Engaging Families as Experts: Collaborative Family Program Development

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This article presents the collaborative family program development (CFPD) model, a collaborative research-based approach to creating community-based programs for families. In this approach, families are viewed as experts on the nature of their challenges and on what they desire in a program. This approach is particularly useful in developing programs for families who have experienced social oppression and who may have been reluctant to participate in programs created for them by professionals without their consultation. In contrast, when professionals adopt the stance of respectful learners, families respond by actively engaging in the program development research and in the program created from it. This article describes the nature and complexities of a collaborative program development stance, the unique contribution to community-based program development offered by a family systems focus, and the 10 steps in the CFPD approach. These 10 steps guide movement from initiating the project and forming collaborative professional partnerships to engaging cultural consultants; conducting in-depth research to understand the problems, resources, contexts, and recommendations from the perspective of families who will receive the program and from the perspective of front-line professionals working with these families; transforming research findings into program contents and formats; and implementing, evaluating, revising, and replicating the program. The approach is illustrated by a program called Fresh Start for Families, developed and replicated for families in New York City who are homeless and attempting to move from welfare to work.

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This article describes the nature and usefulness of a collaborative stance in family-based program development, highlights the complexities of defining what it means

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to be collaborative, and describes the steps in the collaborative family program development (CFPD) approach. The approach will be illustrated by a program called Fresh Start for Families, which was developed and replicated for families in New York City who are homeless and attempting to move from welfare to work.

THE COLLABORATIVE STANCE IN PROGRAM DEVELOPMENT

In his book *Collaborative Therapy With Multi-Stressed Families*, Bill Madsen (1999) eloquently captured how the fundamental stance that we helping professionals take powerfully shapes our interactions with the persons we serve. He wrote, ''The foundation of clinical effectiveness lies in the basic stance we hold in regard to clients and the way we position ourselves in relation to them. [I] think this is particularly true with families we designate as 'difficult''' (p. 14). Drawing on postmodern-influenced family therapies, such as narrative, solution-focused, and collaborative language systems, Madsen described an approach to therapy in which the therapist takes the stance of an ''appreciative ally,'' honoring the family's definitions of its problems, resources, and potential solutions. This approach involves ''standing in solidarity with clients'' (p. 16) against the problems that challenge them, rather than viewing them as the problem to be changed. It is an approach that focuses and builds upon families' resilience in the face of these challenges (Minuchin, Colapinto, & Minuchin, 1998; Walsh, 1998) and is designed to bring forward experiences of ''competence, connection, vision, and hope'' (Madsen, p. 16). These practices create a new bas-relief of family experience that highlights strengths against a background of problems and adversity, rather than the other way around. Madsen noted that such an approach is not only advisable for ethical and aesthetic reasons (e.g., in terms of how most professionals would prefer to interact with clients) but he also reported clinical experiences suggesting that a collaborative approach is more effective and efficient.

Since 1998, when we began our program development research that has now involved almost 300 families (Fraenkel, 1999, 2002, 2003a, 2003b, 2004a, 2004b; Fraenkel & Hameline, 2002a, 2002b; Fraenkel & Wilson, 1998), our[1] experiences using this collaborative stance in developing a program for families who are homeless have echoed those that Madsen (1999) reported in conducting collaborative therapy. To collaborate with families in building programs means that the professional program developers view families as experts on the life situations that challenge them and as experts on what they would find most useful in a program to support their coping and resilience. In this approach, rigorous research practices featuring qualitative analysis of in-depth semistructured interviews are coupled with a ''not-knowing'' stance to increase the likelihood that program developers will accurately hear and represent the life accounts and perspectives of families as the program takes shape.

Although this approach can be used in developing programs for families of all sorts, it is particularly appropriate in working with families marginalized because of class,

[1]In addition to the influence of families, the implementation and refinement of this approach has been shaped by numerous colleagues and students over the years. I would like to acknowledge Tom Hameline, Pat Gray, and Catherine Shugrue-DosSantos of HELP USA; Peter Steinglass of the Ackerman Institute; Michele Shannon; and my students Skye Wilson, Jody Brandt, Errol Rodriguez, Letisha Marrero, Alba Cabral, Jason Kruk, Marley Oakes, Sarah Kowal, DeShaunta Johnson, Marzena Srorzynska, Nate Thoma, Rumana Mansur, Monique Sulle Bowen, Leticia Perez, Aoife West, Leonidas Eracleous, Laura Diaz, and Israel Savage.

race, ethnicity, or other dimensions of difference associated with societal oppression. Whether they are mandated or volunteer recipients of social services, these families are often provided programs created with little or no consultation from them. As a result, these families may not find the programs engaging and may elect not to attend them. They then may be described as ''resistant'' or ''unmotivated'' by staff members of the service institutions that offer the programs. However, experience with the approach to program development described in this article suggests that families will eagerly engage in programs when they have some control over the processes used to create the program; when they have contributed to the program's content and structure through their wisdom, experiences, and desires; and when the relationship between professional program developers and program recipients is a collaborative, mutually respectful one. As Reason and Heron (1995) argued, ''One can only do research with persons in the true and fullest sense if what they do and what they experience as part of the research is to some significant degree directed by them. So persons can only properly study persons when they are in active relationship with each other'' (p. 123). Reason and Heron's words ring true for research in general and for applied research that results in programs or other interventions.

