Relational Social Work

The CARe model. The relationship as the heart of good care

Jean Pierre Wilken
Utrecht University of Applied Sciences, Netherlands

CORRESPONDENCE:
Jean Pierre Wilken
e-mail: jean-pierre.wilken@hu.nl

Abstract

This article describes the main features of the CARe model. This model is developed over the past 35 years and is used in social work and care practices around Europe. The core of the approach is a compassionate personal-professional relationship between service providers, service users and the wider social network. This relational connection is the basis for understanding needs concerning Quality of Life and, based on this understanding, providing adequate support regarding vulnerability and empowerment. The methodical framework of the CARe model is connected to these four so-called core acts: connecting, understanding, ensuring and strengthening. The CARe model enables professionals to support people in their personal recovery process.

Keywords

Relationship-based care, strengths-based social work, recovery, quality of life.

The CARe model is one of the most widely used approaches in Dutch and Belgian social work practices, especially in mental health care and homeless care. In addition, the model is used in a dozen other countries in Eastern Europe and Central Asia.[1] This approach is based on the principles of ethics of care, recovery and empowerment. The central focus is on the personal relationship as a foundation for working on well-being and participation. We consider social work as a form of good care, defining this as «care that is experienced as beneficial and helpful» (Wilken, 2010, p. 16). In other words, the efforts of a social worker need to be experienced by the recipient as supportive in a social — and by extension, relational — sense and helpful in a practical sense.

[1] This is part of The CARe Network, which is a network of professionals, service users, peer workers, service organisations and universities promoting recovery-based mental health care and social inclusion in Europe and Central Asia. See: https://www.thecare-network.com/

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In this article we will be setting out the most important characteristics of this approach. We will start by briefly sketching the genesis of the CARe model, after which we discuss the core elements and the methodical framework.

History

Development on the CARe model started in the 1980s in the Netherlands, drawing inspiration from psychosocial rehabilitation approaches followed in the UK, the US and Italy.[2] In the wake of anti-psychiatry and democratic psychiatry, psychosocial rehabilitation came to the fore as a global movement that focused on the humanisation of care. Its point of departure was the collaboration — on the basis of equality between service users, people from their social network and care providers, with the aim of providing service users with personalised support that enables them to achieve objectives that they have set themselves and to fully participate in their society. The first Dutch-language book about the CARe model (Wilken, Kaiser, & Den Hollander, 1994) was published in 1994, followed by a number of other publications (Wilken & Den Hollander, 1999; Den Hollander & Wilken, 2011; Wilken & Den Hollander, 2012; Wilken & Den Hollander, 2019; Den Hollander & Wilken, 2020). The first international publication, *Rehabilitation and Recovery. A comprehensive approach* (Wilken & Den Hollander, 2005), dates from 2005. Ten years later, a new book about the methodology was published under the title *Supporting recovery and Inclusion. Working with the CARe Model* (Den Hollander & Wilken, 2015). These titles have been translated into several other languages such as Danish, Estonian, Czech, and Russian.

Although the CARe model was originally developed to support people contending with long-term psychiatric vulnerability, over the years many different applications have been developed for use in other domains — for example youth work, elderly care, and support provided to people with intellectual disabilities and refugees. The CARe model is also increasingly being used by peer support workers in mental health services, addiction care and care for the homeless.

Principles

The CARe model revolves around efforts to improve quality of life, embedded in a collaborative relationship in which both parties are on an equal footing. In this approach, the personal relationship forms the foundation and framework for giving further shape to the provided aid and services. The intrinsic value of this relationship is highlighted in a

[2] Originally, CARe is an acronym for Comprehensive Approach of Rehabilitation. Nowadays we simply use the name CARe-model.

wide range of studies focussing on recovery and quality of care (Baart, 2002; Wilken, 2010; Leamy, Bird, Le Boutillier, & Williams, 2011). The CARe model concentrates on improving the quality of life of people with a psychological and social vulnerability, in which the main focus is on quality of life as experienced by the individuals themselves. In this context, we prefer to speak of *people in vulnerable positions*, since vulnerability is always the sum of individual factors and environmental factors. These efforts are methodically developed in terms of form and substance via four core activities: *connecting*, *understanding*, *ensuring,* and *strengthening*. The first letters form together the acronym CUES: keys to good practice. The methodical elaboration of the model helps professional care givers and peer support workers to support service users in achieving the quality of life they desire. In addition, the CARe model also pays attention to the environment and society at large. This concerns contextual factors like the quality of the service user's social networks and participation opportunities.

