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DOUBLE ACTORSHIP IN COMMUNITY HEALTH WORK FROM THE PERSPECTIVES OF PRESENCE AND EMPOWERMENT

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ABSTRACT

This article is based on a qualitative case study that was carried out in a health community practice of 25 years' standing. In this study 'double actorship' emerged as one of the most important elements in the health-based community approach. The people in this community are regarded as active individuals who are able, to a greater or lesser degree, to improve their health autonomously by engaging in sustainable, confidential and supportive relationships. When we analysed the strategies of the professionals and volunteers we found that they took account of both the limitations and potential of the clients. We conclude that both presence and empowerment are necessary factors in community-based health work. The strengths and the weaknesses of people are taken into consideration and attention is paid to how they can help themselves and each

other. Double actorship occurs when a relationship develops in which worker and client are both subject and actor; a mutual relationship with a place for limitations and potential, for weakness and strength, even in the case of the most vulnerable people.

Keywords

Community-based health work, presence, empowerment, double actorship

INTRODUCTION

In the literature a community-based approach towards health improvement is regarded as a highly promising concept, particularly in socio-economically deprived neighbourhoods. Initiatives to promote community health are organised in primary healthcare, health promotion and social work. Accessibility, inter-sectoral cooperation, the community-based approach, participation, and empowerment are recurrent themes in reviews and evaluations. However, the literature also stresses the need for more clarity about the community approach and its effectiveness. Projects have been criticised for being too short and too systematic (Stronks & Hulshof, 2001; Alting *et al*., 2003; Kok & Ten Dam, 2003; Saan & De Haes, 2005; Mackenbach, 2005; Jacobs, 2005).
In her PhD thesis, *Wijkgezondheidswerk: een studie naar 25 jaar wijkgericht werken aan gezondheid in Den Bosch-Oost* (Community health work: a study of 25 years of community-based health work in Den Bosch Oost', Paes, 2008) Mariet Paes examines the long established practice of community health work in a qualitative case study. This article addresses one specific aspect of this study, *viz*. the 'double actorship' that emerged as a key element of the community-based approach in Den Bosch-Oost (the eastern part of the Dutch city of 's-Hertogenbosch). In 'double actorship' the health worker and the client assume the role of both subject and actor in a mutual relationship. The definitions of relationships that were offered by the interviewees were examined from the perspective of the presence theory and the empowerment theory. The defence of the thesis prompted a discussion about presence and empowerment and led to suggestions that empowerment should be a central concept in the community-based approach and that presence should be seen as a first step in the empowerment process. On another occasion, Baart maintained that empowerment should be embedded in a firm theory of vulnerability (Baart, 2008).
The discussion is continued in this article.
In the literature on community-based health work, presence is an approach that has not been used until now. Presence and empowerment are different orientations, which are important in community-based health work and which also underlie the concept of double actorship.

In this article we concentrate on the double actorship that emerged as an element of the community-based health work in the study of Den Bosch-Oost. We shall begin with an explanation of the research framework of the study and a brief review of the results. We shall then examine double actorship from the perspective of the presence theory and the empowerment theory.

RESEARCH FRAMEWORK

The aim of the study was to gain insight into community-based health work in the long-established healthcare centre in Den Bosch-Oost, not by collecting quantitive data, but by discovering what the centre means to those involved.
Four research questions were formulated for this purpose:

1. Do people working in primary healthcare, health promotion and social work share the same ideas about health, the community, health differences, deprived communities and the community-based approach?
2. Which activities and strategies do the professionals and voluntary workers in the community of Den Bosch-Oost employ in the community-based approach towards the improvement of health? What are the values that underlie their opinions and what motivates them to work in the community? Do they reach the socio-economically deprived groups?
3. What are the results of 25 years of community-based health work in Den Bosch-Oost and how are these to be evaluated?
4. What are the possibilities and limitations of community-based health work, and how do health and the community interrelate?

These questions were addressed in a qualitative case study. The case study is an interpretative research method in which a subject is studied intensively within its context, so that the relationships between relevant factors are preserved (Hutjes & Van Buuren, 1992). The most important research material was acquired through interviews with forty professionals and volunteers who had worked in the community for between 5 and 30 years. They are collectively termed 'the workers'. Additional material was found in the archives of the local authority and community institutions, and in previously published work on aspects of community-based health work in Den Bosch-Oost. The information was collected via explorative (in-depth) interviews (Baart, 1990/2002) and autobiographical research (Nijhof, 2000). The interviews were transcribed and analysed with Atlas-ti, a computer programme for qualitative research. The research line took

the form of exploration, specification, reduction and integration (Peters & Wester, 2000–2001). In the specification and reduction phase, links were sought with 'clustered summary tables' and 'conceptually clustered matrices' (Miles & Huberman, 1994).