Depending on the degree to which professional program developers and community members share in the activities of identifying problems, developing research and other program-building methods, analyzing data, creating program formats and activities, and implementing, evaluating, and replicating the program, the CFPD approach can be used within levels 3–5 of Doherty and Beaton's (2000) five-level classification of therapist community involvement.[2] For instance, the CFPD methods can be used in building a clinically focused intervention program that coordinates and uses community systems and community resources but in which the therapist is still the central healing force (level 3). Such a program would fall more within Doherty and Beaton's category of collaborative models of practice, as opposed to their citizen model, characteristic of levels 4 and 5. In a level 4 effort, the CFPD methods can be used to provide high-quality information about community members' needs so as to accurately and systematically direct community change efforts. Professionals have the role of linking community members with various community systems and inspiring community members to solve problems together as citizens. The CFPD methods can be used in level 5 endeavors, in which the professional's role is largely to stimulate public action by citizens around a common issue of family life, often one that involves the professional personally. Whereas Doherty and colleagues have provided some details and examples of the necessary skills for professionals in levels 4 and 5—leading, forging, facilitating, encouraging, stimulating, activating, developing,

[2] In Doherty and Beaton's (2000) classification system, level 1 is characteristic of most ''traditional models of family therapy and individual psychotherapy'' (p. 152) and refers to therapists who engage with schools and social service, medical, legal, and other ''community systems'' solely to obtain or provide information or to make referrals as necessary for ethical, professional practice. These therapists do not engage with a family's community per se, such as are represented by friends, neighborhood improvement groups, sports, or other activities-based organizations or religious congregations. In level 2 involvement, therapists more actively engage and coordinate community systems and communities as part of a more comprehensive treatment, but they do not typically engage persons and groups in the family's communities. Doherty and Beaton advocated a new role for therapists as participants in community-change efforts, as characterized by those in levels 4 and 5.

joining, cocreating, and self-monitoring (Doherty & Beaton, 2000)—they have not described in detail their methods of systemically assessing and naming needs/problems and solutions in communities. The strength of the CFPD approach is that it links detailed procedures for learning from families with creating and evaluating programs that serve their needs.

It is important to note that although it is a relatively new approach for family therapists and researchers (McBride Murry & Brody, 2004; Turner, Wieling, & Allen, 2004), collaborating with families and communities to build and evaluate programs has long been a core practice of the field of community psychology. One prominent text even incorporates ''collaborative research and action'' into the very definition of the field (Dalton, Elias, & Wandersman, 2001, p. 5). The authors emphasized the recursive link between ''the development of psychologically valid knowledge . . . [and] making that knowledge useful in community life'' (p. 75). The authors wrote,

> Moreover, community psychology research and action are collaborative, based on partnerships with the persons or communities affected. A research project or action program developed from a community psychology perspective is planned and implemented with community members, recognizing their expertise and practical understanding of their community, and addressing their questions and aims. (p. 75)

Although family systems practitioners and researchers need to be careful not to reinvent the wheel in entering the domain of community research and intervention, family therapists adopting the methods and broader intervention approach pioneered by community psychology stand to make an important contribution through their greater focus on the distinctive qualities of families and on the reciprocal relationship between families and communities. Although programmatic efforts of community psychologists have long worked with families, much of the writing in the field describes the link between individuals and their communities, classifying families as but one example of an individual's ''microsystems''—a level of ecological analysis that includes classrooms, networks of friends, athletic teams, small businesses, self-help groups, and other ''environments in which the person engages in direct, personal interaction with others over time'' (Bronfenbrenner, 1979, p. 22, as quoted in Dalton et al., 2001). Family therapists and researchers bring a perspective and agenda that values community-level change not only so that families can better facilitate individual members' health and growth, but also because improving the quality of family life is a worthy goal in itself.

COMPLEXITIES IN DEFINING A COLLABORATIVE APPROACH

Paradoxically, researchers' intentions to be respectful and collaborative may require them to cut back on original plans to engage in a fuller partnership with families when such a partnership would be overburdening (Dalton et al., 2001; Serrano-Garcia, 1990). For instance, our original plan was to meet with homeless families individually to get their feedback about the codes that we had created based on their interviews, and to present them with the program prior to implementing it. However, as we quickly learned from the families and the shelter staff, homeless families are typically quite pressed for time (Fraenkel, 1999; Fraenkel & Wilson, 1998). Parents are busy attempting to balance employment-related activities (job training, job search, or employment, or participating in a work program to earn their families' welfare sup-

port); attending meetings with welfare case workers, shelter staff, and other larger systems representatives; searching for permanent housing; attending to their own or their children's physical health needs; and attending to the needs of aging parents or other relatives living outside the shelter—all before returning to their unit in the shelter by curfew time. Likewise, their children often travel long distances to remain in the schools they attended prior to becoming homeless, some of which may be in a distant neighborhood or borough of the city. If we had insisted on all the initially planned research meetings in the name of collaborative partnership, we probably would have unwittingly engendered a noncollaborative, conflictual quality to these relationships.

In the same vein, intrigued by the philosophy and practices of cooperative inquiry (Reason & Heron, 1995)—a radically collaborative approach in which persons living in the community of interest are invited to become full co-researchers along with professional researchers—we considered having families interview one another about their challenges and coping approaches in the shelter. However, this idea was quickly dismissed by senior shelter staff members, who were also persons of color. They reminded us that for many African American and Latino families, there is a strong belief in not airing one's ''dirty laundry'' to others (Boyd-Franklin, 2003; Falicov, 1998), and most families in the shelter kept to themselves. They recommended that we start with individual family interviews, a process that they believed would be challenging enough for us to carry out. Within the context of the multiple family groups that families joined after the interview, they often did inquire about each other's experiences and shared quite openly. In addition, in the teen program, one early activity is to have teens interview each other about their experiences in the shelter and report back to the group about their interviewee. Thus, in the spirit of collaboration, we tailored back our initial hopes and plans and reduced the demands on the participants for shaping the research and program, while still finding substantial ways to obtain their input and evaluations.

