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Case work and social control in 20th century

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Introduction

Casework methods, initiated in the USA by Mary Richmond and developed in Europe by Alice Salomon, Siddy Wronsky, and other social work scientists have almost one hundred years of history. These methods contributed to the creation of modern social work as a separate professional field and for its vocational training. The methods of casework (observation, home visiting, interviewing of clients) as well as their single steps (social analyses, social diagnoses, and planned social therapy) made the practice of social work more transparent and traceable. These methods began to be adopted in different European societies during the period between the two World Wars and to be practiced according to the different societies' social and political situation. These ideas and practices were communicated by feminist networks and other international and local female organizations and started to be taught in the newly established courses in social work. The newly established methods of casework also changed the forms of social control over the "clients". After World War II, in West European countries we can see radical change in social casework practices – the approaches became more

psychological and psychoanalytical, whereas in most East European countries casework was transformed into more general social policies, which replaced individual and family casework.

The aim of the volume "Casework and social control in the 20th century" is to bring together researchers from different scientific fields (social history, ethnology, social work, psychiatry) and different countries (Hungary, Spain, Bulgaria, Romania, Slovenia) in order to discuss the ways of communication of ideas and practices of casework in Europe, as well as the contributions of authors, translators, and practicing social workers who spread these ideas. The aim is also to compare casework practices in different traditions and their exchange, to use the rich documentation left by the case work practices and to think about writing a history of individual social care.

Case Work and Social Control: the History

SOCIAL WORK AND CASE WORK IN SPAIN DURING THE 20th CENTURY

Emma Sobremonte de Mendicuti, Arantxa Rodrí guez Berrio, Usue Beloqui Marañón

Introduction

Social Work did not appear in Spain until the 20th century. This delay was due to the slowness of the industrialization process. The social protection systems that where born at the beginning of the century had a charitable nature and were influenced both by the catholic thought and the European social policies of the moment. In this context the assistance programs in which the first social assistants worked came up.

But to what extend case work was used in the past century? In Spain, social case work has had a little impact along the whole century. Social reality and State politics, determined by a 40 year dictatorship (1939-75), plunged Spain in a intellectual isolation that prevented the exchange with other international cultural realities. In this way, during

that period there was almost no news of the methodological instruments developed in the United States or Europe.

The three methods of case work: individuals, groups and communities began to be studied in the first Schools of Social Assistants, during the fifties, taken from the Latin American bibliography that in an easier way arrived to Spain.

At the same time, during Franco´s government, in order to denounce the situation of social inequality in which many people lived, Spanish social workers, from a critical approach, promoted the social community work procedure as a way to facilitate the emergence of the conscience that was needed for social change.

Almost without being case work developed during the dictatorship period, by the time democracy arouse in Spain and the Social Services System was created, the incipient psychosocial approach was progressively transformed into social intervention measures that resulted from public policies based on the management and provision of social resources, in order to satisfy the binomial need-resource.

Thinking about the future, we can, -and we must- ask ourselves what happened with case work.

As Eduardo Galeano said, *history is like a prophet looking backwards, due to what it was and against to what it was announces what it will be.*

APROACHES OF SOCIAL WORK IN SPAIN

During the XX century, since the 60s, in Spain social work was con-

solidated as a discipline[1] . As it happened in many other countries, the acquisition of its epistemological status did not take place suddenly. On the contrary, it was developed at the threat of changes that took place in the different forms of social action in the field of social assistance. In this way, as Red (1993[2]) says : *the itinerary of Social Work has been developed as a spiral ascending trajectory in four consecutive stages which start from charity to social assistance and finally from Social Work to social services. This stages have been conventionally defined in the following way: pre-technical stage, technical stage, pre-scientific stage, scientific stage.* Like this, it is easy to understand how approaches, methods and intervention procedures have been configured depending on philosophy, knowledge, and dominant values in each of those stages. Being aware of the difficulty that the attempt to express in a few lines the complexity of the development of Social Work implies, we present here an operative outline which, in the way of a typical-ideal proposal, will facilitate the understanding of it.

ASSISTANCE APPROACH

There is a common agreement to point that the scientific stage of Social Work in Spain started in the middle of the XX century. In that moment, Spain, under the dictatorship founded just after the civil war, was trying to repair the social fabric and to start the economic takeoff. The protection instrument of that period are the ones of patriarchal State which cover basically the contingences associated to poverty and to illness in an assistance way and with a strong component of social control.

The industrialization process in which Spain was, produced important

migrant movements. The exodus from the country to the city made numerous settlement of working people emerge in the peripheral areas of the big cities. In this context of precariousness the Catholic Church would play an important role as help supplier. At the same time companies would develop social assistance programs in order to alleviate the social needs of its workers. In this way, professional functions of social workers, under the institutional mandate of the State, Catholic Church and companies would take the feature of assistance and paternalism. In this frame, the main procedure of help used by social assistants would be individual assistance. But it would have no theoretical, nor the practical basics of the *case work* developed in other countries. It won´t be till much longer when it becomes known, except from a few cases such as the Case Work Course given by the Belgian Julia Tuerlink, in Madrid in 1958. The course took up the scientific and practical approaches of the origins of Social Work in the United States. Julia Tuerlink was at that time working in the European Office of Technical Help of United Nations, which introduced *case work* in Europe as a contribution to the democratic process after the Second World War. But due to the non democratic nature of the Spanish State the course did not have much impact.

In this way, social assistance would be given in a more or less intuitive and personal way, starting from the values proclaimed by the profession and from the theoretical basis of other disciplines, such as Sociology, Psychology or Medicine, which would be studied without being incorporated as a proper *corpus* but applied to professional practice. During this period of time group and community methods would be only applied occasionally.

In this stages Social Work Schools had an important relevance. Due to

the resource shortage of the period they tried to promote employment in different areas, such as education, companies, health, etc., by the training practice of the students. This challenge demanded the development of good projects and strong supervision of the students. The instability and disorganization of the resources put the emphasis of work on the professional competences and in this way a new period started. One of its characteristics was the consideration of the *professional as a resource*. In addition to that, if we take into account the absence of other professionals and disciplines in the area of social action, we will easily understand that social workers were focused on the acquisition of a methodology and frameworks which would guide their action.

For this reason the search of theoretical-practical referents became one of the main objectives. Because of the absence of their own texts and due to the isolation in which Spain was immersed, a theory of social work started to be develop from the works of Latin American authors. Cultural, political and language similarities played a determinant role in the transference of knowledge. In this way authors like Boris Lima, Natalio Kisneram, Nidya Alwyn y Ezequiel Ander-Egg hold a central place during the 70´s.

Due to the political situation and the unease of the working class many social assistants joined the collective claims and mobilizations that, from the local field and being supported by a progressive sector of the Catholic Church, would promote social changed and the defense of social rights.

In a stage in which space was the criterion of the political system legitimacy, and in the absence of other mechanisms of expression, neigh-

borhood associations would become the instrument which would question the current political system[3].

These events would promote our approximation to the thesis held up by the Latin American colleagues and would justify the fact that the profession would be strongly impregnated by an ideological component in the future.

In this way, the definition of social worker as an agent for change, which was imported from Latin American, began to mature in our context. Against the basics of the functionalism that supported the major praxis of social workers, the structural explanation about the social problems of the Spanish population emerged.

The desire of social change guided our sight towards the reconceptualiztion movement started by social workers in Argentina.

THE CRITICAL APPROACH

Until the decade of the 50‘s social work in Latin American had had an aseptic orientation and was considered a social technology with no relation with political movements.

Worried basically about the adjustment of the clients to social structure, the theoretical basis were slowly consolidated around the three classical methods: case, group and community. When the socio-economical problem got worse and the developmental model was implanted, social work, as well as other disciplines, acquired an unusual impulse in the communitarian approach.

In this way, the traditional method of the United States of community organization, was rephrased into the well-known term of community development, as an attempt to expand widely the action of social work and to encourage the takeoff of the communities. As Boris Lima said: *In this way, the role of social work, both in docent reality and in institutions, gives priority to social approach rather than individualism. It is a progress because it tries to get society organized in bigger groups, relating them with variables that go further than the psychological elements of case and group work.*[4]

From this perspective the professional activity was criticized because it continued practicing action far from the dynamics and essence of the social order, even if it had gained a wider and more complex methodological instrument. It was accused of remaining in a reiterative praxis which reproduced in different grades the unfair and differentiating characteristics of the system.

The great social and political convulsions of the continent induced the reconceptualiztion movement within Social Work in Argentina. This movement is characterized by the integration of the political and ideological analysis of the situation into the conceptual frames with the aim to intervene on them. The idea was to generate new practices which achieve to transform those realities.

This new stream would try to go beyond the psychological and functionalist bases of European and North American social work. It would put the emphasis on the structural roots of social problems in each historical and social context and, as a consequence, the need to promote social change, rather than individual change towards adaptation.

New practices and methodological intervention arose, looking in gen-

eral for the promotion of a process of *concientization* within the groups and communities in which intervention was carried out. Communitarian social work and a critical reading of the institutions where some of the changes that occurred in the sphere of practices.

In the academic field social sciences and social work made new readings of Marxism and thought that it was a theory that was able to give a suitable frame for the transformation of the society.

The study of Paulo Freyre´s Works and his well-known *Pedagogy of the Oppressed*, had a singular relevance in the comprehension of the *concientizator* sense of practice from the group and communitarian approach. All this change implied a strong theoretical and methodological review of the discipline and promoted the elaboration of the Basic Method by a group of women professors of the Catholic University of Chile. This new methodological proposal implied an attempt to make a synthesis of the three traditional methods from a critical perspective[5] in order to put social work at the service of radical transformations that most dependent and late societies needed. These political orientations and intervention techniques would coincide in Spain with the social movements for the defense of the democratic liberties and the improvement of life and work conditions, conforming a "breeding ground" suitable to join this process. The incorporation of Social Work to these proposals of reconceptualization would be perfectly reflected in the famous article about The Basic Method that Montserrat Colomer published in 1974[6]. *The basic method* would be a professional intervention model which includes reality knowledge, interpretation, planning, intervention and evaluation.

As Teresa Zamanillo says, *this methodological change contributed to*

overcome charitable schemes which were provoking a crisis in our profession[7]. During this period the activity of Social Work acquired the features of a profession, spreading all over it the name of Social Work and would be recognized in Spain in the I Congress of Social Assistants celebrated in Barcelona en 1968, ratified in 1981 by the approval of the University Degree of Social Work by the Ministry of Education and Science . All of the efforts made in this stage would signify the beginning of a new time for Social Work.

THE WELFARE APPROACH

Since the moment in which the political system returned to normality and new institutional channels were created to answer to social demands, some changes took place.

On one hand, some disappointment and resignation due to the impression that collective action as a developer element of social life is dead. The own declivity of literature about social movements reflects this tendency. On the other, a certain euphoria caused by the Spanish advance towards the construction of Welfare State which would facilitate the development of the Public System of Social Services where social workers would play an important role, especially in the legal definition and in the starting up of the Public System. The inspiration would be found in the European countries that had developed those Systems in more prosperous times and in the development of welfare politics in the 60´s.

While the transition to democracy took place, some efforts were made in order to improve the theoretical and practical basics of the disci-

pline. It is in this moment when some theoretical trends and definitions of social work elaborated in other countries began to come into our profession, operating as catalyst elements for a praxis which is still between the charitable and the critical orientation, between the individual and the communitarian approach[8].

In this sense we can easily understand how systemic theory, applied especially in the first moments to family intervention charmed and rushed into the thoughts of many social workers. The application of the concepts and laws of this theory to the work with families made it possible to understand men and women as a part of the whole, as subsystems of larger systems. For that reason system explanation would foster the comprehension of reality that would facilitate the integration of "Macro" and "micro", of structure and personal, providing a relational perspective that would imply new intervention proposals[9].

This perspective would be progressively introduced in Spain by Mental Health social workers. Figures as Elisa Pérez de Ayala[10] would make an important contribution training many social workers since the end of the 70´s.

The developments that came from the United States would slowly introduce the diagnostic o psychosocial approach into specialized circles and would study deeply the case method and group work, both from a psychodynamic and functional perspective[11].

But as the development of the Public System of Social Services goes on, the binomial *need-resource* would be drawn as the main objective of social worker´s intervention[12], leaving the former theories of knowledge and intervention object of the critical and diagnostic perspectives in a second place. The result of the enthusiasm that the recent achieve-

ment of social rights and political instruments to fight against poverty, marginalization and social exclusion was the confusion between social work and social services which would interfere on the progress of the discipline. In this way few people would think that social work could change society, on the contrary, it would only provide and distribute resources in order to satisfy people´s needs. In this period the demand of more and better public resources became a central matter, both for professionals and for citizens. Because of the quick development of the Public System of Social Services and due to the progressive increase of the demand of benefits and social services, social workers were compelled to dedicate a long time to manage social benefits at the expense of direct social intervention. Other disciplines, such as social education or psychology, would see this fact as a chance to introduce themselves in this area.

Only a few specialized services that belong to the own System of Social Services and to other systems, like Health, would slowly take part in the new proposals of the discipline.

Social Work became more professional because under the pressure of social actors, Welfare State would be developed, citizens would claim for services, as they are aware of their rights and because University would promote and define the academic and job profile of this new profession

THE INTEGRATIVE APPROACH

While all this was happening, both in the academic and in some professional ambits, the sense that our profession in social services was

acquiring began to be worrying and some voices tried to clarify and resituate its object of knowledge[13].

From the decade of the 90´s a great advance took place in the theoretical-practical training of social workers. The perspectives, theories and models of intervention developed in Europe, United States or Canada were quickly integrated and gave way to a productive discussion inside the scientific community[14]. Academy would make a great effort to synthesize, construct and generate knowledge[15] and specialists of different fields would start to incorporate in their praxis systemic, ecosystem, psychodynamic, cognitive-conduction, crisis, etc. approaches and their own methodological proposals for individual and family work, for group and community work. More than resource management, the relational dimension of helping process would be consolidated. In this way the academic field would progressively give an increasing emphasis to individual and family intervention taking up again the procedure of case work from the diverse theoretical approaches and models of intervention. And at the same time, collective intervention would be taken up again from a more institutionalized perspective, basing its action on the social network approach.

Among lights and shadows Social Work in Spain has crossed a large path during the last two decades. If social conflicts of dictatorship let a critical reflexion on the sense and methods of social intervention, the advent of democracy and the achievement of social rights made our professional space and sight be now involved in a changing and conceptual synthesis process. We have named this effort of harmonization of perspectives and orientations “The Integrative Approach”. We are sure that the incorporation of the discipline to the European Space for Higher Education will be an especial opportunity to improve the training of social workers in Spain.

[1] Social Work was consolidated as a discipline after a long way of setting up non university Social Schools of Social Assistance, which most of them belonged to the Catholic Church. The first School of Social Assistance for women was founded in Barcelona in 1932, as a subsidiary of the Catholic School of Belgium. The second one was founded in 1939 in Madrid and in 1970 there were already 42 schools spread all over the Spanish territory. But it will be not before 1983 when studies become recognized by the University System.

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Care, monitoring, control - the first experimental practice for accommodation in foster families in Bulgaria 1937-1938

Milena Angelova

The paper presents a joint initiative of the American Near-East Foundation in Bulgaria and the Department of Social Cares of Sofia Municipality for the accommodation of abandoned children in foster families since 1937. The main sources for the reconstruction of those first steps of foster care in Bulgaria are the reports and surveys of the doctor and visiting nurses of the Child Welfare Station at the Near-East Foundation in Sofia.

Before 1945, "***fostering***" referred to numerous arrangements in which children were cared for in homes other than their own. The point of the term was to contrast institutional care with family placements. The case for foster care was articulated by nineteenth-century child-savers, including Charles Loring Brace and advanced by states that experimented with placing-out children rather than consigning them to orphanages.

Health and Welfare Center in Koniovitza , *Sofia, 1938 - Central state archive, F. 3k, Op. 15, a.e. 241, l. 4*

In the early twentieth century, the cause was taken up by reformers like Henry Dwight Chapin, a New York pediatrician and founder of the Speedwell Society whose wife established one of the country's first specialized adoption agencies, the Alice Chapin Nursery, in 1910. Henry Chapin circulated statistics showing that orphanages literally sickened and killed alarming numbers of children. His conviction that "a poor home is often better than a good institution" spread quickly among child welfare and public health professionals, but the campaign to make families the only acceptable places to raise children still had a long way to go. [1]

Long before "adoption" was commonly used, child-placers appreciated the differences between permanent kinship and temporary residence in someone else's home. Most Progressive-era social workers aimed to keep children with their own families, even if they were illegitimate, out of respect for the importance of blood ties. But advocates also knew

that some children could not or should not live with their birth parents. For these children, becoming a lifelong member of a new family was desirable. Common sense suggested that emotional security was key to children's health and welfare, and developmental science produced additional evidence for this claim. Research on attachment and loss and studies of maternal deprivation in infancy influenced policies of early placement and ushered in a more pro-adoption climate after 1940.

The Near-East Foundation in Bulgaria

The contacts of the Near-East Foundation with the Bulgarian governmental and non-governmental institutions were established in the early 1920's.

In the first war years it functioned as a committee for assisting the Armenian and Syrian population (Near-East Relief). A bit later it was transformed into a permanently active organization whose activity covered the whole Eastern Mediterranean region and the Balkans.

As regards its work in the regions in the 1930's, the Foundation had for its primal principle to assist in improving the health care services and carrying out reforms in the sphere of education. These constitute the platform which served as a base for the work of the Foundation in Bulgaria, i.e. the building of a network of health stations (together with the Union for Children's Protection in Bulgaria), summer children's playgrounds and kindergartens;

During the early 1930's Leontii Feldmahn was a representative of the Near-East Foundation in Bulgaria.

Child welfare Station in Koniovitza. Started in 1931. Examining by the physician. *Central state archive, F. 3k, op. 15, a.e. 241, l. 15*

In 1934 the central agency of the Near-East Foundation in Athens approved a general plan for its future charitable activity in the Balkan countries. The intention was to "improve the public health services and the overall condition of the farm-workers. The Foundation's representatives took into consideration also the communes law that was amended after the coup from 19 May, 1934. This law obliged the communes to maintain health centers and veterinary dispensaries, to co-operate with local medical institutions and to cover a part of the expenses for the poor families, sick and homeless children and elderly people. This enabled the American organization to coordinate more easily its activities with the Ministry of Internal Affairs and Public Health within the frames of the Foundation's program for assistance in Bulgaria.[2]

Child welfare Station in Koniovitza. Started in 1931. Mothers bringing their babies to the Station

Child Welfare Station (Health Counseling Center for mothers and children) at the American Near-East Foundation in Sofia

The center opened in 1931. Dr. Nevena Kantardzhieva-Kozhuharova was the center's director. The Center was sponsored not only by the American Near-East Foundation, but also by the municipality, and the Bulgarian Women's Union.[3]

Since 1935 the doctor and the visiting nurses from the Health Counseling Center had been gathering information on the sanitary and economical conditions in the region, that is the Koniovitza district (Sofia). About 1000 household were inspected. The inspectors were taking into

account also the type of buildings, the number of the household's members, the water-supply, the income, the hygienic conditions, the quality of infant care, etc.[4]

In this very same year, the authorities recommended to the Center's management to organize special training courses for young doctors, maternity nurses and visiting nurses, for the Center had at its disposal the most highly qualified personnel (two doctors-pediatricians, two visiting nurses, and hospital attendants) and the best equipped consulting offices in all the capital town. [5]

Sofia Municipality – public care organization

Till the mid 1920's, in the capital city with its 250 000 inhabitants, there was no special service for providing the poverty-stricken citizens with assistance. Some attempts for institutionalization of social care had been made during the wars and under the administration of the mayor Vladimir Vazov (1926 – 1932). The *Social Care Office* at the Sofia Community was founded.

