

Training professionals in community settings: Change processes and outcomes in a child protection context

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Abstract

This article reports an action-research focused on the improvement of a training program for professionals working with multi-challenged families with at-risk or maltreated children. The program aimed at the implementation of a multi-systemic, collaborative and strength-based family assessment and intervention model. Outcome evaluation results indicate that professionals improved their skills and achieved minimal competence. Process evaluation reveals that participating in the training has been a transformative experience and highlights facilitator and constraining conditions for participants' learning and changing as well as suggestions for improvement of the training program. Implications for practice and future research are discussed.

Keywords: training; systemic thinking; community-based practice; multi-challenged families; case-study

Formar profissionais em contextos comunitários: Processos de mudança e resultados num contexto de proteção da criança

Resumo

Este artigo descreve um estudo de avaliação, de investigação-ação, e de casos múltiplos, focado no melhoramento do processo e resultado de um programa de formação para profissionais

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para a implementação, em contextos comunitários, de um modelo integrador, multissistémico, colaborativo e baseado nas forças, de avaliação e intervenção junto de famílias multidessafiadas com crianças em situação de risco, abusadas ou negligenciadas. Os resultados da avaliação indicam que os profissionais melhoraram as suas competências e que adquiriram um nível mínimo de competência. A avaliação de processo revela que os participantes na formação tiveram uma experiência transformadora e sublinham as condições facilitadoras e constrangedoras para a aprendizagem e mudança dos participantes bem como sugestões para melhoramento do programa de formação. São discutidas implicações para a prática e investigação futuras.

Palavras-chave: formação; pensamento sistémico; prática baseada na comunidade; famílias multidessafiadas; estudo de caso

Themes of training in systemic family therapy have been present in the literature for a long time (Campbell, Draper, & Huffington, 1989; Elkaïm, 1988; Nel, 2006) but empirical studies focused in specific training programs are not abundant (Street, 1997). Solution-focused and strength-based perspectives have expression in community and child protection settings (Berg, 1991; Turnell & Edwards, 1999) but studies focused on these matters are scarce. In these contexts, professionals often work, multisystemically, with difficult to help multi-challenged families (Linares, 1997; Madsen, 2007; Melo, 2011; Rojano, 2004). Their training and supervision are of great importance and should attend to abilities to cope with extreme emotions and personal challenges (Sharlin & Shamai, 2000). Preparing professionals to work with these families is specially demanding in cases of child maltreatment (Reder & Lucey, 1995).

The Integrated Family Assessment and Intervention Model (IFAIM) is an integrative approach developed in Portugal, and implemented in local community-based family support services, which combines therapeutic, social, educational and community interventions with forensic purposes (Melo & Alarcão, 2011). The same interdisciplinary team performs assessments for the child protection services and the courts and, simultaneously, offers support for change to the family. It is a multisystemic and ecological approach in the sense that it attends not only at different levels of family organization (e.g. couple, parental, whole-family) but also at different levels of organization of its surrounding milieu (e.g. housing; material conditions; social network) and their relationship (Rojano, 2004). It is also an in-home based approach since it privileges working with the family at its most natural settings. The model was specifically designed to meet the needs of the child protection system in cases of child neglect and maltreatment and to attend to the

complex needs of multi-challenged families with at-risk children. Therefore, while keeping a focus on child protection concerns, the professionals adopt a collaborative and respectful stance, supporting the family to amplify and use its internal (individual and relational) and external strengths (from the milieu and the family's relationship to it) in working towards change (Berg, 1991; Madsen, 2007).

In a preliminary stage the professional must negotiate a clear contract with the referral entity and the family, clarifying the role of all of those involved in the case, the objectives of the assessment/intervention and the procedures and timings involved. A core team, usually composed of two professionals (often a psychologist and a social worker or educator) works intensively with the family, during one to three months, to conduct an assessment aimed at producing information concerning: (a) the strengths and vulnerabilities regarding parental capacity, family functioning, social and environmental conditions and their possible role in problem maintenance and change; (b) the potential for the family change. To accomplish these objectives the professionals elaborate hypotheses regarding the factors and processes underlying problem maintenance and the potential change and test them, by providing the family with targeted support for change during the assessment period (Melo & Alarcão, 2013). They also aim to provide the family with an opportunity to: (a) explore the possibilities and potential benefits of change as well as its willingness to change; (b) explore the potential and the constraints associated with the change process and the professional support - through "change rehearsals"; (c) expand its capacities and strengths; (d) assume responsibility for its decisions regarding its involvement in a posterior stage of more formal (contracted and purposeful) support for change, aimed at pursuing or consolidating changes identified as relevant for the child's protection and well-being. In the end of the assessment, the team elaborates a report with recommendations and, when suitable, a family support plan - often multisystemic (Melo & Alarcão, 2013). Independently of its multiple components, the plan includes family sessions aimed at the integration of change across levels and the strengthening of the family's autonomy and relational strengths.

