Building a Medical Family: Family Sculpting in Graduate Medical Education

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Abstract: *Introduction*: Family sculpting has been used as a clinical technique for decades within the psychotherapy community to uncover, process, and improve upon the implicit patterns of interaction and communication that permeate the lives of family members. However, even though this technique has been broadly applied to various couple and family populations within the clinical practice of family therapy, its application has essentially been non-existent outside of this venue.

Method: The following article describes the utilization of family sculpting as a bonding technique for a group of family medicine and clinical pharmacy residents, faculty physicians, and upper administration during a yearly organizational retreat.

Results: Not only was the technique well received by the healthcare team as a whole, as evidenced by a post retreat survey, there were also several noteworthy examples of the sculpting process highlighting and addressing relational tension within the residency cohort (*i.e*., second year medical resident) and within administration (*i.e*., chief executive officer) that ultimately lead to greater team cohesion afterwards.

Discussion: While the application of the technique in a medical/educational context can be considered a unique contribution of the article, more so are the specific augmentations made to the technique itself that increases its value as an academic and organizational development tool.

Keywords: Family sculpting, Medical family therapy, Integrated care, Graduate medical education.

INTRODUCTION

Owing its origins to psychodrama and experiential psychotherapy, family sculpting has been a staple for family therapists since its inception in the early seventies [1]. As a technique, sculpting is utilized during psychotherapy sessions when the entire family is present and where the therapist wants to assess and discuss implicit patterns of communication/interaction. Traditional family sculpting begins with the therapist designating one member of the group as the *sculptor*, typically the identified patient, who is then asked to arrange or *sculpt* the rest of the members in the room (*sculptees*) demonstrating their interpersonal relationships/interactions with one another [2]. This can be done through the sculpting of a specific event (*e.g*., a family argument) or through sculpting the general tone of the family. The sculptor goes about arranging each person taking into account everything from facial expressions (*e.g*., frown, smile, scowl), to body placement (*e.g*., open, closed, neutral), to gestures (*e.g*., finger pointing, clenched fist, waving), to how close each respective member is to one another. After the sculptor has finished, the psychotherapist invites the sculptor to discuss the arrangement of each person, and then goes on to facilitate a conversation amongst the larger group about the implicit communication/interactional patterns accounting for that arrangement.

Sculpting derives its greatest benefit from the exposure of the sculptor's perceptions about the group, their relationship with each member, and the members' relationships with one another. Typically, the sculptees rarely agree with how they are arranged, which in turn highlights the underlying incongruity that accounts for most, if not all, of the family's relational tension and difficulty [1]. Once this implicit pattern is highlighted, the family therapist and group can focus on augmenting these interactions to the benefit of each member individually and the family as a whole. Essentially, the technique functions as a group projective psychosocial assessment [1, 2].

Family Sculpting and Healthcare Education

Outside of its use as a clinical technique, sculpting has also found its way into medical education as a tool where students can explore family dynamics (personal and fictitious) related to illness, dying, and death [3]. However, given the intended purpose of the intervention, the spatial representation of patterns of relationship and communication [4], the utility of this intervention outside its use in the context of family for family-specific interactions has been explored sparingly

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[2]. Just as sculpting brings implicit patterns of family communication and interaction to the forefront so they can be explored and discussed, sculpting also has the potential to achieve the same effect when it comes to the communicational and interactional patterns of professional practice groups [2].

METHOD

Sample

AHEC Family Medicine Residency Program. The residency program where sculpting was utilized is housed within an Area Health Education Center (AHEC) and comprised of a combined allopathic/osteopathic (MD/DO) family medicine residency as well as a clinical pharmacy (PharmD) residency. With these programs, the total number of residents at any given time is 26; the family medicine residency has eight physicians per cohort, and the clinical pharmacy residency runs for one year with up to two pharmacy residents. It is important to mention both programs since the residents (physician and pharmacist) attend the same orientations, some of same didactic rotations, practice team-based clinical care together throughout their specific residency experiences, and attend the same retreat and bonding events. As with the residents, faculty composition at the AHEC is equally varied with seven full time faculty physicians: MDs and DOs (1 as residency director, 5 dedicated to resident education and 1 as the manager of the electronic health record system), one faculty doctoral level behavioral scientist: PhD (a licensed marriage and family therapist), and two faculty doctoral level clinical pharmacists: PharmD.

