Chapter 27
Healing Relationships: A Manualized Curriculum for Systemic Primary Care Physicians

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"Great teachers and therapists avoid all direct attempts to influence the action of others and, instead, try to provide the settings or contexts in which some (usually imperfectly specific) change may occur (Bateson, 1987, p. 254)*."*

27.1 Introduction

Seventy percent of medical problems have a significant psychological or behavioral component (American Psychological Association, 2017; Strosahl & Robinson, 2020). Primary care physicians are in a unique position to treat both the biomedical aspects of disease and to address patients' psychosocial context. However, because the dominant model of medical treatment and physician training in the United States is reductionistic and prescriptive, physicians frequently learn to treat patients out of the context of their families and primarily focus diagnosis and treatment on individuals. Because this biomedical model also promotes algorithmic and protocol-driven thinking, manualization of both treatment and training tends to focus on content and procedures and encourages rigid adherence by physicians.

Training primary care physicians to think and act systemically requires a radically different approach to training and the process of manualization. I will describe what a systemic family physician is, present the context of our training and treatment of families who are culturally diverse, experience economic poverty, and have limited access to health care, discuss our approach to manualizing, and present an overview of our manual. Then, I will present quality improvement studies and

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research related to our manualized approach and discuss the evolution of our manualization, which focuses on processes rather than procedures and attempts to balance rigor with the creative imagination essential to addressing the complex needs of faculty, learners, and families who have been marginalized by society.

27.2 Evolution of Medicine in the United States

Until the 1960s, general practitioners had been the cornerstone of American medical care. These physicians delivered babies, treated chronic disease, made home visits, and cared for the whole family as they lived and died. However, in the 1960s, the field of medicine began to change dramatically. Because of the rapid increase in new information about diseases, a surge in medical technology, increased pharmaceutical sophistication, and aggressive marketing strategies, medicine evolved into a number of subspecialties. Specialists became highly trained experts on a specific body part or organ system, and Americans wanted their expertise to ensure they received the best treatment. These changes generated considerable hope that medical science would discover cures for everything from cancer to the common cold. The dominance of germ theory, the development of antibiotics, and the creation of vaccines had become the heroic innovations that would control many of the infectious diseases that had plagued humanity for generations (polio, typhoid, smallpox). The American public soon believed they could live longer and healthier. They viewed pain and stress as daily inconveniences of modern life that could be eradicated by new medications, such as analgesics and tranquilizers. The medical-industrial complex was born.

At the same time that biomedicine flourished, the United States was in the midst of major societal challenges. The post-war generation had grasped the implications of the atomic bomb, watched the horrors of the Vietnam War televised daily, witnessed the violence of racism and the struggles of the civil rights movement, and understood the damage we were doing to the environment. Their vision of the world began to shift from a collection of disconnected nations, classes, and races to that of an ecosystem inextricably linked and in need of change.

In this context, disenchantment with biomedicine also grew. Cures for colds and cancers failed to materialize. The valuable doctor-patient relationship, a hallmark of the general practitioner era, was lost. A revolution among patients and physicians was brewing. A new medical specialty emerged to give physicians the breadth of training to deal with the substantial advances in modern medicine and to recapture the relational and holistic aspect that was so essential for health care. In 1967, the specialty of Family Medicine was created to train systemic physicians to care for the individual, family, and community. Similar changes also occurred in the mental health field leading to the birth of family therapy. Family therapists became natural collaborators with family physicians in developing clinical approaches and training programs (Bloch, 1983; Doherty & Baird, 1983; Saba & Fink, 1985).

27.3 Family Medicine

In the United States, training in the specialty of family medicine requires 4 years of medical school followed by a 3-year residency, during which doctors learn the broad spectrum of medicine: pediatrics, adult medicine, women's health, intensive care, emergency care, inpatient medical care, obstetrics, general surgery, and palliative care. They learn to practice medicine in both outpatient and inpatient settings. They become primary care physicians who provide continuity care for families, deal with most health issues, and only refer to other specialists when needed. Because 70% of medical problems have a significant psychological or behavioral component, family physicians also learn psychotherapy. To be clear, however, systemic family physicians are not psychotherapists or psychiatrists. Rather, they provide both biomedical and psychosocial care from a biopsychosocial perspective.

27.4 UCSF SFGH Family and Community Medicine Residency

In 1977, a group of systems-oriented physicians and family therapists, including Carlos Sluzki and Don Ransom, created a family medicine residency program at the University of California, San Francisco (Ransom & Vandervoort, 1973). They designed a 3-year residency curriculum that provided the requisite training in medicine and surgery. Within that program, they included a behavioral sciences curriculum that trained residents in systemic/relational therapy to care for families who are impoverished and marginalized (Sluzki, 1974).

Since its inception, our residency program has operated in a publicly funded clinic and hospital that cares for an urban underserved, multi-ethnic, multi-racial community that includes many refugees and immigrants, who often do not speak English. Most of our families have low health literacy, live in poverty, experience food insecurity, and have multiple, complex medical, and psychosocial problems. Many struggle to find affordable housing or live on the streets. These families exist on the margins of our society.