Other issues, such as time, space, funding, staffing limitations, and pressures from various stakeholders to complete the basic research and mount the program, also may limit the degree to which collaborative practices can be implemented. Nevertheless, some collaboration is better than none, and it is particularly important to invite participation early in the research relationship. This sets the tone and standard that can frame the less collaborative aspects of the research or program, thereby providing a positive relational context within which deviations from the more collaborative practices can be mutually agreed upon. For instance, by beginning our research with a qualitative interview lasting 2 to 4 hours, we are able to introduce questionnaires (which research participants in many studies often view as too formal and hard to relate to) as ''another, different way of getting to know your family's challenges and strengths'' (questionnaire text). Or, when adult family members give us permission to see their records from the job training and placement program, they understand and agree that this is a more efficient way to track these important outcomes as opposed to having them report these details each week.

STEPS IN THE COLLABORATIVE FAMILY PROGRAM DEVELOPMENT MODEL

Table 1 lists the 10 core steps in the CFPD approach, described in detail below. Although the steps are illustrated with programs developed with and for families that

TABLE 1

Steps in the Collaborative Family Program Development Model

1. Initiating the project, forming the collaborative professional relationships, and engaging cultural consultants
2. Intensive interviewing of family members
3. Intensive interviewing of agency professionals
4. Phrase-by-phrase qualitative coding
5. Creating program formats and contents and writing an initial manual
6. Piloting of the group with session-by-session evaluations by participants
7. Revising the program and manual
8. Intensive interviewing of families for each subsequent group cycle
9. Evaluating the effectiveness in comparison or randomized designs
10. Disseminating and adapting the program to other settings

are homeless, the model can be used, with modifications, to develop any type of program for families across the dimensions of difference. Although models of inquiry exist in which members of communities carry out the work without direct guidance from professional program developers (Greenwood & Levin, 1998; Reason & Heron, 1995), the CFPD model assumes that in most cases, professionals will be centrally involved in creating and implementing community-based programs because of the range of specialized skills and the time requirements needed to research a situation and build a program to address it. Thus, the steps outlined below are written from the perspective of a professional researcher/program developer working in collaboration with communities and other stakeholders invested in addressing the problems facing families.

Step 1: Initiating the Project, Forming the Collaborative Professional Relationships, and Engaging Cultural Consultants

A project may be initiated by a professional researcher/program developer interested in a particular problem in a community; by a mental health, social service, religious, or other professional working with a particular community; or by members of the community who may seek guidance in creating the program from a professional researcher/program developer. Initial meetings center on answering, at least preliminarily, a number of key questions.

Passion and purpose. Do members of the potential collaborative partnership have enough passion and sense of common purpose to sustain the joint effort of researching a problem, and build a program? Far from being dispassionate scientists seeking only to advance knowledge, applied social science researchers, like professionals working with the community and community members, generally care deeply about the communities they engage with in studying problems and designing interventions. First meetings among stakeholders can and should be passionate affairs, with opportunities for all to express their interests, concerns, and desires about the problems facing the community. Members of the emerging partnership should be invited to express these passions in their role as a professional, as a person, or both, as is warranted and comfortable for them. Often these passions are revealed as people share accounts of how they came to be interested in or involved with the problem, the challenges they have faced, and the fantasies they have held about how best to address it. As in psychotherapy, self-help, and other working groups (Yalom, 2005), the interactive proc-

esses that occur in collaborative partnerships provide psychosocial benefits to their members, which in turn contribute to the energy needed to fulfill project goals. Each member's passion is validated and amplified by hearing others with similar and different but related passions about the target problems. Identifying overlapping passions and goals builds a sense of group cohesion, a sense of no longer being alone with one's concerns, but rather part of a community dedicated to making a difference. The relational, emotional, intellectual, and pragmatic benefits of sharing and linking passions and purposes in these initial meetings are crucial as the group commits to embarking on a path of joint endeavor that will inevitably be strewn with roadblocks.

In addition to increasing group cohesion and strengthening collective emotional resilience for the tasks that lie ahead by sharing personal and professional passions, one of the principles of the CFPD approach is to ground all aspects of the program in the narratives of families and other persons (including ourselves) involved in the program so that it is relevant to the ''local knowledge'' (Geertz, 1983) and needs of the persons for whom it is designed. In this way, following Reason and Heron (1995), practical knowledge (how to do something, like conduct research and a program) and propositional knowledge (beliefs and theories about the social-psychological conditions the program is designed to address and about the nature of the program's potential impact) need to be grounded in experiential knowledge (''direct encounter face-to-face with persons, places, or things,'' p. 123). Thus, sharing passions and their sources in professional and personal histories is an important first step in the collaborative program development process.

In our case, our program for homeless families in transition from welfare to work began when an agency, HELP USA, requested assistance from a family therapy training and research institute (Ackerman). The representatives of these two institutions (Tom Hameline, and me, P. Fraenkel, respectively) spoke emotionally about their shared concerns for poor families. Tom spoke of the new challenges that these families and the agencies that served them faced following enactment of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act.[3] Agencies across the country that served poor families were scrambling to develop programs to assist parents to develop ''job readiness'' skills—such as the ability to search effectively for employment, interviewing skills, good work habits and attitudes, and so on—and to find employment. An agency's success in meeting welfare-to-work goals would affect its funding and capacity to provide services. HELP's ability to continue to provide housing was dependent on meeting welfare-to-work goals.

HELP found that although shelter residents were repeatedly reminded by on-site case managers, welfare agency workers, and employment specialists that they needed to obtain employment and that their welfare benefits would end, few residents were engaging in the job programs. Although 65%–70% of those who completed the one-week readiness program and were placed in employment still had their jobs 6 months later, by one year, less than 50% remained employed. These outcomes mirrored those obtained nationally. One review indicated that although national welfare rolls decreased and more persons previously on welfare obtained employment, job loss was common; 25% stopped work within the first 3 months, 50% were not working within

[3] This welfare reform act changed welfare entitlements from an unlimited period to a maximum of 5 years, with continual periods of welfare support for only up to 2 years. The act also required heads of households to work for benefits.