Sculpting

The sculpting exercise took place during the yearly resident retreat. Prior to the exercise, the behavioral scientist facilitated a discussion about communication and relationships with a heavy emphasis on implicit communicational patterns. The focus of the discussion was purposeful since it was used to *prime* the audience to start thinking of communication more broadly than only their verbal exchanges with one another. Also, due the pedagogical and epistemological differences between medicine and the social sciences [5, 6], the context of communication and relationship was discussed in terms of healthcare teams as well as likened to the biological systems within the human body. Utilizing these metaphors allowed the participants to more easily relate to the information being presented.

Priming. The sculpting process began with the facilitator (*i.e*., behavioral scientist) separating the 36 participants into three groups of twelve with each group comprised exclusively of *sculptors*, *sculptees*, or *observers*. Each group was made up of family medicine and pharmacy residents, faculty, and organizational administration. After separating the participants and prior to beginning the exercise, the facilitator explained that the purpose of the activity was to allow the participants to see how they are viewed within the context of their professional relationships. The emphasis on the professional nature of their relationships rather than on the interpersonal was important since the residents spend considerable time with one another outside of their student/physician responsibilities. So, it would be easy for aspects of their personal relationships with one another to bleed into the sculpting process thereby decreasing the effectiveness of the exercise as intended. However, by setting and reminding the participants that the boundaries of the exercise were around that of their professional interactions, the likelihood of this interpersonal bleeding effect was minimized.

The Actors

Sculptors & Sculptees. As with the traditional sculpting exercise, sculptors were given 15 minutes to arrange the sculptees in any way they saw fit keeping in mind their professional relationships with each person [1, 2]. It was emphasized that everything must be taken into account when arranging the sculptees from the positioning of arms and legs, to physical proximity to one another and the entire group, to facial expressions, to the specific activities they were depicted engaging in. It is important to mention that the sculptors were not given specific directions related to the activity the sculptee was to be engaged in (*e.g*., a patient encounter), only that it needed to relate to their professional responsibilities. Sculptors were also asked to work together as a team to sculpt rather than engaging in the process alone, which differs from the traditional activity [1]. In this way, the emphasis on team work, team process, and communication was carried throughout all aspects of the activity.

Observers. The third group of twelve participants was charged with paying attention to and commenting on the process of the sculptors as they worked together to arrange the sculptees. Observers were asked to pay attention to how long it took the group to sculpt each individual as well as how the sculptors arranged

themselves throughout the process (*e.g*., who took the lead, who rarely spoke, whose ideas where dismissed). Periodically throughout the exercise the facilitator would check in with this group and ask them to comment on the processes they observed, along with comments related to how they thought the internal processes of the sculptors, as a group, were impacting the sculptees' arrangement.

Processing

The main deviations from traditional sculpting were most apparent during the processing phase of the activity. After the sculptee group was arranged, the sculptors were then asked to go around to each sculpted individual and explain the arrangement as well as their thoughts regarding the process of sculpting this particular person [2]. After their explanation was offered to the entire group, the observers were then asked to comment on anything of importance that they noticed, as well as if they would change anything in regards to the positioning of the person being commented on. If changes were suggested, the observers then went to the person, rearranged their respective position to accommodate those changes, and subsequently explained their reasoning. After the comments on and rearrangement of the sculptee by the observers, the sculptee was then asked about their thoughts regarding their positioning as well as any changes they would like to make. If changes were suggested, the sculptee was asked to rearrange himself or herself to accommodate the change and subsequently explain their reasoning in a similar fashion. This same process was then repeated for each member of the sculptee group with the entire processing phase taking 20-30 minutes. At the conclusion, each group then rotated to the next role to repeat the entire sculpting exercise.

The specific and most important augmentations to the activity were: the comment period, subsequent rearrangement of the person by both the observers and themselves, and the following discussion of that rearrangement. The purpose of these augmentations was to explicitly showcase not only how others viewed the person being sculpted but, more importantly, to show how divergent those views might be when contrasted against the sculptee's own professional self-view. This particular part of the exercise lead to several very revealing arrangements and rearrangements, and provided a perfect venue to discuss several misunderstandings that had been creating tension within the larger group.