The study systematically explored the significance of the central concepts of community, health, and the community-based approach. The meanings that the interviewees ascribed to these concepts were ordered and recorded through text-coding. A literature search was then performed to ascertain the significance of these concepts in the domains of healthcare, health promotion and social work.
The internal validity of the study was guaranteed by a continuous process of self-monitoring (Hutjes & van Buuren, 1992). Discussions with advisors (Jan Willem Duyvendak and Andries Baart) and other researchers about the content of the research, the methodological and ethical questions, and interpretations of the material were recorded, transcribed and considered in the analyses. 'Member checks' were also carried out and the provisional results were discussed in three sessions with the interviewed workers.
The procedures for checking the reliability of the results were specified and systemised by interview transcription, careful documentation of the collected material, the conversion of analyses into summaries and tables and an in-built control of the quotes on which the report is built. The report is made up of crucial passages from the interviews: the narrative tone of the language reflects the importance of the context and the local rationale.
The study offers specific insights into a complex situation. An analysis of an operational practice offers opportunities to discover connections, to trace underlying processes and orientations, and to gain insight into and a clearer understanding of everyday reality. The outcome of such a study offers a point of comparison (Mol, 2006). The results in Den Bosch-Oost may serve as an example for other communities and contribute to the public debate on community-based health work in general and – within the framework of this article – to double actorship in particular.

GENERAL RESULTS OF THE RESEARCH

In 1980 a group of residents and professionals opened *Samen Beter*, a community health centre run for and by residents in Den Bosch-Oost (*Samen Beter* is a play on words meaning Together Better and Better Together). The aim of the initiative was to help the residents to improve their health themselves. Den Bosch-Oost has a population of approximately 10,000 and is sometimes classified as a deprived area, depending on the indicators used. The health centre staff consists of general practitioners and their assistants, physiotherapists, speech therapists, nurses, social workers and a midwife. There is also a mother and child clinic and an adjacent pharmacy. Volunteers

at the health centre work as hosts or hostesses. These people welcome visitors to the centre, provide information about community activities and ensure a pleasant atmosphere in the waiting-room. They are very knowledgeable about the neighbourhood since they are involved in other community activities as well. They form a bridge between the health centre and the residents.
In the early years the health centre worked closely with welfare organisations and co-developed numerous community initiatives with the local residents. In the 1990s welfare work was reduced to a minimum, but the majority of community activities continued, largely kept alive by volunteers who felt a sense of commitment to the community. Together, the volunteers and professionals form a network in the community, known as Hulpsector Oost (Help Sector East). Over the years this network has grown: new activities have been added and more institutions have joined. (See Figure 1 community network 'Hulpsector Oost in 2002'; Paes, 2008, p. 128.)
The working methods in Hulpsector Oost are developed within a continuous learning process. Over the years, the everyday practice at the centre has been studied from the perspective of bottom-up and self-management theories (Freire, 1996; Ulburghs, 2004), emancipatory assistance (Rubin, 1976; Chodorow, 1978; Irigaray, 1981; Roelofs and Straver, 1986), empowerment (Kieffer, 1984; Steenbrink, 1992; Jacobs, 2001), community-based health work (Stuurop, 1990; Kal, 2001; Joseph, 2002), the health-based community approach (Crawford, 1984; Cosijn, 1992; Saan & De Haes, 2005; Hoeijmakers, 2005), coherent care (Barten & Van der Gulden, 2002; Schrijvers *et al*., 2002; Plochg, 2006), and social capital theories (Putnam, 1993, 2004; Portes, 1998; Swann & Morgan, 2003). None of these were applied as ready-made methods or blueprints, but rather as ideas that could be reflected upon from the perspective of individual hands-on experience.
This shared process of reflection that has taken place over many years has been instrumental in the formation of a close community network and in the development of a powerful underlying vision of community-based health work.