1 year, and periods between jobs were often long (Strawn & Martinson, 2000). Existing employment skills and placement programs tended to be created solely by experts, with little input from recipients, and either took the form of a graduated, progressive course in work skills and attitudes (for example, Adkins Life Skills; http://www.adkinslifeskills.org) or adopted the confrontational ''therapeutic community'' (TC) approach used primarily with persons involved in chronic drug abuse (for example, http://www.strivenewyork.org). The guiding premise of such programs is that persons on welfare lack positive work attitudes and skills and need to learn them, or they lack adequate motivation and must be challenged forcefully. Neither type of program addressed the challenges related to the changes necessary in family life when a parent makes the transition from welfare to work. Tom heard about these challenges from speaking with case workers, employment specialists, and participants in the employment programs at HELP.

In addition to urgent issues about families' and the agency's survival, Tom brought a passion for creating coordinated services. I brought an abiding interest in how families create and sustain family time (Fraenkel, 2001) and how they balance work and family responsibilities (Fraenkel, 2003c), which had not been explored extensively in poor families and families of color. I also brought an interest in collaborative approaches to intervention, which was developed over 8 years in work with sexually abused children and their families (Fraenkel, Sheinberg, & True, 1996; Sheinberg & Fraenkel, 2001; Sheinberg, True, & Fraenkel, 1994) and in qualitative study of family members' perceptions of what was useful about the therapy (Fraenkel et al., 1998). Having witnessed the powerful impact of providing families opportunities to take charge of their therapy and to comment about it in some detail, I responded to Tom's casting the main problem as parents' lack of ''engagement'' in work programs by suggesting a collaborative approach to research and program development featuring qualitative interviews. The interviews would focus on what families see as the challenges they face and what they wanted in a program to serve their needs.

The fundamental premise of treating families as experts who could inform us in building and evaluating the program made good sense to all the participants in the process: to Tom and his colleagues at HELP USA, to the staff of the shelter whom we met with to obtain their guidance and assistance, to me and my students as the main conductors of the research and program, to senior colleagues of color whom I engaged as mentors (see below), and most important, to the participant families. Having the research and program development practices make good sense to all strengthened everyone's commitment to the project, aligning with and linking their respective passions. Thus, having the fundamental premise of one's approach to program development hold a certain face validity is one important way to address the issue of engagement for all involved.

Multiple perspectives. Do the persons assembled in the collaborative team represent a diverse enough range of ideas, skills, and goals? Just as qualitative research seeks out diversity in experiences about the phenomenon of study in order to build an inclusive, comprehensive theory, a well-functioning collaborative team requires diverse contributions. Hearing different passions, concerns, and goals from members' differing perspectives and sources of expertise also lends members a sense that they are part of an emerging team; that they will not need to solve all the problems or seek out all relevant information themselves (thereby decreasing the sense of overwhelm that can

discourage change efforts); and that they stand to learn something from one another. An open discussion, at the beginning, of the range of possible goals for the project allows for a sense of inclusiveness of all members' concerns and for thoughtful planning so that foci that could have been addressed are not discovered after most of the data are collected. Such a discussion also allows the group to prioritize and sequence goals realistically.

Although the point of the collaborative approach is to include and even prioritize the perspective of persons who will participate in the program, in many cases, especially when working with communities that represent multistressed, vulnerable populations, early meetings will be solely among professionals (for example, researchers and agency directors). This is due to the need to decide whether a project and partnership are even feasible before involving members of the community, and due to various legal and institutional regulations regarding confidentiality and researcher access to community members. However, in the CFPD model, community members are involved in the project as soon as these conditions are met so that the project does not develop without their contributions.

Following the initial meeting between Tom and me, the next meeting included HELP's regional director, the director of the shelter where Tom thought the research and program might best take place, and the director of that shelter's social services. These professionals, all of whom had master's degrees in social work and exposure to family systems theory and community research, were quite excited about the possibility of a program to help parents move into the workforce. They too shared a concern, and some frustration, about the inconsistent attendance of the parents in job readiness, training, and placement programs, especially given the specter of the new welfare time limits. These professionals were all African American or Afro Caribbean, and their years of experience in the field enabled them to serve as senior mentors to me. They did not voice concerns about the idea of developing the program through collaborative research in terms of the race or ethnicity of the residents. Rather, they responded enthusiastically to the stance of approaching families as experts and were cautiously optimistic about the potential for this stance to engage resident families.

Expert cultural knowledge. Do members of the team include persons who can provide insider knowledge about the community cultures of the individuals who will participate in the program? Although the CFPD model's guiding premise of ''families as the experts'' and the correspondingly respectful approach to interviewing increase the likelihood that program participants will speak openly about their cultural beliefs and traditions; about the impact on their lives of racism, sexism, ethnicism, classism, and other oppressive societal practices; and about the adequacy and sensitivity of the research methods and program in addressing these themes, a number of forces may restrict participants from speaking fully on these topics. First, no matter how friendly and collaborative the interview, there remains an implicit hierarchy and power differential between the interviewee and the interviewer; even if of the same racial and ethnic background as the interviewee, the interviewer will be of a higher social class and educational level. The hierarchy is likely to be even greater when interviewers and program developers are White. Second, interviewees may be gracious and forgiving when questions are worded in ways that are linguistically awkward or even unwittingly insensitive from a cultural perspective, or when program elements don't have the best cultural fit. Unfortunately, their graciousness may limit the degree of