RESULTS

Noteworthy Examples

Chief Executive Officer (CEO). A particularly interesting example of the effectiveness of this exercise centered around how the CEO was sculpted. Initially, the sculptors placed her in front of everyone with her hands on her hips looking out as if she was *surveying* the landscape. When asked to describe why she was arranged in this particular fashion, the sculptors commented that she was the organization's leader and thusly was ultimately responsible for *forging ahead* with everyone following *behind*. A discussion then followed about what this meant in regards to her day-to-day interactions, of which everyone replied that they had little personal contact with her with the exception of the residency program director. When the observers' were then asked to comment on her arrangement and suggest changes, they had the CEO stay in the same position but had her stand atop a chair to denote that she was *above* everyone else in the organizational hierarchy. They commented that this was done not only to denote her standing at the top of the organizational hierarchy but was also a metaphor for her *control* and *power* over the organization.

However, the most surprising and telling part of this particular interaction was how the CEO rearranged herself and subsequently explained the reasoning behind that rearrangement. When asked, the CEO promptly stood down off the chair and laid at the feet of the program director and rest of faculty. She explained that rather than being unilaterally in control and dictating how things should be within the organization, she saw herself as being beholden and responsible to the faculty and residency program in supporting them to best of her ability- a stark contrast to the previous two versions.

Second Year Resident. Another noteworthy example came with the sculpting of a second year resident. The sculpting group placed him in the corner of the room with his back to the rest of the group and his head down. When asked by the facilitator to comment on why they had placed him in this position, they remarked that he, "Always seems to be in his own world." When the observers were then asked to comment, they remarked that they had no changes to make and agreed with the sculpting group's placement and assessment. It is important to note that this was one of the only instances where both the sculpting and observer groups agreed.

When the second year resident was asked if they had any changes to make, he re-oriented himself towards the rest of group with his head slightly up but maintained his relative position outside of the rest of the group. When asked to explain his re-orientation, he stated that while practicing medicine he constantly felt like he was "falling behind" and "needed to stay on top of things," which in turn meant that he devoted much of his time to focusing on the task in front of him. However, he also commented that because of his need to devote so much focus to his work and the subsequent decrease in his overall interaction with the larger group, he more often than not felt like an outsider.

DISCUSSION

As with traditional family sculpting, the most critical portion of the exercise, the processing phase, was also the time where acrimony and disagreement was most likely to manifest. Given this potential for emotional volatility, it was incumbent for the facilitator to constantly gauge the tone and tenor of the conversation between the participants and explore specific comments when necessary. A prime example of the need for this conversational exploration was during the explanation of the second year resident's placement and subsequent statement of him "being in his own world." After this comment, it was apparent that not only did the resident not know he was viewed in this particular way but also seemed to be offended. Recognizing this, the facilitator then engaged the sculptors and observers in a conversation as to whether or not the resident's perceived disconnection with the rest of the group was a problem. When the group answered in the affirmative, the facilitator asked more probing questions as to why this was the case, which in turn lead to the group stating that they valued the resident's thoughts and clinical skills and felt deprived when he was not fully engaged. The resident's affect clearly changed after these comments, and not only did he voice understanding of their concerns but went on to clarify his own actions, which ultimately resulted in a more fruitful conversation than had the sculptees' original statement gone unexplored.

Another consideration in using sculpting in this context is the need for the facilitator to adequately prime the audience to engage in this type of experience [2]. As previously mentioned, the sculpting exercise was subsequent to a brief didactic session (30 minutes) on the nature of communication in interpersonal relationships, which was couched within medical terminology that the audience was familiar with. The importance of arranging the information in this way was to help the audience relate to the material, which in turn kept them from summarily rejecting the exercise and its premise. While healthcare professionals might be familiar with terminology related to the psychosocial field as well as the clinical application of some techniques/principals (*e.g.*, empathy, motivational interviewing, cognitive behavioral therapy), engaging in this type of experiential exercise may be a first for many. Also, while medical education may be starting to place a greater emphasis on the emotions of patients [7], there remains a paucity of concurrent emphasis on one's own emotional state as a physician and/or player within the larger healthcare team [8, 9].

Although healthcare teams are designed for specific professional purposes, the elucidation of perceived relationships and interpersonal patterns of behavior offered by sculpting can and does lead to improved care delivery. It is worth mentioning that a week following the retreat, a survey was given to the participants where they were asked to comment on their overall experience. Many who returned the survey commented specifically on the benefit of the sculpting exercise with one respondent stating that the experience had changed, in a positive way, how they viewed many of their colleagues. That statement best exemplified the success and purpose of the exercise, to carefully highlight and make explicit the implicit so all involved could feel more understood and ultimately better coordinate their actions as a care delivery system.

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