Some female *social consultants* were involved in the public aid initiatives of the Sofia Municipality (12 of those consultants were appointed to position around year 1939). The first social consultants were nurses, but later it was the graduates from the *Higher Social School for Women* who were being appointed social consultants.

At the end of 1939 the public aid service helped about 15 000 households (of the total 60 000 on the whole Sofia territory).

Home visitation of Public Health nurse. Child welfare Station in Koniovitza. Started in 1931. *Central state archive, F. 3k, op. 15, a.e. 241, l. 15a.*

The campaign for fostering accommodation of orphans in foster families in Bulgaria 1937-1938

Among the Foundation's initiatives supervised by the Health center, the campaign for adoption of orphans was considered by Feldmahn and Archer as the one to have achieved "the biggest success". The idea was conceived by the Ministry of Internal Affairs and Public Heath, which, in the beginning of 1937 issued an ordinance for providing accommodation for orphans aged 1 to 6 with childless or well-off families till the children turn 18. The state encouraged the families that were prone to accommodate orphans by using the public relief funds. The

foundation itself participated in the campaign by announcing that it would provide accommodation for 23 orphans. The Foundation assigned to the Health Center's personnel the task of controlling how the funds were being used, to maintain a continuous connection to foster parents and of the further popularization of this experimental practice all over the country.[6]

The campaign was a joint initiative of the American Near-East Foundation in Bulgaria (Child Welfare Station in the Koniovitza district) and the Department of Social Cares of Sofia Municipality.

The children were under constant surveillance of the doctor and visiting nurses in the Child Welfare Station of the Koniovitza district.

An extensive report of the representative of the Near-East Foundation in Bulgaria Leontii Feldmahn to the General Directorate of Public Health in the end of 1938, indicate briefly the reasons for taking this attempt: The child's upbringing in the family, although another family, is under natural conditions, not in artificial atmosphere, inherent of every orphanage, even the best placed; as it is cheaper;

Foster families receive a monthly payment to cover the costs of the children. The Directorate of Public Health and the Department of Social Cares of Sofia Municipality took payment to the families, while the monitoring of the implementation of the initiative and the staff are provided by the Foundation. The fixed amount was 700 leva at first, but was reduced to 600 leva later. According to observations and calculations of the visiting sisters the actual support should be 520 leva. In the Reports of the doctor and visiting nurses there are several weaknesses in the adoption campaign:

Child welfare Station in Koniovitza. *Central state archive, F. 3k, op. 15, a.e. 241, l. 15*

- Absence of a preliminary study of the child - often there are no documents for the children;
-Moving children from one family to another; happened several times; moving a part of the children in families of Kalofer to foster families' terror;
-In some cases – aggressive attitude of the own children in families that have adopted homeless.

Among the children placed in foster families have fatherless, illegitimate children, one neglected child (both parents have a severe form of sleeping sickness), and abandoned children of parents who did not support their children.

The Reports of the visiting sisters provide extensive cases in which the biological parents of some of the abandoned children interfere in their lives in the new families:

The child Yoncho Yonchev, born on 15.02.1935 was placed in the family of Traicho and Maria Traikovi in the Koniovitza district until 26.05.1937. The child's father left his mother and went to France. His mother lives in Sofia, works as a maid. The child is placed on behalf of the Sofia Municipality, to enable the mother to go to work. She regularly comes to see the child. The child knows that it is his mother, but because she is a reasonable woman, she maintain the prestige of the foster mother. Both women are in very good relations, they became good friends and fully agreed with the issue of the upbringing of the child .... [7]

There are also other examples in which the visits to the 'real mother' is presented as "extremely harmful".

Despite the short period of conducting this campaign, in the report of its results, Leontii Feldmahn indicate:

Summed up all the above, I owe to note that our experimental practice, at least so far, I see completely successful. Noted deficiencies are fully removable. However, I would like to underline, that the success of the experience I mainly attribute to the careful selection of families and the actual and unyielding control over them by the servants in the Child Welfare Station at the Foundation - the doctor and visiting nurses.

This control affects all aspects of child's life and never is interrupted. Mothers are required to bring children in Child Welfare

Station regularly; they attend our children's playground; the nurses come to them very often and unexpectedly. They monitor how children eat, how they relate to them, how they are dressed, how they sleep and, if something is not quite right, they immediately, but with tact, intervene ... Most children are placed near the Station, so unknowingly they are in front of the eyes of our staff .... [8]

Despite the optimistic assessments, the experiment practice ends at the end of 1939. Overall then all common projects of Near-East Foundation with the Bulgarian institutions interrupt. What would be the results of a longer-term and large-scale campaign didn't become clear.

In the late 1930's, the financial problems (World Economic Crisis) and the complicated international situation forced the Foundation's Board of Directors and the Near-East Foundation's Agency to make some considerable reductions in their charitable activities for the Balkans. This went on till the fall of 1939 when the breaking of the war in Europe almost completely terminated their co-operation on Bulgarian territory.[9]

In the fall of 1939, the Near-East Foundation utterly ceased the financing of its projects in Bulgaria. The Italian attacks on Greece and the prospect of a German invasion in 1941 made the representatives in Athens start packing.[10] In Bulgaria it was only Leontii Feldman who insisted on staying even after the termination of the diplomatic relations with the USA in December 1941. Besides, he was heartily encouraged by the Ministry of Agriculture to continue his work in Bulgaria.[11]

The following events made it impossible for the co-operation to be preserved in the way it had been before. Thus, the official engagements of the foundation in Bulgaria were put to an end.

[1] The adoption history project - http://darkwing.uoregon.edu/~adoption/topics/fostering.htm

[2] Velichkov, Al., American charity in Bulgaria between the two world wars, University Publishing house "Saint Kliment Ohridsky", Sofia, p. 153-154.

[3] Central State Archives, f. 372K,Op. 1, a.e. 1326, p. 2-7.

[4] Central State Archives, f. 583K, Op. 1, a.e. 12, p. 15-17.

[5] *Social Support* Magazine, 11-12, 1936, p. 315.

[6] Central State Archives, f. 365 Op. 1, a.e. 1326, 1328; Velichkov, Al., American charity in Bulgaria… p. 165.

[7] Central State Archives, f. 264, Op. 7, a.e. 948, p. 17-18.

[8] Central State Archives, f. 264, Op. 7, a. e. 948, p. 24-25.

[9] Velichkov, Al., American charity in Bulgaria…, p.131.

[10] Ibid., p. 174.

[11] Ibid., p. 175.

(Im-) Possibilities for Case work in Socialist Bulgaria at the Example of the Extramarital Motherhood

Anelia Kassabova

I'll try to highlight some problems of social policies in socialist Bulgaria with relation to extramarital births and motherhood.

The possibilities as well as the impossibilities for Case work and Social Control in this concrete field result from the inherent contradiction between pro-natalism and the affirmation of marriage. On the one hand, Motherhood and child welfare services stood in the center of the socialist paternalistic and pronatalistic policy. Extramarital births also contributed to intended population growth, but they seemed problematic from the point of view of family stability. Depending on policy priorities official attitudes towards extramarital births and single mothers, therefore, changed.

Nationalization and Fragmentation of Social Work

The goal of the socialist state was to grasp all pregnant women and

infants. The “inherited” network of social institutions - gynecological departments, maternal and child care centers was reorganizeed:

In the immediate postwar years, yet some pluralism in the area of welfare, certain balance between associations, state and municipalities existed.

Soon the leading role in the field of social work was taken over by the state, an attitude all parties at that time shared.[1]

The end of the 1940-1950s was period of institutional instability and structural changes - the ministries responsible for social work were not just often renamed, from one to another responsibilities and Ressouren were transferred (devolved upon). The disagreements between the different ministries begun with the struggle for the property of the charitable organizations. All welfare organizations were liquidated beginning of the ‘1950’s or explained as “self-liquidate”. The old system finally was removed 1951.

The entire socialist period is connected with discussions, even clashes on ministry level – with regard to problems such as building, equipment, financing of the social institutions.

The ministries retained the overall supervision; the direct welfare work went on the competent departments of the municipalities over.[2]

The many fragmentary social activities were not integrated in broad functional services. The institutional disunion and the lack of coordination were per se part of the problems/obstacles for an effective social work which at the same time led as a consequence to a relatively weak social control.

De-Professionalization

The Women academy for social work was closed 1946 - professional education for social work was designed to equip its practitioners to deal with social problems, including broadly standards of living and social relationships. This means that it utilized knowledge derived from other professions, notably the social aspects of medicine, law, psychology and psychiatry.[3] The complexity of the education/training, necessary for defining and solving the social problems gets lost for decades.

The individualized, on the needy person case-related social work was rejected ideologically.

The social work system in the pre-socialist period developed in direction of self-determination and democracy, the methodical proceeding enclosed increasingly participative interactive forms.[4]

In the socialist period this was changed basically.

The faith that the state would solve all social problems led to the fact that from the new massive social changes caused social problem situations were not expected. The utopia was leading a new morality “to persuade”, “to plant” in a „hard and concentrated fight“ with the old habits which should be “torn out”.[5]

With the investigation of social problems the accent was not laid on the social environment and social networks, the problems were led back on weakness or underdeveloped willpower of the individual/person. It was not about personality development, but about forming of the person, after which the individual should adapt his own life to the

interests of the socialist society. The main goal was through scientific study and complex measures to achieve control and management of the reproductive behavior.

Socialist social policy was from the outset paternalistic and hierarchic, since it lacked any instrument with which the objects of social policy could arrive participatory forms.

One can illustrate this at the example of the Case Work towards extra-marital mothers.

Politics toward extramarital motherhood

Legislation

Soon after the communist regime had come to power, the new Decree on Marriage (May 1945) proclaimed the equality of children born in and out of marriage. The constitutions of 1947 (article 76) and 1971 (article 38) reiterated this principle. Socialist legislation on this issue used the expression “non-” or “extramarital” children, rather than the traditional differentiation between “legitimate” and “illegitimate” births (the terminological shift had already been made by the Law on Extramarital Children and Adoption of 1940). The last remaining legal obstacles for the determination of fatherhood (most of them had been abolished in 1940) were also done away. The Law on Inheritance of 1949 gave equal rights to marital and extramarital children.

Despite these changes, which were also motivated by the need to emulate the Soviet model, the regime remained committed to keep down births outside marriage. This was a stark difference to Soviet bio-politics, the

reason of which has to be sought in the demographic differences: Soviet acceptance of extramarital births was caused by the significant surplus of women in the fertile cohorts due to the war losses of World War One and Two. In Bulgaria the gender balance was only slightly in favour of women.[6] Hence the Bulgarian communist regime felt no pressure to modify its dismissive stance on extramarital births: "It is possible to think of situations when extramarital births solve important social problems. Looking at the demographic processes in our country, however, there is no need (…) to accept children out of marriage in order to secure biological reproduction."[7]

Another demographic factor was the fact that fertility levels of unmarried women were significantly lower than of married women and, thus, did not correspond with the reproductive ideals of the regime. For these reasons, the government adopted various measures to prevent extramarital births in the first three decades after the Second World War. Especially in the 1950s and 1960s this led to an almost definite taboo of single motherhood and to extensive attempts to regulate sexual life "in the struggle for the socialist family".[8]

Table 5: Share of extramarital births, 1945–2001

1945	1946/49	1953/60	1960	1965	1970	1980	1985	1989	2001
	annual average								
in percent of all live births									
2.2	2.4	6.6	8.0	9.4	9.3	10.9	11.7	12.4	42.0

In the 1940ies the annual average of extramarital births in percent to all live births remind low. Extramarital births were not seen as a big social problem. Hence the Bulgarian communist regime felt no demographic pressure to modify its dismissive stance on extramarital births.

Prevention by Stigmatization of unmarried mothers

Prevention of extramarital births by "hiding" and taboo was the main strategy of the state.

As a leading official principle, the confidentiality of all data, combined with the biological origin, was adopted.[9]

Despite the officially proclaimed "principles change" in relation to the extramarital birth,

in socialist Bulgaria unmarried mothers were seen as a bad role model and a constant threat considering the limited norms of sexual morals focussed on married couples with the goal of procreation. In the words of a prominent female family theoretician: "Let's not forget that citizens, who already once neglected their social responsibility (…), may tomorrow violate other norms of moral and ethical behaviour. Therefore the efforts to restrict extramarital births are reasonable, although we must not cease the struggle against prejudices towards them."[10]

Unmarried motherhood had been considered as being the result of the seducation of an overcredulous girl, who was particulary weak in character, they were castigated as immature, careless, irresponsible, imprudent, egoistic, psychologically volatile and ugly.[11] Although legislation used the neutral term 'unmarried woman/mother', many

official documents also used the word ‘lonely mother’, which provided associations with ‘loneliness’ and ‘non-membership in the community’. The medical literature of that time made a connection between loneliness and psychic instability as well as liability to mental illness and suicide.

A complex pattern of morality ensures the continuous control of womens sexuality.

The stigma of extramarital birth was not attached only to the mothers but also their family of origin. Although the early socialist state rejected the educative functions of the family, parents were still made responsible for the ‘correct’ education of their children, especially for daughters: “Young girls are not mature enough to anticipate the consequences of friendship neither to assess their own behaviour.”[12] If girls ignored the principles of socialist morality, her parents were stigmatised as well, because they had failed as educators and had obviously set a bad personal example: “If we want to prepare others, we must be prepared ourselves.”[13] The extension of the stigma forced parents to control the sexuality of their daughters more rigidly than the attitudes of their sons. As there was nearly no sexual education taught in schools, families had to compensate the lack of sexual education.[14]

Instead of useful information, various mass organisations and schools were called upon to send moral appeals to the young generation.

The theories about the guilt of the mothers, the whole discourse towards extramarital motherhood, influenced the social case work.

Case work

Individual Patronage did exist as an idea.

In fulfilment of the government documents to the protection of motherhood and childhood, the foundation of the so-called 'Social Juridical Cabinets' (SJC) began in the '1950's, until middle of the '1970's such cabinets were opened in all districts. They introduced free legal advice and representation of single mothers and the guidance of paternity in court after request of the mother or child. Their responsibilities included the patronage over unmarried pregnant women and mothers.

The patronage includes first an 'inquiry' of unmarried pregnant women.

Already the term points to the hierarchical and one-sided character of the patronage concept. The archives of the SJK contain no materials which conclude about a case work model in whose centre the personality of the mother stands. Not the woman, her predicament, personal needs stood in the centre, but the prevention of a possible abortion. After the "inquiry" the individual patronage went on with measures with this goal. That included conversations, however, not individually carried out, but in the SJC or in front of a committee in which as well as doctors and maternity nurses as well as representatives of the mass organizations and the "society" took part. This publicly character makes clear that a trust-building process was not put on in the concept of case work. This led to the low trust of unmarried mothers in these institutions.

"The visit of a lonesome mother is often connected with big difficulties – it is difficult to determine them, to take up personal contact with her and her relatives, difficult it is to be led in the cabinet.... Often, it is impossible to fulfill the patronage – because for absconding, giving

false addresses, etc."[15]

This quote is from the annual reports by an SJC in the capital from 1975 - a time when serious changes in the official policy towards extramarital mothers already have taken place.

Absconding and respectively inquiry was even stronger in the 1940-1960ies. Abortion was till 1956 qualified as a crime, extramarital motherhood was considered to be a symptom of social and psychological unbalance. Whenever the putative father of the extramarital child was himself married, the SJC protected his legitimate family by trying to preserve the married couple. This principle could be seen as a kind of protection of the legitimate family - Any marriage was tought to be potentially good. If the putative father was unwedded, the SJC could write if requested by the pregnant woman letters to him and speak with him with the goal legal marriage of the „lonely" mother."[16]

If the mother was persuaded of the need of the birth of her child, the SJC took over the release of a patient's chart/sick note with other diagnosis (in order pregnancy to be hidden), as well as the preparation of the documents for inclusion in a medical institution. The main focus was medical monitoring of pregnancy.

After the birth the Patronage had to be continued. According to the law the mother had the right to meet in frame of 6 months the decision – to take the child, to release it for adoption or to leave it at the "Mother and Child" Home for time limited upbringing.

Not only Interviews with medical personal in the responsible institutions, but also published materials show that on the mothers pressure/duress was proved to sign up the declaration for releasing of

the child for adoption during the days after the birth and not to use the full 6-month term. The dominant discourse about the different quality of motherhood according to the marital status of the mother influenced the social work deeply and greatly modified the practices of state institutions, responsible for unmarried mothers.

The leading concept was the child needs a "normal" environment, a "normal" family with healthy mother and father. The child psychological wellbeing having become the focus of attention, adoption was sometimes presented as the best solution available to unmarried mothers. The single mothers, who sought adoption, were, according to these ideas, more mature and less irresponsible than those who kept their babies because the former had ambitions for themselves. The theory of different quality of mother-love according to the marital status of the mother led to a greater pressure to unmarried mothers in order to get her consent for adoption.

Not all mothers whose children were adopted consented under pressure, but, whether it came from their parents or from the institutions, it was not uncommon. Once signed, the declaration came into force and could be changed only by court procedure.

So the emphasis in social work what set not on individual work with the goal personality development and personality strengthening, but rather on the control of the women fertility.

Despite of the attempts to grasp all non-married mothers, one deplores up to the end of the socialist period the impossibility of the full control of this category woman. Thus the percentage from the gynecologic departments and SJC grasped non-married pregnant remained scarcely more than 60%, one quarter of the unmarried women were taken up in

the „Mother and Child“ homes (approx. 24%).[17]

“Mother&Child” Homes

Group Work

The „Mother and Child“ homes served also as a mean of regulation women’s sexuality and way of life. Unmarried mothers were considered to be a “risky group” - a risk for their children, for the immediate environment and for the whole society, so the objective of the homes was to make unmarried mothers responsible towards their child and the society.

Not individual, but “group work” was leading in the organization of the „Mother and Child“ homes. The homes were considered by most unmarried mothers as a form of material help, essential whenever their parents would not or could not (because of the financial burden) accept the situation. Most of them (the mothers) were there because they wanted to hide or have their baby adopted.

Measures for their morally and politically re-education through political lessons and work had been introduced. The woman who came out of the home was supposed to be very different from the one who had entered it: amended, “employable” and a “good” mother.

The “Mother & Cild” Homes served not only to preserve legitimacy, but also to produce it. The “Mother & Cild” Homes acted like a sorting out centre, which redistributed statuses. It gave legal status to the out of wedlock born child through adoption, legitimizing at the same time a childless marriage and allowing the unmarried mother to marry and

thus to produce 'legitimate' children. The "Mother & Cild" Homes and the other institutions provide respectable socialist families (clients) good quality babies.

After release of the child up for adoption, the woman was strike off from any patronage. Any contact with the child was prohibited for her, even information about the child was not allowed to be given to the mother. Curiously, when the psychological suffering of the child had become such a great concern, the psychological suffering of the young women whose child was snatched from her was completely and scientifically denied.

If the unmarried mother decides to up bring her child alone, the patronage goes on: the mother had the right to name the father and got free assistance in the possibility of getting children's allowance, but the procedure was so complicated and for such paltry results, that it was not very often used.[18]

The institutions are required to support lone mothers in the housing and job search. One quotation for the art how it works: Report of a Sofia SJC from 1976: "*We started with the correspondence for finding lodging (accommodation). The applications (BG - plea) has been worked out / draw up by our layer. Special visits were approved by the nurse and the layer in connection with the labor readjustment refund ....Direction in this regard has been given to the women consultations at the polyclinics."*[19]

So the support of single mothers not only often remained on paper only - the SJC could only make recommendations not binding/obligatory for the other institutions. The example shows also the transfer of responsibilities from one institution to another.

