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Case Study #1: Children Witnessing Parental Violence

By Onkemetse Mbazo-Montsheki

Amina is a 40-year-old recently divorced mother of 3 boys currently aged 14, 12, and 11, and is recovering from a long-term abusive marriage. She reports that shortly after she married at the age of 20, her husband began insulting her, comparing her with other women, and employing demeaning language when addressing her. He restricted her daily movements, giving her a specific time to arrive home from her factory work. When she was late, which was rare, he verbally harassed her. He even banned Amina from visiting her parents, saying they had a negative influence on her. Nor did he allow her to have friends, explaining that they wanted to control his family.

After several years of restrictions and verbal abuse, he began to physically abuse her. His beatings were regular and involved hitting and punching, but never required any hospital treatment. He also decided that Amina could not be trusted to work outside the home and she had to quit her job and stay home all day.

When they were ten, eight and seven, the boys tried to protect their mother. They closed themselves in their bedroom with their mother whenever their father began to be angry and aggressive. The eldest boy tried to protect his mother by standing in front of her to prevent his father from hitting her. The father, undeterred, beat both Amina and their son. When the other boys tried to protect Amina, the father insulted them and beat them as well.

Eventually, Amina decided to leave her husband and moved in with her parents in a nearby village. However, she did not take the boys with her and their home situation got worse. There was now no parent to protect the boys from their father's beatings. Once when she visited the boys, she found that her youngest son had a medical problem with his ear. He had not attended school for a week due to the problem and yet his father had not taken him to a medical clinic. Amina took her son for medical treatment and then reported the matter to police. At this time, she applied for divorce and interim custody of her children. She was eventually given full custody of the boys. The father was awarded visitation rights, but Amina and the boys were anxious about the situation, fearing a resurgence of abuse during visits. Amina decided to consult with the court social worker assigned to their case.

Children Witnessing Parental Violence: A Social Worker from the U.S. Responds

By Kathleen J. Moroz

Prevalence and Incidence

In the U.S., more than 1 million incidents of domestic violence are reported each year with estimates as high as 3–4 million women being battered by their partners annually. Estimates of the number of children who witness each act of domestic violence range from 3–10 million. Only about a quarter of domestic violence cases are reported to police, making it difficult to determine the actual number of adult and child victims. Many incidences of domestic violence are undetected and undocumented. The current economy in the U.S. has led to a sharp increase in domestic violence and growing numbers of victims seeking assistance from beleaguered shelters and emergency programs across the nation.

Country Policies

There are federal laws that apply to all states, as well as variations in state and county laws that are relevant to this case. In particular, there are laws concerning the protection of children from abuse (including witnessing parental violence), parental rights (including rights to visitation), divorce, child custody, child (financial) support, child education, the use of corporal punishment, and domestic violence. While there
are legal and practice commonalities across states, there are also variations in policies, practices, and systems of care between states. Some states have laws specifying who may provide services to perpetrators of domestic violence, including specifications about who may meet jointly with domestic partners to address and resolve conflicts. It should also be noted that employees in various social service agencies in the U.S. may be called social workers, but this title does not guarantee that the person has any education in social work or a professional license to practice social work.

While domestic violence may be perpetrated by women, the majority of violent domestic situations involve a man physically (including sexually) assaulting a woman, often in the presence of children. These children are at much higher risk of physical, emotional, and sexual abuse at home. Domestic violence, as well as child abuse and neglect, are under-reported and under-investigated in the U.S.. There are considerable risks (first and foremost, of increased violent retaliation) for any victim who reports violence or abuse (informally to friends or family, or formally to police or a child protection agency). As much as it is hoped that communities will ensure the safety and protection of victims or potential victims of violence, a woman taking action to provide safety for herself and her children is taking a brave and precarious first step.

The father's beating of the mother would be grounds for a police investigation and possible charges for domestic assault. His physical beating of one of the three boys, even a single incident of physical abuse, could be grounds for a child protection investigation and substantiation of physical abuse. Substantiation of the abuse and the father's perpetration of it would depend on a number of factors, including the credibility of the witnesses' reports, the child's report, and/or the presence of physical evidence such as marks on the child's body, bruising, fractured bones, head injuries, etc. Child abuse investigation, substantiation, and interventions are the responsibility of designated child protection agencies, as mandated by federal and state laws. The perpetrator of the physical abuse could be subject to criminal charges as well as court-mandated participation in a range of services, including child and family, as well as domestic violence, services. Substantiated physical or sexual abuse would likely result in court-ordered restriction of the father's contact with the child(ren), including the requirement that visits be supervised.

**A Social Worker Responds**

The terms complex trauma, or in the case of children, complex developmental trauma, are now widely used to describe the impact of multiple exposures to traumatic events as well as the immediate and long-term adverse effects on the child's functioning and development. Complex trauma typically includes child maltreatment (physical, sexual, and emotional abuse or neglect) and exposure to parental and/or community violence. Although the terms witnessing and exposure have been used interchangeably, children and adults not only witness or see the violence, they experience it with all their senses. The experience of multiple traumatic events has a pervasive effect on the body, mind, and spirit of the individual. Many trauma experts recognize that the effects are widespread and insidious not only affecting individuals but families, communities, cultures, and nations.

There are common physiological and psychological responses to acute and chronic exposure to traumatic events, and many variations in the human response to fear. Immediate and long-term responses to trauma may vary considerably among children in the same family. Very young children are especially vulnerable to trauma from parental violence because they are physically, psychologically, and emotionally dependent on their parent(s) for protection, nurturing and guidance. Their coping strategies are limited and may include hyper-vigilance, hyper-arousal, and/or dissociation, or a combination of all three.

