Special Article

Parallel Process in the Family Medicine System: Issues and Challenges for Resident Training

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ABSTRACT

This article uses the concept of parallel process to examine resident training as one component in a system of interlocking relationships. Parallel process is defined, and its applicability to the dynamic exchange of help-seeking and help-giving behaviors which lies at the core of the health care system is examined. The concept of stages or phases in parallel process development next is explored. A relational model for optimal functioning between resident-patient and attending-resident is proposed, as well as an illustrative examination of one of the more problematic issues which a parallel process analysis can bring to light. Therapeutic interventions to enhance help-giving and help-seeking at different levels of the system are defined and analyzed, and educational implications for resident training are summarized.

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Models of Resident Education

Resident training comprises one of the essential functions of family medicine departments. Like the practice of medicine itself, its execution derives from a variety of different models. For example, both patient care and residency teaching are still sometimes characterized by a unilateral model, which in the former instance has been labeled "physician centered"[1] and in the latter might be called "attending centered." In this model, resident education becomes a one-way flowing of information from the attending into the essentially passive receptacle of the resident.[2] Other models in both patient care and resident education acknowledge the interactive, relational nature of the exchange.[3] In both cases, however, the object of attention is generally restricted to the doctor (resident)-patient dyad.[4]

More recently, theoreticians have assaulted the "illusion of the dyad in medical practice."[5] Instead, the concept of the therapeutic triangle has been substituted, in which the traditional doctor-patient relationship has been expanded to include the family as well.[6] It is possible to think analogously of resident training as encompassed by a kind of educational triangle, consisting of resident-patient-attending (Figure 1). While the specific interactions themselves tend to be dyadic (resident with patient, resident with attending), on another level the relationships explored are actually more likely triadic in nature. For example, the attending and resident are generally focused on the (absent) patient. Resident and patient often find that their interaction symbolically will include the attending as well.

It is this potential triangulation[7] of patient between resident and attending, or attending between resident and patient which may contribute to dysfunctional relationships. The attending, for example, may use the patient's purported needs and feelings to discharge personal issues toward the resident; while in encounters with the patient, the resident's need to please the symbolically present attending may affect the genuineness of the exchange.

In fact, resident training occurs as simply one facet of the coming together of at least two large and complex systems --that of medicine and that of the patient's family.[8] While this article cannot hope to examine all the dimensions and ramifications of this union, or more often collision, of systems, it focuses on the above-mentioned triangle, acknowledging with Doherty and Baird[5] and Haley[9] that the three-part system is the most efficacious in the analysis of multilateral relationships.

Parallel Process

The theoretical construct used here to advance this interpretation of resident education is that of parallel process. This term, which is derived from psychoanalytic analyses of psychotherapy supervision,[10] has been technically defined as a situation in which the trainee "unconsciously identifies with the patient and involuntarily behaves in such a manner as to elicit in the supervisor those very emotions which he himself [sic] experienced while working with the patient but was unable to convey verbally."[11] Thus, the supervisor (or attending) may end up interacting with the trainee (in this case, the resident) in much the same way that the resident is interacting nonverbally with the patient (or wishes to interact with the patient).[12]

For example, the resident may feel angry toward a patient he or she perceives as inappropriately clinging and demanding. Although this feeling will not be overtly expressed to the patient, the resident may behave in such a manner toward the attending as to elicit responses of anger and frustration in

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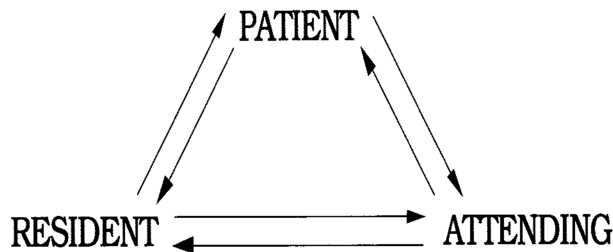
Figure 1

The Educational Triangle in Family Practice



this individual. In this way, without conscious awareness, attending and resident act out the conflicts and tensions of the resident-patient relationship.[13] The resident may also express toward the attending feelings that remained concealed from the patient because of their lack of safety.[14] In this case, although the anger is primarily directed toward the patient, the resident may adopt a hostile tone in presenting the patient. The attending unconsciously then may become enmeshed in the interactions, automatically responding to the resident's anger either in a placating or an aggressive fashion.