Shortage of specialists

Not only was the concept of individual case work with its accent on the process of independence of the personality suspended.

A next structural problem for effective case work was the shortage of personnel, especially trained specialists.

As stressed, the social work becomes "cut in separate pieces"; the single problems were delegated to narrow specialists.

In relation to single mothers we can speak about a dominant medicalization – the focus on the prevenation of abortion, of childbirth and of the physical health of the children fall. But even the medical staff was not enough - one of the main problems in the whole period was the inadequate and insufficient staff even after the normative:

"Every doctor is responsible for children 50-60, distributed in 2-3 departments. If you consider that the majority of infants are children 6-7 months old, some of them born prematurely and that the sick children are cured here, you have to stress that the workload of the doctors is very high."[20]

The difficult working conditions, the work overload, the low pay, the negative attitude towards the staff too, cause the constantly insufficiency and the fluidity of labour. This led to permanent problems with the qualification, and caused the strong feminization of this field.

The nurses and the legal practitioners were working often job assigned and leaved/quitted their jobs at the first chance/opportunity.

Continuities and Changes since the late 1960s

Since the late 1960s the family and reproduction policies changed in direction stronger pronatalism what led to new attitudes by the party towards the issue of extramarital birth. Furthermore, society experienced a significant growth of births outside wedlock despite the official attempts to the contrary. The demographic concerns of the regime resulted in the re-evaluation of children born to unmarried mothers – they also contributed to population growth. An important factor is the affordability of social policy. The socialist economy was not in a position to raise large sums of money, which the increasing social services required. Since the mid-1970s we can speak about a slower economic growth, rising state indebtedness, what influenced the social policy.

In view of fiscal scarcity, the state had also concerns about the raising bill for mother-child homes and other institutions which cared for children born out of wedlock. Now, the state began to urge unmarried mothers to keep their children and to raise them on their own.

Single mothers who raised their child were praised in the media as 'saints' and 'heroes'. In 1972, a reader wrote a letter to the editors, responding to a series of articles on single motherhood in the popular women's journal 'Woman Today' (•enata dnes): *"I would kiss the hand of the one, who remains mother, who does not give away her child and who realises motherhood as the point of her life. A person like this, I can absolutely respect. But I cannot respect those, who come to the maternity hospital only in order to liberate themselves from the unwanted pregnancy."*[21]

The government introduced complex administrative, material, social and educative measures for the purpose to make unmarried women raising their offspring. In the beginning of the 1970s, for example, the child allowance scheme was changed so that single mothers would receive twice as much as married mothers. If they were not employed, they would get a monthly allowance by the state in the amount of the minimum wage until the second birthday of their child (in case of second and third children as well as twins, until the third birthday). Children of single mothers enjoyed priority for placement in crèches and kindergartens which were a social service in short supply.[22]

So, in the 1970s the break of the taboo 'single motherhood' took place. The press published articles about 'lonely mothers' discussing also the problems of fatherhood and family relations:[23] *"In case the parents or friends do not give her shelter, the single mother has no place to live (…). She also hardly finds a job."*[24] It is interesting to see that critique is now directed against 'public opinion' and, above all, 'family morale' and 'philistine parents' regarding their unmarried daughter as a personal disgrace. Of course, there was no reflection about the fact that these attitudes had been produced by the negative stance of the government towards single mothers.

Now, those mothers were blamed who left their children in mother-child homes, especially educated women who deserted their children. Mass media portrayed them as women who were full of egoism and bourgeois behaviour, searching for a comfortable life and adopting 'Western' models. Public discourses continued to condemn unmarried pregnancies, without reflecting the social structures which dominated this kind of fate. Hence, despite the heroic portray of single mothers, the stigmatization of extramarital birth survived.

The stigma was even doubled against unmarried mothers from the minorities (especially gypsies) who left their children in the mother-child homes.[25]

Quantitative criteria for social work

At the same time in the 1970-ies for the evaluation of the work of social institutions strongly quantitative criteria were introduced.

The report forms became formalized, the whole system – highly bureaucratized.

The number of visits in the SJC, divided into different categories, was important to be counted: "Lonely mothers"," Lone mothers for abortion","Divorced","Widows","Child-rich mothers","Adopters" etc.

The archives demonstrate the high quantitative work-load of the SJC and the „Mother and Child Homes". The SJ Cabinets had to accompany not only unwed mothers and the guidance of paternity in court, in their responsibilities laid the whole activity in relation adoption, as well as the preparation of all documents for the transfer of children in the "Mother & Child" homes. Only for the period 1975 – 1989 the SJC of II. Gynecological Hospital in Sofia, for example, was visited daily by 15-25 'clients' from the different categories.[26] The SJC developed in direction advice in legal matters. The archives show the efforts of the staff to cause a change of the normative base, so that the SJC receive more rights in solving the problems.[27] These attempts remained fruitless till the end of the socialist period, so their recommendations to the other institutions (regarding job and housing search) remained

not obligatory and that's why often on paper only. The limited opportunities for solving the problems (because of institutional splintering), combined with the structural problems of the staff (number and qualification) could led to rising formalism, ex officio of at least part of the staff.

Till the end of the socialist period it was not developed a bearing psychologically grounded case work system which would put in the centre the personality of the single mothers under inclusion of the influencing environmental factors.

Conclucions

The example of the patronage of extramarital births shows, that Bulgarian socialist state did not develop a bearing Case work method.

Ideological reasons (as the priority of the collective before the individual) as well as a number of structural basic conditions like total nationalization (absence of the instruments with which the objects of the social policy could participate), long lasting de-professionalization of social work, fragmenting, institutional disunity/splintering of social politics and increasing bureaucracy are under the main reasons/factors.

[1] Kristina Popova, Die Soziale Fuersorge nach dem 9. September 1944: buerokratische Kontinuitaet, soziale Diskontinuitaet, in: Ulf Brunnbauer/ Wolfgang Hoepken (Hg.), Transformationsprobleme Bulgariens im 19. und 20. Jahrhunder. Historische und ethnologische Perspektiven, Muenchen 2007, 109-124.

[2] Ibidem, 121.

[3] Stefanie Rehaender, Gestalt- und Bedeutungswandel der sozialen Kasuistik in Deutschland nach 1945, Diplomarbeit, Universitaet Siegen, 2003.

[4] Hausbesuch

[5] Ljubovta, brakat I semejstvoto v socialisticeskoto obstestvo. Borbata sa sazdavane na zdravo socialisticesko semejstvo – moralen dalg na vseki trudest se v nasata strana, Ruse, 1961, 5-23.

[6] In 1946, the total population was made up by 3,497,900 women and 3,479,200 men (Statistièeski godiš nik 1943–1946, 19).

[7] Dinkova, Maria: Labirinti na lekomislieto i bezotgovornostt [Labyrinths of carelessness and irresponsibility]. In: *Žnata dnes [W oman today],* 7/1972, p. 6.

[8] Ivi.

[9] See Vanya Nikolova, Tajnata na osinovjavaneto – javnijat beleg na modela, in: Balgarska etnologia 2008, 3, 5-22.

[10] Maria Dinkova, op. cit.

[11] See Anelia Kassabova, Begrenzte Transformation oder Transformation der Begrenztheiten? Politik und eneheliche Geburten im sozialistischen Bulgarien, in: Ulf Brunnbauer/Wolfgang Hoepken (Hg.), Transformationsprobleme Bulgariens im 19. und 20. Jahrhunder. Historische und ethnologische Perspektiven, Muenchen 2007, 125-148.

[12] St. Doceva, Majkata i sazrjavaš tata devojka [The mother and the adolscent girl], In: Zdrave [Health], 9/1965, 9-10.

[13] Stanka Markova/Miladin Apostolov, *Intimen razgovor s mladež a [Intimate/ Personal Conversation with the Youth],* Sofia, 1983, 38.

[14] Anelia Kasabova-Dintcheva, Neue alte Normen. Die versuche Normierung *der Sexualität im sozialistischen Bulgarien,* in: Ethnologia Balkanica, 8/2004,

155-178.

[15] ZDA, F. 2340, op. 3, a.e. 96, 5.

[16] ZDA, F. 2340, op. 3, a.e. 96, 6.

[17] Sashka Popova, Medico-sozialni aspekti na izvanbracnata razdaemost, Diss. Sofia 1977, 188.

[18] ZDA, F. 2340, op. 3, a.e. 96, 1-40; ZDA, F. 2321, op. 3, a.e. 56, 1-7.

[19] ZDA, F. 2340, op. 3, a.e. 96, 9.

[20] ZDA, F. 2330, op. 2, a.e. 2, 24.

[21] Ilieva, Violeta: *Èuždata žena, kojato me e rodila [The unknown woman, who gave birth to me]* In: •enata dnes [The Woman Today], 5/1972, p. 19; see analyses: Anelia Kassabova, Begrenzte Transformation...; Ulf Brunnbauer/ Anelia Kassabova, **Socialism, Sexuality and Marriage. Family Policies in Socialist Bulgaria (1944 - 1989), in: Sabine Hering (Hg.) ??(in print).**

[22] *Sbornik materiali za nasãrèavane na razždaemostta* , Sofia 1986.

[23] Maria Dinkova, Op. cit., 6; Pavlina Popova, Stop, '•ulieti', stop! [Stopp, Juliettes, stopp!], in: •enata Dnes [The Woman Today] 9/1972, 14-15; Margarita Martinova, Kukuvitsi jaitsa v gnezdoto na blagoè estieto [Cuckoo's eggs in the nest of the devotion], in: Narodna mlade• [People's Youth], 7/1978, 4; Atanas Stamatov, Problemãt za 'baš tite' [The problem of the 'fathers'], in: Narodna mlade• [People's Youth], 17/1978, 4.

[24] Velislava Dareva, *Detsa na ljubovta [Children of love]*, in: Komsomolska iskra [Comsomol flame], 4/1978, 8.

[25] The ethnic problematic will be discussed in a separate article (forthcoming)

[26] ZDA, F. 2340, op. 3, a.e. 96, 1-40; ZDA, F. 2321, op. 3, a.e. 56, 1-7.

[27] ZDA, F. 2340, op. 3, a.e. 96, 11, 14.

From Casework to Co-creating Good Outcomes in the Working Relationship

Gabi È aè inoviè Vogrinè iè, Nina Meš l

1. Introduction: Co – creating individual working projects for help in working relationships

Casework meant always helping people, it meant meeting them in a personal and responsible relationship and work with them to help and support. The history of social work shows that there were times, where casework seemed less important, even minor to group and community work. As if casework meant dependency, lost autonomy, lost competence that should be avoided and replaced by more empowering methods like working in groups and supporting community projects.

Casework had to carry the burden of the late development of the science of social work. Casework needed its own, social work way to define, practice, evaluate and research the process of help. The helping process was for to long not the main issue in social work theory. A real clear step in that direction was made just now, in the late 90ties, challenged by postmodern concepts for social work practice.

Our thesis is that »co – creation« is the best term to be used in the new language of social work to describe how we define the process of help. Co – creation articulates the new, postmodern paradigm and redefines the roles of both – the client and the social worker: in the co – creating process for good outcomes there are the client as expert on experience and the social worker as accountable ally. Lynn Hoffman's extremley important concept, the ethic

of participation (1994, p.22) emphasizes the quality of the relationship between social worker and clients: they co-create interpretations, meanings, solutions. A postmodern social worker supports conversations to create new, useful narratives. Hoffman *(Ibid.)* suggests to "[…] replace the objective observer with the idea of collaboration in which no one has the final word." And: "Statements like this suggest that an ethic of participation rather than a search for »the cause« or »the truth« is now emerging as a central value of social thought and action." A new responsibility is emerging: the responsibility to collaborate for understanding, exploring alternative meanings, creating new meanings and new narratives together with the clients. The social worker no longer owns solutions or right answers. He or she has to face the uncertainty in confronting open spaces in searching with all in the problem involved.

The concept of co-creating good outcomes in a working relationship with clients brings a re – definition of the concept of help in social work. Critical analysis and redefinition of the concept opens at least two important issues for research. There is a question of help definition in different historical periods, the question of how action objectives in social work are defined on the level of assumed social measures and institutions, on the level of social values, on the level of

knowledge which the professionals need, on the level of social and professional outcomes. The second issue points toward the question how the process of help is defined in social work, how it is established, maintained, which methods, techniques and skills social work has developed, how the role of the professional and the user in the process of help is being changed.

Both issues are still crucial points in creating specific knowledge in and for social work. The international definition of social work, accepted in Adelaide 2004, proves it. It says:

»The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well – being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. «

We think there are important points missing. There are social work theories to rely upon, we need and we must focus our research on developing actionable knowledge in a theory for social work practice. The definition offers no answers to one basic question: how do social workers promote social change, how solve problems, how empower, liberate, and how enhance well being? What is the specific, special social work way of support, change, and help?

In modern social work social workers still have to combine sometimes divergent, even contradictory roles, caught between care vs. control without clear theoretical frameworks for practice. Parton and O'Byrne (2000, p.33) say that at its crudest, social work involves both care and control. They think that the attempt to try and categorize and separate

these roles (i.e. practical helper, counselor, protector, supervisor, advocate, general provider of support and maintenance, the role of a person, who performs control) is in great danger of missing the essential nature and characteristics of social work.

The authors support our points speaking about the second dimension, which defines the way of helping in social work – about the influence of relation between the individual and society. The relationship between the individual and the environment or the relationship between the individual and society is the key to understanding the nature of social work, and it is the role of the state which is the major influence on the way this relationship is mediated and articulated (*Ibid*., p. 36).

The aim of this article is to offer some answers to these questions, because they are important to understand the shift from casework to relationships between social worker and user, where changes, help and support are co-created.

In the first part we present the beginnings of the social work profession in Slovenia, the first institutions, the first concepts. In the second part we present a postmodern frame to answer the important question of how we help in social work.

2. A brief history: The institutional context of help provision since Second World War till the establishment of *Social Work Centers* in Slovenia

Institutional contexts and the concept of help

After Second World War the help for individuals and families was or-

ganized within *District People's Committees, Municipal People's Committees* and *Local People's Committees.*

Help for individuals and families were organized within *Social Welfare Councils* and *Health Councils* at *District People's Committees* and *Municipal People's Committees*. Main questions the councils dealt with were the provision of disabled, orphans of death fighters, victims of fascistic terror and others protection needed (ZAC, OLO, 29th nov.1946). During this period the help meant giving financial help and work and apartments provision to the "health, social and moral threatened families" (ZAC, MLO, may 1947).

Care for children in a family where parents were described as "negligent, as parents, who don't take care for the children's upbringing, as bad parents, moral threatened parents etc." meant to take them away. (*Ibid.*). First years after the war children were taken to "children homes", after the year 1955 they were settled in foster care families. Decisions about such issues were first made in meetings of *Social Welfare Councils* (at *District People's Committees* and *Municipal People's Committees*) and later in meetings of *Mother and Child Protection Council*; after the year 1958 on *Family Protection Council*.

During this period the members of *Social Welfare Council* made decisions on general and also about concrete questions on social policy and social welfare about concrete person (for example - from the foundation of social institutions to taking away children from a family). With the help of outreach workers who reported on living conditions in the field, specialized officers from different offices (such as welfare office, adoptions office and similar) prepared material upon which practical help was based.

During first years after the war the help was provided from specialized officers who didn't have appropriate education for working with people on such a demanding field as social welfare. There were only short trainings organized for officers working in different departments. In the record of the first meeting of the *Social Welfare Councils* at *District People's Committee Celje* in 28th of September 1955 we can for example read: "[…] *Municipal People's Committees* have set suitable officers for these businesses and they took over all the leaving files for their field. For the training of those officers there was a two days seminar organized, where officers from *District People's Committee* presented all the material from their field of work and they also gave written instructions for work. The school education of officers is not sufficient, but some of them have experiences on the social welfare field and on seminar it looked like they will manage the job […]" (ZAC, OLO, 28th Sept.1955).

Professional education in social work: the school of social work in 1955

The School of Social Work in Slovenia was established in 1955. Yugoslavia was the only socialist country of that time to offer professional education for social work.

It was an important step to enhance quality in care and support for people needing help and the beginning of serious work on new professional knowledge.

The first manual with the title "Social Work Methods" was published already in 1959. Katja Vodopivec, a much respected professor of law

traveled to the States to learn and bring useful literature. We can't enter into details of this extremely interesting manual, but we would like to quote her point of view, so revealing for that time. Katja Vodopivec says (1959, p.12):

"Methods are neither the main nor the crucial subject in schools of social work. Other subjects enable social worker to understand social and economic issues, to understand human beings and that is the content of social work. Social work methods are those techniques, which are not regulated by law, but are developed through long years of practice here and in the world. We need a long time to observe social work practice, to be able to generalize and to build a theory of methods."

This was a visionary statement. We are still in the process of observing social work practice, learning slowly the value of the how, the process.

Sociology, law, economics, psychology, social policy… were the main subjects of the curriculum. But what was the content of the "Manual on social work methods"? "The Manual" presents two broad social work fields: preventive social work and social work helping people, who need care and support. For preventive social work it brings group dynamics and group work methods and skills. There is a strong emphasis of social responsibility of social workers and their engagement in social actions in the community.

The language Katja Vodopivec uses for »social work helping people« says: helping people who alone are not able to cooperate in a healthy way and fully in social and working processes. For casework she already speaks of »the special social work way of helping« (*Ibid*., p. 82), meaning enabling for cooperation and using elements of the strength perspective (Sallebey 1997). Students learn details of how to set up an

interview, that is at the same time a respectful and a working tool.

It is a great pity that the »observing and generalizing« to build up new knowledge of social work processes stopped. One reason certainly was that social workers in Slovenia had till the 90ties not the academic status to research.

But the social work practice showed results of education. The turning point was in 1957, when the first graduates from *School for Social Workers* started their jobs.

District People's Committees and *Municipal People's Committees* wanted educated coworkers and they made effort for people to educate themselves on the *School for Social Workers*. In the records we can for example read about "the need to fill free scholarship spaces – there is a need to go trough the list of children which parents died as fighters or were victims of fascistic terror" (ZAC, OLO, 1st Aug. 1956).

The *Social Welfare Council* at *District People's Committee Celje* wrote in the program for the year 1960: »[...] The Council will take care that the professional knowledge of employers of social welfare at *District People's Committee* and *Municipal People's Committee* will be improved, that the systematization and rewarding is arranged, [...] it will recommend to employers to improve their knowledge on the *School for Social Workers* [...]« (ZAC, OLO, 1960.)

The *Society of Social Workers of Slovenia* was also founded in year 1957, as were the first social work centers and residential units.

At the founding assembly of the *Society of Social Workers of Slovenia* on 17th and 18th of May they wrote:

“In the socialist arranging and development the social work has even bigger social meaning and value. In this time this field strongly exceeds frames of state administration and it offers wide possibilities for various organizations to work [...]

[...] the *Society of Social Workers of Slovenia* will give efforts to explore social problems and show modern methods for their solving [...]« (ZAC, OLO, 30th May 1957).

From the meeting records and specialized officer’s reports in that period we can see that there was a bigger amount of work on the social welfare field. Specialized officers weren’t satisfied with the way of solving problems – they stared to talk about the quality of social work. In their opinion they were doing only the curative work, preventive work couldn’t be done because of work overload. They started to talk about the need to separate social work from administrative work. In that time they started to think about the establishment of social work centers, which would take over the preventive tasks, which weren’t connected to administrative procedure.

The purpose of social work centers establishment was defined as:

“The extensive social work demands the separation of some social work form the administrative institutions; especially preventive ones. There for the social work centers should be organized in towns and industrial centers.

The center will take over:

- the office for socially unadjusted youth,

- the office for foster care.

