THE DILEMMA OF MENTAL HEALTH
PARAPROFESSIONALS AT HOME

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Abstract: The use of community member paraprofessionals in the delivery of mental health services is complicated by the changing nature of the paraprofessional's social relationships within the community. We use an anthropological model of Coast Salish social organization and data from a current delivery system, the Swinomish (Washington) Tribal Mental Health Project, to suggest ways to conceptualize and account for such complications.

Health care administrators serving Indian communities are increasingly aware of the value of employing community members as health providers in order to make their services culturally sensitive and relevant. There is now a general recognition that Indian peoples are frequently alienated from non-Indian health care institutions, practices, and practitioners. And there is a growing academic literature advocating the integration of native caregivers in the form of community paraprofessionals and indigenous healers into health care programs, particularly mental health care, as a means of overcoming this alienation (for example, Dinges, Trimble, Manson, & Pasquale, 1981; Guilmet & Whited, 1989; Jilek, 1982; Jilek & Jilek-Aall, 1973; Minton & Soule, 1991; Runion & Gregory, 1983; Trimble & Hayes, 1984). Although the existing literature shows an appreciation for the difficulties of such collaborative efforts, there is little attention given to understanding how the changing relationship between the caregiver (and the caregiver's family) and the client (and the client's family) may influence access to services. The purpose of this article is to examine several related issues: (a) how Coast Salish health providers are socially situated in their communities, in particular within the family network structure that frames community relationships; (b) the ways changes in relationships within the community affect the providers' placement over time; and (c) the implications for mental health care delivery.

These issues are addressed by the application of an anthropological model of Coast Salish community dynamics to an existing clinical model of service delivery, the Swinomish Tribal Mental Health Project.

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Interviews with a paraprofessional collaborator who was formerly a tribal support counselor (using the pseudonym Mrs. Johnson) provide insight into family network relationships and difficulties associated with counseling clients across family boundaries. In addition, our observations are sharpened by collaboration with a former Indian Health Service public health nurse who employed family network concepts in facilitating the delivery of health services, including mental health services, to her Coast Salish clients.[1] We approach this research from an ethnographic and historic perspective, and our nurse collaborator has provided information that helps in applying the ethnographic lens to the process of providing health services. We argue that our approach provides a systematic way to view one significant set of problems faced by mental health programs that employ community members as service providers.

Health Care Delivery and the Role of the Native Caregiver

Generally, two solutions have been proposed to overcome the problems of service delivery to Indian people by mainstream institutions: one is to train practitioners in cultural sensitivity; a second and perhaps more important approach is to employ Indian caregivers who can combine Western and indigenous practices and who are aware of community members' needs, beliefs, and attitudes. The advantages of native caregivers over Western health professionals are numerous. Indian health providers are said to generally be trusted and to occupy a position of respect and positive regard in the community, whereas Western practitioners are frequently distrusted (Guilmet & Whited, 1989; Trimble & Hayes, 1984). As members of the communities they serve, native caregivers are more familiar with local community dynamics, kinship patterns, religion and spiritual needs, values, attitudes, the native language, communication styles, and client expectations (Dinges et al., 1981; Guilmet & Whited, 1989; Runion & Gregory, 1983; Trimble & Hayes, 1984). Whereas Western practitioners are outsiders who are sometimes only temporarily employed by the clinic, native health providers (if they are local) are personally tied to the community and provide continuity in care. They may also be able to reinforce cultural values, pride, and identity, which are important elements in maintaining mental health (Guilmet & Whited, 1989).[2]

Although collaboration between mainstream service providers, community paraprofessionals, and traditional healers can be a successful means of reducing cultural and social distance between caregiver and patient, many authors have recognized problems associated with such collaborative efforts. Dinges et al. (1981) note that relationships of trust in which mutual credibility is recognized can be difficult to establish between Western practitioners and native healers. Nonnative (Western) practitioners may reject traditional healing methods and be unwilling to make referrals to native curers. Western health professionals may be unaware of

patient expectations and not know when referrals are appropriate. Sufficient and culturally appropriate compensation for native healers often does not occur (Dinges et al., 1981). Community members sometimes oppose integration of native and Western medicine, preferring to keep their practices private or at a distance from health agencies (Attneave & Beiser, 1974). Dinges et al. (1981, p. 266) raised the problem of frequent differences in values between community paraprofessionals and patients because of different degrees of assimilation: "There is a prevalent but unwarranted assumption that indigenous paraprofessionals will automatically identify with and have empathy for the community of which they are a part." They observe that some Western-trained paraprofessionals adhere to Western psychological models and therefore do not represent a middle ground between Western and Indian perspectives.