It emerged from the interview analyses that the workers in Den Bosch-Oost define health in the broadest terms (see Table 1). Indeed, their definitions are reminiscent of that of the World Health Organization 'Health is more than the absence of illness and is a position of physical, psychological and social well-being.' (WHO, 1981). Volunteers and professionals who have worked in the community for a considerable length of time place great emphasis on social health. Notably, immigrant volunteers and those who were involved in the founding of the health centre explicitly mentioned access to health facilities in their definitions.
Community-based health work in Den Bosch-Oost is characterised by the integration of the medical approach, the lifestyle approach, and the social environment approach. In other words,

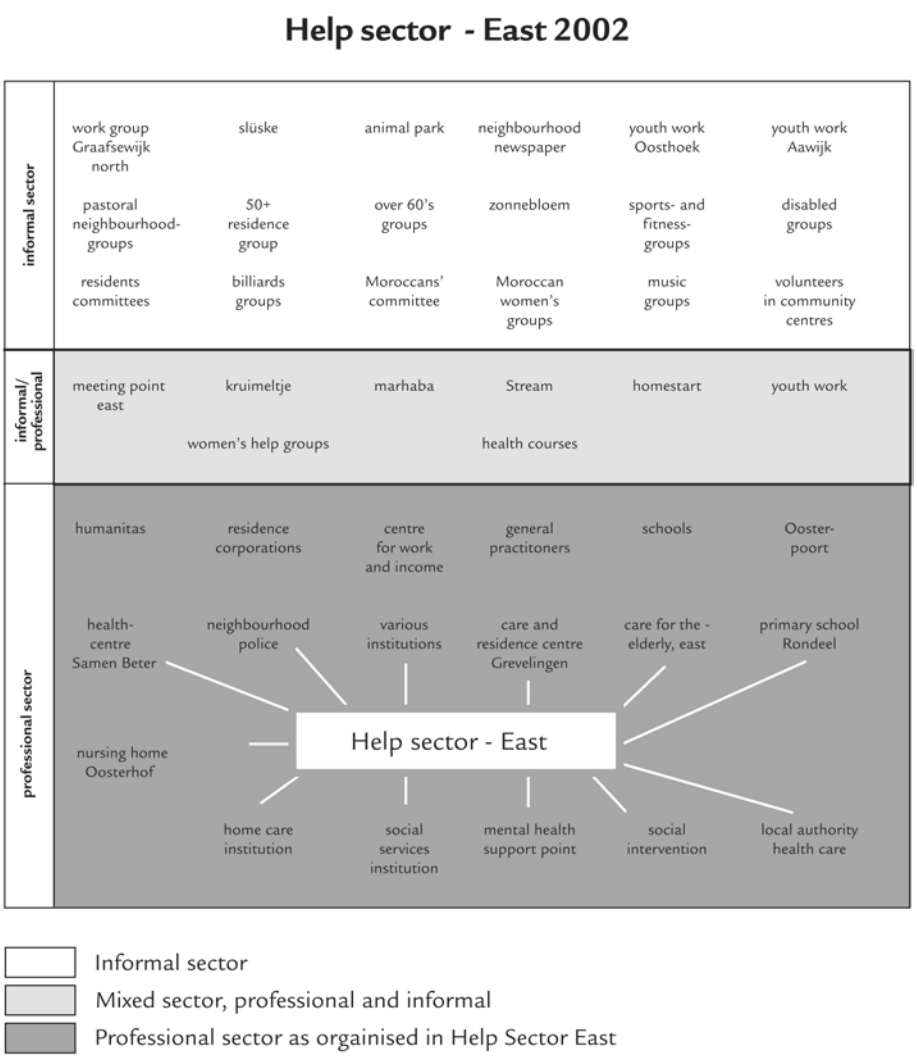

Figure 1: Community network `Hulpsector Oost' in 2002 (Paes, 2008, p. 128).

Table 1: Definitions of health (Paes, 2008; p. 185).

Physical health	Psychological health	Social health	Facilities
Healthy body Healthy lifestyle	Healthy balance (can cope with limitations and problems) Well and healthy (well-being, happiness, love, contentment)	Healthy relationships Healthy social position Healthy activity Healthy socio-economic position	Good health facilities in the community

attention is paid to the damaged, sick part of people and the medical care they need and also to mutual support and the client's strength and potential to improve his own health.
The health centre makes use of the expert knowledge and practical experience of professionals and volunteers. It fits in with the everyday life of residents and builds sustainable links of mutual trust between professionals and residents. The professionals and the volunteers say that their working strategies are connected to their underlying values. 'Double actorship', one of the characteristics that emerged in the study, is discussed below.

