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Case work and social control in 20th century

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Introduction

Case work 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. The methods contributed to the creation of modern social work as a distinctive professional field and vocational training. The case work techniques (observation, home visiting, interviewing of clients) as well as their separate steps (social analyses, social diagnoses, and planned social therapy) made the practice of social work more transparent and traceable. These methods had been adopted in different European societies during the period between the two World Wars being applied to different social and political situations. Case work 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 new methods of case work also changed the forms of social control over the "clients". In the West European countries after the World War II a radical change in the social case work practices could be observed – the approaches became more psychological and psychoanalytical, whereas in the most East European countries case work was transformed into more general social policy, which replaced individual and family case work.

The aim of the volume "Case Work and Social Control in the 20th Cen-

tury" 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 both the ways of communicating the ideas and practices of case work in Europe, and the role of authors, translators, and practicing social workers who contributed to the spread of these ideas. We aim at comparing case work practices in different social traditions using the rich documentation left by the case workers. The exchange of ideas and practices and the possibility of writing a history of individual social care have been also discussed.*

The book is divided in two parts. The historical roots of the social case work and its development and dynamic in different countries is presented in the first part. This development in Spain, Bulgaria, and Slovenia presents a lot of common issues in the early development of case work method: the importance of the international exchange, the significant role of women and women organizations, as well as the dependence of the social work methods on the political framework in the different countries. We can see how individual methods were connected to the democratic social conditions and it was hardly possible to be established in dictatorship and anti-democratic political conditions. **Emma Sobremonte de Mendicuti, Arantxa Rodrнguez Berrio, and Usue Beloqui Maracyn** point out that in the 40 years of Franko dictatorship

*After the political changes in East Europe in 1989 and especially in the last decade the interest about history of social work in different European societies arose. See: Sabine Hering/Berteke Waaldig (Eds.)History of Social Work in Europe (1900-1960). Female Pioneers and their influence on the Development of International Social Organizations, Opladen 2003; Kurt Schilde/Dagmar Schulte (Eds.), Need and Care – Glimpses into Beginnings of Eastern Europe's Professional Welfare, Opladen 2005. ; Hering, Sabine; Waaldijk, Berteke (Eds.), Guardians of the Poor – Custodians of the Public: Welfare History in Eastern Europe 1900-1960., Barbara Budrich Publishers: Opladen/Farmington Hills 2006.

from the second half of the 1930s till 1975 **Spain** was in cultural and political isolation. The case work methods were introduced through Latin American authors as well as by the Case Work Course given by the Belgian Julia Tuerlink in Madrid in 1958. The authors present different approaches of the social work in Spain (assistance approach, critical approach, welfare approach, integrative approach as well as the great advance in the theoretical-practical training of social workers in the last decades.

In **Slovenia** in the political conditions of Yugoslavia which made its way after 1947 different from the Soviet Block and was more open toward Western models it was possible in the 1950s a School for Social Work to be opened and the first manual to be published in 1959. **Gabi Иаinovia Vogrinaia and Nina Меlы** present the rise of the importance of social work in Slovenian society from the time of the early 1950s as social officers were trained in two days courses for the so called *District People's Committee*. The School for Social Work in Ljubljana became an important place for training and later on for research. The authors present the history of the social work in four waves: from pathology-based social work to the postmodern "co-creation" arguing that the ethic of participation is the path for social workers.

In **Bulgaria** case work methods appeared in the 1930s. **Kristina Popova** presents the predecessors of the social work education and practice as well as the importance of the German model of individual social work. She points out the place of the Women Movement and international contacts for the establishment of social work education in Bulgaria. She also analyses social work pioneer's publications about social work methods. Also in the 1930s it became possible to establish in Bulgaria modern children fostering practices. **Milena Angelova** presents the role of the American Foundations for the first attempts and

first cases of fostering practice in Bulgaria and the various institutions which took part in this process. This practice was interrupted in the next decades during the socialist time and it is remarkable that today it is very difficult to establish again the children fostering practice in Bulgaria. **Anelia Kassabova** raises a very important question: in what extent case work methods were possible in the socialism? On the example of the authorities attitude toward unmarried pregnant women and unmarried mothers she argues that there were individual approaches also during socialism. Analyzing documents left by the authorities Anelia Kassabova concludes that the main goals of such commissions were not motivated by the concern to support such women but by biopolitical considerations.

In the second part of the Proceedings the current trends in case management practice are presented. **Vaska Stancheva-Popkostadinova** presents current trends in case management as an effective procedure to overcome the fragmentation of services and minimize the gaps in their provision. The discussion on case management models and their implications is made. Based on the standards for social work case management, the key functions and qualifications of case managers are presented. The various definitions and functions of case management are presented, and the process of case management is delineated. The extensive world wide research literature show the effectiveness of the case management in the various areas of its implication. **Vesselka Christova** discuss case management problems trough several case vignettes from the perspective of a community-based center for psychotherapy, counseling, and psychiatric consultations. The case vignettes are given as illustration for the role of the case management in some of the referrals to the Center when clients with complex needs are addressed. The problems of the 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.

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 discussed. **Andrea Fabian** presents the parallel family therapy with juvenile delinquents and their families. The case study is based on Hugh Jenkins's approach "family therapy without the family". During the sessions different methods are used: dramatic instruments, accentuated the role of symbols and sculpture development, genogram, symbolic gift, family scheme, etc., and different scales. The therapy fulfills its role: familial roles became clearer, communication between family members was improved, and the conflict solving practice has changed from a competition-based to more compromise-seeking approach. The result of the therapy 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. **Tamős Ragadics and Eszter Pűntek,** examine the state, troubles, and chances of the local communities supporting the social work and try to take into consideration the powers of community development, the factors that work for a stronger and more effective local society. Local governments are not able to solve the problems of the underprivileged population. The need for more understanding and support from the state is discussed. The recommendation is made that social experts 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 deprived people living in underdeveloped small settlements. Interesting ideas presents **Svetoslava Saeva** in the article about case management and English language for people with hearing loss**.** Managing a case with a deaf or hard-oh-hearing client is challenging for social workers and other helping professionals. Many peculiarities of deaf people, deaf community and deaf culture should be known by social workers, as well as the best way for communication. The stress is on some facts about being deaf in hearing society. There is discussion about myths and realities about deafness, as well as communication tips in order to make case management as much successful as it might be. **Stefka Chincheva** presents the first for Bulgaria *Master Program in Psycho-Social Rehabilitation.* Delineation of quality characteristics, compulsory and elective subjects are made. The main objective of the program is to provide knowledge and skills for dealing with people with severe mental illness and their families, and support the community living.

The idea of this volume is not only social work ideas and institutions to be outlined. Beyond them we searched the attitude toward the individual, the change in the communication with the client. This directed our research toward individual methods, their history and presence, toward the change of the relationship between social worker and client from a more hierarchical toward a cooperative relationship. We hope that our volume will encourage interdisciplinary research of those important processes which are not only professional issues but also a part of our social worlds. For the opportunity to fulfill this idea and to attract colleagues from different countries to take part in this volume we thank very much the Phoenix TN for the support and personally the project leader Prof. Laurinda Abreu.

Case Work and Social Control: the History

Social Work and Case Work in Spain during the 20th Century

Emma Sobremonte de Mendicuti, Arantxa Rodrıguez Berrio, Usue Beloqui Maranion

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 by both 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 had a little impact along the whole century. Social reality and state policy, determined by the 40 years of dictatorship (1939-75), plunged Spain in an intellectual isolation that prevented the exchange with other international cultural realities. In this way, during that period there was almost no knowledge of the methodological instruments developed in the United States or Europe.

The three methods of case work: with individuals, groups, and communities - began to be studied in the first Schools of Social Assistants during the 1950s, taken from the Latin American bibliography that arrived to Spain in an easier way.

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 point of view, 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 psycho-social 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 20th century, since the 1960s, in Spain social work was consolidated 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 these 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 20th 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 instruments of that period are the ones of patriarchal state which cover basically the contingencies 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 settlements 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, neither 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 develop-

ment of good projects and strong supervision of the students. The instability and disorganization of the resources put the emphasis of work on the professional competence 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 developed 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 1970'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 change 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, neighborhood 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 pro-

fession 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 1950'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 general 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 in 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 1960's.

While the transition to democracy took place, some efforts were made in order to improve the theoretical and practical basics of the discipline. 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 Pйrez de Ayala[10] would make an important contribution training many social workers since the end of the 1970's.

The developments that came from the United States would slowly introduce the diagnostic psycho-social approach into specialized circles and would study deeply the case method and group work, both from a psycho-dynamic 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 achievement 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 restate its object of knowledge[13].

From the decade of the 1990'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 reflection 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 Care of Sofia Municipality for the accommodation of abandoned children in foster families since 1937. The main sources for the reconstruction of these first steps of foster care in Bulgaria are the reports and surveys of 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**

In the early 20th 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

- *Central state archive, F. 3k, Op. 15, a.e. 241, l. 4

keep children with their own families, even if they were born out of wedlock, 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 Child Protection in Bulgaria), summer children's playgrounds and kindergartens.

Child Welfare Station in Koniovitza, started in 1931. Examining by the physician*

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

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 19th of May, 1934. This law obliged the communes to maintain health centers and veterinary dispensaries, to cooperate with local medical institutions, and to cover a part of the

*Central state archive, F. 3k, op. 15, a.e. 241, l. 15

Child Welfare Station in Koniovitza. Mothers bringing their babies to the Station

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 (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 of 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 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 the year 1939). The first social consultants were nurses but later it was the graduates from the Higher Social School for Women who were appointed as social consultants.

Home visitation of Public Health nurse. Child Welfare Station in Koniovitza*

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

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

* Central state archive, F. 3k, op. 15, a.e. 241, l. 15a.

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 years with childless or well-off families till the children turn 18 years. 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 doctors and visiting nurses of 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 by the end of 1938, indicated briefly the reasons for taking this attempt: Child's upbringing in family, although not the own family, is under natural conditions, not in artificial atmosphere inherent of every orphanage, even the best placed; as it is cheaper.