When internal safety (within their bodies) and external safety (in their relationships, homes, or communities) are repeatedly threatened, children experience repeated arousal of the sympathetic branch of the central nervous system. Activation of the sympathetic nervous system mobilizes the body/mind's fight or flight mechanism. This response involves elevation of the heart rate and increased blood flow away from the core of the body to the extremities and the temporary shutting down of core physiological functions such as digestion and elimination. These responses make it possible to fight or flee from the threatening person or situation, either physically or psychologically, and are accompanied by the release of multiple hormones and enzymes in the child's brain and body. Initially adaptive, the responses serve to keep the child alive. However, with repeated use, they become over-used and over-generalized, eventually limiting the brain's
repertoire of possible responses to arousal. Repeated activation of the fight or flight response releases the stress hormone, cortisol, which can be toxic to brain cells. Chronic exposure to traumatic stress can result in a loss of brain cells and the disruption of critical developmental processes that ultimately may alter structures in the young child's brain.

We do not know the impact of traumatic stress on each individual's development and ability to function, nor do we know about resiliency and protective factors that may have shielded them or mitigated the harmful effects of exposure to trauma. Culture also plays a significant role in shaping a person's view of the significance of life events as well as individual and collective perceptions of ways to respond to events. The practitioner needs to understand how each individual is functioning and the unique ways in which events have affected their perceptions of self and the world.

A complete multidimensional assessment by a practitioner familiar with the developmental effects of complex trauma is needed. Amina continues to play a critical role in her and her children's trauma recovery. She may be able to provide a developmental history for each child, including significant milestones, illnesses, injuries, and stressful events in the life of each child and the family as a whole. Assessment should identify areas of strength or resilience, domains of functioning in which each child is having difficulty, what is known about each child's history of trauma (separations, losses, accidents, injuries, illnesses, episodes of witnessing violence or experiencing emotional and physical abuse, as well as risk-taking or aggressive behaviors or victimization in settings other than home, such as bullying or being bullied at school.) Assessment should reveal areas that may need further observation or additional information from other sources (e.g., medical doctor, teacher, other family members, or neighbors). The assessment process would need to begin with Amina, in the context of a safe, empathetic relationship, and continue with each child separately. Individual and family therapy may be indicated to address the treatment needs of each child and the family as a whole.

The physical and psychological safety of this family must continue as a top priority. The boys' perceived and actual sense of safety during visits with their father is critical, as is their perception that their mother has sought to safeguard their safety and well-being during contact with their father. More information is needed about the father's current situation, the facts of the case which contributed to the judge's decision to award Amina fully custody, and any provisions that mandate or make it possible to require supervised visitation. Given Amina's and the boys' concerns regarding "a resurgence of abuse during visits," supervised, brief visitation in a setting the boys perceive as neutral and safe, is recommended.

With regard to Trauma-Informed Intervention, Judith Herman in her book, *Trauma and Recovery* (1992), described the stages of recovery from trauma as follows: a healing relationship, safety, remembering and mourning, reconnection and community. Although knowledge of the effects of trauma and evidence for the effectiveness of particular treatment approaches continues to grow, Herman's stages of treatment still ring true. Other researchers and clinicians have also made contributions to the body of knowledge about child development and trauma. The efforts of the National Child Traumatic Stress Network (Complex Trauma in Children and Adolescents, NCTSN, 2004) have also been significant in the promotion of research and dissemination of knowledge and skills to create and strengthen trauma-informed systems of care and develop treatment expertise across disciplines and organizations across the country.

Effective treatment for traumatic stress in children (as well as adults) incorporates a number of common core elements. These are:

- A healing relationship
- Safety
- Reducing and balancing overwhelming arousal and emotions (Ogden & Minton, 2000; Perry, 1997; Siegel, 2006)
- Integration of memory and making sense of traumatic experiences
- Engaging verbal as well as nonverbal information-processing abilities (Siegel, 2006)
- Enhancing sense of self-control and self-efficacy
- Increased insight, access to intuition and creative expression
- Individual and family well-being
Children Witnessing Parental Violence: A Social Worker from Aotearoa/New Zealand Responds

By Emily Keddell & Tepora Pupepuke

Prevalence and Incidence

The prevalence of child abuse in New Zealand stands at 4–8 per cent of children experiencing physical abuse according to the statutory (federal) agency that manages child abuse notifications and investigations: Child, Youth and Family Services (CYFS). CYFS reported 53,097 notifications in 2005 of which 81 per cent required further follow up (Ministry of Health, January 2010). Furthermore, there was an average of seven deaths per year due to child abuse (Ministry of Social Development, 2005 as cited in Shanahan, 2011), while in 2008 almost 75,000 children were found to be present during family violence incidents when police were called (Shanahan, 2011). One community-focused approach used by CYFS is the “differential response” model. This model provides increased flexibility in the way practitioners respond to potential care or protection concerns through referral to an external community agency that can provide long-term interventions from the earliest stages of notification.

Another government service aimed at violence prevention and intervention is Whanau Ora. Whanau Ora is a holistic and inclusive approach to dealing with families as a whole, rather than a focus on an individual within a family. Its objectives are to empower the family and to be influenced by the family way of approaching their issues. It recognizes that families are different and diverse and that there cannot be a “one size fits all” approach. Rather, the program has to be designed to be flexible in meeting the needs of family. Whanau Ora relies on the practitioner to work with the family to identify its needs, develop strategies to address those needs, and seek appropriate referrals to a range of health and social service agencies.

Country Policies

CYFS is the New Zealand government agency with legal powers to protect children and young people at risk of harm, abuse, or neglect, as well as dealing with young offenders. Its primary responsibility is to protect children and young people at risk of abuse or neglect, or at risk of offending. It has residential and outpatient care services, and funds community organizations that protect and help children. CYFS is a statutory agency governed by the Children, Young Persons and their Families Act (1989) and is charged with providing investigation, assessment, and intervention services to children who have been abused and/or neglected. A social worker from this service would view his/her role as investigating the abuse and neglect of the children. In their approach to this task, CYFS workers are required by the legislation to assist the family to: “...discharge their responsibilities to prevent their children ... suffering harm, ill-treatment, abuse, neglect or deprivation;” include children and families in decision making; assist them to prevent harm to their children; and provide services with due regard for the “...needs, values and beliefs of particular cultural and ethnic groups” (CYFS Act 1989, p. 1, section 4). Following investigation, the CYFS agency is required by law to utilize Family Group Conferencing (FGC) as a method of encouraging family participation in decision making about the future care and protection of children. However, the agency can also override family wishes if these are considered to conflict with the “paramountcy principle” (CYFS Act 1989, p. 1, section 6). This principle, that the “best interests” of the child should be the “paramount” consideration, is applied to ensure that the safety of the child overrides all other considerations. In addition, protection orders are a common legal remedy, gained by application to the family court under the Domestic Violence Act (1995). The orders are designed to protect victims of intimate partner violence (IPV). They prohibit the perpetrator from using abusive or threatening behavior, and prevent contact with the victim and/or their children.

