

IMPACT OF SOLUTION-FOCUSED TRAINING ON CHILD PROTECTION WORKERS

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**The Impact of Training in Solution-Focused Brief Therapy on Professional Beliefs,
Practices and Burnout of Child Protection Workers in Tenerife island**

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Abstract

This paper presents the first results of a large-scale research project on the child protection services in Tenerife, Spain. In Study 1, the professional beliefs and practices of 152 child protection workers, as measured by a *Professional Beliefs and Practices Questionnaire* (Medina & Beyebach, 2010), were correlated with their scores on the *Maslach Burnout Inventory* (Maslach, Jackson, & Leiter, 1996). Higher scores in a variety of deficit-based beliefs and practices were associated with higher burnout scores, while strengths-based beliefs and practices correlated negatively with burnout. In Study 2, the workers were assigned either to a control group, or to an experimental group that received 30 hours of training in solution-focused brief therapy (SFBT) plus 30 hours of supervision. Workers in the experimental group changed their professional practices and beliefs in a more strengths-based direction from pre-test to 6-month follow-up, with large effect sizes for the SFBT training (from $d=1.42$ to $d=2.07$). The SFBT training also had a small but significant effect on burnout at follow-up ($d= .48$). A regression model was able to account for 83.8% of the variance in burnout scores at 6-month follow-up. Neither time working in child protection nor severity of cases predicted burnout at follow-up. Burnout at follow-up was predicted by burnout at pre-test and by changes in the professional beliefs and practices of workers. Workers who changed in the direction of more strengths-based beliefs showed lower burnout scores at follow-up, whereas those who changed to more deficit-based beliefs increased their burnout. Workers who changed their professional practices in the direction of focusing more on the difficulties of service users showed increased burnout. Changing practice in the direction of becoming more collaborative, “leading families from one step

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behind”, and of working in a more trans-disciplinary way with team members and other colleagues predicted lower burnout.

Keywords: child protection, burnout, solution-focused therapy, professional beliefs, professional practices

The Impact of Solution-Focused Training on Professionals' Beliefs, Practices and Burnout of Child Protection Workers in Tenerife island

For decades, the field of child protection worldwide has been characterized by an emphasis on the deficits of service users and their families, and by a negative view that considers them as lacking resources and unwilling to cooperate cooperate (Blundo, 2001; Conrad & Schneider, 1985; De Jong & Berg, 2008, 2012; Goldstein, 2002; Graybeal, 2001; Martín, 2005, 2009; Rodrigo, Máiquez, Martín, & Byrne, 2008; Turnell & Edwards, 1999; Weick, 1992). Under the weight of statutory obligations and government guidelines, child protection workers have often assumed a paternalistic model *vis a vis* their customers, taking the role of an expert with all the answers, whose role is to diagnose existing deficits, problems or shortcomings and then propose corrective interventions. In this model, service users are treated as passive recipients of the advice and interventions by the workers; if they do not accept the proposed interventions, they are described as uncooperative or even “resistant”. These practices may lead to user dissatisfaction, as the voices of families are seldom heard and the relationship with professionals often becomes one of opposition and distrust (De Jong & Berg, 2008; Turnell & Edwards, 1997).

In recent years, a number of authors around the world have expressed their concerns about the practical and ethical implications of these practices and have proposed an alternative conceptualization of child protection, based on a strengths or resource model (Gilbert & Lee, 2011; Martin, 2005; Rapp, 1998; Rodrigo, Máiquez, Martín, & Byrne,

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2008; Saleebey, 2006; Turnell & Edwards, 1997; Walsh, 1997; Weick et al, 1989). In this alternative approach, service users are seen as people “worth doing business with” (Turnell & Edwards, 1999): the voices of abused or neglected children and their families are sought out, and families are seen as having resources upon which intervention can build. The relationship that professionals promote is one of partnership more than of paternalism, and workers are aware that child abuse and neglect are not only an objective reality but also something that is constructed in the interaction. Two child protection approaches that fit into this new frame are Solution-Focused Child Protection (Berg, 1994; Berg & De Jong, 2004; Berg & Kelly, 2000) and the Signs of Safety approach (Turnell, 2006; Turnell & Edwards, 1997, 1999).

The present study is part of a wider project that intends to explore the effects of implementing a strengths-oriented, solution-focused approach in the child protection system in the island of Tenerife, Spain. 152 municipal child protection workers received training in solution-focused brief therapy (SFBT). The effect of this training was evaluated at three different levels: (a) effectiveness and cost-effectiveness (number of sessions attended by service users, type of termination, type of legal measures taken, etc.); (b) consumer satisfaction (the views of families on the intervention process); and (c) changes in the beliefs, self-reported professional practices and burnout of child protection workers. This paper presents two studies that focus on this third issue, the changes reported by the workers.

Professional beliefs

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Professional beliefs are the implicit assumptions that guide professionals' decision making and behaviour (Rodrigo, Rodríguez, & Marrero, 1993). Following Visser (2012), they can be grouped into three broad categories:

-Assumptions about persons, including how the professionals perceive the families they work with, for instance if they see them as competent and with resources, or as incompetent and resource-less.

-Assumptions about change, including whether change is understood as a lineal process that has to start by recognizing that there is a problem or as a more circular process, where "insight" is not needed first for behaviour change to happen.

-Assumptions about the helping relationship, including the role of the worker (for instance, "expert" *versus* "non-expert" stance), the role of the service users (for instance, passive *versus* agents of change), and the type of interaction that is expected.

When a child protection worker makes a decision or follows a given course of action, these will be influenced by his or her assumptions about the persons he is working with and their problems, about the change processes he or she expects, the role that should be adopted and the type of relationship that should be promoted. Conversely, the worker's behaviours and professional practices will have an influence on his or her assumptions, and on the behaviours and beliefs of service users, which in turn will tend to confirm the worker's assumptions. In this way, if a worker expects resistance from a family, he or she is likely to create it (De Shazer, 1988). Similar processes operate at the organizational level, so that each actor contributes to the creation of a conjointly constructed reality (Gergen, 1985).

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Professional assumptions in the child protection field can be seen as varying along a continuum from normative, deficit-based beliefs on the one hand, to strengths-based, resource-oriented beliefs on the other. The differences between the two extremes of the continuum can be found in a number of different areas (Wheeler & Vinnicombe, 2011):

From the normative, deficit perspective, families of abused or neglected children are often described as abusive, incompetent, multi-problematic, lacking in motivation to change, and resistant. The overall role of child protection services is to fix the problems that these families present, to supplement their shortcomings and to correct their dysfunctional beliefs and behavioural patterns. Assessment is seen as an objective process in which deficits, risk factors and vulnerabilities of the families are evaluated; historical information is relevant and the goal of assessment is to formulate a diagnosis based on normative criteria (Calder, 2008; Ochotorena & Arraubarrena, 2002; Ochotorena, Arraubarrena, & Torres, 1996; Wheeler & Vinnicombe, 2011). Prevention is understood as controlling risk factors and reducing the likelihood of future problems. Intervention is seen as a consequence of diagnosis; the worker takes the role of an expert that establishes the goals of the intervention and delineates the changes the family have to make; the helping relationship is asymmetric, with the worker often taking decisions unilaterally.

From a strengths-based, resource-oriented perspective, families of abused or neglected children are described as multi-challenged families that are struggling hard to overcome serious financial, social or personal challenges; they are seen as motivated to reach their goals and willing to change. The overall role of child protection services is to help these families work out their goals and use their own pre-existing resources (and those of extended family and the community) to overcome their problems, using their

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idiosyncratic views and own values. Assessment is understood as an interpersonal co-construction process with emphasis on the present and on the desired future; there is no formal diagnosis, but instead difficulties and strengths are described in specific and behavioural terms, avoiding judgement. Prevention is understood as promoting protective factors and increasing the overall wellbeing of the family. Intervention is seen as an on-going process that starts with the first contact with the service users; the family is seen as an expert who co-constructs the goals of the intervention and defines the changes they wish to take; the helping relationship is cooperative, with the worker actively including the family in the decision process and trying to “lead from one step behind” (Cantwell & Holmes, 1994).

Burnout

Child protection workers intervene with difficult and demanding cases, where the safety and even the life of children may be at risk, and in a social environment where they are quickly criticized for any perceived errors in judgment or practice, “damned when they intervene and damned if they don’t” (Turnell & Edwards, 1999, p.1). This situation is liable to create burden and stress, and therefore it is no wonder that for child protection professionals high levels of burnout and of turnover are reported (Del Valle, López & Bravo, 2007; Garrido et al., 2009; Kim & Stoner, 2008; Lloyd, King & Chenoweth, 2002; Pouling & Walter, 1993). Maslach, Jackson, and Leiter (1996) developed the Maslach Burnout Inventory (MBI) as a self-report measure of burnout that can be applied in organizational settings. Maslach’s scale differentiates three different subscales: *emotional exhaustion*, the feeling of being emotionally overextended and exhausted in one’s work; *depersonalization*, an unfeeling and impersonal response toward recipients of one’s

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service; and *personal realization*, which measures feelings of competence and successful achievement in one's work

High burnout among child protection workers may be construed as reflecting organizational and professional constraints (short-term contracts, understaffing, work overload, lack of support by supervisors) but also as being a result of unrewarding, difficult relationships with service users and a consequence of adopting a paternalistic attitude with them. This is why professional beliefs and burnout may be related, as we will examine in Study 1.