Foster families received 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 were provided by the Foundation. The fixed amount was 700 leva at first, but

Child Welfare Station in Koniovitza*

was reduced to 600 leva later. According to the observations and calculations of the visiting sisters the actual support should be 520 leva.

According to the Reports of the doctor and visiting nurses the adoption campaign had several weaknesses:
- Absence of preliminary investigations of children's history - often there were not any documents about adopted children;
- Moving children from one family to another happened several times;
- In some cases the attitude of the family's own children to the adopted ones was aggressive.

* Central state archive, F. 3k, op. 15, a.e. 241, l. 15

The children placed in foster families were fatherless, born out of wedlock, abandoned, and one neglected child (both parents had a severe form of sleeping disease).

The Reports of the visiting nurses described several cases in which the biological parents of the abandoned children interfered in their lives:

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 her child. The child knows that she is his mother, but because she is a reasonable woman, she maintains the prestige of the foster mother. Both women are in very good relations, they became good friends and fully agreed on the issue of the upbringing of the child .... [7]

There were also other examples in which the visits of the 'real mother' was presented as *extremely harmful*.

Despite of the short period of conducting the campaign, Leontii Feldmahn, who reported its results, indicated:

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 experiment 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 it is never 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 are treated, 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 experimental practice ended at the end of 1939. About this time all common projects of the Near-East Foundation with the Bulgarian institutions interrupted. What would have been the results of a longer-term and large-scale campaign we can only guess.

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 on 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 pre-

served 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 (Amerikanskata blagotvoritelnost v Balgaria mezhdu dvete svetovni vojni), Sofia, pp. 153-154,1994.

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

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

[5] *Social Support* Magazine (Obshtestveno podpomagane) , 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, pp. 17-18.

[8] Central State Archives, f. 264, Op. 7, a. e. 948, pp. 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 Extramarital Motherhood

Anelia Kassabova

The aim of my article is to highlight some problems of the social policies in socialist Bulgaria as regards to extramarital births and motherhood.

The possibilities and the impossibilities for case work and social control in this specific field result from the inherent contradiction between pronatalism 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 the intended population growth, but on the other hand, 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 all infants. The "inherited" network of social institutions - gynecological

departments, maternal and child care centers, was reorganized. 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 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 resources were transferred. The disagreements between the different ministries begun with the struggle for the property of the charitable organizations. All welfare organizations were liquidated at the beginning of the 1950's which was explained to the public as 'self-liquidation'. In 1951 the old system finally was removed.

The entire socialist period was 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 in 1946. The professional education for social work was designed to equip its practitio-

ners 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 got lost for decades. The individualized 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 the new massive social changes caused social problems which were not expected. The utopia was pleading for a new morality which should have 'persuaded', 'planted' in a 'hard and concentrated fight' with the old habits doomed to be 'torn out'.[5]

The accent of the investigation of the social problems was not laid on the social environment and social networks, but on the weakness or underdeveloped willpower of the individual/person. It was not about personality development, but about forming of personality type, after which the individual should adapt his own life to the interests of the socialist society. The main goal of this policy 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 achieve participatory forms. One can illustrate this at the example of the case work with extramarital 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 wedlock. 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 of the 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 of 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 the Soviet biopolitics, 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 unmar-

ried 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 1940s the annual average of extramarital births in percent to all live births remined 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 focused 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 behavior. 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 seduction of an overcredulous girl, who was particularly 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 women's sexuality. The stigma of extramarital birth was not attached only to the mothers but also to 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 behavior.*[12] If girls ignored the principles of socialist morality, her parents were stigmatized 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 organizations 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 fulfillment of the government documents to the protection of motherhood and childhood, the foundation of the so-called *Social Juridical Cabinets* (SJC) began in the 1950s, until middle of the 1970s such cabinets were opened in all districts. They introduced free legal advice and representation of single mothers, 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 centered around the personality of the mother. Not the woman, her predicament, personal needs stood in the center, 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 the 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 1940-1960s. 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 taught to be potentially good. If the putative father was unmarried, 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 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 that the child needs a 'normal' environment, a 'normal' family with healthy mother and father. The child psychological well being 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 was 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, the state deplores up to the end of the socialist period the impossibility of the full control of this category women. Thus the percentage from the gynecologic departments and SJC of the grasped non-married pregnant women remained scarcely more than 60%, one quarter of the unmarried women were taken up in the *Mother and Child Homes* (approx. 24%).[17]

Mother and Child Homes

Group Work

The *Mother and Child Homes* served also as means of regulation women's sexuality and way of life. Unmarried mothers were considered to be a 'risky group' - risky 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 children and the society.

Not individual, but 'group work' was a leading form 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 the mothers attended the *Homes* because they wanted to hide their pregnancy or to have their baby adopted.

Measures for raising their morally and for political 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 and Child Homes* served not only to preserve legitimacy, but also to produce it. The *Mother and Child Homes* acted like a sorting out center, 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 and Child Homes* and the other institutions provided to respectable socialist families (clients) good quality babies.

After the release of the child for adoption, the mother 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 children were snatched from them was completely and scientifically denied.

If the unmarried mother decided to upbring her child alone, the patronage goes on: the mother had the right to name the father and to get free assistance in providing child's allowance, but the procedure was so complicated and for such paltry results, that it was not very often used.[18]

The institutions were required to support 'alone' mothers in the housing and job search. One quotation from a Report of a Sofia SJC from 1976: *We started with the correspondence for finding lodging. The applications have been worked out by our lawyer. Special visits were approved by the nurse and the lawyer 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 the single mothers not only often remained on paper - the SJC could only make recommendations not obligatory for other institutions. The cited example shows also the transfer of responsibilities from one institution to another.

Shortage of Specialists

Not only the concept of individual case work with its accent on the process of independence of personality was suspended. The next structural problem for effective case work was the shortage of personnel, especially trained specialists. As I emphasized, the social work became fragmented *cut in separate pieces,* different problems being delegated to different narrow specialists.

In relation to single mothers we can speak about a dominant medicalization discourse focused on the prevention of abortion, on childbirth, and on the physical health of children. But even the medical staff was not sufficient - one of the main problems in the whole period was the inadequate and insufficient staff: *Every doctor is responsible for50-60 children distributed in 2-3 departments. If you consider that the majority of the children are 6-7 months old, some of them born prematurely, and that sick children are also 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, caused a constant insufficiency

and often change of the staff. This led to permanent problems with the qualification, and caused the strong feminization of the field.

The nurses and the legal practitioners were assigned to these jobs and quitted them at the first opportunity.

Continuities and Changes since the Late 1960s

Since the late 1960s the family and reproduction policies changed in direction to stronger pronatalism which led to new attitudes of the Communist Party towards extramarital birth. Furthermore, society experienced a significant growth of births outside of wedlock despite of the official attempts to the contrary. The demographic concerns of the regime resulted in the re-evaluation of the children born by unmarried mothers – they also contributed to the population growth. An important factor was the funding 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, raising state indebtedness, which influenced the social policy.

Considering the fiscal scarcity, the state had also concerns about the raising bill for *Mother and 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': *I would kiss the hand of the one, who remains mother, who does not give away her child and who considers 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 raise their offsprings. 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 children (in case of second and third children as well as twins, until the third birthday). Children of single mothers enjoyed priority for placement in creches 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, the mothers who left their children in *Mother and Child Homes* were blamed, especially educated women who deserted their children. Mass media portrayed them as women who were full of egoism and the ones who adopted bourgeois 'Western' behavior, searching for themselves a comfortable life. Public discourses continued to condemn unmarried pregnancies, without reflecting the social structures which determined 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 and Child Homes*.[25]

Quantitative Criteria for Social Work

At the same time in the 1970s strong quantitative criteria were introduced for the evaluation of the work of the social institutions.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', 'lonely mothers for abortion', 'divorced', 'widows', 'mothers with many children', 'adopters', etc.

The archives demonstrate the high quantitative work-load of the SJC and the *Mother and Child Homes*. The SJC had to accompany not only unwed mothers and to assist the guidance of paternity in court, in their responsibilities laid the whole activity in relation to adoption, as well as the preparation of all documents for the transfer of children in the *Mother and 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 mentioned categories.[26] The SJC provided advice in legal matters. The archives show the efforts of the staff to cause a change of the normative base, so that the SJC would 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 is 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 a bearing psychologically grounded case work system was not developed to put in the center the personality of the single mothers accounting for the influence of the 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 instruments with which the objects of the social policy could participate), long lasting de-professionalization of social work, fragmenting, institutional splintering of social policy and increasing bureaucracy determined the social work in socialist Bulgaria.

[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.

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From Case Work to Co-creating Good Outcomes in the Working Relationship

Gabi Chachinovich Vogrinchich and Nina Meshl

1. Introduction: Co – creating Individual Working Projects for Help in Working Relationships

Case work 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 case work meant dependency, lost autonomy, lost competence that should be avoided and replaced by more empowering methods like working in groups and supporting community projects.

Case work had to carry the burden of the late development of the science of social work. Case work 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 1990s, 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 extremely 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 organized 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, 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 the *Social Welfare Council* made decisions on general and also about concrete questions on social policy and social welfare about concrete persons (for example - from the foundation of the 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 the *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, 28 th 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 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 case work 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 1990s not the academic status of research.

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

District People's Committees and *Municipal People's Committees* wanted educated co-workers 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 were not 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 could not be done because of the 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 were not connected to administrative procedure.

The purpose of the 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.

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 the *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 the social work centers in 1960s, 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 were not strictly attached to administrative procedure, were not 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 need the attention to understand the historical development of the 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. Case Work 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 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 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 meta-communicate, 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*. Anderson's 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 case work toward the postmodern paradigm in social work best illustrates O'Hanlon (1993). The 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 could not 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: the First Steps

Kristina Popova

1. The Origins of a New Method in England and USA: COS and the Settlement's Movement

Case work methods originated from the women charity society activities (first of all of the Charity Organization Society[1]) in England and USA and their home visiting practices[2] as well as from the settlement movement. Casuistic approaches replaced the unsystematic charity work which had been practiced till the first part of the 19th century and made possible the social support to become an important field of social knowledge and social work to become a profession.