The purpose of this article is to describe a mixed-methods multiple-case study evaluation aimed at assessing the process and outcome of a training program for professionals implementing IFAIM. Specifically, this study aims to answer the following research questions: (a) are there differences in the professionals' practical skills before, during, and after the training program? (b) how do the professionals' skills evolve throughout the training? (c) what changes do participants experience during the training program and what meanings do participants ascribe to the training program? (d) how useful are the components of the training program? (e) how can the training program be improved to facilitate IFAIM's implementation with fidelity and the participant's skills?

METHOD

Evaluation methods and rationale

This study was included in a broader research project aimed to develop and assess the effectiveness of IFAIM and its training program (Melo, 2011). This is essentially a pragmatic, evaluation study, in the sense that it aims at the improvement of a training program (Fishman, 1999; Patton, 1997). This focus is particularly important since the training program was new and uninvestigated. Therefore, its outcomes should be assessed with a complementary focus on the processes that may affect them. Additionally, it was important to use the participants' input to refinement of its overall organization as well as specific components. We adopted an action-research model (Taylor, 1994) so that changes could be experimented while the program was being developed and tested. We combined quantitative and qualitative methods to assess the outcomes of the training and to capture the professionals' personal experiences.

Table 1 summarizes the method used for data collection, the timings of data collection and sources, as well as the content of the data.

Table 1
Data Collection Methods, Moments, Sources and Content

Data collection method	Type of data and data retrieval	Data collection moments	Sources	Content of the information
Observation/ Unstructured interview	Qualitative Facilitator/Researcher's (first author) notes	Meetings with the participants (team)	Facilitator/Researcher (first author)	Participants' experiences, difficulties and mastery of IFAIM' skills; utility of strategies used to support participants
Questionnaires	Quantitative and qualitative Case study database; statistical software package database; printed questionnaires;	At the end of each group training session At the end of the initial training (Part 1)	All professionals participating in the initial training (Part 1) All professionals concluding the initial training (Part 1)	Satisfaction with the session; evaluation of the performance of the group and facilitator Evaluation of the utility and satisfaction of participants with the specific components of initial training
Documentation	Quantitative and qualitative Case study database; statistical software package database;	At each module of the initial training (Part 1)	Participants and facilitator (in regard to grading)	Ratings of assessment/integration and personal assignments
Observation/ rating form assessment	Quantitative and qualitative Case study database; statistical software package database; documents with ratings	At each module of the initial training (Part 1)	Facilitator/ Researcher (first author)	Evaluation of participant's practical skills to implement IFAIM with the Scales for the Assessment of IFAIM's professionals skills
Focus Group	Qualitative Audio recordings; 2 transcriptions in case-study database	End of supervised practice (at 12 months following the end of initial training for Group 1 and at 6 months following the end of the initial training for Group 2)	All professionals participating and concluding supervised practice (Part 2)	Participants' experiences throughout the training; participant's qualitative process and outcome evaluation of training utility; suggestions for improvement

Participants

Two-groups of professionals, in a total of 31, from community-based family support centers, (Centers for Family Support and Parental Counselling - Centros de Apoio Familiar e Aconselhamento Parental-CAFAP) initiated training, of which 18 completed initial training. The main reasons for drop-out include change of jobs, health problems and failure to comply with minimum training tasks (e.g. not performing the written assignments, recording sessions or self-evaluation). Due to lack of funding or maternity leaves of absence, only fourteen professionals participated in supervised practice.

It was not possible to collect quantitative data at all collection times, for some participants. Quantitative evaluation concerns 12 participants (5 social workers, 4 social educators, and 3 psychologists). It was realized within the logic of a multiple case-study and action-research approach, in order to explore likely outcomes of the training and the evolution of targeted skills. They provided some objective outcome indicators, which the qualitative assessment could not offer. Participants had between 2 and 21 years of experience. Seven participants had no previous training in family systems theories, 3 had participated in short-term introductory trainings to systemic thinking and 2 were enrolled family therapy courses.

Seventeen professionals collaborated in evaluating the initial training and 14 professionals participated in the focus group. Written informed consent was obtained from all participants and the families involved in the sessions collected.

IFAIM's initial training program

Initial training was organized in nine monthly modules each with five components: (a) mandatory reading of a training manual; (b) discussion with the facilitator (first author), of a written integration/ evaluation assignment; (c) discussion, in individual meetings, of a written personal assignment (including elaboration of a portfolio of skills and experiences during training); (d) a monthly 7-hour group training session; (e) a component comprehending the analysis, feedback, and discussion, with each participant/team, of their performance in a real session (audio or videotaped) with a family. Core themes of each module are summarized in table 2.

