The Full-Frame Approach: A New Response to Marginalized Women Left Behind by Specialized Services

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Increasing emphasis on specialization in social and mental health services leaves these systems largely unable to attend to marginalized women's complex needs, despite new models designed to ameliorate specialization's impact. In this article, the authors describe how inattention to these women's contexts leaves them ill-served and leaves programs struggling. The authors articulate a new framework of principles and practices that privileges context and community, and describe two programs that use this "Full-Frame Approach." The authors contend that systemic recognition of full-frame programs as a strategic counterbalance to specialization is a vital component of helping marginalized people and communities move to new levels of health and cohesion.

Keywords: context, community-based programs, marginalized women, fragmentation, relationships

Throughout our communities, policymakers, funders, and practitioners are working diligently and creatively to address and meet the needs of marginalized[1] populations—those whose situations are highly unstable and crisis-prone because of current or past trauma, mental and/or physical illness, addiction, significant economic hardship, ethnic/racial or other discrimination, and/or societal disinvestment in them and their communities. Over the last several decades, progress has been made in the identification, treatment, and remediation of major psychosocial problems facing these communities—problems such as homelessness, addiction, domestic violence, and mental illness. Alongside and, in part, propelling these accomplishments has been an increasing emphasis on developing and documenting focused interventions that target specific difficulties facing specific subgroups; some of these have been packaged as models for replication, allowing other geographic communities to benefit from lessons learned without reinventing the wheel.

This movement toward greater specificity has obvious advantages for communities and providers and those individuals struggling with exactly (and only) those issues or constellation of issues that specialized services target (Austin & Prince, 2003; Blom, 2004; Flaspohler, Wandersman, Keener, Maxwell, & Ace, 2003). However, the movement toward increasing specialization has also meant that specific issues faced by program participants are targeted at the expense of the complex situational factors in which they are inevitably embedded—their contexts—leading to the further marginalization of those people and communities who can least afford, and are least able, to disentangle themselves from their contexts. Furthermore, calls from public and private funders

and policymakers for proof of the success of services using simple outcome metrics can lead to a complicit de-emphasis of those aspects of people's lives that are not easily measurable or within the defined parameters of the service model (Austin & Prince, 2003; Blom, 2004; Meagher & Healey, 2003; Tsemberis, Gulcur, & Nakae, 2004). The obfuscation of factors, situations, and issues outside the scope of a program's goals, together with the implicit message that only certain kinds of changes count as success, undermine individual practitioners' and programs' valiant efforts to address larger issues (Blom, 2004; Meagher & Healey, 2003) in comprehensive ways (Dyeson, 2005).

It is impossible truly to separate any people from their situations—their contexts; certainly, this is no less true for marginalized women and men. By contexts we mean relationships with family, friends, and community (relational context); the material and socioeconomic conditions that shape experiences and options (material context); and the intersecting demographic dimensions that shape one's identity and society's response to that identity (e.g., race, ethnicity, gender, sexual orientation, religion, disability; identity context).

Specialized services focus attention on a prescribed issue or constellation of issues, rather than on the person and her experience of contending with the issue. We assert that these programs and systems are insufficient and unable to meet the needs of marginalized people.

We further contend that promoting lasting change in the lives of marginalized people and communities requires significant attention to context as an integral part of our work. In this article, we

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[1] We recognize the power and limitations of language, and preferentially use the descriptor "marginalized" understanding that it may connote "other" to some readers. We feel it a somewhat more appropriate choice than its rough synonyms, "vulnerable" or "underserved", because "vulnerable" locates pathology too squarely in the person and also implies a passivity that we rarely observe in working with those who must struggle to meet even basic needs. We choose not to use "underserved" as it implies that more of the same type of services is adequate.

describe an approach based in observed and realized practice that emphasizes context and, in doing so, strategically counterbalances the negative consequences of specialization. This approach incorporates and goes beyond relational and holistic practices. It requires that programs and initiatives be embedded in and informed by their particular communities, whether communities develop and define themselves on the basis of geographic proximity (neighborhoods), common interests (e.g., religious, leisure, or professional activities), shared identity and experiences (e.g., race, gender, class, or occupation, personal history), or circumstance (workplace, residential institution, schools). This framework is purposefully not a model of service, but an approach to guide program design and function, as well as system-level approaches to addressing entrenched community problems.

We call this set of principles and practices "the Full-Frame Approach," because it calls on providers and programs to frame their work not just around an issue, or even a person, but to pull the lens back still further. The Full-Frame Approach recognizes the impossibility of truly knowing a person and therefore helping her holistically without understanding how she interacts with, is affected by, and influences those around her, and how she is shaped by contextual factors such as personal and social history, race, class, culture, and intentions. Incorporating these factors into one's understanding of another is cultural competence in its fullest form.

The recognition, practice, and funding of the Full-Frame Approach will require a radical shift in systems of care, where specialized programs and full-frame programs are recognized as constituting a double helix, each type of program constituting a strand reliant on the strengths of the other. To the extent that marginalized women have access to full-frame programs, they may have a greater likelihood of success within specialized systems of care, and a greater likelihood of success in realizing and sustaining larger, positive changes within their lives.

We begin the article with a brief review of literature and ideas on specialization, and explore further the negative consequences of specialization for marginalized women. We frame our discussion with regard to marginalized women in particular because they are the focus of the programs that inform this article, although it is our expectation that these ideas can be generalized to other marginalized populations as well. In the second section, we advance the Full-Frame Approach's defining principles and practices. To illustrate the surface divergence among programs that nevertheless share the full-frame spirit, we then provide two examples of programs that have adopted the framework. We conclude by briefly outlining some of the challenges and possibilities inherent in this approach and the system change necessary to achieve it.

When Specialization Leaves Women Behind

Specialization has led to a situation in which "issues" (e.g., domestic violence, mental illness, homelessness, addiction) become the targets of intervention, rather than people and their actual situations. A closely correlated development is the adoption of narrowly defined and often binary definitions of success for a given specialized program and its participants. Such absolute outcome metrics (e.g., she left her batterer or returned to him; she is taking her psychotropic medication or she is not; she is housed or is not; she is drinking or is not), enable us to assess the immediate effect of an intervention with respect to a single short-term goal,

but leave us with little sense of its staying-power and longer-term impact, once the complexities and vagaries of a woman's life exert their force (Blom, 2004; Fetterman & Wandersman, 2005; Fine, Tore, Boudin, Bowen, Clark, Hylton, et al., 2003; Levin, 1999; Suarez-Balcazar & Harper, 2003; Uziel-Miller & Lyons, 2000; Wandersman, Snell-Johns, Lentz, Fetterman, Keener, Livet, et al., 2005). The allure of seemingly straightforward metrics, whether or not they actually can describe long-term impact, can alter the perspective of service providers, who over time will come to focus on those things that are being measured and may consciously or inadvertently ignore other relevant events and factors. As we discuss throughout this article, the resultant failure to attend to contextual factors marginalizes those who face multiple challenges. Broadly applied, externally imposed measures of success and failure also victimize service providers, who cannot work with clients in more individualized ways, and marginalize those programs whose impact cannot be measured using the same tools.

Many marginalized people experience a range of problems and crises that cannot be distilled into one straightforward issue, to be resolved through a rigidly defined, predetermined intervention (Eby, 2004), the success of which can be measured and assessed through a set of standardized indicators insensitive to nuance or interpretation. Often, various difficulties or obstacles interact with and impact each other over time (Belle, 1990; Belle & Doucet, 2003), and the interaction of issues may create something different than the sum of the individual issues. The teasing apart of a woman's situation to identify specific issues generally involves either relegating key aspects of her context to the background, as they are seen by providers to be irrelevant to or complicating the issue at hand (Blom, 2004), or expecting her to abandon her relational context as part of treatment, given the "harmful" nature of certain relationships (Bogard, McConnell, Gerstel, & Schwartz, 1999). Failure to understand a woman in a comprehensive, contextual way may actually undermine the long-term success of the intervention and the woman herself. Indeed, data from a number of studies demonstrate that interventions targeted to an individual's own complex perceptions of herself, her relationships, and her needs are more successful in eventually effecting change than interventions that emphasize a narrow and predetermined goal (Epstein, Bell, & Goodman, 2003; Marcus Banspach, Lefebvre, & Rossi, 1992; Prochaska, DiClemente, Velicer, & Rossi, 1993).

Certainly, internalized stigma and bias and other "self-perception" issues create barriers of their own, but those who are not heterosexual, middle-class Caucasians may experience very real bias and barriers to care that are externally based (Blanchard & Lurie, 2004; Limbert & Bullock, 2005; Sullivan & Eagel, 2005). This furthers the marginalization of those with the type of issues (e.g., addiction, mental illness, or domestic violence) that specialized services are designed to address.