Using a somewhat broader definition, parallel process implies that problematic behavior in one member of the system runs the risk of producing either an excessively sympathetic, enmeshed response (essentially duplicating the behavior) or an antipathetic, distancing counterresponse. The parallelisms occur either as an imitation of the dysfunctional initial presentation or as a mirror reflection (its opposite). Thus, the parallel process referred to may be either a replication in one member of the triangle of behavior observed in another member or a counterreaction to that behavior.

This conceptualization of parallel process is closely related to, and indeed may be considered a subset of transference and countertransference phenomena which Stein[15] and others[14] have identified as operating in the doctor-patient relationship.

The parallel process model appears to add to our understanding of these phenomena in that it emphasizes the parallel or similar hierarchies of response which can be elicited from a systems perspective, involving not only resident and patient, but attending and resident as well. Stein has referred to this rippling effect as "cascades,"[16] which vividly captures the multiplicative effects such parallelism can have throughout the system. Essentially, the model implies that all members participating in the system are subject to similar affective experiences and reactions. Thus, the parallel process model highlights the commonalities and shared experiences of all system participants from an educational perspective.

The Necessity of Role Redefinition

Most traditional analyses of doctors and patients have emphasized the distinctions and differences between these two roles. Terms such as "attending," "resident," and "patient" further exacerbate this exclusionary impression. According to this way of thinking, these entities are necessarily dissimilar and separate. Each has unique needs, values, and priorities; each needs to be analyzed and understood in distinction from the others. This categorical approach makes a clear contribution to our understanding of the discrete dimensions of some of the available roles involved in the health care system.

In part, however, the assumption of dichotomous roles is made to help protect the one "rendering help" (and therefore the one supposedly in charge) from some of the anxiety and fear inherent in a situation of vulnerability and limited control. While the assumption is intended to facilitate optimal patient care, and often does by beneficially controlling the care giver's emotional involvement, it may also have dysfunctional implications for both patient care and teaching. For example, the sense of "otherness" produced by the assumption of role uniqueness can lead to a lack of empathy and sensitivity for the patient's most important priorities. It may also result in a distortion of what residents are taught is truly important in terms of adequately fulfilling their professional roles.

An alternative assumption states that an underlying emotional humanity exists which inexorably links attending, resident, and patient, and which makes it likely that the fear, defensiveness, or anger in one member of the system has the potential to be reflected in the other members as well. Parallel process analysis illuminates for all members of the educational triangle core themes of their experience which they share. It helps us to see not rigid, dualistic roles of resident, attending, and patient, but more fluid, interchangeable notions of help-seeking and help-giving, which at various times and under various circumstances are applicable to all participants in the system.[17]

In this model, the patient enters the health care system primarily as a help-seeker.[18] However, the patient also frequently participates in the role of help-giver, both in terms of providing information and, on occasion, emotionally supporting and reinforcing the physician. The attending's role is defined primarily as a help-giving one (addressing resident fund of knowledge needs, management needs of patient). But the attending also can enter into the help-seeking role when baffled by a given set of circumstances that require problem-solving help from resident, patient, or others within the larger system. In this triad, the resident literally plays a pivotal role. From one perspective, the resident is a miniature attending, imitating the attending's help-giving functions. Turned the other way, the resident becomes patient-like, seeking help from the attending for confusion and pain. It is this role flexibility, built into the heart of the training system, that makes parallel process such a fruitful concept to explore.

Help-Seeking and Help-Giving: Complementarity and Conflict

Help-seeking and help-giving in this context are both based on an "intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate development of therapeutic competence in the other person."[19] Help-seekers and help-givers, whether they be attendings and residents or residents and patients, come together in an effort to apply the knowledge and insight of one to address the confusion and suffering of the other.

The primary function of help-giving must be the monitoring and protecting of the help-seeker's welfare. Other help-giver functions may include enhancing the help-seeker's sense of personal responsibility, promoting help-seeker transition from poorly to well-informed, and encouraging creative problem-solving in the help-seeker.[20] Help-seeking, on the other hand, implies a willingness to address problems or symptoms, the receptivity to acquire knowledge or understanding, the readiness to seek out help from those with special expertise and to apply their suggestions in a self-help mode, and the ability to master or cope with new input.[21]

However, in addition to these positive and complementary functions, there are more problematic issues in both the help-giving and help-seeking roles which may diminish their effectiveness in pursuing a shared goal of healing. Help-givers may fall prey to delusions of omnipotence or the necessarily futile pursuit of perfection. They may exploit the power they hold over help-seekers by using them as "guide dogs through minefields,"[22] meeting their own needs and anxieties under the guise of rendering service to another. Help-seekers, on the other hand, may easily succumb to feelings of helplessness, inadequacy, fear, and loss of control. The needs and anxieties inherent in the system have the potential to lead to power struggles[23] between help-seeker and help-giver. Thus, the initial lofty aims of the health care system may easily become constrained by such dysfunctional responses if they operate in the system in an unconscious and unmanaged fashion.