In the future center should take over also other social offices, except those strictly attached to administrative procedure and the leadership of social policy (ZAC, OLO, 27th Spt.1960)."

The organization of institutions for helping people within *People's Committees* already defined the way of help. Helping meant realizing administrative tasks based on legislation and the work of *People's Committees* – in a relation care vs. control – put itself on the other pole – control.

The idea about the role of social work centers in sixties, when - as we can see from the records of *People's Committees* – they were thinking the centers would take the preventive tasks and other social services, which weren't strictly attached to administrative procedure, weren't realized. The centers actually took over all the work of social welfare from *People's Committees*. There is still kept the similar structure off offices somewhere; centers also perform the administrative procedures. So separating the tasks of counseling and the task from administrative procedure is still the important issue on social work centers.

The institutional contexts, social values, social measures are important issues which needs the attention to understand the historical development of concept of help. But, as we write at the beginning of our paper, there is also another important issue - the question of the process of help in social work, the question of methods, techniques and skills social work has developed, how the role of the professional and the user in the process of help was changing in history.

3. Casework today: Co-creating the working relationship in social work

Two models, the working relationship and the individual working project of help are proposed and explored as possible definitions of the specific, social work way of help. The working relationship defines relationships and conversations that make changes possible. It is about the how in doing social work, about important elements that have to be taught and learned: the language, methods, and skills.

Establishing a working relationship is the first, highly professional task of the social worker. What is a working relationship in social work? Which elements define the concept?

The basic elements of any social work working relationship are:

a. agreement to cooperate;

b. instrumental definition of the problem and co – creating solutions; (Lussi 1991) ;

c. personal leading (Bouwkamp, Vries 1995).

Those three basic elements are embedded in the context of contemporary concepts in social work:

d. the strength perspective (Saleebey 1997);

e. postmodern concepts: the ethics of participation (Hoffman 1994);

f. co-presence, »here and now« (Anderson 1994);

g. actionable knowledge (Rosenfeld 1993) .

a) The issue is to make the agreement to work explicit. It is always important, to gather all in the problem involved in this important ritual. There is time and space for decisions instead of being »made to«, persuaded, forced or drift into vague projects. Agreement contains the decision to collaborate »here and now«; agreeing about duration of the meeting; and finally, about the how in the process: co-creating solutions in an open space and safe space for conversation.

b) It is obvious that the definition of the problem together with the client is a highly professional act of the social worker. Systemic concepts made it possible to reframe the client in the social context as the in the problem involved person among others in the problem involved persons and the task of the social worker to start the process where all involved in the problem are reframed as involved in the solution (Lussi 1991).

Defining problems together with clients, investigating the endless variety of solutions and the concrete share of the individual in solutions, is possible in a social work working relationship where understanding, agreement, consensus, can be explored, enhanced and maintained.

c) Personal leading demands the ability to lead towards explored, clarified and agreed solutions, the ability to create and maintain a personal relationship with all in the problems involved. Vries and Bouwkamp (1995) offer a useful formula: »be concrete, personal and here and now«.

The personal leading role is complex: leader, in the problem involved, leading, catalyzing, joining, confronting, reflecting…

There is always Pfeiffer-Schaupps (1995) ironic statement: » If you don’t know where you are going, you must not fear to arrive«. In the

working relationship solutions and ways to achieve them, are co-created or co-defined.

d) The ethics of participation. Lynn Hoffman (1994, p. 22) emphasizes the quality of the relationship between social worker and clients: they co-create interpretations, meanings, solutions. A postmodern social worker supports conversations to create new, useful narratives. A new responsibility is emerging: the responsibility to collaborate for understanding, exploring alternative meanings, creating new meanings and new narratives together with the clients. The social worker no longer owns solutions or right answers. He or she has to face the uncertainty in confronting open spaces in searching with all in the problem involved.

I interpret the concepts of Hoffman, Anderson and Goolishian, Gergen elaborating the social construction of therapy as possible model for a social construction of social work in the frame of the ethics of participation.

In social work the setting is different, the invitation is to communicate and metacommunicate, not therapy, but the Dialogical Mode describes what is needed: free conversational space, facilitation of emerging dialogical processes where new narratives are created. Taking the client's story seriously the social worker joins in the mutual exploration of the clients understanding and experience. It is an attitude of respect for the personal language, for the familiar words people use. The process is co-development of meanings, co-interpretation and understanding.

e) The strengths perspective brings a new, paradigmatic shift, enlarging the concept of empowerment. Dennis Saleebey (1997, p.3) says: "Practicing from a strength orientation means this – everything you do

as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit clients' strength and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings."

To act from a strength perspective is first of all a very personal decision of the social worker. The shift from seeing problems, failures, obstacles, to looking for power and discovering strength is not easy. In his Lexicon of Strength, Saleebey (1997, p. 11) emphasizes: "It would be hard to exaggerate the extent of disbelief of clients' words and stories in the culture of professionalism. While social work, because of its enduring values, may fancy itself less culpable in this regard, than other professions, a little circumspection is warranted." So again: we have to learn in social work. The other elements in the Lexicon show, how the strength perspective is integrated in social work action. The elements are: empowerment, membership, resilience, healing and wholeness, dialogue and collaboration.

f) Co – presence. The working relationship focuses the attention of the social worker to the present, the here and now. We have said it already: the emphasis is on the conversation, on the dialogue with the client, on discovering and co-creating new narratives and new solutions. Confrontations, understanding, agreements are sources of new experiences and possible changes. I know from my experience with social workers and students that it is not easy to stay in the present and save time enough to make a conversation possible and a relationship meaningful. We need time in social work, to make conversations happen, to explore and exploit, to redefine where we are and where we want to go, to conclude the conversation in a way we can continue the working relationship. Tom Anderson (1994, p.64) puts it this way: "Talking with

oneself and/or others is a way of defining oneself. In this way the language we use makes us who we are in the moment we use it." And: "One might say that the search for new meaning, which often comprises searching for a new language, is a search for us to be the selves with which we feel most comfortable." Andersons concluding remark (*Ibid.*, p. 66): "The listener is not only a receiver of a story, but also, by being present, an encouragement to act of making the story. And that act is the act of constituting oneself". A working relationship needs time to be established, to grow, to be useful.

g) Iona Rosenfeld presented the concept of actionable knowledge on the European Seminar of the IASSW in Torino, 1993. He meant professional knowledge that can be transformed into professional action. He pointed to a very important aspect: the relationship between theory and practice.

"Social work knowledge has to be shared with clients. Conversation means translating professional concepts into local language and back into professional concepts. The professional language is important, because it sets the frame for social work: a working relationship needs words to be described and maintained."

Both – the professional and the client - need actionable knowledge. The social worker, who is able to share knowledge and create dialogues with clients, is involved in processes of understanding and exploring solutions and able to invite clients to participate and to learn to maintain the working relationship too. One important aspect of the working relationship is the learning of social work concepts by clients, so their co - responsibility for the helping process becomes a reality.

In the working relationship social workers and users, or as we like to

say, responsible and respectful allies and experts in experience, create unique *working projects* for and with clients. Working projects are outlines of steps that bring co-created solutions into action**.**

It is a model that social workers can use and share with clients to make co – creating good solutions possible.

4. Conclusion: From pathology-based social work toward the ethic of participation

Our brief journey into the history of concepts of help, the journey from the beginnings of casework toward the postmodern paradigm in social work best illustrates O'Hanlon (1993). Author is speaking about psychotherapy, but the described changes are clearly valid also for social work. He says:

"The First Wave in psychotherapy was pathology-based. The Second Wave was problem-focused problem-solving therapy. The Third Wave was solution focused oriented. The Fourth Wave is what is emerging now. Only no one has a good name for it yet."

Our brief journey from pathology-based social work to the postmodern "co-creation" of help in a working relationship couldn't illustrate all the steps that had to be made in our profession to be where we are now. Certainly the goal for social work today is "the Fourth Wave", which in our interpretation is postmodernism that puts in front the question of the relationship and the process between social worker and clients. The ethic of participation (Hoffman 1994) is the path for social workers to take, the path which leads to co-creation of good outcomes.

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Adopting Case work methods in Bulgaria

Kristina Popova

Individual care

Case work methods were introduced in Bulgaria in the early 30s. They were introduced by the initiatives of various women organizations. International contacts and exchange contributed case work ideas and practices to be spread.

The individual social care began in the earlier decades in the practices of the Women's Charity Organization "Samarjanka" (Samaritan Women). The organized women from the society were trained by the Red Cross Society. Instructed also by two American Red Cross Nurses (Rachel Torrance and Helen Scott Hey) they started home visiting practice during the World War I . After the War Samarjanka Society continued this practices of visiting poor or ill families in the next decades. The Samarjanka women introduced also the regular documentation of home visits and the social support they gave.

In 1926 the Nursing School in Sofia opened a course for visiting nurses which established home visits practice as a common method in the new opened (after 1924) children health consulting centers. Home visit practices were introduced also by the Bulgarian Union for Child Protection which organized training courses for female teachers in the villages in order to prepare them for educational and charity work for peasant mothers and children. They were so called teachers – advisors. The female teachers – advisors visited family homes in order to observe hygiene, food and living environment and to give advises to the mothers. They also described their home visits and run a documentation of their work.

Rachel Torrance (1886-1937)

The High Social School for Women by the Bulgarian Women's Union

The professional case work methods and procedures in Bulgaria were introduced by Bulgarian jurist Rayna Petkova (1895 – 1957). In 1932 Bulgarian Women's Union opened a female preparation course for social work which became in the next year a High Social School for women. It followed the model of the Alice Salomon's Women's Social Academy in Berlin. Bulgarian jurist Rayna Petkova was send by the Women's

Rayna Petkova (1895 – 1957)

Union in 1929 to Berlin in order to finish the academy and to implant her knowledge in Bulgaria after that. Coming back in March 1932 she gave lecture to the Bulgarian Academic Women Society in Sofia about the social work methods in Germany. In the next 1933 she published a book " The social Work in Germany" based on this lecture. In her article "Methods of the social assistance in Germany (before Hitler's coming to power)" Rayna Petkova described the beginnings of the "individual method" in the social work in the Elberfelder System. She pointed out that the procedures of this method were established after the First World War. Rayna Petkova translated texts by Alice Salomon and other German authors and published some articles about the professional social work. In the new opened Social school for women in Sofia she became a lecturer for the social work methods. She pointed out the importance of the personal contact to the needy and the home visit for collecting data, creating trust relationship and support.[1]

Rayna Petkova wrote that the social worker had to have some professional skills. The social worker had to be competent to observe the social situation, to have the courage to take decisions, to have hygienic, juridical and ethical knowledge, to know the legislation and institutional base for social work. She had to posses also the skills to speak good, to be kind, to have warm and responding heart, to know the psychological characteristics of the persons in authorities and outside them.[2]

According to their curricula in the High Social school for women, the students visited regularly poor homes in Sofia outskirts in order to observe them and to study how to report the social situation of the families. The women graduated the School were prepared for social work as a very important work for the people, which has to improve their live and to change the society. One of them wrote:

"…Armed with the necessary knowledge acquired after two years of hard work, the alumni of the Higher Social School for Women proceed to the implementation of their skills under extremely severe external conditions but with a burning internal flame for real social work.

The theory time is all over now. The thought in the mind is clear – to heal the pains of society, to educate and re-educate friends and relatives – certainly a hard but noble task. There is no place for delicacy, for sentimental sighs, no, the harsh law of life is all around. When taking her duties in hand a social worker faces the daily round of those nearby who are living in grief and misery and who are only sometimes lit up with small delights. They want, seek, struggle, fall in desperation, yield... It is the social worker's duty to help those people, to make their lives less painful and not as dark. She must save them from getting enraged and losing faith, she must infuse faith into their souls, bring them to a new life, better and more humane. Undoubtedly it is a hard task but the strength of mind for its implementation is solid. The mind is armed

Sofia municipality social service department in the 30-s

with knowledge, the determination to stop human suffering is unshakable, the awareness of occupational and personal duty is above all…"[3]

The High Social School for women contributed very much for the establishment of the methods of social work. In 10 years about 500 students were trained. Many of them started to work in social institutions: orphanages, children homes, old people homes in Sofia and other towns as well as in municipality social services. They created personal contacts to many women by the regular home visits. Some of this visits and contacts were used also by political or women organization activists to spread political ideology among the visited women housewives or workers.[4]

The municipality female social advisors: the power to help or to deprive?

In 1934 the Municipality social services in Bulgaria were reorganized. Female municipality social workers - social advisors - replaced in Sofia the former commissions which included municipality council members and priests. The first eight female social advisors led by a senior female social advisor were hired in the municipality in the same year. Some years later their number were doubled. According to the municipality rules every female social advisor was responsible for a part of the town.

The female social advisor became a key figure in the social assistance system. She had to visit regularly the families in her residential district, to collect and to prove data about pure families. She fill the data in the index cards of the poor families. She also assisted the poor people who needed help to fill the formularies for the different kinds of social support (social institutions, material support etc.). She proposed a decision for every case which was taken by the chief of the department. According to the prescriptions of the Sofia municipality rules , she had to fulfill her work with "empathy, devotion and love"[5] . The female social advisor had also an professional uniform and as well as tram card for free for her visits.[6] In 1941 a new position was introduced in the hierarchy of the social service office: a senior female social advisor – instructor. The change was motivated by the very high importance of the work.[7] The senior social advisor- instructor had to have worked for at least 5 years. The social advisor's occupation became to be accepted as a profession for the hall life.

The first municipality social advisors were visiting nurses, later on Sofia municipality service started to hire women, graduated the High social

Sofia municipality social service department in the 30-s: card indexes

School for Women. The female social advisors were also involved in the work of the district's councils for social support, which coordinated the hall social assistance activities of state, municipality and private charity organizations. The council included representatives of state authorities, municipality and civic charity organizations in order in order to prevent a misbalance of the social support among the poor population.[8]

As we can see by the case with the poor citizen's petition in Sofia in 1939, poor families accepted the power of the female social advisors, but their mutual communication remained a sensitive field where trust had to be negotiated constantly. Home visits were an important place for this negotiation where people needed respect and recognition.

Conclusion

In the time from 1915 – 1939 women created a large space for various activities for social support which became legitimate places of speaking about social problems. In the 30-es this female activities existed parallel to each other. Volunteers and professionals: Samaritan women, visiting nurses, teacher – advisors, municipality social advisors, High social school students made the home visit a common practice where power and trust were negotiated. Women of a large scale of social and educational background took part in these activities crossing regularly class and spatial borders.

As a female work it was based on the social maternity ideological views demanding from professional and voluntary social workers devotion to their work, empathy and specific communicative skills. In order the home visit to be accepted by the people in their homes the voluntary and professional social worker needed in that time the authority of their societies or institutions. In order their advises to be heard they needed also to be different in their outlook, speaking and behavior from women in both upper and low classes.

The home visit practices changed the topography of social regulation in urban and rural space in Bulgaria. Female social worker and volunteers were accepted as key figures of the modern social work and biopolitics in the 30-es which changed the public image of women in Bulgaria.

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[2] Rayna Petkova, Socialnata rabota v Germania, Sofia, 1933.

[3] Ana Mancheva, From the practical educational work of the Higher social school for women.

[4] See Vera Nacheva, Vremeto e v nas, spomeni I razmisli, p. 67 – 68.

[5] Municipality rules for the social assistance department, 1939.

[6] Municipality rules for the social assistance department, 1939.

[7] State Archive – Sofia, Fond N 1k, opis 4, a.e.1088, l.108.

[8] Pravilnik za nachina na rabota pri obshestvenoto podpomagane v Bulgaria, Central State Archive, F. 588, op.1, a.e.90, l.1-5.

Current Trends in Social Work Case Management

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Much experience of and writing about case management takes place in

countries, disciplines, fields of practice,professions and client populations. Despite the continuing popularity of case management as a vehicle for service delivery, the debates about what it is, who needs it and under what conditions it is best provided are recurring themes in the literature and on the international conference circuits.

The term ‘case management’ evokes a sense of understanding that is more elusive than is generally acknowledged. There is a perception of shared wisdom about case management that permeates the discourses and distracts us from the level of critical analysis that is sorely needed to develop knowledge and practice.Without deconstructing or teasing apart the deals about case management, we do not establish precise knowledge about the various manifestations of the approach in diverse practice settings. What is, or is not, identified as case management is

often determined by the commentator's own position in the field. For example, the community care practitioner may see little common ground with the practice of case management in a prison environment, in managed care or case flow management in court administrations. What is known of case management? Case management is simply a challenging fact of contemporary health and human service worlds which demands analysis and response from all who are involved with it. If—as is likely in future—new and more fashionable terms replace case management, the principles underlying it will probably remain and thus an understanding of it can add depth to a critical appraisal of its successors.

Three matters of language must be addressed: case management itself; who it is directed at ; health and human services. *There are various definitions for case management:*

"A procedure to plan, seek, and monitor services from different social agencies and staff on behalf of a client." (*The Social Work Dictionary).* Case management is a highly individualized approach that considers the unique aspects of the person and at the same time provides a holistic orientation that views all aspects of the client system, including the client family, friends, their situation, and their environment.Case management, often referred to as care management, requires knowledge of community resources and entitlements, skills in matching clients with resources, linking of resources, and serving as an advocate.

While there is no single definition of case management, the term generally encompasses

• assessment
• formulation of a case plan
• coordination of the necessary services clients need to remain living in the community
• monitoring these services and
• making adjustments to services when individuals' needs change

The second question of terminology is what to call the person or people for whom services are delivered:

• **'Client'** is the term commonly used in the human services and now more universally**. 'Patient'** is the health term.

• '**Consumer' and 'customer'** are newer general names with managerial origins and, as Sheppard (1995, p. xii) says, they are redolent of 'popping into Woolworths for some toys'.

• '**User'** is also an increasingly evident label, it is now regularly used in relation to substance abusers

• *All of these terms carry historical, professional and ideological significance and there is no entirely satisfactory way to resolve problems of language in this area. We are most familiar with the word 'client' and tend to use, rather than endorse, it sometimes along with 'service user' and 'consumer'.*

Any claim to produce a single history of case management defies the reality of its diversity and multiple applications. Depending on the

commentator's discipline base, orientation to the approach and experience, the perspectives on history vary. The exercise of searching for a single and continuous development of case management inevitably leads to simplistic analysis and detracts from our understanding of the complex and parallel processes that have contributed to a shift in service delivery approaches in the human services and health sectors. With a critical eye, it is possible to discern a number of trends and issues that have contributed to the emergence of case management since the 1970s.

• overview early historical accounts of case management documented in the nursing and social work professions.

• for various stakeholders, the rhetoric of case management has served different purposes and that the shifts in the culture of service delivery have yet to be fully explored.

However, different terminology does prevail in particular countries and/or program contexts. For example, in UK community care policy and programs, the preferred term is 'care management' .The adoption of the term 'care management' addresses the frequently voiced criticism that the emphasis on 'case' management detracts from the personal nature of services being offered. The consistent use of the term 'care management' is peculiar to the United Kingdom, but this term and other variations can be found in programs around the world.

Within programs, alternative terms such as Ê case' or Ê care coordination' and 'service coordination' are applied most often where service provision is focused on brokerage or service management. The coordination task is paramount, and the activities of the case manager are directed towards ensuring that the services deemed necessary in the assessment process remain responsive, effective and cost efficient

for the client. When specific terms like clinical case management, team coordination, strengths or empowerment approaches are referred to, we are likely to find the case manager involved in more intensive activities, with clinical specialization being incorporated into the case manager's responsibilities. Examples of these clinical or specialized case management roles are frequently found in mental health, diagnostically based services in health, community based services and institutional settings. Terms such as critical or clinical pathways, risk or disease management, life care planning and managed care are synonymous with service provision in acute health and insurance based medical and injury management Many of these procedures are 'algorithmic' and are driven by systemic and clinical needs for demonstrable outcomes, quality improvement and cost containment. In acute health situations, for example, the case managers are focused on responding to variance from the clinical pathway to capitalise on gains from improved practice or to rectify individual or recurring incidents that require responses beyond the predicted pathway.