Once the obstacles to collaboration with indigenous healers are removed and culturally sympathetic paraprofessionals are found, it is frequently assumed that social barriers between caregiver and client will disappear. Whereas the Western practitioners are socially distant from the community, native health providers may be socially extremely proximate; they are normally active, participating members of the community. This social proximity give the native provider a significant advantage over the Western practitioner. However, it may also complicate the client–health provider relationship. Coast Salish communities are made up of integrated kin-based social networks that influence the relationships between individuals (Amoss, 1978; Miller, 1992b; Mooney, 1976; Suttles, 1963). Both the native caregiver and the potential client occupy particular social statuses and carry out roles in this family network complex, a fact that may influence the likelihood of an individual seeking the provider's care or finding such assistance socially appropriate. As family composition changes (a phenomenon discussed later in this article) and as interfamily alliances and tensions build and diffuse, the native caregiver's relationship to potential and existing clients may also change.

We present here a preliminary model of the social placement of native caregivers and show the implications for health care delivery of that placement. While the specifics of the model apply particularly to Coast Salish communities, the consistently central role of the extended family in native Indian communities suggests that, with local revisions to account for social organizational differences, these ideas have relevance on a wider scale.

Applying Family Network Theory to Health Care Issues

The origin of the concept of a "social network" is often attributed to Barnes, who imagined "a net of points, some of which are joined by lines. The points of the image are people, or sometimes groups, and the lines indicate which people interact with each other" (Barnes, 1954,

p. 43). Network models are sometimes used to emphasize what Wellman and Berkowitz (1988, p. 4) call the "ties" that represent "flows of resources, symmetrical friendships, transfers, or structural relationships" between social system members. Such models of social structure stress the relationship among members of the social system and the exchange of resources — including goods, services, money, information, love, and support — between them.

Health care studies employing these network ideas are concerned principally with the exchange of one resource within the network, that of psychosocial support, and how the presence or absence of support networks affects mental health (e.g., Llamas, Pattison, & Hurd, 1981). The principal application of such studies is to develop "network intervention strategies" in an attempt to strengthen impoverished social support networks as a means of treating mental health problems (e.g., Pattison & Hurd, 1984). Thus, the present literature is primarily concerned with social support within the network and its direct effects on mental health. We wish to consider other aspects of network relationships, especially how these relationships influence access to health services and the ability of service providers to engage their clients.

LaFargue's (1983) analysis of middle-class African-American family networks is suggestive for the study of the Coast Salish because her work shows the value for health care delivery of understanding changes in family networks over time. LaFargue combined exchange theory and network analysis and found that the patterns of interaction and exchange among family members affected their use of health services, particularly when nurses were unaware of these patterns and misunderstandings ensued. In Indian communities, the family network is equally important as a realm of influence and resource exchange. Family heads and elders control the allocation of resources and only certain family members are seen as appropriate to fulfill particular roles, such as teaching and disciplining children (Miller, 1989; 1992a). As with the families LaFargue studied, Coast Salish family networks possess and exchange private information that is not to be indiscriminately spread (Amoss, 1977; Suttles, 1958).[3]

The work of LaFargue and others (Murdock & Schwartz, 1978) recognizes that a client–health provider relationship is not defined by these two actors alone — the attitudes, beliefs, and social roles of the client's family network can be equally or even more important. When the caregiver is also a member of the complex of family networks that make up the community, he or she has a particular social role and relationship to both the client and the client's family. The success of a client–health provider relationship may depend on whether or not they are both of the same family network, the nature of the relationship between their networks if they are not the same, the degree of access the caregiver has to the client's family head and to private information about that family, and so on. These relationships may change over time as family composition

changes and as relationships between families change. All of these factors affect the appropriateness of care and the possibility of accessing services by a particular caregiver.

Coast Salish Family Networks

Coast Salish Indians lived aboriginally in large, extended family households, and the extended family, in a somewhat altered form, remains the core socio-organizational unit today. A family network, or "family" as it is referred to locally, is a corporate unit in which members operate collectively to carry out such activities as running fish camps, organizing ceremonies, and sponsoring family members in ceremonial life; family members interact and carry out generalized reciprocity on a regular basis, may pool resources, and assist one another in the care of the elderly and children.[4] Family networks composed of linked households are the central unit through which resource exchange and mutual aid occurs (Mooney, 1976). Family members provide one another such essential services and goods as employment advice, transportation, financial assistance, food, equipment, and information. Modern reservation communities are composed of a number of such family networks that compete for the resources available to the tribal community.

