

Professional/paraprofessional team approach in groupwork with Cambodian refugee women

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Abstract: *This paper describes a support group for Cambodian refugee women. The members were all survivors of the Khmer Rouge from the 1970s and 80s and had current diagnoses of post traumatic stress disorder. The group consisted of 16 women aged 44-60. The members describe their trans-cultural experiences of ageing within the United States. The paper also describes a therapy team approach which uses an English speaking licensed professional and a Khmer speaking paraprofessional. The strengths and challenges of this approach are discussed. Agencies that serve refugees may not have professionally trained mental health providers who are from the country of origin of their clients. This model holds promise to provide culturally sensitive treatment. However, it is a model that is in its infancy in terms of knowing what works and how to duplicate that to other agencies and populations. This paper shares some of the benefits as well as some of the drawbacks.*

Key words: *refugees; women; groupwork*

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Introduction

In 2005, the United States admitted 53,000 refugees and granted asylum for 25,000 individuals (U.S. Dept of Homeland Security, 2007). It is generally accepted that refugees and those seeking asylum not only experience multiple stressors and trauma in their countries of origin, but also additional stressors as a result of resettling in the United States (Musser-Granski & Carrillo, 1997; Nou, 2006). Public agencies are increasingly called upon to offer services to these populations. Education about refugee and immigration issues, however, is available at only a third of this country's schools of social work (Gozdziak, 2004). Consequently, when challenged to meet the language and cultural needs of various refugee populations, many social service agencies turn to paraprofessionals who may not be clinically trained, but are familiar with the language and culture of the communities being served. These paraprofessionals serve as interpreters, outreach workers and, often, as co-counsellors (Musser-Granski & Carrillo, 1997; Owen & English, 2005). The use of paraprofessionals as co-counsellors necessitates the development of culturally appropriate and effective treatment models to better meet the mental health needs of immigrants and refugees. Such a model needs to incorporate the use of bilingual paraprofessionals in the provision of therapeutic treatment.

The setting

Groupwork is one treatment for refugees who experience symptoms of post-traumatic stress, and mood and anxiety disorders (Nicholson & Kay, 1999; Owen & English, 2005). Support groups allow members to share their experiences with others who have similar stories. It is suggested that doing so decreases the experience of loneliness and isolation, and can nurture a more hopeful outlook of being capable to survive stressors as others have (Ying, 2001).

This paper presents an overview of my experiences and observations as a Caucasian licensed clinician, with 20 years of direct practice experience, working with a Cambodian paraprofessional in both individual and group therapy sessions for Cambodian refugee women. The group meets twice a month, and at the time of this writing, has been meeting for over a year. The group is held at a community health centre

in Lowell Massachusetts, a city with the second largest Cambodian population in the United States.

The participants

The selection criteria for this group were minimal. The group was designed for adult Khmer speaking Cambodian women who have been diagnosed with post-traumatic stress disorder. Any woman fitting this description who was evaluated by her individual psychotherapist to be likely to benefit from this group was invited to join.

The group consisted of 16 women aged 44-60. All participants had refugee or asylum-seeker immigration status. All had lived in Cambodia during the time of the Khmer Rouge. The youngest member of the group (age 44) was nine during the Khmer Rouge. Five other members were in their adolescence during this violent era, while the other group members were in their twenties. All the participants had tested positive for the diagnosis of post traumatic stress disorder according to the results of the Cambodian Harvard Trauma Questionnaire (Mollica et al., 1991). Each reported having witnessed and/or experienced forms of torture. Only one member did not have children, and the children of the others were grown. Marital status varied with nine members divorced, four married, one single, and two widowed. Before joining the group, the participants had each been seen by her individual psychotherapist who assessed and diagnosed the participant and determined that the group would be of therapeutic value. All the participants continued to see a counsellor on at least a monthly basis.

The group was designed to provide support for the members. A number of topics became common among the members. These topics underscore the barriers many of these women faced as refugees decades after resettlement. These topics included: a) health issues. Many of the women had chronic health disorders such as cardio-vascular disease and diabetes; b) immigration issues. Many of them continued to face immigration and citizenship issues for themselves or close family members; and c) disability. Many of the members were navigating the requirements and procedures to obtain disability public assistance. While all of the women had worked throughout their years in the United States, many were experiencing an exacerbation of post-traumatic stress symptoms which made them 'too slow and unreliable' for their assembly-

line work. Therefore, some of the overarching concerns of the group members were issues of immigration, health, and public assistance.