Scope

In this paper we present only the data related to the child protection workers participating in the wider Tenerife research project. We are presenting two different studies.

Study 1 focuses on the professional beliefs and practices of the child protection workers of our sample before the training in SFBT was undertaken. It was hypothesized that more strengths-based professional beliefs in the workers of our sample would be associated with lower levels of burnout; and that more deficit-oriented beliefs and practices would correlate with higher levels of burnout.

The aim of Study 2 was to test the hypothesis that training in SFBT would promote more strengths-based and less deficit-based beliefs and practices in the workers, and therefore a reduction in their level of burnout. Although previous studies have documented the effect of training in strengths-based principles on child protection workers (Turnell & Edwards, 1999, 2012; Berg & Kelly, 2000; Sundman, 1997), no previous research has

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specifically tested the impact of a training in SFBT on the professional beliefs, self-reported professional practices, and burnout in child protection.

Study 1: Association of Professional Beliefs and Burnout

The first study examined the correlation between professional beliefs and self-reported professional practices, on the one hand, and burnout on the other.

Method

Participants. The sample was recruited by inviting all local child protection workers in Tenerife (Spain) to participate. The final sample consisted of 152 workers from 34 teams of the Child Protection Services in the island of Tenerife, 84% of the workers in the service. 69% worked in “Prevention Teams” and 31% in “Risk Teams”. “Prevention teams” deal with low or moderate risk cases, where the psychological wellbeing of children is at risk, but not their physical safety. “Risk Teams” deal with high-risk cases, where the safety of the child is in danger and he or she may need to be removed from the home. Workers ranged from 25 to 48 in age; 121 were female, 31 were male. 24,5% were psychologists, 41,5% social workers, and 34% social educators. In the traditional organization of child protection teams in Spain, psychologists tend to do psychological change work in their offices, intervening with family sessions to achieve cognitive and behavioural changes, whereas social educators provide support for the education of children visiting both homes and schools. Social workers work in the community, promoting support networks, linking users with relevant services, and mobilizing additional resources. Their experience in the Tenerife child protection service averaged 76.42 months.

Instruments.

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Professional Beliefs and Practices Questionnaire (PBPQ, Medina & Beyebach, 2010). This instrument was developed for the purposes of this study. The construction of the instrument followed various steps. First, a big pool of items was derived by a focus group discussion procedure among professionals attending a Conference on Child Protection in Tenerife. These items were then refined by the two authors eliminating redundancies, and reduced to 125 items. This 125 items form was applied to a pilot sample of 30 child protection workers, which lead to a further reduction to the final 87 items form. This final 87 items PBPQ was applied to the sample of 152 workers; on that sample Cronbach's alpha was established and then factor analysis performed.

PBPQ includes twenty-five five-point Likert type items that conform a Deficit-based Beliefs Scale and twenty-five items that constitute a Strengths-based Beliefs Scale; it also includes thirty-seven five-point Likert type items that form a Professional Practices Scale. Results on the 152 workers sample revealed high internal consistency for the Strengths-based Beliefs Scale (Cronbach's alpha = .861) and for the Deficit-based Beliefs Scale (Cronbach's alpha = .862), and moderate internal consistency for the Practices Scale (Cronbach's alpha = .709).

The Factor analysis was performed with a Principal Components extraction procedure and Varimax rotation method, identifying 7 deficit-based beliefs factors that explained 61.13% of the variance in the Deficit-based Beliefs Scale, and 7 strengths-based factors that loaded 60.96% for the Strengths-based Beliefs Scale (Table 1). For professional practices, 8 factors explained 57.48% of the total variance. (Table 2). All factors were selected on the basis of their eigenvalues, the observed slope of the sedimentation graphs (Figures 1, 2 and 3), and the proportion of the total variance

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explained by each factor (Tables 1 and 2). The threshold to decide that an item belonged to a given factor was a correlation above $r = .40$. As shown on Tables 3 and 4, professional beliefs showed moderate correlations with professional practices.

Maslach Burnout Inventory. Maslach et al. (1996) developed the Maslach Burnout Inventory (MBI) as a self-report measure of burnout that can be applied in organizational settings (Seisdedos, 1997). This twenty-two Likert-type items questionnaire has three different subscales: *emotional exhaustion* (range of scores 0-54), *depersonalization* (range of scores 0-30), and a positive dimension, *personal realization* (0-48); the scores of the three subscales are combined to yield a global burnout index (raw scores range from 0-99 and can be recombined into a 0-3 index). Psychometric studies on Spanish samples have reported high internal consistency for emotional exhaustion, ($\alpha = .87$) and personal realization ($\alpha = .72$), with somewhat lower figures for depersonalization ($\alpha = .57$). Factorial analysis has confirmed these three factors, explaining 43.7% of the variance (Gil-Monte & Peiró, 1999). Previous studies that have used the MBI to measure the effect of a variety of interventions to reduce burnout have found significant post intervention improvements (Cherniss, 1990; Huebner, 1993; Ross, 1993). However, no studies so far have studied the relationship between solution-focused practice and changes in burnout. SFBT has been shown to be effective for service users in a variety of clinical and non-clinical contexts (Gingerich, Kim, Stams, & MacDonald, 2012; Kim & Franklin, 2008) but no comprehensive effort has been made to study the effect of solution-focused practice on the wellbeing of professionals.

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Procedure. All child protection workers were administered the PBPQ and the MBI at pre-test, before the training in SFBT for the experimental group started.

Analysis. Pearson correlations were calculated for the data with the SPSS.

Results

Pearson's r correlations were calculated for the data. A number of professional beliefs factors showed significant correlations with global burnout scores and with the three burnout subscales (Table 5). Various self-reported professional practices factors also correlated with burnout scores (Table 6), and specific professional practices also showed association with burnout (Table 7).

Global burnout scores correlate positively with believing that user families are resistant to change ($r = .240, p < .05$) and negatively with the belief that they cooperate with workers ($r = -.240, p < .05$). As far as the professional practices factors are concerned, global burnout score displayed significant positive correlations with adopting an expert or paternalistic attitude ($r = .290, p < .01$) and with focusing on families' difficulties in in-between-session work ($r = .196, p < .05$). The correlations were negative with three others: keeping a cooperative stance and "leading from one step behind" ($r = .268, p < .01$), focusing on improvements and accomplishments ($r = .395, p < .01$), and adopting a trans-disciplinary approach with other team members ($r = .216, p < .05$) were all associated with less burnout.

At the level of specific professional practices, global burnout score showed a number of significant associations. Global burnout scores were lower for workers who ask families about their goals ($r = -.192, p < .05$) and what they want to accomplish ($r = -.244,$

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$p < .01$), accept users' explanations about their own problems ($r = -.236$, $p < .05$), ask about improvements and accomplishments ($r = -.195$, $p < .05$), focus on strengths ($r = -.366$, $p < .01$) and give compliments ($r = -.291$, $p < .05$). They also were lower for workers who ask users about satisfaction in order to improve services ($r = -.261$, $p < .05$) and cooperate with co-workers in a trans-disciplinary way ($r = -.254$, $p < .05$). Global burnout scores were higher for workers who focus more on negative aspects of the families in written reports ($r = .273$, $p < .01$), and use coercion and control strategies to put pressure on families ($r = .267$, $p < .01$).

Personal realization correlated positively with the global measure of Strength-based beliefs ($r = .227$, $p < .05$) and with the belief factor that families tend to cooperate with workers and that therefore workers should respect and adjust to the own unique cooperation style of each family ($r = .275$, $p < .05$). It correlated negatively with the global measure of Deficit-based beliefs ($r = -.226$, $p < .05$), and with believing that families tend to show resistance ($r = -.275$, $p < .01$). Specific professional practices associated with higher personal realization were: leading from one step behind by asking service users about their preferred future ($r = .197$, $p < .05$) and about their goals ($r = .187$, $p < .05$) versus exerting pressure and control ($r = -.229$, $p < .01$); focusing on improvements and achievements during sessions ($r = .305$, $p < .01$); complimenting families ($r = .252$, $p < .01$); and working in a trans-disciplinary way with other workers of the service ($r = .272$, $p < .01$).

Emotional exhaustion did not correlate significantly with any professional belief factors, nor with the global Deficit-based beliefs score or the global Strengths-based beliefs score. At the level of professional practices factors, emotional exhaustion showed a positive correlation with keeping an expert and paternalistic relationship with families ($r = .268$, $p <$

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.01). It correlated negatively with keeping a cooperative relationship by leading from one step behind ($r = -.205, p < .05$) and with focusing sessions on improvements and accomplishments ($r = .268, p < .01$). Three specific professional behaviours correlated positively with emotional exhaustion: telling user what they have to do ($r = .203, p < .05$), using coercive methods in order to get the cooperation from families ($r = .220, p < .05$), and trying to correct erroneous family behaviours during the sessions ($r = .193, p < .05$). Four specific professional practices were associated with less emotional exhaustion: to spend time asking families what they want ($r = -.239, p < .01$), to ask about improvements ($r = -.203, p < .05$), to inquire about resources and strengths ($r = -.230, p < .05$), and to find out about users satisfaction in order to improve the service ($r = -.211, p < .05$).