In the United States, physicians often learn medicine by treating people who have no other choice receiving their health care for public institutions. However, many of these physicians prefer then to care for insured patients upon graduation from residency training. Fundamental to our program's mission, we recruit physicians who choose to care for the families and communities we serve throughout their career. We train our physicians to expand their scope of treatment beyond the walls of the exam room and work toward healing their community, society, and world. They gain expertise in community health and political advocacy to address broad issues that influence health such as racism, poverty, violence, and climate change. They are committed to working for all forms of justice (e.g., social, racial, sexual, gender, and economic). Therefore, the 3-year curriculum teaches these

physicians to work systemically at multiple levels to maximize the healing process. We ask residents to consider "What is the pattern that connects" the beta cells of a child to the emotions of a father to the communication between the parents to the food insecurity of the family and community, to national immigration policy, and to the physician and team involved in their care?"

27.5 Behavioral Sciences Curriculum

Once the family medicine residency was created, Carlos Sluzki became director of its Behavioral Sciences curriculum. This curriculum focused on specific training for the intimate relational therapy work with individual, couples, and families who comprised the residents' primary care medical practices. From 1977 to 1982, he trained residents in the therapeutic approach he had helped create at the Mental Research Institute, and began to draft proto-manuals for that curriculum to assist residents in working therapeutically with couples.

Howard Liddle became director of the Behavioral Sciences curriculum in 1982, and I joined the faculty the next year. Together, we expanded the therapeutic model that residents learned to encompass the structural-strategic approach that we had been developing (Liddle & Saba, 1985; Schwartz et al., 1985). This approach was rooted in our training by and work with Salvador Minuchin, Braulio Montalvo, and Jay Haley. In addition to building the curriculum on the concepts of the structural-strategic model, we began to apply findings from two research projects that we were simultaneously conducting in the residency's outpatient clinic. One project explored families' experience with chronic illness and health, and the other was a National Institute of Health-funded randomized control trial on adolescent substance use and family therapy from a structural-strategic approach. This latter project was an incubator for Liddle's development of the highly effective, manualized Multidimensional Family Therapy model.

In 1986, I became the director of the Behavioral Sciences curriculum and began to grapple with codifying our therapeutic and training models. Over the next few years, we began to write more formal manuals that were specific to particular components of the curriculum. These focused manuals took the form of paper handouts which were distributed at the start of the particular curriculum.

27.6 Manuals, Epistemology, and Pedagogy

Articulating our epistemologic and pedagogic foundation was a necessary first step to more formally codifying our work. From the beginning of our residency, we had grounded our behavioral science curriculum in a systemic and relational epistemology. When Gregory Bateson's posthumous work *Where Angels Fear* appeared (Bateson and Bateson, 1987), it provided a new shift in our work. To counter the

mechanistic interpretations that people were making regarding systems (i.e., a system is an object that can be tinkered with), Bateson introduced the epistemology of the sacred. In the burgeoning field of systems-based medicine, we had experienced the same phenomena. The biopsychosocial model (Engel, 1977) was often interpreted as a guide for seeing the individual in context rather than multiple interconnected subsystems. Bateson's focus on the sacred seemed a valuable correction that we needed in our treatment and training.

Bateson described the sacred as the larger immanent mind, the pattern that connects, with its vast network of interconnections, circuitry of feedback, branchings and communication patterns of information wrapped up in a beautiful organized whole. He believed the sacred could repair the Cartesian tear in the fabric of life. However, by its very nature, the sacred eludes simple definition, because as Bateson believed "we never see in consciousness that the mind is like an ecosystem - a self-corrective network of circuits. We only see arcs of these circuits" (Bateson, 1979, p.8). Yet the sacred is available for our experience and awe, as it holds multiple dimensions of organization in its gaze and allows us to focus on the beauty of organizational process even in the face of pain, suffering, and death.

In addition to Bateson's work, we were also influenced by other systems thinkers whose work was pertinent to the community we serve. As our mission has always been to care for those families and communities which are historically disenfranchised and underresourced, we wanted to explicitly address how our physicians would interact in a just manner that would counter the oppression these families experience and not replicate oppression in our care of them. Paolo Freire's (1970) *Pedagogy of the Oppressed* and bell hooks' (sic) (1994, 2013) *engaged pedagogy* became influential in developing our anti-oppression and anti-racist therapeutic and educational approaches. The work of two systems thinkers and researchers, Chris Argyris and Donald Schön, also became a valuable resource for training physicians to engage in recurrent sequences of action and reflection (Argyris & Schön, 1974; Schön, 1983, 1987). All of these systemic and relational influences presented well-developed models of learning that aligned well with one another and emphasize learning is always a mutual process in the context of relationships that include ourselves, our learners, and the families and communities we serve.

In the 1980s, we also began the process of codifying the training program. An early step involved formally delineating specific goals and objectives for the various components of the 3-year training. We then transposed the research manuals of the structural-strategic treatment approach developed in our chronic illness and substance use studies to inform a curricular manual. This information provided an evidence base for our manualized clinical model.