critical feedback that might greatly improve the research and program. Third, as was noted, one of the major beliefs in most communities of color, at least in the United States, is that one does not share intimate details of family problems with outsiders (Boyd-Franklin, 2003; Falicov, 1998; Sue & Sue, 1999). This may apply particularly to the intimate details about experiences of oppression, which often carry painful, highly charged, and incompletely metabolized emotions. Fourth, the pernicious effects of internalized racism (Watson, 2000) and internalized classism (Sennett & Cobb, 1972) may extend to interview and program participants, silencing their anguish and well-deserved rage about these forms of social injustice; they may instead blame themselves for failing to overcome adversity in the manner of the great American myth of the rugged individual (Sennett & Cobb). Fifth, although there are outstanding examples of oppressed persons who have written and spoken eloquently about their experiences, most persons struggling with multiple sources of marginalization and limited resources have not been afforded the luxury to research and reflect on the larger social forces that silence them. As a result, senior social scientists and interventionists who have focused their professional efforts on issues of race, ethnicity, class, gender, and other dimensions of difference that they also inhabit as persons provide a unique and crucial resource for program developers who need cultural consultation.

It is not sufficient to include a multiracial, multiethnic, and multiclass team if the director of the project is White and educationally and economically privileged, and all other members of the team are students or junior colleagues. For instance, in my experience, despite engaging bright, clinically sensitive, advanced, and outspoken students of color as team members from the beginning, and despite my attempts to engage them in critically evaluating our interview protocol, they lodged few critiques that focused on the appropriateness of the language of questions from a cultural point of view. Only when I repeatedly conveyed my concern that we needed to do better at providing an opportunity for participants to talk about their experiences of oppression did they begin to offer suggestions about adding new questions and revising old ones. My attention to these issues was heightened by conversations with senior colleagues of color.

For all these reasons, it is essential that the program developer obtain ongoing cultural consultation and mentoring from persons senior to him or her who can provide expert and insider information (Dolan-Del Vecchio, 1998; Tamasese & Waldegrave, 1993; Waldegrave, 1990, 1998). This is especially necessary when program developers inhabit locations on dimensions of difference—such as race, ethnicity, education, and class—that afford them more privilege than the persons who will participate in the program.

In our case, Patricia Gray, the shelter director, senior social service professional, and a woman of color, agreed to consult with the research team on an ongoing basis in shaping the research methods and procedures, including reviewing the interview questions in terms of suitability of language for the shelter population. She also consulted with us on the creation of the program. One useful suggestion that would not have occurred to us was to hold a graduation ceremony at the end of group, complete with diplomas, speeches, and dinner. She noted that a graduation ceremony, commonly included in programs offered in social service contexts, would be a meaningful incentive to stay in the program, both for the adult residents who had completed high school and remembered the event with pride, and those who had not but longed to do so. Children would enjoy it as well, and it might provide them an incentive

to stay in school so that they could experience those graduations. I realized from my initial critical reaction to her suggestion that this idea would not have occurred to me for two reasons. First, possibly as a result of my own educational privileges, I thought it might seem patronizing to hold a graduation for an 8-week program. Second, the program is not conducted as a psychoeducational course, but as a discussion and support group in which the families are the experts. We wanted to distinguish our program from the typically more hierarchical training programs offered.

However, Pat Gray turned out to be absolutely on target. The graduations have been extremely moving experiences, with graduates dressing in their finest clothes, inviting family members living outside the shelter, and offering powerful accounts of the impact of the group in their lives and inspiring à cappella songs from the African American popular and spiritual traditions.[4] A number of graduates referred to the program as the ''Ackerman class,'' and most spoke of what they learned, and yet they were the instructors. Several noted with much emotion that this was their first graduation and that it inspired them to complete their high school degrees and go on to college—a lifelong dream. This is a good example of how it is critical to access and incorporate ''insider knowledge'' about the cultures of persons who will attend programs, and of the institutions in which the programs will take place. It also illustrates the importance of forming collaborative teams of people with different sorts of expertise who can complement and correct one another.

In addition to the in-depth involvement of Pat Gray and other senior staff of HELP USA, I have engaged several senior colleagues of color at particular junctures to assist me in remaining accountable to issues of culture, race, ethnicity, class, and immigration in doing this work and in presenting it at conferences.[5] Although these consultations typically started out focused on these issues, they often moved to other key issues in program development and dissemination. For instance, in a day spent with Paulette Hines,[6] her major emphasis was on strategies for acquiring greater funding and pairing training with dissemination of the program manual.

Roles. What roles will each member of the team take in the project? The distribution of roles usually follows from the particular types of expertise and positions that each member holds in his or her respective context.

My area of expertise is family therapy, research, and program development, so I took the lead in designing and conducting the research and implementing the program. Tom Hameline's area of expertise is the administration of social service programs, so he took the lead in that area. Families offered their experiences, insights, and programmatic suggestions, and their time and energy to be in the program. Many of the key roles are filled by graduate students, who gain invaluable research and

[4] In working with families in treatment in which children have been placed in a residential care facility, Nichols and Jacques (1995) described a similar celebration ritual in which people come together who can continue to support a family once they are reunited and living in their new home. The family in therapy participates in creating the ritual and naming the persons to attend. Those attending may be extended family, friends, therapists, and representatives of the larger systems institutions, such as schools, social services, and the residential facility.

[5] I am especially grateful to Paulette Hines, Kenneth Hardy, Marlene Watson, Carmen Rodriguez, and Nancy Boyd-Franklin for their comments.

[6] Director, Office of Prevention Services and Research, and executive director for the Center for Healthy Schools, Families, and Communities, University of Medicine and Dentistry of New Jersey-University Behavioral Health Care.

intervention experience, and funding if possible. Various agency staff members also fill critical roles: following up with families who do not show up for scheduled interviews; coordinating set-up, meals, and room scheduling; linking the family support program with the job readiness and placement program; and coleading family groups.