Depersonalization showed a positive correlation with the belief that child abuse investigation and intervention are separated processes ($r = .276, p < .01$), and a negative one with understanding investigation as part of the intervention process ($r = -.276, p < .01$). As to professional practices factors, focusing on the difficulties and shortcomings of families in team discussions and network meetings ($r = .195, p < .05$) and taking an expert or paternalistic role ($r = .197, p < .05$) showed a positive correlation with depersonalization, whereas focusing on improvements in out-of-session work ($r = -.221, p < .05$) had a negative one.

Discussion

The main finding in this study was that there are a number of professional beliefs and practices that are associated with child protection workers' burnout scores.

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Although emotional exhaustion did not correlate significantly with professional beliefs, depersonalization correlated positively with seeing investigation as separate from intervention, and higher personal realization scores were associated with a higher global strengths-based beliefs score and a stronger belief that families cooperate. Global burnout scores were also higher for workers who believe that service users display resistance and lower for those who believe in users' cooperation.

From the perspective of professional practices factors, there were two relevant findings: taking a paternalistic role was associated with higher global burnout, depersonalization and emotional exhaustion scores, while focusing on improvements was associated with lower scores on global burnout, depersonalization and emotional exhaustion and with more personal realization.

At the level of specific professional practices, the global burnout score correlated significantly with 10 out of 15 practices. To discuss families' strengths, to give compliments, and to ask for feedback to improve services were most strongly associated with lower global burnout scores.

Taken together, our findings suggest that burnout is more likely among workers who believe that families are resistant and who see investigation as an independent process, separate from intervention. Workers with higher burnout scores tend to take a paternalistic, expert stance in their interaction, and they use more coercion and control strategies in their interaction with their clients. Also, they seem to spend less time discussing user's expectations and goals and to focus less on their improvements, strengths and resources; and they tend to give less compliments and to ask less for feedback. Workers' personal

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realization is associated with the opposite beliefs and practices: professionals with higher personal realization scores expect cooperation instead of resistance from users, tend to ask families about their expectations and goals, to focus on users' improvements and strengths, and to compliment them; and they are less likely to use coercion and control strategies.

Workers with higher personal realization are also more likely to work conjointly with another team member and to cooperate in a trans-disciplinary way with the rest of the team, meaning that the response to service user's need does not depend so much on static professional qualifications (psychologist/social educator/social worker) but is flexibly decided on the basis of the fit of each particular worker with any given family. In summary, higher burnout scores seem to be associated with normative, deficit-based beliefs and practices; whereas less burnout and more personal realization correlate with a more strengths-based, resource-oriented profile.

Limitations and future research. The professional practices were not observed, but self-reported in the same measurement session in which the beliefs and burnout questionnaires were filled out. Therefore, it cannot be ruled out that all three measures reflect a global view, by the workers, of the child protection process, a view which may or may not translate into actually different professional practices. Also, most of the correlations found were small, and some may be chance findings due to the high number of correlations that were calculated, increasing the risk of experiment-wise type II error; however, the global pattern of results is compelling and provides a coherent picture of the close association of professional beliefs, practices and burnout. In this respect, the burnout data lend concurrent validity to the dimensional characterization of workers' professional beliefs and practices in the PBPQ: deficit-based ones on one side of the continuum,

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associated with more depersonalization and more global burnout, and strengths-based assumptions and practices on the other side, associated with more personal realization and less global burnout. In any case, the correlational nature of the data precludes rising any claims about causality: it may well be that certain deficit-based professional beliefs and/or practices promote burnout and that strengths-based beliefs and/or practices protect from it, but it could also be that more burned-out workers come to assume a more negative, deficit view of the families they work with, and therefore interact in more normative, deficit-based ways with them. The effect of a third variable (like for instance years in service or type of families that are worked with) on both burnout and beliefs/practices can also not be ruled out. To demonstrate that strengths-based professional beliefs and practices protect from burnout, it would be necessary to show that a change of professional beliefs and/or practices in a strengths-based direction indeed produces a change of burnout scores in the expected direction. This is the aim of Study 2.

Study 2: Impact of Training in Solution-Focused Brief Therapy on Professional Beliefs, Practices and Burnout

The purpose of Study 2 was to test the effectiveness of a training in SFBT in modifying the professional beliefs of child protection workers and in reducing their level of burnout. It was hypothesized that the SFBT training would promote more strengths-based professional beliefs and reduce deficit-based professional beliefs, and that these changes would translate into a reduction of burnout among the child protection workers.

Method

Participants.

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The sample was the same as in Study 1, 152 workers from 34 teams of the Child Protection Services in the island of Tenerife (Spain). They ranged from 25 to 48 in age; 121 were female, 31 were male.

Instruments. Professional beliefs and practices were assessed with the PBPQ. For the purpose of this study, the beliefs scores on the PBPQ were collapsed into a global score of “deficit based beliefs” (range 1-5) and into a global score of “strengths-based beliefs” (range 1-5). For professional practices, the eight PBPQ factors were analysed independently, given that a global score is not possible.

Burnout was measured with the MBI (Maslach et al., 1996), validated for a Spanish sample (Seisdedos, 1997). The global burnout score (1-3) was used.

Treatment. Training in solution-focused brief therapy (SFBT) was provided by the second author. SFBT (Berg & Kelly, 2000; de Shazer, 1994; de Shazer et al., 2007) stands in stark contrast to the medical model and to problem-focused treatments because it is a strength-based and future-oriented therapy. Rather than focusing on diagnosis, etiology, and nature of the problem, SFBT seeks to initiate and maintain conversations with users about their strengths and resources. In SFBT, user’s visions of their preferred future are elicited, steps already taken in that direction (exceptions) are highlighted, and next small steps are discussed using scaling questions. The emphasis is on partnership and empowering, on offering clients “choice and voice” (Walsh, 1997, p.80), and on speaking the users’ language.

In this study, training consisted of two 15-hour workshops that were taught two months apart. 30 hours were selected as the total duration of training because evidence

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suggests that at least 20 hours might be necessary to make a difference in training professionals in the approach (Gingerich et al., 2012). The training taught the basic solution-focused principles and intervention techniques (Miracle Question, scaling questions, exceptions and pre-treatment changes questions, safety questions, compliments and solution-focused homework tasks) by showing videotapes of actual therapy sessions, exercising the techniques in role-plays and having group discussions. The methodology of the training was in itself solution-focused: participants were encouraged to list their own goals for the training, and their professional resources were valued and promoted; possible “baby steps” in their professional practices were negotiated and encouraged after the first 15-hour workshop, and changes were reviewed and encouraged two months later.

After the 30 hours of training, all members of the experimental group received an additional 30 hours of supervision, one five-hour session every month during six months. Supervision was also solution-focused: each session started by reviewing positive changes and “stories of success” and highlighting families’ and workers’ resources (Turnell & Edwards, 1999); stuck cases were discussed in the group in a variety of solution-focused formats.

Procedure. The 152 participants from the initial sample were allocated either to the control or the experimental group. Allocation was not done individually, but by teams, in such a way that in both groups there was an equivalent number of rural child protection teams, urban child protection teams and semi-urban teams. In both groups there was an equivalent number of “risk teams” (dealing with severe risk cases) and “prevention teams” (dealing with light and moderate risk cases) (chi square= 0.421; p= 0.51). The workers’ professional experience in the Tenerife child protection service averaged 75 months in the

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experimental group and 79 in the control group, a non-significant difference ($t= 0.672$; $p < 0.50$). There were also no differences between the experimental and the control group in relation to age ($t= 0.801$; $p= 0,42$), professional qualification ($\chi^2=0,651$; $p=0,72$), or workers' sex ($\chi^2= 2.280$; $p= 0.13$). Participants had received no previous training in SFBT. At pre-test, the N of the experimental and control groups was $N= 73$ and $N=79$ respectively, at post-test, $N=70$ and $N=69$; and at follow-up six months later, $N=62$ and $N=58$. The reduction in sample size was not due to dropout, but to the fact that the local authorities reduced the number of contracts due to the current financial crisis in Spain.

Professional beliefs were measured in both the control and the experimental group at three points: at pre-test, at the end of the SFBT training of the experimental group (post-test), and at follow-up six month later. Professional practices were only measured at pre-test and at follow-up, given that at the termination of training (just after it had finished) there would have been no time to implement any practice changes. The MBI was administered at pre-test and at follow-up six months after the SFBT training.

Analyses. The equivalence of the control and experimental group was established with Student's t test. To test the effect of training on professional beliefs, MANOVA was performed on the scores at pre-test, post-test and follow-up. T-tests were used to compare the scores in professional practices at pre-test and follow-up. To test the main hypothesis of the study, a stepwise multiple regression analysis was performed, with global burnout at follow-up as the dependent variable, to be predicted following a backward elimination approach. Effect sizes for the SFBT training were calculated for professional beliefs, professional practices, and burnout. All analyses were undertaken with the SPSS.