Residents frequently requested a "how to" cookbook for a step-by-step approach to care for families. At this time, a substantive literature on the growing field of family systems medicine emerged. Don Bloch (1983) created the journal *Family Systems Medicine* (now *Families, Systems, & Health*) which served as a forum for mapping this new territory. Doherty and Baird (1983) offered a perspective of collaboration between the family therapy and family medicine fields, and followed with a volume of case studies demonstrating it in practice (Doherty & Baird, 1987). McDaniel

et al. (1990) published *Family Oriented Primary Care: A Manual for Medical Providers*. They discussed how primary care physicians could implement a family systems approach to various topics including conducting a family meeting, treating a couple, focusing on chronic illness, and life cycle stages, and ended each chapter with step-by-step protocols.

We found these resources useful supplementary material to our teaching, as they provided residents multiple examples of how physicians could conceptualize and treat families. However, we faced a continual challenge when residents read these publications. Frequently, the discussion and examples in this literature maintained an exclusive focus on the family, and did not demonstrate how to think of the multiple, interconnected systems inside and outside the skin of those in the family. Residents were vulnerable to the reductionistic approach common in the tendency of biomedical training, and were applying it to this literature. They were interpreting a more reductionistic perspective to the work (e.g., the family, not the individual, was now the object for assessment and treatment; the assessment did not include themselves, and understanding or intervening in social, political, and discriminatory systems was not part of their work).

Similarly, we faced a challenge from some of the literature emerging from the family therapy field that focused primarily on a narrow definition of family, an implied mandate to only seeing whole families in treatment, and a content-focused approach to clinical issues. For example, the cross-cultural literature of this time often involved delineating the typical behaviors of Black families or Asian families. Development literature described how families move through discrete, predictable life cycle stages, regardless of class, race, or other sociopolitical factors. While this literature offered important information and lent itself to being manualized and offering algorithms and protocols, such as the key things to know about treating Latino families or the stages of therapy with people who are refugees from a war zone (Hoang & Erickson, 1982; McGoldrick et al., 1982), the guidance was not systemic, could lead one toward a deficit rather than strength focus, tended toward overgeneralization and was unable to deal with the uniqueness and complexity of the families who came to us for care (Liddle & Saba, 1982; Saba & Rodgers, 1989; Saba et al., 1990). In any attempt to manualize our training, we knew it would require a format that was process rather than content oriented. For example, rather than talking about the expected changes in life cycle stages (e.g., leaving home), we shifted to asking: "How does the family I now care for move through this particular time of change, adapting and learning to internal and external demands?" Questions replaced statements. Rather than borrowing the emerging "how to" approaches, we needed to actively contextualize the literature on "family" to help residents recognize that the family was one key system and not the only one to consider in their systemic care (Saba, 1985, 2002a). It became important for us to develop a means of providing a systemic guide to the work of the family physician that was process oriented rather than protocol oriented, to counter the tendency to follow a mechanistic, algorithm for how to treat the families we served.

Shifts in therapeutic approach. In the late 1980s, based on our clinical experience, increased research on the physician/patient/family relationship, and Bateson's

epistemology of the sacred, I moved away from a strict structural-strategic approach and developed a systemic and relational treatment approach. This approach orients physicians toward acknowledging they are participants within the systemic mind, that is, within the sacred, and involved in a process of healing within a living organism, rather than acting as an outward agent who enters to cure disease. Adopting this stance requires physicians to radically and continuously remain vigilant to function "as a part of" rather than "apart from." The therapeutic effort includes asking everyone in the system (physician/family/others) to search for patterns, sequences, and interactions; identify strengths; co-create stories and reframes; engage in mutual learning, support reflection and action; think and act systemically; manage complexity and uncertainty; maintain humility; and work actively against oppression (Saba, 1987). Because of the tendency to learn an approach and apply it, we knew that a manual served the vital role of reminding residents of their correct place within the organism.

As we further drafted the manual, we reinforced that this approach was appropriate both for seeing couples and families and also applicable to any level of the system (within the individual; the community; the health care team; the training program; and larger social and political systems). Residents needed to see the connections among the multiple systems and decide whether at a particular moment in care they prescribe medication for asthma, work with the patient and partner who are in conflict, and/or write the landlord to ask for a move from the fifth floor to a first-floor apartment.

We also became conscious of how the language in the manual could unwittingly reinforce a more mechanistic way of talking about systems and systemic treatment. We needed to be careful that the explication of concepts and strategies did not lead to discussing families as if they were gears in a machine that should be tinkered with and manipulated. Therefore, we adopted more formally the language of the sacred, emphasized every person and family's uniqueness, focusing on the mutuality of the interaction, and used examples to help physicians envision a living organism that they and families were co-creating.

27.7 Manuals and the Sacred

In 1990, our Behavioral Science faculty shrank from three to one, due to severe budget cuts. I took this opportunity to write the first comprehensive and complete training manual to communicate the goals and processes of our curriculum and to externalize its development outside of me. This manual was the by-product of the mutually influencing activities of training, our clinical approach, and our research that had been co-evolving up to this point.