Just as we needed to scale back our initial hopes that families might play an even more active role in the research, professionals also have their plates full. Unless someone expresses interest in serving a time-consuming new role or has some of her or his other responsibilities scaled back, it is unlikely that he or she will be able to follow through with research and programmatic responsibilities. On several occasions, the staff person assigned to assist us in coordinating meals and logistics suddenly was deployed to another site or accrued additional responsibilities but did not want to withdraw from the project. The result was that critical tasks were not accomplished. Therefore, it is important to outline carefully the tasks and time commitments for each responsibility, to negotiate with supervisors from host institutions release from other responsibilities for participating staff (or provide additional salary), and to encourage project staff to recognize and discuss when they cannot fulfill their roles.

Step 2: In-Depth Interviewing of Family Members

Collaborative approaches to research typically use qualitative methods (Strauss & Corbin, 1998), especially interviews, either alone or in combination with quantitative methods (Dalton et al., 2001; Denzin & Lincoln, 2000; Reason & Heron, 1995). The goal of qualitative research is to develop detailed, multilayered ''thick descriptions'' (Geertz, 1973) of the nature and meaning of events, situations, and experiences from the point of those interviewed. This is the insider, or ''emic,'' perspective. Qualitative methods rely upon the researcher's ability to socialize with the respondent or participant[7] in such a way that the relationship is comfortable and the participant feels free to reveal intimate details of her or his experience. This quality of relationship between researcher and participant is sought so that the participant is more likely, rather than less likely, to go beyond the prestructured stimuli—for instance, to expand on the preset questions or even suggest better or more important questions, and then answer them. All participant verbal and nonverbal behavior is noted and considered as potentially useful data, including comments made after the semistructured interview and formal video or audiotaping ends. In this approach, research is viewed as an inherently biased, socially constructed activity (Denzin & Lincoln; Kidder & Fine, 1997); therefore, the qualitative researcher does not strive to control the interaction or data analysis to eliminate all biases, but rather, through cultivating a curiosity about others' experiences and an enthusiasm for disconfirming his or her own views, poses open-ended questions that allow participants to share experiences that may disconfirm the researcher's preconceptions. These qualities of the researcher-community relationship may lead qualitative methods to be experienced as more

[7] These terms for referring to interviewees emphasize their active participation in the co-construction of knowledge and the researcher's stance as a learner. The participant/informant is in the position of teaching or informing the researcher about the phenomenon under study. The language and stance are in contrast to those used in much of quantitative, experimental, or quasi-experimental research, in which participants are termed *subjects*, connoting that they will be *subjected to* particular experimental or naturally occurring conditions and their reactions studied by a researcher who administers the study procedures.

inviting and less threatening for members of marginalized, oppressed communities as compared with traditional quantitative methods (Dalton et al., 2001), at least until the researcher has gained the community's trust.

In line with this emphasis on ascertaining the insider's viewpoint, the in-depth qualitative family interview is the heart of the CFPD approach. Through it, family members are explicitly engaged as experts on their experience and as consultants in constructing the program. For the Fresh Start program, the interview inquires into how families came to be in the shelter, how they have coped with living in the shelter, their experiences with welfare and work, the challenges that they have faced or believe they will face as individuals and as a family when the parents move into employment, their beliefs about family time and how this shifted or may shift with the transition into work, and what they recommend should be in a program to support them. For the families-with-teens program, we conduct a whole-family interview and separate interviews with parents, each teen, and if there are two teens, a conjoint interview with the siblings. We also ask families to comment on the interview questions and overall process.

Interviews need to be at least 2 hours long, preferably 3–4 hours, so that neither interviewer nor interviewee feels rushed. This allows the interviewer to indulge his or her genuine curiosity about the family's experience and ideas without causing anxiety about ''getting through the interview.'' A longer interview also allows family members to respond fully and go off the path of the question, where they sometimes share their most spontaneous and heartfelt memories and opinions. A longer interview also necessitates breaks, during which informal conversation occurs around snacks. These informal conversations help to create a feeling of ''hanging out'' together. Without creating a false intimacy, these informal conversations almost imperceptibly shift the frame from a formal interview to a more authentic conversation in which the underlying roles of interviewer and interviewee are softened although not abandoned, thereby encouraging families to describe their experiences even more intimately.

Families are also asked to evaluate the interview process. Along with some useful suggestions for rephrasing questions, families invariably reported that they enjoyed it and seemed in no rush to end it. They often confused the program development research interview with the program itself. They often remarked spontaneously that this interview was the first time that they had been asked to give an account of their experience being homeless, of their positive qualities as a family and means of coping with adversity, or for input about programs. For instance, one African American man—who reported frequent run-ins with police as a teenager, time in prison as an adult, and consequently, mistrust of ''the system''—noted with a warm smile, ''You got a lot of answers out of us that *no one* else could get out of us!'' His female partner, viewed by some staff of the shelter as uncooperative, noted with an enthusiastic tone, ''It's a good program—you definitely are on the right track with the questions.''

Prior to the interview, families must be contacted to inform them about the research and program that will follow and to obtain the adult family members' oral agreement to participate with their children. In our program, we randomly select families from a roster and call them in their units. To increase the likelihood that families will be able to participate in the research and in the 9-week group program, we select only families who have been in the shelter for no more than 12 weeks. Random selection also increases the likelihood that we will obtain a more representative sample of families and associated experiences and ideas, rather than incurring

the usual biases endemic to self-referral (in our case, biases could include being more or less motivated, more or less available because of employment or lack thereof, greater or lesser levels of coping, and so on). We then schedule a time to describe the study to the family in more detail and have each member sign age-appropriate informed consent forms.[8] In addition to the usual guidelines about confidentiality, we emphasize that, barring information that raises our concern about possible harm to self or others, we will not disclose to professional staff of the shelter anything families tell us. With their permission, we may relate general themes—for instance, complaints about the behavior of the shelter security guards or child care workers—but will not link any comment to a particular family.