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Results

Group equivalence. Analyses at pre-test confirmed that the control and experimental groups were equivalent, with no differences found in deficit-based beliefs ($t=1.46$; $p=0.14$), strengths-based beliefs ($t=1.45$; $p=0.14$), deficit-based practices ($t=1.41$; $p=0.14$), strengths-based practices ($t=1.21$; $p=0.22$), nor in MBI scores at pre-test ($t=1.08$; $p=0.28$).

Changes in professional beliefs and practices. Table 9 provides a summary of the mean scores in the PBPQ and MBI for both the control and the experimental groups at pre-test, post-test and follow-up.

For the control group, MANOVA showed that there were no significant differences neither for the normative, deficit-based professional beliefs ($F=0.704$; $p=0.404$) nor for the strength-based professional beliefs ($F=0.806$; $p\leq 0.372$), as shown in figure 4 and figure 5. In contrast, MANOVA found significant differences between the professional beliefs of the experimental group at the three measurement points. As shown in Figure 6, a gradual decrease in normative, deficit-based professional beliefs was found from pre- to post-test, and from post-test to follow-up ($F=106.8$; $p=0.000$), while, as shown on Figure 7, strength-based professional beliefs increased gradually ($F=106.9$; $p=0.000$). Both for deficit-based and for strength-based professional beliefs, the difference between pre- and post-test was larger than between post-test and follow-up, suggesting that the training component had more of an impact than supervision.

Professional practices were only measured at pre-test and follow-up. For the control group, Student's t-test showed that there were no significant differences. For the

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experimental group, there were significant changes: deficit-based practices went down from a mean score of 3.03 to 2.27 ($t= 8.12$; $p= 0.000$), while strengths-based ones went up from 3.02 to 3.60 ($t= -7.60$; $p= 0.000$).

All eight factors identified for professional practices changed in the expected direction. At follow-up the professional practices that increased were: working with families focusing on their improvements and strengths ($t= -5.21$; $p= 0.000$) in a “leading from one step behind” style ($t= -5.64$; $p= 0.000$), and focusing on improvements and strengths in the interaction with other professionals and within the team ($t= -6.22$; $p= 0.000$). On the contrary, the following deficit-based professional practices decreased from pre-test to follow-up: to focus on families limitations and shortcomings ($t= -7.94$; $p=0.000$), adopting a paternalistic, expert position in the interaction with families ($t= -4.95$; $p= 0.000$), to focus on difficulties in the interaction with other professionals and team members ($t= -6.69$; $p= 0.000$) and to promote insight and awareness of the problem ($t= -6.85$; $p= 0.000$). Trans-disciplinary professional practices increased from pre-test to follow-up ($t= -3.76$; $p= 0.000$).

The effect sizes of the SFBT training on professional beliefs and practices were also calculated. To that end, Cohen's d was used (difference between the means of the experimental and the control groups, divided by the standard deviation). Comparing pre-test with follow-up scores, the effect size for deficit-based beliefs was $r= -.62$ (Cohen's $d= -1.61$); for strengths-based beliefs, $r= .62$ (Cohen's $d= 1.42$); for deficit-based practices $r= -0.71$ (Cohen's $d= -2.07$); and for strengths-based practices $r= .58$ (Cohen's $d= 1.42$). These can be considered large effects.

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SFBT training and workers' burnout. Effect size for the SBFT training on the global burnout score was $r = -.22$ (Cohen's $d = -.46$), a small effect. Calculating it for the experimental group only (pre-post), it reached a medium effect ($r = -.28$; Cohen's $d = -.59$).

In order to analyze the effect of the relevant variables on burnout at follow-up, a stepwise regression analysis was performed, selecting the following variables for a backwards approach: MBI at pretest; years working in child protection services; type of cases seen (prevention team versus risk team); training in SFBT; change in the global score of normative, deficit-based beliefs (difference from pre-test to follow-up); change in the global score strengths-based beliefs (difference from pre-test to follow-up); and the change from pretest to follow-up in the 8 factors describing professional practices. The total set of variables accounted for 83.8% of the variance of MBI scores at follow-up % ($R^2 = .838$), and the regression model was highly significant ($F(5.42) = 15.07$; $p = 0.000$) (Table 9).

Table 10 shows the weights and partial correlations for each predictor variable. From the initial of predictor variables, seven were excluded from the regression model because of their low predictive value: years working in child protection services ($\beta = 0.011$; $t = 0.13$; $p = 0.893$), type of cases seen ($\beta = 0.007$; $t = 0.08$; $p = 0.931$), training ($\beta = -0.105$; $t = -0.80$; $p = 0.424$) the change in professional practices that consist in promoting users' awareness of the problems and their causes ($\beta = 0.102$; $t = 0.87$; $p = 0.389$); change in paternalistic professional practices ($\beta = 0.208$; $t = -1.654$; $p = 0.106$); change in professional practices that focus on families' improvements and resources, both in direct work with families ($\beta = -0.032$; $t = 0.298$; $p = 0.767$) and in the interaction with other professionals and in the team ($\beta = -0.110$; $t = -1.068$; $p = 0.292$).

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Further examination revealed that the variables with the highest predictive power on burnout at follow-up were:

Further examination revealed that the variables with the highest predictive power on burnout at follow-up were:

-The scores of initial burnout ($\beta = 0.846$; $t=11.29$; $p= 0.000$), which had a positive effect, so that higher initial burnout scores were associated with higher burnout scores at follow-up.

-The global change in beliefs, with change in the direction of more deficit-based professional beliefs associated with increased burnout ($\beta = 0.355$; $t=2.56$; $p= 0.015$), and change towards more strengths-based professional beliefs with decreased burnout at follow-up ($\beta = -0.356$; $t= -2.55$; $p= 0.015$).

-The change of professional practices in the direction of focusing more on difficulties and deficits of service users, which predicted more burnout, both in direct intervention with families ($\beta = 0.286$; $t= -2.43$; $p= 0.02$), and in the interaction within the team and with other professionals ($\beta = 0.285$; $t= 2.41$; $p= 0.021$).

-The change of professional practices in the direction of becoming more collaborative, “leading families from behind”, which was associated with a reduction of burnout scores at follow-up ($\beta = -0.318$; $t= -3.13$; $p< 0.003$).

-The change in professional practices in the direction of working in a more trans-disciplinary way in the teams, which predicted lower burnout scores ($\beta = -2.88$; $t= -2.50$; $p= 0.016$).

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Discussion

The first finding of Study 2 is that the professional beliefs and practices of the experimental group changed in the expected direction after training, with a decrease in deficit-based beliefs and practices, and an increase in strengths-based beliefs and practices. Given that in the control group the professional beliefs remained unchanged, it may be concluded that the training in SFBT helped the child protection workers in this sample change in a more solution-focused direction. In fact, the effect sizes of the SFBT training for both professional beliefs and practices were large, larger than the effect sizes found in most studies on the impact of solution-focused interventions on a variety of measures (Gingerich et al., 2012). Therefore, it can be claimed that the SFBT training had the intended effect on the child protection workers of this sample.

The second main finding of Study 2 is that the training in SFBT also had a significant effect on burnout as measured on the MBI. In this case, the effect size was small, which seems logical, as the main purpose of our overall project is not to reduce workers' burnout, but to test the impact of the SFBT training on how the child protection workers in our sample intervene with service users. Therefore, the SFBT training included a lot of exercises to promote strengths-based attitudes, but no ingredients aimed specifically at reducing workers' burnout. It can be speculated that a SFBT training that included ingredients targeting burnout directly would have achieved a larger effect.

The third major finding is that the level of child protection workers' burnout at follow-up was not predicted by the years of work in the child protection service or by the type of cases seen by the worker (risk teams *versus* prevention teams). Instead, what

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predicted burnout at follow-up were the initial level of burnout at pre-test and the changes in the professional beliefs and in the professional practices of workers. The data suggest that even professionals who have been working longer with more difficult cases seem to be able to reduce their levels of burnout if they change towards more strengths-oriented beliefs and engage in more strengths-oriented professional practices. Therefore, it can be inferred that participating in a SFBT training protects workers from burnout, as the significant effect size mentioned before indicates. The data support the interpretation that this buffering effect of training in SFBT is produced by the reduction of workers' deficit-based beliefs and practices and by an increase in their strength-based ones. Among the practices, it seems particularly protective from burnout to focus less on families' shortcomings and deficits, and to adopt more of a "leading from one step behind" professional position. To our knowledge, this is the first time that the positive effect of this position receives empirical support. Changing professional practice in the direction of a more trans-disciplinary teamwork also predicts lower burnout scores.

Limitations and future research. Assignment to experimental and control groups was not random, and therefore it cannot be ruled out that the two groups differed at pre-test in some unknown, but relevant variables. In any case, our analyses show that they were equivalent on all variables that were tested: PBPS scores, MBI scores, months in service, "prevention teams" versus "risk teams", workers age, professional training and sex. Another confounding factor could be the fact that both the experimental and the control teams work in a relatively small geographical area, with frequent contact among teams; therefore, it could be that some of the skills and attitudes that the participants in the experimental group received during their training were also transmitted to the workers of

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the control group; however, if this had happened, it would have produced a reduction of the differences between the control and the experimental group, therefore introducing a conservative bias.

