On describing the residential care process: social interactions between care workers and children according to the Structural Analysis of Social Behavior (SASB) model

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1 Residential child care in the Netherlands

1.1 Introduction

Every year, more than 18,000 children and adolescents are treated in about 750 residential child care services in the Netherlands (Stichting Registratie Jeugd Voorzieningen [SRJV], 1996). The problems of these youngsters and their families vary from rather simple material deprivation to complex developmental, behavioral, psychiatric or psychosocial problems. The purpose of residential care services is to provide care in such a way that the problems of the children and adolescents are being lessened, or ideally resolved.

This chapter focuses on the context of residential child care in the Netherlands. Paragraph 1.2 describes how residential child care is embedded in the total field of child care in the Netherlands and presents a concise overview of different residential child care services. In paragraph 1.3 it is explained why residential child care workers shape the most important part of the residential care process. The professional tasks of residential child care workers are summarized. Additionally, in paragraph 1.4 the theoretical orientation of residential programs is outlined. Paragraph 1.5 explains why the care process in residential child care still is so vague and in paragraph 1.6 it is argued why there is a need for process evaluation in this field. Finally, the research question of the present study is formulated in paragraph 1.7.

1.2 Residential treatment in the field of child care in the Netherlands

Although the first orphanage was founded in the Netherlands in the 16th century, it was not until the first half of the 19th century that the idea that children in need deserve care and protection was seriously acknowledged. Through the development of concern for orphans, poor children and juvenile delinquents, child care was beginning to take shape (Tilanus, 1994). At the outset, child care institutions were private and charitable institutions or established by the church, but government support increased over the years. In the Netherlands nowadays a wide variety of services is provided, which cover the child population as a whole.

Growing concern for child care by the Dutch government resulted in the constitution of a new law on child and youth care. This law came into force in 1989. Both the Department of Public Health, Welfare and Sports and the Department of Justice of the Dutch government are responsible for the enforcement of this law (Tilanus, 1994). In accordance with the policy of these departments, three areas are distinguished in the field of child care in the Netherlands: child and youth care, child protection, and mental health care for children (Boers, Van Dam, Martens, Wiebes, & Wisselink, 1996).

Services in the field of child and youth care concern many different information services and facilities for children and adolescents with psychosocial problems, as well as for
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their families. These services are brought within the scope of the new Dutch law on youth care. Although the Department of Welfare holds responsibility, there is a high degree of decentralization. Administrations from regions in the country, called provinces, are free to divide a fixed total budget over separate services. Additionally, the system features collaboration between different services within a region (Van der Ploeg, 1993a).

Services in the field of child protection are involved when some parental responsibilities need to be taken over by the state, when children are at serious risk of abuse, or when children show persistent anti-social or delinquent behavior. The Department of Justice lays down responsibility for child protection services. These services concern the Child Welfare Council, institutions for (family) guardianship, judicial treatment institutions, and community or detention homes. The latter can be both private and federal institutions. Placement of a child can be achieved by voluntary agreement between parents and professional practitioners or by order of court. Without explaining further details, it should be noted that the Child Welfare Council and institutions for (family) guardianship is provided for by special chapters of the law on child care (Deerenberg, 1995).

Services operating in the field of mental health care for children include ambulant and inpatient services for children with psychiatric problems. The Department of Public Health holds responsibility for this area of child care. These services are not brought under the scope of the law on child care, though the ambulant facilities in this field are mentioned in this law as services which have a legal right to place children in care institutions. These services are not within the scope of the present study.

The focus of the present study is on child care services that are regulated by the Dutch law on child and youth care in the fields of child care and child protection. A total of approximately 1800 child care services in the Netherlands is regulated by this law (SRJV, 1996). Child care services look after minor children in the age of 0 to 18. In case it would be irresponsible to stop the care process or in case of a court order, also young people in the age of 18 to 23, who have reached maturity, are offered child care services (Boers et al., 1996). According to the particular type of care offered, these child care services are classified in four categories: ambulant care, day-care, foster care, and residential care. With the exception of day-care services, child care services are either a nationwide or a local service.