Table 2
Summary of Core Themes of Each Module of Initial Training

Module	Core themes and contents
1	Introduction to systemic thinking; family life cycle; introduction to development psychopathology; multi-challenged families; Introduction to IFAIM's objectives, stages and logistics. Exploration relation between personal and family values with working with families.
2	Strength-based perspective to working with families; basic systemic, collaborative, strength-based assessment skills. Working in the families' homes or in the community; In-home sessions' skills. Exploration of professional's strengths and preferred visions.
3	Multi-challenged families and social services; Types of requests; Working collaboratively in a context of coercion. Introduction to narrative approaches and initial deconstruction of problems in reception (initial interviews) with the family. Skills to conduct reception sessions. Mapping participants' strengths and vulnerabilities.
4	Dynamics of child maltreatment. Categories of assessment in child protection cases. Collaborative and solution-focused approaches in child protection. Assessment in IFAIM and associated skills. Professionals' strengths and skills improvement and initiation of the portfolio.
5	Parental and family development. Introduction to schools of family therapy. Assessment of parental capacity and family functioning. Assessment skills in IFAIM. Reflection on personal development in relation to themes of family functioning and development.
6	Assessment focused on environmental and social factors. Social networks. Integration of Assessment in IFAIM and elaboration of assessment reports. Reflection on personal development in relation to social and cultural contexts of family development.
7	Integrative conceptualization of change process in IFAIM. Facilitating family change: contributions from family therapy schools and models. Negotiating, contracting and supporting change in IFAIM: theory and practical skills. Reflection on personal change processes.
8	Strategies to support parental development and change. Facilitating change at the level of environmental and social conditions, and implications for an integrative practice. Final organization and reflection about the personal portfolio.
9	Documentation, amplification and validation of change: contribution from narrative practices. Follow-up and case closure in IFAIM. Validating and celebrating practitioner's changes.

Supervised practice

Supervised practice was initiated and implemented with each group after initial training. Meetings with each team were focused on IFAIM's procedures, case conceptualization and practical skills as well as on the participant's experiences and difficulties. Procedures to support participants were revised and new support mate-

rials were created throughout action-research cycles. In all meetings, the facilitator discussed with the participants their performance based in an audio or videotaped session previously analyzed. Three to seven hour meetings were held biweekly.

Quantitative data collection procedures

All participants collected audio or videotape recordings of sessions with families prior to initiating training, seven times during the initial training, one time after the end of the initial training, and one time after the end of supervised practice. These recordings of the sessions were analyzed and rated by the first author to evaluate participants' practical skills. Twenty-five sessions were randomly selected, transcribed and also analyzed by one of three trained raters which independently scored participants' skills for inspection of inter-rater agreement.

Instruments

The Scales for the Assessment of IFAIM's Practitioners' Skills were used to assess the professionals' skills (Melo, Alarcão, & Pimentel 2012a, 2012b). These rating scales assess skills in a 3-point Likert scale (1 - "skill absent/ incorrectly applied"; 2 - "skill inconsistently or poorly applied"; 3 - "skill adequately and consistently applied". A fourth point (0) is used when the item is "not applicable" to a particular session.

Scale 1 has two sub-scales focused on reception skills, namely contracting and relationship negotiation skills (6 items; e.g. "clarifies the request") suited for mandated cases and skills pertaining systemic, solution focused and strength-based assessments (5 items, e.g. "explores family's competencies and strengths (...)"; "maps the problems and dominant meanings (...)).

Scale 2 assesses basic skills to conduct different types of sessions conforming to a systemic, collaborative and strength-based perspective. It is organized in two sub-scales, corresponding to session organization, collaborative and reflexive participation skills (10 items) (e.g. "stimulates reflection and the construction of alternatives"; "adopts a collaborative stance and discourse") and skills to facilitate the emergence and integration of relation information (e.g. "contributes to make information circulate in a neutral/multi-positioned way"; "encourages mutual support and positive interactions"). For purposes of data reduction we created a composite variable with the mean of these two sub-scales.

Scale 3 assesses support for change skills related to change rehearsal and amplification (sub-scale 1, 4 items; e.g., “notes, reinforces and amplifies family’s competencies (...)”; “supports the family in the search and construction of moments of exceptions (...)”), facilitation of change and overcoming obstacles (sub-scale 1, 5 items; e.g. “anticipates difficulties and obstacles (...)”; “reframes the family’s problems in a more positive and flexible way”), and collaborative contracting-for-change negotiation skills (sub-scale 3, 2 items; e.g. “helps the family define precise and clear change objectives and a change support for plan to accomplish them”).