Case management practice defies universal description because of the myriad ways in which it is applied across fields in different settings. Tensions surrounding practice dimensions like the relationship between client and worker, degree of worker authority, level of advocacy and the effective management of information and resources are responded to in the context of the practice setting which determines organizational goals and dictates service priorities. The term 'management' produces a bewildering array of paradoxes and contradictions in relation to case management. Moxley (1997, p. 6) refers to the multiple meanings of management in this context. Case management and case managers are certainly products — and perhaps victims — of management thinking, processes, language and structures which may be both liber-

ating and oppressive for workers and users of services alike. How can these things coexist?

What are the management facets of case management and what is their significance for workers? What is being managed, by whom and why? To start exploring these questions we must detour briefly through some material on management which is more abstract than that which we have just left. However, it is particularly worthwhile—albeit in a different register—because it helps to expose, clarify and validate many of the often unarticulated tensions and paradoxes of case management practice and experience. It also explains the new language

Case management as policy - It aims to answer questions about the several histories of case management, whether or not case management is really different from what went before, what the international policy trends around case management are, and how it has been applied and researched in many countries and fields of practice.

Case management as policy an approach to service delivery, some features which distinguish case management from traditional approaches to service delivery

Practice of case management is connected with important practice variations and critical and emerging practice challenges; the process of case management; the impact of the many variations of case management on case manager roles, responsibilities and functions.

HOW CASE MANAGEMENT WORKS

Usually, one agency takes primary responsibility for a client and as-

signs a case manager, who:

coordinates services, advocates for the client, and who sometimes controls resources andpurchases services for the client.Case management may involve monitoring the progress of a client whose needs require the services of several professionals, agencies, health care facilities, and human services programs. It typically involves client outreach and identification, comprehensive multidimensional assessment, and frequent reassessment. Case management can occur within a single, large organization or within a community program that coordinates services among agencies.

The primary goal of case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs.Like all methods of social work practice, case management rests on a foundation of professional training, values, knowledge, theory, and skills that are utilized to attain goals that are established in conjunction with the client and her or his family.

The core functions **of case management are:**

1) Engagement: identification of, and outreach to, clients;

2) Assessment: needs, functional, biopsychosocial, strengths, comprehensive intake, sociocultural, and resource/financial assessments;

3) Planning: intervention, treatment, care, rehabilitation, strategic, support, and crisis intervention;

4) Implementation/Coordination: service brokering, monitoring service delivery, project implementation, and client support;

5) Advocacy: systems improvement, client well-being and functioning, liaison, and mediation;

6) Reassessment/Evaluation: monitoring,

efficacy, efficiency, data collection, and analysis; and

7) Disengagement: discharge planning, transfer, and termination.

While there may be situations in which case mangers simply link clients with resources, the real world of professional social work case management is much more complex. Clinical skills, such as the development of the client-worker relationship, interviewing, assessment, and problem solving are all crucial elements in the development and implementation of an accurate and holistic care plan.These skills are also necessary to understand and deal with a client's ambivalence, fears, and resistance.Research suggests that experienced professionals, such as master's level social workers, are best at providing case management services.

The 'professional business' of case management

• what the management component of case management actually means, especially for workers.

• who case managers are, the professions most involved with case management, questions of contested professional territory and implications of case management for the professions.

• preparation for case management through education and training

• the ways in which case management practice is regulated and how various formal and informal regulatory forces impact on workers and their decision-making.

• The broad application of case management, its diverse forms, nomenclature and practice by human service professionals and other personnel poses significant barriers to such attempts to regulate practice.

• Should we focus on strategies to support the practitioner to address the contradictions that inevitably arise from this service delivery approach? Again, we have taken a particular position about the practice, arguing that the practitioner will draw on all their professional knowledge to undertake the case management task.

• We have deliberately avoided a focus on the detail of practice interventions and attended to the critical practice themes that are raised by the approach. So where does this leave us?

• Conceptual basis and the context for case management as an international phenomenon in service delivery

• It is asserted that case management now pervades policy statements, program development and practice in the human services and health sectors.

• We support the view that it is through the context of service delivery that the nuances and diversity of the approach are best understood .

• It is the broad application of case management that has created conditions that are redefining the nature of professional practice, service provision and consumer expectations.

CONCLUSIONS

The increasing emphasis on the use of case management in the social service and health care delivery system is an attempt to provide a strategy that will minimize the gaps in services and fragmentation in the provision of services to clients with mental illnesses. Today, professionally trained social workers providing case management services can be found in virtually every service setting, from community agencies, to hospitals, from managed care to private practice. The expected rise in the number of persons with SMI who will live in the community, along with continuing changes to the health care system, suggests that there is likely to be an even greater demand for professionally trained and credentialed social workers to provide and oversee case management services for people with SMI and their family caregivers.

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Case Management Issues. Several Case Vignettes from Dinamika Centre for Psychotherapy, Counseling and Psychiatric Consultations, Sofia

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A paper presented at the PHOENIX TN Workshop "CASEWORK AND SOCIAL CONTROL", Blagoevgrad, 16-17 January, 2009, South-West University "Neofit Rilsky" Blagoevgrad

Abstract: The paper examines the case management issues from the narrow perspective of a community-based centre offering psychotherapy, counseling and psychiatric consultations. The problems of professional cooperation, interorganizational coordination and collaboration towards achievement of mutually accepted goals within shared responsibilities are discussed in the light of the case management role. Several case vignettes are presented showing the difficulties for care coordination and continuity of care. They are given as illustration for the role of case management in some of the referrals to the Centre when clients with complex needs are addressed. The possible benefits and outcomes case management could deliver for the individual clients and their families, and the community care system as a whole, are

submitted for discussion, taking in consideration the infant age of case management practice in Bulgaria.

Key Words: case management, interorganizational coordination, collaboration, networking, and community care

Introduction

People with disabilities, mental illness - especially severe, and people with chronic health conditions face many challenges in living as independently as possible in their own communities. Since the inception of the community care programs case management is perceived as a generally effective component of care for clients with complex needs. It has been applied in various ways in mental health settings, tailored to meet the needs of specific client groups and service settings.

David Macarov and Paul Baerwald[1] argue that "the social work profession has always been ambivalent about how to divide time, personnel, knowledge and resources between dealing with current pressing problems, and attacking the conditions, which create those problems…. The reason for the ambivalence rests in the fact that social work theory and practice cannot be divorced from the economic, social, physical, governmental and ideological world in which they exist", and this is constantly changing. Therefore, whether planned or not, change takes place - not only ideas emerge and disappear as attitudes, activities, and situations change, but the tools with which these are dealt also change.

Compared to countries with traditions, the practice of case management in Bulgarian social work, among many other issues, is in its in-

fant years. This form of service for patients with severe mental illness in Bulgaria has become a topic for professional discussion and service delivery only in the last 4-5 years with the establishment of the first pilot Day Care Centers and Supported Houses for severely mental ill patients.

The issues of case management are presented in this paper from the narrow perspective of a community based centre – Dinamika Centre for Psychotherapy, Counseling and Psychiatric Consultations. The problems of everyday cooperation between professionals, the need for interorganizational coordination to meet the complex needs of people with chronic mental illness, most often severe, and for collaboration towards achievement of mutually accepted goals within shared responsibilities are discussed in the light of the case management role.

Centre Dinamika

Dinamika Centre[2] was established in 1995 by a group of psychologists and psychiatrists with the main objective to provide psychotherapeutic and psychosocial services. From 2001 it is registered under the Law of Medical Establishments as a psychiatric practice. This legal status provides a clear framework for the activities of the Centre, which are directed towards the achievement of mental wellbeing for our clients (individuals and families). The overall orientation of the Centre is psychotherapeutic. It provides psychotherapy, counseling, psychiatric consultations, supervision and training for the helping professions. The training programs are therapeutically oriented and draw heavily from the team's experience. The team of the Centre consists of professionals specialized in a variety of therapeutic approaches – psychodynamic,

systemic, psychodrama, cognitive, behavioural.

Teamwork is a core feature of Dinamika Centre. Teamwork ensures the maintenance of high quality services coupled with a better consideration of the individual needs of our clients. This approach allows a combination of different therapeutic approaches while maintaining clear professional standards and procedures. The Centre collaborates with a wide network of services and professionals (psychologists, general practitioners, psychiatrists, school counselors, social workers, etc.)

Centre Dinamika offers individual psychotherapy, psychological counseling, family and marital therapy – for families and couples (parental, marital, partners); counseling for children and adolescents with emotional, behavioral and/or learning difficulties. It is usually accompanied by parents' counseling; treatment with medications; group psychotherapy.

The work at Dinamika Centre is guided by the belief that provision of optimal help needs consistent maintenance of high professional standards. This is achieved through the procedures of the Centre that include regular team meetings and case conferences; continuing education of the team members; development of training and research projects in the field of mental health care; networking with other professionals and services.

Networking

Networking is important prerequisite for a community-based practice in order to achieve optimal help for needy clients, especially for small

size group practice like Dinamika Centre. When clients with mental health problems, especially severe mental illness, are concerned, Dinamika can offers services for patients in remission. This can be either supportive therapy (individual and/or family) or medication with focus on maintaining stability and independence. The contact with the general practitioner and the psychiatrist in charge is required. And here the issue arises: How to collaborate for achieving this goal? Is networking enough for this activity, and what do we imply using the term networking? What other social and mental health services are available in the community? Are there procedures that foster collaboration? What is the role of case management here?

The "Co" Quality of the Working Interaction

The always-existing tension between individual needs and wider community needs has to be observed when we aim at providing services tailored to meet the needs of needy clients in the community. There is a need for realistic assessment of the limitations of the professional help within the present institutional system.

Mari-Anne Zahl[3] claims that the "co" terms of cooperation, coordination and collaboration appear in everyday life and in the professional literature as more mixed and intertwined than as separate entities. She argues also that "cooperation and coordination are among the politically correct terminology of today; they are self-righteous and accepted in every-day life at face value."

And yet, what do we mean under networking? Does this happen on case/worker level, or on institutional/governmental level? When do

we chose to name it just cooperation, or do we have collaboration with clear procedures?

Several authors[4] have tried to delineate the differences between these "co" terms, elaborating on the levels of autonomy, rules, responsibility and freedom in the decision taking process. According them:

Cooperation - takes place between individuals ad hoc; there are no formal rules; trust exists between workers; there exists freedom of choice based on self-interest

Interorganizational Coordination - two or more organizations create/ use existing decision rules to deal collectively with their shared task; it results in adjustments among the organizations; it is a top-down phenomenon, hence a threat to autonomy is experienced

Collaboration - involved parties search for solutions that go beyond their own limited vision of what is possible. Barbara Gray[5] emphasizes that "the objective of collaboration is to create a richer, more comprehensive appreciation of the problem among the stakeholders than anyone of them could construct alone". She presents five key aspects necessary for collaboration: (a) The stakeholders (parties) are interdependent; (b) Solutions emerge by dealing constructively with differences; (c) Joint ownership of decisions is involved; (d) Stakeholders assume collective responsibility for the future direction of the domain; (e) Collaboration is an emergent process, an achievement[6].

Thinking about the need for clear procedures, roles, responsibilities and rights that will be abided by community services like Dinamika Centre, where is the place of case management among these definitions and activities?

Case Management Definition, Functions and Community Care

Looking in the professional literature we are coming across a fairly good agreement about what case management is.

Case management is a process, which aims to ensure the client receives the best possible treatment and support through the identification of needs, planning individual goals and strategies and linking to appropriate services to meet these needs. It is a method of providing services by a case manager (social worker, psychiatric nurse, consultant psychiatrist, occupational therapist, medical officer or psychologist) who has the primary responsibility for case management of a particular client. "The case manager is assessing the needs of the client and the client's family when appropriate, coordinating, monitoring, evaluating, advocating for a package of multiple services to meet the specific client's complex needs. The case manager shall treat colleagues with courtesy and respect and strive to enhance interprofessional, and interagency, cooperation on behalf of the client[7]"

The complexity of the individual's care needs and the response provided distinguishes case management from other models which essentially focus on single need care coordination. Case management involves working across many boundaries, with health care and various systems that interlink in many ways throughout a person's life. Case management ensures a match between the available resources and the client needs, making the best use of what is available[8].

Case management is a professional term used to designate philosophy, strategy and policy, and practice of delivering social services. It is about decisions, and about authority and power to make them. Case management is not a one-person, one-organization activity. It requires persons

and organizations participation and provision of resources. Case management is about more than services. It includes education and what case manager is trained to do.

Case Management Functions in Community Care

The National Community Care Case Management Network of Australia outlines the functions of a case manager as[9]:

Comprehensive needs assessment. In collaboration with the client and their families/ carers, identify personal needs and function levels to maintain quality of life in the community.

Care and service planning. A care plan is developed in consultation with client nominating short- and long-term goals, incorporating family and carer needs, and defining the service responses required.

Resourcing the care and service plan. The care plan is resourced in a variety of ways including purchasing services and support; provision of services from relatives; support provided by carers; client fees and contributions; and seeking funding from alternative sources.

Navigation. Case managers know the various services and supports available for people. They determine what is needed in consultation with the client and carers

Implementation. Fostering community support and linking with and commencing services where required in a timely fashion.

Monitoring. Ensuring the client is receiving the level and quality of service provision that best meets their needs.

Advocacy. Support the client in appropriate services that meet individual needs and goals, support and educate the individual to develop self-reliance in self-advocacy.

Evaluation. Ensure services provided are meeting the needs of the clients and carers and are cost effective to the service system.

Closure. When case management is no longer required discuss with client and carer, inform services, develop a transfer plan and then withdraw.

CMSA also recognizes the need fort a policy direction for case management in relation to the community care service system. In the discussion paper from May 2006, "Case Management and Community Care", are listed number of factors which – if a client experiences one, or most likely a combination of them – make case management most effective to be chosen as treatment approach.

Factors defining case management as most effective treatment approach to chose in community care [10]

1) Limitations in cognitive, perceptual or social functioning

2) Behavioural, emotional or mental issues

3) Lack of informal support network, or carers who need support

4) Social or geographic isolation

5) Physical frailty or vulnerability impacting on the ability to organize one's own care

6) Involvement of multiple services

The expected benefits of the community case management approach are:

(a) The clients are supported to access the system. Case management provides a single point of contact for the client, carer, and other service providers. The case manager navigates the system with the client and carer and through this provides extra support for families.

(b) Optimal use of available resources. Case management identifies the most appropriate type and level of service and/or support. This results in better utilization of available resources through better coordination of services.

(c) Supporting independence and providing confidence. Case management provides a package of care plus the security of having one person you can contact if you have any difficulty. This combination provides a sense of security that you can stay at home and be adequately supported.

(d) An alternative to residential care. A major aim of many community care programs is to reduce or delay inappropriate admission to residential care. Case management is one way to assist in achieving this aim of the community care.

(e) Service innovation. Case management is often a driver for service innovation through ensuing the best interorganizational coordination and collaboration.

The above cited definitions, roles, function, expected benefits referring to case management in the community cover a broad spectrum and it is accepted that case management should be viewed along a con-

tinuum, with differing levels of intensity used with different groups of clients, based on the need of the client. However, one area of shared agreement is the issue of the development of social work in the community. This is often represented in terms of five phases: (1) problem definition; (2) goal selection; (3) structure building; (4) action taking; (5) evaluation. And even here there exist diversity in the definitions of the roles and tasks of the expected case management functions of the community worker, varying among: social therapist, broker, leader, mediator, lawyer/advocacy, supervisor, activator, negotiator, etc.

To this point too little attention has been paid in Bulgaria to the real benefits that a case management programme in the community for meeting the problems of severe mental illness can bring. It is important to develop empirical research and other approaches to record the real situation with regard to community organization. And just afterwards to undertake steps towards implementing a community programme for specifically shaped modes of working for needy clients. This is important for the improvement of the theoretical and practical base of community social work but also because of the general social and economic conditions in Bulgaria now.

Case vignettes

The case vignettes described here are given as illustration for the expected favourable role of case management when dealing with some of the referrals to Centre Dinamika when clients with complex needs are addressed. The possible benefits and outcomes that case management could deliver for the individual clients, their families, and the community care system as a whole are submitted for discussion. Each of the

cases presented emphasizes on one or another item of the factors, listed above, which were shown to make the case management one of the most preferred and effective treatment approaches to be chosen.

Case No 1: Onset of Severe Mental Illness. Is the patient at risk to become dropout of the social system?

A 21-year old woman, single, unemployed, low-income class. The referral for treatment is from neurologist. Practically the client has no contact with her GP at the moment. Her mother, who expects only medication, brings her to the Centre.

Diagnosis: Observation: Onset of Hebephrenic type of Schizophrenia

At the time of referral: Only her brother (23 years) from the nuclear family is working. Mother and father are unqualified workers, at compulsory leave from factory at the moment, and not paid salaries for 3 month. The identified patient quitted job 2 months ago, and has no health insurance. The family lives in a suburb of the big town, far from Dinamika Centre. The patient is not capable to reach the Centre alone. The mother declines eventual hospitalization, and is denying the severity of her daughter's condition.

Case No 2: Second Opinion or Burnout of a Carer

A 47-year-old married woman, unemployed, carer of two daughters (22 and 20 years) - both with Epilepsy Grand-mall and Schizophrenia-like psychosis. The older daughter is also mentally retarded.

The woman is self-referred for psychiatric consultation - expresses need for second opinion concerning the younger daughter who has recently been discharged from hospital but rejects taking antipsychotic medica-

tion at home under the pretext that it rises ictal activity. Mother feels law and exhausted.

Only the father is working. Both daughters are on disablement pensions, and are seen by neurologists and psychiatrists in turn. At the moment it is not clear whether somebody of them is in charge. Both daughters recently stopped visiting a community centre for disabled people with the argument: “It is not interesting there”.

Case No 3: Deterioration of Chronic Illness or Life Transition and Lack of Support

A 53-year-old man, single, unqualified worker. Diagnosed with Schizoafective disorder for more than 30 years, combined with secondary alcohol abuse - binges of heavy drinking. The client has with dependent personality traits and has had traumatic childhood. Several times has been admitted to hospital, usually after a heavy drinking period. He lives with elderly parents (mother 84, father 86). Three months ago the mother has broken a leg and can not get out of bed.

His sister seeks the consultation (46year, married, two children of 24 and 21, expecting soon a grandchild) together with his father. Both of them complaining that the client is unbearable lately: quarrelsome, abusive, talking that it’s high time to look for his own family. The parents are secretly giving him Haloperidol, and not keeping contact with psychiatrist. The father and the sister insist that he is seen alone by consultant - “to be able to speak freely”, and taken for psychotherapy.

The client declines drugs and individual counseling. At the end of the interview he shares that he has been most happy when during a hospital treatment 15 years ago had visited inpatient support group for 1,5

months.

Case No 4: Impending Hospitalization or Lack of Informal Support Systems

A 32-year-old woman with Borderline Personality Disorder and Bipolar Affective Disorder lasting for 10 years. The client has not been hospitalized till now. She has quitted previous job (seller consultant) one year ago while switching from hypomania to depression and has moved back to living together with her mother. The client does not take medication regularly.

Her parents are not divorced but are separated for more than 4 years. The father, 51 year old, suffers from alcohol dependence and pathological gambling. He does not work and lives on house rent. The mother, 50years old, with mixed personality traits of dependence and passive-aggression is working as hospital attendant. The clients' brother, 5 years younger, has died 7 years ago from heroin overdose.

