Parallel Processes – Walking Our Talk Across the Behavioral Health Service System

Parallel process as a term generally refers to dynamics of transference and counter transference in the therapeutic process. It also has supervision applications. Supervisory interaction often replays, or is parallel with, the direct healing relationship. It also has implications beyond the healing relationships in SUD care. A major influence in understanding these areas has risen out of the work of Dr Sandra Bloom, past President of the International Society for Traumatic Stress Studies. Dr. Bloom has written extensively about trauma-organized systems and parallel processes.

Whole systems can replicate these dynamics. To sustain effective healing systems, these are processes we must pay attention to in order to be effective at helping people (and systems) heal. A promising strategy would be to shift the way we think about the term parallel process to focus on the dynamics we want to emphasize in healing and wellness across the work and the workforce. A strengths-based orientation.

That is not how we often think about the term. In 2021, I wrote On Pervasive Systemic Stressors and Restoring Safety reflecting on parallel process dynamics compounded by the COVID Pandemic, the Addiction Epidemic and societal upheaval. Also, the majority of our workforce were raised in homes in which trauma, anxiety or addiction were often present. Childhood adversity is common among healthcare workers and is associated with a greater number of life events, more psychological distress, and impairment. One study, Prevalence of Adverse Childhood Experiences (ACEs) among Child Service Providers found 73% of social work students experienced one or more problems that defined a dysfunctional family, a figure significantly greater than the comparable graduate students in education or business.

That people who are raised in adverse conditions are drawn to helping professions is common sense. Having lived experience can increase empathy, insight, and model resiliency. Yet unhealthy coping patterns, replicated across our service delivery system also have implications for how our human service system functions. Walking the talk means addressing these issues at all levels of our care system.

Consider how our systems of care can replicate the “rules” of a dysfunctional family system. Don’t talk, don’t trust, don’t feel and maintain rigid roles. Keep doing what we are doing because it is what most people working in our care systems learned in their formative years. Like any system, including a family system these dysfunctional dynamics become more pronounced under stress and strain. Our system can thus operate antithetical to the healing it espouses. As noted by Claudia Black, beyond these rules are several others:

- don't think (just don't think about what is going on)
- don't question (don't question what is happening)
- don't ask (don't ask for anything or expect anything)
- don't play (be mature)
- don't make a mistake (mistakes are not tolerated)

These dynamics play out across systems as people respond in ways consistent with their formative experiences. Similar to the “rules” of a dysfunctional family, systems under strain can end up avoid the most challenging problems occurring within them. They perceive that they are too overwhelmed to address the challenges. Trust across these systems degrades as strain increases. People working in these systems shut down their feelings about what is occurring to keep going. They tend to stick to whatever way they do things rigidly. Acting in ways contrary to these “rules” threatens the system and is at risk of being quashed. Systems generally sustain the status quo even when they operate in ways that are dysfunctional, just like families often do. Reflecting back on that last point, systems tend to eliminate messages that threaten dysfunctional dynamics, similar to how families tend to kill off attempts to address them. This is an area where leadership, which encourages hard questions and does not kill off the messengers is most vital.

In some ways, what we need to do is rather simple. We need to break the dysfunctional family rules that operate at the macro level of our care systems. We need to talk, trust, feel, and examine our rigid roles. The things that make this hard

in families also make it hard in our systems of care. We can be afraid that talking about difficult topics in depth may make things worse. We can be worried about not knowing the outcome or how people may react. We tell families experiencing these dynamics that they have the greatest likelihood of change when the pain from inertia becomes unbearable. Are we at such a point in respect to our healing institutions? If not now, when will be at such a point when we will do these hard things that must occur?

A few weeks ago, I had dinner with a colleague in Philadelphia. We ended up listing all the issues that need in depth and difficult discussions across all the subgroups within our system that far too often are avoided. They span all facets across national and state government entities to prevention, harm reduction, treatment and recovery community stakeholders. It was clear that forward progress would require investments in time and resources, but not doing so would styme forward progress. We get mired down in the age-old dynamics that play out through avoidance and inertia. We have to storm, before we can norm and preform. That first step is scary, but it should be clear we are expending more resources to avoid it. Our times require us to do better. Are we in enough pain to try? How do we have such conversations? They require some mutual agreements to proceed. Things like:

1. Starting from the premise that the status quo is harming our workforce and our work. We collectively want a system of care that can address our needs more effectively, together.
2. Participate with positive regard for all, as we all would want others to show us.
3. Listen to things that challenge us, particularly where we defend our most tightly held perspectives.
4. Seek common ground in areas in which a disagreement is identified, keep searching in areas of disagreement until common ground is found. At our core, we want the same things, we set our roots there.
5. Seek clarification, even if we are certain we understand what the other person is saying. We are in essence one people separated by a common language using the same words that mean different things to each of us.
6. Acknowledge that change is difficult, and that we must to change to help those we serve do so more effectively.

Deep conversations of this nature will tend to be reflective of recovery values to emphasis strengths and resilience over problems and deficits. Other groups are reframing parallel processes to reflect an asset-based lens. To emphasize the healing and wellness values across both our work and our workforce. As noted in this JAMA article, research on positive childhood experiences shows promising applications for how we view and support resiliency, even in the face of ACES.

It has long been said we cannot give away what we do not have. In the midst of the challenges we face, we need to start walking the talk. How can we not do this and expect that we reflect the values we espouse? One may ask when faced with a plethora of challenges where to start. We tell clients to start where they are with one step forward. It is something that readers working in our systems can do wherever they are now.

It is time our systems of care walk the talk of healing and wellness. Our work and our workforce hang in the balance, and we have never been needed more than we are needed right now. We are in a crisis. Crisis is also an opportunity to change. It is what we tell the people who seek our help. It is true for us, too. Let's heal us to help those we serve. It would involve talk, trust and open expression of issues experiences across our workforce with the goal of changing us.

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