DOUBLE ACTORSHIP

Health is usually approached from a medical, lifestyle or social environment perspective. In the literature the medical approach is criticised mainly for its focus on the illness, on the complaint rather than the whole person; the patient is regarded as an object. The main criticism levelled at the lifestyle approach is that the message of healthy living is imposed from the top-down and does not reflect the experience of the people for whom it is intended. The departure point of the social environment approach, on the other hand, is the person, seen as a whole, in relation to his or her environment. The social environment approach has been only marginally developed in the health sector (Kickbusch, 2001; Baum, 2002; Saan & de Haes, 2005).
We examined the empirical data from the study to ascertain differences between the workers' strategies. The workers were divided into professionals and volunteers, and were then subdivided according to the sort of work they do: medical, medico-social or social. In all categories differences were observed in the degree of attention paid to the limitations or potential of the client. There was no evidence of the object approach, not even among those who placed greater emphasis on the limitations. The words 'adapt', 'listen', 'follow', 'understand' and 'closeness' recurred frequently in the descriptions of the working methods. These are terms that express how the workers make contact and build relationships with the clients. Kaja, a social worker, explained how she contributed to the process: "And I say each time, but what is in your heart […] you must find

out what you yourself want. That way, bit by bit, you can give her back her self-respect. No, not give, but discover" (Paes, 2008; p. 223). In the relationship that Kaja describes, the client is not an object, but is just as much an actor as Kaja. The traumatised clients are also actors. This is what Deria, a Somali refugee, said:

"In the beginning there were problems and misunderstandings because of the different sorts of organisations in the Netherlands. […] We discussed the problems with the doctors. […] Later, when we worked with other foreigners in a volunteers' group – the immigrant group – we helped to sort out the misunderstandings by holding discussions between doctors and foreign patients, Somalis, Moroccans, Turks, all sorts of nationalities. […] We translated and we told the doctors the impact their behaviour had on us […] how it made us feel. […] *Samen Beter* was the only centre where people could speak freely, where they could talk about their problems and where they felt understood. What the pain is like and what has caused it. The most important thing is trust. Can you give the patients a feeling of trust? Our problem is that in the war you can trust nobody – no doctor, no policeman, no army. So for us the most important thing is trust. The second point is that you have seen so much – people killed, children who witnessed it. These people can no longer sleep at night; and it is all caused by the war. You have to move from one place to the next. Traumas caused by the war. That is where the pain comes from – the hunger, the pain, the prisons. Everything that you experienced in the war – that causes the pain, and the doctor must understand that" (Paes, 2008, p. 222–223).

What Kaja and Deria are describing are mutual relationships in which all those involved work to improve health. These situations are characterised by double actorship: the client is seen as a whole person, an actor in the relationship.

ACTOR AT COMMUNITY LEVEL

The diverse personal histories of the volunteers indicate that they became active after experiencing illness. This applies not only to activity in relation to themselves or their immediate environment, but also to activity concerning other residents. For instance, after many years of illness, Clarisse has become a hostess in a women's project.

"Clarisse is 60 and has two children, both with a higher education. Clarisse comes from Portugal and has lived in the Netherlands for 26 years. She speaks reasonably good Dutch. When she first came to the Netherlands her children were very small. She followed her husband, who was already there. Not long after her arrival she went through a divorce and had a rough time. She found a job in a laundry, but had to give it up due to numerous health complaints. She cannot

return to Portugal because she would lose her social security benefit and because her children have made their home in the Netherlands. There is nothing for her in Portugal. Clarisse has had numerous health problems; she has had a hysterectomy and is classed as partially disabled due to allergies and pains in her back, shoulders, pelvis and hips. She is, in fact, depressive, but she refused to accept that. For a long time she argued against doctors and specialists who said that her complaints were psychosomatic. Only later did she accept that one could be 'psychologically ill' without being 'mad'. Her story is a string of battles with welfare organisations and doctors' diagnoses. The general practitioner at the *Samen Beter* health centre referred her to social services and a psychiatrist, and then to *De Stroom,* a women's support project in Den Bosch-Oost. Clarisse is dependent on *De Stroom* and the women she has met there for social contact. She was taught to cycle at *De Stroom* and can now move around more freely. She is very dependent on the helpers and stresses the importance of the contact with her general practitioner. After a time she became a volunteer at *De Stroom*. She sees her work there principally as a means of coming into contact with others" (Paes, 2008, p. 200–201).

Clarisse has become a volunteer in a community initiative and welcomes other women to the support project. That way, she takes a step towards making new contacts and she can mean something for other women in the community. In the interviews the volunteers placed the emphasis on actually doing things together in community-based health work, instead of just talking and discussing.