Critiques of specialization have been offered in several fields. Blom (2004) reviews relevant social work literature and frames specialization as a counterpoint to generalist social work practice, concluding that the primary problem with specialization is that it interferes with knowing the whole person. Addressing only discrete issues can grossly neglect the needs of people who face multiple challenges, a population that Blom suggests constitutes the majority of social service agencies' clients. Uziel-Miller and Lyons (2000) investigated the efficacy of highly targeted substance abuse models and concluded that specialization often cre-

ates false divides between those who are eligible versus ineligible for services (e.g., the denial of available services that target addicted pregnant women to addicted, parenting, nonpregnant women). In fact, the very eligibility criteria established to ensure "success" and continued program funding often screen out those most in need of services.

In the wake of such critiques have come a host of important steps and suggestions on how to mitigate the fragmentation and other negative sequelae of specialization. We briefly review some of these below, recognizing that each has something to teach and offer us, but that none, in our view, steps back far enough from a specialized service paradigm to address its fundamental flaws, laid out in the next section.

A seemingly obvious retort to specialization's downside is a call for generalist practice. But this is not in itself a solution, as it almost requires practitioners to be expert in everything and ignores the value of having practitioners with deep, specialized knowledge. Even if it were possible, such a "solution" would leave practitioners and program participants overwhelmed by the prospect of dealing with all issues at the same time, yet lacking the expertise, time, energy, and resources to deal with any issue in depth. Even generalist practice as a "glue" for specialized service as is sometimes practiced in coordinated case management is insufficient, because it does not attend to the contextual realities and needs of vulnerable women, including being rooted in and known as a member of a community, discussed below.

It is not surprising, therefore, that more common than the call for a return to generalist practice are calls for and innovative models of service coordination and integration. In this paradigm services remain specialized, but they are coordinated either at the administrative level or, occasionally, at the level of program content. Examples range from centralized intakes for multiple services, organization-level reciprocity agreements, and information sharing to cross-training and case consultation. These efforts are often carried out by umbrella human service organizations (Austin & Prince, 2003) or through increased collaboration and linkages across programs (Darlington, Feeney, & Rixon, 2004; Flaspohler et al., 2003; Haddad & Knapp, 2000). Sometimes, initiatives attempt to overcome the barriers of specialization by focusing their interventions on groups facing multiple challenges, such as domestic violence programs for women contending with addiction, thereby creating a subspecialty. Other approaches seek to embed a body of knowledge about one issue within specialized services that target other issues, such as in trauma-informed programming (Cocozza, Jackson, Hennigan, Morissey, Reed, Fallot, et al., 2005; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005). Although such efforts represent important contributions to overcoming and mitigating the downside of specialization, they remain inadequate, because they are ultimately focused on knitting together generally intensive, short-term, and highly focused interventions, ill-suited to addressing the shifting and intertwined needs of marginalized people, and unable to attend to or build a lasting relationship with the whole person underneath the issues.

As the pioneers of trauma-informed practice remind us, trauma pervades the lives of marginalized populations; the prevalence of childhood and adult trauma is extraordinarily high among low-income, homeless, mentally ill, and addicted women (Bassuk, Weinreb, Buckner, Browne, Salomon, & Bassuk, 1996; Goodman, 1991; Goodman, Saxe, & Harvey, 1991; Uziel-Miller & Lyons, 2000). Childhood abuse is a significant predictor of homelessness, reabuse, and substance abuse (Stein, Burden, & Nyamathi, 2002). The consequences of childhood and adult trauma in the lives of women, including posttraumatic stress disorder or depressive symptomatology (Kaysen, Resick, & Wise, 2003; Kemp, Rawlings, & Green, 1991; Woods, 2000), fragmented or lowered sense of self and self-esteem (Mullen, Martin, Anderson, & Romans, 1996; Romans, Martin, & Mullen, 1996; Stein et al., 2002), mistrust of others (Goodman, Koss, & Russo, 1993; Stevens, 1997), reduced capacity to work (Browne, Salomon, & Bassuk, 1999), or addiction (Najavits, Weiss, & Shaw, 1997; Solomon, Bassuk, & Huntington, 2002), form a potent backdrop which can stymie the best of targeted interventions and magnify the problematic consequences of specialization.

A growing recognition of the need to work with people more holistically has spawned a number of important initiatives at the federal, state, and local levels to reform individual systems of care. It has also triggered a range of innovative approaches, which have been used within existing specialized programs and systems. Certainly, our work has been influenced and informed by these ideas and movements. "Patient-centered care" improved medicine with its recognition that hospitals need to work for patients, not only for doctors and medical staff, and that technical quality does not preclude the need to focus on and validate the patient's subjective experience of how well she or he has been responded to as a suffering person (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993). Similarly, "woman-defined advocacy" reframes the provision of battered women's services as a partnership between staff and client, wherein the client retains significant control for defining the advocacy and help she needs (Davies, Lyon, & Monti-Catania, 1998). Relational–cultural theory emphasizes the primacy of relationships for growth, development, and change (Jordan, Hartling, & Ballou, 2002). Harm reduction theory, applied primarily in addiction treatment in the United States (e.g., needle exchange programs), gives us language and techniques for meeting clients "where they are at" and logging small gains (Marlatt & Witkiewitz, 2002; Tsemberis et al., 2004). Strengths-based work (e.g., Leadbeater & Solarz, 2004) focuses on identifying internal and external strengths to generate and support solutions. And feminist therapy (Brabeck & Brown, 1997; Brown, 2004) provides a set of tools with which we can attend to power differentials between ourselves and our clients and raise awareness of the structural causes of their internal distress.

Yet the application of these modalities to mitigate specialization's weaknesses still falls short for many marginalized people, who cannot be disentangled from their relational, material, and identity contexts. Four particularly problematic consequences of specialization, outlined later in this article, cannot be fully addressed by antidotes to specialization such as those described previously, yet must be addressed in concert if marginalized women are to move from chaos and crisis and the revolving doors of specialized services to increased healthy, stability, safety, and community connection, and ultimately to liberty and healthy interdependence. The Full-Frame Approach described later responds to these consequences.

Consequence One: Internal psychological dynamics and external material conditions are treated as discrete

Specialization understandably requires stripping away unrelated or seemingly distracting factors to get at the issue defined as at hand, whether it is an internal difficulty (e.g., a mental health issue) or an external one (e.g., lack of housing). But, much of poor and marginalized women's suffering represents the nexus of failed social policy, overstressed families or communities, individual vulnerabilities and illness, and poor judgment exercised at critical moments. As such, rarely is the cause or the cure found solely within the individual or within external realities. For example, low-income women seeking mental health services often contend with a broad range of material stressors, including substandard housing, unemployment or unstable employment, racism and classism in the workplace and in daily living, inadequate access to heath care and health insurance, lack of childcare or transportation, and rising levels of deprivation (Belle, 1990; Belle & Doucet, 2003; Bullock & Caplan, 2002; Burnham, 2002; Goodman, Littwin, Bohlig, Weintraub, Green, & Walker, in press; Goodman, Saxe, & Harvey, 1991). Yet, low-income women who present to the mental health system with symptoms of depression or anxiety are often offered treatment that assumes that with the right medication and increased insight achieved through counseling, their lives will improve significantly.

Although mental health practitioners do what they can to help their clients, they often lack the training and community connections or are too hobbled by what is reimbursable and what is not to access material resources and benefits that mitigate the weathering effects of poverty (Haddad & Knapp, 2000). Those who do intercede may suggest a name and telephone number of a material aid program, but will most likely not put themselves in the position of bridging the divide between the internal and external (Bullock & Caplan, 2004). On the other side, social services that specialize in "case management" and/or material aid and assistance may marginalize the woman further because she has mental health issues (Reinhard, 2000), or may pathologize her poverty, seeing the one mattress shared by four people as a sign of neglect that should be penalized. In both of these settings, women who attempt to examine and respond to the complex, and sometimes contradictory, dimensions of their experiences risk being labeled "resistant" (Tsemberis et al., 2004) if they express ambivalence about needing such basic assistance or shame about asking for help (Belle & Doucet, 2003) in an era of social denigration of those who continually need public assistance. Women then blame themselves for their suffering and are taught, once again, to feel ashamed of their situations and their emotional distress. Eventually, the external brutalities of poverty may become internalized as self-loathing, which may then be reinforced by cultural views of poor women as lazy, stupid, masochistic, or helpless (Bogard et al., 1999).

Consequence Two: Relational context is deemphasized or devalued

It is increasingly accepted that personal growth and change occur primarily through relationships with others (Baker Miller, 1993; Jordan, Hartling, & Ballou, 2002; Sarason, Sarason, Gurung, & Sarason, 2001). Yet in going into "treatment," whether for addiction, domestic violence, or mental health issues, marginalized women are often encouraged or, in some cases required, to sever relationships, many of which are deemed unhealthy or damaging by the treatment and service community (Bogard et al., 1999).

Although the tenacity of relationships is the stuff of legend among front-line providers, the grip that relational context has on all of us is routinely downplayed or pathologized in the case of marginalized women. "Progress" of the individual in treatment is often benchmarked by her decisions and actions to physically and psychologically distance herself from informal supports, family, and peer relationships—her relational context—in order to improve (in the eyes of the provider) her material context (e.g., housing) or safety. At the same time, these focused interventions do not facilitate the building of alternate relationships, therapeutic or otherwise. In place of family and friends, a woman is offered a 30-day outpatient program, a regimen of medications, a series of sessions with a therapist, or a vague promise that she deserves better.