The CARe model represents an integrated approach, with a strong, comprehensive focus on the whole individual, including his or her social environment and network. Since a wide range of life domains are interconnected, it may be necessary to provide support in more than one area. The term «integrated» also reflects the attention we strive to pay to all sorts of social factors that affect an individual's quality of life — such as safety, stigmatisation, human rights, legislation and regulations and employment. By social environments (or life domains) we mean those locations where the service user lives, works, learns or spends his free time (or wishes to participate). This could be the individual's neighbourhood or village, a company or a petting zoo, for example. Learning would relate to locations like a school or education centre. Leisure time can be spent at a volleyball club, for instance, or a chess club. This also includes the various social networks that the service user belongs to (or wants to belong to). These are sometimes associated with one of the aforementioned places, but some of these also exist independently — the individual's own family, for example, or a network on a social media platform. We pay attention to every area that may be important to the service user. Sometimes, one area will take a bit more precedence; sometimes, another. But there is always a connection between what someone wants, his or her personal abilities and limitations and the quality of his or her environment.

Elements of quality of life and recovery

A wide range of research shows that various elements are important to an individual's quality of life and the recovery of this quality (Slade, 2009; Leamy, Bird, Le Boutillier, & Williams, 2011; Wilken, 2010; Wilken, 2019). We can summarise these aspects in ten single or twin notions. The core elements in question are:

– Compassion and attention;

- Hope and trust;
- Personal story and own identity;
- Qualities and talent development;
- Handling vulnerability, stigma and self-stigma;
- Autonomy and self-sustainability;
- Positive relationships and sense of belonging;
- Meaningful activities and social roles;
- Beneficial environments;
- Material resources.

Each of these elements is equally important but which significance they have for the service user differs from one individual and situation to the next. A number of these concepts concern relational elements like compassion, attention and trust. A share of them relate to personal development, e.g. identity, autonomy and handling vulnerability. They can also concern the quality of the individual's resources, such as a decent housing situation or income security. In the methodical implementation of the CARe model, these elements are elaborated based on the service user's specific wishes and needs and subsequently translated into concrete objectives, plans and activities.

Core acts

Actions based on the CARe model can be summarised with the aid of four verbs: *connecting, understanding, ensuring, and strengthening*. We also refer to these notions as «core acts». These four core acts are used to develop good care in terms of both shape and substance. As previously explained, by good care we mean all forms of aid and services that are experienced as beneficial and helpful by a service user. «Beneficial» means that the provided support «feels right» to the service user. This can concern both the individual's relationship with the professional, and how the professional gives shape to the provided support. It can also relate to a pleasant and comforting environment, a place where you feel at easy (a «beneficial» environment). Helpful means that in the service user's experience, he or she personally gains from the efforts of the professional or the environment. Suffering is alleviated, for example, or the service user gains new perspectives, or becomes more self-confident.

Substantiation

The general scientific foundation for these core activities is formed by insights from studies into recovery stories (among others, Wilken, 2010). In the context of *connecting* and *understanding*, these insights are complemented by knowledge regarding rela-

tional care as elaborated in ethics of care (among others, Held, 2006; Leget, Gastmans, & Verkerk, 2011; Van Heijst, 2011) and the associated presence approach (Baart, 2002), as well as theories in the fields of relationship-based social work (Ruch, Turney, & Ward, 2018) and relational social work (Folgheraiter, 2003; 2007). In the context of *ensuring* and *strengthening*, we can draw from knowledge regarding coping with various forms of psychological and social vulnerability, well-being and positive psychology, and from theories of empowerment (among others, Zimmerman, 2000; Wilken & Den Hollander, 2019). In the following section, we will briefly describe the core acts from the perspective of a social work or (mental) health professional.