Now for a few more examples: Dorus has a disability pension. At the community centre he teaches carpentry to people with a handicap. Deria is a political refugee who interprets for his countrymen and women at the health centre; Jeanne and Theresa have joined women's rights groups in the community and want to use their new insights and skills to help others. They organise activities with and for psychiatric patients who live in the community and they accompany them on holiday. They describe the activities and the positive influence they have on their own health and that of other residents. They also describe how professionals either do or do not support them in these activities. These practical community activities mean that efforts to improve health can continue outside the surgery walls. After all, health can be improved by other means, besides contact with professionals. Some professionals encourage this by forming a bridge between their individual contacts and the community. Take, for example, the physiotherapist who takes his patients to the gym; or the social worker who organises parties and theme sessions with female residents. In community-based work the workers come into contact with another side of the residents. Those who have been damaged and traumatised can experience healthcare and learn to become active by drawing on their own potential. They can show their strength and potential in the community,

the group, relationships and activities, but they need support to do so. The community reveals what the professionals do and what residents (can) do for themselves. Shared responsibilities and mutual relationships are visible. That way, both the professionals and the volunteers can make clear *"what they want to be for the residents, what expectations of residents can be met and what we are working on"* (Baart, 2001, p. 765).
Reciprocal care is evident in the community; it highlights what people can mean to each other. Some residents follow a path of personal development. Clarisse, Dorus, Deria, Jeanne and Theresa have all developed personally through engaging in activities in the community and have enriched the community in the process.

A CLOSER LOOK AT DOUBLE ACTORSHIP

It appears therefore that residents – even vulnerable residents – can develop personally within sustainable relationships based on trust. This does not, however, apply in every case. And the rate of progress can vary; it may take years for someone to take the first step. The study *Wijkgezondheidswerk* looks at actorship in and for the community and the accompanying personal growth from the concept of empowerment, which was introduced to Den Bosch-Oost in 1992 by Steenbrink (Steenbrink, 1992) and has played a role in the development of knowledge in the community. Steenbrink defines empowerment as a process through which an individual sheds a life of powerlessness. Empowerment is a learning process, which aims to increase and strengthen the individual in order to restore his sense of self-determination in everyday life. The individual undergoes a long process in which he leaves powerlessness behind and develops a new self-image. Following on from Kieffer, Steenbrink identifies four phases: 1) 'era of entry': the process begins with personal and painful experiences; 2) 'era of advancement': progress through recognition of and support for people in the same position in order to acquire new insights and competencies; 3) 'era of incorporation': the fruition of the new self-image, the assimilation of the new insights and competencies; 4) 'era of commitment': applying the new insights and competencies in a social context (Kieffer, 1984).
As a rule, the learning process begins with a profound, often painful, experience in the life of the person concerned, such as a serious illness, or the loss of a partner or job. Such experiences are often shared with a doctor, social worker or confidant. Vulnerable people need to have such people close by and to feel they can trust them. The learning process does not start with cognitive realisation or intellectual analysis but with a deeply emotional confrontation. There is not always a single clear emotional experience: many cases are characterised by an accumulation of factors. The art is to discover from their stories why people feel trapped and where potential competencies are to

be found. In group evaluations the learning process invariably begins at the moment when people begin to speak spontaneously about diverse subjects – subjects that are not always planned, but which touch them deeply, and about which they can share experiences and emotions. Phases can be discerned, but they do not always follow each other linearly. One person may need the safety of the group or the stories of others in order to be able to, or dare to, discover the source of his or her own pain. Sometimes, people become active on the basis of experiences and discover their capabilities in the activity. They take on jobs, organise things, do voluntary work… The qualities that they discover in themselves help them to form a new self-image and give them insight into the connection between their own situation and the social context (Paes, 2003 and 2008).

When describing their working methods various workers in Den Bosch-Oost explicitly pointed out that what matters most is to make contact with the people standing on the sideline, and not only the people who are willing to take the steps towards empowerment. The way in which contact is established and the mutual relationship of trust that emerged in the analysis were further explored via the theories of Baart and Van Heijst (Baart, 2001; Van Heijst, 2005). The presence theory of Baart explains how the 'socially superfluous' will begin to talk in long and unhurried contact with the parish priest. The parish priest shares in the life of the parishioners. He is concerned for the restoration and preservation of human dignity and offers or sets in motion the sources of support to achieve it. For him, it is all about being there and staying there, not intervention (Baart, 2001). The workers in Den Bosch-Oost build long-lasting relationships to provide care and improve health via action. The relationships are not a goal in itself.
Van Heijst studies care-related actions in her book about 'professional loving care'. She describes an intervention as a 'movement of approach, treatment and departure'. After the intervention the person is left to cope; ultimately, he or she remains alone. She calls an intervention 'professional loving' if it not only consists of relieving, helping and healing, but also takes account of what cannot be helped and what the professional can mean to the other person under the circumstances. Van Heijst claims that presence offers an opportunity to understand what 'actorship' means in an unequal relationship, to see the whole person behind the limitations, a person who is unique and who, to some extent, steers the help, thus making it impossible to determine the form of the care or treatment in advance. If the person remains a subject, remains an actor, with the space to become involved, then this, says Van Heijst, is a true relationship (Van Heijst, 2005).
Baart says that relationships are the key to effective and caring support for vulnerable people. The relationship is an instrument, a vector for effective help. At the same time, it is a goal in itself. People know that they are noticed and valued in a relationship and that they have a place in society. The action they need to take crystallises gradually from the relationship and is not decided