Family membership is flexible; it is not based simply on descent, and individuals may choose to affiliate themselves with any one of a number of family networks to which they can show common descent with members or other relationship (such as adoption or marriage). As such, family network composition changes over time; new members are recruited, old members may decide to disaffiliate themselves, new families form around a leader or leaders, and old families lose their cohesion and cease to exist as units. A new family frequently is formed around one or more influential leaders and includes an adult sibling set of brothers, sisters, and cousins. New members are incorporated and recruited as children are born and adults marry into the family or when individuals activate latent kin ties in order to affiliate themselves with the family. Leaders compete with other families' heads to acquire resources for the family and are responsible for allocating them. The quality of leadership influences the composition of the family; followers are attracted and cohesion is maintained by the leader's ability to do such things as speak for the family in public, represent its interests on the tribal council, get jobs for family members, bring them prestige in the Coast Salish regional system, and contribute directly to members' material and spiritual well-being. Members defer to specialists within the family, such as ceremonial leaders, on appropriate occasions.

Because individuals can potentially belong to several different family networks by activating different kin ties, they can attempt to strategically choose which network to affiliate with based on the resources it

can provide. As Amoss (1978, p. 36) observed concerning the Nooksack, a Coast Salish tribe: "Very few people really know who all their relatives are, so it is fairly easy for a person to affirm or ignore distant relationships as it suits his or her social needs." Although there is pressure to belong to only one family network at any given time, members may relinquish ties to a network in which leadership is weak and affiliate themselves with another family in which their life chances will be improved.

The negotiability of membership is one factor prompting changes in family network composition. In addition, family networks appear to follow a somewhat predictable cycle of growth, maturation, and collapse. This is not to suggest a unilineal pattern; variation occurs. This cycle may be divided for convenience into four phases in order to show the implications for service delivery. In the "incipient phase," a leader or group of leaders, ordinarily consisting of one generation of siblings or cousins and their spouses and children, begin to establish a basis for group action. Reciprocity is established within the group, and the group begins to acquire heritable resources (such as fish camp sites useful in commercial fisheries), compete for tribal resources, and attract followers.

As time passes (the "early phase"), the children of the family network members grow to maturity and the network grows as more followers affiliate themselves. Family network leaders become better connected in the information chain of the reservation and are more successful in gaining political office and providing jobs for family members. As second-generation members marry and have children, the family sometimes enlarges to 80 members or more.

By the time the third generation reaches adulthood, the network has attained the height of its size and political influence; this is the "mature phase." Despite the strength and influence of the family, problems of group cohesion arise. As families grow, members find themselves associated with distantly related fellow members. As genealogical and social distance between members increases, the likelihood of social friction and disputes within the network also increases. There may be too many members for all to use the family fish camp (if they have one), conflict over resources occurs, and reciprocity begins to break down. The leadership may no longer be able to provide resources and assistance to all of the members because of the size of the group. Leadership may also break down as family heads die or become aged or incapacitated; such a collapse, combined with the problems of maintaining cohesion, leads to the "fissioning phase," or breakdown of the network. The family network may remain intact by eventually reconstituting under a new head; otherwise, the network disintegrates and individual members may reaffiliate themselves with other networks to which they have latent kin ties or be left without a network of ties and either leave the community or become marginalized in it.[5]

A Model of the Family Network and Health Service Use

The nature of family power relationships within the community and of the significance of the patterned linkage of powerful families to community institutions can be incorporated in the model of network cycling in order to better understand the factors affecting the individual's access to health facilities. The material, financial, emotional, and labor resources available to individuals, as well as their links to sources of community power, fluctuate with changes in network phase. These fluctuations affect health care in two ways: first, the size of a network affects the availability of kin to provide resources such as care, transportation to facilities, and emotional support. Second, the size and power of a network affect the individual's relationship to and identification with tribal institutions that provide services; individuals who are not part of a coherent network or whose family networks are small may feel isolated from sources of community power and be less likely to use services than those from better-placed families.

There is a relationship, then, between network phase, the availability of kin to provide care and assistance, and the degree of identification with community services. Given the nature of family network cycling, the changes that will likely occur in the individual's access to health care over time can be anticipated to a degree. In the incipient phase, there are a limited number of family members available to provide care for the sick, children, and the elderly, transportation to health services, and emotional support. This problem is compounded by a lack of power in community institutions and associated alienation from community services.

In the early phase, more familial assistance is available, and members become more involved in community institutions. The family is better able to sponsor members in religious ceremonies, such as winter spirit dancing and the Shaker Church, which promote strong Indian identity and, indirectly, mental health (see Miller, 1990).