Another issue is that the SFBT package included both a formal “training” part and a “supervision” period, so that the effects of these two ingredients are difficult to untangle; for instance, it could be argued that it was the supervision, and not the training, that produced the effects. However, our data show that the changes in strengths-based versus deficit-based beliefs were larger after the training than after the supervision: participants in the experimental group continued to become more strengths-based in their beliefs during the supervision period, but the change was less marked than during their training. The question, then, becomes if having supervision really added to the impact of the training, or if the continued change in professional beliefs after the training would have occurred also without supervision. To answer this question, a group of workers that received training but no supervision would be needed. Another follow-up, sometime after supervision has stopped, would help to establish how lasting the effects of training are. In this respect, the support that managers and supervisors provide (or provide not) play a central role too (Walsh, 1997).

It could be argued that the effects of the SFBT training on burnout were not specifically produced by the solution-focused elements of the training and supervision, but by the “common factor” of the workers in the experimental group having the chance to get together, reflect on their practice and discuss cases. However, the finding that the training *per se* did not add to the predictive power of the regression model, whereas the changes in

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beliefs and practices did add to it, suggests that in fact it was the solution-focused emphasis on strengths and resources what made the difference.

The child protection workers in this study were relatively young and with a brief professional career in protection services. This might account for the fact that the average MBI scores were low for depersonalization and emotional exhaustion, and intermediate for personal realization. It also limits the generalization of the results of this study to other child protection worker samples with initially higher levels of burnout. It may be that more burned-out workers are more reluctant to accept a strengths-based view of their users and their service, as the finding of the high predictive power of initial burnout scores suggest; but it could also be that precisely with more burned-out workers, the impact of a solution-focused training could be bigger. Replications of this study with different samples of workers could settle this issue.

An open question is also to what extent self-reported practices translate into actual professional behaviours in the interactions with service users. Studies examining videotaped sessions of child protection work may advance our knowledge on if and how the professional behaviours of SFBT-trained workers change in their actual interaction with service users. The other, even more important issue for future research is whether these changes translate into a more efficient handling of child protection cases and into higher user satisfaction. This is, after all, the ultimate goal of any intervention and is also the main question that the overall Tenerife study will try to answer. If positive effects are found, it is hoped that a fine-grained analysis of specific professional practices via videotape analysis will shed light on the interpersonal processes through which these effects are produced, and

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generate specific suggestions as to how workers may interact with service users in a more productive way.

Conclusions

The first study described in this paper has shown that professional beliefs and practices can be described on a continuum from more normative, deficit- based to more strengths-oriented, and that these differences in beliefs and practices are associated with differences in child protection workers' global burnout, depersonalization and personal realization. The second study has produced evidence that training in SFBT plus supervision can have a lasting effect on the professional beliefs and practices of child protection workers, and that these changes in professional beliefs and practices translate into lower burnout scores. It remains to be shown if and how these changes have an effect on user satisfaction and on the effectiveness of the child protection intervention. This analysis is currently underway.

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Table 1. Factor Loadings of the Deficit-based Beliefs Scale and of the Strengths-based Beliefs Scale, with percentage of explained variance and eigenvalues

PROFESSIONAL BELIEFS OF CHILD PROTECTION WORKERS	
Deficit-based, normative professional beliefs.	Strengths-based beliefs
<i>Total explained variance 61.13%</i>	<i>Total explained variance= 60.96%</i>
<p>Factor 1 <u>Beliefs on family cooperation (<i>Families are resistant, they do not cooperate</i>):</u> The worker believes that families do not cooperate (item 1b), that they do not acknowledge the problems that have called for an intervention of Social Services (item 2a), are resistant to change and reject the help they are offered (item 6b). In order to create cooperation, the worker has to find ways to overcome family resistance to change (item 10b) and it is often necessary to use coercitive strategies to get families to cooperate (item 7a). Therefore, the family problems are difficult to change and a long and complex intervention is required (14 b) (<i>Eigenvalue 6.41; 25.650 % explained variance</i>)</p>	<p>Factor1. <u>Beliefs on family cooperation (<i>Families do cooperate with the workers</i>):</u> The worker believes that families cooperate (item 1a), that they acknowledge the problems that have called for an intervention of Social Services (item 2b), and that they really want to change their situation (item 6a). Families have different ways to cooperate, it behooves the worker to respect them and to adjust to them (item 10a) in order to promote cooperation (item 7b). Therefore, family problems can be solved without long and complex interventions (item 14a) (<i>Eigenvalue 6.38; 25.524% explained variance</i>)</p>
<p>Factor 2. <u>Beliefs about families (<i>families lack competencies and resources</i>):</u> The worker believes that families lack the necessary resources and competencies to overcome their problems (item 3b), and are unable to formulate their own goals and to create solutions (item 25b). Therefore, the cooperation depends on the personal characteristics of each family (item 19a). The worker should focus on helping families get the resources they are lacking of in order to solve their problem (item 9b), first diagnosing the problem in order to develop an effective intervention (item 18a). The goals of intervention and the measures taken are defined by the worker (item 4a). (<i>Eigenvalue 2.25; 9.018 % explained variance</i>)</p>	<p>Factor 2. <u>Beliefs about families (<i>families have competencies and resources</i>):</u> The worker believes that families have the necessary resources and competencies to overcome their problems (item 3a), and are able to formulate their own goals and to create solutions (item 25a). Therefore, the cooperation depends on the professional relationship established with families (item 19b). The worker should focus on helping families use their own resources to overcome their problems (item 9a), first clarifying their goals and then helping them to get their own solutions started (item 18b). The goals of intervention and the measures taken are defined by the family (item 4b) (<i>Eigenvalue 2.29; 9,166 % explained variance</i>)</p>
<p>Factor 3. <u>Beliefs about families in the child protection system (<i>families lack skills to raise and protect their children</i>):</u> The worker believes that families in the child protection system show many deficits in the education of their offspring (item 11a), they are unconcerned and irresponsible in their care (item 5b), and often expose them to risk situations (item 12b). Families that are defined as abusive or neglectful by the child protection service rarely show responsibility and adequate care (item 20b). (<i>Eigenvalue 1.77; 7.102 % explained variance</i>)</p>	<p>Factor 3. <u>Beliefs about the worker's role in child risk situations (<i>help families to protect their children by themselves</i>)</u> The worker believes that his/her main mission is to help families so that they can, by themselves, ensure the safety of their offspring (item 16b), to work with families in order to co-construct a safe environment and to connect them with their natural support network (item 21b). Therefore, the worker has to pay close attention to the protective and resilience factors (item 13b), and his/her main goal is to create a cooperative relationship with the family (item 23b). (<i>Eigenvalue 1.73; 6.952% explained variance</i>)</p>
<p>Factor 4. <u>Beliefs about the worker's role in child risk situations (<i>to watch over and protect children in abusive situations</i>):</u> The worker believes that his/her main mission is to protect children from abuse or negligence, preventing these behaviors in their families (item 21a), and to ensure children's safety and take them from their families if they are at risk (item 16a). Therefore, the worker has to pay close attention to the risk factors and possible vulnerabilities of children and their families (item 13a), and his/her main goal is to create an awareness of the problem and a motivation to change (item 23a) (<i>Eigenvalue 1.41; 5.656 % explained variance</i>)</p>	<p>Factor 4. <u>Beliefs about families in the child protection system (<i>families have skills to raise and protect their children</i>):</u> The worker believes that families in the child protection system show many strengths and competencies in the education of their offspring (item 11b), that they are concerned and responsible in their care (item 5a), and keep them safe most of the time (item 12a). Families that are defined as abusive or neglectful by the child protection don't behave in that way frequently, and rather show responsibility and adequate care most of the time (item 20a). (<i>Eigenvalue 1.40; 5.603% explained variance</i>)</p>

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<p><u>Factor 5. Beliefs about the change process (<i>families need to gain awareness about the causes of their problems</i>):</u> The worker believes that in order to solve or improve their problems, families have first to acknowledge that they have a problem and that they are responsible for it (item 8a). It is necessary to first understand the causes of problems and how they have developed (item 17b). (Eigenvalue 1.20; 4.827% explained variance)</p>	<p><u>Factor 5. Beliefs about the change process (<i>no awareness on the causes of their problems is needed</i>):</u> The worker believes that in order to solve or improve their problems, families do not have first to acknowledge that they have a problem and that they are responsible for it (item 8b). It is also not necessary to know the causes of the problems and how they have developed (item 17a). (Eigenvalue 1.21; 4.871% explained variance)</p>
<p><u>Factor 6. Beliefs about education models (<i>universality</i>):</u> The worker believes that there is an universally accepted “good education model” that should set the standard in his/her work with families (item 22a). (Eigenvalue 1.14; 4.567 % explained variance)</p>	<p><u>Factor 6. Beliefs about education models (<i>relativism</i>):</u> The worker believes that no education model is universally valid and that parents have the right to choose how they raise their children (item 22b). (Eigenvalue 1.14 4.566% explained variance)</p>
<p><u>Factor 7. Beliefs about investigation in child protection (<i>investigation as independent</i>):</u> The worker sees investigation not as intervention, but as a preliminary process that is independent from investigation and does not produce changes on its own. (Eigenvalue 1.07; 4.318 % explained variance)</p>	<p><u>Factor 7. Beliefs about investigation in child protection (<i>investigation is intervention</i>):</u> The worker sees investigation as an intervention in its own right, that can produce changes in families (item 24b). (Eigenvalue 1.07; 4.278 % explained variance).</p>