or imposed from without. In the relationship even the most vulnerable person appears as a subject and actor. According to Baart, it is all about keeping together both sides of the relationship: the vulnerability and the actorship (Baart, 2001; 2007; 2008).
The relationships of the workers in Den Bosch-Oost fall into the category of professional loving relationships that go the extra mile: residents or patients are helped to step outside the relationship, and to show themselves (in the community) as subjects who can mean something to others. The analyses of *Wijkgezondheidswerk* revealed that residents come to speak with the workers and are willing to take small steps, sometimes after years, to improve their health and to utilise opportunities for self-development through community activities.

DISCUSSION ON PRESENCE AND EMPOWERMENT

During the defence of the *Wijkgezondheidswerk* thesis one of the questioners suggested that presence is a preliminary phase in an empowerment process. This comment touched on the discussion on how vulnerable people can achieve self-development and self-sufficiency. Is empowerment a suitable concept for this? How does empowerment relate to presence when the health of vulnerable groups is involved? The debate on empowerment is summarised below.
In recent years, empowerment has found wide acceptance with the emphasis on a range of elements: the individual in a help relationship (Jacobs, 2001), the interpersonal and the development of a 'voice' as a group and the broader social, political context and citizenship (Saan & de Haes, 2005). The 'Empowerment Quality Instrument' (Visser *et al.*, 2007), developed in 2007, attempts to incorporate the entire concept of empowerment in a model for health promotion, which can be applied in projects aimed at developing empowerment. In a study involving eight health promotion and prevention practices Jacobs (Jacobs, 2005) says that the role of the professionals in empowerment is in need of further exploration and development. It is not about a project that aims to get across a message about health, but about creating a bond with citizens on the basis of dialogue.
Baart points out the dangers of empowerment (Baart, 2008). If too much emphasis is placed on independence and self-sufficiency as the aims of empowerment, there is a risk that vulnerable people may feel that too much is being asked of them. They will then become isolated, feel hurt and lose their sense of dignity. Baart maintains that it is important to help vulnerable people to regain their strength by increasing their resilience and not by replacing vulnerability with power. Vulnerability and vulnerable people tend to evoke an ambivalent response from us. Vulnerability is always a sign of something that we value: everything we see as vulnerable, fragile, is always

worth the trouble. If we encounter vulnerability we should not try to erase it but rather see it as something of value. Empowerment is only worth fighting for if it is embedded in a strong theory of vulnerability.

Duyvendak sees empowerment as a far broader concept than the Dutch term of *zelfbeschikking* (self-determination) or *zelfredzaamheid* (self-sufficiency). Empowerment means that, on the one hand, power rests with the person himself, but on the other, that he needs help to acquire it. Duyvendak argues that, for many years, policy was dominated by a radical-liberal interpretation of autonomy, which said that one should be as free as possible from social commitment. He stresses that it is precisely through social commitment that people become strong (Duyvendak, 1997). Van Regenmortel points out that, in healthcare, empowerment means commitment and the least intrusive and closest form of care. She values cooperation between professionals and volunteers, and encounters between people in the same sort of situation. She further maintains that empowerment is a multi-layered concept in which the individual well-being of persons and groups is intrinsically linked with the broader social and political context. It is about autonomy within commitment; it is not a fight for independence. The social environment has an important responsibility in building up the resilience of vulnerable people (Van Regenmortel, 2008).

What can we say about presence and empowerment in the study of community-based health work in Den Bosch-Oost?

Empowerment is never brought in or used as an instrument in Den Bosch-Oost, but to understand, clarify and support the processes that people undergo. These are long-term processes at individual and community level. Empowerment should not be seen as a model with goals and instruments as this would ignore the need for relationships of trust with people – including vulnerable people – and the organic development of the community. The experience in Den Bosch-Oost clearly shows that people can – do not have to – develop in sustainable relationships of trust. These relationships give them the support they need to take steps, large or small, in their own process of empowerment. They gain support from each other, fellow sufferers and other residents and they can develop through community activities. The workers in Den Bosch-Oost do not accord central place to the relationship, as in the case of the presence theory, but engage in long-term relationships based on double actorship and health improvement.