First, ambulant care concerns outpatient treatment and is involved in preventive actions and treatment for children who still live at home with their families. Some examples of ambulant facilities are the children’s helpline, consultancies for young people, institutions for (family) guardianship, and hometraining services. Second, day care is provided in medical centers for pre-school children and care centers for schoolchildren. Third, foster care services include foster homes, therapeutic foster families, families for short-term emergency care, weekend or holiday foster families, and services that guide foster parents.

The scope of the present research project is restricted to the fourth category of child care services: residential child care services. Residential care is appropriate in case children are experiencing emotional or behavioral difficulties that can be more effectively addressed outside the home. Another indication for residential treatment exists when parents are unwilling or unable to care for the children. There are approximately 750 residential services
in the Netherlands (SRJV, 1996). Again these residential services are divided into several categories (Van der Ploeg & Scholte, 1988; SRJV, 1996; Boers et al., 1996):

- Judicial treatment institutions and youth detention homes for treatment in the light of court orders. In total around 70 institutions in which yearly more than 1500 children are treated.
- Around 60 emergency care services for brief placements in order to provide crisis-intervention, in which yearly almost 4000 children are treated.
- Approximately 130 supervised independent living arrangements for learning self-help skills, which hold almost 2000 children a year.
- Around 50 family style homes with a maximum of four children per home, operated by volunteer foster parents, for more then 350 children a year.
- Approximately 450 institutions for upbringing and treatment, including facilities for periods of observation, facilities for vocational training, and local and nationwide operating residential treatment centers. In these institutions yearly more than 10500 children are treated. The residential child care center in which the present study is carried out belongs to this category.

It should be noted that boarding schools, facilities for children with physical disabilities or mental handicaps are beyond the scope of residential child care in the Netherlands.

1.3 Professional tasks of residential child care workers

Residential care services provide care for the purpose of decreasing or ideally resolving the problems of the children and young people. The main reasons for admission regard serious emotional or behavioral problems of the child, (suspected) child abuse or neglect, parental problems, and multiple family problems.

The size of residential institutions for upbringing and treatment generally ranges up to more than 100 children. However, in these residential settings functional units of an average of ten children are identified and housed separately and therefore often recognized as different services. In these living units or living groups the children and up to five child care workers live together. The living group is considered as the primary treatment environment in residential settings. Consequently, child care workers are the primary treatment staff (e.g., De Ruyter, 1971, 1992; Gieles, 1981; Gualthérie van Weezel & Waaldijk, 1984; Van der Ploeg & Scholte, 1988; Lyman & Campbell, 1996).

In order to exercise their profession adequately, child care workers have to fulfil a wide range of tasks and responsibilities. In the Netherlands during the last decade, considerable effort has been put into preparing an outline of all these occupational activities and thereby into preparing an adequate profile for the profession of child care workers (Van Breugel, 1989; De Bree, 1992; Landelijke Beroepsvorinig Groepsleiders [LBVG], 1994; Hens & Geomini, 1996). As a final result, all professional tasks of child care workers are summarized in six so-called task areas, each of which concerns a group of related professional tasks (Hens & Geomini, 1996). Table 1 presents these six different task areas, together with the main tasks that fall under each task area.
TABLE 1:  
Professional tasks of child care workers summarized in six task areas.