In the mature phase, the family network is large and able to provide more extensive care for its members. The network has power and influence in community-directed institutions, such as health facilities, and members therefore can more easily identify with them. Use of services in Coast Salish communities depends in large measure on personal ties to health care providers and service staff, and it is in the mature phase that people are most likely to have family members occupying tribal service positions.

When family networks fission, the regular pattern of reciprocity breaks down and the number of family members available to provide assistance is once again limited. Members typically lose their power to influence institutions and may become alienated from community services and institutions. Some people move away from the reservation and are too geographically distant from tribal services and programs to make effective use of them. Those who remain may be unwilling to trust and reveal personal

information to caregivers and service staff who are members of other families, given the strong cultural emphasis on private family knowledge.

This analysis reveals the importance of knowing a client's place in the family network complex and where the family network stands in its natural history in order to understand issues of access to health facilities. We wish to extend the analysis to consider an additional factor that appears when community members are employed as health providers: what the social position is of the community health provider in this same family network complex and how the relative placement of client and caregiver influences the likelihood of the former effectively accessing the latter's care.

Applying the Model

The Project

The Swinomish Tribal Mental Health Project, which employs native paraprofessionals on Coast Salish reservations, provides an ideal context in which to explore these issues.[6] The program was established in 1984 through a cooperative effort between the Skagit Community Mental Health Center and the Swinomish and Upper Skagit Tribes. Two tribal support counselors at each reservation deal with such problems as suicide attempts, domestic violence, social withdrawal, family crisis related to substance abuse, child abuse, runaway teens, unresolved grief, conduct disorders, somatoform disorders, and spiritual problems (Swinomish, 1991, p. 207). Aspects of the program include:

1.   Employing and training tribal members who are seen in the tribal community as natural helpers.

2.   Cooperating with traditional Indian healing systems.

3.   Developing a culture-specific model of service delivery.

4.   Serving traditionally oriented and "hard to reach" Indian clients.

5.   Increasing linkages with other mental health and social services programs available in both tribal and mainstream communities. (Swinomish, 1991, p. 206)

The success of the Swinomish Tribal Mental Health Project team in incorporating native health providers, knowledge of community social structure, and the active involvement of community members makes their approach worthy of careful consideration. We wish to add our model of family network cycling in order to reconsider the implications for health care accessibility of the native caregiver's social placement in the community.

The Social Placement of the Paraprofessional

Structural analysts point out that the relationship between two individuals can be understood only if it is considered in the context of the social networks in which it is embedded (for example, Wellman, 1988). This is especially true in Coast Salish communities, where members of an individual's family network guide one's relationships and behavior both directly through influence and pressure and indirectly through the links that they create between the individual and other community members. The Swinomish project team emphasized the importance of this issue, noting:

> Almost all tribal members are influenced by subtle and not so subtle family loyalties, obligations and conflicts. Political and social ties, as well as spiritual and career choices are often determined by which extended family a person belongs to. (Swinomish, 1991, p. 174)

The individual's social place in the community and relationships to others are determined, to a significant degree, along family lines:

> The importance of the Indian person's extended family cannot be overestimated. An Indian person is carefully trained in family relationships and traditions, and his/her social place is largely determined by family connections. (Swinomish, 1991, p. 227)

The nature of an interpersonal relationship is therefore not defined purely by two individuals. Furthermore, particular community members are regarded as appropriate to offer assistance to any given individual. One of the goals of the Swinomish project is to employ tribal members who are seen by the community as "natural helpers," someone who is already recognized as having a helping role and who is a well-known, knowledgeable member of the community.

The client's family must know the counselor's ancestry because it establishes the context for the relationship. The counselor must be recognized as "one of us," in the sense of being of the community. However, to be seen as "one of us," a person may need to be more than just an Indian or even a community member; he or she may also need to be family:

> Family membership can be an important way of defining who is "in" and who is "out" of one[']s social group. . . . it can be difficult to become really close to anyone who is not in some sense a part of one[']s family. As one of our Tribal Support Counselors puts it, it is rather like being on a team: "you're either in or you're out." (Swinomish, 1991, p. 147)

Although being an appropriate helper may not always require that the counselor belong to one's own family network, being a member of a distant or rival family network may classify the counselor as "one of them"

and therefore unacceptable as a helper. Many factors affect whether or not two families have personal ties and a positive relationship, including:

1.   The relative social status of each family.

2.   Whether the families are related through marriage.

3.   The religious affiliations of the two families.

4.   The degree of traditionalism of both families.

5.   Their history of friendly or unfriendly relations. (Swinomish, 1991, p. 175)

These factors affect the possibility of a successful interfamily, client–health provider relationship. If a counselor is from a distant, rival, or powerful family, he or she may not be a "natural" helper to that individual. No one individual can be a "natural" helper to the entire community; any given counselor will be an appropriate helper to some families but not to others.