The approach: Team therapy

Providing services to a large population of Cambodian refugees, our health centre uses a bi-cultural therapy team approach that pairs an English speaking licensed clinician with a bilingual paraprofessional. This model holds great promise, but has few precedents. Other writers have described using bilingual paraprofessionals to work with clients for whom English is not a first language (e.g., Musser-Granski & Carrillo, 1997; Nicholson & Kay, 1999; Owen & English, 2005). However, these do not identify the model as a therapy team approach. A therapy team approach implies that both the licensed clinician and the paraprofessional provide treatment interventions. This model also implies that each is an expert: one in clinical assessments and interventions, and the other in the language, culture, and shared experiences of the clients. Rather than relying on the bilingual paraprofessional solely as an interpreter, this model creates a very different dynamic and approach.

The group: Three characteristics

The goal of the group is to provide support for the women as they cope with symptoms of post-traumatic stress and living as Cambodian refugee women in the United States. There are a number of characteristics that shape the group.

Characteristic one

All of the women are survivors of the Khmer Rouge and came to this country as refugees. Cambodian refugees first fled from Cambodia during the reign of Pol Pot's Khmer Rouge (1975-1979). During Pol Pot's regime, nearly 3 million – close to half of Cambodia's population at that time – were tortured, murdered or died of starvation (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Ying, 2001). Thousands fled their villages and struggled across a mountain range to reach UN sponsored refugee camps in Thailand. Some stayed in these austere camps for nearly ten years before being assigned to a sponsoring country. Once told of their new country, they were given a one-day workshop about

the host country, which consisted of concrete information such as how to flush a toilet or operate a shower.

Like other Cambodian refugees, the women in this group have had difficulty finding work other than manual assembly jobs (Ying, 2001). Cambodian refugees in the United States have the lowest incomes and lowest attainment of education when compared to other Asian groups (IAAS, 2004). Inability to find life-sustaining work, has forced most to live in crowded living conditions.

Each group member continues to experience disturbing memories, nightmares, and symptoms of post-traumatic stress originating from their experiences under Pol Pot's regime. Some of the women were held captive and either witnessed or were victims of torture. All of the women lived in fear during this reign. They heard stories about murders, and had friends and family disappear in the middle of the night never to be seen again. For these women, loss and fear have been constants for over 30 years. Today, they present with symptoms consistent with the Diagnostic and Statistical Manual (DSM-IV, 1994) definition of post-traumatic stress disorder, including exaggerated startle response, nightmares, intrusive memories, confusion, avoidance of reminders of traumatic events, and a sense of a foreshortened future.

Studies have found that up to 86% of all refugees suffer from post-traumatic stress disorder (PTSD), and Cambodian refugees are the most severely affected (Nou, 2006; Ying, 2001). In addition to post-traumatic stress disorder, depression is highly prevalent within the refugee population (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Ying, 2001).

The following quote from a member reflects well one of the many PTSD symptoms experienced among the members of this group:

I wake up screaming. I don't always remember them, the dreams. But I am screaming. Sometimes I am sweating. My heart is pounding.

The members report feeling most affected by the symptoms of post-traumatic stress that they experience during the day. As is common in this group, the following member becomes dizzy when she experiences sudden triggers.

I get ... I jump when I hear loud sounds. I get so dizzy I don't want to hold the

grandchildren. I think I will pass out. My heart beats so fast. Sometimes I think I will have a heart attack.

In group the facilitators help the members share their coping skills. In the following exchange the professional responded to a member's description of her nightmares.

The professional leaned in closer to the paraprofessional and said, *'I'm wondering how the other members cope with similar experiences.'*

The paraprofessional leaned toward the group and spoke in Khmer, looking at each individual as she spoke in order to engage all members. Several women shared their own nightmares and how they tried to distract themselves when they woke up. One woman described turning on the television until she fell back to sleep. Another said she goes into the kitchen and 'coins' herself, a practice of rubbing her skin with the side of a coin. By the end of this particular session a number of the women expressed relief in knowing that they were not 'crazy'. This seems to be an important benefit for the women of this group: normalization of their experiences.