The case work methods appeared in the time of the birth of the modern social policy and modern public health. In the time of industrialization and urbanization, when population became an object of regulation, new methods of "administration of life" appeared. The health and welfare of individuals and populations as well as the power strategies used to "normalize" individuals and populations became the main concern of

the policy. Michel Foucault introduced the term "biopolitics" for this development.[3]

Rachel Torrance (1886-1937)

Public health and welfare measures needed new kind of social techniques and vocational training. New social techniques of social discipline, social control, "normalization", social advising, and education were elaborated. In difference to the more evident power and direct social control the organized social advising and various educational courses became important techniques of indirect influencing the population. This "pastoral power" – the power of advising, counseling, and facilitating, appeared in different courses, lectures, exhibitions, instructions, booklets, and issues. It was no less effective than the coercive power in determining how people shall understand and live the social world.[4] The concern about the struggle against epidemics, tuberculoses, and other contagious diseases as well as against infant mortality drew attention to the social hygiene and poverty, to the homes in the poor outskirts, to working class families, mothers, and children. Religious, feminist, economic, and other motivations and interests shaped the discourse about poverty, infant mortality, and public health.

In Victorian England a lot of visiting societies appeared. They spread religious, hygienic, child rearing, and other practical knowledge among the poor population. In 1857 the Ladies' National Association for Diffusion of Sanitary Knowledge was organized in order to study the living

Rayna Petkova (1895 – 1957)

circumstances of the working class, the ignorance of mothers, the effects of diarrhea, whooping cough, measles, and bronchitis – which affected also upper – middle class children. The Ladies' Sanitary Association set up branches around the country. The invention and the spread of visiting practices as a technique of pastoral power contributed to the more systematic charitable work. By developing techniques of surveillance visitors played an important role in "normalizing" the working-class families and especially the mothers. The important steps in this direction were made by the Charity Organization Society (COS) organized in the late 1860s. COS was an organization of middle class women who wanted to help the poor families in the outskirts in an organized way, to educate the mothers, and to change the social situation there. They rejected the occasional aid of the poor and even struggled against organizations that simply gave money. Women from COS who introduced a questionnaire to each family and case report, started to record their charitable work and introduced formularies for the individual cases.[5] This new kind of documentation replaced the former practice of lists of clients and aid given to them and made the social support more transparent. Such practice of organized charitable work with poor families created a base for the systematization and elaboration of the social work methods.

In the 1880s a new organizational form of educational and social work among poor population in England and USA appeared: the settlements. A new generation of women joined the settlements searching indepen-

dent life[6]. Settlements movement was motivated by both the general thought to settle among the poor citizens and by social reformists ideas. In England it was started by Octavia Hill (1838 – 1912), in USA by Jane Addams (1860 – 1935). Both COS organizations and settlements wanted to bring reach and poor together, but the settlement's people wanted instead of visiting the poor to live among them, to build friendship with the poor people instead of practicing charity.[7] In 1884 the Toynbee hall settlement was organized, in 1887 the famous English social reformist Octavia Hill initiated a women's settlement - the Women's University Settlement in Southwark.[8] In the next years settlement movement spread in USA. In 1889 the Hull House Settlement opened in Chicago. Women in the settlement worked among poor immigrant families. Famous pioneers of social work like Jean Addams and E. Starr worked there. The settlements attracted idealists willing to sacrifice their security and ease to work among the poor, to be neighbors to the needy ones[9]. Pastoral power was also used by the settlers who organized various forms to influence "the natives": open air schools, neighborhoods, children summer camps, etc. Working and living in the settlements contributed to the self confidence and independency of middle class women. The settlers in the slums would colonize the "natives", teaching them not only cleanliness but also standards of speech, deportment, and manners.[10]

"Middle class women could safely colonize the slums – Martha Vicinus wrote - because they brought with them the structures and beliefs of their own class, the educated upper-middle class. Neither the idealism not the self-confidence of a new generation of educated women could be satisfied by an amateur philanthropy of their mothers. Settlements were particularly appealing solution in both America and England, for they promised public leadership and professional yet womanly work.

Sofia municipality social service department in the 30-s

The loyalties of college women to their college and friends were strengthen by a sense of being different from their peers, of being better prepared to take up public responsibilities. The fellowship of college life could be broadened to reach out to the poor…" [11]

Some settlements became also important Centres for international collaboration and exchange. Although settlements movement remained a specific social work formation for England and USA and was not wide spread in continental Europe and in particular in Eastern Europe, English and American settlements played their important role for East European pioneer social work. Alice Masarykova (1879 – 1966), President of the Red Cross in Czechoslovakia, who organized the Social work education in her country, was in 1904 in America and worked in Chicago University Settlement, which was close to the Hull House

Settlement. During her stay in Hull House Settlement she had close contacts with Jane Addams and later she was supported by her in difficult moments.[12]

In the early twenties several young Bulgarian women studied public health and practiced "field work" in Henry Street Settlement in New York: "…I will very probably take a course in public health – the Bulgarian student Nevena Sendova wrote from Henry Street Settlement in April 1924 - which I think will help me a great deal as I have had the field work at H.S.S….[13]

Hull House Settlement in Chicago organized by Jane Addams was a leading center for family social work with poor immigrants families. Sophonisba Breckinridge (1866 – 1948) and Edith Abbott (1876 – 1957) from Hull House Settlement, who also taught in the School of Social Service Administration, Chicago University, collected and published family care cases in Chicago. The volume included family case stories of Chicago immigrants and some legislations texts were also added[14]. "The case" appeared on the base of the systematical generalization of the individual poverty parallel to the analyses of the social environment of the needy. It contributed to the methodology of research and to the establishment of scientific methods in the social work.[15]

The central figure for the elaboration of the casuistic approach was Mary Richmond (1861-1928), who was a COS women. She began her career as a social worker by doing charitable work in 1889. Through her work with charity and caring for the poor, Richmond was able to coordinate and specialize the social work profession. She believed that the poor and helpless could be reformed, and her strong belief contributed for the formalization of social work. She wrote a handbook for charity workers and their visiting practices stressing the importance of

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

the individual service as well as of the settlement movement. She wrote:

"... We are still inclined to take a conventional attitude toward the poor, seeing them through the comfortable haze of our own excellent intentions, and content to know that we wish them well, without being at any great pains to know them as they really are. In other words, out intentions are good, but they are not always good enough to lead us to take our charitable work quite seriously, and found it solidly upon knowledge and experience.

But the century drawing to a close has seen two very important developments in charitable work in England and America; developments quite as important in their own field as the advances of the century in the art of fiction. The first of these is the wonderful growth of the spirit of individual service, which has found one of

its highest expressions in the work of friendly visitors in the homes of the poor. The second is the new but vigorous growth of the spirit of social service, which has found its best expression in social and college settlements….” [16]

In her book “Social Diagnoses“ Mary Richmond defined the social work procedures based on the analyses of the causes and the situation of the poor. She stressed the interaction between the individual and his / her social environment, which determined the personal character and the individual personality. According to her, poverty and need of support were not a result of the personal weakness or weak individual life will, but a result of the personal history of the needy, as well as of his/her social network. A stable improvement could be reached not only by giving material goods, but by systematic social learning aiming at achieving a balance between individual forces and social environment.[17]

According to Mary Richmond the “social diagnoses” had 4 steps:

- differentiation of the factors of influence

- systematic analyses

- activating of the available resources

- treatment

The process of social diagnosis represented also a democratic collaboration between the client and the social worker, which leads to the connection between the American social work and the American ideal of self-determination and democracy.

2. Germany

In Germany preconditions for individual social work approaches were laid in 1853 by the Elberfelder System of Municipality Social Assistance. The spread of this system laid the grounds for elaboration of professional methodological standards for individual care work, systematic data collecting practices, analysis of the social problems and poverty, etc[18].

The German charity centers in Berlin oriented their work to the model of the English – American COS [19]. In Germany Janette Schwerin was the first one who elaborated prescriptions for individual social work. These prescriptions were also based on the analyses of individual cases. Working in "German Society for Ethical Culture" as well as in "Women and Young Women's Groups for Social Support" in Berlin she introduced education course for the societies members. The four steps of the education course included: analyses of selected cases, protocol of the conversations, home visits and confidence, independent work and documents of cases and writing of reports. She trusted the analyses of the social environment and believed that this could be changed. In 1893 Alice Salomon joined the "Women's Groups" and after the death of Jeanette Schwerin in 1899 she took the leadership of the groups. In 1908 she established the first Women's Social School in Berlin, in 1925 – the German Academy for Social and Pedagogic work.

The three German pioneers: Janette Schwerin (1852-1899), Alice Salomon (1872-1948) and Siddy Wronsky (1883 – 1947) developed the casuistic methods not strictly in the American tradition but as an "individual help" which emphasised not so much the collaboration between the client and the social worker but the work of the social worker. Salomon and Wronsky settled high requirements to the social

worker. In the German case it was important that the establishment of social work was connected to the German women's movement and the emancipation struggles of women. Social work aimed at both supporting the women to practice a social responsible work and giving an opportunity for continual education.

After the First World War Alice Salomon was in USA (1923-1924) and got acquainted with the work of Jane Addams and especially of Mary Richmond's book about the social diagnoses. She came back to Berlin inspired to write a book facing the German conditions. As a result she published in Berlin in 1926 "Social diagnosis". According to her, the process of social diagnoses followed the phases: anamnesis, analyses, diagnoses and prognoses. Alice Salomon went a step further in comparison to Mary Richmond. She stressed the responsibility of the client and the self-reflection of the social worker. In 1926 Alice Salomon, Siddy Wronsky, and Eberhard Gise published the book "Social Therapy" in which cases were selected according to the requirements of the education.