Treatment and services cannot make up for the sudden lack of a known social network. A woman who continues to maintain her relational context, especially if this involves being in touch with a batterer or with substance users, can be left feeling guilty, or labeled as "noncompliant" for favoring those connections that most others are allowed—those to (imperfect) family, friends, and partners. Indeed, a marginalized woman may also identify a relationship as problematic, but may choose to remain in it as a reasoned choice. For her, perhaps, the negatives are far outweighed by the needs met through the relationship—needs that could not possibly be met by a specialized service. For example, a homeless woman in substance abuse treatment may well choose to remain with a substance abusing partner who provides her with constant and long-term companionship, as well as safety and protection on the streets. As it now operates, the system unfairly pulls women from existing networks, often forcing them to start life anew and isolated with the expectation that they, who have little reason to trust the system, will hitch a wagon to a service program with fungible staff and an issue-oriented focus (Bogard et al., 1999). In effect, the present system cannot provide essential emotional sustenance and support, and yet demands that women rely solely on it.

> *Consequence Three:* A marginalized woman's definition of her situation and her problems are subjugated to a provider's definitions, and her autonomy in addressing these is curtailed

As noted above, specialization often translates into programs defining their target populations in terms of well-defined problems and focusing their intervention on those deemed most likely to benefit from a given program. It is then only logical that these programs require that a participant self-identify as having a primary problem and actively be seeking help for it. Yet in this statement lies the uncomfortable truth that specialization of programs actually limits access to services for many of the most marginalized among us (Courtney, Needell, & Wulczyn, 2004), those whose multiple problems cannot be disentangled cleanly, making it difficult for them to fit exacting admission criteria (Uziel-Miller & Lyons, 2000). That accountability is often equated with helping people achieve very specific outcomes entraps providers as well, altering their perspectives of what they should pay attention to.

Treatment readiness is often determined by assessing whether a woman's understanding of her situation squares with the provider's (Courtney et al., 2004; Uziel-Miller & Lyons, 2000). Many

marginalized women know this, and adjust their narrative to fit the provider's expectations (Blom, 2004; Markoff et al., 2005; Uziel-Miller & Lyons, 2000). The more vulnerable the woman is, the more pronounced the power dynamic between her and the provider is, and the less likely she may be to speak up for her own understanding of her situation. When a woman's culture and identity contexts are not considered or are even maligned, the dissonance between her framing and a provider's framing is even more pronounced.

If a women's authority is curtailed in the problem-definition stage of an intervention, her ability to frame, understand, and address her own difficulties may continue to be frustrated as she progresses through a program. For example, women in domestic violence shelters must continually meet expectations and rules that can feel demeaning and infantilizing (such as having no contact with the batterer, who may be the father of her children), or risk receiving warnings or actual termination from the program or even a system (Bogard et al., 1999; Tsemberis et al., 2004). Commitment to change is often equated with a woman's willingness and ability to flex to the needs, expectations, and priorities of the service provider or service model, however costly or nearly impossible these may be. Many women thus experience an exchange of being controlled by others in their personal lives for being controlled by the system. It is no wonder that many low-income women end up "resisting" treatment or giving up on the system altogether. In light of goals increasingly expressed by service providers (goals such as "empowerment," "client-centered services," and cultural competence), women's experienced loss of control is therefore particularly troubling, and their resulting "resistance" all the more understandable. A woman must choose between a version of herself that trims away aspects of her situation deeply interwoven with the "presenting problem" or risk losing services. This process can be *dis*-empowering, traumatizing, and humiliating, and compromises the efficacy of the services.

> *Consequence Four:* Fragmentation undermines a woman's development of an internally consistent sense of self, rooted in a cultural and/or geographic community

Specialization begets fragmentation simply by creating issue "silos", as described earlier. As such, fragmentation is generally described as a system phenomenon (Haddad & Knapp, 2000). It must be recognized that marginalized women often experience fragmentation as a personal phenomenon, as the splitting of their whole selves into a set of jigsaw puzzle pieces, each with a label of pathology. The jigsaw puzzle pieces often do not fit neatly together, leaving the marginalized woman alone to process conflicting norms and protocols (Haddad & Knapp, 2000; Kibbel, 1999). For example, a woman's addiction counselor may tell her that methadone is necessary to treat her heroin addiction, but the only domestic violence program that will take her on methadone is halfway across the state and her probation officer doesn't want her to leave the county. She puts her best self forward to each of these and other providers, but the specialization of each obscures the wholeness of her situation. She is left feeling "crazy" or is seen as problematic, when it is the system that is failing, regardless of how integrated it may try to be on the surface.

Coordination of services within and across systems is often seen as the antidote to this system fragmentation. However, even when successful in helping a woman negotiate conflicting norms, values, and practices, it does little more than, and may serve to, emphasize a sense of self as an unmoored conglomeration of discrete problems. We contend that a critical failure of this and the other antidotes to specialization described in the first section of this article is that they fail to address the need for embeddedness in social networks as a prerequisite for emotional health (Baker Miller, 1993; Jordan, Hartling, & Ballou, 2002; Sarason et al., 2001).

Neighborhoods, communities (both cultural and geographic), family, friends, and workplaces often provide a woman with the recognition that she is a whole individual, while imparting the sense that she is part of something larger. Having a place to be known in this way where she can have broad-ranging impact on others is vital to the development of a healthy sense of self (Baker Miller, 1993; Kibel, 1999). Because specialized services often use a "continuum of care" model, wherein people are required to move as the reward for progress, marginalized women are often unsuccessful in their attempts to create places within the system where they are known holistically, where they are rooted and can have positive impact, and where involvement is long-term (Tsemberis et al., 2004).

Principles and Practices of the Full-Frame Approach

We contend that programs and initiatives seeking to help marginalized women affect significant, lasting, positive change must directly address each of the negative consequences of specialization. This is accomplished by the practice of the four principles and four practices laid out later in this article that form the backbone of the Full-Frame Approach we are proposing as a counterbalance to specialization. Each principle feeds into the others, and therefore they cannot be viewed or practiced piecemeal or separately. We briefly explore each principle, providing some examples, and then discuss briefly four practices that must undergird these principles. The language "staff" is used here as a short-hand for providers—volunteer and paid, advocates and outreach workers, and clinicians and counselors.

> *Principle One:* "Can't separate the inside and the outside": Expect, explore and address the interplay between external and internal needs, wants and goals using a variety of tactics particular to the situation and the program participant

The Full-Frame Approach requires that service providers address external and internal difficulties and realities not only simultaneously but also in an integrated way. Without deeply integrated attention to the internal and external, many "successes" are short lived. With practice of this principle, a marginalized woman's gains are far more readily solidified and built on. For example, a woman struggling to maintain custody of her children presents her electronic food stamps (EBT) card in line at the grocery store. She feels the stares of other shoppers scrutinizing her food choices—is everything she is buying wholesome and nutritious? She cringes as the cashier calls on the store-wide address system, "I need a manager to help with food stamps" and as there is grumbling in line behind her about the ensuing delay. It is possible the humiliation is so great that she won't use food stamps again, and the next time she is visited by a caseworker from the state, the refrigerator

may be empty, and her capacity to parent may be further questioned. But if the person helping her sign up for food stamps is someone who knows her and her situation well, and is someone who may even go shopping with her the first time she uses her card, acknowledging and understanding the degradation of accepting public assistance even as such assistance creates new possibilities, the cycle may be broken. Practice of this principle is not simply about empathy in all cases. It is determined by the particular set of circumstances and people involved. For instance, for some women, having an advocate help with social action—educating the store manager, for example, about food stamps and the importance of cashiers' sensitivity—might be warranted.

This principle also means that service providers must recognize and acknowledge that alleviating stress or crisis in one part of a woman's life or context may bring new stress to another element, and not all "progress" for marginalized women feels empowering. For example, completing a job-training program may help a woman economically, but the wages she is in line to earn may disqualify her for subsidized housing and be insufficient to cover market rate rent and childcare costs. She may need practical, logistical help from a support person who will attend to her ambivalent feelings about moving beyond day-to-day survival to a place she may not feel, as a result of internalized shame and oppression, that she deserves to be or can sustain. The form that practice of this principle takes in general is highly varied and requires immense flexibility; it might be talking, taking a walk, advocating on a woman's behalf in court, sitting for hours in an emergency room with her to help her resist the urge to up and leave, or lending her the money she needs for medication she has decided to try after years of anxiety.

> *Principle Two:* "Friends and family matter": Understand and respect the centrality of a woman's relationships and role definitions, and the adaptive reasons for them

The strength of familial and friendship bonds is not an artifact of class; we all rely on those closest to us for support and self-definition (Baker Miller, 1993). Those who lack access to conventional social symbols of moral worth (e.g., respected employment; Dudley, 1994) may depend all the more on relationships with others for a sense of identity and worth (Murray, 2005). Respecting and understanding the complexities of a marginalized woman's relational context requires acknowledging her role in others' lives—mother, daughter, wife, lover, friend—even when those roles may, at first glance, appear to jeopardize her well being in specific ways.