Connecting

The first core act is *connecting*. Connecting relates entering into a personal-professional relationship, in which you aim to work on an equal footing with the service user to add value to the quality of life. You strive to be attentive and respectful in your interactions with the service user and members of his or her circle. It is all about realising what we call an effective personal-professional relationship. You connect with the other and his or her situation. You closely connect with daily realities and personal experiences. You enter into a personal relationship that is characterised by, among other things, compassion and attention. Without compassion and involvement, a relationship tends to remain strictly instrumental. Particularly when people are contending with long-term or complicated issues, this rarely yields durable results. When you truly connect with the other, this embeds the relationship in a form that fosters trust and can lead to a constructive alliance or partnership. By «partnership», we mean an interpersonal relationship within which you, the service recipient and significant others work together on the basis of equality. Although we adhere here to person-centred principles and values such as unconditional positive regard, mutuality and dialogue originally developed by Carl Rogers in the 1940s and 1950s, we do acknowledge the fundamental difference — inequality — between the position of a social worker and the position of a service user. Matters related to this inequality (in terms of power, skills and knowledge) should always be considered. This is also the case for contextual factors, such as the quality of the social network, and statutory obligations, which are important in case safety issues are at stake (compare Murphy, Duggan, & Joseph, 2013). The latter is included in the core act of ensuring. In the CARe model, the relationship is not considered as an end in itself (Trevethick, 2003), but as a foundation for assessment (understanding) and outcome or solution-focused interventions (ensuring and strengthening).

Understanding

The second core act is *understanding*. Who is this other person? What are his or her experiences? What's going on? What's required? How can I best tailor my support? You want to get to know the other, and really understand him or her: his or her experience of the world, situation, wishes, needs. This requires you to be an attentive listener. The key is to gain insight into both his or her vulnerability and strength. You try to *understand* the other's perspective: in other words, really hear and comprehend what he or she is communicating — while taking care to hold back your own judgement. How about pain and suffering? In which ways has he or she been injured? What are his or her desires, wishes and needs? How about the quality of social relationships? Sometimes it is easier to make an adequate assessment of these aspects if you are familiar with the service user's experiences in some way, because you have a similar cultural background, for example, live in the same neighbourhood or have had similar experiences with mental health problems, poverty or exclusion. This understanding can contribute to insight into who the other person is, his or her motives and drivers, desires and needs. By showing the other that you wish to understand him or her, you can offer recognition and affirmation. This kind of acknowledgement is particularly important when interacting with people who feel insecure and uncertain in everyday life due to everything that has happened to them — including negative experiences with service providers. And it also contributes to trust: «... finally someone who understands me and sees me for who I am. He listens to me and "gets" what I'm trying to say». Understanding is followed by two other types of activity: *ensuring* and *strengthening*.

Ensuring

Ensuring relates to vulnerability: doing what needs to be done to offer the other person something to hold on to, a feeling of security, and to decrease tensions. Ensuring encompasses all those activities that contribute to the service user feeling more in control and secure in relation to vulnerability. In the case of some aspects of vulnerability, this may involve offering short- or long-term protection. In the act of ensuring, safety is very important. While this holds true for everyone, it is even more important for people who have low self-confidence, suffer from high anxiety or are vulnerable in some other sense. Safety can be provided in several ways, but already the personal support that you are able to offer as a professional can provide important guidance and safety. It is important that you are reliable and consistently do what you said you would do. If someone has become confused or overwhelmed by his or her situation, it may offer some relief when you help to «sort things out». Sometimes safe environments or «social niches» are needed. This could be a community centre, a meeting place or workplace or some form

of assisted living where the individual is offered protection, guidance and support. But it can also be a closed facility like a forensic setting or a psychogeriatric nursing home. There can be a tension between the principle of self-determination and the interest of safety. A person can be in a crisis situation where safety is at risk. As professional you may decide to take certain measures which are at that moment maybe not preferred by the service user. We believe that also in these tense situations working in a relational way is essential. Working relationally does include that opinions are exchanged and that the professional is clearly communicating his motivation behind acts of ensuring safety. It does also imply that after statutory measures are taken, the relationship is maintained, as well as working on connecting, understanding and strengthening.