When a CYFS social worker assesses this case, he/she would undoubtedly find that the father's actions constitute abuse and neglect, given the level of physical violence and neglect of his son's need for medical attention. At this point, an FGC may be held to encourage the extended family to devise a legally-enforceable plan for the children’s future care. This legislated forum invites family members, agency
workers, and psychologically significant adults to discuss the relevant issues. The meeting follows a clear format whereby all parties are given relevant information, with time set aside for family discussion and decision making. The best outcome of such a conference is the family reaching a consensus on action to ensure the children’s welfare now and in the future. This participative format and inclusion of extended family members draws heavily on indigenous Maori concepts relating to the importance of face-to-face conflict resolution and the value of input from wider kinship networks.

A Social Worker Responds

Social work within each national context is complex and multifaceted—Aotearoa/New Zealand (A/NZ) is no different. Social workers fulfill a vast array of roles ranging from care to control, from agent of the state to activist, from educator to health promoter to family worker. The role of “social worker” has public, sanitized, and carefully delineated definitions made by professional associations, registration boards, and agency-based role descriptions, yet these often belie the underlying rubric of inconsistencies, power dynamics, tensions, and complexities of actual practice. Thus, it’s difficult to state with authority what a typical social worker would do in regard to this case study, as other A/NZ social workers may dispute the version of the “truth” about what actions a social worker might take in this case. Given these general caveats, the presentation here is one possible response within the A/NZ setting to the case study of Amina.

In the A/NZ context, this case would have followed a slightly different trajectory from the moment Amina “took her son for medical treatment and then reported the matter to police.” At that time, either the police or physician would have referred the children to CYFS, and encouraged Amina to apply for a Protection Order. Based on the legal remedies that would follow, it is unlikely that Amina’s husband would have unsupervised visitation rights, certainly in the short term.

However, since Amina is already living apart from her husband and has full custody of the children, the social worker may have decided that the children were already safe and that an FGC was not necessary. Amina may have been referred directly to a community organization for general social work support. This referral pathway is part of CYFS’ “differential response” (DR) initiative, which aims to refer situations regarding family needs, welfare, and resources (as opposed to abuse) to community based agencies, thus “ring-fencing” child protection services for the most extreme cases of child abuse and neglect. This process aims to provide “wrap around” service, one that is able to look beyond the narrower focus of statutory child protection, where children are viewed as the clients, to examining the needs of the whole family. Indigenous Maori approaches can provide a range of perspectives for assessment and intervention that are holistic, family-centered, and inter-relational. While they are sourced from indigenous roots, these perspectives are often drawn from Indigenous and non-Indigenous families alike. Many Maori models conceptualize a families’ health from physical, mental, spiritual, and social perspectives. The well-being of a family requires balance and harmony of these components to assert safety and happiness for both children and adults. Thus, an important question a social worker would consider is what is the family’s ethnic, cultural, or religious background, and how does that affect the situation? If immigration issues exist, how do these affect the case? For example, if Amina was not a New Zealander and her husband was, she may lose her right to remain in A/NZ and face deportation.

A social work practitioner would explore the ways Amina’s gendered experience of being a woman and mother has affected her situation. How might a feminist perspective of considering violence against women as an expression of patriarchy assist Amina? From a psychological perspective, what are the psychological and emotional effects for Amina and her children of exposure to violence and do they require therapeutic support to assist them in their recovery? What services can Amina’s husband access that might help him maintain a respectful and violence-free lifestyle?
These questions lead to a number of directions for further intervention, and signal the careful individual tailoring of services depending on the client's situation. An example of an approach based on a traditional feminist understanding of IPV, the Women's Refuge movement, is well established in the country and provides programs for both women and children recovering from the effects of domestic violence. They work closely with “Stopping Violence” services that provide court-approved group services primarily for men. Women’s Refuge provides services for both Maori and non-Maori women, often in separate agencies to ensure that Maori women's cultural needs are met. The services are an important component of the social service landscape for families affected by IPV. However, if Amina were to return to her husband, whether for cultural, religious, or personal reasons, she may find child protective services may force her to choose between her husband and children, and she may be referred back to the Women’s Refuge involuntarily.

In response to this common situation, and in recognition of cultural differences in the conceptualization of family relationships, some groups, in particular Kaupapa Maori organizations (those run according to Maori principles) and some community police initiatives, are offering family-based services to couples who are affected by IPV. The services aim to include the extended family as well as both the male and female partners in such a manner as to address the violence without requiring the parents to separate. For example, initial investigations may include conversations with extended family, held at the marae (Maori cultural centres) and predominantly rely on face-to-face meetings. The Maori context, which lends the investigation to fully explore genealogical links and similarly to other strengths-based approaches, presumes that good outcomes for the family may be found through the resources of extended family members. It remains to be seen whether these approaches represent an over-idealization of the family unit that places women and children at further risk or maintains culturally responsive family services. It is clear, however, that a range of services aimed at the myriad of people’s lived experiences helps to provide a diversity of services that are based on families' complex cultural, social, and personal backgrounds.

In conclusion, it is difficult to comment on further case progression without talking with Amina and her family; however, this brief discussion shows how Amina’s situation would be constructed within the A/NZ social work context. Conceptualizing social work as having theoretical roots in ecological, indigenous, feminist, and psychological theories shows the ways her problems would be viewed within an A/NZ social work context, and the variety, especially in the community organizational sphere, of possible responses. The A/NZ social work landscape is complex, containing both state and community-based agencies with multifaceted roles for a social work practitioner. The indigenous Maori perspective lends complementary tools to provide well informed family-based decisions in case work. The ecological approach, feminist critique, and burgeoning discourses relating to domestic violence solutions add richness and value to complex interrelated practice responses.