A fourth scale, named Scale for the Assessment of Practitioners’ In-home Sessions Skills (Melo, Alarcão, & Pimentel, 2012b) and its four sub-scales pertain skills to work in the families’ homes: (a) establishment of balanced boundaries’ and joining skills (4 items; e.g. “shares the session’s control with the family while keeping a focus on the intervention objectives”); (b) facilitation of the emergence of meaningful relational information (2 items; e.g. “discusses with the family how the organization of their home influences or is a reflection of the organization of the family’s relations”); (c) social skills (2 items; e.g. “kindly asks the family’s authorization to move and act inside its home”; “Greets and bids farewell to the family in a friendly way”). A composite variable was created with the means of all sub-scales to provide an index of participant’s in-home skills. Previous research has shown good psychometric properties (Melo, Alarcão, & Pimentel, 2012a, 2012b), with inter-rater agreement *kappa* values ranging from .60 to .80 and *alpha of Cronbach* internal consistency values ranging from .65 to .91. In this study, mean *kappa* inter-rater agreement values of .75 were obtained for the variable of reception skills, .68 for the variable of assessment skills, .73 for basic skills, .70 to support for change skills, and .65 to in-home skills.

Qualitative data analysis procedures

Qualitative data from the focus groups and the questionnaires were analyzed through a thematic content analysis (Coffrey & Atkinson, 1996; Silverman, 2006). In a preliminary stage, the first author read all the material and registered broad impressions considering what the reports seemed to be about. The transcriptions and written records were then coded, line-by-line, through open coding and constant comparison (Strauss, 1987). Afterwards, the codes, attached to examples/indicators, were compared and classified in order to identify overarching themes. They were progressively merged and/or integrated in higher-order categories/themes – largely corresponding to the subtitles/categories used in the section of the presentation of the results – and sub-themes were also identified.

RESULTS

Outcome evaluation

We calculated the mean scoring for each category of skills, correcting the calculation in order to exclude the non-applicable (0) items since they could lower the mean of the scale, misrepresenting the actual level of skill of the participant.

Figure 1 shows the graphics with the distribution of the mean scorings for each category of skill, at each evaluation time. The graphics show scorings for all sub-categories of skills and composite variables.