Included in this step is the information that we pay the family a small amount ($25) for their time in the interview and for completing questionnaires at three points ($25 for each point): following the interview, following completion of the group, and 1 year later. We also provide dinner on the night of the interview so that parents are able to participate into the early evening.

To facilitate families agreeing to participate, it is recommended that they be seen in a setting that is most convenient and comfortable for them. This will vary depending on the community; some may prefer to be interviewed at home, in a community center, or other setting. In our case, all interviews were carried out in comfortable, fairly quiet rooms in the social services wings of the shelters.

Step 3: In-Depth Interviewing of Community Professionals

Individuals in a professional service-delivery role with members of the community offer unique perspectives that can powerfully shape the program. Whereas the initial planning meetings of step 1 often involve professionals higher in an agency or institution's hierarchy, step 3 involves interviewing professionals in all roles. Often, those lower in the hierarchy have more regular contact with the families served and so can provide the kind of detailed observations that provide a stimulus to creative program development. Interviewing these professionals also engages them as stakeholders and collaborators in mounting the program.

As informative as they can be, we wait to interview professionals until we have had an opportunity to meet with several families and learn directly from them. We do this to avoid privileging the perspective of professionals, which often occurs in traditional program development. Sequencing the interviews this way also allows us to share with the professionals some of our emerging observations and helps us have referent experiences for their comments.

In our work in the shelter, we interview the directors of all departments: child care, employment, housing, social services, security, recreation, and maintenance, and workers at all levels of the hierarchy in these departments. In one focus group with these professionals at HELP's domestic violence shelter, a number of professionals described the frustrating experience of seeing women repeatedly miss appointments with them and respond in a belligerent or scattered manner when reminded of these

[8] The study is conducted with the approval of the City College of New York's Institutional Review Board, which carefully assessed the study in terms of its potential for harm to participants because the groups we study are deemed vulnerable by federal standards. Along with our collaborative stance, this mandatory process provides yet another safeguard limiting the likelihood that the study will cause undue distress.

appointments. Asked for their opinions about what motivated this behavior, a number of the professionals spoke of the women's low self-esteem. Further questioning led to the hypothesis that underlying the low self-esteem and unproductive, uncooperative behavior was fear that remained from the experience of battering, and fear about taking the next steps to locating housing and employment. The importance of addressing fear and all the ways women strove to hide their fear resulted in one of the central activities of the group program (the Mask of Fear; Fraenkel & Shannon, 1999). In this activity, women are given paper plates and arts and crafts materials and asked to create a mask that depicts the face that they use to hide their fear. On the other side, they are asked to depict the fear and other emotions that they hide. The masks become a stimulus for further discussion of how the women handle their emotions, and the relational resources available to them to express themselves and obtain soothing.

Just as families may experience the research interview as therapeutic, interviews of professionals may change their perspectives and practices. According to the director of the domestic violence shelter, the focus group conversation led to a profound shift in the culture of the shelter, with professionals' discussions about residents taking a more psychological and sympathetic tone. Remarkably, without any additional efforts to institutionalize it, this shift in professionals' ways of thinking and talking about the resident families was reportedly sustained four years later.

Step 4: Phrase-by-Phrase Qualitative Coding of Interviews

To locate themes of challenge and resilience and to capture families' and staff members' suggestions for the format and content of the program, we qualitatively code the video or audiotapes. In qualitative coding, each new participant's interview provides an opportunity to create new codes. Codes are retained even if generated in response to only one participant; the data are not reduced to the most frequently used codes. Indeed, rather than being viewed as outliers that threaten to dispel an existing theory, unique responses are highly valued for the diversity they bring to building a truly inclusive theory that captures the lived complexity of the phenomenon under study.

To do justice to the richness of the information and feelings that interviewees share, codes are created for the smallest meaningful unit of speech, termed a *thought unit*. On average, a thought unit is a sentence in length, although when an interviewee's sentences are long and include multiple ideas, a thought unit may be as short as a phrase (in written text, a dominant or subordinate clause, such as the material up to or following a comma). This approach to qualitative coding can be compared with microanalytic, quantitatively driven coding systems of couple interaction, versus more global approaches (see Markman & Notarius, 1987).

Because of our need to transform qualitative data fairly quickly into program materials, we do not have time to transcribe the interviews prior to coding. Instead, we code directly from the tapes and record the precise time code for the beginning and end of each thought unit.

Step 5: Creating Program Formats and Contents and Writing an Initial Manual

The created program represents a dialogue between themes named by the potential participants and our knowledge base as professional program developers. Rather than

being rigid templates for how to conduct a set of interventions, manuals adapted over time become the document that captures that dialogue and evolving story of the collaboration between professionals and families. In the CFPD model, the program materials and activities are revised based on new themes learned from each new family interview. Of course, to conduct valid evaluations of the program in matched comparison or randomized clinical trials (see step 9), the manual must be at least temporarily stabilized for the period of the evaluation.

The core format of our programs is a 9-week multiple-family discussion group (MFDG; Gonzalez, Steinglass, & Reiss, 1989; McFarlane, 2002) that meets once a week for 1 1/2 hours, and dinner is served prior to the meeting. This format seemed well-suited to meeting the need that many families named of providing a safe, nonjudgmental context in which they can connect with one another, benefit from one another's support and wisdom, and decrease the sense that they are the only ones experiencing challenges endemic to this situation.

