and the pattern continues indefinitely unless an external intervention disrupts the loop. The therapist’s task is not to assign blame for the first move but to make the circularity visible, thereby allowing the participants to see that the problem is not located in a single act but in the ongoing relational pattern.

Symptoms, from a systemic perspective, are not merely signs of pathology residing inside an individual; they are communicative acts that convey information to the system and, at times, serve as functional solutions to systemic dilemmas. This functional view of symptoms was articulated by Virginia Satir, who described maladaptive behaviours as “survival strategies” that maintain equilibrium in a family system. A child’s tantrums, for instance, may function as a lightning-rod that diverts parental conflict, thereby preserving a fragile peace. The symptom persists because it fulfils a purpose, and attempts to eradicate it without addressing the underlying pattern are likely to encounter resistance. This does not romanticise suffering; rather, it provides a pragmatic explanation for why certain behaviours are resilient in the face of conventional individual-focused interventions.

To illustrate these principles, let us examine a concrete case that demonstrates the transition from linear to circular thinking. Nine-year-old Maya attends a community school and has been referred for repeated episodes of aggression towards peers, which have escalated over the past six months. The school’s initial assessment, using the Strengths and Difficulties Questionnaire, flags her on the conduct subscale, and the school counsellor recommends a series of individual sessions focused on anger management, employing cognitive-behavioural techniques to monitor mood. After three sessions, Maya’s aggression remains unchanged, and the

counsellor notes that the behaviour appears “instrumental” – it seems to achieve something beyond mere emotional expression.

When the family consents to a systemic session, the therapist begins by mapping the relational context surrounding the aggression. Maya lives with her mother, Ana, and her father, Raj, who have been experiencing increasing marital tension following Raj’s recent job loss. The parents have adopted a pattern of avoiding direct discussion of financial stress, instead focusing on routine tasks such as school drop-offs and grocery shopping. On mornings when the parents are particularly silent, Maya’s aggression spikes, often resulting in a call to the school and a subsequent meeting with both parents. The therapist observes that the school’s response – calling the parents together – is the only occasion in which Ana and Raj cooperate in a coordinated manner. Moreover, Maya’s younger brother, Sam, begins to exhibit sleep disturbances during weeks when Maya’s aggression is low, suggesting that the system seeks to maintain a certain level of tension.

In this vignette, the therapist identifies a circular pattern: Raj’s unemployment leads to marital tension; the tension prompts the parents to avoid emotional contact, creating an emotional vacuum that Maya fills with aggression; Maya’s aggression triggers a joint parental response at school, providing the couple with a rare moment of collaboration; the system, in turn, reinforces the pattern by rewarding the parents with this collaborative moment, and the whole loop repeats. The symptom – Maya’s aggression – is thus a communication that signals the need for a shared parental engagement, and it also functions as a solution that temporarily restores a sense of partnership for the parents.

The therapist’s intervention proceeds by first describing the circle without assigning blame, using language that reflects the systemic stance: “What I am hearing is that when the home feels quiet, Maya’s aggression rises, and that brings you together at school, which is a time you both feel you can work together.” By externalising the pattern, the therapist invites Ana and Raj to view the aggression as belonging to the relational system rather than to Maya herself. The next step involves a process of re-punctuation. The therapist asks each parent to recount the sequence from their perspective, highlighting how each partner’s story begins at a different point. Ana may describe the pattern as “Maya becomes angry because we are silent,” whereas Raj may describe it as “We become silent because we are worried

about money, and Maya reacts." By making the divergent punctuations explicit, the therapist demonstrates that the conflict is structurally undecidable – there is no single point of origin – and that the focus should shift from blame to the maintenance of the loop.

Having established the circularity, the therapist collaborates with the family to design a new pattern that satisfies the system's need for joint engagement without relying on Maya's aggression. This may involve scheduling a brief daily check-in between Ana and Raj, creating a ritual that replaces the school-based collaboration, and introducing a shared activity that acknowledges the financial stress while fostering emotional connection. The therapist also works with Maya to develop alternative communication strategies, such as using a feelings chart, thereby reducing the necessity for aggression as a signal. Over the ensuing weeks, the family reports a reduction in Maya's outbursts, and the parents note that they are now able to discuss financial concerns in a structured manner, without the need for a crisis to bring them together.

The case of Maya exemplifies how circular causality reframes a presenting problem, how punctuation explains the persistence of divergent narratives, and how symptoms can be understood as functional communications within a system. It also demonstrates the therapeutic process: externalising the pattern, re-punctuating the story, and collaboratively constructing a new relational configuration. The evidence base for these interventions is robust. Meta-analyses of systemic family therapy for adolescent behavioural problems (e.g., Carr, 2009) have shown effect sizes comparable to, and often exceeding, those of individual cognitive-behavioural therapy, particularly when the intervention targets the relational patterns that sustain the behaviour. Moreover, systematic reviews of brief systemic interventions for school refusal (e.g., McIntyre et al., 2015) highlight the importance of addressing the family's interactional loops rather than focusing solely on the child's anxiety.