During the manic episodes the client allies with her father who uncritically supports her destructive and gambling behaviour. During her depressive episodes she clings to her mother and obeys her almost flawlessly.

A month ago the client alternated again from depression to mania - started spending spree, selling out minor belongings, staking, quarreling with her mother, and two weeks ago pledged her car. Meanwhile fathers' somatic condition deteriorated seriously and the daughter brought him back to the apartment where they live together with mother. The mother insists that the client be hospitalized. The father resists the idea. The client reluctantly consents to taking medication and opposes

hospitalization.

Case No 5: Adolescent Crisis Precipitating Unfinished Separation of Spouses

A 49-year-old woman is referred for consultation by a friend of hers. Help is sought for her 16 years adolescent boy who lately started to shirk from school and became verbally aggressive. From time to time he flees out to sleep with his father (who lives together with his own parents). The mother puts accent on the medical condition of the boy.

The boy's parents divorced when he was 3 years old and none of them was married again. The boy stayed with mother but kept contact with father and visited him relatively regularly. The father declares that the boy has very good contact with him and with his grand-parents, but he (father) does not want him to stay with them because he feels that the boy "needs to has his home!" The father visits his ex-wife house when she is away at work, which fact makes her furious.

From the boy's history: about the age of 7-9years he has been consulted by psychiatrist and diagnosed with Attention Deficit Disorder and Dyslexia. He has been consulted by neurologist as well and diagnosed with Minimal Brain Damage. The boy has approximately 4 years of contact with a child psychotherapist until today. His mother threatens that she will stop him going to his therapist as a punishment for his late disobedience and conflicts with her.

Discussion

Case management is part of professional social work. Case management for clients with severe mental illness can be applied in various

ways in mental health and social settings, and should be tailored to meet the needs of specific client groups. Research has established that case management is generally effective in the treatment of severe mental illness[11] . Community case management is seen to be beneficial service for some of the clients of Dinamika Centre. Case management should be viewed as a flexible process that changes as the needs of the clients change.

In each of the vignettes quoted, the individual client, his/her family, and wider social context would have benefited, had case management been an option. All of the clients' cases illustrated here indicate at problems, which (as listed above) are the combination of factors where case management in the community is at its most effective.

When dealing with most of the cases presented cooperation between professionals existed. It has been spontaneous; the workers have acted on self-interest and the duration of the co-work varied across cases till the achievement of better ends.

However, this was not real case management with its specificity of functions, decisions, worker and service interaction following the requirements and the practice guidelines of the case manager role as described above based on the *"What is Community Care Case Management?"* paper. In other words networking existed but it has been restricted to the goodwill cooperation between professionals in the name of better services for the clients/patients.

The mere involvement of a number of workers (different professionals and settings) and services "is in itself neither effective, nor a guarantee of quality care î f services, as Mari-Anne Zahl[12] points out. There exists a potential for conflict on many levels in the "co"-work relation-

ship. The case management is more than simply providing services. It is practically impossible to establish the kind and quality of interaction necessary for effective case management when conflicts are possible between the potential partners. This is partly due to the limitations of professional help within the present institutional system in our country: the lacking standards and practice guidelines for case management. In the light of the evidence-based conceptualization for the case management process listed above, interorganizational coordination is the next step to be achieved on a community-based level. And just afterwards, and in a process of gaining the key aspect qualities of collaboration (based on B.Gray), it will be possible to lay out the basis for practical implementation of community case management. And since case management is something more than only worker and agency interaction as we already mentioned, the role of the teaching institutions and the student education of how to involve client participation in the case management process will be also very important.

Case management on a wider level is a managerial response to the increasing service demands on one hand and the parallel budget restrictions on the other, and it ensures a match between the clients needs and the available resources. That is why it is primarily based on interorganizational coordination. This is tough to be carefully aimed at now because of difficulties and problems on many levels. Here is just a list of them on random principle: lack of communication; lack of knowledge about the other institutions' capacities; budget deficits; logistic problems; potential for interorganizational conflicts and competition; legal and normative issues, etc.

This is the reason why collaboration is very fragile for the moment. And thus the goodwill cooperation between professionals can not be

transformed into real collaboration and the continuity of care is thwarted.

Conclusion

Case management is part of professional social work and is very appropriated for supporting people with complex social and health care need to achieve better living in the community and to maximize their independence when possible.

It is however not merely a challenge for “co”- work, good intentions and care coordination but requires philosophy, policy, strategy, education, and will to introduce this practice of delivering social and health care to needy people.

Working across many boundaries in case management is not an easy task and requires appropriate education and practice. The best implementation of case management would be a real and effective collaboration (as mentioned above), where collective responsibility for activities is assumed and joined ownership of decisions is involved.

To this point too little attention has been paid in Bulgaria to the real benefits that a case management programme in the community for meeting the problems of severe mental illness can bring. It is important to develop empirical research and other approaches to record the real situation with regard to community organization. And just afterwards to undertake steps towards implementing a community programme for specifically shaped modes of working for needy clients. For the moment being this is rather wishful in our context of lack of policy and strategy for launching case management practice in our public health and social services.

Dinamika Centre for psychotherapy counseling and psychiatric consultations, like many other community based health and social services, would only benefit if case management becomes part of a professional activity and practice in the community to provide framework for coordinated services for people with complex care needs, including severe mental illness.

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FAMILY THERAPY WITHOUT THE FAMILY

(Parallel Family Therapy Technique with a juvenile delinquent and his family)

Andrea Fabian

My experiences as a family therapist show that the success of re-socialization of young delinquents is achieved only if their family supports them and cares of them even during the period of incarceration. However, this ideal situation is frequently endangered due to stigmatization, shame and isolation. That is the reason of why therapist should help not only the delinquent, but also his/her family in terms of activating their social and emotional resources.

My case study is based on Hugh Jenkins' method regarding the 'family therapy without the family', according to which the change occurring in the life of one family member affects the whole family system (Jenkins, H. & Karl Asen, 1993; Hugh Jenkins, 1987; Hugh Jenkins, H.& Michael Donelly, 1983). I'll present the case of two, 17 years old cousins who were imprisoned because of robbery and serious physical

injury caused in a disco-fight. Behind the two youngsters I've found healthy families and the boys continued to study, to exercise and to visit the library even during their incarceration. One of them, Alex, expressly asked for psychological help and in fact that was the starting reason for the family therapy.

At the beginning of the therapy, when signing the therapy contract, we have agreed on the participation of the parents. Hoverer, because I was aware that session can not be conducted with parents and children in the same time, I've opted for the therapy method "family therapy without the family". I've contacted the parents by phone.

In both cases I've talked with the mothers and we've established a schedule for the first meeting. I've met the parents of both youngsters in separate sessions. After this I've worked in different, parallel sessions with the parents and with youngsters.

As far as the cases were quite similar, I was aware of the following facts:

1. To avoid the two cases to "flow" into each other

2. To carefully apply those ideas which have emerged during one or the other of the sessions.

3. To ensure that participants themselves remain within the limits of their cases.

In this case-study I'll present the therapy with Alex and his family.

At the beginning, parents were not open-minded at all, they were afraid of committing mistakes. They perceived the whole situation as a pa-

rental, educational failure due to which they are now the subjects of community blame, stigmatization and isolation (they lived in a village and the family had a great prestige).

After the first meeting with the parents, I've formulated the following objective: the two parents should reconcile with themselves and reach a compromise; should forgive to each other but for these they need to perform the compulsory "mourning". For this objective, I've worked in separate sessions with Alex, respectively with his parents.

The therapy took place in eight parallel sessions, with Alex, the boy in prison, with his parents, and with his sister. Problems in discussions during each session were carefully closed within the sessions, i.e. there were no problem transfer between the sessions and parents met Alex only during the period of prison visits.

The short characterisation of the family members

Alex

Alex is a tall teenager, 17 years old boy with a round face. He is the oldest within the family; his sister is 8 years younger. He was born during the parents second year of marriage, and according to the mother "he was a desired child". He was always "obedient and hard-working", he had relatively good marks in the school. He has not had very many friends, he used to meet only with 2-3 boys, but he was mostly attached to the cousin with whom he is now imprisoned.

Emotionally he is a labile person who is very much parenticated by her mother. He loves his father, meanwhile he is afraid of him, because "he

cannot meet the standard of the father". This wish to be accepted by the father was a continuous source of frustration for him during the childhood "how could I play football as far as according to my father footballers are stupid, so that I started to learn skiing".

Alex's father

I call Alex's father Sandu. Sandu is the shorter form of Alex. Both the father and the son have the same name. Sandu's ancestors are from a rich family, he is 45 years old, tall (approx 1,85 cm) with brown hair and moustache, he is an entrepreneur. He appears as a sportive, active man, who hardly can stand-to-the place giving the impression that he is in hurry, and does not have time. His small, deep eyes create the same impression.

He explained that in his family the quality of being "able", to show up something in his life was always a value. In this sense, his father was the mayor of the village, his grandfather the postman of the village and besides these "important functions" both succeeded to take care of the family as well: both had huge properties and beautiful families, "but now I don't have anything to be proud of and neither has my son". These words created the impression of self–reproach. I felt this man blames himself and not his son for the current situation.

Sandu is that kind of man who hardly shows out his feelings and never talks about them. In his opinion, "emotions" are characteristic for women, and the duty of the man is to ensure the livelihood of the family, to ensure the well- known character and welfare of the family.

At the beginning of the therapy he was very reticent and did not cooperate with his wife, rather he tried to get solutions before the wife gets them. He didn't like to talk about Alex, the opinion was that "right now there is nothing to talk about; we will see what happens after Alex gets out of the prison". At the end of the therapy he changed his behavior, I felt he reached the common parental destiny with his wife, the common responsibility and finally he contacted his imprisoned son.

Alex's mother

I call her Monica, who is a 38 years old housewife. She is the middle child of a five children family, coming also from a village. Although she never worked in her profession, she is proud of her engineering diploma. According to her, the greatest achievements are the children. Besides Alex, the family has a daughter, Nicoleta, who is in the 3rd class of the primary school and is an excellent pupil, a calm girl.

Monica's parents ware poor, but "honorable" people, who encouraged her to learn. Her father used to work in parallel in many jobs in order to ensure the well-being of the family. The mother was a housewife, who dedicated her life for the five children.

Monica is a tall, well proportioned woman, who takes care of herself. According to her "my husband always made observations if I looked negligent, and according to him the duty of a woman is to educate children, to keep the home, and to look always beautiful".

She meets her husband early, during the school years. She meets him at a girlfriend's birthday party. They've married after some years; she

was in the last year of her student years. Before their marriage she had an abortion, but they have never talked about this issue.

She is very proud about her husband but she is also afraid of him. I felt that in their family there are no clear parental roles, which results in contradictory messages towards their children, but finally the decisive opinion is the father's.

According to her opinion, she has close relationship with her boy, she can deeply trust him, "he behaves like a real man". Right now she is afraid about "not to happen something with the brain of her son in the prison" because she knows so many cases in which people who come out of the prison could never behave normally after that.

She continuously mentioned her emotions, saying that "since my son is not at home, nobody understand me", "my husband thinks that after coming home from a business trip and eating the lunch I've prepared he has also made me happy, however…", " I think people should also say they love each other, not just think this", etc..

I've discovered that in this woman there is a lot of uncertainty, about which she never talked. She is just mentioning them, without a deeper discussion. I've suggested her to change this manner of communication and she agreed with. I felt a duplicity regarding her relationship with her husband: partly she is proud of him, because he is "full of skills ", but meanwhile probably because of these skills the husband does not spend enough time with her. He "was never at home when we needed him" – she is saying.

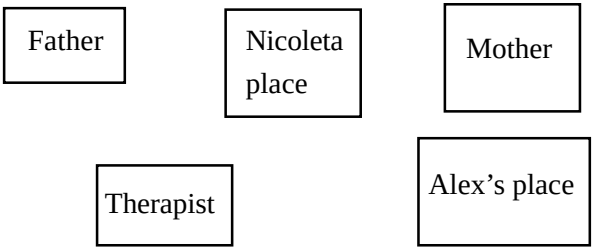
Alex's sister

I call her Nicoleta. She is a 9 years old, smiling girl. She has very good school results and is very obedient. She doesn't really understand what is happening with her brother, but since he is not at home, she succeeds in keeping the room clean and she draws very much for her brother and puts the drawings on his desk – "to be something getting him happy after gets home". She makes the impression of a child who tries to meet everyone's standards and tries to get everyone's love.

The information of the first family therapy session

At the first meeting there were present only the father and the mother, Nicoleta remained at home. According to the father "does not make any sense to tell her about the heroic acts of her brother".

The sitting during the first meeting



However the members of the family had the opportunity to sit next to each other, the father took place in an armchair, the mother in a chair

moved away, and when I asked them where Alex should stay, the mother showed the chair next to her. For Nicoleta they've shown another chair, between the two parents.

I explained to the parents that no matter that neither Nicoleta nor Alex are present, at the session it is important to establish their place.

At the beginning of the session we analyzed two tables of the Rorschach test. I asked them to work on the test together. During this exercise I noticed that the two parents do not collaborate, on the contrary, they perceive the situation as a competition. As a continuation I used the home-scheme–method. The intention was to discuss what is important for each of the parents, where are the limits between the generations, which sub-systems are inside the system, do they have any suggestion regarding the changing of their lifestyles, is there any place within the home which has a same importance for both of them (ex., they used to take lunch in that place, they used to argue when they are at that certain place, etc) (Piroska Komlósi, 2000; Gill Gorell Barnes, 1991; Insoo Kim Berg, 1995).

After we've discussed the drawings, I shortly summarize the aim of the meeting. I explained that during the therapy we should not talk about the truth, as far as we are not those persons who can establish which is the truth in this situation, but the discussion during the therapy can help to notice the facts and to pass over them. For this purpose, it is important to resign, to reconcile, to be smart and intelligent as far is life is full of fatalism. As a psychologist, first of all I want to help to render the opinion of the parents and to help them to see the perspectives.

After that I asked the parents – as an exercise – to try to think about

similar sudden events, which may have even more complicated consequences that the fact that Alex is an inmate.

I optioned for this exercise not to obtain the result according to John Ranz and Andrew Ferber (1972) but with the aim to ensure a continuous objective. My aim was to begin the collaboration, to ensure the awareness of the problem.

We agreed upon the fact they will collaborate, help each other to communicate, to moderate the situation and to contribute to the rehabilitation of their son. We established a meeting schedule consisting in eight sessions, out of which four with the participation of the parents and the sister and four with the participation of Alex.

My impression regarding the family after the first meeting

I noticed that there is no functional communication between the parents. They are cold and reticent towards each other. The woman, however rarely, tries to break up and mention her emotions, desire, but she appears as a subordinated person towards her husband. The husband considers that his wife's "break–ups" are nothing else than "feminine hysteria" rooted in the fact that "she stays all day long at home, has nothing to do and probably she is boring". The parental subsystem thus is full of malfunctioning and I noticed the same about their marital subsystem as well.

The subsystem of the children's is not clearly framed. I felt that Alex's case corresponds to the case of "parentificalt child, as far as the mother raises him to the place of the father, replaces the father with the boy,

talks her marital problems with the boy: “Alex was always a mature child….. He understood everything, he was more emotional that his father, he also knows that I live only for him” – the mother said (Ferenc Túri, 2002).

During the meeting I succeeded to remain neutral towards the fact.

The starting hypothesis was not rejected, it was only completed by the supposition that mother “replaces” the father with Alex, and she may create the impression that she does not need her husband; she has somebody else to take care of her. Such a possibility created the need to consolidate the parental and marital subsystem of the family. The idea was that if they succeed in collaboration and communication with each other, then they can do something together for Alex, for his returning into the children subsystem of the family.

Once again I’ve thought that we can maintain the main purpose of the therapy: parents should reconcile and they need to forget their former parental roles.

Description of the work schedule

The table below describes the participants of the following therapy meetings, the applied methods, their goal, respectively the homework for the participants and the aim of these.

Meetings	Participants	Methods	The aim of the methods	Homework	The aim of the homework
2nd meeting	Alex	The imaginative placement of the parents within the room	The clarification of the role of the parents	Drawing related to the familial relationship before Alex's imprisoning.	To show out and to mobilize the potential or real resources of these networks.
3rd meeting	Alex's parents and his sister	The method of sculpture-building	To show out and speak out the tensions between the members.	-	-
4th meeting	Alex	Symbolic scheme of the family	To show out familial resources	To make a symbolical Christmas gift for parents and for the sister.	
5th meeting	The parents	Genogram	To learn about their childhood and the relationship between them and their parents.	They haven't got a newer exercise, but I told them that in Christmas time people need more attention and love.	Preparing the end of the therapy.
6th meeting	Alex	Family sculpture through drawing.	To show out the differences between the real and desired family.	He hasn't got a new duty but I mentioned that the next meeting will be the last.	Preparing the closing of the therapy
7th meeting	Alex's parents and his sister	On a 0-10 scale to mention the perceived changes occurred during the last period.	To show out the personal opinions regarding the therapy. The sister ranked the changes at 10, the mother at 8, while the father at 7.	To think about further changes, suggestion regarding marital therapy.	The closing of the therapy
8th meeting	Alex	On a 0-10 scale to mention the perceived changes occurred during the last period. Resources	He ranked the changes at 8 and said "it is fantastic how things have changed, now everything is fine, but it is true that I personally need to develop". He is not alone	Talking about possible further assistance.	The closing of the therapy

(*Source*: Fabian, A., 2007)

During the first session with Alex, with the of chairs, it was revealed the structure of the family: it seems that his role within the family is to prevent conflicts and shocks, while his younger, 9 years old sister do not participate in these conflicts.

In the second session with the parents, the sister was present, too; regarding her case, the therapy revealed that she knows much more about the whole familial situation as the parents previously believed. She succeeded in formulating that the worst thing could happen to the family is Alex's death, comparing to which the present situation is encouraging. Therapies thus envisaged that due to the recent facts family roles has changed: during the crisis, the little girl is that person who begins to open the eyes of the parents, to show new perspectives which then enable the beginning of parental communication.

During the therapy we received good news from the prison: Alex was visited by his former schoolmates who brought him books, and he still wants to be his friends. After all the parents decided to go to visit Alex together, and during the visit Alex succeeded to tell his father how important is encouraging for him.

Within the therapy I've used many dramatic instruments, accentuated the role of symbols and also used the methods of sculpture development, genogram, symbolic gift, family scheme, etc., and different scales (. At the end of the 8 sessions, each participant rated the outcome. Results indicated that Alex will get a place within the re-structured, healthier family after his get-out (Ilona Székely, 2002; Sándor Bí ró & Piroska Komlósi, 1989;)

The closing of the therapy. Summary

Alex's case was very peculiar for me, because I have not met his family in a traditional way. I've previously known Alex and he asked me to contact the parents and try to work with them.

When we summarized the results of the therapeutically work with the parents, they've mentioned that they realized the biggest progress regarding their communication. Familial roles became clearer, and so became the differences between the generations and the limits between them. As another result of the therapy, the parental subsystem of the family became more crystallized and more stable. The father changed his confident behavior to a concerning one; as for the mother, she succeeded in freeing her son and in directing her attention towards the husband and to the satisfaction of their common necessities. Their conflict solving practice has changed from a competition-based manner to the compromise-seeking.

Alex understood that no matter what happens to him, he will always have a certain place within the family, while family-members understood hat problem solving is possible only through open direct communication, but for this purpose they need to know better each other and to accept each other. Previously, within the family we had roles which were agreed only by one person, while all the other members were suffering. These old roles needed to be abolished and changed (Gábor Hézser, 1996).