<table>
<thead>
<tr>
<th>Task area</th>
<th>Professional tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Orientation</td>
<td>• To collect information in order to list problems, needs, and possible solutions</td>
</tr>
<tr>
<td>2 Design</td>
<td>• To contribute to analyzing and diagnosing the problems</td>
</tr>
<tr>
<td></td>
<td>• To contribute to preparing individual treatment plans</td>
</tr>
<tr>
<td>3 Intervention</td>
<td>I To equip the clients with knowledge:</td>
</tr>
<tr>
<td></td>
<td>• prevention</td>
</tr>
<tr>
<td></td>
<td>• advice and information</td>
</tr>
<tr>
<td></td>
<td>II To equip the clients with skills:</td>
</tr>
<tr>
<td></td>
<td>• in order to adequately function in their living environment</td>
</tr>
<tr>
<td></td>
<td>• in order to adequately function in social relationships</td>
</tr>
<tr>
<td></td>
<td>• in order to adequately function as an individual person</td>
</tr>
<tr>
<td></td>
<td>III To provide parental support</td>
</tr>
<tr>
<td>4 Evaluation</td>
<td>• To evaluate the care process: to determine if the treatment goals and</td>
</tr>
<tr>
<td></td>
<td>the method are still adequate, and to discuss and provide aftercare</td>
</tr>
<tr>
<td>5 Profession-bound tasks</td>
<td>• To detect problems</td>
</tr>
<tr>
<td></td>
<td>• To increase one's expertise</td>
</tr>
<tr>
<td></td>
<td>• To professionalize the profession of child care worker</td>
</tr>
<tr>
<td></td>
<td>• To consult with external experts</td>
</tr>
<tr>
<td>6 Organization-bound tasks</td>
<td>• To contribute to the policy of the institution</td>
</tr>
<tr>
<td></td>
<td>• To contribute to the management of the institution</td>
</tr>
<tr>
<td></td>
<td>• To function as a member of the treatment team</td>
</tr>
</tbody>
</table>

Note. Adapted from: Hens and Geominii (1996) and slightly modified on the basis of Van den Berg and Radema (1997).

The first four task areas that are mentioned in table 1 (orientation, design, intervention, and evaluation) concern the primary care process of residential treatment. It should be noted that these four professional activities are regarded as phases of a cyclic care process. During the intervention phase, continuous assessment is needed in order to determine whether the treatment goals and method are still adequate. Once adjustments have to be made, the cycle of orientation, design, intervention and evaluation starts all over again.

Another aspect of the professional tasks of residential child care workers regards the complexity and diversity of tasks related to being a substitute or professional parent. Generally, the ultimate purpose of residential treatment is described as raising children to maturity. In this respect, the fundamental task of residential child care workers may be described as the full and adequate fulfillment of parental responsibilities (Kok, 1984, 1995; Klomp & Waaldijk, 1993; Jackson, 1995; Durning, 1995). As a result of an extensive empirical study, these parental responsibilities are operationalized in seven dimensions that represent aspects of the development of children. These are the following dimensions: health,
education, identity, emotional and behavioral development, self-care skills, family and peer relationships, and performance in society (Parker, Ward, Jackson, Aldgate, & Wedge, 1991). Residential child care workers have to take care of the desired outcomes associated with the developmental dimensions for children of different ages. This means that they should meet standards that go beyond what might be expected of an average parent, since the needs of children in residential care are considered as far more complex and demanding than those of children who grow up in their own families (Jackson, 1995).

It is evident that child care workers are professionals whose tasks and responsibilities demand a high level of expertise. Their professional activities are based on a complex interplay between qualities such as instinct, love, choice, skill and status (Durning, 1995). In other words, their profession requires judgement, intuition, creativity, and also knowledge of what works best with what type of child in what kind of situation.

1.4 Theoretical orientation of residential programs

In a residential setting the children experience the therapeutic milieu because they interact with residential staff. The children learn to live together with peers and adults, sharing meals, chores, and leisure time. Furthermore, children should learn coping and problem-solving skills, and also basic living skills such as maintaining personal hygiene and caring for their personal belongings. The therapeutic milieu has to guarantee basic security. First, this means physical safety, promoted through design of a safe physical environment, provision of adequate nutrition and medical services, and careful selection and training of residential staff. Secondly, basic security means psychological safety, promoted by treating the children in a caring, fair, humane, respectful, predictable, and positive way. The therapeutic milieu also has to guarantee the protection of the children's rights and it has to provide as many normal experiences as possible (Lyman & Campbell, 1996).