Case Study #2: Medical Neglect of a Child

By Caren J. Frost

Ethan Anderson is a 12-year-old boy who has been having difficulty swallowing. His parents, Joel and Molly Anderson, take their son to a physician who discovers there is a lump under Ethan's tongue. After being sent to the pathology lab for analysis, the lump is discovered to be cancerous. Ethan's physician recommends that the boy undergo chemotherapy to ensure treatment of the cancer by appropriate biomedical standards. The chemotherapy regime recommended by the physician is new and its effectiveness in youth under the age of 18 years is not well documented. A clinical trial is available for Ethan under his physician's guidance and Ethan's medical team believes his death will be imminent if he does not receive the treatment.

Ethan’s parents decide to obtain another opinion about their son's cancer status during which they decide not to utilize biomedical therapies for their son and make the decision to use alternative and herbal remedies. Ethan's physician disagrees with their course of action, states that alternative therapies are a death sentence for Ethan, and reports the Andersons to a child protection agency. The social workers at the agency of child protection decide this case is one of serious medical neglect, resolve to remove Ethan from his parent's custody, and decide that Ethan will receive the trial chemotherapy treatment as ordered by the physician.
Since Ethan’s parents refuse to have him removed from their home they flee the state to go and live in another part of the country. They are charged with kidnapping a child and are tracked down by police and returned to their state of origin. Ethan is allowed to remain with his parents but they may not leave the state. Currently, there is a lawsuit pending between the state and the Andersons about whether there are medical grounds to treat Ethan without his parents’ approval.

Medical Neglect of a Child: A Social Worker from Israel Responds

By Nehami Baum

Prevalence and Incidence

There is no well-founded information about the extent of the problem in Israel. In fact, every now and then one may find a news report about a large number of cases, but a close inspection reveals that they combine all cases of child abuse and neglect. In fact, there is no information at all about the extent of medical neglect of children in Israel. A recent document mentions an estimated rate of 16 new cases per 1000 children (0–18) for all cases of child abuse and neglect, and estimates that 45 per cent of these are cases of neglect of all kinds. The number of medical neglect cases is bound to be much lower because almost the entire population is covered by one of the health maintenance organizations (HMOs) and almost all children under five years of age obtain some coverage and inspection by the public family health services.

Country Policies

Most social workers in Israel are employed in the public or voluntary sector, in municipal welfare departments, NGOs, or state services such as the correctional/probation system, the educational system, and the health system. The hospitals and ambulatory clinics in Israel are all owned and managed by either the government or one of the country’s four HMOs. All of them employ social workers. Their jobs include assisting patients and their families to cope with the patient’s illness and any difficulties that may arise after the patient’s release. They also investigate and report any suspicion of abuse or neglect. Every municipality in Israel has a welfare department staffed by social workers providing services to the residents of the city, town, or designated rural communities. Service provision in these departments is usually organized with reference to specific populations (such as the elderly, children and youth, and new immigrants); specific problems (such as drug use, family violence, and conflictual divorce), or to specific residential districts, chosen by the department itself. Most social workers in these departments work with a designated population group or problem. There are also “generalists” who work with all populations and problems. The regulations of Israel’s Ministry of Welfare require each municipal welfare department (depending on its size) to employ one or more child protection officers. These are specially trained and licensed social workers responsible for the protection of children at risk, each officer being in charge of a specific residential area. Among the many responsibilities of the child protection officers are putting a stop to any injury being inflicted on a child, protecting children at risk, and ensuring these children’s physical and mental well-being. To carry out their responsibilities, they have the legal authority to intervene in cases of possible danger to a child. They have the authority to investigate and report suspicion of neglect or abuse, to draw up intervention programs, to demand the cooperation of the families and children involved, to issue emergency warrants in instances of immediate danger, and to write reports for the courts.

A Social Worker Responds

The case in question would be handled first by a hospital social worker and then, if necessary, by a child protection officer in the city where the family resides. While both social workers would probably accept the physicians’ assessment of the urgency of providing the boy with biomedical treatment, it is highly
unlikely that either would accuse the parents of neglect or recommend removing their sick child from their care. Their efforts would be directed towards understanding the parents’ objections to the treatment and obtaining their cooperation by means of persuasion and moral pressure. Only if that does not work would the matter be referred to the court.

The hospital social worker, after being informed that the parents refused recommended treatment for their child, would arrange a meeting with the family. This meeting would entail a psychosocial assessment aimed at understanding the parents’ refusal of the recommended treatment. The social worker would try to understand the family dynamics, how the family deals with stress in general and illness in particular, their previous experiences with the medical system, their responses to the illness, and their perception of its danger to life. The assessment will also include their objections to both the recommended treatment and conventional medicine, and their overall attitude towards and experience with alternative medicine. In the course of the assessment, the social worker would try to win the trust of the family and create a bond with them, all the while knowing that given the short time at her disposal and the stress the family members are under, she might not be able to do so.

Because of the experimental nature of the recommended biomedical treatment, the hospital social worker would try to keep an open mind. She would try to persuade the parents to consult with another physician who practices conventional medicine and has no connection with the hospital. She might also suggest that the parents allow their son to take both the conventional and alternative courses of treatment. At the same time, she would report the details of the case to the responsible child protection officer. If the parents cooperate with the hospital social worker, the child protection officer would probably remain in the background, in the hope that her intervention would not be necessary. If the parents proved uncooperative, she would probably summon them to a meeting or visit them at their home with the dual purpose of learning their position and informing them that an emergency warrant might be issued against them.

In tandem, because of the imminence of the danger to the child’s life, the hospital social worker might set in motion an “ethics committee.” This ad hoc committee is composed of doctors, religious representatives, lawyers, and social workers, and deals with critical medical situations. This committee would reconsider the doctors’ recommendations in light of their understanding of the child’s medical situation, the objections of his parents, and their own knowledge and understanding of such a case. If they were persuaded that the course of treatment recommended by the child’s doctors was, in fact, the only treatment that might save his life, they would apply their moral authority to try to persuade the parents to follow the doctors’ recommendations. It is only as a last resort that the child protection officer would refer the case to the court.