CONCLUSION

At the start of the 1980s the *Samen Beter* team responded to the one-sided medical approach that focused on the complaint, the problem, saying that it demeans people and obscures their potential

to work on improving their health themselves. The community-based approach attempts to deal with healthcare in an alternative way, and not to treat only the illness. In recent years the emphasis placed on self-sufficiency and empowerment has led to an unequal tension between the sick, damaged part of a person and their strength and potential. The current over-emphasis on potential is steering people towards a situation in which they must be able to do everything themselves. We learn from the presence theory that the process of empowerment can grow gradually from relationships of trust and that we cannot make it a goal in itself. We learn from empowerment that it takes many steps to recover self-confidence. This can be worked on together; contact with people in the same situation plays an important role in this process, as does learning and practising in a familiar environment as a preliminary to engaging in activities. Presence and empowerment are both necessary orientations in community health work. They pay attention both to the traumatised and the strong side of people, to what they can do themselves and what they can mean to each other. Double actorship is the development of a mutual relationship in which both the worker and the client are subject and actor, a mutual relationship in which there is a place for limitations and potential, for weakness and strength, even for vulnerable people.

REFERENCES

Alting, D.E.M., Bouwens J. & Keijsers J.E.F.E.M. (2003). *Review: Community Interventions*. Woerden: NIGZ.

Baart, A. (2001). *Een theorie van presentie (2e herz. druk)* [A theory of presence (2nd rev. ed.)]. Utrecht: Lemma.

Baart, A. (2007). *Kwetsbaar, maar niet alleen kwetsbaar* [Vulnerable, but not only vulnerable]. Utrecht: Actioma.

Baart, A. (2008). *Over kwetsbaarheid en empowerment vanuit presentie belicht* [Vulnerability and empowerment from the perspective of presence]. Inleiding op het congres 'Wijkgezondheidswerk' te 's-Hertogenbosch: PRVMZ.

Barten, F. & Gulden J. van der (2002). *Health and Sustainable Development. Visions on Health and Sustainable Development*. Nijmegen: SSN.

Baum, F. (2002). *The New Public Health*. 2nd edition. Melbourne: Oxford University Press.

Chodorow, N. (1978). *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*. Berkely/Los Angeles/London: University of California Press.

Cosijn, J. (1992). *Het gezonde steden project. Achtergronden en praktijk* [Healthy cities project: contexts and practice]. Assen/Maastricht: Van Gorcum.

Crawford, R. (1984). A Cultural Account of "Health": control, release and the social body. In J.B. McKinlay (Ed.). *Issues in the Political Economy of Health Care* (pp. 60–103). New York and London: Tavistock Publishing.

Duyvendak, J.W. (1997). Opbouwwerk zorgt voor cement [Community organisation makes cement]. *VWS-bulletin (6).*

Freire, P. (1996). *Pedagogy of the Oppressed* (2nd rev. ed.). United Kingdom: Penguin Books Ltd.

Heijst, A. van (2005). *Menslievende zorg. Een ethische kijk op professionaliteit* [Professional loving care: an ethical look at professionalism]. Kampen: Klement.

Heijst, A. van (2008). *Iemand zien staan. Zorgethiek over erkenning* [To see somebody standing: care ethics concerning recognition]. Kampen: Klement.

Hoeijmakers, M. (2005). *Local Health Policy Development Processes. Health promotion on local health policymaking in the Netherlands*. Maastricht: CAPHRI.

Hutjes, J.M. & Buuren, J.A. van (1992). *De casestudy. Strategie van Kwalitatief onderzoek* [The Case Study: strategy of qualitative research]. Meppel/Amsterdam/Heerlen: Boom.

Irigaray, L. (1981). *Dit geslacht dat niet (één) is* [This line which is not (one)] Amsterdam: Hölderlin.

Jacobs, G. (2001). *De paradox van kracht en kwetsbaarheid. Empowerment in feministische hulpverlening en humanistisch raadswerk* [The paradox of power and vulnerability: empowerment in feminist support and humanist council work]. Amsterdam: SWP.

Joseph, M. (2002). *Against the Romance of Community.* Minneapolis: University of Minnesota Press.

Kal, D. (2001). *Kwartier maken. Werken aan ruimte voor mensen met een psychiatrische achtergrond* ['Kwartier maken': Working on space for people with a psychiatric background]. Amsterdam: Boom.

Kieffer, C. (1984). Citizen empowerment: a developmental perspective. *Prevention in human services,* 1983–1984 Winter-Spring, 3(2–3), 9–36.

Kikbusch, I.S. (2001). *Health literacy addressing the health and education divide. Health Promotion International*. Oxford: Oxford University Press.