Past experiences have strongly influenced the unsuccessful problem solving strategy of the family and the efficient working of the familial subsystems, their stability and integrity. Unsolved problems (like the abortion) and secrets blocked the good functioning of the marriage. I

felt that Alex – as far as he appeared after the former abortion as a "desired child" – was very much parentificated (maybe unconsciously) by the mother, and became that person who is attentive to her problems, in contrast with the husband with whom "you can never discuss the problems".

Based on Jenkins method, I did not plan the therapy before its beginning, but I've developed the strategy based on the words, sentences and imaginations of the patients, with other words on the inner processes of the therapy. In this way I suggested for the client that I am attentive to her/him. During the therapy I've tried to mention neutrality and in turn I was an ally for everybody. I was aware of the possibility mentioned by Jenkins (1993), according to which in case of family therapy, the therapist may build a covert alliance with the child. To prevent this possibility I tried to maintain during the therapy such a tension which may occur between the members without the therapy as well, and I've avoid to express my personal emotions.

Through the method of the genogram it became possible the drawing of the family tree through which family members got a better look to their life, have realized the genetically or socially transferred characteristics, roles, rules, secrets and repressed mistakes. The method of the family sculpture showed out the actual relationships within the family and the needs of the members regarding certain relations. I've used questions which were very flexible both in contents and time frame, since they've covered the past, present and future of the family. E. g. Alex's situation before the imprisoning, Alex's actual situation, Alex's situation after the prison, etc. Through these questions, participants became aware about the fact that they have already previously thought about such issues.

Through the questions directed towards the future (strategic questions) I've mapped the motivation of the members towards the change. Through these questions the accent was placed from blaming to solution seeking.

I tried to select and formulate questions which are linked to the main problems of the patients, albeit I used also questions through which I tried to create a change in their thinking and to provoke them. Many of my questions were suggested by the clients' answers. I've created hypothetical connections within the questions by referring to other people, situations, time, etc.

The therapy was closed by the agreement that we will follow the situation of the family after the therapy, as well.

I think that during the therapy we succeeded in fulfilling the goals we set before: parents have got more in touch, they've began to communicate and to assimilate the situation created by the imprisoning of their son. This understanding made possible to corrugate the formerly destructured familial system and every member of the family have entered into a new, corresponding relationship to each other.

I was aware that after the getting out of the prison, Alex and his family might face newer challenges as well, around which I suggested further meetings. I've also suggested that in order to be able to cooperate on a longer period, parents should participate in a marital therapy as well.

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COMMUNITIES IN SMALL SETTLEMENTS

The Powers of Community Development in the Rural Area of Hungary

Tamás Ragadics – Eszter Péntek

In the period after political changes in 1989-1990 primarily the negative processes have been strengthened in the rural area of Hungary. The local government obtained a stronger autonomy from the parliament and also more tasks. At the same time the governmental redistribution decreased, so local communities did not get the sufficient financial sources for these new duties. The transformation of economical-territorial system began: most of the industrial areas (building and development forced by the communist regime) became crisis zones, only the capital and the north-western part of the country could prosper and attain a significant economical growth. The Hungarian settlements set off into different ways. The main basis of their heterogenization is the distance from the economical centres and – in connection with this – the state of the inhabitant in the labour market.

The problems of small settlements far from developed cities and economical centres are great challenges for Hungarian experts and politicians and also for the leaders of other countries in our continent. In the background of the depopulation of rural areas we can find the high rate of unemployment, the underdeveloped infrastructure and the lack of the health and social care system. Increasing the welfare of the rural population is one of the priorities of the European Union.

Our paper is focusing on the problems of Hungarian small settlements far from the prospering centres. The bases of this essay are some interviews made with opinion leaders of village-society in the south part of *Baranya County*. We examined the state, troubles and chances of the local communities supporting the social work and tried to take into consideration the powers of community development, the factors that work for a stronger and more effective local society.

Rural society in Hungary: migration, conflicts and deviance

There are different destinations of migration from rural area to the cities and from the bigger towns to villages. The young and qualified population moves to the economical centres for workplaces and for a higher level of services. Some of the villagers undertake a hard manual work abroad and use the village as a temporary place of living. Small settlements could not exist as a complex of home and workplace anymore. Less than 10% of the active rural population works in their own village.[1]

The *underclass* (people living in poverty, without any chances on the labour market) heads to the distant villages for a lower cost of living. There is a huge difference in the costs of real estates and overheads

between the villages and cities. Mayors of towns try to charge the expenses of changes to the rural area: they support the migration of underprivileged strata to the small settlements. We can find a high rate of roma population in these disadvantaged villages. The invasion of poor, unqualified, roma people elicit a further rural exodus of original population. The smallest elements of the territorial system become ethnic ghettos. After this trend of migration village-society is neither a community anymore nor a civil society – it is a split society with heavy conflicts. After the continuous process of changing people do not have enough time to become acquainted with the culture, customs, problems and goals of each other. Also the expansion of individual values supports the disintegration of this broken society.

In the small settlements far from economical centres there is a high rate of unemployment and a significantly inactive population. Most people obtain their incomes from seasonal and casual work, from pension, disability pension, child benefit, social benefits and sometimes from crime (smuggling, stealing). Crime for living is one of the most important grounds of giving up the traditional vegetable gardening in the villages. In addition to crime there are various forms of deviant behaviour (alcoholism, gambling addiction etc.) According to a research on a great sample almost 40% of the adult population had some kind of mental problem in the rural society in the late 1990's.

One part of the families uses the strategy of having just one child or being childless for retaining their standard of living. For other families children mean the way of getting more incomes through the benefits from the state. We can see the second generation growing up after 1990 without any patterns of job and labour. On the other hand, also these people are the members of the consumer society – they have got the

same expectations as other wealthier parts of the society.

There is a low level of services in the rural area. The local governments have the compulsion of cost-cutting, so they close their institutions on the ground of financial problems. This practice strengthens the process of rural exodus. Without schools and social institutions the local intellectuals disappeared, so the traditional leader strata are missing from the villages. Negative processes strengthen each other and the economical, social, demographical, sanitary and infrastructural gap is continuously growing between the central regions and the underdeveloped rural area.

The importance of communities in Hungarian society

The development of small settlements mainly depends on the power of local societies. Man is a social being – communities help to develop healthier personalities. They also give social security in case of need, defencelessness and poverty. Social integration is also the base of stronger democracy, solidarity and subsidiarity. Furthermore, individual interest can have a more effective representation by an organized community (association). Although it is a slow and laborious way of governing to initiate civil society into the process of decision making by the local government it is the only guarantee for functioning of real feet-back mechanisms and the base of local democratic governance in the small settlements.[2]

Governmental programs and EU-projects for rural development usually have low efficiency, because these investments could not build on strong and integrated local society. People are undermotivated and passive

and the Hungarian social system supports the lack of self-care. It is a system of a wide and extensive redistribution – inheritance from the communist regime – without any motivation for work and any adaptation to the labour market. Hungarian people are socialized for this paternalist structure: "Problems must be solved by the government."[3]

The missing of strong communities is based on several different issues. The traditional village-communities do not exist anymore in consequence of the communist politics of conscious community-destruction, the forced development of agricultural co-operatives and rapid industrialization and after the trends of migrations mentioned above. The most important reasons of the disintegration are the values of Hungarian society. Hungarians have strong material values and a low rate of common-traditional values.[4] There is a high level of individualism and also the values of consumer society have strong effects.

On the grounds of that are very important to increase the autonomy of rural communities and to help the common recognizing, discussing and solving of local problems.[5] Community development is one of the best methods for basing the success of programs realized on the field of local economy and settlement development. It is an efficient tool for stopping the rural exodus, protecting the mental health of people and increasing the local well-being.

Ormánság in South-Transdanubian Region in Hungary

Ormánság is one of the historical small-regions of Hungary in *South-Baranya County*. This area consists of 47 settlements and almost 18 000

inhabitants so the average number of the inhabitants per settlement is 383. In the most densely populated town, (*Sellye* – the only city in this region) live 3 300 people. The stock of settlements is frittered, and the transport network is underdeveloped. Although *Ormánsá*g is rich in folk-traditions and in treasures of nature (well-watered with forests and wild animals in the flood area of the river Drava), this region is one of the most underprivileged areas of Hungary. The main problem is the unemployment and the disadvantageous status on the labour market. After 1990 the whole country lost the 22% of workplaces – in the villages this rate is 33%. The employments' rate is 57,3% in Hungary (between the adult population in the age of 15- 64), it is 51,5% in the South-Transdanubian Region and 50,7% in *Baranya* county. The rate of unemployment in the villages of *Ormánság* is more than 50-60%. The real problem in this crisis area is the long-term passivity of the unemployed.

People pursued traditional agricultural activity in the *Ormánság* region. After the forming of agricultural co-operatives in the communist period, redundant local employees worked as a commuter for the mines in the *Mecsek-hill* and in the industrial factories in *Pécs* (biggest city in South-Transdanubian Region). After the political and economical changes in the 90's mines and industrial plants were closed and people had less chance for work. They tried to manage farming in their village but most of the compulsory entrepreneurs became bankrupt because of the strong competition created by the multinational and trans-national companies.[6] People had to sell their estates and the concentration of landed property has begun. Independent self-employed farmers became passive dependants of the social system and left the skills of the individual initiative to improve their lives.

Ormánság is ill-famed for the special self-destructive strategies people used for the higher standard of living. In the end of the 19th century farmers could not expand their landed properties because of the inflexible system of great noble and chapter estates. Hungarian right of inheritance is to distribute the land into equal pieces among the inheritors. Small plot of land meant the poverty for the family, because they did not have any other way for growth and enrichment. Most of the young women had just one child, because they wanted better chances of living for the descendants. Old women in the villages knew the cruel and primitive methods of abortion. The closed historical region had a characteristic culture of matriarchy and a lot of clans and families died out by the brutal birth control in the first decades of the 20th century.[7] People could not manage the cultivation of jealously guarded lands without manpower. In the communist period government moved roma *beás* families to the empty houses in the small settlements. The original inhabitants are the members of the Reformed Church and roma people usually belong to the Catholic Church so heavy social and economical conflicts are often combined with ethnic and religious oppositions, too.[8]

Base Research: General information about villages in the *Ormánság* region

We made interviews in 20 villages[9] in *South-Baranya County* because we wanted to become acquainted with the problems of rural population. We also wanted to map the working NGOs and other communities and all the powers and factors basing the social integration in this area.

In the first period we collected information from the small settlements of *Ormánság*.[10] General information and statistic data helped us to

understand the difficulties and chances of local communities. The important fields of opening research are the following:
- geographical and environmental state of the settlement
- infrastructure, transport to centres
- history, traditions, local culture
- social composition: ethnicity, religion, occupation, age-structure
- local services, public institutions, organizations
- local entrepreneurs, workplaces, state of local economy
- fees, chances strategies for additional incomes
- financial state of local government, improvements, local taxes and support
- NGOs, local churches, local initiatives
- cultural organizations, annual programs, festivals

Historical data can be found in the Archives of County and in the Historia Domus written by the local priests. We can often find some monographs about the history of single villages, too edited by a local teacher or amateur historian. For statistical research we can use the territorial data of Central Statistic Bureau working in every county. Sometimes there are useful pieces of information on the settlement's web-sides, too. The most detailed and current data come from the statements and application-texts of local government.

Powers of Community Development

In the second phase of the research we wanted to reveal the local societies of *Ormánság* more profoundly. The main actor in local scenes is the local government. It is the depository of local power. In small settlements being in disadvantage most of the resources of local

government are spent on social benefits and for the payment of debt by instalments. The only community initiatives in these settlements are the village days (once in a year) and communal work for unemployment supported by the government.

There are just a few NGOs in the *Ormánság* region mostly founded by the local government supporting the obtaining of resources from application system. On the other hand, representatives of churches (Catholic Church and Reformed Church) play an important role in the social integration of village society. In addition to religious life, they undertake an important task on the field of social help and community development.[11] There are programs and games for children and youth organized by church representatives, and also the promotion of communal traditions is usually connected with the members of religious organizations. Priests are often the only local intellectuals in the villages.

Public institutions – mainly on the field of education and health care – are communal meeting points and important places for local communication. In small settlements local governments usually close the public institutions on the ground of financial problems.

We looked for the key men, the opinion leaders, the central figures of villages. They are mayors, priests and other representatives of churches, teachers, doctors and entrepreneurs. They have got the prestige and power to influence people. The succession of closing local institutions decreased the number of positions, too. The interviews made with the local leader strata in the villages of *Ormánság* region showed us, that most of the mayors and priest are aware of their special, important roles in this underprivileged area.

Community Builder Interview: a Way for Supporting Village Life

We looked for our roles and tasks in the process of improving the quality of rural life in the field of community development. Making community-builder interviews is one of the possible ways we plan for the future in the *Ormánság* region.

The community builder interview is a method to enhance the local responsibility and the social participation of people. It has been worked out in the USA on the field of social work[12] since the first decades of 20th century and it has been mainly used in urban ghettos. In Hungary this method was adopted by some adult educators in the 1980s and put into practice in the settlements of rural area. People obtained moderate issues, because they did not have any financial support and there is a long time needed to achieve the results of this activity.

At the practice of community builder interview we play the role of the activator. The goal of questions is to stimulate people for living a more communal life. By that way we can activate the members of local society for improving their attitudes to the local problems and the emotional relationships with their own settlement. In the following there are some typical, simple questions of the interview:

- What do you think about your settlement?
- What does it mean for you to be a citizen responsible for your village?
- Why is it good / bad to live here?
- What would you change? By what means?
- Would you take part in the solution of local problem? On what tasks could you undertake?
- Who are the suitable people for solving these exercises?
- Will you come for a common reconciliation / conversation?

The tasks of a community builder are encouragement, stimulation, informing people and initiation of new participants into the programs of settlement development. The long term goal of this method is to make people able to solve their problems relevant in the life of small settlements. In short term we had to induce a more intensive local communication and in consequence of this people found new clubs, associations for the better prosperity of the villages.

Summary

Small settlements in Hungary far from economical centres are hotbeds of exclusion, social problems and deviant behaviour. Local governments running into debt are not able to solve the problems of the underprivileged population. Social experts supporting the social work realized in the rural area of the country have complex tasks. They have to reveal the general and particular problems of small settlements, and to become acquainted with the state of village societies. They can support the working NGOs and communities by the way of presenting successful patterns and examples from other settlements and stimulate the self-organization in villages by special methods. One of these methods is the community builder interview. Researchers and social experts are important members of the multilevel collaboration for deprivated people living in underdeveloped small settlements.

[1] Juhász, Pál, Village-society, in: Nation-ideas – village-politic, Budapest, 2004, 42-50.

[2] Lukovich, Tamás, Common participation, common planning, in: Rural and urban sociology, Budapest, 2004, 182-206.

[3] Hankiss, Elemér, Crisis and lack of communities, in: Social traps and diagnoses, Budapest, 1983, 205-240.

[4] Inglehart, Ronald – Baker, Wayne E., Modernisation, Cultural Change and Persistence of Traditional Values, 2000, 29.

[5] Varga A., Tamás - Vercseg, Ilona, Community Development, Budapest 1998, 9.

[6] In the *Ormánság* region people cultivated water-melon as a traditional and famous plant of the area. The new supermarkets in the 90s kept the prices of fruits and vegetables permanent under the cost of productions level and most of the farmers got a huge unpaid debt and gave up the agricultural enterprise.

[7] Kiss, Géza, Ormányság, Budapest, 1937.

[8] Ragadics, Tamás: Ecclesiastical actors in the Development of *Ormánság*, in: The rural Hungary after the EU-connection, 2007, 369-375.

[9] The name of villages: Alsószentmárton, Besence, Bogádmindszent, Bogdása, Drávasztára, Felsõszentmárton, Gyöngyfa, Hegyszentmárton, Ipacsfa, Kákics, Kémes, Kemse, Királyegyháza, Magyarmecske, Markóc, Marócsa, Molvány, Sósvertike, Vajszló, Zaláta

[10] The collection of data realized by the help of students from the University of Pécs and the Theological College of Pécs

[11] The catholic priest of Alsószentmárton – the only inhabitant from the 1100 people who does not belong to the roma population – founded a caritas organization. This foundation operates the local kindergarten with roma nursery-school teachers. The Caritas provides 200 people with hot meal every day.

[12] Biddle, William W. – Biddle, Loureide J., Community Development Process: The Rediscovery of Local Initiative, New York, 1965.

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Casework, case management and English language for people with hearing loss

Svetoslava Saeva

Managing a case with a deaf or hard-oh-hearing client is challenging for social workers. The specialist must be aware of many peculiarities of deaf peoople, deaf community and deaf culture. They should also be familiar of the best way to communicate with them as well as with some facts about being deaf in hearing society.

Hearing loss

A hearing impairment or deafness is a full or partial decrease in the ability to detect and/or understand sounds. Caused by a wide range of biological and environmental factors, loss of hearing can happen to any organism that perceives sound.

Approximately four to six percent of world population is in some degree hearing impaired (Angelina Baltadzhieva, 2000, p 8). There are

apporximately 9 000 – 12 000 people with hearing loss in Bulgaria by non-oficial statistics.

Some of the hard-of-hearing people and all deaf people experience difficulties in learning mother tongue as well as acquiring any other spoken language since they cannot selfcontrol their voice.

Some of the deaf and hard-of-hearing people use Sign language. A sign language is a language which, instead of acoustically conveyed sound patterns, uses visually transmitted sign patterns including body language, lip patterns and manual communication, to convey meaning. It simultaneously combines hand shapes, orientation and movement of the hands, arms and/or body, and facial expressions to express fluidly a speaker's message. Sign languages commonly develop in deaf communities, which can include interpreters, friends and families of deaf people as well as people who are deaf or hard-of-hearing themselves.

Wherever communities of deaf people exist, sign languages develop. Their complex spatial grammars are markedly different from the grammars of spoken languages. Hundreds of sign languages are in use around the world and are at the cores of local Deaf cultures. Some sign languages have obtained some form of legal recognition, while others have no status at all.

"Deaf culture" is a term applied to the social movement that holds deafness to be a difference in human experience rather than a disability. When used in the cultural sense, the word "deaf" is very often capitalized in writing. Deaf communities do not automatically include all those who are clinically or legally deaf, nor do they exclude all hearing people. As with all social groups that a person chooses to belong to, a person is a member of the Deaf community if they identify themself as a mem-

ber of the Deaf community. The Deaf community typically includes individuals who communicate via sign language, individuals who attended schools for the deaf, children of deaf parents, and sign language interpreters. Deaf communities also often possess social and cultural norms that are distinct from those of surrounding hearing communities.

Bulgarian Sign language

Bulgarian Sign language is not officially recognized by the state. Several factors have influenced this situation, one of which is the fact that there are different signs for one spoken word in the different regions of Bulgaria. That is a result of the concentration of deaf people in certain towns in Bulgaria (for example, there are more deaf people in the towns with special schools for the deaf).

There is interesting division among Bulgarian signers. Younger and older deaf people tend to use different signs for the same word. This situation could be compared to slang and literary language used by younger and older hearing people.

Bulgarian fingerspelling

There are two ways to fingerspell in Bulgaria: with one hand and with both hands. There is difference in the fingerspelling preference between younger and older deaf people. One-handed manual alphabet is used primarily by younger signers while two-handed fingerspelling is preferred by older deaf people.

At the time when methodology for teaching deaf pupils was introduced, Bulgaria was strongly influenced by German and Russian pedagogy for the deaf. Since the Roman alphabet is used in Germany, Bulgarian specialists borrowed the Russian fingerspell method (Russians use cyrillic alphabet as Bulgarians). As a matter of fact, the Russian alphabet has three more letters than the Bulgarian alphabet. The rest of the letters look identical. Russian fingerspell is one-handed.