To some degree, it is irrelevant whether women's relationships are primarily healthy and fulfilling or stymieing and abusive if there are no real and tested relationships to take some or all of their place. Yet, providers frequently ask women to give up on these relationships without offering anything besides services to take their place. One might analogize this process to the rebuilding of a porch: If certain central pillars of a porch are corroded and need to be replaced, one does not pull them all out at once with the promise that new ones will be erected in their stead; this would undoubtedly cause the entire structure to come crashing down. Instead, service providers would do better to establish temporary supports that can facilitate the gradual removal of certain pillars until new, permanent ones can be established. These temporary

supports may need to remain in place for quite some time. In a full-frame program, a staff-participant relationship provides the foundation of this new, additional relational context for the woman, which can then grow to include other new informal peer and mentor supports without a requirement that the old relationships be abandoned first or perhaps ever.

Marginalized women are often "transitioned out" of a specialized program because they have achieved a predetermined mark of success ("graduation"), or they are "terminated" for violating program rules or for failing to meet certain milestones. Too often, the completion of a certain number of days, for example, is conflated with success. Both graduation and termination can be experienced by a vulnerable woman as retraumatizing and abandonment. It may present a forced choice between either a relationship with a staff person who has helped her reach some milestone or a goal she is supposed to want, where the staff person will no longer be present. A woman's ability to continue using a full-frame program, regardless of whether "progress" has moved forward or backward, and continue leaning on trusted staff people as well as providing and receiving peer support, albeit in different ways and for different things, often leads to long-term changes in self-defeating patterns of behavior. When a woman can believe that a staff person or other program participants may be constants in her life, she will have a new relational framework with which to assess the import and primacy of other, destructive relationships that had earlier been the only constants in her life. She may then choose to continue to maintain these relationships, or she may not.

For example, a homeless woman who is beaten regularly and fiercely by her boyfriend may not define herself as a domestic violence victim and might view the beatings as the price of protection on the streets and emotional security of sorts. She sees him as the only one who always takes her back no matter what, particularly because most programs might kick her out permanently for her own violent outbursts, drinking, and threatening behavior. Staff in this situation who adopt a Full-Frame Approach must navigate a fine line between encouraging this woman to confront and reject the violence (along with its perpetrator if need be) and respecting her autonomy to choose her own partner and live her own life, as well as understanding the precarious nature of her situation, which might cause her to need certain types of protection in addition to the companionship he provides. This occurs through recognizing and validating what she is getting from her relationship with her boyfriend beyond the abuse. Only when an advocate or staff member can establish herself as a stable, nonjudgmental, consistent, and caring presence can the woman begin to envision and move toward a life that is not defined entirely by her relationship with her abuser. And still, she may choose not to leave.

The paradox of understanding and respecting a woman's relational context is that the more deeply she is understood, the less obvious the "right" answer is. But from a shared understanding of contextual complexities and constraints, staff and program participants can explore the pros and cons of specific actions with a shared recognition that neither has a crystal ball. Exploring and acknowledging complexity is, of course, not an excuse for abdicating responsibility, nor is it a license to become complicit with what may be a self-destructive pattern or relationship. In our experience, it often means challenging and even arguing with a woman, person to person, not out of any sense of knowing better

than she does, and not before deeply understanding her reasons, hopes, and constraints. This understanding grows out of a relationship and perspective that allows for the presence and influence of many different facets of the woman and her life, crossing the boundaries of specific "issues" such homelessness, domestic violence, mental health, and public benefits.

Principle Three: "It's her life": Create space for women to control the process of framing their own narratives and intentions, and addressing their concerns

In a full-frame program, a woman determines the nature of the work to be done, sets her own goals or intentions, and collaborates with staff to determine how those goals might be met. Those working with her recognize that identity context and material context may have significant impact on how she frames her life history, how she sees her choices and options, and how others see her. Although specialized services presume readiness for change, readiness to address a specific problem is often preceded by a need for help framing the problem (Brown, 1997; Burman, 2003). As her understanding of her situation evolves, or as the situation itself changes, she must be given the space and support to return to this process again and again, refining or changing goals as the need arises. Staff are facilitators of self-assessment, not assessors, and are active partners in a journey, not guides. Neither party is passive; each expresses views, opinions, and hopes as trust develops.

Practice of this principle requires understanding and validating the inner calculus that leads a woman to choices providers might wish she not make. For example, many marginalized women are considered "treatment resistant": they do not follow regimens of pills; they miss appointments; and they fall out of touch with providers, only to resurface in the acute stages of a crisis. But this is the providers' perspective, and we contend that such women often have very convincing reasons for avoiding treatment and services: a mistrust of professionals based on previous experience; complex trauma histories that result in difficulty forming trusting relationships, particularly with those in positions of power; side effects of medication that make life more dangerous or unpleasant; an unwillingness to be categorized as "crazy" or "neglectful"; multiple and conflicting requirements from other providers; or just being overwhelmed by myriad crises that seem impossible to control or navigate.

This does not imply there will always be a neat coming together of understandings. Although a relationship between staff member and participant may create space for expressing concerns and perspective, it also creates space for those concerns and perspective to be summarily rejected. A woman who self-medicates her depression with alcohol and prescription drugs wants to honor her niece's *Quinceanera* celebration in Florida with the rest of her family, including the stepfather whose sexual abuse she fled as a teenager. Although a full-frame program will not necessary fund a bus ticket to Florida, it will not summarily dismiss the idea on the grounds that sobriety comes first, or on the grounds that no contact with a past abuser is ever all right. In our experience, as complicated and nuanced as it may be, valuing her relationships and understanding her perspective and priorities above a particular outcome ultimately leads to creative new solutions and possibilities. Within this framework, therefore, the role of the staff must be

flexible, and any actions must be based on a developed knowledge of the participant, whose voice has been encouraged and validated throughout any goal-setting process.

Principle Four: "The cheers factor": Create and be part of a community in which the individual is rooted in something bigger and broader than herself and her problems.

Full-frame programs recognize and respond to the human need to be anchored in a place where one is known by others. A relationship with a single person or even a pair of people is not sufficient, particularly if that one relationship is based on solving a problem and addressing needs. Space must exist for positive, communal, and mutually strengthening interactions that occur for the sake of interaction and community building. ROAD and On The Rise, Inc., the two programs described in the following section, grew out of women's craving, respectively, for a place to meet regularly where they could share their daily struggles as mothers trying to raise families within the confines of poverty; and a place that was safe and peaceful, and where they were seen as people, not problems. When a woman is known and celebrated by a group of others for talents and characteristics she possesses, and not just asked to overcome yet another obstacle, she gains a psychological and physical space that is both safer and more hopeful, and which has the capacity to support her when she is not safe or hopeful.

Practice of this principle requires creating a space and a community that is deeply tailored to and by the larger community and the context in which it exists, and must recognize that in some settings race and culture are uniting points, and in others, such as the two programs described in the next section, other factors not generally described as a demographic (e.g., women who want help but are not getting it from mainstream programs), are uniting factors as defined by those participating. The community created must resonate with those who are using it. Certainly, language accessibility is critical, but cultural competence goes far beyond this. When program design flows from a deep knowledge and respect for cultural factors and geographic community context, widely varying models will emerge, each uniquely responsive to its own setting.

This is not to imply that full-frame programs become the substitute community for women; instead, they add a needed dimension both for participants and for the fragmented and specialized service system.

Low-income women's social networks, generally comprised of other marginalized people, can be as much of a burden as a help to the individual women within them (Belle, 1982; Belle & Doucet, 2003; Toohey, Shinn, & Weitzman, 2004), but these networks are still vital to the women's sense of place. The communities at the heart of full-frame programs become a scaffolding upon which participants' informal networks can build, and a setting in which women can "burden" the group (other participants and staff) with their struggles without "overburdening" individuals. These communities become appropriate places in which to release the feelings that have built up over time and get help, if participants so desire, developing and carrying out strategies to articulate and address (to the extent possible) the underlying roots of these feelings. (When so many of the underlying roots are systemic such as oppression and discrimination, it is inappropriate to expect a

woman truly to be able to "address" the larger social factors on their own; but full-frame programs recognize the need to address these issues as much as possible and create change when possible). Members of ROAD and On The Rise, Inc. refer to the other women and the staff as their other "family," and the place itself as their extended home. Such a sense can give women traction to stick with the often conflicting treatment norms and cultures they encounter when engaging with multiple systems, and to access support and assistance from staff and others to increase their health and well-being should they seek to do so. The impact of this sense of belonging and community is profound. As one example, participants in ROAD often remark that reaching out to others and creating a real community of women helps alleviate their symptoms of depression more than anything else.