As already stated, residential child care workers primarily are responsible for the daily treatment in the living group environment. In addition to this, the impact of the theoretical orientation upon which a residential program is based should not be overlooked. Critical features of a therapeutic milieu depend on the theoretical perspective of the residential program and also intervention techniques are selected for theoretical reasons. Four theoretical models determined the characteristics of the methods of treatment used in residential settings (Lyman & Campbell, 1996).

The first treatment model concerns the psychoanalytic or psychodynamic model, mainly postulated by Aichorn and Redl and Wineman, for children with emotional disorders. A basic element is the isolation of the child from the influences of the family during treatment. The treatment environment should be structured in such a way that it allows the child to explore inner personality states and resolve their dynamic conflicts. Generally, the importance of formal analytically based psychotherapy for individual children or a group of children is questionable (Kazdin, 1994).

The second treatment model concerns the behavioral model, among others postulated by Wolpe and by Lazarus, for children with behavioral and emotional disorders. This model
is based upon the principles of learning theory. Maladaptive behaviors are viewed as a main result from past learning experiences and the focus is on overt behavior rather than on covert elements as inner personality states or dynamic conflicts. Many intervention techniques are developed on the basis of the behavioral model, for example positive and negative reinforcement techniques, self-control training, role model identification, and behavior management techniques. A variant of the behavioral model is the so-called psycho-educational model. The focus is on the teaching of more appropriate behaviors and coping skills, but there is an emphasis on community involvement and continued contact between the child and the family.

The third treatment model concerns the medical inpatient model, which has a strong emphasis on medical diagnosis and interventions, for children with chronic mental illness, including mental retardation, autism, thought disorder, and conduct disorder.

The fourth, and more recent, treatment model concerns the peer culture model, among others postulated by Polsky, for children with externalizing and substance abuse disorders. Intervention techniques regard peer support for positive behavioral change and group discussions.

In practice, residential child care settings encompass multiple treatment models in their treatment philosophy.

The Dutch pedagogue Kok played a prominent role in shaping practice in Dutch residential child care settings. With reference to the classical theoretical models, he developed a new treatment vision, explicitly directed at education and upbringing of a child as a therapeutic situation. Basically, he developed a comprehensive orthopedagogical frame of reference (Kok, 1973, 1984, 1995). A central element in Kok’s framework is the child’s implicit or explicit requests for help. A practitioner should not only pay attention to overt symptoms or verbally expressed problems, but, more importantly, he should take notice of covert needs of the child and the meaning of the child’s behavior. This request for help of the individual child serves as the basis for intervention. Care workers have to be able to vary their interventions depending on this request for help. They have to make considerable effort to understand the child’s behavior and needs. In addition, they have to meet the children’s dependency needs and create opportunities for the children to have positive experiences. In order to provide an adequate answer to different requests for help, Kok introduced two main types of care in residential settings.

The first type of care is described as primarily providing structure. This type of care aims at children who show externalizing behaviors as in conduct disorder, attention deficit disorder, and hyperactivity. Structure refers to boundaries that are adequate for healthy development. The most important forms of structure are rules, behavioral limits, and daily routines. Rules and behavioral limits must be few in numbers and need to be stated clearly.

The second type of care is described as primarily providing emotional and affective care. This type of care aims at children who have experienced abuse, neglect, disrupted family relationships, or other trauma. These children have difficulties with developing attachments. The relationship between care worker and child is considered as a critical therapeutic element. The care worker must try to build a relationship based on mutual trust with these children, which is supposed to become the motivation for the children to start behaving more adaptively.
1.5 Residential care process as a black box

Even though significant residential treatment models have been developed over the years, and even though a considerable amount of literature has been devoted to the professional task of residential child care workers, few research findings are available on what exactly is going on between workers and children during residential child care.