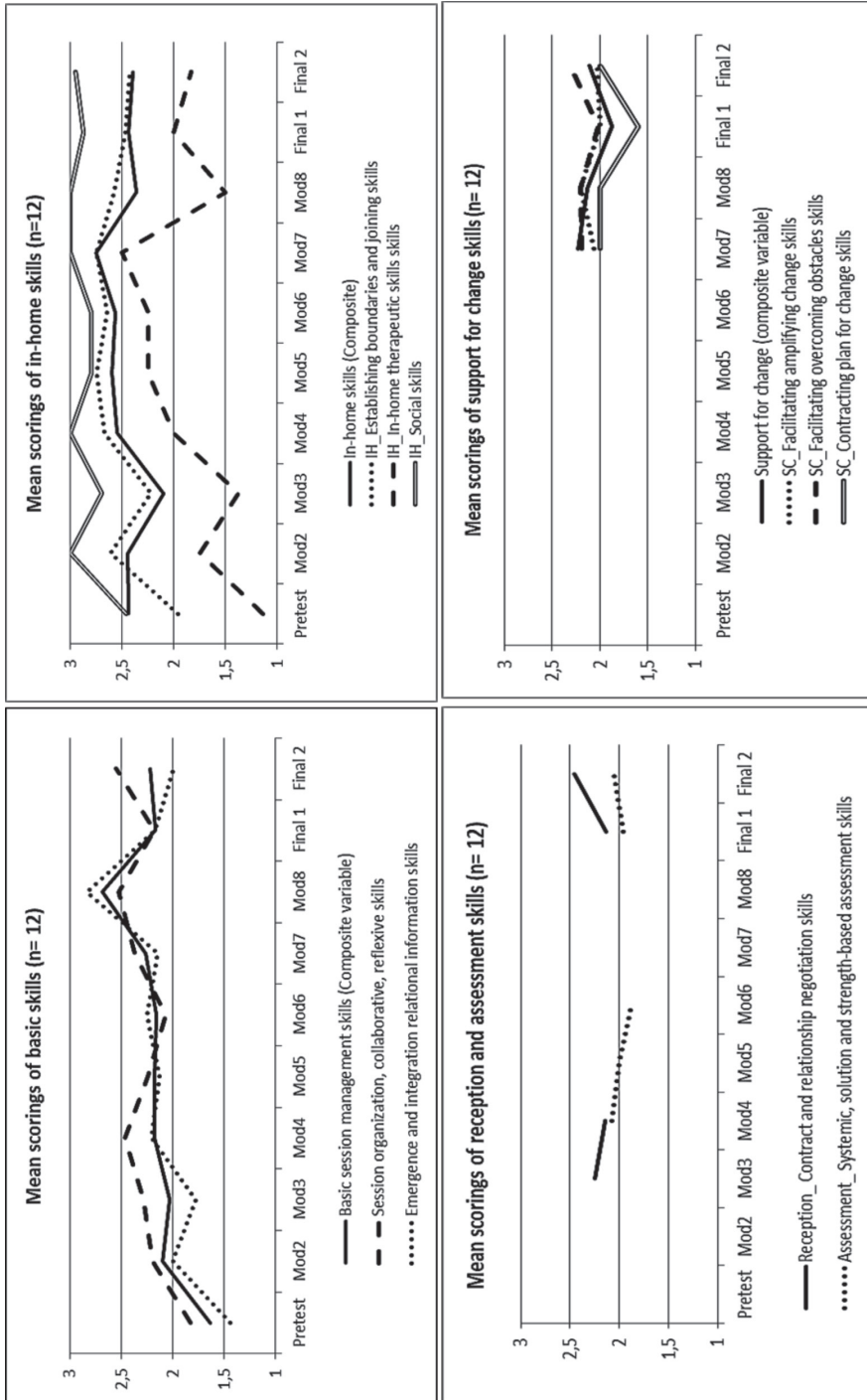


Figure 1. Mean scorings of professionals' skills.

One-way repeated measures within-subjects analyses of variance (ANOVA) were computed for all main categories of skills. A significant effect of assessment time was found for all categories of skills (table 3).

Table 3
Means, Standard Deviations, Minimum, Maximum of Categories Skills from Pre-test to Final-posttest and Repeated Measure ANOVA Statistics

Evaluation moment	Basic session management skills				In-home skills				Reception skills					
	M	SD	Min	Max	Statistics	M	SD	Min	Max	M	SD	Min	Max	Statistics
Pretest	1.63	.28	1.28	2.05		2.44	.18	2.00	2.67	1.90	.48	1.33	3.00	
Posttest1mod2	2.10	.21	1.60	2.40	$F(4,302)$	2.45	.22	2.00	2.75	-	-	-	-	
Posttest2mod3	2.03	.12	1.90	2.22	$F(7,326) = 11.04$,	2.10	.20	1.83	2.33	$F(3,310)$	-	-	-	
Posttest3mod4	2.18	.32	1.65	2.65	$p = .000$,	2.55	.02	2.50	2.58	$36,409) = 10.67$,	2.25	.39	2.50	$F(4,44)$
Posttest4mod5	2.18	.32	1.65	2.65	$\eta^2 = .501$	2.60	.11	2.22	2.83	$p = .000$,	-	-	-	$= 3.16$,
Posttest5mod6	2.16	.32	1.85	2.80	$\eta^2 = .501$	2.57	.26	1.83	2.92	$\text{partial } \eta^2 = .492$	-	-	-	$p = .000$,
Posttest6mod7	2.26	.45	1.75	2.95	(with Green-	2.75	.06	2.58	2.83	(with Green-	-	-	-	$\text{partial } \eta^2 =$
Posttest7mod8	2.68	.25	2.15	2.95	house-Geisser	2.36	.08	2.25	2.58	house- Geisser	-	-	-	$.223$
Posttest end initial training	2.17	.26	1.93	2.90	correction)	2.44	.18	2.99	2.67	correction)	2.13	.67	1.00	3.00
Posttest final	2.22	.35	1.48	2.85		2.40	.33	1.92	3.00		2.46	.34	2.00	3.00
Support for change skills														
Evaluation moment	M	SD	Min	Max	Statistics	M	SD	Min	Max	Statistics				
Pretest	1.39	.40	1.00	2.00		1.44	.18	1.22	1.81					
Posttest1mod2	-	-	-	-	$F(2,773)$,	-	-	-	-	$F(1,976)$,				
Posttest2mod3	-	-	-	-	$30,506) = 4.85$,	-	-	-	-	$21,741) = 8.65$,				
Posttest3mod4	2.08	.46	1.33	2.80	$p = .008$,	-	-	-	-	$p = .002$,				
Posttest4mod5	2.00	.36	1.50	2.50	$\eta^2 = .306$	-	-	-	-	$\text{total } \eta^2 = .440$				
Posttest5mod6	1.88	.57	1.40	3.00	(with Green-	-	-	-	-	(with Green-				
Posttest6mod7	-	-	-	-	house- Geisser	2.23	.43	1.75	2.85	house- Geisser				
Posttest7mod8	-	-	-	-	correction)	2.13	.48	1.23	2.76	correction)				
Posttest end initial training	1.96	.22	1.80	2.60		1.87	.26	1.56	2.20					
Posttest final	2.05	.38	1.60	2.80		2.11	.52	1.25	3.00					