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Table 2. Factor loadings for the Professional Practices Scale, with percentage of explained variance and eigenvalues

PROFESSIONAL PRACTICES	
Total explained variance 57.48%	
<p><u>Factor 1. Practices focused on awareness (insight) and on knowing the causes or origins of problems as a prerequisite for change:</u> At the beginning of the work with families, questions are asked about the causes or origin of their problems (item 4) and how these problems have developed over time (item 3), spending many sessions to promote that the family gets an awareness of the problem and accept their responsibility in it (item 32).</p>	<p><i>(Eigenvalue 6.20; 17.224% of explained variance)</i></p>
<p><u>Factor 2. Practices outside the session and with other professionals that focus on the difficulties and shortages of families:</u> When reports are written, negative aspects are more emphasized than positive ones (item 17). Meetings with other professionals focus on “what is wrong”, on the difficulties in the work with families (item 18). Team meetings usually focus on stuck, chronic or difficult cases, or on “what goes wrong” with families (item 25)</p>	<p><i>(Eigenvalue 3.73; 10.370% of explained variance)</i></p>
<p><u>Factor 3. Practices outside the session and with other professionals that focus on improvements and family strengths:</u> When reports are written, positive aspects are more emphasized than positive ones (item 24). Meetings with other professionals focus on “what goes well”, on the improvements and achievements in the work with the family (item 27). Team meetings usually focus on what “goes well”, on improvements and accomplishments, on what has contributed to these improvements and what the next steps can be (item 26).</p>	<p><i>(Eigenvalue 2.44; 6.797% of explained variance)</i></p>
<p><u>Factor 4. Paternalistic practices, expert role (“leading from ahead”):</u> The worker tries to guide families, telling them what steps to take (item 9) or providing advice (item 1). At the beginning of conjoint work, some time is spent evaluating families’ shortages and deficits –diagnosis- in order to determine their needs (item 33), then they are told what the goals are and what they should accomplish (item 35). Coercitive, control or pressure measures are taken in order to ensure that the families cooperate and follow the guidelines (item 34). Lack of cooperation on the family’s part is enough to stop the intervention process and refer the case (item 29)</p>	<p><i>(Eigenvalue 2.09; 5.829 of explained variance)</i></p>
<p><u>Factor 5. Cooperative practices, facilitative role (“leading from one step behind”):</u> Questions are asked and the worker avoids making judgments or giving his/her opinions on what the family should (item 2). At the beginning of conjoint work, time is spent asking about the family’s preferred future or how they see their future without the problema (item 6), spending much time asking what they expect from Social Service (item 7). Questions about how they solved similar problems in the past are asked (item 30). The goals and aims of the families are accepted, and the worker follows their (item 14). Before a report is written, its content is discussed with the family and the worker tries to work out a consensus document (item 23). Families are asked about their satisfaction with the services, and their suggestions are taken into account to improve the quality of services (item 37)</p>	<p><i>(Eigenvalue 1.80; 5.005% of explained variance)</i></p>
<p><u>Factor 6. In-session practices that focus on difficulties and shortages of families:</u> In the sessions with families, a lot of time is spent identifying their shortcomings and vulnerabilities (item 11). Interviews focus on what “goes bad”, on the difficulties and problems the family is having (item 15), trying to correct the wrong behaviours of family members (item 28). Each worker intervenes only with the families s/he gets assigned??** (item 19)</p>	<p><i>(Eigenvalue 1.60; 4.450% of explained variance)</i></p>
<p><u>Factor 7. In session practices that focus on families’ improvements and strengths:</u> In the sessions with families, a lot of time is spent identifying their strengths and resources (item 12), and sessions focus on “what is better” and on improvements (item 10), complimenting service users for their successes, even if they are small (item 13) and accepting their explanations for their problems without confronting their views (item 8)</p>	<p><i>(Eigenvalue 1.43; 3.972% of explained variance)</i></p>
<p><u>Factor 8. Transdisciplinary teamwork:</u> In the sessions with families professional work conjointly with another team member (item 22). Teamwork is organized in such a way that all functions and tasks are shared by team members; knowledge is transferred among team members (item 21)</p>	<p><i>(Eigenvalue 1.38; 3.834% of explained variance)</i></p>

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Table 3. Correlations between self-reported Professional Practices and Deficit-based Beliefs

PROFESSIONAL PRACTICES	BELIEFS OF THE NORMATIVE, DEFICIT-BASED MODEL						
	Factor 1 Families resistant, they do not cooperate.	Factor 2 Families lack competencies and resources	Factor 3 Families have no protection skills	Factor 4 The role of the worker is to watch over the child	Factor 5 Insight on the causes of the problem is needed	Factor 6 Universal education model	Factor 7 Investigation as an independent process
Factor 1: Awareness of problem's causes	.264**	.139	.201*	.200*	.210**	.319**	.148
Factor 2: Out of session practices focused on difficulties	.044	-.025	-.013	.140	-.136	-.110	.030
Factor 3: Out of session practices focused on improvements and family strengths	-.108	.128	.033	-.044	.128	.106	-.005
Factor 4: Paternalistic, expert role	.256**	.219**	.175*	.262**	.061	.117	.055
Factor 5: Facilitator role, cooperative practices	-.115	-.155	-.081	-.124	.041	.053	-.008
Factor 6: In-session work focused on difficulties	.241**	.191*	.369*	.217**	.076	.121	.086
Factor 7: In-session work focused on improvements.	-.208*	-.148	-.075	-.217**	.074	-.001	.034
Factor 8: Transdisciplinary teamwork	-.157	-.075	.028	-.006	.033	-.133	.044

* $p < .05$; ** $p < .01$

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Table 4. Correlations between self-reported Professional Practices and Strengths-Based Beliefs

PROFESSIONAL PRACTICES	BELIEFS OF THE STRENGTHS-BASED MODEL						
	Factor 1 Families cooperate with workers	Factor 2 Families have competencies and strengths	Factor 3 Workers' role help families protect children	Factor 4 Families have protection skills	Factor 5 No insight on the causes of the problem is needed	Factor 6 Relativity of education models	Factor 7 Investigation as intervention
Factor 1: Promote awareness of problem's causes	-.266**	-.094	-.202*	-.199*	-.185*	-.321**	-.154
Factor 2: Out of session practices focused on difficulties	-.036	.033	-.136	.017	.125	.106	-.034
Factor 3: Out of session practices focused on improvements and family strengths	.104	-.115	.046	-.037	-.139	-.103	.007
Factor 4: Paternalistic practices, expert role	-.254**	-.211**	-.262**	-.174*	-.063	-.118	-.057
Factor 5: Facilitator role, cooperative practices	.107	.112	.125	.078	-.024	-.058	.002
Factor 6: In-session work focused on difficulties	-.237**	-.183*	-.218**	-.366**	-.072	-.119	-.086
Factor 7: In-session work focused on improvements.	.201*	.219**	.213**	.073	-.056	.000	-.036
Factor 8: Transdisciplinary teamwork	.153	.094	.005	-.030	-.029	.131	-.047

* $p < .05$; ** $p < .01$

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Table 5. Correlations of Professional Beliefs factors and Burnout dimensions.

PROFESSIONAL BELIEFS	BURNOUT			
	Emotional exhaustion	Depersonalization	Personal realization	Global burnout score
Deficit-based Factor 1 Beliefs on family cooperation (<i>Families are resistant, they do not cooperate</i>)	.139	.098	-.275**	.240*
Deficit-based Factor 2. Beliefs about families (<i>families lack competencies and resources</i>):	.162	-.071	-.121	.124
Deficit-based Factor 3. Beliefs about families in the child protection system(<i>families lack skills to raise and protect their children</i>)	.073	.027	.000	.054
Deficit-based Factor 4. Beliefs about the worker's role in child risk situations (<i>to watch over and protect children in abusive situations</i>)	.069	.126	-.133	.140
Deficit-based Factor 5. Beliefs about the change process (<i>families need to gain awareness about the causes of their problems</i>)	-.141	-.066	.065	-.126
Deficit-based Factor 6. Beliefs about education models (<i>universality</i>)	-.082	-.146	.060	-.116
Deficit-based Factor 7. Beliefs about investigation in child protection (<i>investigation as independent</i>)	-.035	-.276**	.112	-.160
Strengths-based Factor1. Beliefs on family cooperation (<i>Families do cooperate with the workers</i>):	-.139	-.098	.275**	-.240*
Strengths-based Factor 2. Beliefs about families (<i>families have competencies and resources</i>):	-.122	.071	.178	-.130
Strengths-based Factor 3. Beliefs about the worker's role in child risk situations (<i>help families to protect their children by themselves</i>)	-.068	-.127	.146	-.146
Strengths-based Factor 4. Beliefs about families in the child protection system(<i>families have skills to raise and protect their children</i>)	-.073	-.027	.000	-.054