Working from an epistemology of the sacred raised its own challenges in the process of manualizing. According to Bateson, the sacred is not an object or a "thing" that can be delineated; it is a vast unconscious that cannot and should not be brought wholly into consciousness. Can we, therefore, manualize an approach to training and therapy that is grounded in the sacred? How do we ensure the rigor

needed to consistently teach physicians in our approach and also foster the creativity and beauty needed for learning and healing?

For us, manualizing is a methodology to guide residents and faculty to provide these contexts. Manualizing does not simply produce a written document nor a list of directives that uni-directionally tells the physician what to do to a family, at certain points in treatment, that must be rigidly adhered to in order to guarantee consistency. Rather manualizing serves as an anchor to help us rigorously keep our gaze on the sacred, rather than drifting into extreme reductionism. It serves to reorient us to the correct position in the systemic mind. Our manualizing is a living process, which provides a nodal point that reflects the co-learning within the relationships of the physician, supervisor, family, and the training program. It coevolves in an iterative fashion between theory and praxis, and in a sense, represents an ongoing research methodology. By manualizing, we are forced to state what we do, define it, and recognize its limits. The manual not only reflects what we teach, but is also an intervention, that impacts the faculty, the residents, the families, and other systems with whom we were interconnected.

Initially, we developed separate manuals—one for the therapeutic approach with families, another for the training of residents, and third for the training of faculty. However, we realized that all three activities were isomorphic and interconnected, as they were all based on a systemic perspective on learning and change (Liddle & Saba, 1985). Therefore, we moved from three discrete manuals to one meta-manual that could then be applied more specifically to each activity. For example, the meta-manual discusses the importance of mutuality of learning or the importance of recurring acting and reflecting. Then we have provided guidance on how those concepts operate in the encounter between the physician and the family, or between the faculty and the resident.

The manual is in constant flux and revision. Feedback from all three of these groups shape changes in emphasis or content. Changes in the needs of the community we serve may require a shift in what physicians may focus on at a particular point in time. For example, changes in immigration policy may result in some families becoming more fearful to engage in treatment and require physicians to focus primarily on relationship building and/developing specific skills that communicate an attempt to create as safe an environment as possible. Increased messaging in medical school for a particular generation of physicians that individually oriented therapies and/or antidepressants are the gold standard requires further attention to explicating the systemic epistemology and debating its clinical value. While clearly the manual is a map and not the territory, our process of manualization has always reflected the complex dance between the map, territory, cartographers, and travelers.

27.8 The Manual

Throughout the 3-year residency program, our physicians receive 300 h of training in our systemic and relational therapy approach. Teaching methods include lectures, seminars, live supervision, video review, and group reflection (see Table 27.1). The

Table 27.1 Number of hours of behavioral science curriculum for each resident

	Outpatient clinic	Classroom	Inpatient hospital	Hours
PGY 1	Linkage 60 h	Lectures and seminars 10 h	Behavioral health rounds 20 h	90
PGY2	Linkage 20 h Family care unit 55 h	Lectures and seminars 25	Behavioral health rounds 10 h	110
PGY3	Linkage 10 h Family care unit 55 h	Lectures and seminars 25	Behavioral health rounds 10 h	100
Hours	90	170	40	300

Table 27.2 Goal of behavioral science curriculum

To increase the capacity to rigorously assume and maintain a correct position in relation to the sacred that will ground learning of a systemic and relational approach to family medicine. To increase capacity, we need to:
1) Create liberating rather than oppressive relationships;
2) Experience the interconnectedness of life in which we are a participant in the ecosystem;
3) Search for the patterns that connect;
4) Engage in and encourage continual action and reflection within the system;
5) Foster respect, awe and humility;
6) Catalyze interactional processes that will link dislocated or disrupted relationships back to the systemic mind, the sacred.

manual is distributed to all residents at the beginning of their training and again at the start of each main component of the curriculum. Much of the training is done in small groups, so that the relationships among the learners and with the faculty and family become an added dimension that is addressed in the manual. The synergy among peers as they use the manual and see how they interpret it variably in practice often helps to inform needed changes in the approach. Residents are provided with an overview of the manual at the start of their training. The complete manual has moved from paper handouts to an electronic format and we introduce the manual progressively as they begin each component of their training over the 3 years.

The manual begins with stating the goal of the curriculum—to build physician's capacity to rigorously assume and maintain a correct position in relation to the sacred that will ground their learning of a systemic and relational approach to family medicine. To increase their capacity, physicians need to engage in a number of experiences that, as Bateson notes, are essential to learning and healing—become adept at catalyzing interactional processes that will link dislocated or disrupted relationships back to the systemic mind, the sacred. Table 27.2 highlights some of the experiences physicians will need to increase their capacity. We delineate how systemic physicians do not structure their practice as systemic therapists do. Therapists typically begin work with an individual, couple, or family focusing on a problem already identified by them or another professional, spend on average an hour for each session, and have