The problem of gaining the trust of community members is repeatedly cited in the Swinomish project's publication (1991) as an issue in mental health care delivery. This theme is echoed elsewhere, and Lewis (1970) noted, somewhat cynically, that among Coast Salish peoples there is a prevalent distrust of all who are not close kin. Collins observed in the 1940s that distrust of Coast Salish community members who are not family affected the choice of practitioner to heal a supernaturally inflicted illness:

> A victim's family calling in a local shaman, who is not a relative, can never know for certain that he is favorably disposed toward them. It might even have been he who caused the illness in the first place. . . . This doubt of the good interest of members of one's own community sometimes leads to the precautionary measure of calling doctors from distant villages, men who will be less likely to be involved emotionally in the success or failure of the cure. (Collins, 1974a, p. 38)

It may even be preferable to be treated by a stranger than by nonfamily community members who could potentially have interest in exploiting the relationship for their own gain. Mrs. Johnson noted that it is sometimes easier to help people she doesn't know than community members who are not part of her family.

A related reason for the unwillingness to take problems to members of other families is a cultural emphasis on family "advice," the privately held knowledge, noted earlier, that should not go outside the family. This practice of restraint is extended to apply to information about health, finances, and other family affairs (Miller, 1992a). Mental health care often requires clients to reveal information not only about themselves but also about their families, especially when dealing with many of

the issues that the Swinomish Tribal Mental Health Project identifies as motives for seeking care, such as domestic violence, family crisis, child abuse, runaway teens, and conduct disorders (Swinomish, 1991, p. 207). A person will likely not seek help from someone to whom it is not appropriate to reveal such information. This is a significant impediment to a counselor's ability to assist someone from a family network other than his or her own. The Swinomish project's literature recognizes the importance of personal links between the support counselor and the client as a criterion for acceptance of the counselor's services: "People are accepted as helpers not primarily on the basis of their training, experience or job role, but on the basis of their personal connection in the tribal community" (Swinomish, 1991, p. 143).

Mrs. Johnson believes that every family has "someone like her" whom family members go to for help with personal problems. Thus, each intact family network normally contains a "natural helper" who is viewed as an appropriate person to counsel family members. When problems are too difficult for this person to solve, or if an individual has no such family member to ask for assistance — as in the case of a fissioned family network — the individual or his or her family may seek help from Mrs. Johnson. When a client is not from Mrs. Johnson's own family, she asks the client about family and ancestry in order to establish a relationship and build trust between the client and herself. This enables her to gain the client's confidence and provides a basis for their relationship. Familiarity with the client's family is used to bring her closer to the client so that she will not be perceived as a stranger. The importance of establishing trust before a therapeutic relationship when dealing with nonfamily members is evident. However, the amount of information about a family that can acceptably be revealed to an outsider is limited; although Mrs. Johnson uses the family context as a basis for establishing a therapeutic relationship, there are limits to the degree to which she can get "inside" a family other than her own.

Mrs. Johnson noted that the quality of the relationship she is able to have with a client depends on how she thinks of the client's family. If she regards the client's family as "good people." she believes this helps her have a positive relationship with the client. If she has a negative relationship to the client's family, she will have difficulty communicating with and helping the client, especially at first. She stated that once an individual relationship was established between herself and the client, her perception of the family, as well as their opinion of her, becomes less important. Mrs. Johnson believes that her own relationship to the client's family, independent of the client's personality, influences her initial ability to establish a positive rapport.

Personal links are important not only as the basis of acceptance of a counselor's services but also as a channel through which they are accessed. Mrs. Johnson observed that most client-counselor relationships

are initiated when a person seeks care on behalf of a family member by approaching the counselor socially, outside of the clinic setting. This requires that a family member know the counselor personally and be comfortable asking for assistance. Thus, personal links are necessary not only for a client-counselor relationship to be seen as appropriate but also as the principal channel through which care is sought. Such personal ties are often based on family connections.

Whether or not a particular client-counselor relationship is viewed as appropriate is an issue for not only the client and the client's family but the counselor as well. Indian health providers may feel less comfortable dealing with the personal life of a member of another family, since "Indian people usually try not to intrude on each other's business, and are particularly reluctant to interfere with other families" (Swinomish, 1991, p. 179). Individuals who are winter spirit dancers have powers that are frequently unknown, and because powers can be dangerous, community members intrude into another's affairs with caution. A certain social distance and respect for privacy may need to be maintained when dealing with clients from other families, and open communication may be more difficult, especially when the personal lives of the client's family members are involved.