Strengthening

In a recovery process, you also examine whether vulnerability can be reduced by drawing on the strengths of the individual and his or her network, or by helping to make an environment more «vulnerability-friendly». These actions are part of the fourth core act: *strengthening*. Strengthening is based in part on theories of empowerment and positive psychology (Zimmerman, 2000; Snyder, Lopez, Edwards, & Marques, 2021) and has both an individual and a collective component. This act focuses both on strengthening the service user's individual capacities and strengthening the quality of his or her social environment.

Individual empowerment involves aspects like increasing self-confidence, experiencing hope, learning from personal experiences and gaining new positive experiences (Wilken, 2010). These processes can benefit from a reinforcing environment: an environment where you live, work, learn or spend your free time and feel welcome and appreciated, and where you can unfold your talents. Or a self-help group where you can share your experiences and enjoy the support of people with similar experiences. Other inspiring examples include the recovery colleges that have been set up in several countries over the past few years. We also refer to such settings as «beneficial environments», since on the one hand, they give people a sense of security and acknowledgement; while on the other, they offer them opportunities to make the most of their ambitions and talents. In environments like these, one can often see each of the four core acts at play.

Case example

Mr. Morse is a 44-year-old male. After years of staying in a mental health institution, he has been living by himself again in an apartment for two years now. Nonetheless, the prospect of loneliness is a threat. He rarely answers the phone and usually doesn't

open the door if somebody rings the doorbell. If he does, then he can be rather rude and ill-tempered.

Caroline is a member of an assertive outreach team and the only person with whom he has occasional contact (if he needs her). She visits Mr. Morse a few times a month (always on a Thursday because Mr Morse prefers this), rings the doorbell and if he doesn't open the door, she puts a note in his letter box. If he does open the door, Caroline is usually able to help him with practical things such as the settings for his mobile telephone or with Internet banking.

This has been going on for two years now. In the past three months she has not been able to get in touch with Mr Morse, until one Thursday he opens the door once again. He looks dishevelled, talks loudly and incoherently and immediately throws a pile of paper on the table. It seems that his medical insurance policy has been suspended because he did not pay the bill, and he has no idea as to how to remedy the situation. Caroline cheerfully sits down at the kitchen table with a cup of coffee and goes through the paperwork with him. He visibly calms down and shows his gratitude by offering her a piece of chocolate.

In this example we see that Caroline uses different strategies to connect to Mr. Morse. By staying present in his life, even when he does not open the door, she is maintaining a relationship. Thanks to this connection she is able to understand his needs and to respond adequately. The emphasis in her actions is on ensuring.

Methodical elaboration

Travel guide

The methodical elaboration of the CARe model can be seen as a kind of travel guide. It helps the professional to chart the most effective course when it comes to providing the service user with optimal support. The professional can be regarded as a travelling companion on the service user's journey. As a companion, you can help him or her to determine the best route and stay on course, offer «breakdown assistance» where required but also reminisce on positive experiences during your shared journey.

Support can be focussed on a variety of areas:

- Supporting the service user in the context of wishes relating to his or her wellbeing and personal development;
- Supporting the service user in the context of needs and wishes relating to dealing with vulnerability;
- Supporting the service user in the context of wishes relating to the quality of his or her social relationships and/or environments: this can concern the indi-

vidual's own network, or the different settings (social or physical) that he or she finds himself in, or wishes to participate in (residential, workplace/day centre, learning, leisure time).