a limited time frame for treatment. Family physicians see people in continuity over years, in appointments that often last 20 min and can focus on multiple physical, emotional, and behavioral issues. Family physicians' relationships with families are built through various avenues (caring for a parent's diabetes; attending the delivery of a baby) and trust to address mental health issues is often already developed by the time they emerge; in addition, they can focus on preventing relationship problems in addition to treatment. Treatment strategies tend toward maintaining the physician-family relationship in order to allow families access to come for the breadth of care. Residents do not set ultimatums with patients (e.g., "If you are not ready to deal with your problems (e.g., depression, substance use, diabetes) please come back into care when you are ready."). Rather they learn to make small changes while working on other health issues and being ready to intervene when the time is right. Therefore, the manual clarifies that residents are not learning a twelve week, one hour per week, therapy model which is focused on a particular presenting problem. Rather it helps them learn systemic therapy principles and strategies to use in each visit. The manual provides guidance on how to be systemic whether the visit is twenty or 40 min and whether the strategies combine treatment of diabetes and family communication or have an emphasis of one over the other at any given time.

The manual then presents the core beliefs about the systemic medical model (Table 27.3) and the objectives of the Behavioral Science Curriculum (Table 27.4). Systemic-centered medical care expands beyond curing disease to include healing. Rather than seeing the physician as the expert who transfers knowledge to a passive family, it views both physician and family as having expertise. In biomedical care, the physician and the family unilaterally try to control the treatment process and protect themselves; the systemic approach envisions mutuality—of control, responsibility for the outcome, and protection. The goal of treatment is to optimize the mutual learning, growth, adaptation, and healing of multiple interconnected subsystems (e.g., family, physician, and training system).

Table 27.3 Core beliefs of behavioral science curriculum

Core beliefs about the systemic medical model include:
1) Refusing to participate in and maintain oppressive, racist structures and relationships to actively challenging them and creating ones that are collectively liberating;
2) Moving from a pathology, deficit-based assessment to a more strength and resilience-based approach;
3) No longer using reductionism as the only way to understand the disease, but including it as one tool alongside more complex, contextual methods;
4) No longer privileging dichotomous thinking or linear cause and effect, but moving toward both/and thinking, circularity, and complexity;
5) Recognizing the limits of certainty and accepting uncertainty, ambivalence, and ambiguity;
6) Valuing emotions as much as rational thinking;
7) Expanding beyond the bio-organic and physiologic processes within the patient's skin to exploring the social and interpersonal determinants of health, in particular appreciating the oppressive structures and institutional racism that negatively affect health;
8) Moving away from an external objective observer/intervener to a participant within the system.

Table 27.4 Objectives of behavioral science curriculum

1) Develop caring and trusting relationships that are collectively liberating rather than oppressive
2) Understand the influence of and address the socio-cultural determinants of health (racism, oppressive systemic structures, poverty, unstable housing, food insecurity, cultural beliefs)
3) Create contexts that foster mutual learning, development, adaptation, and resilience of the interconnected family, therapeutic, and training systems (e.g., deutero-learning)
4) Assess inter and intrapersonal interfaces and patterns related to health and illness
5) Construct a meaning-centered narrative
6) Foster reflective, engaged participation within the system
7) Learn relationship-oriented strategies for learning-joining, reframing, enactment, between session tasks
8) Utilize digital and analogic communication
9) Collaborate as a team, and specifically learn to work in an integrated way with therapists

27.9 Examples of Objectives from the Manual

The manual next delineates how one can develop competency within each objective and offers clinical examples. For example, for the objective of "**Develop caring and trusting relationships"** we have identified three areas of foci: (1) What skills will facilitate a patient/family's trust in the physician? (demonstrating empathy, offering support, instilling hope, expressing one's openness to questions and disagreement; following through on promises; acknowledging mistrust); (2) What skills are necessary to establish and maintain effective communication patterns? (revealing one's assumptions, using professional interpreters rather than family members, assessing health literacy). (3) What skills will convey that the physician cares about the family (overtly expressing their concern; active listening)? One of the clinical examples describes a family who expresses concern about receiving care at a public hospital. The family is African American and well aware of the historical experimentation on Blacks in the United States for scientific research. They wonder if the physician is only interested in them for learning rather than truly wanting to help. The systemic physician says, "I know that you are mistrustful of me, and that is understandable. I want to earn your trust. I truly care about you. Please let me know if at any point you believe I am not working towards your best interests."

Another objective in the manual: ***Foster a Reflective, Engaged Participation within the System*** also has three specific foci: (1) What skills will enhance everyone's consideration of each other's perspectives (reflect what one hears from each family member; circular questioning; double listening); (2) How can we focus on observable data that allows reflection, agreement, and disagreement about what we see and how we interpret? How can we identify the "difference that makes a difference" occurring in observable data, rather than at a distant point of inference? (3) What will foster a mindful presence in the encounter? (4) What skills will stimulate "reflection on action," which is the ability to reflect on something that has just happened (inquiring about thoughts and feelings regarding what family members have

just enacted; involving an observation team of colleagues)? and (5) What will stimulate "reflection-in-action" (reflect on one's own and/or other's actions)? One example involves a single parent and her 16-year-old daughter with retractable migraines which has resulted in missing school. The mother is recently unemployed, and the daughter has received a scholarship to transfer from the worst school, in San Francisco to the best, because of her intelligence and hard work. They are African American, and the mother wonders if the teachers are racist. The physician asks them to discuss together the daughter's concerns that her teachers are not supportive when she misses school or turns her homework in late. As they talk together, the mother becomes angry, saying she will go to the school to confront the teachers. The daughter becomes visibly nervous, touches her mother's hand and tells her to calm down. The mother raises her voice, reasserting she will go and defend her daughter. The daughter again tries to calm her down. The physician intervenes, describes what he sees, and asks what they were thinking and feeling.