Stages in the Help-Seeker—Help-Giver Relationship

It is theorized that both the resident-patient and attending-resident relationships may evolve through a variety of stages or phases.[24,25] Help-seekers and help-givers may be functioning at any of these phases at a given time, and it is not unusual to observe motion back and forth among the various stages in a given individual. It is most likely that the different members of the system also will be exhibiting characteristics of different phases at the same time.

Stagnation/Denial

One early stage has been identified as that of stagnation or "stuckness," which often occurs in response to some kind of crisis within the triadic system. In this phase, help-seekers, whether residents, patients, or attendings, may deny any problems either in the content or the process of their interactions with their designated help-givers. Residents may refuse to recognize fund-of-knowledge deficits; patients may avoid the implications of a serious diagnosis; attendings may ignore cues that they are not succeeding in communicating with particular residents. Each may struggle against the awareness that a significant problematic element has emerged in the equation. They strive to maintain "business as usual," despite baffling and distressing developments. For example, a patient may continue to worry about the adjustment of high blood pressure medication after receiving a diagnosis of cancer. In this stage, help-seekers tend to become either excessively dependent, relying on the apparently boundless expertise of the resident or attending to "rescue" them from impending crisis, or counterdependent, denying that the parameters of the situation have been permanently altered. In this phase, the help-giver is variously revered or viewed as irrelevant.

From the help-giver perspective, whether attending, resident, or patient, there may be a lack of awareness that any problems exist, a stale reiterating of techniques or information without attention to relevance for the receiver. Like the help-seeker, they are afraid to recognize that, at some level, a shift has occurred, calling for the application of new paradigms.[25] A resident may persist in eliciting a medication allergy history after a patient has expressed suicidal ideation. In a fashion similar to help-seekers, they respond to the challenge of unexpected or overwhelming circumstances either by retreating into withdrawal and helplessness or by assuming a facade of pseudo-expertise. For the help-provider, there is a determined plodding along well-worn paths, but with an increasing lack of efficacy. Creativity and compassion as expressed relationally may seem to have disappeared. There is avoidance of input from the care-seeker which might challenge the existing homeostasis.[27]

Chaos/Confusion

Next can come a period of confusion and lability for both help-seekers and help-givers. There is instability, fluctuation, conflict, and ambivalence. Often there is a crisis point at which attendings, residents, and patients alike must acknowledge that their standard modes of coping are inadequate to the demands confronting them. Help-givers must deal with the recognition and acceptance of their own limits to creating therapeutic conditions, while help-seekers must deal with anger and disappointment at help-givers for not being able to rescue them completely from their own suffering and for intentionally or involuntarily revealing their own limitations.

All participants in the system wrestle with issues of human fallibility and imperfection,[28] and often experience guilt at their own shortcomings or anger at the shortcomings of others. This phase is one of great anxiety for patient, resident, and attending alike, because of its inherent flux and lack of framework. However, it can also be an opportunity for great creativity and personal development.