Kok, H. & Dam, J. ten (2003). *Evaluatie Gelijke gezondheid Gelijke Kansen* [Evaluation of Equal Health Equal Chances]. Woerden: NIGZ.

Mackenbach, J.P. (2005). *Health Inequalities: Europe in profile. UK Presidency of the EU.* Retrieved from www.dh.gov.uk/publications

Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analyses: an expanded sourcebook* (2nd ed.). London: Sage.

Mol, A. (2006). *De logica van het zorgen. Actieve patiënten en de grenzen van het kiezen* [The logic of care. Active patients and the limits of choice]. Amsterdam: Van Gennep.

Nijhof, G. (2000). *Levensverhalen. Over de methode van autobiografisch onderzoek in de sociologie* [Life stories. About autobiographical research in sociology]. Amsterdam: Boom.

Paes, M. (2003). *Kleine stappen met een grote betekenis. Gezondheidsparticipatie voor kwetsbare groepen* [Small steps with a big meaning: health participation for vulnerable groups]. Zwolle: LCO.

Paes, M. (2008). *Wijkgezondheidswerk. Een studie naar 25 jaar wijkgericht werken aan gezondheid in Den Bosch-Oost* [Community-based health work: a study of 25 years of community-based health work in Den Bosch-Oost). 's-Hertogenbosch: PRVMZ.

Peters, V. & Wester, F. (2000–2001). *Kwalitatieve Analyse en Kwalitan* [Qualitative analysis and Kwalitan]. Nijmegen: Katholieke Universiteit Nijmegen.

Portes, A. (1998). Social capital: Its Origins and Applications in Modern Sociology. *Annual Reviews Sociology, 24*, 1–24.

Putnam, R.D. (1993). *Making Democracy Work: civic traditions in modern Italy*. Princeton: New Jersey.

Putnam, R.D. (2000). *Bowling Alone: the collapse and revival of American community*. New York: Simon & Schuster.

Putnam, R.D. & Feldstein, L.M. (2004). *Better Together.* New York: Simon & Schuster.

Roelofs, I. & Straver, B. (1986). *Klassewerk – Klassenverschillen overbruggen via training* [Classwork – class differences bridged by training]. 's-Hertogenbosch: Stichting Klassewerk.

Rubin, L.B. (1976). *Worlds of Pain*. New York: Basic Books.

Saan, H. & Haes, W. de (2005). *Gezond effect bevorderen; het organiseren van effectieve gezondheidsbevordering* [Organising effective health promotion]. Woerden: NIGZ.

Schrijvers, A.J.P., Rooij, E. van, Kodner, L.D. & Rijsemus, T. (Eds). (2002). *Health and Health Care in the Netherlands: a critical self-assessment of Dutch experts in medical and health sciences (*2nd rev. ed.). Maarssen: Elsevier gezondheidszorg.

Steenbrink, A. (1992). *Gezondheid in eigen hand. Wijkgericht gezondheidswerk in Den Bosch-Oost* [Health in your own hand: community health work in Den Bosch-Oost]. Utrecht: NIZW.

Stronks, K. & Hulshof, J. (Eds.). (2001). *De kloof verkleinen* [*Closing* the gap]. Assen: Van Gorcum.

Stuurop, K. (1990). *Netwerkontwikkeling en volksgezondheid. Komen er gezonde wijken?* [Network development and public health: will there be healthy neighbourhoods?]. Sittard: WOZON.

Swann, C. & Morgan, A. (Eds.). (2003). *Social Capital for Health: insights from qualitative research.* London: Health Development Actorship.

The, A-M. (1999). *Palliatieve behandeling en communicatie. Een onderzoek naar het optimisme op herstel van longkankerpatiënten* [Palliative treatment and communication: a study on optimism about the recovery of lung cancer patients]. Houten: Bohn Stafleu Van Loghum.

Ulburghs, J. (2004). *Culturen zonder muren. Een overzicht van het Limburgse Integratieproces in negentig gesprekken* [Cultures without walls: an overview of the integration process in Limburg in ninety conversations]. Hasselt: Concentra Media.

Van Regenmortel, T. (2008). *Zwanger van empowerment. Een uitdagend kader voor sociale inclusie en moderne zorg* [Pregnant with empowerment: a provocative framework for social inclusion and modern care]. Eindhoven: Fontys Hogeschool, Sociale Studies.

Visser, F., Molleman, G., Peters, L., Jacobs, G. & Rozing, M. (2007). Empowerment Kwaliteit Instrument [Empowerment quality instrument]. Woerden: Universiteit voor Humanistiek, ZonMW, NIGZ.

World Health Organization (1981). *Global Strategy for Health for All by the Year 2000*. Geneva: WHO.