Recognizing the importance of being part of a larger community means that women's roles in full-frame programs can evolve over time. The ability to positively impact and help others is a self-described indicator of success among marginalized women (Murray, 2005). Women find ways of giving back to others and the program as a whole as their sense of ownership evolves, revealing strengths and building ties to the community that are based on those strengths. Such "giving back" is not contrived or controlled, whether it occurs through formal channels (such as serving on an advisory group or planning committee) or informal ones (e.g., at On The Rise, Inc., a woman who had been homeless for years lugged a printer/fax/copier she had salvaged from the trash several miles because she had seen the need for one listed in the program's newsletter).

This principle applies as much to program planning and development as it does to work with individual women. Social action, participatory planning, and other methods of program participant involvement turn over significant oversight and control to program participants. In fact, we find that women who might appear to others as being too much in crisis to look beyond themselves actually grow through involvements such as these in full-frame programs.

Four Practices: The tracks along which the four principles run

Four practices weave through each of the principles laid out above. First, enduring, flexible relationships between staff and participants are the foundations of the work. Because marginalized women so often have histories of trauma and have been involved with multiple systems and bureaucracies, trust is rarely forthcoming. It is earned as much through actions and "doing together" as through conversation (Baker Miller, 1993). To gain trust, a practitioner must frame her concern from the vantage of caring about the woman rather than caring about a particular outcome. The promise of a relationship is very powerful and should not be made lightly. Staff turnover is inevitable but must be minimized and dealt with carefully. Its negative effects are often buffered somewhat by the peer relationships and community as described in principle four.

Second, full-frame programs recognize and expect that things change, even as the work adheres to the four principles above. The nature of the work with an individual woman evolves over time as the relationship deepens and as the vicissitudes of life co-opt and supplant the best-laid plans and present new opportunities. Programs must evolve, too, as the context that they exist in—systems, communities, politics—shape and affect organizations as much as those who participate in our programs. Strict, long-term adherence to a detailed and inflexible model does not allow an organization, a program, or its staff to be responsive to program participants and community needs. The nature of the work is therefore left purposefully open to persevere in the face of obstacles and to capitalize on opportunities and strengths.

Third, selecting and supporting staff through supervision and other means is essential. Because continuity is of paramount importance and is directly tied to women's progress, staff's ability to remain engaged is vital. To expect them to do this without adequate training, reflection, and support is unreasonable and harms those who count on us and our programs. The support required goes well beyond traditional supervision and calls on supervisors to respond holistically to the needs of staff. There must be space and support to consider and discuss the range of ethical dilemmas that emerge as staff become important parts of marginalized women's lives, as well as to process the burden of holding and addressing the myriad issues presented by program participants. Furthermore, staff members may themselves have experienced significant societal marginalization; only when fully supported do these staff members have the potential to facilitate transformation in the lives of program participants. In our experience, boundary setting takes on new meaning and nuance in the Full-Frame Approach. Without adequate time and structures to explore the confusions that may arise, staff may retreat into a rigid understanding of boundaries or may fail to delineate any boundaries at all. Either of these undermines the promise of the Full-Frame Approach.

Last, full-frame programs are community-based in several ways. Not only must they bridge to other programs, but they are also places of meaning-making and community building for community volunteers who do not benefit directly from their services. Full-frame programs take advantage of specialized services and resources in the community, while remaining places of sense-making and assistance when the priorities, cultures, and expectations of specialized service providers conflict or clash. This bridging process requires staff to have a deep knowledge of community resources and an unflagging curiosity to learn more. It requires diplomacy in helping women navigate various treatment protocols and a willingness to let a woman reject a referral or say "no" to services that do not fit her needs.

None of these principles or practices calls on providers to work with every woman who seeks help from them. But, the Full-Frame Approach does call on providers to work with women in their contexts and holistically, and in a way that creates a sense of belonging and being part of something.

The ROAD Project and On The Rise, Inc.: Two Full-Frame Programs

Full-frame programs can look entirely different in their models, even as they adhere diligently to the principles and practices described above. In this section, we illustrate this through brief descriptions of the ROAD Project and On The Rise, Inc., two innovative full-frame programs in the Boston area that differ markedly in the communities they serve and therefore in the ways they operationalize the Full-Frame Approach (as evidenced starkly by their operating budgets of approximately $100,000 and

$1,000,000, respectively). The second author is the Lead Evaluator of ROAD and the first author is the founding executive director of On The Rise, Inc.

ROAD: Reaching Out About Depression

ROAD is a grassroots mental health and organizing project for low-income women with depressive symptoms in Cambridge, Massachusetts (for a detailed description of ROAD, see Goodman et al., in press). In 1999, the City of Cambridge conducted focus groups of mothers receiving welfare in the wake of welfare reform. A key finding was that participants craved a place to meet regularly where they could share their struggles coping within the confines of poverty, an ever-shrinking social safety net, and highly stretched informal social support networks. The city began sponsoring weekly dinners where low-income women could come together with community activists "around the kitchen table" to talk about their lives and the policies that affect them.

Eight members of this "Kitchen Table Conversations Project" decided to meet separately with one of the community activists[2] to create ROAD as a supportive, action-oriented, and community-building project for poor women. Perhaps not surprisingly, given the extent of life crises and obstacles that they were struggling with, all eight of these women coped with various symptoms of depression (which they labeled feeling "blue," "hopeless," "despairing," "depressed," or "down in the dumps") and wanted depression reduction to be a core aspect of the new program.

In the course of their discussions, each woman expressed frustration about those very aspects of the social services system described above. They told of feeling dismissed, misunderstood, labeled, judged, or outright insulted by the social services they were told would help and support them, and spoke of the resultant mistrust these experiences sowed. They expressed longing for a program that would "see" them in comprehensive ways and that would be a community, not just a program, where they could effect some change in the service system.

Now at the beginning of its third year, ROAD has served 35 ethnically diverse women in Cambridge, recruited through flyers and word-of-mouth, all of whom self-identify as struggling with symptoms of depression. Almost all these women are trauma survivors, many of whom contend with posttraumatic stress symptoms, and whose past experiences have left them reluctant to trust other people and systems. The vast majority are single mothers whose children struggle with a range of psychological, cognitive, and physical disabilities. ROAD remains largely administered by its eight founding members and others from the same community who have joined them, along with a full-time Project Director.

ROAD has two components: The Supportive Action Workshop Series (SAWS) and the Resource Advocacy Team. SAWS provides a setting and a workshop structure for low-income women to come together to support each other, name and describe their difficulties in ways that integrate internal and external factors, develop their own strategies for identifying and addressing their needs, and take action to improve service systems for low-income women in their community. More specifically, it is a 12-session interactive workshop series led by ROAD's founding members (the facilitation team) that covers a range of topics related to depression in the lives of low-income women, including "debunking myths about depression," "the relationship between depression

and social and economic inequality," "depression and violence and abuse/safety planning," and "parenting and depression."

In the workshops, the "provider/patient" hierarchy is largely collapsed, with participants and facilitators sharing personal stories, thoughts, and feelings. Facilitators are not there to gain the same ends as are participants, of course, but they are also not there to diagnose, label, or treat. A mental health advocate sits in on workshops with the express purpose of helping any woman who self-identifies as wanting to connect with mainstream treatment. Many participants report that the trust and community bonding developed through the workshop series stems from their recognition that ROAD creates and is a place where they are accepted and heard for who they are, and where their needs and hopes are validated and echoed.

The workshops' structure and facilitators' actions help participants navigate the obstacles many low-income women face when in need of help or services. For example, to help women stay connected to ROAD and to help them get to the workshop sessions, one of the facilitators calls all participants a few days before each workshop to check in, encourage them to attend the meeting, and ask if they need help with transportation. If participants request it, calls like these can be made more often.

The desire to give back is strong for facilitators and workshop participants alike. For this reason, each series also includes a group-determined social action activity in which participants take collective action on a problem affecting low-income families. For example, one group worked with a local coalition writing letters, talking to neighbors, and visiting politicians to protest the governor's proposed welfare cuts. Ultimately, they were the only "consumer" group to do so. Another group developed a TV show on poverty and depression for local access TV.

Another opportunity for participants to contribute their own strengths and skills arises at the end of each workshop series, when participants who have made it through to the end are invited to join the facilitation team. Underscoring the intense and positive impact the workshops have had on participants' lives, every woman who participated in the first series elected to either become a facilitator for the second round or take the workshops again. Of course, becoming a facilitator is not a panacea. Even as they help bring others in and through the workshop series, facilitators are themselves supported by ROAD's second component, the Resource Advocacy Team.