In response to the numerous statements by families in research interviews that they felt put down and stigmatized because of their homeless status, and in response to several families' urgings that we include attention to the positive things about them, we adopted the practice of eliciting stories of pride used previously in the Ackerman sex abuse project (Sheinberg & Fraenkel, 2001; Sheinberg et al., 1994). We created an exercise that involves families stating one thing that they feel proud about in general, and then, in a second round, something that they feel proud about that is related to work. In response to the numerous negative effects of homelessness identified by families, we adapted the narrative practice of externalization (White, 1988) and created an activity in which families externalize the impact of homelessness. In response to teens' requests for activities and not only discussion, we created a number of exercises that use the arts to express challenges and coping, and a game show activity in which parents guess what their teens view as challenging about being in the shelter.

A specific method through which we directly link coded themes from the research interviews with program materials and activities is the ''card sort.'' We place each of the coded challenges named by at least one family on a single 4''$\times$4'' card (over the 8 years of the program, we have assembled a stack of over 100 cards). We now have three separate sets of cards—one represents challenges facing families as a whole, one represents challenges facing the adults in their roles as workers and employees, and one represents challenges for teens. In the third session of the 9-week multiple-family group, each family is given the entire stack of family-as-a-whole cards. They are asked to sort each card into one of three envelopes depending on the degree to which they have experienced these challenges affecting their family; the envelopes are *not at all* (1), *somewhat* (2), and *definitely* (3).[9] Families then rejoin the circle and are asked to select a card from envelope 1 (*not at all* a problem) to share with the group. Inevitably, a card/challenge that one family views as *not at all* a challenge will be viewed as *somewhat* or *definitely* a challenge by another family. This leads to lively group discussion as one family shares coping skills and ideas with another family.

[9] In subsequent separate sessions for parents and teens, parents also sort the cards about themselves as workers and sort the teen cards in terms of their teens' challenges. The teens sort the teen challenge cards about themselves.

Conversely, the stories shared by a family who has experienced struggle with a particular challenge have helped families who have not yet experienced this challenge to anticipate how it might be a problem for them in the future.

Step 6: Piloting of the Group with Session-by-Session Evaluations by Participants

Families are invited to provide informal (oral) and more formal (written) feedback on the quality of their group experience and are reminded that they are helping to shape the program. We use an adaptation of a short evaluation form originally developed for research on the aforementioned family-based child sexual abuse treatment (Fraenkel et al., 1998). The scale asks family members to write a sentence in answer to the question, ''What was the most important thing that happened or was said today?'' They also rate the helpfulness of the group on a scale from 1 to 5 and are provided space to answer the question, ''Was there anything you did not like about today's meeting? Or any suggestions you'd like to make for future meetings?''

Because all families who participate in group previously participated in the extensive family interview, they may be more able to provide authentic critiques and suggestions on everything from logistics and formats to specific activities than if this were the first time their opinions were being requested.

Step 7: Revising the Program and Manual

We use families' feedback, feedback provided by shelter staff, and our own reflections on what worked and what didn't to revise the program and manual. For instance, one major change brought about by families' evaluations was to revise the program to include time for parents to talk without children present. This necessitated obtaining (paid) after-hours assistance from the child care service of the shelter. As another example, one intersession activity created on the suggestion of one group member (and with agreement of all other members) was for each family to think over the problems of another family between group sessions and offer potential solutions in the following session. This particular group member went beyond mere possible solutions and actually solved another family's longstanding difficulty finding permanent housing.

Step 8: Intensive Interviewing of Families for Each Subsequent Group Cycle

In a step that differs significantly from typical program development procedure (Dalton et al., 2001), program development interviews are conducted with each new potential participant even after the program has been created, and the program is revised as needed based on their comments. We maintain this time-consuming step because of our hypothesis that the interview has been crucial to our high level of program engagement: Whereas the average rate of engagement in shelter-based programs at HELP is about 24%, 76% of the first 55 families we interviewed participated in the subsequent group cycle. Because there are many potentially confounding variables in this informal comparison of program engagement rates, we plan to test the impact of program development interviews in a randomized clinical trial.

Step 9: Evaluating the Effectiveness of the Program in Matched Comparison or Randomized Designs

Ultimately, for scientific and funding purposes, collaboratively-developed programs need to be subjected to rigorous matched comparison or randomized clinical designs to test their efficacy and effectiveness. Having obtained some quantitative pre-post findings from the first 55 families suggesting that the Fresh Start program leads to significant decreases in demoralization and in overall psychological distress for parents, we plan to conduct a randomized clinical trial of the program comparing it with ''treatment as usual.'' One challenge we anticipate is how to maintain the collaborative atmosphere of the program while engaging in the more formal research endeavor of random assignment to treatments.

Step 10: Disseminating and Adapting the Program to Other Settings

Just as we interview each family for each new cycle of the program, we conduct entire new sets of interviews for each new agency that wants to bring in the program because each setting and its potential participants face unique challenges and have unique sets of resources. This practice led to important changes (represented by separate manuals) in the content and format of the program that we developed for families who were homeless because of domestic violence, and for the program that we developed for families with teenagers.

CONCLUSION

The Collaborative Family Program Development (CFPD) model provides a philosophy and set of associated practices that link rigorous research methods with contemporary family therapy sensibilities. These sensibilities enjoin professionals to view families as holding untapped strengths and considerable expertise on their problems and on what they need to overcome these problems. Engaging families as experts seems to lead them to engage more actively and regularly in programs because these programs are designed with their input. As an older single mother of two teenagers, with a history of imprisonment and reliance on welfare, noted emotionally at the end of a postprogram follow-up interview 6 months after she had left the shelter, ''You didn't treat us like we were clients—you treated us like we were friends, and that's what made the difference, and let me stop now or I'll start crying!'' The CFPD model has been used successfully in creating a community-based support program for homeless families in which parents are attempting to move from welfare to work, and in creating two variations on the program: one for homeless domestic violence survivors and one for homeless families with teens. We look forward to refining the CFPD model as we hear from the community of professionals who adopt it in their program development work with families who face a range of problems across the various dimensions of difference.

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