Another objective, ***Utilize Digital and Analogic Communication***, encourages physicians to engage in verbal discussion as well as art, music, dance, poetry, and rituals. Physicians historically have the experience of verbal communication through conveying information and nonverbal communication primarily through physical touch. However, beginning to engage in more creative activities within a medical exam can be conceptually difficult to imagine. The manual provides guiding questions and multiple clinical examples. Questions include: What do you enjoy/or have you enjoyed doing? Who do you enjoy doing this with? How often do you engage in that activity now? Can we engage in that activity now during our visit (draw, sing; write a story/poem, look at pictures of loved ones, ask children and parents create a game (theme and rules), and then play at home/future visit. Various rationales are provided to suggest how analogic modes can be effective (access other dimensions of consciousness; change the tone in the interaction; connect patients/families to their strengths). The physician is caring for a woman from Cuba who has worsening diabetes. Their visits typically involve the physician talking about diabetes, medication, and recommendations to eat better and walk, and the patient agreeing. This visit the patient tells the physician that she was too tired to walk more and her husband, who is in the visit, agrees. The physician shifts to ask her what she used to do when she was more active. She replies that she and her husband regularly went salsa dancing. The physician, also a salsa dancer, begins to play a song on her IPhone and asks the patient to dance with her. As they begin to dance, the physician motions for the husband to join them. The couple then dances to another song. The patient smiles, saying, "We have not danced together for years; I now know we can." The couple begins to dance weekly and her diabetes improves.

27.10 Value of Our Manualized Training

How do we know if this manualized training and therapy approach is beneficial? And how can research inform the evolution of the manual? The experience of our graduates in practice provides real-world feedback for the manual. The American

Council on Graduate Medical Education, the national accrediting organization for medical specialties, independently contacts our physicians 3 years after graduation and inquires about the full range of the training (obstetrics; pediatrics), including psychotherapy. Annual surveys from 2016 to 2020 have found that 90% of our residency graduates have said they were well-prepared to provide psychotherapy compared to 86% of the graduates in family medicine in the United States who responded to the survey; also 87% of our graduates were still actively involved in providing psychotherapy therapy compared to 85% of the national respondents.

As part of our ongoing quality improvement process, we continually review the therapy training clinic experience (Family Care Unit) which then also shapes the manual. For example, once our physicians complete their rotation in this clinic, they continue to provide the patients and families systemic therapy and/or co-follow their therapy with our clinic's therapists. Resident's evaluations of the clinic reveal that the vast majority of patients and families they care for during this training clinic are substantially improved, and nearly all of the physician-patient/family relationships are improved. They note that they prescribe approximately 15% of their clinic patients' psychiatric medications. While this is low compared to 70% of those patients receiving medications in the national studies (Abed Faghri et al., 2010; Gill et al., 2010). This percentage has risen slightly in the last 2 years; residents attribute it to guidelines they learned prior to medical school and our county's health systems' metrics which are tied to funding. This trend has shaped the manual to include further focus on the risks and benefits of following current evidence-based guidelines regarding psychiatric medication which we have introduced at the beginning of their training.

Qualitative research also provides information to shape the manual. In a recent study using Stimulated Recall (Thom et al, 2016) families in our clinic identified that the quality of the physician-family relationship greatly affected their capacity for healing. Families said that to engage in the treatment, the physicians needed: (1) to demonstrate that they care for them as people, not just patients, (2) to show a sincere interest in the families' interpersonal context, and (3) to gain their trust to ensure they were not being used for experimental purposes. These findings lead to changes in the manual to highlight how physicians can specifically attend to these issues.

27.11 Recurrent Challenges

Qualitative research with residents about using the manualized approach revealed recurrent challenges they face.

27.11.1 Reductionism

While our physicians choose our training program because they fundamentally believe in a systemic approach, they are still susceptible to thinking reductionistically given that their medical school education remains based on a biomedical

reductionistic model. The dominant field encourages them to focus only on the individual level. The health care delivery system requires them to assign diagnoses to the individual, use screening measures and employ individually oriented treatment approaches. Residents said they were vulnerable to protocols that told them what to do when. “I know what to do to start treatment for hypertension; I just follow the algorithm. I know it’s not the same, but I sometimes want an algorithm on how to treat depression or what to do in a family meeting. Then I won’t make a mistake. Ultimately, I know that isn’t possible though.” Over the years, residents have wanted protocols for treating diagnoses that become highlighted in the field as important to attend to: trauma, substance use disorder, culturally competent care, interpersonal violence. Early in training, they also acknowledge thinking rigidly that systemic therapy only happens when you have a family in front of you. These concerns are most evident at the beginning of residency and begin to resolve in the third year in which they have more practice with our manual and the systemic approach.