Medical Neglect of a Child: A Social Worker from Botswana Responds

By Onkemetse Mbazo-Montsheki

Prevalence and Incidence

In Botswana, child abuse is a most controversial topic, as the culture of Botswana is such that a child is only “seen” and not “heard.” More often than not, decisions are taken for and on behalf of children without a chance to have their say in the matter, regardless of their age. For a very long time, abuse was not perceived to be a bad thing, because some of the cultural practices that are followed were actually perpetuating the abuse of children. For example, verbal abuse is one of the most common forms of abuse that children are exposed to, but the culture condones it as long as it is done by an adult. Moreover, this has also resulted in some of the abuse going unreported by witnesses due to the fact that it is perceived to be condoned by the culture. By virtue of being children, they are vulnerable and thus there are instances where a child would not be able to report abuse because the perpetrator is someone who is trusted or respected in the community.

Culturally, assertiveness in children is also something that is not encouraged as it is perceived that a child who is assertive lacks respect or discipline. This perception perpetuates the practice and makes it difficult for children to report abuse; thus cases may only be presented after a long period of time, when some of
the evidence has been lost. There is also a great deal of secrecy surrounding abuse in families, especially if it is of a sexual nature. Families prefer to resolve such issues with uncles or other relatives rather than reporting incidents to the police and, more often than not, the child's feelings and wishes are not taken into consideration when making decisions on the matter. These decisions are usually because, in Botswana, having a "good" name in the society is highly esteemed at times to the neglect of what is in "the best interest of the child." Abuse carries embarrassment and shame for the family that fall victim to this social ill and thus, in many instances, families maintain a culture of secrecy. One may also attribute this situation to the cultural advice which a new Botswanan bride receives from older women in the family and community. The emphasis is usually on taking care of the husband and protecting him while nothing is said about protecting children. Moreover, Botswana still has to review legislation that is outdated in terms of protection of children. Acts related specifically to children and education still condones corporal punishment which is shown to translate into physical abuse in some instances.

Botswana is a country that has diverse cultures and beliefs. However, many people are now educated or have at least received basic education and, as such, knowledge of the importance of science in the health system is more widely spread. There are still traditional doctors who are actually registered with the Traditional Healers Association that came into being to ensure that people/patients are not put at risk by neglecting to take their prescribed formal medication. In the case of HIV and AIDS, patients who are already on antiretroviral medication are encouraged to adhere to the medication without default through concurrent use of traditional medication. In relation to children specifically, there is a situation whereby mothers whose children exhibit signs of dehydration traditionally believe that it is caused by the child being exposed to evil spirits or to people who are promiscuous. The practice still continues despite the efforts of medical practitioners to educate the public on the issue. This belief has even resulted in fatalities due to extreme dehydration.

**Country Policies**

There are several pieces of legislation related to children in Botswana but they lack harmonization on the definition of a child. For example, that governing employment defines a child as someone who is 14 years of age and under, while the 2009 Children's Act definition is someone who is below 18 years of age. Moreover, in the original Children's Act of 1981, social workers in government hospitals and in civil society organizations had no powers to appear in the children's court, or to prepare social enquiry reports to the court on children in need of care. In the 2009 Children's Act, all social workers are granted the same authority in this regard. The guiding principle in all cases is "the best interests of children." Moreover the Act asserts that, where dissonance occurs, the Children's Act will take precedence.

**A Social Worker Responds**

More often than not, a perception about various circumstances of life is determined by one's past experience, educational background, and belief system. The approach of a social worker handling this case in Botswana might be guided by social learning and cognitive theories which assert that all behaviors are acquired by conditioning and influenced by internal states such as motivation, problem solving, decision making, thinking, and attention. The intervention by the social worker might also take into account a general systems theory that seeks to promote the child's social functioning through positive interaction with all the systems that affect and are affected by him.

The social worker in this case would initially have one-on-one sessions with the parents as well as with Ethan. All the ethics of counseling, such as keeping information confidential, would initially be communicated to the family. In these sessions, the social worker would get to know each member, their personal beliefs on issues such as health based on cognitive and behavioral theories, and how they cope with their own personal challenges, their past, the kind of experiences that they might have gone through in their lives, and how they dealt with all these issues. Furthermore, the social worker would also gather information on their educational background and anything else that would add value to understanding the dynamics of the case.
Having individual sessions also affords each member of the family the comfort and liberty to communicate what he/she may truly feel or believe about the case. In addition, reflecting on each member’s experiences gives him/her a chance to conduct their own self-introspection on what influences him/her to think or believe as he/she does. The social worker would also have individual sessions with Ethan and examine his perceptions about the situation. In the individual sessions, the social worker may determine which of the parents is the most influential, and which one of them is influencing resistance to the medical efforts to assist the child.

After having the individual sessions, the social worker would then bring together all the concerned members of the family, especially the mother, the father, and the child. In this group session, the worker would then facilitate the opening up of each member of the family to express his/her feelings about the whole situation. By this time, the social worker would have gathered enough information to understand why the family does not want the child to receive medical treatment and, if it is due to lack of information, the social worker would then explain to the family members the health needs of the child. If it is due to the belief systems of the family, the social worker would attempt to rationalize the decisions of the family with regard to the reality of the child's medical condition.

If, however, the social worker has done her best to convince the family members about the importance of medical treatment and they remain intransigent, the worker would have to do what is in the best interest of the child. This guiding principle is used for all cases involving children as outlined in Botswana’s 2009 Children’s Act. The social worker would then find a place of safety for the child and sign the consent for the doctor to start chemotherapy for Ethan. The social worker can sign the consent representing the government in this matter, because, in Botswana, the government is the legal guardian for all children and thus, in cases where the parents are deemed not to be acting in “the best interest of the child,” government takes over and acts in loco parentis. The social worker would take the child to a place of safety where he/she can be sure that he is taken for medical treatment without fail. In this case, Ethan would be allowed visitation by the family if this is considered to be in his best interest.