By means of observation De Ruyter (1971) described social interactions between child care workers and children in the living units of a residential center. He concluded that during free time a care worker and a child have an average of five interactions per half hour. In 59% the interactions are congruent (intentions of the care worker are in accordance with those of the child), but in case they are discrepant they last longer. Children show more desired behavior than undesired behavior. Most of the time a care worker reacts upon a child when this child makes an appeal or when the child shows undesired behavior. Care workers react upon inconspicuous and pleasant child behavior significantly less.

In a broader context, Van der Ploeg and Scholte (1988) described different types of residential institutions by means of questionnaires, interviews, and analysis of documents. They focused on child characteristics (e.g., demographic data, reason for placement, family characteristics), institutional characteristics (e.g., capacity, number of workers, length of stay, physical environment), and treatment characteristics (e.g., intake procedure, type and amount of care worker activities, daily routine procedures, rules in the living units).

By means of analysis of documents, interviews with care workers, and a process of abstraction Gieles (1992) developed a method that can be used by care workers for managing collisions and conflicts in daily life in a residential setting. This method consists of three prevalent courses of action and a recommendation for preference. The courses of action, in order of preference, are as follows: meeting with the person (thus resolving conflict and maintaining the contact), avoiding the conflict (thus creating distance), and controlling behavior (thus winning conflicts).

Klomp (1992) studied the guidance (treatment as well as training aspects) of youngsters in supervised independent living arrangements for learning how to live in lodgings. On the basis of written reports of counseling sessions, Klomp developed a methodological framework for the guidance in such homes. He derived a taxonomy for the problems of the youngsters and for guidance acts and gathered ‘if-then combinations’. By means of sequential analyses he determined which counseling activities occurred more frequently as a reaction to which specific problem, and called these typical responses.

By means of interviewing trainees and experienced care workers Grubben (1994) listed the daily activities of residential care workers. Results pointed out that care workers mainly function as disciplinarians, contrary to the conceptualization of group care work as the application of treatment methods on the basis of well thought-out treatment goals. Grubben concluded that there is a gap between theory and practice; custodial practice dominates and treatment planning is no more than a formal aim.

Rietdijk (1996) developed a so-called practice-oriented framework for design of treatment in an inpatient setting for child psychiatry. On the basis of analysis of documents and interviews, she distinguished a framework as defined by practitioners and one as used by practitioners. At the same time she distinguished a framework for the treatment setting and one for the treatment process.
Despite the efforts of these investigators, in the research literature it is frequently stated that true understanding of the actual residential care process is limited. One important question still remains unanswered. What exactly is going on in daily treatment between care workers who provide care and children who receive care? What precisely is happening between care workers and children in daily situations in the residential living unit? So far, in the Netherlands residential settings lack a systematic description of the institution as a whole as well as of the different treatment approaches (Van der Ploeg, 1990). Thorough understanding of the professional way in which residential child care workers are acting is lacking (Van Gageldonk & Bartels, 1990; Grubben, 1994). The main gap in our knowledge concerns what goes on between the time a child is received into care and the time this child is discharged (Madge, 1995). Hardly any research is carried out that focuses on the treatment process in the residential living groups (Rietdijk, 1996).

The expression *black box* already is introduced to describe the vagueness of ideas about the care process in residential child care settings. What professionals exactly are doing to help the children in institutions is still a black box (Van der Ploeg, 1990). We know very little about what happens in the black box in between admission and discharge of the children and adolescents (Madge, 1995). Exploration of the residential treatment process itself is necessary to provide greater insight into the critical elements in the black box of residential care (Harinck & Smit, 1995). Empirical researchers should play a major role in opening this black box.

The main reasons for this general lack of description of the residential care process are the following. Residential child care is rather complex and consists of many different elements that are hard to unravel. Appropriate methods for measurement of the care process are scarce and still need further development. Furthermore, this type of research is time consuming and thus expensive and lack of funding is more the rule than the exception. In addition, residential care is subject to rapid changes due to new legislation, policy decisions and cut-backs in expenditure, and by the time research findings are available these might already be out of date.