Integration/Resolution

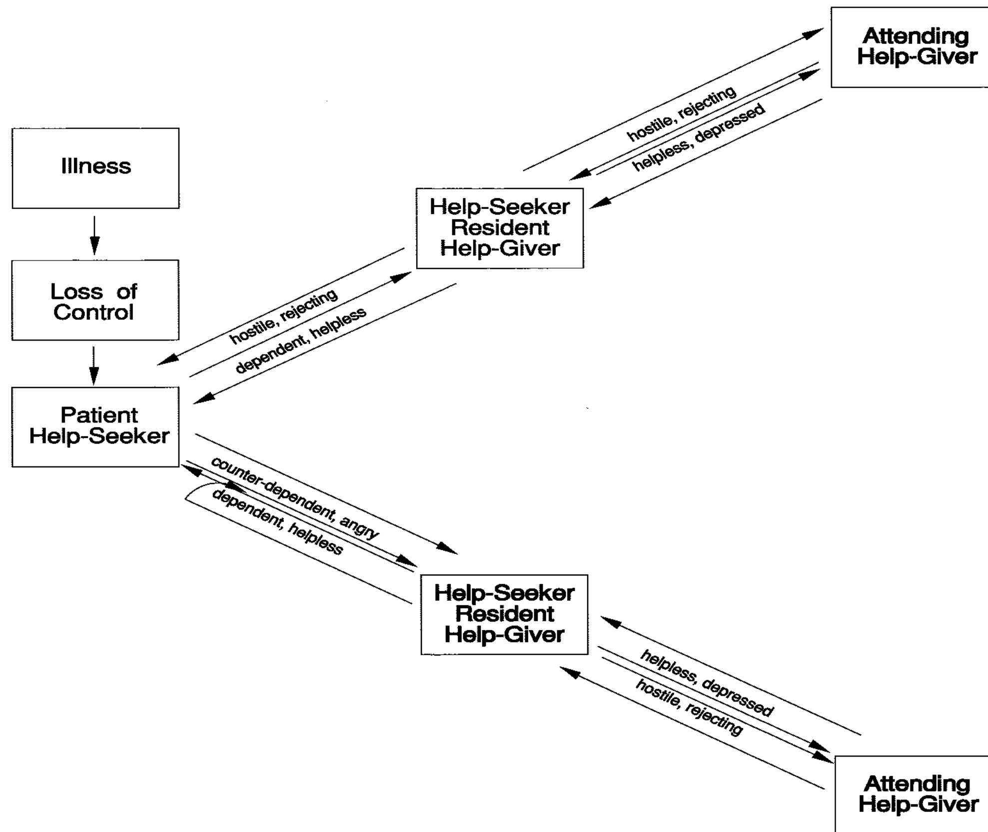
Finally, one may observe a phase of integration and reorganization, in which help-givers and help-seekers are able to enter more willingly and comfortably into each others' realities, in which boundaries between roles become more fluid, in which they can accept their limitations without guilt and have a certain trust in their responses and abilities. There is at this point a quality of personal security and a realistic and accepting view of both self and others in the system.

Problematic Parallel Process Issues

Several potentially problematic issues exist within the triadic system of patient, resident, attending--themes of dependency, authority, trust, and anxiety due to vulnerability and loss of control, to name only a few. Such issues have been thoroughly identified elsewhere.[29] What is sometimes overlooked, however, is the parallel nature of such problems. Thus, the resident frustrated by a difficult patient[30] in turn may become an equally difficult and frustrating resident to the attending.[31] The resident's efforts to distance from and contain the patient also may be replicated by the attending's efforts to distance from and contain the resident. An interpretation which takes into consideration the commonalities of these issues and responses provides a framework from which to consider more systemically oriented solutions.

Figure 2

Parallell Processes Activated by Loss of Control in Response to Illness



Control and Loss of Control: An Illustrative Problematic Issue

The parallel process model suggests that, rather than identifying particular problems for patients, for residents, and for faculty in separate categories, it is more helpful to identify thematic issues which are systemic in nature and which apply to all participants in one form or another. The illustrative issue considered here focuses on control and loss of control in the educational triangle previously identified. This issue is illustrated thematically in Figure 2.

Issues of control and loss of control are paramount in the relationships of resident, patient, and attending. Patients and residents alike, in their initial entry into the health care system, identify certain problems, deficits, and pains which they cannot master on their own. These become the impetus for seeking help. In the role of help-seeker, both patients and residents share the anxiety stemming from an essentially imposed, unsolicited relationship.[20,32] Unlike an elective procedure or an optional consultation, external circumstances compel the patient to seek medical attention and the resident to seek attending feedback and approval. By definition, both relationships contain an inherent power imbalance in favor of the help-giver. The help-seeker also must confront the psychological stress arising from the direct proximity of vulnerability, loss, chronic impairment, even impending death. Thus, the help-seeker struggles with feelings of resentment or fear, both toward the vulnerability of his or her condition and toward the power the resident/physician suddenly appears to exercise over the help-seeker's well-being.