For the purpose of this study, we defined point 2 as a cut-off point for minimal competence to implement IFAIM. To score at this level the professionals need to exhibit the required skill, although it might be inconsistent or coexist with undesired practices. At the final posttest all categories of skills had mean ratings superior to 2. However, at the posttest after the initial 9-month training, assessment and support for change skills mean scorings were still below the cut-off point.

Process evaluation

Participants' experiences of change

One of the most salient and common features of the participants' reports was the mention to personal change and growth beyond learning, at different levels ("a growth", "it is so deep"; "this is not just about learning, it is about changing, at different levels"). Several participants reported self-development of character strengths or virtues ("I think I am much more tolerant, more patient") and self-knowledge ("this helps us understand better who we are").

Changes were particularly highlighted concerning reasoning and thinking style, ("it is not the knowledge, it is the thinking!"). There were reports of increased reflexivity, and flexible ways of thinking about families ("we see there are millions of ways of doing things, of being a family, of being a parent"), changes in language reflecting the former ("IFAIM made me stop a lot to think, stop to change the way I talked, I am different"). Changes were also experienced in personal and family relationships ("there are times that I was elaborating reflexive questions in my personal relationships"). Changes in thinking seemed to be associated with more optimistic stances ("It [IFAIM] helps us be more optimistic and not see only the bad things").

The changes made participants feel like they were departing from dominant expert-based and deficit-focused practices and acting differently ("In a meeting I was making an effort to reframe what they were saying (...) but it was disturbing (...) they were just 'she is so incompetent, and this and that' and I thought 'I used to be like that!'").

Some participants reported changes in their professional roles ("It changed our way of thinking and seeing what we can do with our job. We value more the human person, which we didn't"). There was a general increase in professional satisfaction and, for some, the realization of preferred views ("It was like a breath of fresh air (...) it's good to see people grow, to improve"; "(...) I realized how interesting the work (...) can be").

The changes reflected more collaborative practices and empathic behaviors ("(...) place ourselves in the family's shoes", "now we really try to find those dimensions in

which the person is competent”; “I now share with them my hypotheses. I now know how to share”) and transparency regarding child protection (“not being [anymore] afraid of talking about the problems”; “IFAIM gave us a language to co-construct the desired pathway”). Some professionals reported expecting more from the families (“we can be more by their side and they have more power (...) we can also expect and ask more from them”).

At a practical level, IFAIM offered guidance and organization (“Now we know where and why to go in that direction instead of another”).

At the end of supervised practice, there was still some ambivalence and insecurity (“It’s about knowing we know a lot of things but still don’t know very well how to apply them all to practice”).

IFAIM’s theoretical skills, for case planning and conceptualization integrate different levels and dimensions of analysis. These skills were the hardest to master (“the hardest thing was the formulation of hypothesis and case comprehension (...) I may use all the practical skills and get nowhere and that is what is still harder”). For some participants this aspect was, at times, excessively demanding (“I can’t think beyond the way I think and feel and I feel frustrated by it.”). These skills were perceived by the facilitator as the ones demanding more support. Her observations indicate that there may be a relation between poor case conceptualization skills (e.g. linear thinking; inattentiveness to interaction between different variables and ecological levels of analysis; arbitrariness or absence of assessment questions; deficit based case readings) and low scorings of in-session skills.

Change process and constraining and facilitating factors

Participants were unanimous in classifying the change and learning process as very demanding but worthwhile (“it was difficult but gratifying”). Their enthusiasm and involvement were nonlinear (“we invested, but by waves”; “there were times I thought I couldn’t make it”) with ambivalence and contradictory feelings (“On the one hand we wanted to continue (...) but I had some difficulty dealing with the discomfort”). Difficulties in accommodating changes and learning were accompanied by a sense of confusion, loss of spontaneity (“there were so many things (...) I felt I had lost spontaneity and that was also a conquest”) and discomfort for feeling incompetence (“it was a shock, feeling I could not master what I was being asked (...) I already had some professional experience and had conquered some security and recognition and I felt it was complicated”). The change process had costs (“the change is good at the end but it has many negative aspects that we had to accept and digest”; “I compare this with the families (...) in the end they (...) recognize what

was done but during the process they wanted to quite”). Reports of irreversibility of change somehow confirm it (“I think I could no longer think differently”).