Stages and activities

The travel guide has six stages. These stages amount to methodical elaborations of the four core acts, as set out in the following chart. The first column lists the different stages, while the second column lists the associated activities. We emphasise that establishing, improving and keeping a personal-professional relationship is underlying all stages.

Stages	Activities
1. Connecting: establishing relationship (and subsequently maintain it)	• The core act *connecting* centres on establishing and building an equal relationship with the service user and significant others in his social network. Among other things, this involves fostering mutual trust and offering a sense of recognition. • We work according to the principles of relationship-based care and adopt an effective communication style, taking due account of cultural norms of interaction and language proficiency. We strive to connect to what the service user indicates is important to him or her. • During each consecutive stage, we *continuously* pay attention maintain or improve the relationship.
2. Collecting information in order to be able to understand	• The core act *understanding* centres on gaining the best possible understanding of the service user's perspective. What does he or she find truly important? What's at stake for him or her? • It's all about getting to know the service user and his or her context — e.g. the individual's life story, current situation, social network and the issues he or she is dealing with. • We look into experiences, abilities and constraints, «life goals», ambitions, personal preferences, resources, desired support, support needs (in relevant life and personal domains). We also take contextual factors into account (like the quality of social and material resources, and legal requirements).
3. Determining objectives (focussing on ensuring and strengthening)	• Based on a wish expressed by the service user, he or she is supported in setting one or more goals. These goals can be focussed on exploring, choosing, obtaining or retaining a desired situation. • If the service user is not — or not yet — able to set a goal, as professional you can formulate a support goal that is in line with the service user's recovery process and needs.

Stages	Activities
4. Draw up plan (focussing on ensuring and strengthening)	• A set goal serves as the guideline for the creation of a plan. Information collected in stage two can serve as input for this activity. • In the context of the set goals, during the *ensuring* core act you primarily focus on activities that relate to vulnerability, while during the *strengthening* core act you primarily focus on activities that contribute to the individual's personal capacities and the quality of an environment. • You help the service user to draw up a plan (a personal recovery plan, for example) or draw up a personal support plan as a professional. • To choose the best possible activities, you can elaborate a number of options with the service user, map out their respective advantages and drawbacks and subsequently choose the best option.
5. Executing the plan (focussed on ensuring and strengthening)	• Put the plan to practice: undertake activities. The activities centre on dealing with vulnerability (*ensuring*) and strengthening the individual capacity of the service user and his or her network (*strengthening*), guided by the set goals.
6. Learning, evaluating and adjusting	• This stage revolves around a continuous and dynamic learning process. Goals and activities can be adjusted in response to experiences.

Table 1 Stages and activities in the CARe model[3]

While these different activities generally occur in a particular order, we should not see these as clearly delineated steps. In practice, this process is dynamic and cyclical. For example, establishing and maintaining a connection (consolidating a relationship based on equality) continues throughout the entire process. The point is to constantly adapt your actions to the service user's needs or what the situation calls for, while simultaneously keeping an eye on future requirements and further development. As a professional, you should always realise that everything you do relates in some way or other to the four core activities. For example, during your interactions with the service user (*connecting* and *understanding*), the way in which you express yourself may also be relevant to the core acts of *ensuring* or *strengthening*.

[3] The methodological stages can also be used when working with the service user's environment. For example, they can be followed when engaging with the service user's social network, with a group in a residential environment or a community where the service user works or spends his or her time. This application of the CARe model is beyond the scope of the present article.

Case example

Frank is receiving support from Rita. They have known one another for a while now and get along fine. They have built a degree of mutual trust. During his initial period in the Supported Housing accommodation, Frank was really struggling with what happened in the past. Rita listened attentively and gave him plenty of support during this difficult time. Now Frank wants to make fresh progress.