Responses to the anxiety generated by the role of help-seeker are varied. Behavioral manifestations of withdrawal, passivity, tentativeness, defensiveness,[33] overenthusiasm, argumentativeness, concealment, and compulsive talking[34] may at times characterize all participants in the system. Some help-seekers, whether patients, residents, or attendings, may overtly reject this role and attempt to exert total mastery over their environment. These can be patients determined to prescribe their own medications, residents who refuse attending consultation, or faculty who exhibit excessively unilateral or dogmatic behavior. Others take exclusive refuge in the helpless, dependent characteristics of the help-seeker role, seeking a sense of safety in the conviction that nothing is expected of them. Such dependency is seen in the patient who is exaggeratedly clinging, the resident who requires guidance at every point of the decision-making process, or (less commonly) faculty who are inappropriately tentative and indecisive.

The help-seeker response to vulnerability and loss of control also generates a reaction in the designated help-giver. Some feel engulfed and threatened by the help-seeker's fear and helplessness, and punish the help-seeker by inappropriately demanding too much self-responsibility too quickly. Others have their own sense of competence and superiority reinforced by the presence of a highly dependent complement in the relationship dyad and encourage the help-seeker to rely excessively on their wisdom. Conversely, a counterdependent response in the help-seeker can generate a sense of helplessness in the help-giver (when they feel they are losing control or are in a power struggle with the help-seeker) or an angry, rejecting response, in an effort to quash what is perceived as an authority challenge.

The control and authority expected of the help-giver, on the other hand, may generate anxiety that one's knowledge is not broad or deep enough and the resultant deflective hostility of blaming the help-seeker for exposing these limitations. In these circumstances, help-givers may inadvertently withdraw from one of the crucial aspects of the role to which they have been assigned, ie, assisting the help-seeker to ascertain the meaning and implications of various symptoms and conditions, and to truly confront their loss of control. Residents and attendings at times may need to examine their own fears relating to impairment, vulnerability, and mortality before they can assume a facilitative position vis-a-vis the help-seeker.

The expectation of control also may induce anxiety associated with what has been called "conflicts between the old master and the new professional."[19] This dilemma applies to attending, resident, and occasionally patient in the help-giver role. All may resent seeing their "secrets," insights, and expertise appropriated, sometimes more skillfully, by the help-seeker. Whether it is the resident who has learned of a treatment strategy unfamiliar to the attending, the patient who suggests a complementary intervention based on independent investigation, or a penetrating comment by the resident which questions the patient's world view, all may be perceived as threats if they challenge the authority of the help-giver. By contrast, when the help-giver is uncomfortable exerting any authority and pretends that the relationship is completely egalitarian, the help-seeker may feel unsafe and adrift, even blamed for the difficulties of the situation.

Real dangers exist for help-givers to exploit the inequalities of the help-giving—help-seeking relationship, to enhance their own egos by belittling or patronizing the help-seeker or by indulging in a range of inappropriate uses of the power they hold. The balance of power between help-seeker and help-giver deserves ongoing examination, particularly since, as the skills and understanding of the help-seeker evolve, the balance should be continually shifting. As Szasz has observed,[35] such relationships may evolve through several phases, moving from the total authoritarian control of crisis management to greater mutuality and participation of the help-seeker.

Two points are worth reiterating regarding the parallelisms evoked by the presence of control issues in the health care process. The first is that a response in any participant in the triangle can provoke either a parallel (similar) response (eg, helplessness in the patient stimulating helplessness in the resident) or its mirror opposite (eg, helplessness in the resident leading to anger and rejection in the attending). Both of these responses constitute examples of parallel process.

The second point is that such problematic issues and the responses they provoke are the property of the system as a whole, rather than being isolated within one particular subset of members. This is particularly important because it is so often ignored in the teaching process. Too often what the attending most severely criticizes in the resident is simultaneously being reproduced in the relationship with that resident. For example, the resident who acts punitively toward a highly dependent patient may, in turn, be punished by an attending who correctly perceives the destructive dynamic between resident and patient, but then proceeds to recreate it in a critical, judgmental interaction with the resident. While the "error" may have been corrected on a content level, it continues to be modeled on the level of parallel process. Similarly, while attendings can easily identify anxiety due to loss of control in patients, they will often overlook the parallel anxiety operating in residents and in themselves as well. Thus, the anxiety emanating from loss of control becomes artificially enclosed.[16] The emphasis becomes one of containment rather than exploration, management rather than understanding. Yet it is precisely the examination of how this anxiety pervades the entire system which will at once arouse empathy for the patient and at the same time reduce the compelling nature of the anxiety at all levels.