Characteristic two

All the women in our group consider themselves to be in 'old age'. A study on ageing Cambodians by Becker and Beyene (1999) reports that participants believe old age begins at 40 years of age. This self-perception is important because it influences how the women define themselves in relation to their future expectations and goals, to their relationships with their families, and to their role in society.

While there is a paucity of research on the experiences of ageing refugees (Becker & Beyene, 1999; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Nou, 2006), there is agreement that ageing refugees appear to be a vulnerable at-risk group. Marshall and his colleagues (2005) found that more than two decades after having arrived in the United States, 62% of their sample ($N = 490$) revealed high rates for PTSD, and 51% for depression. They believe their results indicate that refugees can continue to have substantial mental health needs long after they have resettled.

Each group member has lived in the United States for at least 20 years.

Each has worked consistently over the years supporting themselves and, for all but one, their children. Had these women been living in Cambodia, at this stage in their lives their focus would be moving away from work and toward caring for their grandchildren. As one member described this period,

In Cambodia, by the time you are in your forties, well, you marry before you are 20, you have two or more children by your early 20's. By the time you are in your forties, your children are having children. It is time to be a grandmother.

When a woman becomes a grandmother in Cambodia her social role changes. As another member has shared,

You would work less, not do so many chores. Your work would be caring for your grandchild. You would go to temple and cook for the monks. You would live with your children and they would look to you for advice.

The women in this group experience sadness and fear at the differences between what they believed old age would be, and how it is in the United States. All the members but one had grown children. They shared their sadness and hurt at not feeling as respected by their children as they expected they would be at this time in life. For the one member without children, she expressed her fear at not being cared for as she aged. *I don't have anyone. I am alone. I am scared. What will happen to me? Who will care for me?*

This sharing brought on a rich discussion within the group about everyone's fear of ageing in the United States.

Here in this country I am afraid my children will put me in one of those homes. I will be left alone. In Cambodia the children would never leave their parents to care for themselves. You would know your children would care for you. But here, here it is different. I don't want to be alone.

In this exchange the professional acknowledged the differences in the United States. The professional asked the group and the paraprofessional if reaching out to each other and other members of the community would lessen this fear and isolation. The paraprofessional turned to the group and translated. She then waited and let the members respond.

Many of the members acknowledged that the group helped them to feel less alone. Two members reported that they already called and visited each other outside of the group. This began a discussion among the members about how they could help each other. In the session, they exchanged phone numbers and some offered to drive other members to the next group.

Characteristic three

The co-facilitator team represents another characteristic. All the group members are Cambodian and speak Khmer as their primary and sole language. As mentioned earlier, one of the facilitators is a Caucasian English speaking licensed professional and the other facilitator is a Cambodian bilingual paraprofessional who has no clinical training. The groups are conducted in Khmer. The expectation is that professional and paraprofessional will work as a co-counsellor team. This differs from a model that uses a professional to lead a group and an interpreter to translate verbatim the words and meanings between group members and the professional. In the latter model, the interpreter's role is to interpret English into Khmer and Khmer into English with as much of the original meaning intact. The interpreter may interject when she feels a cultural meaning is being missed. However, when she does interject, she clearly announces to both the group members and the facilitator that she is stepping out of her interpreting role and into a cultural interpreting role. She makes her point, and then resumes acting solely as an interpreter.

In the team model, the bilingual paraprofessional is also a co-counsellor, facilitating discussion, initiating member interactions, and performing therapeutic interventions. In addition, she serves as a cultural interpreter for the members and the facilitator in a seamless dialogue with both the professional as well as the members. In this model, the bilingual paraprofessional focuses on the theme of the group discussion rather than the verbatim content, thus interpreting a summation of the group discussions for the professional practitioner.

Team model in practice

This professional-paraprofessional team therapy model is in the early stages of development. It is a working model that has evolved as the

relationship with my paraprofessional colleague has deepened. The process has included successes and moments of stagnation in our group facilitation.

Professional roles

Clearly, the professional role changes in this model. In a sole facilitator model in which group members and the facilitator share a common language, the professional listens to the content of the group discussion and focuses on core issues pertinent to the group as a whole, or to a specific member's needs. The role of the professional facilitator changes dramatically when language is not shared in common.