Frequently, successful mental health care requires not only the tacit approval of the client's family but also their active involvement in the form of consultation and support. The family leader must be consulted and their approval obtained before decisions can be made and action taken. The Swinomish project team recognized that should such permission fail to be granted, treatment might be impossible: "In Indian culture, important decisions require the approval of spouses and senior relatives, particularly grandparents. Without the support of key extended family members, mental health treatment is likely to be ineffective or even sabotaged" (Swinomish, 1991, p. 228). If family leaders feel that a therapeutic relationship between a particular counselor and a member of their family is inappropriate, permission may not be granted and treatment may not occur even if the client approves of the relationship.

Mrs. Johnson considers consulting family members about important problems affecting a client essential. Before making decisions concerning the treatment process, she goes to family members whom she sees as "important to that person" to establish a relationship and discuss the client's problem. She would not make significant decisions concerning a health problem without first consulting at least one member of that person's family, even if the client did not request such consultation. For example, she stated that if a young woman were pregnant and considering an abortion, she would not help the woman to make a decision or take her to have an abortion without first consulting and gaining the support of the woman's family. She feels that the health clinic's confidentiality rules are an impediment to her ability to help people; it is difficult to operate effectively as a counselor without violating these rules by consulting family

members about clients' problems.[7] Even if a client were willing to take action without consulting family members, the support counselor, obliged to comply with community values, may feel ethically bound to consult family authorities before taking action to provide treatment. This is in conflict with Western concepts of confidentiality and causes a dilemma for the counselor. On the one hand, the Swinomish Tribal Mental Health Project's "Confidentiality Guidelines for Tribal Support Counselors" state, "Never repeat things you are told by clients, even to members of your family or of the client's family" (Swinomish, 1991, p. 293). On the other hand, counselors risk losing their already precarious position of trust if they do not violate individual confidentiality by consulting family leaders. Such a loss of trust could jeopardize not only the present client-counselor relationship but future ones as well. The Swinomish project's literature suggests that "workers must find the appropriate balance between maintaining strict individual confidentiality and involving family members" (Swinomish, 1991, p. 255), however, Mrs. Johnson indicated that this issue is far from resolved.

The counselor often relies on the supportive presence of family members in the treatment process: "Extended family may need to be called upon for support, discipline, teaching, or for spiritual activities" (Swinomish, 1991, p. 355). Active family involvement is an essential element of the Swinomish project: "Our Tribal Mental Health services rely heavily on family involvement. Even when 'family therapy' is not specifically used, extended family are often involved as consultants and helpers in the treatment process" (Swinomish, 1991, p. 227). In such cases, a relationship of trust and approval between the client's family and the counselor is all the more critical, because treatment relies on the family's active involvement. The Swinomish project literature recognizes that gaining family support is "a sensitive task that must be approached in a culturally 'right' way," and that "utilizing 'inside' family connections is a key in this process" (Swinomish, 1991, p. 228). Where inside family connections do not exist or interfamily tension and distrust prevent them from being used effectively, the counselor's power to mobilize the important therapeutic resource of family presence and guidance is significantly reduced. Family members are actively involved in determining access to a support counselor's care in one further respect: the most common means by which a client-counselor relationship is initiated is through a person seeking assistance on behalf of a family member. As Mrs. Johnson noted, family members must commonly persuade an individual to seek help. Given the general disinclination to trust health services, this requires a strong trust in the support counselor on the part of the client's family members.

Interfamily conflicts were cited as a significant impediment to effective client-counselor relationships across family boundaries. Mrs. Johnson stated that if another family and her own were "fighting" (on bad terms), it would be impossible for her to help individuals from the other family with whom she had not already established a client-counselor

relationship. If a strong relationship had already been established, she would be willing to continue counseling the client; however, the client's family would be angry and disapproving. Despite Mrs. Johnson's willingness to continue helping a client, she believes that interfamily disputes could prevent the family support necessary to make a therapeutic relationship successful, and she (or any counselor) would be unable to obtain vital permission for treatment from a disapproving family or consult with them and involve them in the treatment process.

Changing Relationships I: Interfamily Conflict

We have shown how the state of interfamily relationships at any given time can affect an individual's access to the care of native health providers. These relationships are not static; a client-counselor relationship is therefore susceptible to change. One factor that may alter these relationships is changing interfamily alliances and rivalries. New alliances between previously distant families may make links between a counselor and certain individuals possible. Conversely, rising tensions and disputes between previously cooperative family networks may jeopardize existing client-counselor relationships or prevent new ones from forming.