Since Russian fingerspell has been used for teaching deaf pupils in both special and mainstream schools in Bulgaria, one-handed fingerspell is preferred by younger deaf signers. They have been taught this fingerspell at school and have got used to it.

The two-handed fingerspell originates from Bulgarian Deaf people. It is more logical for Bulgarians than the one-handed fingerspell (for example, in the two-handed fingerspell "B" is touching your cheek because the Bulgarian word for "cheek" - "*áóçà*" *(buza)* begins with "B"). In spite of the differences mentioned above, all Bulgarian deaf people know and would understand both ways of fingerspelling.

Myths about deafness

There are many myths about what people with hearing loss can and cannot do. Here are some of the most popular (Svetoslava Saeva, 2009, pp 7 – 13):

Myth one: Deafness can be cured.

There are certain physical states that cannot be cured even by the means of modern medicine and technologies.

Myth two: Deaf people are alike in abilities, tastes, ideas and outlooks.

Deaf people are as diverse in their abilities, tastes, ideas, habits, and outlooks as any other large group of people.

Myth three: Deaf people are not sensitive to noise.

Some types of hearing loss actually accentuate sensitivity to noise. Loud sounds become garbled and uncomfortable. Hearing aid users often find loud sounds which are greatly magnified by their aids, very unpleasant.

Myth four: All deaf people use hearing aids.

Many deaf people benefit considerably from hearing aids. Many others do not, some of them find hearing aids to be annoying, and they choose not to use them.

Myth five: Hearing aids restore hearing.

Hearing aids amplify sound. They have no effect on a person's ability to process that sound. In cases where a hearing loss distorts incoming sounds, a hearing aid can do nothing to correct this and may even make the distortion worse. Hearing aids are assistive devices which improve hearing for some individuals. Hearing aids do not correct hearing. A hearing aid may enable a person to hear someone's voice, even though they may not be able to understand distinct words. Just because someone wears a hearing aid does not mean the person hears normally.

Myth six: All deaf people should have a cochlea implant. Many deaf people are against cochlea implants, especially when it comes

to deaf children. This is because there is no disability in being deaf. Deaf people cannot imagine coping with the distraction of noise all day. There is a belief among deaf community that cochlea implants should never be given to children who are born deaf. This is a decision children must make on their own.

Myth seven: Deaf people are mute.

Some deaf people speak very well and clearly, others do not because their hearing loss prevents them from learning spoken language. Deafness usually has little effect on the vocal chords, and very few deaf people are truly mute.

Myth eight: Unusual sounding speech means the person is mentally retarded. Speech development depends greatly on one's ability to hear hemself talk. For a deaf person, the foundation for learning speech which hearing people take for granted is missing. The situation has nothing to do with intelligence.

Myth nine: Deaf people are not very bright or educated because they have not learned to talk or do not use proper grammar of spoken language. The first language of the Deaf Community is Sign language. The spoken language of the country is usually second language. Most deaf and hard-of-hearing people learn the spoken language and have speech training, but naturally enough they may find it easier to use their primary language most of the time.

Myth ten: All deaf people use sign language.

Many deaf people, especially prelingually deaf people, use sign language. Many others do not.

Myth evelen: All deaf people use the same sign language. Each country has its own sign language. Just as there are many spoken languages and many variations within each language. For example, people from Scotland and those from America speak English. However, they may have difficulty understanding each other. It is the same with sign language. There are some similarities between British Sign Language (BSL) and Auslan, but there are more differences. Within the international deaf community there is an International sign. However, this is generally only known by deaf people who travel overseas regularly.

Myth twelve: If a deaf child learns to sign, they will never learn to speak.

It is on the contrary. When a child uses two but not one code for communication, the both languages support each other in the communicative process.

Myth thirteen: The best way to communicate with a deaf person is by writing. Sign language uses a different structure and grammar than written Bulgarian (and any other spoken language). Deaf people are very visual.

Myth fourteen: All deaf people can read lips.

Some deaf people are very skilled lip readers, but many are not. This is because many speech sounds have identical mouth movements. For example, sound P and sound B look exactly alike on the lips.

Myth fifteen: If you speak louder, the hearing impaired person will hear you better.

When a person shouts, their facial muscels change and their overall facial expression looks different. In addition, the voice characteristcs change when someone speaks louder and this could cause physical discomfort to the person with hearing aids.

Myth sixteen: Hearing impaired people hear only when they want to.

Some types of hearing loss make it so that today the person hears nothing and tomorrow they can hear well. This might be confusing for their interlocutors. Also, hearing aid users hear better when they speak to one person, in quiet room and their lipreading skills are better when they are not tired.

Myth seventeen: Deaf people cannot use the telephone. Some hard-of-hearing people have enough residual hearing to talk on the phone. Deaf persons use a device call a telephone typewriter or teletypewriter (TTY).

Myth eighteen: Deaf people cannot drive.

Deaf people can and do drive. 97% of the warning signals that reach the driver are gained through the visual channel. Statistics ranks deaf drivers as as good or better than hearing drivers.

Myth nineteen: Deaf people cannot appreciate the arts because they can't hear music, voices, opera.

Throughout history, deaf individuals have participated in and contributed to the performing arts. Beethoven is a brilliant example. Today there are deaf artists, dance troupes, and actors. Captioning of movies and other audiovisual media is helpful for deaf citizens, and this practice

should be continued. As long as there is rhythm and visual image, deaf and hard-of-hearing people will be valued performers and patrons of the arts.

Myth twenty: Deaf people lead totally different lives from other p e o p l e .
Deaf people are set apart by only one thing. As I. King Jordan, President of Gallaudet University has said, “Deaf people can do anything except hear.”

Communication tips

If a social worker has a case to deal with where a deaf or hard-of-hearing person is involved, they would only benefit if they follow some of these comminication tips:

Attention

First, get the person’s attention, make sure you have it and then start talking to them. This will reduce you having to repeat what you say and any frustration on both sides. If the attention is wavering, this could be a sign that the person is becoming tired.

Way of speaking

Try to look the deaf or hard-of-hearing person in the eye and speak clearly, with normal rate. Keep your hands away from your face. This will ease the communication.

Location

Proximity to the person is very important. The farther you are, the more a person with hearing loss will miss. Situate comfortably close to them. Ask the person if they have a better ear, sometimes people will prefer you sit on a particular side when you are talking. For other people sitting opposite to them is best.

Noise background

Hearing aids and cochlear implants amplify noises as loudly as the amplify speech (unless noise reduction programmes are being used). Thus, background music, finger drumming, keys tapping, fan blowing, traffic noises and others will all make it more difficult for the person to hear. Control the noise in your environment as much as possible.

Place to talk

Try to find a quiet corner where you can converse with the person. Sometimes, stepping out into the hallway or outside can make a great difference. Keep in mind that the person with hearing loss has to work very hard to keep up in social situations. It could be very exhausting for them, especially for a child.

The social work involves direct consideration of the problems, needs, and adjustments of the individual case (as a person or family), which is why family background of a deaf or hard-of-hearing client is a very important issue. About ten percent of all deaf children are born to deaf parents, the other 90 percent are born in hearing families. Hearing parents expect their child to be hearing too and when the hearing loss is diagnosed the family goes through shock and different levels of frustration, depression and rejection of the facts.

If a social woker manages a case with deaf or hard-of-hearing client, they should team work with the other specialists in the other healthcare professions. Since case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality costeffective outcomes, there should be sufficient number of comminication codes. Comunication is the base of social worker's profession. They should be able to understand and support their client.

English for the deaf

Typically, considerable number of people who need social services are people with migrant background especially in the host-countries. There are also people with biligual or multilingual status who need special attention in social work.

English is so widely spoken that it has often been referred to as a world language, the lingua franca of the modern era. It is spoken as first language by 309–400 million people and as second language by 199–1,400 million people (depening on how litearacy or mastery is defined). Overall English is spoken by 500 million–1.8 billion people in the world. English is also learned as a second language by million of people all over the world including deaf and hard-of-hearing people. English is official language in 53 countries, Unated Nations, European Union, Commonwealth of Nations, North Atlantic Treaty Organization, North American Free Trade Agreement, and UK-USA Security Agreement.

Usually, deaf and hard-of-hearing people find it challenging to acquire

spoken language, even more when it comes to second spoken language. In some respects, there are certain similarities between deaf and roma learners as representatives of minority groups in society (Milen Zamfirov, 2008, p 40). The both social groups of young learners take benefit from using informational technologies in the teaching process. There are different types of language teaching that are typical only for learners with hearing loss and do not fully correspond with such for hearing learners. In order to answer the special needs in learning English for Bulgarian deaf and hard-of-hearing English learners, a computer teaching strategy is designed. The multimedia teaching strategy – English for people with hearing loss (beginners) – consists of 220 phrases presented in four topics which follow the regulations of the State Requirements of the Ministry of Education and Science. Each phrase is colour-coded: the pharase is blue when it is in English, the same phrase translated into Bulgarian is green and the phonetic transcription with Bulgarian letters (not in the phonetic symbols of the International Phonetic Alphabet) is in red. This is necessary because of the specifics of Bulgarian deaf learners. They use three written codes: the cyrillic alphabet (the first written code to learn), the Roman alphabet (second code) for English, and the International Phonetic Alphabet, which consists of different graphemes and symbols (third written code). In addition, they have to translate all of these graphemes into sounds.

In the teaching programme (English for people with hearing loss (beginners) all phrases are presented in Bulgarian Sign language and in spoken English with a close-up screen, so the ability to lip-read in English can be trained. On the right of the screen there are pictures which present the objects or actions that the phrases refer to. They are used to show the action as realistic as possible (they are not presented with drawings). The demo version of this programme is available at: http://

signlanguage-bg.com/bg/english.html.

ntering the programme.

Screenshot 1: Beginnig of the programme. I. Topics, II. Alphabets, III. Authors.

The four topics in the programme are as follows:

1. Personality and communication (including six subtopics);
2. Everyday life (three subtopics);
3. The world around us (five subtopics);
4. Activities (three subtopics).

Once choosing destination in the programme, for example: I. Topics, 1. Personality and communication, the screen shown on screenshot 2 is visible.

Screenshot 2: I. Topics, 1. Personality and communication, subtopic 3 – Clothing.

Part I Topics cosists of three subtopics each of it including various number of themes.

There are examples of the programme's contents on screenshots 3 to 11.

Screenshot 3: I. Topics, 2. Everyday life, subtopic one – School.

Screenshot 4: I. Topics, 3. The world around us, subtopic one – Motherland.

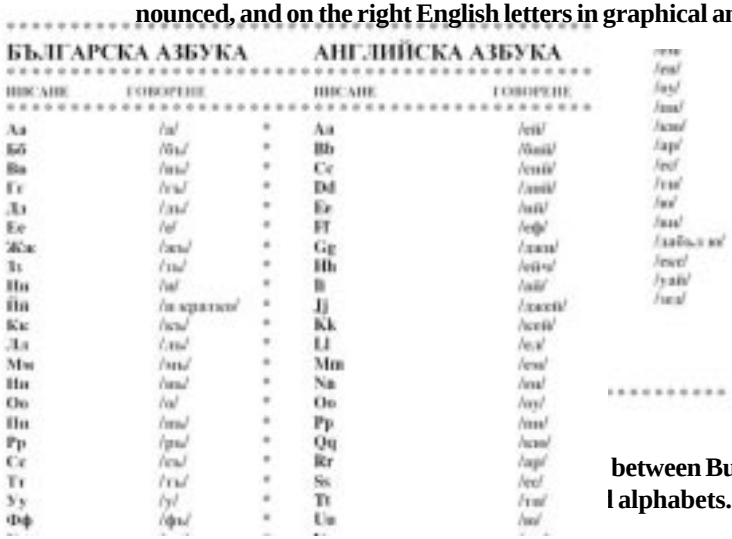
Screenshot 5: I. Topics, 4. Activities, subtopic one – Free time activities.

Screenshot 6: II. Alphabets, 1. Bulgarian one-handed fingerspell, Bulgarian letter *Ï* (letter "P" in English).

Screenshot 7: II. Alphabets, 2. Bulgarian two-handed fingerspell, Bulgarian letter *Ï* (letter "P" in English).

Screenshot 8: II. Alphabets, 3. International fingerspell, letter P (in English).

Screenshot 9: II. Alphabets, 4. Comparison between Bulgarian and English alphabets. On the left Bulgarian letters: the way they are written and pronounced, and on the right English letters in graphical and phonetic way.



БЪЛГАРСКА АЗБУКА

НАПИСАНИЕ	ГОВОРЕНИЕ
Аа	/а/
Бб	/бъ/
Вв	/въ/
Гг	/гъ/
Дд	/дъ/
Ее	/е/
Жж	/жъ/
Зз	/зъ/
Ии	/и/
Йй	/и кратко/
Кк	/къ/
Лл	/лъ/
Мм	/мъ/
Нн	/нъ/
Оо	/о/
Пп	/пъ/
Рр	/ръ/
Сс	/съ/
Тт	/тъ/
Уу	/у/
Фф	/фъ/

АНГЛИЙСКА АЗБУКА

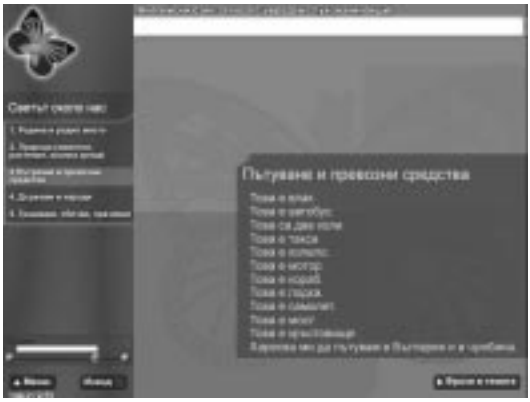
НАПИСАНИЕ	ГОВОРЕНИЕ
Aa	/ей/
Bb	/бий/
Cc	/сий/
Dd	/дий/
Ee	/и/
Ff	/еф/
Gg	/джи/
Hh	/ейч/
Ii	/ай/
Jj	/джей/
Kk	/кей/
Ll	/ел/
Mm	/ем/
Nn	/ен/
Oo	/оу/
Pp	/пи/
Qq	/кю/
Rr	/ар/
Ss	/ес/
Tt	/ти/
Uu	/ю/

/ви/
/ви/
/ъкс/
/уай/
/зед/

between Bulgarian and English alphabets.

Some differences between the two alphabets, that are noticeable for Bulgarian deaf learners, are pointed out:

Bulgarian letters are 30 and English letters are 26. Bulgarian letters are pronounced the way they are written, while English letters are not. Upper and lower case in Bulgarian are equal (except for the size) while in English they differ (for example, in Bulgarian “Pp”, while in English “Rr”).



Screenshot 11: Example of linguistic contents (senteces to choose from) in part I. Topics, 3. The world around us, subtopic 3 Travelling and vehicles.

Picture 1: Application of the programme: English classes at the special school for the deaf in Sofia, Bulgaria.

Some pecularities of Bulgarian deaf English learners are shown in the two examples.
First example: Writing a Bulgarian words with Roman letters is their concept of English language.
Òîâà å êîòêà. ("Tova e kotka" - "This is a cat") in Bulgarian;
Tova e kotka. Bulgarian Deaf people concept of English;
This is a cat. – in English.
Second example: Generalization of grammar rule and mixing words because they are homophones.
„goods – buy" – writing of a deaf student, meaning "good-bye". She added s – for plural because she is saying "good-bye" to many people. The other part of that example shows the homophones "buy" and "bye". Sometimes it is unintelligible what deaf people mean in writing, especially when they write to another deaf person.

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Psycho-social rehabilitation — First Master's Program in Bulgaria

Stefka Chincheva

Master Program in Psycho-Social Rehabilitation is accredited by the National Evaluation and Accreditation Agency in 2007 to assess "Very. good "for 6 years. This master's program was developed by the Department of medical and social science at Southwestern University "Neophyte Rilski" Blagoevgrad MATRA project in partnership with the Global Initiative in the community and has the support of specialists from the Netherlands and Finland. Its implementation will help to promote a new model for equal treatment of people with severe psychiatric disorders and will be part of the National Action Plan for implementation of Mental Health Policy of Bulgaria for the period 2004-2012 on Qualification Characteristics to acquire the qualification degree "master" in the professional field with professional social work qualification Master of psychosocial rehabilitation.

Teaching Masters program aims to prepare qualified specialists for mental health services through strengthening of the scientific and theoretical and specialized training in the professional field social activities. The curriculum was developed in accordance with the Ordinance on

state requirements for acquiring the qualifications MA (SG. 76/ 06.08.2002). It is designed for students who acquired the qualification degree "bachelor" or "master" in the professional fields Social, Psychology, Public Health. The training provides theoretical and practical training in the field of social work and the specific problems of individuals, groups and communities in the implementation of psycho-social rehabilitation. The main objective is to provide knowledge and skills to work with people with severe mental illness and their families through therapeutic approaches to learning of the lost social skills and skills for independent living.

The curriculum includes compulsory, elective and optional subjects. **Required courses:**

• Fundamentals of psycho-social rehabilitation The aim of the course is to acquaint students with basic approaches to psychosocial rehabilitation, which are used at home and abroad. Affect not only the general questions of the existing models, but the practice of their application in our country and the existing difficulties in this respect.

• Organization of mental health services The course introduces students to the values, ideology and politics of psychiatry in the community, which sets the basis for its individual, its development potential and needs and how to solve this problem at the local office, local and central politics.

• Therapeutic behavior. In this course students must learn the importance of professional-client relationship in the development of the therapeutic process. The course includes a set of knowledge about the therapeutic situation, the distribution of roles in it for the allocation of responsibilities between professional and client.

• Case Formulation. The aim of the course is students to acquire skills to build on the formulation and its use as a tool for involving the client, achieving the therapeutic contract and planning terapiyata.Obrashta attention to the use of the formulation to achieve a holistic approach to clients with mental illness and continuing evaluation over time of interventions.

• Case management. In this course students acquire the necessary knowledge and skills for the role of key professionals in the mental health system in the community. The course discusses the meaning and methods of establishing a personal relationship with a client with severe mental illness and support of social participation.

• Mental-health policy .The aim is to provide knowledge of policies and legislation on mental health in Bulgaria and Europe. To build skills to synchronize mission, vision and management of service and care organization with global, national and local priorities in mental health policy.

• Working with families in the practice of mental health care.The focus of the course is to understand the importance of professional cooperation with the families of persons with severe mental illness in the community. To bring theoretical concepts and methods of evaluation of resources and patterns of family coping.

• Interdisciplinary teams. Severe mental illness harms the ability of man to satisfy a wide range of biological and psychosocial needs, thus ensuring optimal functioning in the community requires the efforts of other professionals who are coordinated and meet the needs, resources and vision of the client.

• Leadership in mental health services. Students are introduced to the

role of leadership in the establishment of mental-health services in the community. Supporting the process of liderstvane services contribute to the motivation of staff, reducing the professional pregaryane, improving the quality of services in the community.

• Management of mental health services in the community. The course introduces students how mental health policy is applied in everyday practice of mental health services and to reach each individual user of mental-health care. Examine the management of mental health programs and services in the community and dealing with daily management and technology as a human process.

• Home care in psychiatry. Students are introduced to a model of community psychiatry, which offers therapeutic services in the home of the client programs for home care and mental rules j.

Optional disciplines:

• Communication and communication training

• Communication Disorders

• Public Relations

• Information aspects of social work

• Occupational rehabilitation in specialist

Practical training

Practical training is an important component for the formation of skills and competences in education. The total workload of the practice is 60 hours.The program is finalized by diploma thesis.

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Case work and social control
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