In the professional-paraprofessional team therapy model, the bilingual paraprofessional shares both culture and language with group members and becomes the lead facilitator. The professional acts as the paraprofessional's mentor, guiding the choice and process of therapeutic interventions. In our group, members see me as an authority because of my status as a Caucasian United States native. I have been assigned the status of wise elder, and I am referred to as Grandmother. This is notable in that I am the age of the youngest Cambodian group member. Due to this role, the members rely on me to serve as a case manager, brokering their social service needs. Invariably, at each group session, at least one member presents me with letters from various social service or legal agencies, and asks for assistance. With the translation assistance of my paraprofessional colleague, I explain the letter and offer to follow up with a phone call to the agency if needed. These communications are often from debt collectors or public assistance offices dealing with issues such as housing, food stamps, social security, or income taxes.

While I am presumed to be the expert on the culture of the United States, I am also seen as a student of Khmer culture. This becomes a source of enjoyment for the group members who explain Khmer cuisine, landscape, and customs. They smile and laugh when I struggle to pronounce Khmer words. During these instances, my paraprofessional colleague is a member of the 'Khmer group' and I am the foreigner. My colleague joins in the laughter and enjoyment of educating me about her language and culture.

Mentoring

I also function as a mental health mentor for my paraprofessional colleague. I observe the group for behaviour and topics that warrant therapeutic intervention. Because group discussion is occurring in Khmer, other forms of communication are prominent in assessing group dynamics: body language, vocal intonations, facial expressions, and pacing of verbal exchanges. During the group, my colleague quietly provides me with a summary of the discussions. Summarization typically happens when a pause in discussion occurs, after a bout of laughter, or when a topic appears noteworthy to the paraprofessional. I will then speak softly to the paraprofessional, and offer her perspective about the group discussion from a meta-analytic position. The following provides an example of such an interaction. During one session, my paraprofessional colleague quietly informed me of the following:

She is talking about going to housing [authority]. She wanted to tell the worker [housing authority worker] that her children need her to move out. The worker told her to get a letter from her children saying she didn't have a place to live.

I responded on a number of levels. Having assisted others with housing assistance, I understood the process that our client must go through to get on the housing list. Having worked with the Cambodian population, I also understood that being told that she must move by her children was sure to elicit feelings of sadness, shame and fear. I also understood the powerlessness that this woman and many group members feel when trying to navigate social service systems. I wanted to address these issues as therapeutic topics for the entire group. To be most effective, the topics needed to be framed in such a way that reinforced that the group was a safe place to talk about sad and shameful feelings, and a platform from which to feel affirmed and empowered.

In the professional-paraprofessional team therapy model, the roles of the professional and paraprofessional are fluid and change throughout each session. The paraprofessional pulls back to interpret for the professional. The professional conceptualizes an appropriate intervention and relays this to the paraprofessional. The paraprofessional then returns to being the primary facilitator. Even though the group is aware of the consulting between the two facilitators,

the group discussions continue. This necessitates the attention of the paraprofessional even as she consults with the professional. This is challenging to both the mentoring relationship and group dynamics. To be most relevant, the professional must convey the meta-analysis quickly to the paraprofessional so she can make a timely intervention. Even when the professional expresses her intention and suggests an approach, she cannot know the paraprofessional's understanding of this intervention. Nor can the professional know what the paraprofessional has said to the members.

In the foregoing example, I suggested that my paraprofessional colleague validate for the member that it is scary to live alone. My colleague did this and then reported to me that, '*She said yeah, it is scary.*' She nodded toward the group, '*They are all scared of living alone.*' This then began a discussion on ageing and the members' fears of growing old in the United States.

Choosing the role

At times, I address the group directly to draw attention to a topic or to accentuate an intervention. In this example I wanted to underscore the commonality of their experience. I asked, '*What is it like to be your age and living in the United States? How is this different from how you thought your lives would be at your age?*' The members were quiet and then looked towards my colleague who then spoke to the group in Khmer. Members began talking to me directly and then to each other. My colleague leaned towards me and said, '*They are afraid their children will send them to a nursing home. They are afraid they will be alone.*' She added, for my benefit, '*In Cambodia, we never live alone.*'

There are times when I choose not to address the group. The decision of when to act as leader is based on what will be most therapeutic for the group. There are two factors that affect the manner in which the group experiences my interjections. First, because my English needs to be translated into Khmer, there is a pause in group process while my colleague translates. In a mono-lingual group, a professional facilitator can time interjections to maximize their therapeutic effectiveness. It is also possible to intervene in such a way that group process is enhanced. In my experience in a bilingual group, each time I speak, the dynamic of the discussion changes. Naturally, group members have to pause while

my comments are translated. I have also noticed that group members seem to become more self-conscious. This effect, when used well, can be a powerful intervention. Other times it can be disruptive.