One day Frank and his support worker Rita are sitting together discussing a Quality-of-Life profile (one of the tools that is often used in the CARe model). The profile features a number of important life domains, such as the place you live, your leisure activities, etc. Frank scores these: a 7 for the house he lives in right now, 5 for recreation because he thinks his free time is rather empty. Frank is a music fanatic, and when he talks about it with Rita his eyes light up and he starts to talk louder. He always wanted to play an instrument but never got round to learning. He rates the social relationships domain with a 4. This is in part down to his empty free time, but predominantly because of not seeing his daughter often enough. Frank feels like he is not really a father to her, and this is increasingly starting to bother him. Gradually it dawns on him that he wants to get back to working on his paternal role. Whilst talking about this it emerges that this is a wish directly associated with meaningfulness.

Thus, Frank and Rita set out on a journey entailing two wishes on Frank's part: reviving his role as a father and being able to play an electric guitar. Frank's passion is evident in both wishes. And «passionate» wishes are always associated with meaningfulness. These wishes are transformed into journey goals.

In this example we see that on the basis of the trustful connection, which was established between the client and Rita, an understanding developed of wishes related to Quality of Life. The emphasis in this personal-professional relationship shifted from ensuring (providing support regarding vulnerability and traumatic experiences) to strengthening (focusing on social recovery).

Care responsiveness

Good care comes down to letting your actions be guided by what is important to the other party — and to attune continuously to his/her perspective. We call this «care responsiveness». By this we mean preserving (or indeed developing) a certain sensitivity that allows you to recognise the needs of the other person. This can be different from one individual to the next — a need for personal interaction, attention and recognition, for instance; or practical assistance of some kind. Care responsiveness involves using your intuition and all your senses. You need a sensitive «antenna». At the same time, you also take advantage of your knowledge in the field of specific conditions, impairments, self-regulation, communication and behaviour. Handling the care process in a «responsive»

manner is an on-going effort. We see this as a three-pronged effort that simultaneously takes place in the dimensions of relationship, action and time. We constantly strive to align these dimensions with one another. The action dimension relates to the concrete activities that you engage in as a professional to support the other party. The time dimension relates to the process — your professional contribution over the course of the process, in other words. This contribution should be closely aligned with the service user's personal recovery process and life course.

In short, care responsiveness is based on a combination of relational actions (the quality of the relationship), practical actions (the quality of the provided support or aid) and actions that connect to developments over time (the quality of the process).

In closing

The CARe model was initiated some 40 years ago as part of a movement to make the provision of care more «humanised» and «person-centred». At the time, people working in long-term psychiatric care had a strong need for innovation and practical handles. Since its introduction, a number of countries, including the Netherlands and Belgium, have gone through a process of emancipation that put increasing focus on service user' personal experiences. Originating in the service user movement, this process was later adopted by the recovery movement that came out of this movement. The experience-based insights gained through this approach — accessed via countless individual stories and studies — were combined into a collective body of knowledge that in turn engendered positive changes in the provided care. Over the past decades, this knowledge has continued to serve as new input for the CARe model. One of the key factors of «good care» mentioned by many individuals who have experienced services is the personal attention and tailored support offered by professionals. Time and again, this feedback emphasises the importance of a personal, supportive relationship. Support is expressed both through the relationship itself and through the professional's contributions in the area of safety, helping the service user deal with vulnerability (or an unwanted life situation) and mobilising and increasing abilities. Capacities that can help the individual to strengthen his or her identity, take care of him- or herself, gain control over his or her life course and be recognised and valued as a member of society.

From experiences gained over the past decades with the CARe model — via applications both within and beyond mental health care — we have learned that care-relational principles and the four core acts can be applied in a wide range of contexts. In the Netherlands, this model has also been included in the Social Work bachelor's and master's degree programmes, since it is particularly well suited to the social work discipline.

The CARe model can be considered a broad movement that advocates good care and the humanisation and emancipation of vulnerable groups. Its added value lies in

the connection of knowledge from a number of different sources: research, practice and service user' input (Bitter, 2018). At the same time, the CARe model also provides a solid and comprehensive methodical framework — made up of stages, activities and resources — that can be used to give shape of practices that effectively supports an individual's personal and social recovery. In other words, the CARe model can be defined both in broader terms as a movement to realise good relational care; and in narrower terms as a well-delineated methodology, a framework in which a professional can opt for a specific method or intervention in response to a specific setting and/or the characteristics of a specific service user group.