27.11.2 Evidence-Based Treatment

When they hear about new evidence-based treatments (such as the Transtheoretical model, Cognitive Behavioral Therapy, Motivational Interviewing, Serotonin Selective Reuptake Inhibitors), residents report that they feel the urgency to learn about them and incorporate them into a 15-min office visits. The evidence-based medicine movement is a strong force in their medical school training. In residency, evaluation by faculty from other specialty departments, expected answers on their national licensing examinations, externally applied metrics for our clinic’s revenues, reinforce what they feel required, that they expect themselves to apply it to the therapeutic realm. Conversely, they also learn that if you do not have a proven treatment, then you should not ask patients about problems you cannot treat. Even if one suspects that there is a psychosocial issue that families are struggling with, if you cannot treat it with an evidence-based approach, you should not broach the topic. They report most influenced by this approach until the middle of their second year, when they have patients who do not fare as well as the research may suggest and as they have more skills themselves to work systemically.

27.11.3 Desire to Fix

Residents reported that the pressure to follow evidence-based treatments is intensified because they have a strong desire to “fix” their patients’ and families’ many medical and psychosocial problems. They consciously try to fix a problem in a lineal way. These epistemological pressures lead them say to us: “Tell me what should I do, step by step, to fix this problem.” They want the type of manualized algorithms or protocols that they see so frequently in their biomedicine for treating

hypertension or diabetes. These challenges particularly plague our physicians in the first 2 years of residency. We have increasingly shaped the manual to overtly address this tendency, which Bateson (1982) identified as "conscious purposiveness," that is, the desire to fix problems in a lineal way that often creates new problems. This tendency leads physicians to see only arcs of patterns and conclude that they represent the whole and are the only information needed to resolve health problems. Bateson cautioned that by treating arcs out of context, we risk ignoring other messages in the ecosystem, but by relaxing that arrogance of conscious purpose in favor of creative experience we can optimize the opportunity for real healing to occur.

We have used these findings from research with residents to include extensive discussions and examples of these themes in the manual.

27.12 Program Evaluation

Prior to and after finishing each curricular component of the behavioral science curriculum residents complete self-evaluations and evaluate the usefulness of the manual. Recent resident comments include the following:

- *"It is really great that what we are experiencing is guided by the manual, and also can change it. It's like we are creating the curriculum for the next group." (2nd year resident)*
- *"I really needed the manual at the beginning of 2nd year, just to know I wasn't missing anything; although I realize I was doing what was in the manual and more; so I was reassured. By 3rd year, I think it is just part of me now. I only really rely on it when I have a really challenging situation and feel stuck." (3rd year resident)*
- *"I was glad to see this at the start of training, because I get anxious if I don't know if I am going to learn everything I need to know." (1st year resident)*
- *"Looking back, it's interesting to see how we all act so differently from one another in the room with patients but still seem to be following the same principles. I really learn so much from seeing how differently we can work and still help." (3rd year resident)*
- *"I know what's in the manual, but I don't like reviewing it before the visit. I like doing first, then going back to the manual to put a name for what I was doing. That consolidates it for me." (2nd year resident).*

Comments on the use of the manual over the years reveal that residents vary greatly from those who want to rely on the manual with a methodical application of the approach to those that primarily want to know the principles, engage first with families, and then reflect on their experience by reviewing the manual with colleagues.

On the self-evaluations, the average change in score for residents from prior to and after completing the Behavioral Science curriculum is from 2.75 to 4.80 (on a 5 point Likert scale; 2017–2019). The residency program has an official body that

reviews all components of the training annually, including the Behavioral Science Curriculum, in part basing the review on the residents' anonymous of the experience. This review is conducted by the program director, residency faculty, and residents. In addition, our residency clinic has a Patient Advisory Council, which consists of a group of Family Health Center patients whose role includes evaluating the current treatment of patients and families and collaborating with the residency program to ensure training curricula are responsive to patients' and families' needs. Feedback informs any necessary revisions to the training and to the manual. Suggestions based on patient, resident, and faculty feedback have helped evolve the manual to remain relevant and responsive to clinical and educational needs.