Stages of Control Issues

Finally, one must consider in this example how stage development interacts with the parallel process model. In terms of control and loss of control issues, one might hypothesize Stage 1 as denial of feelings of vulnerability and helplessness on the one hand, and feelings of hypervigilance and excessive mastery on the other. The stuckness or lack of progress of this stage may often be accompanied by behavioral manifestations of anxiety, as illustrated in Figure 2. Stage 2 might reflect an awareness of anxiety on the part of all participants, a sense of loss and confusion, and perhaps a vacillation between different dependent and counterdependent modes of response. The final resolution of Stage 3 would be characterized by a feeling of interdependence among the participants of the triad, as well as a renewed sense of purposiveness and direction, in which appropriate control was exercised and the limits of control recognized by all members of the system.

A Model for Relationship Between Help-Seeker and Help-Giver

As was stated in the original definition, the ultimate successful functioning of the helping component of the medical system hinges on the quality of the relationship between help-giver and help-seeker. At its best, this should be a mutually intimate and self-revealing relationship. The help-seeker, to be effective in fulfilling his or her role, must be transparent, vulnerable, and authentic.[36] The help-giver, whether resident or attending (and at times, patient), is dependent on the help-seeker's willingness to provide accurate and often sensitive information. For their part, help-givers require similar qualities and must be able to create personal accessibility, model certain self-disclosing behaviors,[37] and encourage trust. Particularly difficult is the reality that such a relationship will, in all likelihood, include

a dimension of conflict,[38] as it is rare to have this openness between individuals without triggering some core differences and fears. Ideally, as the resident learns about how to develop and maintain a relationship with the attending which includes components of both intimacy and conflict, he or she is also developing skills for communicating these insights in the relationship being built with the patient.

In this situation, the help-giver may be compared to a master craftsperson; the help-seeker, to an apprentice.[39,40] To the apprentice, the skills which the master executes may seem mysterious and incomprehensible. The apprentice has little or no concept of how to proceed from Point A to Point B. Even the language used between master and apprentice may be open to misinterpretation or may be simply incomprehensible. There is an atmosphere of confusion and uncertainty, anxiety, even despair. As one author expressed this from a supervisorial framework, the help-seeker "must mourn the loss of systematized and controlling. . .styles of relating. . .must suffer tension and depression, and must struggle to comprehend the unknown inside himself [sic] as well as what is around him and his patients."[41] Responding to the sense of loss of the familiar and the controllable and to the simultaneous challenge of the unknown comprises one of the essential tasks of the help-seeker. It is the master's role to provide the linkages from the known to the unknown and back again, to make accessible the mysterious.

Because of the fluid nature of the roles suggested above, the master will not always be right or know all the answers. Lack of certainty is a dimension of the health care system which affects all participants equally at some point. However, what the help-giver can communicate to the help-seeker is a context of control and safety, within which uncertainty becomes tolerable, even challenging. The goal of the relationship is not to create rote imitation on the part of the resident or slavish, unthinking compliance in the patient. Ultimately, it is the help-giver's intent to bring forth the help-seeker's own special creativity, insight, and problem-solving skills applied to the dilemma at hand.[42] This model suggests that it is the challenges and rewards of cooperative effort, shared exploration, and mutual problem solving which help all participants transcend the confusions, ambiguities, and general "swampiness"[43] with which such help-giving and -seeking relationships are inevitably invested.

Educational Implications

The parallel process model has important implications for the training of residents. First and most obvious is the ability of the attending to be attentive and sensitive to parallel process issues operating between teaching and patient care. For example, is there disharmony between advocacy of patient-centered medicine and doctor-centered medicine, and resident-centered and attending-centered teaching? Is mutuality in the resident-patient dyad stressed, but authoritarianism practiced between attending and resident? To what extent is the relationship between attending and resident clinical (ie, focused purely on medical management), adversarial, or relational (concerned with interpersonal as well as biomedical components[3]), and how does this distribution compare to that being advocated in the resident-patient relationship? Finally, is there a large discrepancy in the balance between intimacy and distance espoused for resident and patient and that adopted between resident and attending?[5]