The Resource Advocacy Team is composed of law and psychology volunteer graduate students, supervised by faculty at two local universities, whose role is to provide emotional and instrumental support to members of the ROAD facilitation team, whom the students refer to as their "partners." These "advocates," work one-on-one with their ROAD partners once a week for a full year to help address acute crises (e.g., threatened evictions, loss of benefits, debt, layoffs, health problems, or parenting difficulties); support them in their continuously difficult interactions with social services; help them achieve self-determined short- and long-term goals to address chronic challenges; and support the workshop's community action component. An advocate and her partner may

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[2] Angela Littwin, the community activist who convened these meetings, was the cofounder (with the Kitchen Table women) of ROAD. She is now the Clemenko Fellow at Harvard University School of Law.

also collaborate on policy level advocacy, bringing awareness of barriers to human service agency directors and other policymakers. The close, highly collaborative relationships that develop between advocates and their ROAD partners form the foundation for the work agenda that they then develop together. Advocates meet with their ROAD partners at the partners' homes, at other easily accessible settings, and at various relevant community agencies as they provide advocacy, emotional support, or practical help to their partners. After the year is over, the formal relationship ends, although some partners continue to have informal contact. Each ROAD facilitator also has the option to continue with the Resource Team in the fall with a new advocate.

The symptoms of depression experienced by ROAD women are caused, sustained, and exacerbated by a host of interrelated issues and circumstances and cannot be alleviated easily. Advocates therefore approach their work with maximum flexibility, as unencumbered as possible by preconceived notions of what is an "appropriate" goal or strategy for achieving it. This process purposely departs from the more traditional outcome-oriented approach of social services, facilitating growth based on each woman's goals and objectives.

Participatory evaluation of ROAD has just begun. The evaluation uses a qualitative method—focus groups and in-depth interviews—in order to explore fully the complex and ever-shifting ways in which the ROAD program and its participants reciprocally influence each other. Preliminary data indicate that the ROAD workshops (SAWS) and the ROAD Resource Advocacy Team provide a desperately needed opportunity for participants to obtain the skills, confidence, and emotional and instrumental support required to make changes in their lives and communities. In addition to reporting reduced levels of depression and a greater sense of empowerment over the course of involvement with ROAD, many participants have created substantive changes in their lives by, for example, addressing loan issues, seeking mental health services, focusing on substance abuse problems, reentering the workforce, combating obesity, or applying to go back to school. Others describe feeling less isolated, more empowered to advocate for themselves for the services they needed, and better able to use those services. The women from both the workshops and Resource Team report that having someone on their "side," who knows them as real and full people and supports their efforts in a truly collaborative way, helps them feel that their goals are possible, that the world is not full of people who judge and dismiss them, and that they are neither alone in their struggles nor crazy for experiencing the difficulties they face.

On The Rise, Inc.

On The Rise, Inc. is a Cambridge, Massachusetts-based organization working with women who are homeless or at risk of homelessness who have not been able to meet their needs through mainstream services. On The Rise, Inc. was founded in 1995 in response to the hopes, fears, concerns, and suggestions of homeless women who were falling through the cracks of the mainstream service system. Most wanted help with something, just not what others thought they should be prioritizing (e.g., a woman might want help paying for her storage locker, but not perceive herself as having a mental health issue, whereas providers saw little point in paying for a storage locker for a woman unwilling to address

mental illness, lack of income, and other factors that they believed led to her situation). The resultant impasse left them feeling either marginalized or caught in a cycle of participation in specialized programs without gaining enough traction to maintain progress. Women did, however, articulate common desires for a place where they were not "bossed around" and where they were seen as people, not problems. On The Rise, Inc. operates 6 days a week out of a comfortable Victorian house in an attractive, safe neighborhood to combat internalized stigma about what poor women "deserve."

On The Rise, Inc. positions itself as the end of the line, a place and a program for women who are largely disengaged from services and systems of care (e.g., they have been kicked out of multiple other programs and/or have not found the help they need or seek elsewhere) or are "overengaged" (e.g., they have multiple case managers in multiple systems, yet never seem to move beyond their crises). Women come to the program through its limited street outreach, referrals by other programs, word of mouth, and other means. A series of informal conversations with outreach workers help determine whether On The Rise, Inc. might be a helpful program for women to participate in. No information is required up front (not even a name); women who can clearly articulate goals and have no difficulty revealing personal information are generally referred to structured case management available in the community. Women regulate their comings and goings; 25 to 35 women participate in On The Rise, Inc. daily; 90 to 100 different women each month; 250 to 300 women participate annually.

Almost every woman involved with On The Rise, Inc. is a survivor of abuse and trauma, which often began when she was a child. Significantly, few initially identify this way (in 2004, only 40% of women who used the program intensively for a period of time self-identified as trauma survivors in the first months, yet after a year, almost all of these women disclosed histories of violence and abuse). Many struggle with mental health and addiction issues; many also face medical, immigration, and undereducation issues and have histories of incarceration, often for nonviolent, drug-related crimes. Some grew up in poverty, others in relative comfort; all are now poor and socially stigmatized for needing public assistance. Most need a long time to engage with staff; some have difficulty articulating needs and goals that are in line with others' perceptions; all need to be engaged creatively, with no requirements that they be at specific services at specific times; and many have difficulty containing anger and/or effectively self-advocating, often resulting in bars and discharges from mainstream programs. Some are currently in abusive or controlling relationships.

On The Rise, Inc. works through a two-stage process. The first is *person-to-person engagement,* wherein women build trusting, healing relationships with members of the outreach team on their own timeline. Through these relationships, and as they begin to integrate into the community of On The Rise, Inc., women build a sense of self that is not rooted in pathology but in a balanced and evolving sense of agency and interdependence. Continuity and trust are directly tied to women's making increased use of mainstream services. Specific issues—addiction, mental illness, trauma, housing, family relationships, credit problems—rise and fall in immediacy, and women's attention to them may vary, but attention to a relationship can be consistent and constant. Given the primacy

of relationships, hiring and retaining excellent staff members is vital. The program is staffed by a diverse team of six outreach workers and a director of program management and development, who is involved with and accessible to program participants as well as staff. Two outreach workers are licensed clinicians, but their job is not substantially different from that of the paraprofessionals. Outreach workers are hired for their integrity, passion, ability to integrate life experience into work, and other intangibles as much as for professional experience. They serve alternately as supporters, cheerleaders, "truth-tellers," and advocates. Even as they engage with staff, women engage with other program participants, creating an alternate community for many women.

Engagement occurs through talking and doing with, and also by leaving women relatively alone to "do their own thing." The Safe Haven, as the house is called, contains a kitchen, telephones, an address for women to receive mail, voicemail, a clothing room, a nap room, and other home-like amenities of which women can avail themselves. Wellness activities bring practitioners of art, massage, writing, yoga, and other positive and rebuilding experiences into the Safe Haven as an adjunct to the work program participants do with the program's staff. It is not uncommon that a woman initially comes to On The Rise, Inc. once a week for a few hours, maybe sitting on a couch with a cup of coffee and looking at the paper (perhaps she'll strike up a conversation about the day's headlines with an outreach worker), maybe revealing where she stays at night, only to come in one day and pull an outreach worker aside for a more in-depth private conversation about, for example, addiction or a nagging medical issue.

When such conversations occur, outreach workers leverage relationships to provide the second of the two-phase process, "*mortar between the bricks" support*. The outreach team serves as the cohesive, consistent support (the mortar) for women as they access and make full use of specialized programs in the community and mainstream resources, such as imperfect public transportation systems (the bricks) and as they reintegrate into the community, facing day to day challenges—noisy neighbors, landlords unresponsive to code violations, getting a new ID after a wallet is stolen on a crowded subway platform. "Mortar between the bricks" work takes into account what exists in the community and works to increase the match between an individual's needs and a partnering agency's and a community's capacity. It also helps women process the effects of internalized stigma and shame and move forward or sometimes keep afloat in a world that is at times biased and discriminatory. By remaining focused on the woman and her context, rather than on one or a constellation of issues aiming for prescribed outcomes, mortar between the bricks goes far beyond traditional case coordination. The activities involved in mortar between the bricks are as varied as the experiences, needs, fears, and hopes of each individual woman who uses On The Rise, Inc., and include accompaniment and support to more specialized services and programs, referrals, advocacy, onsite partnerships, and providing modest but strategically significant financial assistance. Some examples of actions taken by staff include visiting a woman in the hospital and helping her make treatment decisions, helping a woman carry a mattress secured through a furniture donation program to her third-floor walk-up, supporting a woman experiencing panic attacks on the anniversary of her rape, paying for a roundtrip bus ticket to another town so a woman can visit her mother who is gravely ill, and accompanying a woman to court as she strives to regain custody of her children. Active intervention and advocacy on behalf of a woman is sometimes necessary when a woman cannot advocate for herself or when a system will be more responsive to a professional than to the individual in need of services, as is often true in medical, court, and government benefits settings (onsite legal and medical services facilitate this advocacy and put "friendly faces" on systems often perceived as frightening and unresponsive). Throughout this work, women's network of support broadens into the larger community, but they are not cut off from On The Rise, Inc. For many women, it remains their community long after they secure permanent housing or their situations stabilize.

On The Rise, Inc. assesses effectiveness through both qualitative and quantitative measures and has determined short-term broad benchmarks and indicators that keep the program on track to achieve long-term impact. Each month, the outreach team endeavors to work "actively" (meaning significant engagement with) 55 to 70% of women who use the program in that month (other women come to On The Rise, Inc. as a place to "be," using it as their community base as in principle four). Almost all women engage actively with the outreach team at various points, but no woman has to be "working on her issues" to come to On The Rise, Inc. We have learned that a higher engagement than this may signal that On The Rise, Inc. is not serving the hardest to reach women (who, at least initially, prefer to come to the Safe Haven and not engage with staff) or that staff are pressuring each woman to work on her issues; a lower percentage generally signifies that the team isn't being as assertive in creating openness and space for women to explore issues.