Changes in the team composition seemed to affect performance such as lack of time to study IFAIM’s manual, and work overload. Other personal factors included insecurity or fearing change. On the contrary, a growing feeling of self-confidence was positive (“as we gain more confidence, we become more at ease, and it helps”). Other aspects included: “believing” in the model; doing “hard work”; holding interest in self-development and growth; being interested in learning and novelty; valuing doing a “good job”; being willing to abdicate of “professional power”; being “new to the field”, without “vicious habits”; being empathic with families; observing positive results; having “easy cases” to build confidence and the internal mutual support from the team.

Some factors were related to the facilitator and her relationship with the participants. Keeping the group activities as planned without making changes in the intermediate modules was perceived, by some, as a constraining factor and a non-collaborative practice (“we talked about how demanding you (the first author) were with us and how we could not respond to that”). At times, participants considered that it was hard to keep up with the facilitators’ thinking. On the other hand, the adjustment of the facilitator’s behavior to match the group’s current level of competence and characteristics was beneficial (“It was enough [for the facilitator] to understand that we were a little bit distressed to be more tolerant with us and I think it was important”). The recognition of competence of the facilitator was apparently beneficial (“I think we learned a lot because [the facilitator] was extremely competent”) such as her respectful support during individual or team meetings (“I felt very comfortable [in individual discussions] in the sense that I felt respected and supported”). Nonetheless, there were reports of ambivalence in the relationship (“sometimes we wanted to turn the table and send [the facilitator] home, because we were tired. And there were times we valued and realized we still needed it [the support] because we were only taking the first steps.”). The participant’s perception of the facilitator’s reactions to their learning contributed, at times, to feelings of discouragement (“the feeling of not corresponding to what was expected from us”). However, the support provided in individual or team meetings was generally perceived as helpful (“They were demanding, yes, but I think I could better understand what we had to do and could get a sense of competence and master things in a way that didn’t happen in the group training”). The context of a closer relationship with the facilitator in individual/single team meetings allowed more effective scaffolding to reasoning (“one important thing in supervised practice was [the facilitator] thinking with us (...) making a path together with us; [the support] was fundamental to help me unblock and reorganize my thought”).

Individual/team focused support during supervised practice was also important for the revision of core concepts, theory and procedures (“*the amount of times we revised procedures or elaborated hypotheses! (...) after discussing it [with the facilitator] it seemed easy!*”).

External pressures were often disturbing. Observational data provides some indication that professionals were more likely to neglect the family’s strengths and their preferred visions and exhibited lower competences when: (a) the pressure from child protection services was higher, (b) these and other professionals held very negative expectations about the case outcomes, (c) the professionals engaged in unorganized and unplanned action or (d) neglected case conceptualization.

Process evaluation of initial training components and supervised practice

Overall, the training program was perceived as “*well-structured and organized*”, although demanding. The initial training was a period of confrontations, perturbations, activation of core changes as well as attempts to assimilate new concepts. The supervised practice was seen as a period of integration and consolidation, and its pace was experienced by the participants as more respectful of their own pace.

The readings were positively evaluated but their length was perceived as an obstacle. They were considered to be an important support to the implementation of IFAIM and a good knowledge base to which participants could come back anytime.

The initial period of group training was globally experienced with enthusiasm, but around modules 4 and 5 some participants experienced a pressing feeling of discouragement and stress (“*it was too demanding for what we were prepared to deal with*”). The second group felt they had insufficient preparation to meet the requirements of the group sessions’ exercises. Around modules 5 and 6, with Group 2, the facilitator adapted the exercises, reduced their number and provided more scaffolding. The group components facilitated the normalization of the difficulties and fostered motivation. Several participants wanted the group sessions to include theory revision, more discussion of video or audiotapes or transcripts of sessions.

The written integration/assessment assignments were useful concerning the integration of concepts and improvement of case conceptualization skills. The personal assignments helped participants to empathize with the families and understand the challenges of being in change and under assessment. The individual supervised component was perceived as very helpful or quite helpful for the clarification, development and consolidation of practical skills. It provided the opportunity to focus strengths and vulnerabilities.

Improvements were made in supervised practice from the first to the second group. The latter considered supervised practice as demanding but easier to cope

with than the initial training and more respectful of their rhythms since the facilitator was more focused on each participant's needs and provided tailored support.

There was variation in the participant's skills in the first months of supervised practice. Few cases were discussed in the support for change stage. Some participants expressed difficulties in preparing change rehearsal sessions and felt the need for additional preparation in specific topics (e.g. couple issues; alcoholism).