Siddy Wronsky elaborated in more detailed way the methods of the social work following the three-stage model of Alice Salomon: diagnosis, prognoses, therapy. The first step was the anamnesis: it concerned the formulation of the client's psychological type – sensitive, strong will, etc. as well as his language and gestures. The next step was to analyse the history of the case, the social environment of the client, the family, religion, etc. The aim was to reach a balance between the client and the social environment. The next step was the selection of the therapy and the mobilization of the client's own potentials and resources. Wronsky motivated the scientific interest in the case - its origins, resources, and possibilities for social – pedagogic intervention - the case with its own

regularity. The central notion by Alice Salomon and Siddy Wronsky was the social diagnoses where the social problems were interconnected. The case was defined as an "abstract social construction where the individual had first of all social characteristics".[20]

3. Individual Care in Bulgaria: the Predecessors

"Samarjanka" Societies and the First Visiting Practice 1915 - 1918

Since the mid 19th century a lot of local charity societies were organized in Bulgaria which was till 1878 under Ottoman rule. Most of the social problems like poverty, low social hygiene, children malnutrition, infant mortality, youth delinquency, female work etc. started to be discussed in the media in the 1890s. It was the time of the beginning of the industrialization. Public health and biopolitical problems became also an important part of the public discussions. In 1901 the existing women's societies were united in Bulgarian Women's Union which activated the struggle for women civic rights and the discussion about women's participation in the public sphere. Sofia University opened its doors for women. A lot of new charity societies were organized: Society for Abandoned Children "Evdokia", "Society for Free Pupil's Soup Kitchens", "Society for Struggle against Children Delinquency", Women' s Charity Society "Conciseness" , "Society for Children's Camps" and others. Local charity societies were organized in almost every town in the country but without systematical charity work and education. Women took part also in Red Cross activities. In the 1890s the first schools for midwives and nurses opened in Sofia.

It was the Queen Eleonora (1860 – 1917, Bulgarian Queen since 1908) who initiated in 1910 the first training course for charity women. She herself was a trained nurse and activists of the Red Cross during the Russian-Japanese War (1904-1905). In 1910 she inspired the first charity women training course in Sofia which was organized by the new established society "Samarjanka". The society united women, most of which took part in different women charity organizations in the earlier years. In the training courses women were trained to do some sanitary and nursing work and to help doctors. Instructors were doctors from the Bulgarian Red Cross Society.

"Samarjanka" women were not organized in settlements in an American or British way and they were not trained to organize social support by themselves but to work under doctor's instruction. The most "Samarjanka" women were young women from the middle class. Some of them took part in the women's movement which struggled by that time for voting rights.

Although "Samarjanka" charity women were not trained for social work, the individual social care began in their practices during the World War I. After the first course in 1911 regular courses started not only in Sofia but in other cities like Plovdiv, Russe and others. "Samarjanka" women were the first trained people who started to practice some casuistic methods during and after the First World War. In 1915 in Plovdiv two American nurses from the American Red Cross (invited by Queen Eleonora in 1914) started to organize together with the local "Samarjanka" society social help initiatives for the city poor population. Instructed in the methods of home visiting practices by two Americans - Rachel Torrance(1886-1937) and Helen Scott Hey (1869 – 1932), they started home visiting of sick poor families. In the same time ar-

ticles by Helen Scott Hey about home visiting and about the important vocation of public health nurses were published trying to attract young women for such activities. Two American nurses Rachel Torrance and Helen Scott Hey taught Samarjanka women in Plovdiv to organize home visits in the poor suburbs, to work with city map, to instruct mothers, to organize charity initiatives by themselves and to run documentation. During the same time in other towns in Bulgaria Samarjanka women started also to collect data about poor families in order to support them. After the war "Samarjanka" society continued these practices of visiting poor or ill families in the next decades after the end of the First World War. The "Samarjanka" women introduced also the regular documentation of home visits and social support services they gave.

In 1915 the first Municipality Social Assistance Service was organized in Sofia. One of the activists of the Bulgarian Women's Union who was also prepared for voluntary nursing work was appointed to be assistant director of the service. Her name was Dimitrana Ivanova (1882 – 1957). Later on she became a leading feminist and President of the Bulgarian Women's Union.

The collaboration between "Samarjanka" society women and the American nurses Helen Scott Hey and Rachel Torrance contributed to the development of more self confidence of Bulgarian charity women. After the War the American Nurses led several years the Nursing School in Sofia. They stressed the high importance of nurses' work for the society and supported in their correspondence to the young Bulgarian nurses abroad the need of personal self confidence: "*…Are you remembering all the advice we gave you before you left us?* - Rachel Torrance wrote to a young Bulgarian student in London - *Perhaps not, but I know that with experience you will be able to give yourself*

very good advice in the ways of life. Just keep a level head – that means always remember that you are Todorina Petrova and be yourself…"[21]

First Bulgarian Visiting Nurses 1923 – 1926

After the War a lot of young women were attracted by the health professions. Young women attended the Nursing School in Sofia, which was led in the early 1920s by Helen Scott Hey and Rachel Torrance. Some young women – Nevenka Sendova, Krustanka Pachedjieva and others - went to New York to continue their education. They attended Henry Street Settlement; they studied public health disciplines and practiced also in Presbyterian Hospital. In the same time another Bulgarian Nursing School graduate – Boyana Christova was in the Bedford School in London where she was trained as the first Bulgarian professional visiting (public health) nurse. Because of the lack of skilled social worker (as well as of the idea for social work vocational training) at that time public health nurses were seen as the proper professionals for social services. In 1928 Boyana Christova was one of the Bulgarian representatives who took part in the Social Work Congress in Paris. Nevena Sendova took part in the International Congress of Nurses in Montreal in 1929 where social work was also discussed.

Coming back to Bulgaria as young nurses prepared for public health service they started to work in the field of children health and child protection. In 1924 the first children health station in Sofia opened by the Bulgarian Red Cross Society and Boyana Christova was appointed

there as visiting nurse. Hygiene, better child rearing and child nutrition, organization for child protection especially for refugee children were seen as the most important tasks of social assistance.

In 1926 the Nursing School in Sofia started the first Bulgarian course for visiting nurses (public health nurses) which established home visit practice as a common method in the new opened children health consulting centers. In 1928 a separated Institution for Disabled Children (Children Health Station for "nervous and backward children") opened.

Home visit practices were introduced also by the Bulgarian Union for Child Protection (initiated in 1925) 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 called teachers – advisors. The female teachers – advisors visited family homes in order to observe hygiene, food and living environment and to give advises for hygienic child rearing to the mothers. They also described and reported their home visits to the society's leadership and run a documentation of their work. This way in the late 1920s pastoral power forms of advising and counseling became common practices in various charity organizations and in the spreading system of health stations.

3. The High Social School for Women at the Bulgarian Women's Union and the Beginning of Social Worker's Vocational Training 1932 – 1933.

The professional social work as a profession with its methods and procedures in Bulgaria was introduced by the Bulgarian Women's Movement activist, jurist, and social worker Rayna Petkova (1895–1957). In 1932 Bulgarian Women's Union started a female preparation course for social work which became in the next year a new educational institution – the High Social School for women. It followed the model of the Alice Salomon's Women's Social Academy in Berlin. Young Bulgarian jurist Rayna Petkova was send by the Women's Union in 1929 to Berlin in order to study in the academy and to make Bulgarian women union familiar with the professional social work and the opportunities it is giving for women.[22] As a student in Berlin Rayna Petkova had the opportunity to attend lectures and seminars of Alice Salomon and Siddy Wronsky and to study case work methods. 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.

This small book was the first book about social work in Bulgarian. For the first time Rayna Petkova described shortly the professional social work (using the terms "social work" and "social worker"), and the Alice Salomon's views about the steps of the social case work. After this book Rayna Petkova published in the 1930s a lot of articles about social work in Germany. In her article "Methods of the Social Assistance in Germany (before Hitler's coming to power)" Rayna Petkova described the origins of the "individual method" in the social work in the practice

of the Elberfelder System of Municipality Social Services in the 1850s. She pointed out that the procedures of the "individual method" were established in Germany in the time after the First World War as professional social work. Rayna Petkova translated texts by Alice Salomon and other German authors and published some own 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 and established them as a part of the curricula of this education.

Rayna Petkova introduced the notion of professional social work and the terms of the procedures of the case work methods. In her publications she presented the steps of the casuistic social work as she studied them in Germany. She pointed out the importance of the personal contact of the social worker to the needy as well as the home visit for collecting data, creating trust relationship and support.[23]

In personal conversations the social worker had to create mutual confidence with the client. During her visits in the client's environment she should collect personal data for the client. She should use also data about income, property, etc. from the Municipality Central Card Index. After her personal visits, conversations, and both institutional and personal data collection, she should order the different reasons for the situation and create a detailed plan of the social therapy. According to Rayna Petkova's views the social worker had to analyze three groups of factors of the needy's situation: heredity, social environment, occasional reasons. Rayna Petkova as well as other lecturers at the High Social School for Women shared eugenic ideas in their publications.

Rayna Petkova described also the specific personal qualities the female social worker had to posses: ability to observe the social situation,

courage to take decisions by herself, knowledge in practical hygiene, law, and ethics, good knowledge about the legislations and institutions and services, good speaking skills, to be polite, to have a warm and feeling sensitive responsible heart, to understand the psychology of the power persons, etc.[24]

According to the curricula in the High Social School for Women, the students had regular practical work: they visited regularly poor homes in Sofia outskirts in order to observe the social living conditions and to study how to report the social situation of the families. The women graduated the School were prepared for social work figured as a way to reform the society and as a very important social service: as a work for the people, which has to improve their live and to change the society.