Participants report that the program helps them overcome obstacles in the system, in society and in themselves that they had previously felt unable to identify or confront. Women have secured public benefits and others have moved off public assistance; women have moved into permanent housing (over 80% of women retain housing), others have left abusive homes. Many women have kept in contact with On The Rise, Inc. of their own accord even when their situations have stabilized and improved, letting outreach workers know of triumphs and struggles, and reengaging if they need support. Women cite greater confidence in addressing new challenges, and new ways of thinking. Participation in program planning and development, serving on advisory boards and committees, and contributing to the growth of the organization in multiple ways has led women to see their experiences as something to learn from and that can be helpful to others. Many women also remark that their transformative relationships with outreach workers allowed them to develop a newfound trust and ability to open up to others at On The Rise, Inc. and in the larger, specialized service system.

Implications and Conclusions

Our aim in this article is twofold. First, we seek to promulgate the set of principles and practices we have found uniquely helpful in working effectively with marginalized women. We seek to differentiate the Full-Frame Approach—the second strand of the double-helix mentioned in the introduction— as a necessary and vital component of a more effective social services system. But scattershot adoption of these principles alone will be insufficient. As others have argued, the system needs to be fundamentally

altered to meet the needs of those facing complex, multiple and inextricably linked challenges (Blom, 2004; Haddad & Knapp, 2000; Meagher & Healy, 2003).

Our second aim is therefore to call for recognition of the import of and significant new investment in full-frame programs, starting with those already practicing the work but without the shared language to describe and legitimize their efforts and their impact. As described later, without the dramatic shift in perspective that this recognition entails, our programs and systems will continue to be stymied by and stymieing for the most vulnerable people in our communities.

Full-frame programs are based in and on their specific cultural and geographic communities' strengths and needs. Because every community is unique, the programs described here are not replicable in the way that we have come to think of replication—distillation of a model of curricula, staffing ratios, and personnel policies that can be implemented by another community. In a sense, the more a program resonates with and evolves in tandem with its community, the less scalable it is. For this reason, full-frame programs are often sidelined as "boutique"—uniquely quirky gems in their communities—or are perceived as "soft" because they emphasize long-term, individual outcomes, goals, and relationships. Important lessons stay locked at the local level.

One of the promises of full-frame programs is that they help vulnerable and marginalized people make more effective use of mainstream programs. This is often accomplished by individual staff zealously representing and working on behalf of their clients in ways that are highly ethical and of course legal, but which, because they represent essentially exceptions to rules, circumvent bureaucracies and policies that have proven barriers to program participants in the past. Operating within the reigning paradigm of specialization, these programs' ability to do this relies on the very fact that full-frame programs are few and far between. Although this is unfortunate, programs such as the two described here can capitalize on their somewhat "outsider" status because this work is not inherently threatening to the systems and norms and perceptions that it circumvents and mitigates (Schorr, 1997).

This would be fine if full-frame programs were not such a vital component of effectively helping marginalized people. However, given that the Full-Frame Approach—the language and the framework, *and* its practice in communities—must be brought from the margins to the center, we need not only an increase in the number and concentration of full-frame programs, but also a change the system and structures that now dismiss them or minimize their promise.

A radical shift is needed from the reigning paradigm of specialization and coordination to a paradigm that recognizes the need for the double helix that is specialization and the Full-Frame Approach. Subsequent articles will explore the necessity of strengthening the connection between these strands by creating the capacity for specialized services that are not full-frame to become or be recognized as being *full-frame-informed*—maintaining their issue expertise while adopting shades of these principles and practices that will make them more accessible to and effective in working with marginalized people.

In advancing the principles that undergird full-frame programs, we recognize that all the possibilities and challenges inherent in this approach cannot be elucidated. Here, we highlight several challenges—assessment, money, time and training—that merit additional discussion and exploration.

Accountability is vital for both specialized and full-frame programs, but prevailing narrow, often binary, measures of success drive full-frame work underground and, in the case of the two programs here, devalue the long-term and often rich and nuanced impact of the approach. Given the fundamentally different nature and orientation of full-frame programs, different tools will be required for measuring efficacy and ultimately, what is measured will be broader and, most likely, more complex. Significant discussions and future research are needed to design new accountability systems that are creative and robust and that meaningfully assess the excellence and weakness of particular programs, even as these assessment tools embrace the complex realities of people's lives. Furthermore, assessment tools that can help full-frame programs assess impact on participants' health, safety, stability, and community cohesion are vital. Qualitative, participatory, and empowerment evaluation methodologies point the way to potentially interesting approaches in this regard (Downe-Wambolt, 1992; Fine et al., 2003; Sandelowski & Barroso, 2003).

Funding for full-frame programs such as the two described in this article comes primarily from the private sector, because public funding is generally limited by specific types of reimbursement structures that are reductionist in their focus on specific issues and outcomes related only to those issues. Public and larger-scale private funding of full-frame programs and their evaluation, including the methods described previously, are vital if marginalized people and communities are to move beyond basic survival. If the systemic change we call for is to occur, funders and purchasers must also look beyond supporting individual full-frame programs and invest in the potential of the approach as a whole, whether by supporting cohesion among full-frame programs, or by leveraging their dollars to incentivize specialized services to become full-frame-informed.

The Full-Frame Approach assumes that marginalized people will use our programs for a long time. Our work with marginalized women has underscored the damage that society and its institutions have wrought on vulnerable women, and the sometimes self-defeating strategies people use to stay afloat when buffeted by forces largely out of their control. Short-term interventions cannot address these forces and their impact on individuals and communities. The realization that some of our participants may never be fully "done" with us must not be an excuse for not helping women move forward and increasing their self-efficacy. We recognize that the long-term nature of full-frame work may be perceived as a negative, but we posit that evaluation of full-frame programs will demonstrate that long-term engagement actually minimizes repetitive, intensive specialized interventions in the long-term.

The Full-Frame Approach's effectiveness demands that programs retain and support top caliber staff, whether they are paraprofessionals, students, clinicians, or others. Internal support and training as mentioned in earlier sections is therefore of paramount importance. But training on a program-by-program level is impractical and perpetuates the isolation of full-frame programs by devaluing the critical work of staff, too. Currently, clinical and other professional staff working in full-frame programs must handle tremendous dissonance as they are asked to challenge and ultimately revise some of the absolutes they learned in graduate school (e.g., where boundaries are set; when self disclosure is

appropriate; or where meetings should be held). This puts an undue burden on the practitioner, her supervisors, the program she works in, and ultimately the community she serves. The principles and practices of the Full-Frame Approach must resonate with professional training programs (e.g., schools of social work, graduate programs in psychology) that are graduating those who staff full-frame and full-frame-informed programs. Ultimately, school accreditation programs, as well as each school's particular curriculum, course content, and requirements, must recognize and respond to the need to train and deploy a cadre of talented, committed professionals who are ready and equipped to practice this kind of work.

As a final note, we recognize that the type of work proposed here requires sophistication, dedication, and commitment to excellence. We are not so naïve as to think that the called-for systemic shift will be easy. But, we believe it is possible for programs and systems to embrace the complex reality of women's lives without falling into system-wide chaos. Ultimately, our ability to reduce the marginalization of individuals and communities depends on considering people in their contexts. Doing so will help to lead individuals and communities to new levels of health, self-actualization, safety, stability, and cohesion.

References

Austin, M. J., & Prince, J. (2003). The implications of managed care and welfare reform for the integration of health and welfare services. *Journal of Health and Social Policy, 18,* 1–19.

Baker Miller, J. (1993). Growth through relationships. *Advanced Development, 5,* 13–25.

Bassuk, E. L., Weinreb, L. F., Buckner, J. C., Browne, A., Salomon, A., & Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association, 276,* 640–646.

Belle, D. (1982). The impact of poverty on social networks and supports. *Marriage & Family Review, 5,* 89–103.

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45,* 385–389.

Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27,* 101–113.

Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *Journal of Family Practice, 53,* 721–730.

Blom, B. (2004). Specialization in social work practice: Effects of interventions in the person social services. *Journal of Social Work, 4,* 25–46.

Bogard, C. J., McConnell, J. J., Gerstel, N., & Schwartz, M. (1999). Homeless mothers and depression: Misdirected policy. *Journal of Health and Social Behavior, 40,* 46–62.

Braebeck, M., & Brown, L. (1997). Feminist theory and psychological practice. In J. Worrell & N. G. Johnson (Eds.) *Shaping the future of feminist psychology: Education, research, and practice* (pp. 15–35). Washington, DC: American Psychological Association.

Brown, J. (1997). Working toward freedom from violence. *Violence Against Women, 3,* 5–26.

Brown, L. S. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training, 41,* 4, 461–471.