Just as an individual's relationships to others are influenced by family membership, interfamily relationships are affected by individual ones. A dispute between two individuals often results in animosity between the members of their respective families. Such family feuds may persist for years, as noted in the recent studies by the Northwest Intertribal Court System (1991) and the Swinomish mental health project:

> Inter-family rivalries, once begun, can be difficult to end. Tension between two people may involve their entire extended family groups in an ongoing series of unpleasant exchanges. . . . After a period of time, it may no longer be clear to anyone just why these two families don't get along. However, a pattern of suspicion and dislike may be perpetuated for quite a long time, possibly for generations. (Swinomish, 1991, pp. 174–175)

In the instance of interfamily conflict, new client-counselor relationships may not form and existing ones may be jeopardized because of the client's own sense of family loyalty, pressure from the family to sever a relationship, or the difficulty of providing effective care in the absence of family involvement in the treatment process.

Because relationships between family networks can change abruptly for a variety of reasons, ranging from political tension to personal conflict, the degree of access a support counselor will have to different families in the future is not entirely predictable at the time of hiring. A counselor who is presently well situated to serve a large proportion of the

community may be unable to do so successfully in the future as a result of a conflict that has little to do with him or her personally.

Changing Relationships II: Family Network Cycling

The likelihood that a native counselor will be an effective helper for a given family also changes over time as a consequence of the cyclical process of formation, growth, and collapse of family networks. Members of mature family networks are more likely to have ties that make a therapeutic relationship to an Indian counselor feasible than are individuals from families in the incipient, early, and fissioning phases. In the mature phase, an individual is more apt to have a family member who is a counselor, simply because the mature network makes up a large proportion of the community's population. If there is no family member who is a counselor, it is possible that the family will still have a personal link to a counselor's family because the large number of external ties, such as marriage ties, that a mature network maintains. Smaller and fissioned families are less likely to have a family member who is a counselor and have fewer personal links to other families that could help to establish interfamily, client-counselor relationships. Members of small and fissioned families and of unaffiliated households may be unwilling to confide in members of large families or use tribal institutions, as noted.

However, the relationship of a particular family to a counselor is not necessarily permanent. A mature family network may eventually become too large to maintain cohesion and may fission. Members may reaffiliate or reorganize into smaller groups. One or more of these new groups may contain support counselors or individuals who have ties to these paraprofessionals, whereas others may become distanced from counselors because the individuals who linked them to a counselor's family are no longer part of their network. Other families in the formative stages will grow as they recruit new members and will form links to other families as their members marry. Because of this increase in membership and in external ties, these growing families may become more personally linked to a support counselor, making therapeutic relationships more likely.

Families in the mature phase at the time counselors are initially appointed are more likely to have their family members hired than are smaller families because of the prominence of their members on tribal councils and committees. Ultimately, the people whom these decision-makers are most likely to perceive as natural helpers are those individuals who already perform this helping role in the decision makers' own families.

No matter the circumstances of the counselor's family network at the time of hiring, his or her relationship to other families will inevitably change. Just as changes in the size and composition of potential clients' family networks affect their relationships to a counselor, so do changes in the counselor's family network. Counselors from small family networks

will become linked to a larger proportion of community members as their networks grow, new members are recruited, and affinal ties are formed to other families. Counselors from families in the mature phase who are well situated to serve the community will become less so when networks fission and family members, including those who represent important marriage links to other families, reaffiliate themselves with other networks or move away. Thus, hiring counselors who are well connected to many individuals and families in the community does not guarantee that they will continue to be well situated in the future. In fact, quite the opposite may be true. However, given the relatively systematic development and collapse of family networks, these changes are somewhat predictable.

The consequences of the fissioning of a counselor's family network are particularly significant. Not only may fissioning diminish the number of families to which the counselor has ties, it may also have personal consequences that decrease the counselor's effectiveness. When the counselor's family fissions, he or she may become marginalized in the community and feel removed from both the community and community leaders with whom the counselor must work, a process Mrs. Johnson has reported in the case of her own family. As family members reaffiliate themselves or move away, counselors may feel socially isolated. Lacking family support, they may experience increased difficulty in dealing with the stress associated with the complex role demands and emotional strain of a counseling job. They may even decide to leave the community and affiliate with kin who live elsewhere. Loss of counseling staff is particularly detrimental in an Indian community because it takes a long time for new counselors to become accepted and changes in staff can be disruptive to client services (Swinomish, 1991, p. 257).