Unfortunately there are not teaching materials left by this first school for social work in Bulgaria which was closed in 1944. But there is an article wrote by a graduate of the School with the title "From the Practical Educational Work of the High Social School for Women" and published at first in the Women Union's Newspaper "Zhenski Glas" (Women's Voice) and after that in the "Medico-pedagogichesko spisanie" (Medical-Pedagogical Magazine) where Rayna Petkova was also a contributor. In this article the young author Ana Mancheva described a case of a poor street child and how she was provoked by this case of children's beggary to analyze its causes and to prevent it. Further on the author described the steps she followed as a social worker in order to assist the child's family and each family member to have an independent live.

Following the instructions given in the School, the social worker collected data about the child and its family, analyzed the data and elabo-

rated a plan how to support the family members. She visited the family many times and succeeded to overwhelm the prejudices of the parents against social services:

....." After a number of meetings, observations and private talks, a picture of greatest suffering was revealed to me. All ten of these human beings expected their hunger to be satiated by means of the wages of the 19-year-old Elena – 30 levs a day, the irregular earnings of the father, a labourer, and the uncertain gains of the youngest begging in the streets. The family was sometimes supported by friendly people who gave them food and house coal, the alms being carried into the house by the kids. One of the children, a pupil, was additionally supported with free lunch at the school cafeteria, the mother told me while not missing the chance to throw out angry hits at the Social Care Department (at the Sofia Municipality) for assisting others who were not as needy and ignoring or insufficiently supporting her family. At the end of each conversation the mother would emphasize her distress caused by the indolence of her husband, the joblessness of her son, the illness of one of the daughters and the cohabitation of the other, and she would ask for help: for Stoyan, Iliya, Elena, Rayna, and the others...."[25]

In her elaboration of a case "social diagnosis", the social worker described the family members: father, mother, children in their physical and mental characteristics in the way students studied it in the Women's School. The father was characterized by his "muscles" (well built), mind (lazy) his habits (too much smoking); the mother (weak willed, no ambitions), the children (not appear to be talented).

The personal meetings and talks with almost everyone at the house

made it possible for me to get an idea of the basic characteristics of some of the family members and thus to know other details important for my work. This is how I saw the head of the family: physically he was completely healthy and had well-built muscles, he was big, tall, smoke too much though he said there was no bread for the children. Characteristics of the mind – angry at everything and everybody, lazy, evil, in blank despair. He thought the whole misery – for him and his family – was because people around were too bad, envious, selfish, and that they had lived under very bad conditions, with no alternative or a perspective for better days to come. Many times he said he kept special abhorrence of the Social Care Department. There was nothing appealing in his wife's character either. She was healthy, too, strong, of middle height, tenacious although apparently anaemic. There were a few distinguishing features in her intellect – superficial, incapable of getting deeper into matters, not to mention solving complicate problems... Her mind was narrow and slow. Weak-willed. Sometimes she got angry but perfunctorily as everything she did. Apathy was another feature of hers. Such a woman would not have great and complex ambitions in life. The only thing she thought about was how to spend the present day. The children did not appear to be talented." ...[26]

After having the characteristics of the family situation as well as of the family members the social worker elaborated a plan of seven points how to support the members with social and educational measures, to provide them with regular income, to convince the parents to trust the Social Care Department and to teach the mother in hygiene and cleanliness:

"...I had to:

1. Call the attention of the Social Care Department to provide temporary material support to the family until the coming of better days;

2. Provide regular earnings for the family by making maximum efforts to find appropriate jobs for the unemployed;

3. Carry out the necessary proceedings to take the girl with t.b.c, Rayna, out of the house and help for her hospitalization;

4. Find all possible measures for the legalization of Milka's cohabitation;

5. Dissuade the mother from the hitherto existing practice of encouraging and making use of her children's street begging;

6. Explain to both the husband and the wife the true purpose of the Social Care Department and the unreasonableness of their anger at it;

7. Inculcate in the mother at least a basic understanding of cleanliness and hygiene...."[27]

To fulfil this plan the social worker contact municipality social service institutions, women charity societies, kindergarten (where she found a job for the mother). She was satisfied that she reached at least an improvement of the situation of the family and that she managed to mobilize their own capacity, even more, that "...the long line of poor people became shorter...":

"*... Fortunately, on my later visits I was pleased to notice a certain*

change in the house as well as in the family. The floor of the corridor and the room was scrubbed; the clothes and covers were patched up and washed; the walls were whitewashed. There was no nasty odour and stale air; the people were more cheerful and kinder. For the time being, after all accomplishments, no member of the family has done street begging again. A great weakness has been wiped out. But I still have a lot of work to do. People cannot be perfect – perfection can never be achieved, but being re-educated and becoming more virtuous is possible. This is the specific task of a tutor and thus of a social worker being a tutor herself.

Nowadays, under the current conditions, so hard and complicated, when the state represented by its organs, such as the Social Care Department, aims to support citizens in financial need, and when the means granted are insufficient and thus the material support is not effective enough, a social worker's educational task should be especially enhanced. As a result, the implementation of the proposed programme will be better. Provision only of material support to a given family, even under the supervision of a social worker, is not enough and in many occasions can even be pernicious, if a change in the characters of the family members is not simultaneously pursued so that they can, as individuals, realize his/her own personal and social duty and be able to live an independent life. A social worker should be at her post and be alert. When the long phalanx of poor, suffering, and rejected people becomes shorter, her eyes will light up with gladness and delight at the accomplishment of her social and personal duty....''[28]

This article gives a general view of the way case work methods started to be taught in the High Women's Social School in Sofia. The social

worker hold up strictly the procedures she learned in the school and the contacts she had to keep in her work to institutions and clients. The article presented also the general attitudes to clients personalities she internalized in the school: the notions about "will", "ambitions", "talents" as well as to the living situations. She contacted the clients but as social worker she kept her distance so there was not a real process of interaction in which the position of the client to be also respected. She drew her power to take decisions about the clients on her knowledge about the reasons of their situation, their characters, about the social and hygienic norms, about the proper institutions. It was not an occasion that Ana Mancheva's article about the social worker's practice appeared first of all in the women's newspaper "Women's Voice". It was the time of the beginning of the women voting practice in Bulgaria (since 1937). The article was published in order to strengthen the women's presence in the public sphere as well as the self confidence of the young social workers as professionals. The early social work presentation was connected to the first feminist wave as the political rights of women were the main aim of the women's movement.

The Municipality Female Social Advisors since 1934: the Practical Social Work

In 1934 (after a military coup d'etat) the Municipality social services in Bulgaria were reorganized and centralized. The Municipality social service in Sofia was also reorganized and enlarged with new positions. Visiting nurses replaced the former district commissions which included municipality council members and priests and relayed often on occasional personal contacts. In the next 1935 the hired visiting nurses were

called "social advisors" but they continued their work in the Municipality without additional vocational training courses. At the end of the 1930s the Municipality social service started to appoint graduate of the Women's Social School.

The first eight visiting nurses – later on - social advisors, started their work in 1934 and some years later their number were doubled. According to the municipality rules every female social advisor was responsible for a town district.

The female social advisor as a new position 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 poor families and to suggest their category of poverty according to the Municipality rules. She felt in the data in the index cards of the poor families. She also assisted the poor people who needed help to fill in the formularies for a proper kind of social support (social institution, financial support, food supply, etc.). She proposed a decision for every case. According to the prescriptions of Sofia municipality rules, she had to fulfill her work with "empathy, devotion, and love"[29] .

The female social advisors were also involved in the work of the District's Councils for Social Support, which coordinated the social assistance activities of the state, municipality, and private charity organizations. The council included representatives of state authorities, municipality, and civic charity organizations in order to prevent a misbalance of the social support among the poor population.[30]

The female social advisor was also provided with a professional uniform as well as she with a free tram card for her home visits. 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.[31] The senior social advisor- instructor had to have worked for at least 5 years. The social advisor's occupation started to be accepted as a female profession.

The individual social support was recognized for the first time as an important process of professional work. Special formularies for request for social support were introduced. Most of them were filled in by the respective female social adviser on behalf of the clients (signed by the client). The social adviser (according the prescriptions) proved the Municipality Central Card Index Data of the client and filled in the data about income and property in the case formulary. She gave also a short description of the social situation: family members and living conditions, information given by neighbors as well as a statement where she suggested also the kind of support to the head of the social assistance service.

Archive documents left by the social assistance service of Sofia Municipality in the late 1930s give some information about the cases and the practical work of the female social advisers as first municipality professional social workers in Sofia and in Bulgaria.

The archive documents are client's letters and formularies - requests for social support, which documented a wide variety of single cases of social need. There were cases of poor single mothers and single fathers who asked for support for their children or for institutional care, cases of unemployed, ill, homeless or disabled persons, of single poor elderly people, etc. Many of the cases were complicated to be studied by the social worker because of different reasons: changes of addresses, ill persons who were in the hospital during the social worker's home visit and were not found by her at home, old persons sheltered by rela-

tives for a while, contradictions in the information given by the neighbors. Most of the clients were women and men from the working class, who became unemployed in the late 1930s and lost any social support, there were also refugees and emigrants.

The formularies are first documents which afford a glance in the process of the early social work. Despite there were not detailed descriptions of the actions of the social worker they were means for the process of social work to be more transparent and to be retraced. Social advisers mentioned moments of their visits in the client's home, they described poverty they saw, conversations with the needy as well with neighbors. The short descriptions often present the distance or the personal empathy of the social worker to the client.

If we compare the social adviser's statements written in the case formularies in the time 1937 - 1940 we can see a slight tendency of more detailed description.[32] The language of the statements also changed slightly. If in the beginning it was an exception for the social worker to take statements about the personalities of the clients, later on clients were described in terms like: "morally corrupted", "leaning to criminality", „using bed influence", especially when the cases were single women and children.

It was not easy for a young woman - social worker in Sofia Municipality, to practice this new profession, to go every day in the poor streets and homes, to study and to suggest social assistance for the different cases, to negotiate between the people and the authorities, and to offer the kind of support. Her responsibilities were very important because her statements provided the base the cases to be solved. In the most of the cases documented in the archives the clients were supported according to the report of the social advisor.