Browne, A., Salomon, A., & Bassuk, S. S. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women, 5,* 393–426.

Bullock, H. E., & Caplan, P. J. (2004). Diagnosis of low-income women. In Cosgrove, L. (Ed.), *Bias in psychiatric diagnosis. A project of the association for women in psychology.* Northvale, NJ: Jason Aronson, Inc.

Burman, S. (2003). Battered women: Stages of change and other treatment models that instigate and sustain leaving. *Brief Treatment and Crisis Intervention, 3,* 83–98.

Burnham, L. (2002). Welfare reform, family hardship, and women of color. In R. Albelda & A. Withorn (Eds.), *Lost ground: Welfare reform, poverty, and beyond.* Cambridge, MA: South End Press.

Cocozza, J. J., Jackson, E. W., Hennigan, K., Morissey, J. P., Reed, B. G., Fallot, R., et al. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28,* 109–119.

Courtney, M. E., Needell, B., & Wulczyn, F. (2004). Unintended consequences of the push for accountability: The case of national child welfare performance standards. *Children and Youth Services Review, 26,* 1141–1154.

Darlington, Y., Feeney, J. A., Rixon, K. (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review, 26,* 1175–1192

Davies, J. M., Lyon, E., & Monti-Catania, D. (1998). Safety planning with battered women: Complex lives/difficult choices. In *Sage series on violence against women, Vol. 7.* Thousand Oaks: Sage

Downe-Wambolt, D. (1992). Content analysis: Method, applications, and issues. *Health Care for Women International, 13,* 313–321.

Dudley, K. (1994). *The end of the line: Lost jobs, new lives in postindustrial America.* Chicago: University of Chicago Press.

Dyeson, T. (2005). Home health social work: Obstacles to evidence based practice. *Home Health Care Management & Practice, 17,* 316–319.

Eby, K. K. (2004). Exploring the stressors of low-income women with abusive partners: Understanding their needs and developing effective community responses. *Journal of Family Violence, 4,* 221–232.

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33,* 461–477.

Epstein, D., Bell, M. E., & Goodman, L. A. (2003). Transforming aggressive prosecution policies: Prioritizing victims' long-term safety in the prosecution of domestic violence cases. *Journal of Gender, Social Policies, & the Law, 11,* 465–498

Fetterman, D., & Wandersman, A. (2005). *Empowerment evaluation principles in practice.* New York: Guilford Press.

Fine, M., Torre, M. E., Boudin, K., Bowen, I., Clark, J., Hylton, D., et al. (2003). Participatory action research: From within and beyond prison bars. In *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 173–198). Washington, DC: American Psychological Association.

Flaspohler, P., Wandersman, A., Keener, D., Maxwell, K. N., & Ace, A. (2003). Promoting program success and fulfilling accountability requirements in a statewide community-based initiative: Challenges, progress, and lessons learned. *Journal of Prevention & Intervention in the Community, 26,* 37–52.

Gerteis, M., Edgman-Levitan, S., Daley, J., Delbanco, T., (Eds.) (1993). *Through the patient's eyes: Understanding and promoting patient-centered care.* San Francisco: Jossey-Bass.

Goodman, L. A. (1991). The prevalence of abuse among homeless and housed poor mothers: A comparison study. *American Journal of Orthopsychiatry, 61,* 489–500.

Goodman, L. A., Koss, M. P., & Russo, N. F. (1993). Violence against women: Physical and mental health effects. Part I: Research findings. *Applied and Preventative Psychology, 2,* 79–89.

Goodman, L. A., Littwin, A., Bohlig, A., Weintraub, S. R., Green, A., & Walker, J. (in press). Applying feminist theory to community practice: A case example of a multi-level empowerment intervention for low-

income women with depression. In E. Aldarando (Ed.), *Promoting social justice through mental health practice.* Mahwah, NJ: Erlbaum.

Goodman, L. A., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma. *American Psychologist, 46,* 1219–1225.

Haddad, P., & Knapp, M. (2000). Health professionals' views of services for schizophrenia–fragmentation and inequality. *Psychiatric Bulletin, 24,* 47–50.

Jordan, J. V., Hartling, L. M., & Ballou, M. (2002). New developments in relational-cultural theory. In Brown, L (Ed.), *Rethinking mental health and disorder: Feminist perspectives.* New York: Guilford Press.

Kaysen, D., Resick, P. A., & Wise, D. (2003). Living in danger: The impact of chronic traumatization and the traumatic context on posttraumatic stress disorder. *Trauma, Violence, and Abuse, 4,* 247–264.

Kemp, A., Rawlings, E. I., & Green, B. L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter sample. *Journal of Traumatic Stress, 4,* 137–148.

Kibel, S. (1999). Fragmentation and integrity: The search for a moral compass while working as a therapist within the child welfare system. *Women and Therapy, 22,* 53–68.

Leadbeater, B. J., & Solarz, A. L. (Eds.). (2004). *Investing in children, youth, families, and communities: Strengths-based research and policy* (pp. 285–302). Washington, DC: American Psychological Association.

Levin, R. (1999). Participatory evaluation: Researchers and service providers as collaborators versus adversaries. *Violence Against Women Special Issue: Collaboration in research on violence against women, 5,* 1213–1227.

Limbert, W. M., & Bullock, H. E. (2005). 'Playing the fool': US welfare policy from a critical race perspective. *Feminism & Psychology, 15,* 253–274.

Marcus, B. H., Banspach, S. W., Lefebvre, R. C., & Rossi, J. S. (1992). Using the stages of change model to increase the adoption of physical activity among community participants. *American Journal of Health Promotion, 6*(6), 424–429.

Markoff, L. S., Finkelstein, N., Kammerer, N., Kreiner, P., & Prost, C. A. (2005). Implementing a model of change in integrating services for women with substance abuse and mental health disorders and histories of trauma. *Journal of Behavioral Health Services and Research, 32,* 227–240.

Marlatt, G. A., & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behaviors, 27,* 867–886.

Meagher, G., & Healy, K. (2003). Caring, controlling, contracting, and counting: Governments and non-profits in community services. *Australian Journal of Public Administration, 62,* 40–51.

Mullen, P. E., Martin, J. L., Anderson, J. C., & Romans, S. E. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & Neglect, 20,* 7–21.

Murray, A. (2005). What it means to be successful: Lessons from the lives of homeless women. Unpublished report, Robert Wood Johnson Foundation.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions, 6,* 273–283.

Prochaska, J., DiClemente, C. C., Velicer, W. F., & Rossi, J. S. (1993).

Standardized, individualized, interactive, and personalized self-help programs for smoking cessation. *Health Psychology, 12,* 399–405.

Reinhard, J. (2000). Limitations of mental health case management: A rational emotive and cognitive therapy perspective. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 18,* 103–118.

Romans, S. E., Martin, J., & Mullen, P. (1996). Women's self-esteem: A community study of women who report and do not report childhood sexual abuse. *British Journal of Psychiatry, 169,* 696–704.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Studies, 13,* 905–923.

Sarason, B. R., Sarason, I. G., Gurang, R. A. R., & Sarason, B. R. (2001). Close personal relationships and health outcomes: A key to the role of social support. In Duck, S. (Ed.). *Personal relationships: Implications for clinical and community psychology.* New York: Wiley Ltd.

Schorr, L. B. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America.* New York: Anchor Books/Random House.

Solomon, A., Bassuk, S., S., & Huntington, N. (2002). The relationship between intimate partner violence and the use of addictive substances in poor and homeless single mothers. *Violence Against Women, 8,* 785–215.

Stein, J. A., Burden, L. M., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: Mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26,* 1011–1027.

Stevens, L. (1997). Bringing order to chaos: A framework for understanding and treating female sexual abuse survivors. *Violence Against Women, 3,* 27–45.

Suarez-Balcazar, Y., & Harper, G. (2003). *Empowerment and participatory evaluation of community interventions: Multiple benefits.* New York: Haworth Press, Inc.

Sullivan, L. W., & Eagel, B. A. (2005). Leveling the playing field: Recognizing and rectifying disparities in management of pain. *Pain Medicine, 1,* 5–10.

Toohey, S. M., Shinn, M., & Weitzman, B. C. (2004). Social networks and homelessness among women heads of household. *American Journal of Community Psychology, 33,* 7–20.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with dual diagnosis. *American Journal of Public Health, 94,* 651–656.

Uziel-Miller, N. D., & Lyons, J. S. (2000). Specialized substance abuse treatment for women and their children: An analysis of program design. *Journal of Substance Abuse Treatment, 19,* 355–367.

Wandersman, A., Snell-Johns, J., Lentz, B. E., Fetterman, D. M., Keener, D. C., Livet, M., et al. (2005). The principles of empowerment evaluation. In D. M. Fetterman & A. Wandersman (Eds.), *Empowerment evaluation principles in practice.* New York: Guilford Press.

Woods, S. J. (2000). Prevalence and patterns of posttraumatic stress disorder in abused and postabused women. *Issues in Mental Health Nursing, 21,* 309–324.