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Strengths-based Factor 5. Beliefs about the change process (<i>no insight on problems' causes is necessary</i>)	.141	.066	-.065	.126
Strengths-based Factor 6. Beliefs about education models (<i>relativism</i>):	.079	.142	-.077	.121
Strengths-based Factor 7. Beliefs about investigation in child protection (<i>investigation is intervention</i>).	.032	.276**	-.133	.168
Global endorsement of a normative, deficit model	.109	.044	-.226*	.183
Global endorsement of a strengths-based model	-.109	-.045	.227*	-.184

* $p < .05$; ** $p < .01$

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Table 6. Correlations between Professional Practices scores and Burnout dimensions

PROFESSIONAL BELIEFS	BURNOUT			
	Emotional exhaustion	Depersonalization	Personal realization	Global burnout score
Factor 1: Promote awareness of problem's causes	-.060	.080	-.018	.000
Factor 2: Out of session practices focused on difficulties	.167	.195*	-.090	.196*
Factor 3: Out of session practices focused on improvements and family strengths	-.127	-.221*	-.018	-.131
Factor 4: Paternalistic , expert role	.268**	.197*	-.176	.290**
Factor 5: Facilitator role, cooperative practices	-.205*	-.158	.235*	-.268**
Factor 6: In-session work focused on difficulties	.110	.118	-.074	.125
Factor 7: In-session work focused on improvements.	-.268**	-.326**	.324**	-.395**
Factor 8: Transdisciplinary teamwork	-.125	-.032	.297**	-.216*

* $p < .05$; ** $p < .01$

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Table 7. Correlations of specific professional practices with burnout.

SPECIFIC PROFESSIONAL PRACTICES	BURNOUT			
	Emotional exhaustion	Depersonalizatio	Personal realization	Global burnout score
At the beginning of intervention, families are asked about their preferred future.	-.134	-.077	.197*	-.192*
The worker spends much intervention time asking families what their goals are.	-.239**	-.089	.187*	-.244**
The worker accept families' views of their problems, without confronting their explanations.	-.147	-.113	.255**	-.236*
The worker asks what is better, and not about current difficulties and problems.	-.203*	-.191*	.062	-.195*
The worker spends much intervention time with families focusing on their strengths and resources.	-.230*	-.328**	.305**	-.366**
The worker compliments families for their effort and their accomplishments, even small.	-.166	-.284**	.252**	-.291**
Written reports on the families focus more on negative than on positive aspects.	.169	.299**	-.180	.273**
Teamwork is such that each worker shares his/her roles with other teammembers, sharing knowledge.	-.174	-.133	.270**	-.261*
Direct work with families is done with another worker	-.034	.088	.237*	-.102
At team meetings, most of the time is spent discussing progress.	-.092	-.233**	-.095	-.074
Sessions with families have focused on correcting their wrong behaviors.	.193*	.231*	-.031	.188
The worker uses coercion, control or pressure strategies in order to get families to collaborate and follow the instructions they are given.	.220*	.133	-.229*	.267**
A time limit for the intervention is agreed with the families.	.029	-.196*	.162	-.118
The worker asks the family about their satisfaction with the service received and listens to their suggestions in order to improve it.	-.211*	-.222*	.159	-.254*
The worker gives advice, tells service users what they have to do	.203*	.156	-.057	.185

* $p < .05$; ** $p < .01$

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Table 8. Mean PBPQ and MBI scores for the control and experimental group at various measurement points

Pretest	Posttest (after training)	Follow-up (six months)
<p>EXPERIMENTAL GROUP (n= 73)</p> <p>Burnout: MBI global score= 1.83 Depersonalization= 5.32 Em. exhaustion= 17.06 Pers. realization = 38.27</p> <p>PBPQ Deficit beliefs= 2.73 Strengths beliefs= 3.26 Deficit practices=3.03 Strengths practices=3.02</p>	<p>EXPERIMENTAL GROUP (n=70)</p> <p>Burnout MBI global score = 1.40** Depersonalization = 3.65** Em. exhaustion= 16.23 Pers. realization= 40.00**</p> <p>PBPQ Deficit beliefs =2.20** Strengths beliefs = 3.79**</p>	<p>EXPERIMENTAL GROUP (n=62)</p> <p>Burnout MBI global score = 1.40** Depersonalization = 3.65** Em. exhaustion= 16.23 Pers. realization= 40.00**</p> <p>PBPQ Deficit beliefs = 1.87** Strengths beliefs = 4.12** Deficit practices =2.27** Strengths practices =3.60**</p>
<p>CONTROL GROUP (N=79)</p> <p>Burnout: MBI global score =1.67 Depersonalization= 4.50 Em. Exhaustion= 17.65 Pers. realization= 37.85</p> <p>PBPQ Deficit beliefs =2.90 Strengths beliefs =3.09 Deficit practices =3.36 Strengths practices =2.94</p>	<p>CONTROL GROUP (n=69)</p> <p>Burnout: MBI global score =1.69 Depersonalization= 4.52 Em. Exhaustion =17.65 Pers. realization = 37.80</p> <p>PBPQ Deficit beliefs =2.88 Strengths beliefs = 3.11</p>	<p>CONTROL GROUP (N=58)</p> <p>Burnout: MBI global score =1.69 Depersonalization= 4.52 Em. Exhaustion =17.65 Pers. realization = 37.80</p> <p>PBPQ Deficit beliefs =2.81 Strengths beliefs =3.05 Deficit practices =3.35 Strengths practices =2.94</p>

** p ≤ 0,01 (in comparison with pre-test)

* p≤0.05 (in comparison with pre-test)

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Table 9. Summary of the regression model predicting burnout at follow-up

Model	R	R 2
1	.915	.838

ANOVA

Model		Square sum	df	Cuadratic mean	F	Sig.
1	Regression	24.275	3 42	1.867	15.077	.000

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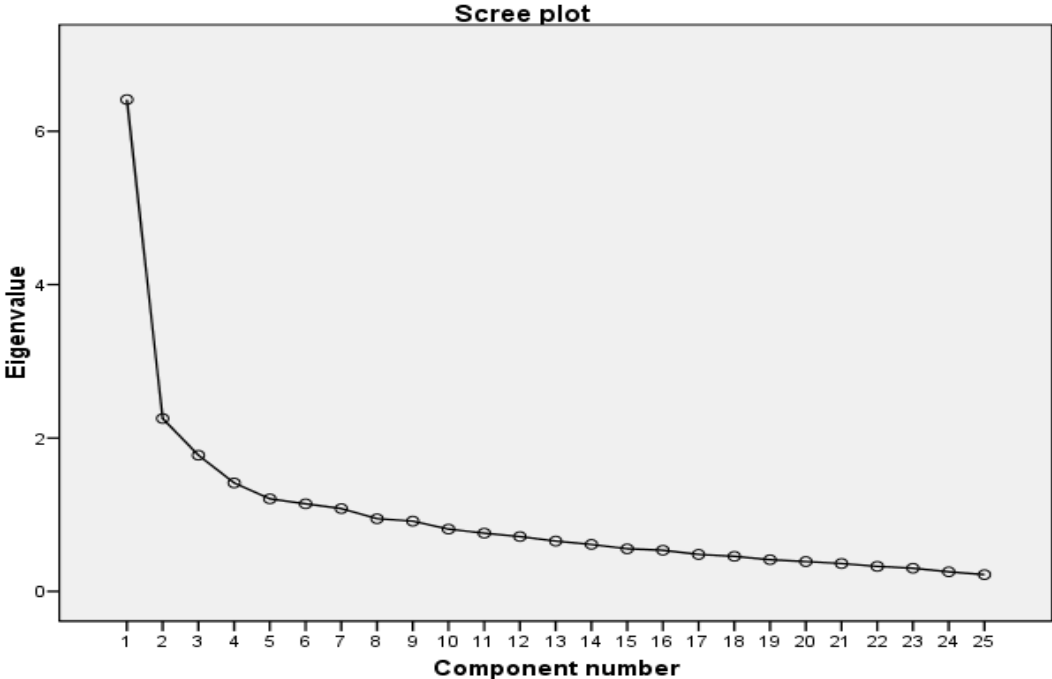
Table 10. Weight, t values, significance and Pearson correlations of the variables included in the regression model that predicts burnout at follow-up.