Secondly, there are two facilitators: one who is engaged with the discussions and the other (the English speaking professional) who is less involved and perceived as the authority. The members stop talking when I speak, whereas when my colleague speaks they feel more able to interrupt or will pause only briefly. Again, the significance of the professional's role is notable and can be both an asset and a barrier to effective group interventions.

Challenges and opportunities in the team model

In traditional groupwork, the facilitator relies heavily on discussion content that is initiated from the group members. The facilitator tailors therapeutic interventions to focus on emerging themes. In the bilingual group, the professional isn't privy to the actual words used by the members. The professional tries to provide effective facilitation with much less information. It is very likely that important connections and therapeutic moments are literally lost in translation. Additionally, the professional must rely on the information that the paraprofessional perceives to be important to interpret. This can severely limit the effectiveness of the professional. Another limitation for the professional is not knowing how the interventions are executed in the language of the group. A carefully planned intervention could be executed very differently by the paraprofessional in the group's language and cultural perspective.

However, with this challenge there are also opportunities. The professional must rely more on body language, vocal intonation, affect, pauses, and other signs of the members' engagement. In our group, this has created an effective teaching bridge between my colleague and me. Relying on what I observe, I am more able to recognize emotional cues. While my paraprofessional colleague is focused on the content, I am concentrating on affect. This has strengthened our team approach and I believe the group has benefited from having two lenses through which group process is observed and facilitated.

In addition, because I am less aware of content, and because discussions are summarized more than translated verbatim, I am better

able to maintain a meta-position within the group. This has proven beneficial in my role as a mentor to my colleague. For example, what my colleague chooses to summarize for me often reflects what she has assumed to be most important. Comparing her perspective with my observations has enabled me to learn about the 'assessment filter' through which my colleague sorts and prioritizes information. In a mentoring role, this is important to understand in order to help the paraprofessional student become more skilled. Often when mentoring a student therapist, it is difficult to know how s/he perceives the client. This team approach has provided a more distinct view.

A clear strength of this model is the cultural interpretation performed by the bilingual paraprofessional. This greatly benefits group members and the professional facilitator. The bilingual paraprofessional acts as a bridge between the two cultures. With each intervention from the professional, the bilingual paraprofessional not only seeks to understand the professional's intention, but also to translate this intention into a culturally appropriate concept.

Evaluation

This approach provides culturally sensitive and appropriate treatment. This is most helpful in translating Western concepts and treatments into Khmer relevant interventions. This approach also provides the Caucasian mental health provider with a culture mentor, providing insight about her clients, which strengthens her ability to develop appropriate interventions. A necessary strength of this approach is enabling professionally trained English-only clinicians to work with non-English speaking clients from various cultures. This model shows great promise as a powerful treatment approach that combines the expertise of a professionally trained clinician and the expertise of a cultural insider.

However, there is much that needs to be understood about the efficacy of this approach. How do the clients experience the team model? How are the interventions executed? What is the feedback system to know if suggested interventions are culturally appropriate and helpful?

A close, cooperative working relationship between a professional and paraprofessional is an essential element of this approach. During

pre-group and post-group briefings, facilitators can discuss their expectations and perceptions of the group. During the post-group briefing, the professional can develop a better understanding of how the interventions were executed as well as the paraprofessional's assessment of their effectiveness. In this group, the paraprofessional advised the professional of the cultural appropriateness of a suggested intervention. This was helpful in the moment. In the post-group briefings, these moments were explored in more depth, thus providing an opportunity for both facilitators to deepen their understanding of group dynamics and effective interventions. These briefings, however, don't answer the question of how the group members experience this approach nor adequately assess its effectiveness.