However, the need for empirical research in order to open the *black box* is strongly felt, both by scientists and practitioners (Hellinckx & Van den Bruel, 1995). Since the interest in the quality and in the effectiveness or outcomes of child care is growing, the interest in understanding of what is happening within the placement is growing too (Veerman & Treffers, 1986). Outcome studies cannot operationalize or reliably describe the events that make up a treatment or care process (Pinsof, 1981). For the purpose of making explicit the ingredients and valuable elements of the residential care process we need process evaluation research.

### 1.6 A need for process evaluation

The actual residential care process is mainly shaped on the basis of thoughts and ideas of scientists and practitioners. As already described, in the Netherlands on a large scale Kok's ideas are brought into practice. This, however, took place without empirical data being
available on a large scale. Foundations of the residential care process lack a solid descriptive base. The ethologist Hinde (1979) already decades ago stated that theory building in any domain that deals with interpersonal relationships must rest on a firm descriptive base. In the field of residential child care such a descriptive base is needed in order to expand the knowledge of the content of the residential care process. In this respect, *process research* is important. Process research or process evaluation concerns research dealing with any aspect of the behavior of the professional and/or clients during the ongoing treatment or care process.

It should not pass unnoticed that process evaluation has to be distinguished from plan evaluation or impact assessment on the one hand and product evaluation on the other hand (Swanborn, in preparation). *Plan evaluation or impact assessment* is carried out in order to design the most effective intervention for a specific problem. The researcher tries to explain what causes the problem and why previous interventions have or have not been successful. On the basis of theories and earlier research findings predictions are made about the way in which a new intervention has to be prepared. In *product or outcome evaluation* the effect of an intervention is assessed, mostly on the basis of a quasi-experimental design.

Process evaluation both has scientific value and clinical value. In the field of psychotherapy research Pinsof (1981) states that process researchers must attend to the actual events that occur in the process of treatment in order to test the growing amount of clinical theory, and to get beyond normative task definitions. Kiesler (1981, in Kiesler 1995) argues that outcome research scientifically gets more adequate when it is demonstrated that the treatment under evaluation actually is carried out the way it is meant to be. The latter task usually is very hard to accomplish and that is exactly why it is important to explicate the treatment process. For this reason, process research of therapist behavior is required.

In the field of research on residential child care it also has been acknowledged that process measures support outcome studies. Process evaluation provides a conceptual framework for outcome studies, since it isolates treatment parameters and it clarifies the nature of the independent variables (Harinck & Smit, 1995). Therefore, it contributes to a better understanding of the connection between child care interventions and outcomes.

However, the value of process evaluation is not restricted to improving the value of outcome studies. Other purposes of process research have been identified. According to Grubben (1994) a clear description of the knowledge and skills required in group care work, as a result of process evaluation, is needed for the education of professionals. Harinck and Hellendoorn (1987) and also Harinck and Smit (1995) argue that process evaluation helps to clarify the treatment content, and therefore enables the staff of residential child care settings to become more aware of the identity of the treatment. Another purpose of process evaluation is to analyze treatment elements to see whether they meet quality standards or not. Finally, results from process evaluation provide insight to what so-called parental actions have to be taken to make it likely that aims for different dimensions of development will be achieved (Knorth & Smit, 1995).

In a recent review of research, policy, and practice of residential child care in the European Union, Harinck and Smit (1995) argue that the term *process evaluation* refers to a broad
concept. Aspects of process evaluation that obliquely contribute to this broad concept are
component analysis, monitoring and evaluation of the underlying processes.

- Component analysis is proposed as a relatively formal, but global, description of the
distinct parts of a residential program, in order to give a convenient overview of the
services available.

- Monitoring is a kind of permanent evaluation that is relevant in order to specify the actual
content of the residential services. Process variables include staff characteristics, child
(client) characteristics, and program activities. Generally, these are limited to tangible and
observable characteristics.