PREDICTOR VARIABLES	Standardized β	t	sig	Pearson correlation
Change in strengths-based beliefs 1-3	-.356	-2.558	.015	-.222
Type of cases (Risk/Prevention)	.007	.087	.931	.210
Months working in the child protection service	.011	.135	.893	.177
Training	-.105	-.809	.424	-.362
Initial burnout (1)	.846	11.297	.000	.738
Change in deficit-based beliefs 1-3	.355	2.560	.015	.221
Change in practices (awareness of problema causes) 1-3	.102	.871	.389	.229
Change in practices (teamwork focuses on deficits) 1-3	.285	2.413	.021	.405
Change in practices (teamwork focuses on strenghts) 1-3	-.110	-1.068	.292	-.292
Change in practices (paternalism) 1-3	.208	1.654	.106	.300
Change in practices ("leading from one step behind") 1-3	-.318	-3.135	.003	-.398
Change in practices (in-session focus on difficulties) 1-3	.286	2.435	.020	.237
Change in practices (in -session focus on strenghts) 1-3	-.032	-.298	.767	-.269
Change in practices (transdisciplinarity) 1-3	-.288	-2.509	.016	-.232

a 1 = pre-test; 3= follow-up

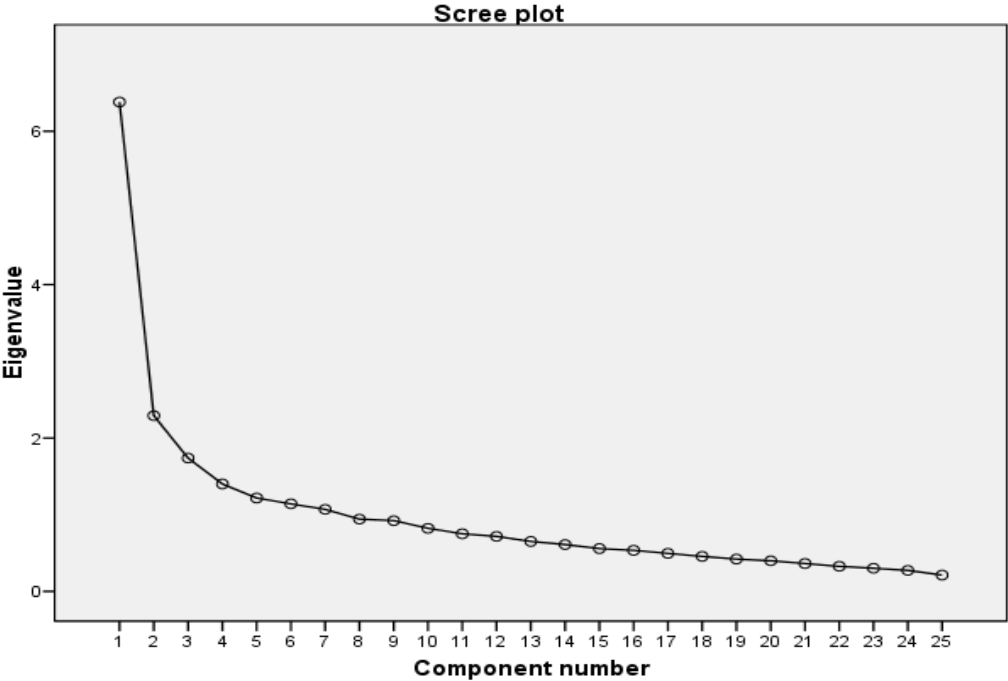
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Figure 1. Eigenvalue graphic of the Deficit-based Beliefs Scale



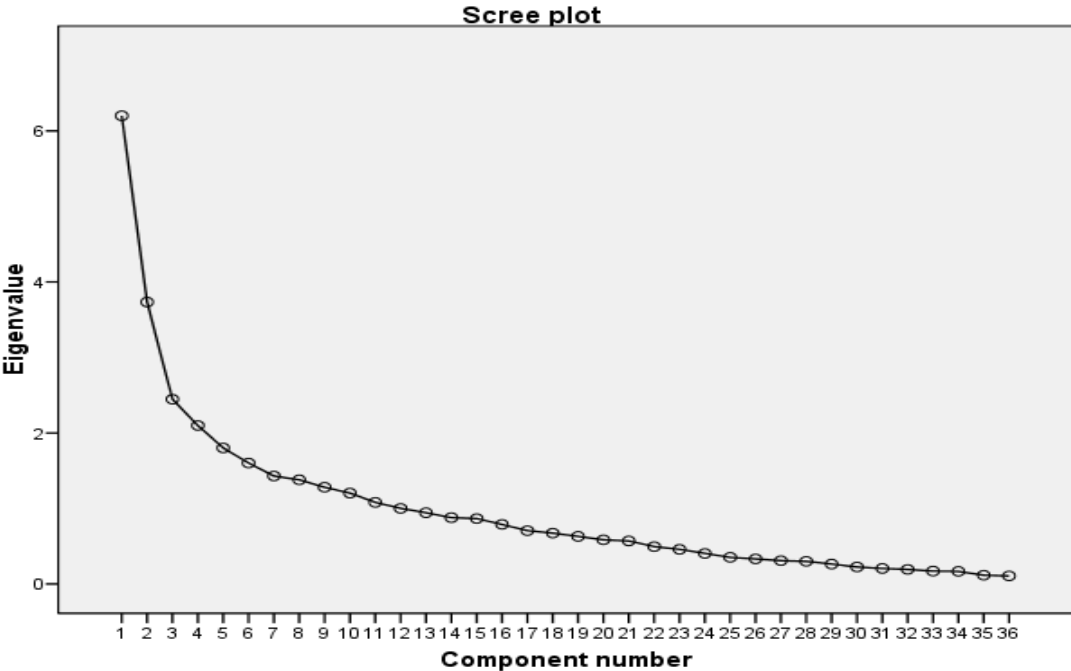
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Figure 2. Eigenvalue graphic of the Strengths-based Beliefs Scale



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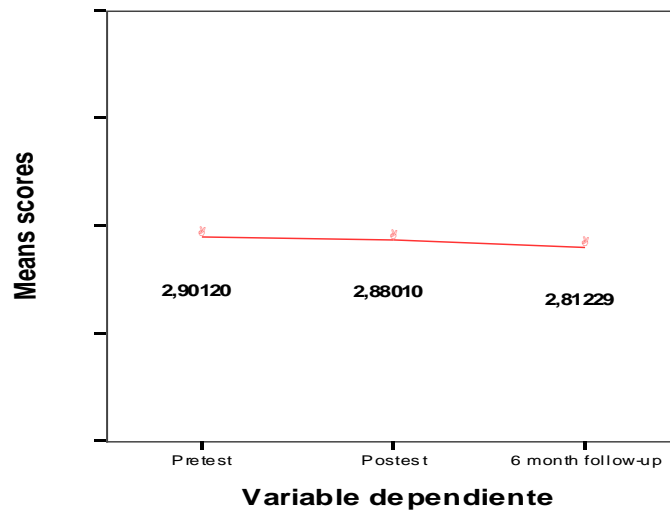
Figure 3. Eigenvalue graphic of the Professional Practices Scale



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Figure 4. Average scores in deficit-based professional beliefs for the control group at pre-test, post-test and 6-month follow-up.

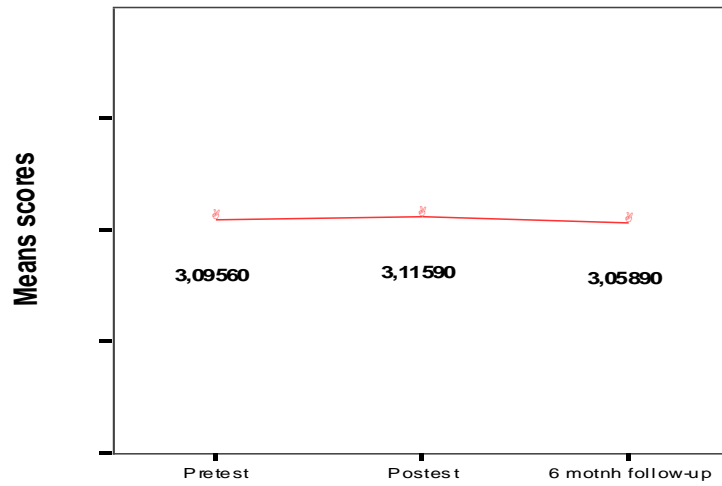
Average scores on deficit-based professional beliefs for the control group



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Figure 5. Average scores on strength-based professional beliefs for the control group at pre-test, post-test and 6-month follow-up.

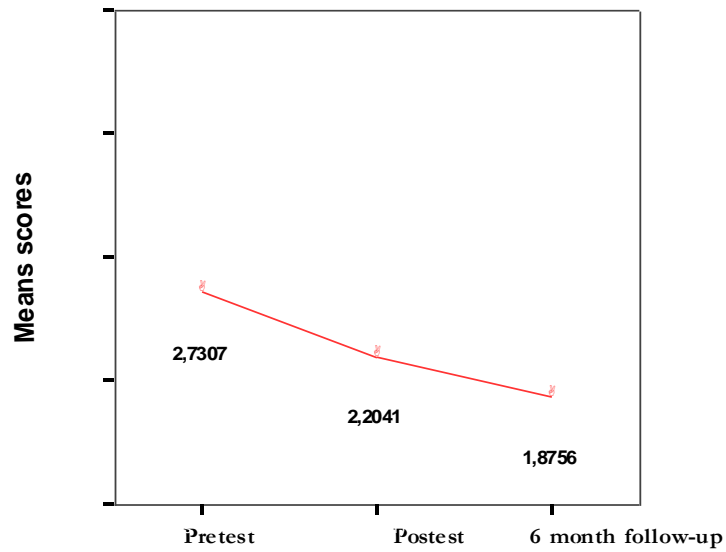
Average scores on strength bases professional beliefs for the control group



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Figure 6. Average scores in deficit-based professional beliefs for the experimental group at pre-test, post-test and 6-month follow-up.

Average scores on deficit-based professional beliefs for the experimental group



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Figure 7. Average scores on strength-based professional beliefs for the experimental group at pre-test, post-test and 6-month follow-up.

Average scores on strength-based professional beliefs for the experimental group