In summary, the transition from linear to circular causality is the cornerstone of systemic thinking. Linear causality posits a unidirectional chain – A causes B – which leads clinicians to search for a singular source of pathology. Circular causality, by contrast, recognises that behaviours are mutually reinforcing within a pattern that perpetuates itself. Punctuation explains why each participant can be convinced that they are the initiator of

the problem, because each draws the line around the loop at a different point, rendering the conflict structurally undecidable. Symptoms, far from being mere signs of individual dysfunction, are communicative acts that may also serve as solutions to systemic dilemmas, maintaining equilibrium in the face of relational stress. By adopting a systemic lens, clinicians expand the unit of attention from the individual to the relational pattern, preserving the relevance of biology, history, and inner experience while adding a dimension that renders previously intractable problems tractable. The therapist's role is to make the circle visible, to re-punctuate the story, and to facilitate the construction of new, healthier patterns that meet the system's needs without relying on maladaptive symptoms. This paradigm shift, grounded in the work of Bateson, Watzlawick, Minuchin, Satir, and the broader evidence base, equips practitioners to navigate the complexities of human relationships with greater clarity and compassion.

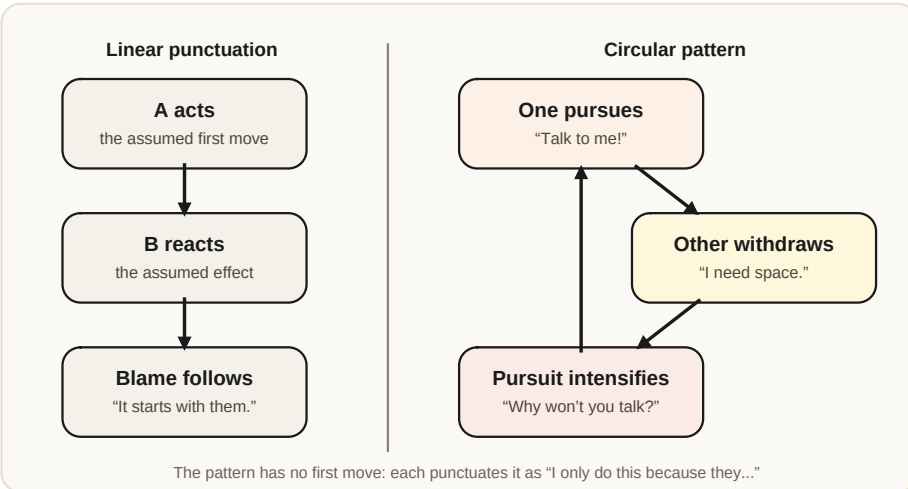


FIGURE 1.1 Linear versus circular causality

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

- Circular causality: patterns, not one-way causes
- Punctuation: each party starts the story where it suits
- Symptoms can be communications and solutions within a system

PRACTICE TASK

Describe one pursue-withdraw loop you have seen anywhere, punctuated from each side in one sentence each.

CHAPTER 2

Homeostasis, feedback and the life cycle

Families, like any living system, strive to maintain a settled range of functioning that they call homeostasis. The term, borrowed from cybernetics, denotes the set of roles, relational distances, and implicit rules that keep the family operating within a familiar, if sometimes painful, equilibrium. When a deviation is detected, the system engages negative feedback, a process akin to a thermostat that senses a temperature shift and activates heating or cooling to restore the preset range. In the family context, the deviation may be a change in one member's behaviour, a new symptom, or an external stressor; the response is an attempt to bring the relational pattern back to its accustomed configuration. This explains why therapeutic work often encounters resistance that is not a matter of stubbornness but a protective mechanism: the system recognises the alteration as a threat to its known organisation and mobilises resources to counteract it. The classic illustration is the father who, after a period of heavy drinking, becomes abstinent. The family, whose daily rhythm has been organised around managing his intoxication, reacts by re-establishing old patterns—perhaps by increasing the mother's caretaking load or by the adolescent assuming a parental role—so that the overall equilibrium is preserved even though the original problem has shifted. The same principle operates in reverse; a previously anxious daughter who gains confidence may provoke a parent to develop somatic complaints, thereby re-balancing the family's emotional temperature.

Positive feedback, by contrast, amplifies the deviation rather than correcting it. When a small perturbation is reinforced by the system, it can spiral into an escalating cycle of behaviour and reaction. The classic escalation spiral illustrates how a parent's reprimand can provoke a child's defiance, which in turn elicits harsher parental control, each step magnifying the conflict. Yet positive feedback also underlies the creation of virtuous cycles, the very phenomenon that systemic therapists aim to seed. A modest change—such as a parent acknowledging a child's effort—can be magnified through the relational network, leading to increased cooperation and a broader shift in the family's interactional style.