Implications for future trainings and program improvement

Throughout the cycles of action and reflection some conclusions were tentatively drawn, discussed with the participants and further validated in the final focus group. Implications to improve future trainings, include: (a) to discuss few but representative cases during supervised practice intensively (in every session); (b) to increase guidance to the professionals to cases of prolonged and severe child abuse and neglect; (c) in cases of self-referral, the professionals may need more assistance to negotiate clear requests and to keep a focus on core objectives; (d) to conduct consultation sessions where the facilitator's conducts sessions with the families, in the presence of the professionals; (e) to add group training sessions in the more demanding modules (e.g. between modules 4 and 5 and in module 7); (f) to include some theory revision in group sessions and provide more time for case and assignment discussions; (g) to increase the number of supervised practice hours, focus case conceptualization skills along with practical skills training and to discuss a selected case from beginning to end; (h) to extend supervised practice to 9 or 12 months in the form of biweekly 6-hour meetings with each team, and after that, provide less frequent supervision sessions; (i) to engage participants in specific additional training, particular on specific helping strategies and special issues (e.g. alcoholism/drug abuse).

DISCUSSION

This study highlighted some important dimensions when training professionals in community-settings to work under a (multi)systemic, integrative, collaborative, strength-focused orientation with multi-challenged families with at risk, abused and neglected children in child protection contexts and, particularly, to implement IFAIM.

The results indicate that the participants achieved minimal competence in all categories of core practical skills to conduct IFAIM's sessions and improved them throughout the training program. However, in general, the participants did not

reach optimal skill levels. We hypothesized that changes at this level were constrained by the difficulties in systematically maintaining a (multi)systemically, circular reasoning. This hypothesis finds some ground in the qualitative evaluations, based on the researcher's observations, and in the fact that the skills to facilitate the emergence and integration of relational information generally scored below other basic skills. In fact, the behavioral skills in question (e.g. use of circular questioning) require a systemic thinking, while informing it. On the other hand, for some participants, the training experience was overwhelming. Therefore, it seems likely that they were changing and learning too much, too fast, and at many different levels and that these processes slowed down particular types of a change at specific moments, such as the behavioral skills. These aspects deserve future research aimed at understanding more thoroughly at what levels change happens and how different types of changes and learning experiences potentiate or inhibit each other.

The kind of reasoning demanded in IFAIM involves the coordination of a multi-systemic outlook with child protection concerns. There is a diversity of assessment and intervention techniques, dimensions of analysis and different ways of thinking (e.g. parenting vs couple vs whole-family; control/rigor/objective information vs focus on collaboration/support/subjective experiences; internal relationships vs external conditions) that need not only to be mastered but also integrated. This kind of complexity seems to be at odds with the participants' ordinary reasoning styles. The participants expressed that the training promoted changes in their thinking patterns. However, they also expressed difficulties in maintaining complex forms of reasoning in face of more challenging conditions (e.g. severe cases; external pressure). This may signal developmental transitions and changes towards that are still not dominant, or stable, or which still depend on external scaffolding. There are indicators supporting this conclusion in the participants' reports. Additionally, the results showed a decay of some skills between the last module of initial training and the supervised practice, which corresponded to a period of interruption of activities, before supervised practice. The results highlight the importance of the timings of training to be congruent with the timings of change. Brief training programs may not be adequate for professionals which need to show complex competencies to support multi-challenged, such as those targeted by our program. On the other hand, the results highlight the importance of supervision to help professionals maintain appropriate levels of competence when challenged by internal or external factors.

Future research should explore how the professionals' personal (cognitive and emotional) development and change may relate to their reasoning/ case conceptualization and practical abilities and the extent that intervention may promote changes. Other studies have suggested that higher levels of cognitive development may be necessary,

for example, for the professionals to master systemic skills (Caldwell & Claxton, 2010) or deal with the complexities of working in the families' homes (Lawson, 2005).

Future research should also investigate how the training and its components relate to changes at these different levels of skills and how to best promote synergies between them.

This study indicates that IFAIM's training might be a transformative experience contributing to an increase of satisfaction and involvement of professionals. This is a particularly relevant result considering that professionals working with multi-challenged and in child protection easily experience burn-out (Sharlin & Shamai, 2000).

Trainers and supervisors should be thoughtful of a variety of aspects related not only to the training components, but also to the participant's change processes and their contributions to them. The dynamics of relationship with the facilitator and the scaffolding provided to participants should be explored in future research (Street, 1997).

The non-experimental design of this study limits its conclusions. Future research should consider more rigorous designs using comparison groups. The exploration of differences in the process and training of professionals in community-contexts where child protection assessments are not an issue can be of interest. Improvements in the IFAIM's training program of can be made according to this study's conclusions.

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