There were clients who did not agree to the statements and to the kind of support. There were also neighbors who did not approve the support of their neighboring families and wrote letters to the municipality against the social adviser. This way the work of a social adviser was constantly controlled not only by the authorities but also by the clients and other citizens.

In 1939 hundreds poor citizens from a Sofia district who were not satisfied by the work of a municipality social adviser signed two petitions one after another against her.[33] They complained that she regular hurt them. They wanted the former female social advisor who was described by them acting "like a mother" for the people.

The petitions pointed out that the municipality social assistance system with its procedures and rules was accepted by the poor population in its coherence to the certain personal qualities of the social worker. The behavior, conversations, personal attitude to clients determined this acceptance.

Conclusion

The individual method of social work was established in the 1930s by the organization of the female social advisors' service at the Municipality of Sofia. In the same time the case work methods were introduced in the curricula of the Women's Social School at the Bulgarian Women's Union influenced by the German model. Both the Municipality work and the education offered the possibilities for the professionalization of social work and its development as an academic social science.

In the beginnings there were not yet textbooks, and only few publications and translations from German done by the pioneer of the social

work Rayna Petkova were the base for the professional knowledge.

The first social advisors in the Municipality were visiting nurses who have studied public health after the graduation of the Nursing School. They established a social service with regular home visits and interviews in which administrative measures and individual social support were often linked with hygienic instructions and medical help. This early practice shaped the expectations of the clients who expected empathy, respect, and advice as well as financial and institutional support.

Case work methods were in their very beginning in Bulgaria when this practice was interrupted by the new government which took the power at 9.9.1944. The High Social School for Women was closed. The Bulgarian Women's Union was replaced by the Bulgarian People's Women Union. The organizational, ideological, and scientific connections to the Women's Movement were also interrupted. The socialist ideology did not acknowledge poverty and basic social inequalities in the sociaety so it was not possible to discuss them. In the next years the social assistance system with its individual approach lost its importance. Social assistance was added to the public health system, the social work education disappeared for three decades.

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[3] More about biopolitics: Michel Foucault, Biopolitics, Lectures at the College

de France 1978-1979 (Ed. By Michel Senellart), Palgrave Macmillan, 2004. See also: Pamela Abbott, Liz Meerabeu, The Sociology of the Caring Profession, Routledge, 2003 (first edition 1998).

[4] Pastoral power is also a term used by Michel Foucault. See also Pamela Abbott, Liz Meerabeu, The Sociology of the Caring Profession, Routledge, 2003 (first edition 1998).

[5] See Noel Timms, Recording in Social Work, Routledge and Kegan Paul, 1972, p. 8 (historical observation).

[6] Martha Vicinus, Settlement Houses: A Community Ideal for the Poor: in: Independent Women, Work, and Community for Single Women 1850-1920, Virago Press Limited 1985. pp. 211-246.

7 Martha Vicinus, p. 215.

[8] Ibidem, p. 217.

[9] Ibidem, p. 219.

[10] Ibidem, p. 220.

[11] Ibidem, p. 221.

[12] More about Alice Masarykova in: Encyclopedia of Women Social Reformers, (Ed. Helen Rappaport) 2001,p. 429 – 431.

[13] Nevena Sendova, Letter to Rachel Torrance, 10.April 1924, State Archive Sofia, F. 360k, Op.1, a. e. 60, l. 57.

[14] See Sophonisba Breckinridge, Family Welfare Work in a Metropolitan Community. Selected Case Records, Chicago 1924.

[15] Sonja Matter, Wissenstransfer und Geschlecht, Die Rezeption "amerikanischer" Methoden in der Schweizer Sozialarbeit der 1950er-Jahre, Ariadne, S. 49-57.

[16] Mary E. Richmond, General Secretary of the Charity Organization Society of Baltimore, Friendly Visiting Among the Poor, A Handbook for Charity Workers, New York: The Macmillan Company, 1899, p. 4-5.

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

[18] Adriane Feustel, Amerikanische Methoden in Deutschland, "Case Work " und Familienforschung, Ariadne, 2006, 49, S. 42-48

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

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

[21] Rachel Torrance, Letter to Todorina Petrova, 24. 9. 1924, State Archive Sofia, f. 360k, op.1. a.e.60, l.34-35.

[22] Kristina Popova, Traces of Rayna Petkova. In Search for a Balance between Social Control, Profession and Charity, in: Kurt Schilde, Dagmar Schulte (eds.), Need and Care – Glimpses into the Beginnings of Eastern Europe's Professional Welfare, Barbara Budrich Publisherss, Opladen & Bloomfield Hills 2005, P. 37-53.

[23] Rayna Petkova, Metodi na obshestvenoto podpomagane v Germania (predi idvaneto na Hitler), Medikopedagogocheski spisanie, 2, 1936, 4-5.

[24] Rayna Petkova, Metodi na obshestvenoto podpomagane v Germania (predi idvaneto na Hitler), Medikopedagogocheski spisanie, 2, 1936, 4-5.

25 Ana Mancheva, Iz prakticheskata vuzpitatelna rabota na Visshata sozialna shkila za zheni (From the practical educational work of the Higher social school for women)., Medikopeadogichesko spisanie, 1942.

[26] Ibidem.

[27] Ibidem.

[28] Ibidem.

[29] Pravilnik na otdelenieto za socialni grizhi na Sofijska obshtina (Municipality rules for the social assistance department), 1939.

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

[31] State Archive – Sofia, Fond 1k, op. 4, a.e.1088, l.108.

[32] See the statements in: State Archive Sofia, F. 1k, op.4, a.e.1106.

[33]See about this case: Kristina Popova, From Visiting Ladies Towards Minicipality Female Social Advisors: Women in Home Visiting Practice in Bulgaria (1915 – 1939), in: Vesna Leskosek (Ed.), Teaching Gender in Social Work, ATHENA Series, University of Utrecht, 2009, p.127-145.

Current Trends in Social Work Case Management

Vaska Stancheva-Popkostadinova

Introduction

Case management is well established procedure in different areas of social work practice. It has its roots in case work from the middle of the last century.

The practice of the case management varies greatly across social work settings and is even more diverse as applied by other professionals. Despite this diversity, several elements distinguish social work case nanagement from other forms of case management.

A professional social worker is the primary provider of social work case management. Distinct from other forms of case management, social work case management addresses both the individual client's biopsychosocial status as well as the state of the social system in which case management is both micro and macro in nature: intervention occurs at both the client (patient and family) and system levels. It requires

the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him/her with needed services, resources, and opportunities (Huber D.L. 2002).

Services provided under the rubric of social work case management practice may be located in a single agency or may be spread across numerous agencies or organizations

Definitions

Nearly 60 years from arising in the field of social work, there still have not an universally accepted definition for case management, as well as definitive model of case management as practiced within the social work profession. Case management is used with various meanings in the countries, disciplines, fields of practice, different professions, and client populations.

Often case management is defined as client-centered, goal-oriented process for assessing the need of an individual for particular services and obtaining those services or as a strategy for coordinating the provision of services to clients, or activities aimed at linking the service system with a consumer, and coordinating the various system components to achieve a successful outcome.

Case management is a term used in many professions with varied meanings. There is still lack of a consensus about the definition of the case management.

The variations and the lack of nationally supported standards create

inconsistent understandings related to social workers practicing case management (The Social Work Best Practice Case Management Standards).

Some of the definitions for case management emphasize the particular characteristics (client needs, approach, method, etc.), while the other delineate more comprehensive framework (procedure, process, etc.). The social work dictionary pointed out case management as "A procedure to plan, seek, and monitor services from different social agencies and staff on behalf of a client." (Barker, R.L. ,2003). Case management has been defined as "a set of logic steps and a process of interaction within a service network which assure that a client receive needed services in a supportive, effective, efficient, and cost-effective manner(Weil at al., p.2), or as a process of service coordination and accountability, and a methods of ensuring the client's right to service (Vourlekis B. S., R. R.Greene p.13). S. Onyett (1998) defines case management as "an opportunity to take a bottom-up approach to planning and delivering services based upon the needs and strengths of individual users" (ix) and as a "way of tailoring help to met individual need through placing the responsibility for assessment and service coordination with one individual worker or team" **(**Onyett, S. p.3.)

The latest definition developed by Case Management Society of America (CMSA) and published in Code of Professional Conduct for Case is more comprehensive: Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and costeffective interventions and outcomes.

Models of Case Management

With the implementation of case management various models have been developed. Case management models evolved from initial social casework approaches designed to help clients to identify and plan for services, and monitor receipt of services. The common theme underlying different models of case management is "….the provision for some greater continuity of care through periodic contact between the case manager(s) and the client that produce greater (or longer) coordination and brokerage of services than the client could be expected to obtain without case management" (Orwin et al., 1994, p.154).

Case management models traditionally have included at leas following core functions: assessment, planning, implementation, advocacy, linkage, monitoring, and review. Different models combine these functions in different ways (Scott and Dixon, 1995). The core tasks of case management should not be split up. The case manager is responsible for the well-being of the user at all times regardless of their engagement with other agencies (S. Onyet, 1998)

The most popular models for social work practice are: brokered model, model of assertive community treatment and intensive case management.

Model of social brokerage (brokered model , also called generalist model) is the first model emerged in the social work and mental health practice. The role of the case manager in the generalist model is to link the client with needed services and specialists , and to coordinate activities and care, provided by other specialists, but not to provide direct service or treatment. The number of clients, served by this model is bigger than in other models (1:35-40).

The main prerequisites for practicing this model are connected with richness of existed resources and client resources.

The richness of existed recourses includes existence of spectrum of services and programs, which must cover the main needs of the clients; clear procedures, and rules for using the services and programs; good connections between them; in advance established good collaborative relationships; the proposed services are sustainable.

Clients who might take advantage of this model are clients who have internal resources as self-organization and possibility for active position in utilization of existed services .

Based on the above mentioned, we may conclude that this model is not appropriate for persons with severe deteriorated functioning, and not applicable in an areas and countries with low resources.