Conclusion

The need to employ native paraprofessionals as health providers in Indian communities is becoming widely recognized. To make these individuals effective, health agency staff must understand the implications of paraprofessionals' social relationships to different segments of their communities. It should not be assumed that all individuals have equal access to a native health provider's care; the present study of Coast Salish family networks reveals that the social placement of paraprofessionals results in differential access for members of different families. Nor should it be assumed that a native health provider's social position in the community is fixed; as family networks grow and fission and as interfamily relationships change, so does the access of family groups to the paraprofessional's care. A knowledge of family network relationships is useful in understanding how individuals access care, who will and will not be likely to use services effectively, and how access patterns will change over time. The Swinomish Tribal Mental Health Project's publication recommends that

"provider and client should be socially related such that therapeutic rapport is possible" (Swinomish, 1991, p. 118). If that advice is to be taken seriously, then interfamily relationships must be taken into account.

Knowledge of family network relationships has helped non-natives working in various social service sectors to provide more culturally sensitive services. However, there are other factors of varying importance that similarly affect client-health provider relationships in Indian communities. Runion and Gregory (1983), in designing paraprofessional programs in four Louisiana tribes, observed that factions, kin-based groups, and age-sex groups all create community biases. These and other group loyalties are seen as the source of ongoing problems in most previous programs employing paraprofessionals. The relationships affecting the social placement of the paraprofessional discussed in this paper could be adapted to help understand similar problems associated with other forms of group affiliations. Other, individual circumstances not related to group memberships affect the individual's use of health services, of course; however, behavior patterns associated with family network and, possibly, other group affiliations have significant and predictable influence on health care access patterns.

Family network relationships are complex, and incorporating knowledge of them into health care programs can be equally complicated. Careful selection of community members to be trained as paraprofessionals and an awareness of the viewpoints of those involved in the selection process could help ensure that health providers have access to different groups. However, we argue for the importance of an awareness of the changing circumstances. Initial client interviews can be designed to chart a community's family networks and their relationships to one another in order to identify the families to which the paraprofessional's ties are weakest. Individual clients can be located within the family network complex in order to understand how they are connected to significant others, including the paraprofessional, the family head, and other individuals who represent important resources, such as native healers, to whom referrals may need to be made. Family network charts can be updated regularly to account for changes in family composition and interfamily relationships. The patterned nature of family network cycling means that significant changes in family composition can be anticipated. Potential problems for client-provider relationships associated with the fissioning of networks and changes in the health provider's social placement in the community can therefore be foreseen and provided for.

Although network relationships present some barriers to the paraprofessional's effectiveness, they can also be used as a positive resource to increase health service accessibility. By actively attempting to forge links to key individuals from families who fulfill important roles as advisors and caregivers — such as family heads, elders, and various types of natural helpers — the health clinic staff may be able to establish

trustful relationships and include themselves in the network of resources utilized by these families. The Swinomish program staff found that the employment of a 78-year-old tribal elder as a cultural consultant was "a significant element in [their] ability to mobilize family involvement" (Swinomish, 1991, p. 228). Once links are formed, the clinic staff can encourage family authority figures to consult directly with paraprofessionals about problems concerning family members, thereby acknowledging their authority and decision-making power and gaining their trust while strengthening the clinic staff's relationship to that family network.

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Notes

1. Laraine Michalson, our collaborator on this study and an officer in the United States Public Health Service, presented some of her views to the 45th Annual Northwest Anthropology Conference,

Burnaby, BC, April 1992, in a paper titled "The Nursing Approach: Family, Community, and Service Delivery to Native Americans."

2.   We believe that these generalizations do not always pertain; some community members are ineffective, just as some outsiders are effective and sensitive. Non-Indian personnel are frequently knowledgeable and represent a largely untapped resource for the study of Indian communities and in the creation of effective mental health planning.

3.   In the contact period, "private knowledge" included such family-held information as knowledge of magic, etiquette, and how to prepare in order to acquire spirit powers. Today the categories of private knowledge are slightly different, but the concept is equally relevant.

4.   The natural history of the family network in Coast Salish communities is considered in more detail and in other contexts in Miller, 1989, 1990, 1992a, 1992b.

5.   The biomedical and mental health implications for the process of fissioning are most onerous for elders, who are sometimes left with little help and a sense of alienation from the community. See Amoss, n.d., Miller, n.d.

6.   We wish to thank Jennifer Clarke, the first director of the Swinomish Tribal Mental Health Project, for her contribution to our understanding of the project. Errors in interpretation are, of course, our own.

7.   Mrs. Johnson believes that in many ways she is able to help people more effectively now that she is no longer employed as a counselor because she is free of the legal obligation to maintain secrecy. We have used the present tense in writing about Mrs. Johnson and her views because she presented them in this way. She is still a "natural helper," and her counseling experiences are important and vivid to her.