References

Baart, A. (2002). *The Presence Approach: an introductory sketch of practice*. Actioma / Catholic Theological University Utrecht, the Netherlands.

Bitter, N. (2018). *Rehabilitation and recovery of people with severe mental health problems living in sheltered and supported housing facilities.* Tilburg University.

Den Hollander, D., & Wilken, J. P. (2015). *Supporting recovery and Inclusion. Working with the CARe Model*. Amsterdam: SWP.

Den Hollander, D., & Wilken, J. P. (2011/2017). *Zo worden cliënten burgers. Praktijkboek Systematisch Rehabilitatiegericht Handelen.* Amsterdam: SWP.

Den Hollander, D., & Wilken, J. P. (2020). *Werken in Verbinding. Praktijkboek Steunend Relationeel Handelen.* Amsterdam: SWP.

Folgheraiter, F. (2003). *Relational Social Work: Toward Networking and Societal Practices*. London: Jessica Kingsley Publishers.

Folgheraiter, F. (2007). Relational Social Work: Principles and Practices. *Social Policy and Society*, *6*(2), 265-274.

Held, H. (2006). *The ethics of care: personal, political, and global.* Oxford: Oxford University Press.

Leamy, M., Bird, V., Le Boutillier, C., & Williams, J. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, (*199*)6, 445-452.

Leget, C., Gastmans, Ch., & Verkerk, M. (2011). *Care, Compassion and Recognition: an ethical discussion.* Leuven: Peeters Publisher.

Murphy, D., Duggan, M., & Stephen J. (2013). Relationship-Based Social Work and Its Compatibility with the Person-Centred Approach: Principled versus Instrumental Perspectives. *British Journal of Social Work, 43*, 703-719

Ruch, G., Turney, D., & Ward, A. (2018). *Relationship-based Social Work. Getting to the heart of practice*. London: Jessica Kingsley Publishers.

Slade, M. (2009). *100 ways to support recovery. A guide for mental health professionals.* London: Rethink.

Snyder, C. R., Lopez, S.J., Edwards, L.M., & Marques, S.C. (2021). *The Oxford Handbook of Positive Psychology.* Oxford: Oxford Library of Psychology.

Trevethick, P. (2003). Effective relationship-based practice: A theoretical exploration. *Journal of Social Work Practice, 17*(2), pp. 163-78.

Van Heijst, A. (2011). *Professional Loving Care. An ethical view of the health sector*. Leuven: Peeters Publisher.

Wilken, J. P. Kaiser, L., & Den Hollander, D. (1994). *Wonen en rehabilitatie.* Utrecht: SWP.

Wilken, J. P., & Den Hollander, D. (1999). *Psychosociale rehabilitatie. Een integrale benadering.* Utrecht: SWP.

Wilken, J. P., & Den Hollander, D. (2005). *Rehabilitation and Recovery. A comprehensive approach.* Amsterdam: SWP Publishers.

Wilken, J. P. (2010). *Recovering Care. A contribution to a theory and practice of good care*. Amsterdam: SWP.

Wilken, J. P., & Den Hollander, D. (Eds.) (2012). *Handboek integrale rehabilitatiebenadering. Theorie en praktijk van het Systematisch Rehabilitatiegericht Handelen*. Amsterdam: SWP.

Wilken, J. P., & Den Hollander, D. (2019). *Handboek Steunend Relationeel Handelen*. Amsterdam: SWP.

Zimmerman M. A. (2000). Empowerment Theory. In J. Rappaport & E. Seidman (Eds.), *Handbook of Community Psychology*. Boston, MA: Springer.

Wilken, J. P. (2021). The CARe model. The relationship as the heart of good care. *Relational Social Work, 5*(1), 34-47, doi: 10.14605/RSW512103.