Case Study #3: Sexuality and Intimacy

By J. Matt Upton & Brandon Andrus

Joe and Diana are a heterosexual interracial couple who are both in their mid-30s. Joe is white and Diana is black. They have been together for eight years, but married for four years. They live in a medium-sized city. The couple has one child who is three years old. Both Joe and Diana work, and they report that they do a good job sharing household duties. Both lead an active lifestyle: Diana prefers running, but Joe prefers to go to the gym to work out with his friends. They both enjoy traveling, although they have not had as many opportunities to travel since they had their child. Diana’s family lives close by, and she likes to spend at least one night a week with them. Joe’s family resides many hours away, but he keeps in close contact with them via phone and email. Joe and Diana both grew up with a Christian background, though currently neither of them is active in any specific church.

Joe and Diana have come to a social worker together because they have had some problems in their sex life. Joe feels that sex is an expression of intimacy and wants to have it more frequently. Diana says that there are other ways to be intimate and that Joe is too pushy where sex is concerned. They report having sexual intercourse twice a week. Joe says that this is not enough. Diana on the other hand says that considering their busy lifestyles and wanting to spend time with their young child and other family members, they are already having enough, if not too much, sex. Joe complains that he has to schedule in sex in order to get Diana to respond and this makes it routine rather than spontaneous and fun. Diana says that she sees sex as more of a chore than something she enjoys. She says that she expresses her love and is emotionally intimate with Joe in so many other ways, including holding hands, cuddling during movies, and spending time together with their child. She says that having sex should not be something that they force into their lives. Joe says that in order to have a fulfilling relationship, they need to have sexual intimacy more often. Joe and Diana feel that they are fulfilled in other areas of their relationship, but that sex causes some strain for them. They want help figuring out which perspective is right, and so they seek help from a social worker.
Sexuality and Intimacy: A Social Worker from the U.S. Responds

By David Derezotes

Prevalence and Incidence

In a U.S. National Survey of Marital Strengths, conducted in 2008, that included a sample of 50,379 heterosexuals, there were 20,675 self-reported happily married couples and 20,590 self-reported unhappily married couples. The authors found that couples’ communication, closeness to each other, sexual intimacy, and spirituality were among factors predictive of a couple’s happiness (Olson & Olson-Sigg, 2008).

Country Policies

In the U.S., social work students learn about the “National Association of Social Workers (NASW) Social Work Code of Ethics” (NASW, 2008) that supports such values as social justice, power sharing, and individual autonomy in marriages (and of course in other settings as well). These values (NASW, 2008) are not necessarily shared by all social workers, and a still larger proportion of client populations probably reject these values.

For example, in the last century, women in the U.S. have gained more equity with men in terms of political and economic power and social status. Social work values support these shifts (NASW, 2008). These gains, however, do not manifest in every heterosexual marriage. Many women still accept positions of economic or power inferiority in their relationship with their husbands (Renzetti, 2003). Similarly, there are many men in the U.S. who are unwilling to give their wives equal power (Kimmel, 2004). Thus, social workers may have different values than clients about marriage and gender equality.

Countertransference reactions (thoughts and feelings that the social worker has about the client) are always powerful influences in case formulation. Couple work tends to bring out some of the most powerful reactions from social workers because most adults have strong values associated with intimacy, marriage, and sexuality.

A Social Worker Responds

It is difficult to describe what a typical social worker from the U.S. would do in this case since social workers are a very diverse group, representing a variety of values. Given the fact that the majority of social workers in the U.S. are female, heterosexual, Christian, and are likely to be married at least once in their lives, the social worker is assumed to have these characteristics. Her likely responses to the case are described below.

The social worker would probably (although not necessarily) over-identify with the female and under-identify with the male in this case. This perception essentially means that the social worker would value Diana’s perspective over Joe’s, although a typical male, heterosexual social worker might have the opposite reaction. A typical female social worker would hopefully be aware of these personal reactions, and be able to objectively use her reactions as data to help assess her clients and their marital system.

The social worker’s own values about marriage will also influence her case formulation. Since she likely believes that divorce is not the best outcome (and since she identifies as a Christian, divorce may also be a sin), she probably wants the couple to stay together. However, if Joe was physically or emotionally abusive to Diana, the social worker might counsel Diana to leave him unless he gets significant therapeutic help. Whether Diana and Joe hold the same values as the social worker about marriage and divorce, the social worker has the responsibility to honor her clients’ values.

Another issue in this case concerns gender-related values about intimacy in marriage. As a female, she would probably value emotional intimacy at least as much as sexual intimacy (Hirsch & Wardlow, 2006) and, therefore, she may attempt to influence Joe to reduce his demands for sex and become more sensitive to Diana’s requests for more non-sexual touching and emotional closeness. However, Joe may not share the
social worker's values about intimacy. Whether they are similar or different, the social worker must honor the values of both clients.

The social worker would need to recognize and accept her countertransference reactions, and then ask herself the following questions: is it possible that Joe and Diana have similar reactions towards each other? It would be important to explore whether Diana, for example, is often frustrated and angry with Joe. If this is the case, Joe may often feel attacked and defensive. Second, is it possible that Joe and Diana have similar reactions towards their own selves? The social worker should also explore, for example, if Joe is also frustrated and angry at himself. He still cares about Diana, and he probably feels guilty that he is causing her suffering. Such reactions might also bring additional guilt and shame for Joe; he might try to deny these feelings by blaming Diana for being so critical of him. The social worker should also explore these kinds of emotions with Joe.

Thus, the counter-transference reactions the social worker would experience in the therapeutic relationship are not about “problems to solve,” but provide potentially useful data about the emotional worlds of the clients that the social worker can further explore. The worker should try to help Joe consider whether he has feelings of hurt, anger, guilt, and shame. If Joe does locate such emotions inside of him, the social worker should help him normalize those emotions, helping him to accept them and express them to Diana in assertive (direct but not abusive) communication. As Joe becomes more aware and accepting of his own emotions, he is likely to become more empowered to listen empathically to Diana's emotional perceptions. Since the social worker might over-identify with Diana, she should check whether Diana feels similarly towards Joe who, in this case, is hurt and angry.