Sensitivity to parallelism and its opposite is also appropriate at the level of intervention. Several types of general clinical interventions have been identified as useful in facilitating teaching objectives. Briefly, these are as follows:[11] 1) facilitative interventions which communicate positive regard and the purpose of which is to nurture the help-seeker, reduce anxiety, convey trust, and provide a safe atmosphere to stimulate reflection and introspection; 2) confrontative interventions which highlight discrepancies within different areas (eg, verbal and nonverbal) of the help-seeker's functioning and which challenge the way in which the help-seeker has organized his or her reality; 3) conceptual interventions which offer more theoretical or abstract understanding relevant to the situation and which may enable the help-seeker to learn to recognize central themes and issues from apparently isolated incidents; 4) prescriptive interventions which provide the help-seeker with a specific plan of action for use in a specific situation and are particularly useful in crisis management; and 5) catalytic interventions, a sort of meta-category of intervention which precipitates and promotes change in the help-seeker by enhancing a process already in progress. Catalytic interventions may be either facilitative, confrontive, or prescriptive in content but have a systemic focus in that an effort is made to place the specific intervention within the framework of the overall system, and these interventions are more likely to take into consideration the significance or probable affect at all levels.

It is important to note that these interventions actually do not operate "downward" in a unilateral direction from help-giver to help-seeker, but are in fact reciprocal in nature. Thus, interventions are not applied to the help-seeker but are rather introduced into the system, where they operate on all participants in a multidirectional fashion.

In terms of parallel process, one often notes significant discrepancies in the nature of interventions being recommended throughout the system. Despite a broad-based biopsychosocial[43] theoretical orientation, in practice help-givers in family medicine have a tendency to rely too heavily on prescriptive interventions, with a resultant neglect of other potentially useful means for effecting change within the system. Further contradictions often surface between the various dyads of help-givers and help-seekers. For example, an attending and resident exploring the utility of a conceptual intervention with a patient usually ignore the added insight which could be derived from considering their own interaction from a conceptual perspective. Similarly, an attending who uses a confrontative intervention with the resident to encourage a facilitative intervention with the patient may leave the resident confused and unsupported.

From a parallel process perspective, what is of importance is attention to inappropriate discrepancies between advocacy of one intervention style in patient care and actual modelling of a less-effective intervention on the part of the attending. Issues of appropriateness may be related to the stage development discussed earlier. Also of concern is when dysfunctional interventions, such as punitive styles, are injected into the educational triad, because of the likelihood they will reverberate throughout the system.

Another level of educational implication has to do with the willingness of both resident and attending to gain insight into resident-patient problems through analysis of attending-resident interaction. Difficulties between resident and patient which appear obscure and inaccessible may be

illuminated by examination of the emotional undercurrents flowing between attending and resident. For example, a resident and attending continue to hammer away at a noncompliant patient without much success. Attention to the attending's frustration with the resident for failing to accomplish a change in patient behavior and the resident's resultant feelings of inadequacy and resentment could provide some clues to understanding the patient's recalcitrance. This approach is currently rarely used and certainly is not relevant in all cases of resident-patient difficulty. However, it suggests one further educational option for those situations in which residents and attendings alike feel that they are at an impasse.

Attendings should also be willing to consider the implications of stage development theory in their educational endeavors. If a resident is basically functioning in a Stage 1 modality, interventions which require a great deal of independent analysis and creativity may be incompatible with the resident's level of ability. Similarly, a patient at Stage 2 may need additional support and comfort in navigating the uncertainties of that phase.

A further ramification of the parallel process model is that it is the attending's responsibility to promote self-reflection in himself or herself, on the part of the resident, and at times, indirectly, on the part of the patient as well. For example, the identification of anxiety at any point in the system suggests its possible presence at other levels as well. Understanding and insight at one level of the system can have a therapeutic effect on other levels, but this is only possible when the resident and attending (and other system members) are willing to engage in internal as well as external observation and be as honest about themselves as they are about patients.

To develop a full and complete relationship, both help-giver and help-seeker must be willing to be aware of their own feelings, motivations, and actions. The promotion of this version of "psychological-mindedness"[45] holds a crucial key to unlocking the true potential for healing dormant in the exchange of "help" between the parties involved. It is especially important for the attending to recognize that the process of self-reflection can create a sense of vulnerability, may be viewed as potentially dangerous, and therefore may be resisted in the interactive process. Again, while the attending may encourage the resident toward an attitude of self-reflection in interacting with the patient, the attending may be notably withholding in this area in his or her own relationship with the resident.

Finally and perhaps most challenging, the implication of this model is that the attending must acknowledge participation in the role of help-seeker. The complexities of an unfamiliar equation or overwhelming problems may force an attending into inappropriately passive or (more often) excessively unilateral behavior. In this situation, the resident and/or patient is at risk for being thrust into a maladaptive and artificial help-giver role. As an alternative, a colleagial network could be created which functions to provide a consistent help-giving response at those times when the attending is struggling with the psychological stresses of help-seeking.