The family life-cycle provides the developmental map that explains where and why these feedback loops become most salient. From the initial coupling of the parental dyad, through the integration of each partner's families of origin, the arrival of the first child, the renegotiations of adolescence, the launch of adult children, and the later stages of retirement and dependency reversal, each transition demands a re-organisation of the family's implicit rulebook. The work of Bowen (1978) on differentiation of self and the later elaborations by Carter and McGoldrick (1999) on family life-cycle stages underscore that symptoms tend to cluster at points where the system has not yet successfully navigated a transition. The adolescent's refusal to attend school, for example, often signals a failure to renegotiate authority and autonomy; the couple's conflict that erupts after the birth of a second child may indicate an unresolved integration of the parental roles established during the first birth; the depressive episode that follows the departure of the youngest adult child can mark a stalled transition to the 'empty-nest' phase. In each case the symptom is not a random pathology but a signal that the family's homeostatic set-point has been challenged and the system is attempting, through symptom-shifting, to preserve its existing configuration.

Understanding the distinction between first-order and second-order change is essential for therapeutic intervention. First-order change involves adjustments within the existing rulebook; it is the application of new behaviours that do not alter the underlying relational logic. A classic illustration is a parent who, faced with a defiant adolescent, intensifies curfews, imposes stricter punishments, or adopts a louder tone of voice. The system may respond by complying temporarily, but the fundamental rule—parental authority exercised through control—remains intact, and the negative feedback loop often re-establishes itself at a higher amplitude. This type of change is what Watzlawick, Beavin, and Jackson (1974) described as a solution that is itself part of the problem: the more the system is forced to act within the old parameters, the more entrenched the maladaptive pattern becomes.

Second-order change, by contrast, alters the rules that govern the system's behaviour. It is a transformation of the relational logic rather than a mere modification of actions. In the adolescent example, second-order change would involve the parents shifting from a rulebook of unilateral control to one that recognises the adolescent's emerging autonomy, inviting

negotiation, shared decision-making, and the co-construction of boundaries. When the rule changes, the previously problematic behaviours lose their potency because the context that gave them meaning has been altered. This insight, rooted in the work of Bateson (1972) on the double bind and later expanded by von Foerster (1979) on second-order cybernetics, underscores that lasting therapeutic impact requires a re-definition of the system's organising principles.

A concrete worked example illustrates the interplay of homeostasis, feedback, and life-cycle transition. Consider the Morgan family: John, a 45-year-old engineer, and Sarah, a 43-year-old primary-school teacher, have two children, Emma, 17, and Luke, 14. Over the past year, Emma has begun missing school, her grades have fallen, and she spends increasing amounts of time in her bedroom, withdrawing from family meals. The parents, interpreting the behaviour as rebellion, respond by instituting a stricter curfew, increasing the frequency of check-ins, and demanding that Emma complete her homework before any leisure activity. Emma's withdrawal intensifies; she begins to stay up later, skips meals, and eventually presents with a low mood that meets criteria for a moderate depressive episode on the PHQ-9. The family seeks therapy, hoping to restore Emma's attendance and academic performance.

A systemic assessment begins by mapping the family's homeostatic set-point. The Morgan family's equilibrium has historically been built on a rule of parental authority exercised through structured schedules and clear expectations—a rule that served well during the younger children's early years. The adolescent transition, however, represents a developmental hinge where the family's rulebook requires renegotiation. The therapist recognises that Emma's school refusal is not merely a symptom of individual depression but a signal that the family's homeostatic balance is being challenged. The parents' negative feedback—tightening curfews and increasing monitoring—aims to restore the familiar equilibrium, but in doing so they reinforce the symptom-shifting process: Emma's depressive mood serves to maintain the family's existing pattern of control, as the parents' heightened vigilance validates their role as the primary regulators of behaviour.

The therapist therefore proposes a second-order intervention. Rather than imposing stricter rules, the therapist invites the parents to explore a new

relational rule that accommodates Emma's developmental need for autonomy while preserving family cohesion. In a series of sessions, the parents and Emma co-construct a shared schedule that includes negotiated study times, agreed-upon leisure periods, and a collaborative approach to monitoring progress. The therapist facilitates a dialogue that reframes the parents' role from enforcers of control to partners in Emma's goal-setting, thereby altering the underlying rulebook. As the new rule takes hold, the negative feedback loop dissipates; Emma's depressive symptoms begin to abate, not because the therapist has directly targeted the mood, but because the systemic pressure that maintained the symptom has been released. The family's homeostatic set-point shifts to a new, healthier equilibrium that integrates the adolescent's growing independence.