The social worker could build upon the emotional work outlined above with historical analysis of the patterns of interaction between them. Many couples in therapy become more empowered to develop effective marital relationships when they understand how their current relatively dysfunctional interactional patterns are rooted in their own pasts. For example, the social worker might ask Diana to talk about the quality of her emotional relationship with her own parents when she was a child. Perhaps Diana would examine whether her parents were emotionally distant from her and, if so, whether she reacted as a child by emotionally withdrawing from them, just as she now does from Joe. The social worker could then help Diana build upon these insights and perhaps make changes in how she reacts when she feels rejected by Joe. Perhaps she could learn to let him know more assertively how she is feeling and ask him for what she needs. The social worker would continue to monitor the effectiveness of her interventions through feedback from Diana and Joe, and make adjustments as the work continues.

The transference that Diana and Joe have towards the social worker will further complicate the case. Transferences are the feelings and thoughts that a client has towards the social worker. Diana might, for example, feel supported by the social worker in this situation and she may try to influence Joe by telling him “see, the social worker agrees with me.” Joe, however, might have a more negative transference towards the social worker. He is likely to feel more uncomfortable in the social worker's office than a female would. He might even have felt initially as though Diana forced him into counseling with the social worker.

The way that the social worker responds to these transference reactions will be a key to the ultimate success of the case. If the social worker becomes overtly defensive or angry with Joe, he is likely to retreat further back into his position that Diana should give him more sex. If the social worker is able to find a way to build a therapeutic relationship with Joe, then he may be willing to let the social worker help him and his wife work out some kind of agreement about how to build a mutually satisfying intimate relationship.

**Sexuality and Intimacy: A Social Worker from Israel Responds**

By David S. Ribner

**Prevalence and Incidence**

Israel, like the U.S., is a nation built on immigration; colloquially we call ourselves the “country of seventy peoples.” As such, a significant number of couples are multicultural, with the most recent waves of immigrants arriving from Ethiopia, France, South America, and varied ethnic groups from the former Soviet
Union. Thus, the kinds of issues presented by Joe and Diana probably ring true for many Israeli clients in sex therapy. No statistical data exist regarding the prevalence of sexual dysfunction in Israel, nor do we have a sense of the percentage of those who actually come for help. In a social context in which security and economic challenges are aspects of day-to-day life, resolving sexual problems may not have a high priority.

**Country Policies**

Social work has been an honored profession in Israel since its formal declaration as a sovereign country in 1948. Bachelor of Arts, Master of Arts and Doctor of Philosophy degrees in social work are granted by five universities and an expanding number of local colleges. Working as a social worker requires formal licensing at the Bachelor's level by the Ministry of Labor and Welfare, with government-sponsored or supported agencies being the primary employers. Social workers in the fields of sexual health are eligible for membership in the Israel Society for Sex Therapy.

**A Social Worker Responds**

Joe and Diana present with one of the most common problems heard by sex therapists in Israel nowadays. Disagreements between spouses regarding frequency and quality of sexual contacts often impact negatively on the entire marital relationship (Henderson-King & Veroff, 1994; Sprecher, & Cate, 2004). It says much about this couple's commitment to each other that they have agreed to seek help before they suffer more emotional damage. What follows is based on the assumption that neither client suffers from a diagnosable mental illness or personality disorder, as listed in the DSM IV (A.P.A., 2000) or the International Classification of Diseases 10 (W.H.O., 2007).

In working with this couple, first the social worker should examine the source of each spouse's understanding and beliefs about human sexuality, such as overt and covert parental messages about sex, information gleaned from peers and the media, formal sex education, either school- or church-based, and assumptions about the nature of female and male sexuality. Second, the social worker should consider the couple's sexual history, both individual and partnered, such as experience with and feelings about masturbation, early sexual experimentation, sexual awareness of self and others, first intercourse, early experiences with current partner, and possible sexual traumas (although there are no such indications in the case presentation). Third, the social worker should consider the development of Joe and Dina's sexual contract over the eight years of their cohabitation, including the openness and clarity of their communication, comfort with sexuality, dealing with changes in expectations and responses, and manifestations of non-sexual and non-physical intimacy.

To gain additional information crucial to the evaluation stage, the social worker should seek to understand each spouse's cultural background and identity. Joe and Diana seem to share core values, such as the importance of family, financial stability, and physical fitness. Yet their cultural differences may lie at the root of their dilemma. The color of each spouse's skin possibly reflects divergent backgrounds, such as family norms and values, formal and informal education, and even dissimilar churches. Each of these cultural anchors may influence any aspect of their sexuality, including, but certainly not limited to, classifying a specific behavior as sexual, defining sexual expectations, or creating a mechanism to resolve sexual conflicts.

One example of this level of difference can be found in Diana and Joe's disparate understanding of the nature and place of sex in their relationship. Joe seems to define sexual satisfaction as deriving solely from penis/vagina intercourse; anything else or anything less, he finds unsatisfying and frustrating. For her part, Diana seems to have a broader perspective: an intimate experience with Joe need not involve sexual organs or be limited to an intense experience of physical intimacy. A significant element, and one which has treatment implications, is that neither spouse expresses any interest in trying to understand or accommodate the other's perspective.

Recommended treatment for this couple should be cognitive and behavioral; both can be initiated simultaneously. A learning piece should begin with helping Joe and Diana gain a thorough understanding of the profound differences between women's and men's sexuality. While physiology is the most obvious dissimilarity, it is definitely not the most significant. Women's and men's brains process the world differently,
influencing every aspect of spouses’ sex lives (Meston & Frohlich, 2000; Pfaus, 2009). A careful theoretical and personal appreciation of the role sex plays in human life in general and in each other’s lives can minimize distortions caused by unwarranted assumptions. Such an appreciation may keep spouses from forming cognitions beginning with “all men…” or “all women…” This appreciation can also enhance their awareness of the need to be sensitive to and accepting of each other’s sexual desires and expectations.