It is widely held that the quality of the relationship between provider and client is a strong determinant of the effectiveness of any therapy. Quality of relationship is particularly important in this group. Each member has experienced a lifetime of fear. Trusting other group members and the facilitators is critical for this group to be effective in providing support and trauma healing. In this professional-paraprofessional team therapy approach, both facilitators must create that safety with the members and each other. Future studies need to address how members experience this approach, and what helps members feel safe in such a group.

Another aspect of safety concerns the paraprofessional. One of the strengths of using a paraprofessional as a co-facilitator is that her life experiences are similar to those of group members. This creates a level of trust and sympathy between the clients and the facilitator that would be much more difficult to achieve by one who has never lived under the Khmer Rouge. The members know the paraprofessional understands what they have gone through. They are able to speak in a cultural short-hand and nod to each other in agreement over shared stories. This creates safety and connection within the group and with the paraprofessional facilitator. However, the paraprofessional is in a difficult role. She is not only a survivor of the Khmer Rouge, but she is a mental health provider, and a cultural interpreter. She cannot engage in the group discussion as a member. She keeps her self removed while listening and interpreting. When a member recounts a horrific story of torture, other members can nod and add their own stories. The paraprofessional, however, listens and interprets and then tries to

interpret back to the group the professional's comments. Future studies need to explore the impact this role has on paraprofessionals. Agencies who currently use paraprofessionals in this role should consider support or training to decrease possible re-triggering of post traumatic stress symptoms in the paraprofessional.

Throughout the year of this group, the professional and paraprofessional met before and after each group session, discussed the progress and needs of the group, and decided together the focus of the group sessions. The post-group meetings included discussions on specific exchanges from that day's group session and how each perceived the effectiveness of the interventions. The professional also encouraged the paraprofessional to advise the professional on the cultural appropriateness of the interventions, as well as culturally sensitive ways of addressing specific issues in future sessions. If a group session involved disturbing material, the professional provided support to the paraprofessional by acknowledging that the material might bring up the paraprofessional's own feelings and the complicated role the paraprofessional is in to be both a survivor and a facilitator. Over the course of a year of working closely together, the professional and paraprofessional have forged a relationship based on trust and respect which makes the post-group meetings safe for the paraprofessional to receive support and safe for the professional to learn to be more culturally sensitive and effective.

Ethics and values

For a professional/paraprofessional team approach to be culturally sensitive, clinically effective and empowering, the model needs to hold sets of ethics and values that maintain the respect for the clients as well as for the paraprofessional and the professional. These sets of ethics and values need to acknowledge the power imbalance inherent between the Caucasian professional and the paraprofessional Cambodian refugee. While acknowledging the power imbalance, this model also holds the paraprofessional to be an equal team member whose expertise complements that of the professional. The team approach is re-enforced in the pre and post-group meetings when the paraprofessional's expertise is sought and in the group sessions when the paraprofessional takes

the lead role. These sets of ethics and values also need to acknowledge that the client's cultural experiences are an important and central component of treatment and should always be considered during treatment. The professional needs to find effective ways of adapting clinical interventions to the cultural needs of the clients. For guidance in this she turns to her team member—the paraprofessional.

The women of this group are traumatized survivors of a violent, oppressive regime. In order to provide effective treatment, the setting, the providers, and the interventions need to be respectful, safe, and non-oppressive. To create this, the centre and providers must be guided by sets of ethics and values that ensure such practice.

Conclusions

This is a personal narrative of a Cambodian refugee women's group which took place over a course of a year. The group used a bi-cultural team therapy approach in which one facilitator was a professionally trained clinician who was Caucasian and spoke only English, and the other facilitator was a Cambodian bilingual paraprofessional. There is a need to have models which can use the expertise of clinically trained professionals and the expertise of cultural interpreters. Currently there are no evidence-based models. This narrative serves to share some of the strengths of a working model as well as areas that warrant attention.

The United States will continue to accept new immigrants and refugees. Mental health providers will be called upon to treat these at-risk populations. Effective treatment will rely on culturally appropriate and clinically sound approaches. Such approaches will not always be possible by a professionally trained provider from the culture of the client. Therefore, the professional-paraprofessional team therapy model will be increasingly used. The United States is not the only country to face this need. We live in a global age where trans-cultural experiences are challenges in various health and mental health care settings. An evidence-based model of this approach will enhance the services that can be provided. This paper is a narrative step toward that model.

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