- Evaluation of underlying processes concerns a highly abstract form of evaluation, which
focuses on identification and measurement of scientific theory underlying a program.
Theoretical concepts are clarified and it is studied whether empirical data match the a
priori theoretical structure.

In addition Harinck and Smit (1995) and Swanborn (in preparation) describe some categories
or goals for which process evaluation can be executed. These categories are not proposed as
exclusive categories. In short these are the following.

- Implementation evaluation, in which program performance is compared with a specified
standard, usually the treatment concept, in order to determine whether treatment
performance is sufficiently close to the blueprint. Alternative standards are empirical
reference data, best practice standards, or a prescriptive theoretical model.

- Clarifying practitioners’ concepts, a kind of process evaluation that focuses on clarification
of vague or implicit concepts and mental maps of field workers and decision makers. The
purpose can be to clarify the institutional or treatment goals, or to construct an impact
model by revealing the underlying dynamics of the program. Another purpose can be to
clarify the way practitioners make decisions.

- Formative evaluation, in which opinions of clients and staff about specific treatment
elements are asked, in order to reveal the strengths and weaknesses of program
performance. The purpose is to improve the program.

- Coverage evaluation, in order to determine which parts of the target group of an
intervention are reached. The purpose is to explain why some parts of a target group may
not be reached.

- Program evaluation, in which is studied whether the goals of a program or treatment are
achieved or not. The purpose is to explore whether an intervention works or may not work,
what bottlenecks or side-effects can be determined, and whether goals should be adjusted
during the intervention.

The emphasis in this study is on social interactions between residential care workers and
children. Here the definition of process research as stated by Pinsof (1981) is appropriate:
process research is any research investigation that, totally or in part, contains as its data
some direct or indirect measurement of behavior of the treatment professional or the patient,
or the dyadic interaction between those two during the treatment.

The present study describes interaction patterns and thus focuses on the micro level of
an organization. The micro level means that the focus is on the individual client (child) and or
on small groups of clients, for example living units or the relationship between the
When a process evaluation is conducted with the purpose of describing the residential care process, researchers may collect data by asking participants in this care process about their behavior (by means of questionnaires or interviewing), or the researcher can observe their behavior. In the present study data are collected by means of observation. Observation is an appropriate method when the focus is on describing actual behavior; many questions about actual behavior are most appropriately answered by observational research (Van de Sande, 1986; Martin and Bateson, 1993). Major justification is that systematic observation is extremely useful in order to study complex situations in which many aspects of social behavior play a part. Observation uncovers aspects of behavior that would not otherwise be known (Traudes & Plooij, 1989). Furthermore, observation does not capture the danger of social desirable answers or recollection bias.

An additional reason for choosing systematic observation is the fact that this method has hardly been used in earlier process evaluation studies in the Netherlands.

1.7 Research question of the present study

As argued in this chapter, the residential care process still is a black box and foundations of the residential care process lack a solid empirical base. Consequently, in the field of residential child care a need for process evaluation is felt.

As the living group environment is the primary treatment environment in residential settings, child care workers are the primary treatment staff, and children experience the therapeutic milieu through their interactions with residential staff. Thus, social interactions between care workers and children are explored and described in the present study.

Moreover, two main types of care or living groups are distinguished in residential institutions for upbringing and treatment in the Netherlands: those primarily providing structure versus those primarily providing emotional and affective care. This indicates that residential child care workers shape the therapeutic environment in two different ways. By observing the social interactions between care workers and children, it is studied whether differences can be detected between these two approaches in the residential care process.

The central research question of the present study is:

- What are the social interaction patterns between child care workers and children in a Dutch residential treatment center, both in residential living units where primarily structure is offered and in living units where primarily emotional and affective care is provided?

In order to describe the social interactions between the residential child care workers and the children adequately, systematic observation is chosen as the technique for data collection. Systematic observation will be discussed in the next chapter.