The service –richness (or poorness) of the community-services is confounded with the effectiveness of the case management (Dyxon and Scott, 1997)

During the last decade there are many achievements which are moved from traditional generalist model of case management.

Assertive community treatment has been used in the last 20 years and it has become the dominant model of specialist assertive outreach to people with severe mental illnesses. It was developed by pioneering psychiatrists in the USA with the explicit aim of helping patients struggling to stay out of hospital to live more successfully in the community. It achieved this by providing them with more intensive support in obtaining the material necessities of life and by placing a greater emphasis on

social functioning and quality of life rather than symptoms (Kent A., Burns T. , 2005).

The target population served by this model are special clients: homeless persons, persons with co-occurring mental and substance-use disorders, persons with criminal justice problems.

Caseloads served by this model are smaller (1:10-15) for case manager to have more time for the provision of care.

The responsibility for each client/patient is shared by the members of the multidisciplinary team which includes: psychiatrist, nurse, social workers, psychologists, occupational therapists. Each member of the team would be involved with each patient. The main characteristic of this model is provision of direct practical support in the everyday activities of the clients (such as shopping, washing, walking…). It emphasises flexible and creative ways of responding to complex and long term needs, in a way that combines a quick and immediate response to needs together with a long term commitment to care. It seeks to enhance the service users' capacities to define and meet their needs and aspirations within their own local neighbourhoods (Ryan & Morgan, 2004).

Most of the services are provided in the natural environment of the client-home, not in the office. The services are 24 hours, and they are not time- restricted. This is connected with the existence of 24-hours crisis intervention services or residential programs.

Assertive community treatment is a pure form of clinical case management (Kanter, 1989) and lies at the opposite end of the case management continuum to the earlier 'brokerage' model (Thornicroft, 1991). Many of its underlying concepts have become emblematic of

good clinical practice. Individualised, needs-led care planning coordinated by a keyworker is the cornerstone of the care. The main obstacles for implementing this model are connected with finances.

Intensive case management practices are typically targeted to individuals with the greatest service needs, including individuals with a history of multiple hospitalizations, persons dually diagnosed with substance abuse problems, individuals with mental illness who have been involved with the criminal justice system, and individuals who are both homeless and severely mentally ill.

This model relies more on a team versus individual approach. In addition, intensive case managers are more likely to "broker" treatment and rehabilitation services rather than provide them directly. Finally, intensive case management programs are more likely to focus on client strengths, empowering clients to fully participate in all treatment decisions (Enciclopedia of Mental Disorders).

It is agreed that whichever model is used, there are main requirement, which are connected with the effectiveness of the provision of care and treatment:

• Regular reassessment of the status of the client and his/her needs

• Multidisciplinary needs assessment requires specific skills of the team member in order to assess the client/patient functioning and decide which are the most appropriate interventions for the particular client in the particular period of time.

• Effective collaboration between team member and between meetings with the client/patient/ his/her relatives and needed services and professionals.

• Regular team meetings (assessment, care planning)

• A development of written plan for each client/patient

• Support for the family or other career

• Provision of suitable accommodation

• Provision of appropriate occupation

The following principles are universal for the practice of case management, no matter which model is implicated:

• The good relationship between case manager and client is of great importance

• Focus on the strengths of the individual, not on his weaknesses

• The interventions are based of the free choice of the client

• The active case management (case manager visits the client in his environment) is e preferred form of case management.

• Active searching for resources-mobilizing resources from the society, utilizing resources from the voluntary sector

• Go together with client

• It is not necessary case manager to do all, but to be sure that the needed services are provided in time and in a way suitable for particular client.

Organizational and Structural Aspects of the Management of the Case

Case management is an effective mechanism to overcome the fragmentation of services and minimize the gaps in their provision. The extensive world wide research literature shows the relative effectiveness of the case management. The primary goal of the case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs (Bellos & Ruffolo, 1995). Of great importance is to match client needs with community resources over a prolonged period.

The main objectives of the case management are connected with the improving access to services; delineated responsibilities for coordinating and monitoring care; ensuring optimal care and care outcomes, and increase cost-effectiveness.

Case management is applied at all levels of service (micro- and macro levels): at organizational level – planning a program, appropriate structural framework, policy development; policy-making-dealing with issues like financial and rational implication of different programs; direct services for individuals and family. Target groups of clients in case management social work practice are individuals in long term care (in the areas of community-based practice/services: child welfare, aging and mental health).

Case management tries to enhance access to care and improve the continuity and efficiency of services. Depending on the specific setting and locale, case managers are responsible for a variety of tasks, ranging from linking clients to services to actually providing intensive clinical or rehabilitative services themselves. Other core functions include out-

reach to engage clients in services, assessing individual needs, arranging requisite support services (such as housing, benefit programs, job training), monitoring medication and use of services, and advocating for client rights and entitlements (Enciclopedia of Mental Disorders).

Appointed one person as a case manager is "an attempt to ensure that there is somebody who is accountable, and who is helping the client hold the service delivery system accountable, someone who cannot 'pass the buck' to another agency or individual, when or if services are not delivered quickly and appropriately" (Miller, 1983).

The best practices in case management require organizational arrangements to support service delivery, staff who have been trained for the approach and its application to the particular practice setting and strategies to ensure that the organization can be responsive to evidence from practice and advocate for policy change to support service delivery .

Many researchers agree that case management requires an astute blend of both the broker and therapist roles (Vourlekis B. S., R. R.Greene, 1992).

There is not a formula for case management but rather there is a need for guidelines for practicing case management, as well as a clear delineation in education, training, and qualification for case managers.

The social work best practice for case management (The Social Work Best Practice Case Management Standards) emphasises that social work case management requires formal education, professional work experience, and professional credentials. The social work case manager shall:

1. Graduate Master Program accredited by the Council of Social Work Education.

2. Maintain current professional state by social work licensure/certification or national social work certification.

3. Complete two years of Master's level work experience related to the bio-psycho-social needs of the served population.

4. Practice in accordance with applicable state and federal regulations, statutes, and laws.

5. Adhere to NASW Social Work Code of Ethics.

Conclusion

The increasing 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.

One of the advantage of the case management is that the responsibility do not divide between different services and specialists, responsible for the clients.

There is a need for organizational framework, that allow to practice case management in order to be meet the needs of the clients, family members, and case managers.

The provision of professional standards for practicing case management, as well as guidelines and requirements for the training and quali-

fications of case managers in different areas, where case management is implemented, are the prerequisites for the effectiveness and efficacy of service provision.

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

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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.

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 infant 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 psy-

chiatrist, 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 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 re-

sults 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 continuum, 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 program 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 program 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, with 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 medication 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 (46 year, 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, 50 years 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 7-9 years 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 of services*, as Mari-Anne Zahl[12] points out. There exists a potential for conflict on many levels in the 'co'-work relationship. 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 stu-

dent 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 imple-

mentation 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 program 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 program 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 the 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 have 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. However, because I was aware that session can not be conducted with parents and children in the same time, I have opted for the therapy method 'family therapy without the family'. I have contacted the parents by phone.

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

tal, 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 have 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 have 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 being *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 parentificated by his 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 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 mustache, 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 did not 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 study. 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 met her husband early, during the school years. She met him at a girlfriend's birthday party. They have 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 have prepared he has also made me happy, however…*; *I think people should also say they love each other, not just think this*, etc..

I have discovered that in this woman there is a lot of uncertainty about which she never talked. She is just mentioning it, without a deeper discussion. I have suggested to 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.

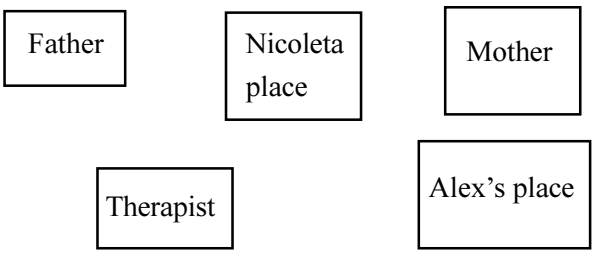
Alex's Sister

I call her Nicoleta. She is a 9 years old, smiling girl. She has very good school results and is very obedient. She does not 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 have 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 Komlysi, 2000; Gill Gorell Barnes, 1991; Insoo Kim Berg, 1995).

After we have 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 is not clearly framed. I felt that Alex's case corresponds to the case of 'parentificated' child, as far as the

mother raises him to the place of the father, replaces the father with the boy, discusses 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 Tъri, 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 have 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 one of the 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 was that person who began 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 they 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 have 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 Szűkely, 2002; Sőndor Внгу & Piroska Komlysi, 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 have 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 have mentioned that they realized the biggest progress regarding their communication. Familial roles became clearer, and so became the differences between the generations and the borders 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 the family-members understood that 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 (Gȍbor Hȉzser, 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 (may be 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 have 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 have 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 avoided 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 have used questions which were very flexible both in contents and time frame, since they have 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 have 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 have 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 have 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 have 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

Tamas Ragadics – Eszter Pentek

In the period after the 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 the 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 the Hungarian small settlements far from the prospering centres. The bases of the research are some interviews made with opinion leaders of the 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 villages.[1]

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

tween the villages and cities. Mayors of towns try to charge the expenses of the 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 elicits a further rural exodus of the 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. Because of 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 the 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 village population had some kind of mental problem in the late 1990's.

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 a way of getting more incomes through the benefits from the state. We can see a second generation growing up after 1990 without any patterns having job. On the other hand, these people are also 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 economy, social, demography, sanitary, and infrastructure gap is continuously growing between the central regions and the underdeveloped rural area.