This example demonstrates how homeostasis explains resistance and symptom-shifting, how symptoms cluster at a failed life-cycle transition, and how second-order change—altering the relational rules rather than merely the behaviours—produces lasting transformation. The therapist's role is to detect the point at which the family is stuck, to identify the feedback loops that sustain the current equilibrium, and to design interventions that either disrupt maladaptive negative feedback or amplify positive feedback in a way that reshapes the system's governing principles. The work of systemic pioneers such as Minuchin, Bowen, and von Foerster reinforces that change is most sustainable when it operates at the level of the system's meta-rules, the deep-seated expectations that dictate how members respond to deviation.

In practice, this means that clinicians must cultivate a keen sensitivity to the family's life-cycle stage and to the specific transition that is currently under negotiation. When a family presents with a cluster of symptoms—whether they be school refusal, marital conflict, or depressive relapse—the therapist should ask: Which hinge on the developmental map is being traversed? What rule is currently governing the interaction at this hinge? Is the system attempting to preserve its homeostatic set-point through symptom-shifting? By answering these questions, the therapist can decide whether a first-order adjustment (e.g., a temporary behaviour change) will suffice, or whether a second-order transformation of the rulebook is required. The distinction is not merely academic; it determines whether the therapeutic effort will merely dampen the symptom or will enable the family to move forward through the transition, thereby preventing the re-emergence of the same problem later in

the life-cycle.

The evidence base supporting these concepts is robust. Meta-analytic reviews of systemic family therapy (e.g., Carr, 2009; Pinquart & Shen, 2011) consistently demonstrate that interventions targeting relational patterns and rule restructuring produce superior outcomes compared with approaches that focus solely on individual symptom reduction. Studies employing the Family Adaptability and Cohesion Evaluation Scales (FACES IV) have shown that families with higher flexibility—an indicator of second-order change capacity—exhibit lower levels of distress across life-cycle transitions. Moreover, research on feedback loops, such as the work of Bartholomew and Horowitz (1991) on attachment and the intergenerational transmission of relational patterns, underscores how negative feedback can perpetuate maladaptive cycles unless a systemic shift in the underlying relational schema occurs.

In sum, the concepts of homeostasis, negative and positive feedback, and the life-cycle map together form a coherent framework for understanding why families resist change and why symptoms often appear at points where developmental transitions have not been successfully negotiated. Recognising that first-order change merely adjusts behaviour within an existing rulebook, while second-order change re-writes the rules themselves, equips the therapist with a powerful diagnostic and intervention tool. By aligning therapeutic strategies with the family's current life-cycle hinge and by targeting the systemic feedback mechanisms that sustain the equilibrium, clinicians can facilitate genuine, lasting transformation that moves families beyond the impasse of symptom-shifting towards a more adaptive, flexible homeostatic set-point.

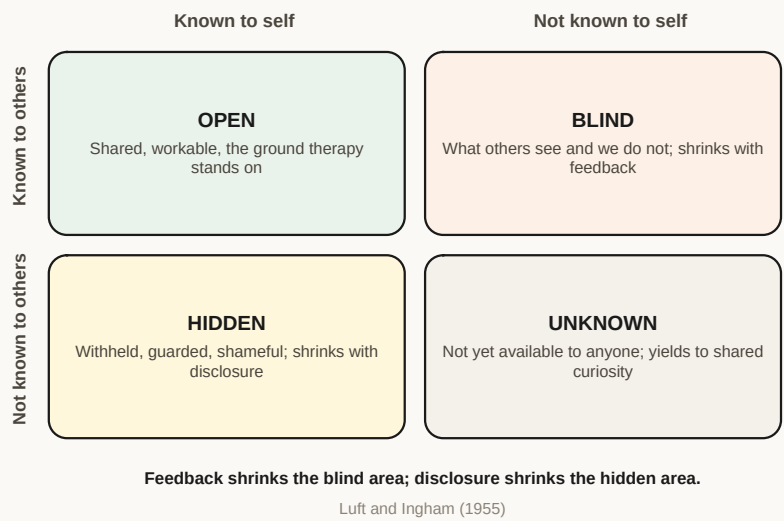


FIGURE 2.1 The Johari window

Luft and Ingham's window maps self-knowledge against what others see. Therapy and supervision both work by enlarging the open quadrant: feedback shrinks the blind area, disclosure shrinks the hidden area, and the unknown yields only to shared curiosity over time. It is a map of a process, not a personality test.

Points worth keeping

- Homeostasis explains resistance and symptom-shifting
- Symptoms cluster at failed life-cycle transitions
- Second-order change alters the rules, not just the behaviour

PRACTICE TASK

Identify which life-cycle transition a family with a school-refusing 13-year-old may be struggling to make, and one rule that may need to change.