27.13 Dissemination of the Manualized Curriculum

Given the continual evolution over the past several decades of a manualized approach and the reluctance of the medical education literature to include manuals, we have not published the manual in its complete form. However, we have disseminated several components of it, particularly once we have been able to research their value (Saba, 2017). Some of these components have also been adopted by other training programs. The Linkage Curriculum training, initiated by Sluzki in 1981, was disseminated (Saba et al., 6) and adopted by a family medicine program in New York City, which formally evaluated it and found it successfully formed trusting relationships with patient, residents, and faculty, effectively taught resident to integrate the family systems approach into patient care and provided a mechanism for faculty to monitor the learning needs of the residents (Williams et al., 2011). The inpatient Behavioral Health Rounds curriculum with qualitative analysis of its process (Saba et al., 2019) has been adopted by five family medicine and pediatric residency programs in the United States. A basic content-oriented toolkit covering 20 key issues for health professionals to consider in clinical care was incorporated into the medical student curriculum at UCSF (Saba et al., 2010), and then revised and included into the training of health psychologists at Università Sacro Cuore in Milan (Saita et al., 2011). Two components of the social justice training, an Anti-oppression curriculum (Wu et al., 2019) and an Antiracism toolkit (Edgoose et al., 2017, 2021), have been used in multiple residencies and health professional teaching programs with significant positive change among the learners. Faculty development programs have utilized the curriculum exploring physicians' model of medicine (Saba, 1999; Rydel, 2009) and the core beliefs and values of the family systems training (Saba, 2000, 2002b; Saba, 2002c; Hepworth, 2003). We plan to submit our complete manual to one of the newer online medical education platforms (MedEd Portal, Family Medicine Digital Resource Library) which have published some of our curricular components previously and may be interested in a disseminating a more comprehensive manualization of a program.

27.14 Manuals and the Pandemic

When the COVID-19 pandemic emerged in the city of San Francisco, our outpatient training clinic and our public hospital were at the center of the health department's response, and we needed to make immediate adaptations. We sheltered in place earlier than other major cities in the United States. Our resident physicians stopped seeing patients and families in person in the outpatient clinic, except for urgent problems and shifted to a telephone visit model of treatment. We moved most of our residents to our inpatient service and other hospital departments to care for patients who had or were presumed to have the virus. We had to drastically alter the behavioral science curriculum, because we no longer could see families in person; and telephone visits were challenging, given the limited technologic resources our families have (lack of phones, many requiring interpreters). As our existing curriculum relied on live supervision and video review of the visits in small groups, we struggled to design a meaningful replacement curriculum. We could not enact much of what we have manualized.

However, we believed that the manual represents a process more than a product and is continually adapting. The pandemic has been an unprecedented test of that hypothesis. Rather than only focusing on what we were unable to do, we returned to the core values and beliefs and then determined how best we could enact them given the current contextual possibilities and constraints (see Tables 27.2 and 27.3). We also actively outreached to our families who were the ones most devastated by the virus in our city. From both of these processes, we reaffirmed that fundamentally we needed to help residents and ourselves find the correct stance within the mind of the sacred, which included the coronavirus. We needed to maintain awe and humility in what we could do, in experiencing interconnectedness of life, and fostering relationships that were collectively liberating rather than oppressive.

We recognized that our families were facing disproportionate effects: Asian American families were facing discrimination for being identified with the cause of the pandemic. The Latin X families had a higher rate of positive test given that they could not easily shelter in place without losing employment and were in jobs that were of high risk, and the African American community was disproportionately hospitalized and having worse outcomes. Systemic racism, which the families we care, have faced for hundreds of years in the United States, was operating at multiple levels, from how it affected economic pressures to an already poor infrastructure to care for families who are marginalized. At the same time as the pandemic, with the deaths of George Floyd and many others, once documented and disseminated publicly, more Americans began to acknowledge the depth of racism in our country and its many adverse effects, none the least are related to health inequities.

While our residency's mission, our therapeutic approach and subsequently our manual have always been focused on creating liberating not oppressive or racist experiences or relationships with the families who come to us for care, we needed to help our residents implement this mission in the context of the social, political, and health issues that our families were dealing with. Our daily work became outreaching to those families and addressing their social needs and stresses. We found an increased ability to talk to family members of patients, previously unavailable

due to work, as more were also sheltering in place and available. We could talk to families who might be experiencing stresses of living for an extended time in close quarters (handling conflict in couples, with children, designing ways to safely discussing the risk of/and action physical and emotional abuse). In our group reflection rounds on our inpatient service, although we were in different locations in the hospital rather than in one room, served a much-needed purpose of helping learners deal with the stresses of caring for patients who were COVID-19+ and who could not see family members; fear of their own infection, and the inadequacy of what they expected to be able to do as physicians. In time, we have found ways to have "live supervision" in using a combination of telephone and video platform. We were able to talk much more readily with patients, families, and each other about how racism was affecting our decision-making and the quality of our care, and provide additional examples and considerations in the manual that furthered our anti-racist and anti-oppressive teaching and treatment.

While this remains a work in progress, we have taken the opportunity to identify what ways of clinical care and education we want to change, for the better, and what now feels more valuable than ever, as we are without it. The manual which required explicitness at all stages: values, beliefs, concepts, objectives, content provided a map for where we needed to find our grounding, what we could continue, what we must abandon, and what new possibilities existed. Without it, we would have had a much harder time in the crisis to determine the rapid changes in clinical care and teaching that were essential. Rather than scrambling to enact a rigid set of procedures in the moment of crisis, we found that the manual served its purpose: to resituate us in a correct position in the living organism of the mind, of the sacred, as we cared for those families most in need.

27.15 Conclusion

To provide meaningful treatment for those families who have been marginalized by society, who face many challenges, and who have many strengths, our experience suggests that systemic physicians can benefit from the rigor of manualizing that can focus everyone's gaze on the sacred, while providing the imagination to foster the humility, awe, and love needed for healing.

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