The Importance of the Communities in the Hungarian Society

The development of the small settlements mainly depends on the power of the local societies. Man is a social being – communities help to develop healthier personalities. They also give social security in case of need, defenselessness, and poverty. Social integration is also the base of stronger democracy and solidarity. 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]

The 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 not motivated 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 adap-

tation to the labour market. Hungarian people are socialized within this paternalist structure: *Problems must be solved by the government*.[3]

The lack of strong communities is due to several reasons. The traditional village communities do not exist anymore as a consequence of the communist policy of conscious community destruction, forced development of agricultural co-operatives, and rapid industrialization. The other reason is the migration mentioned above. The most important reason for the social disintegration is the value system of the Hungarian society. Hungarians possess strong material values, the values of the consumer society have strong effect on them, there is a high level of individualism and a low level of the common-traditional values.[4]

It is very important to increase the autonomy of the rural communities and to help the common recognizing, discussing, and solving of the local problems.[5] Community development is one of the best methods for providing the success of the programs realized in the field of the 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.

Ormőnsőg in South-Transdanubian Region in Hungary

Ormőnsőg 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 *Ormőnsőg* has rich folk-

traditions and 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 the workplaces – in the villages this rate is 33%. The employment rate in Hungary is 57,3% (for the adult population ageed 15- 64 years), it is 51,5% in the South-Transdanubian Region, and 50,7% in the *Baranya* county. The rate of unemployment in the villages of *Ormбnsбg* 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 *Ormбnsбg* region. After the forming of the agricultural co-operatives in the communist period, redundant local employees commuted to the mines in the *Mecsek-hill* and in the industrial factories in *Pйcs* (the biggest city in South-Transdanubian Region). After the political and economical changes in the 1990's mines and industrial plants were closed and people had less chance for work. They tried to manage farming in their villages but most of the compulsory entrepreneurs bankrupted 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 dependents of the social system and left the skills of the individual initiative to improve their lives.

Ormбnsбg is ill-famed for the special self-destructive strategies people used for achieving 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 requires redistribution of the land into equal pieces among the inheritors. Small plot of land meant 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 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 the jealously guarded lands without manpower. In the communist period government moved Roma *beős* 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 the heavy social and economical conflicts are often combined with ethnic and religious oppositions, too.[8]

Base Research: General Information about the Villages in the *Ormőnsőg* Region

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

In the first period we collected information from the small settlements of *Ormőnsőg*.[10] General information and statistic data helped us to understand the difficulties and chances of the 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 the County and in the Historia Domus written by the local priests. We founded some monographs about the history of the villages edited by a local teacher or amateur historian. For the statistical research we used the territorial data of the Central Statistic Bureau working in every county. Sometimes there are useful pieces of information on the settlement's websides, 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 *Ormбnsбg* more_profoundly. The main actor in the local scenes is the local government. It is the depository of local power. In the small disadvantaged settlements most of the resources of the local government are spent on social benefits and for the payment of debt by installments. 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 *Ormőnsőg* region mostly founded by the local government to support the obtaining of resources trough application system. On the other hand, representatives of the churches (Catholic Church and Reformed Church) play an important role in the social integration of the 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 the 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 the villages. They are mayors, priests, 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 *Ormőnsőg* 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 *Ormбnsбg* 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 results, 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 the 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 to 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 better prosperity of their 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 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 deprived people living in underdeveloped small settlements.

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

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

[3] Hankiss, Elemer, 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., Tamas - Vercseg, Ilona, Community Development, Budapest 1998, 9.

[6] In the *Ormansag* 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, Geza, Ormanysag, Budapest, 1937.

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

[9] The name of villages: Alsyszentmarton, Besence, Bogadmindszent, Bogdasa, Dravasztara, Felsxszentmarton, Gyцngyfa, Hegyszentmarton, Ipacsfa, Kakics, Kemes, Kemse, Kiralyegyhaza, Magyarmecske, Markyc, Marycsa, Molvany, Sysvertike, Vajszly, Zalata

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

[11] The catholic priest of Alsyszentmarton – 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-of-hearing client is challenging for social workers. The specialist must be aware of many peculiarities of deaf people, 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 4 to 6 percent of world population is in some degree hearing impaired (Baltadzhieva, 2000, 8). There are approximately 9 000 – 12 000 people with hearing loss in Bulgaria by non-official 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 self-control 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 he/she identify him/herself as a member 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 lan-

guage 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 Finger- spelling

There are two ways to fingerspell in Bulgaria: with one hand and with both hands. There is difference in the finger-spelling preference between younger and older deaf people. One-handed manual alphabet is used primarily by younger signers while two-handed finger-spelling 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 do). 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' – *buza* begins with 'b'). In spite of the differences mentioned above, all Bulgarian deaf people know and would understand both ways of finger-spelling.

Myths about Deafness

There are many myths about what people with hearing loss can and cannot do. Here are some of the most popular (Saeva, 2009, 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 himself/herself 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 eleven: 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. Within the international deaf community there is an International

sign language. 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 muscles change and their overall facial expression looks different. In addition, the voice characteristics 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 noth-

ing 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 lip-reading 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 good as or better than hearing drivers.

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

Deaf people are set apart by only one thing. As I. King Jordan, Presi-

dent 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 communication 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 am-

plify speech (unless noise reduction programs 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 worker 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 cost-effective outcomes, there should be sufficient number of communication codes. Communication is the base of social worker's profession. They should be able to understand and support their client.

English for the Deaf

Typically, a considerable number of people who need social services are people with migrant background especially in the host-countries. There are also people with bilingual 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 (depending on how literacy 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, United 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 (Zamfirov, 2008, 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 color-coded: the phrase 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 program (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 program is available at: http://signlanguage-bg.com/bg/english.html.
The four topics in the program 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).

Some differences between the two alphabets, that are noticeable for Bulgarian deaf learners. 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’).

Some peculiarities of Bulgarian deaf English learners are shown in the two examples.
First example: Writing Bulgarian words with Roman letters is their concept of English language.
Това е котка. ('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

In 2007 the first Master Program in Psycho-Social Rehabilitation was accredited by the National Evaluation and Accreditation Agency for the period of 6 years. The Program was developed by the Department of Medical and Social Science at South-West University 'Neophyte Rilsky' Blagoevgrad, MATRA project in partnership with the Global Initiative in the Community, and with 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. It will be part of the National Action Plan for implementation of Mental Health Policy of Bulgaria for the period 2004-2012.

The Master Program aims at preparing qualified specialists for mental health services through improving of their scientific, 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 Sociology, Psychology, Public Health. The program provides theoretical and practical training in the field of Social Work and concerns the specific problems of individuals, groups, and communities in the implementation of psychosocial rehabilitation. The main objective is to provide knowledge and skills to work with people with severe mental illness and their families using therapeutic approaches aiming at 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 the basic approaches to the psycho-social rehabilitation, which are used at home and abroad. The course concerns 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 local and central politics of psychiatry in the community.

• Therapeutic Behavior. The course teaches students about the importance of the professional-client relationship in the development of the therapeutic process. The course includes a set of knowledge about the therapeutic situation, the distribution of the roles to allocate responsibilities between the professional and the client.

• Case Formulation. The aim of the course is students to acquire skills to formulate the case and to use it a tool for involving the client, achiev-

ing the therapeutic contract, and planning therapy. It draws attention to the use of the formulation to achieve a holistic approach to the clients with mental illness and to continue the evaluation over the time of the interventions.

• Case Management. In the course students acquire the necessary knowledge and skills of the key professionals in the mental health system in the community. The course discusses the meaning and methods of establishing a personal relationship with the clients with severe mental illness to support their social participation.

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

• Working with Families in Mental Health Care. The course focuses on the understanding of the importance of the professional cooperation with the families of the persons with severe mental illness. It relates the theoretical concepts and methods of evaluation of resources to the patterns of family coping.

• Interdisciplinary Teams. Severe mental illness harms the ability of person to satisfy a wide range of biological and psycho-social needs. Ensuring optimal functioning in the community requires efforts of other professionals to coordinate and meet the needs, resources, and vision of the client.

• Leadership in Mental Health Services. Students are introduced to the role of the leadership in the establishment of mental-health services in

the community. Leadership skills contribute to the motivation of the staff, avoiding the professional overwork, improving the quality of services in the community.

• Management of Mental Health Services in the Community. The course concerns how mental health policy is applied in everyday practice of mental health services. It examines the management of mental health programs and services in the community and deals with the daily management and technology as a human process.

• Home Care in Psychiatry. Students are introduced to the model of community psychiatry, which offers therapeutic services in the home of the client.

Optional Disciplines:

• Communication and communication training

• Communication Disorders

• Public Relations

• Information aspects of social work

• Occupational rehabilitation

Practical training

Practical training is an important component for the formation of skills and professional competence. The total workload of the practice is 60 hours.The Master Program is finalized by diploma thesis.

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Case Work and Social Control
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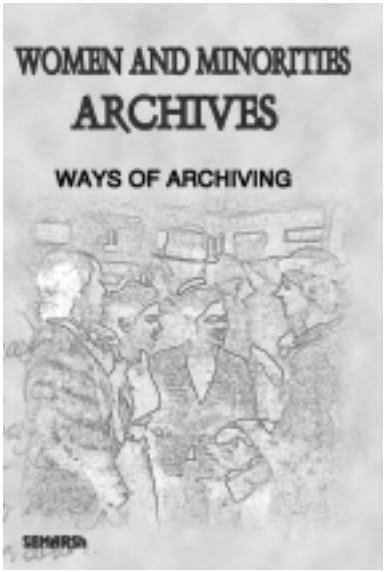

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Case work methods, initiated in the USA by Mary Richmond and developed in Europe by Alice Salomon, Siddy Wronsky, and other social work scientists, have almost one hundred years of history. The methods contributed to the creation of modern social work as a distinctive professional field and vocational training. The case work methods (observation, home visiting, interviewing of clients) as well as their separate steps (social analyses, social diagnoses, and planned social therapy) made the practice of social work more transparent and traceable. These methods had been adopted in different European countries and applied to various social and political situations. Case work ideas and practices were communicated by feminist networks and other international and local female organizations. In the framework of Phoenix TN European Project 15 authors from Spain, Hungary, Romania, Slovenia, and Bulgaria discuss the problems and perspectives of case work in the historical and current perspectives.

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