Summary

It should be evident that the problematic interactional themes and issues which seem to surface repeatedly in relationships in the health care system are neither isolated incidents nor can they be explained away by labels such as "difficult patient" or "problem resident." Rather, they are dilemmas endemic to the system as an entirety and affect not only resident and patient, but attending and resident as well. This realization should be the first step in helping attendings to engage in rather than withdraw from the difficulties and problems which residents and patients face in seeking and rendering care, and interrupting the spiralling nature of this phenomenon.[46]

Working through parallel process increases residents' awareness of a problematic situation and enables them to interact with patients in a less constricted manner. Attendings have the opportunity to gain insight into their own behavior by observing the residents and patients, while the residents' understanding is improved by observation of both attending and patient behavior. In this manner, the conscious awareness of parallel process can be useful in facilitating a more honest and compassionate giving and receiving of help at all levels of the health care system.

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Brief Reports

Gearing Balint Group Leadership to Resident Professional Development

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ABSTRACT

This paper discusses the sequential phases of typical Balint training groups. The cases presented reflect the presenters' professional developmental time line and serve the participants' developmental needs: exploring professional boundaries and intragroup intimacy. The activities and issues arising in the meetings stem from these developmental needs and help the group members acquire specific skills. Knowing where the group members are in their professional development should help group leaders give a seminar its focus, decide on group membership, and recognize when a group is not developing appropriately.

(Fam Med 1990; 22:320-1)

In the Balint group training format[1-4]--seminars designed to study specific doctor-patient relationships --several content and process issues have been observed that will help group leaders. A Balint group passes through two phases (Table 1) over a two-year period of training. These phases are not discrete, but are highly interdependent. Each phase has its own developmental task (purpose). In Phase I, the group task is to explore the professional boundaries (expectations) of a family physician; group members struggle with the issues of omnipotence and omniscience versus realistic role expectations. In Phase II, the group task is to develop and maintain an atmosphere of intragroup intimacy so that individuals can explore participant-specific professional issues. Phase II also provides the setting for leaving at the conclusion of the training. The cases presented to the group raise issues which serve the phase-specific task and mirror the participants' professional developmental time line and skills.

These observations about a Balint group's evolutionary phases resemble Ginzberg's three phases of occupational choice:[5] exploration, crystallization, and specification.

Phase I. Boundaries

Residents in beginning groups are newcomers to family practice. The cases they present explore the boundaries of their professional responsibilities. Residents present patients whose boundaries are either tightly closed to the doctor's understanding or ill-defined and demanding of all-inclusive attentiveness. These patients frequently somatize their emotions and lead lonely lives. Residents hope to learn what they can do to help these patients get better.

At the end of this phase, group members begin to acknowledge the limits of their professional responsibilities with appropriate humility in contrast to feelings of resentment and bitter disillusionment. They learn that it is not always possible to solve all their patients' problems. Instead, they realize that what is required of them is to be there for their patients. This realization sets the stage for the next phase, intragroup intimacy.

Phase II. Intragroup Intimacy

Intragroup intimacy (group cohesion) crystallizes around six to nine months into training, at a time when second-year residents are also becoming involved (intimate) with the philosophy and practice of family practice. This intimacy is derived from trust. Trust in self and in other group members[6] determines degrees of involvement and data flow within the individual member and among group members. The types of cases heralding this second phase often have to do with intimate human relationships. The cases that come next raise issues that reflect individual group member's recurring problems (blind spots) with specific patients or situations.

Toward the end of this second phase many cases presented concern patients with chronic or terminal illnesses. These cases strike a familiar chord of sadness in the participants, reminding them that their life as a group is also coming to an end.

At the end of this phase, group members should be skilled at being fully attentive to one another and to themselves, enabling them to recognize feelings that their patients generate in them and keep these separate from their own personal conflicts.

Discussion

The observation is not unexpected that issues arise in Balint group seminars dependent on a time line in phase with the resident physician's stage of professional development. How can this observation be helpful to group leaders? Consider the following three ways.

1. *Membership of the Group:* When starting a Balint group training program, the leader ideally should limit membership to residents who are at the same level of training. Group membership should be closed early. The author has noticed that mixed groups (different levels of residency training) and open groups (different levels of Balint training) will develop conflicting needs. For example, one subgroup of regularly attending participants may be reaching the phase of intragroup intimacy while other residents in the same group may be coming to the end of their resi-

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