One often misunderstood gender difference revolves around the atmosphere most suitable to allow each to feel comfortable sexually. Women, much more than men, seem to be inherently connected to the world around them (Basso, Brotto, Laan, Redmond & Utian, 2005; Cohen, 2011). For these women, romantic feelings will more likely infuse the couple dynamic when the systems of her life context reach her desired homeostasis. In more concrete terms, for many couples, the most effective aphrodisiac is when the guy helps clean the kitchen. Men, on the other hand, seem to live in a less complex universe, able to shut out other stimuli when confronted by a sexual turn-on.

From a behavioral perspective, this couple needs help in developing alternate intimacies, options for physical closeness that may enhance their sex lives without engendering feelings of frustration, anger, or isolation. To broaden this couple’s sexual repertoire, a technique known as “sensate focus” would be a generally recommended initial intervention. Suspending actual intercourse for several weeks, the therapist instructs the couple to implement a series of graduated massage exercises to be done at home, allowing Joe and Diana to explore new ways of giving each other pleasure. Starting from less erotic body areas, this technique encourages each spouse to focus on the location and type of touch that brings a positive feeling when receiving the massage. This information is then communicated to the partner, enhancing each one’s familiarity with sources of personal and partner pleasure. These massages gradually become more overtly sexual, at the pace and comfort level of each spouse. For most couples, these newly-learned modes of touch develop into items in their foreplay menu, hopefully with a deeper understanding of the place of intimate options in their lives.

An additional benefit of these approaches is that they often lead to improved sexual communication, even in cases where this has not been articulated as a goal. The couple interaction needed to successfully complete the treatment tasks minimally includes verbal specificity around issues of intellectual understanding of sexual issues and enhancing mutual touch. Achieving an improved comfort level around these challenges may help Joe and Diana achieve greater openness around other aspects of their sex lives as well.

As a concluding note, sharpening our sensitivity to cultural values, norms, and expectations must always be a critical element of our evaluation and treatment process. Assumptions, generalizations, stigma, and counter-transference issues may prevent us from fully hearing and accepting our clients and their cultural contexts. Avoiding such pitfalls only enhances our professionalism.

**Case Study #4: Teenage Parents**

By Mark B. Morris & Brian Droubay

Kelli is a 16-year-old female who lives with her single mother, Jessie, in a large urban area. Jessie divorced Kelli’s father 15 years ago, and works full-time during the day at a low-paying job. Neither Kelli nor Jessie has contact with Kelli’s father. At age 15, Kelli became pregnant by her 18-year-old boyfriend, who is currently incarcerated; she no longer has contact with him. Kelli wanted to put the child up for adoption but was pressured into keeping him by her mother. After having the baby, Kelli decided to drop out of high school to raise her baby boy. Currently, she is employed part-time during the day at a local grocery store; her six-month-old, Zach, attends daycare while she is working. Kelli says Zach is a fussy child who has trouble sleeping at night.

Kelli was arrested for driving under the influence of alcohol. She was referred for substance abuse/mental health treatment by a local judge. Kelli admitted that she had been drinking at a party and felt she was sober enough to drive home. Zach was not in the car at the time. Kelli frequently goes out at night with her friends while her mother watches Zach.

Kelli denies having a problem with drinking; she says the arrest was an isolated incident. She displays a lot of sadness and worry. She expresses feeling alone and disconnected from her peers since her child was born. She has never been formally diagnosed with mental illness, though her family does have a history
of mental problems and substance abuse. Kelli feels that her mother is sad all the time and believes she has distant relatives with mental problems. Kelli says that she did start drinking more after Zach was born, though she did not drink during the pregnancy. She says she started drinking socially when she was 13. Kelli only recently began drinking daily—generally after her shift ends at work. Kelli says she loves Zach and feels a bond with him, but is overwhelmed by being a parent. She says she feels hopeless about the future, about always being poor and disconnected from “the rest of the world.” She seems open to talking with a therapist about the current problems she is facing.

**Teenage Parents: A Social Worker from the U.S. Responds**

By Meredith Safman

**Prevalence and Incidence**

The U.S. has the highest teen birth rate (live births to women aged 15–19) of all industrialized countries (Ventura & Hamilton, 2011). Despite significant declines in teen pregnancy and births since the early 1990s, approximately one-third of teenage girls experience at least one pregnancy by age 20 (National Campaign to Prevent Teen Pregnancy, 2011), 82 per cent of which are unplanned. Nearly 750,000 U.S. teens become pregnant each year (Guttmacher Institute, 2011).

Demographic data clearly illuminate high-risk segments within the U.S. population. In 2001, women under age 20 experienced 87 per cent of all unplanned pregnancies (National Campaign to Prevent Teen Pregnancy, 2011). Currently, women aged 18–19 accounts for two-thirds of all teen pregnancies. Significant disparities are evident when race is examined as a risk factor for pregnancy among adolescents. Black and Hispanic women aged 15–19 become pregnant at a rate 83 per cent higher than their non-Hispanic white peers (126, 127, and 44 per 1,000, respectively) (Guttmacher Institute, 2011).

**Country Policies**

Social services have existed in the U.S. since the 1600s when almshouses, privately funded group residential facilities which provided no cost housing for indigent citizens, were established in the state of Massachusetts to care for the poor, elderly, and indigent. Until the Great Depression in the 1930s, a period of severe economic crisis in the U.S., social services consisted of uncoordinated efforts by states, churches, and individuals. In the 1930s, President Franklin Roosevelt formalized the federal government’s responsibility for the welfare of the people through enactment of the New Deal, a legislative action which provided social and welfare benefits to help alleviate mass poverty and unemployment in the U.S. Today, the practice of caring for those who have needs, beyond what they are able to provide for themselves, has grown into a network of government agencies dedicated to bridging service gaps for specific segments of the population. Although priorities regarding the focus of social welfare have shifted throughout history to reflect current U.S. values and societal beliefs, commitment to humanitarian efforts is deeply ingrained in American culture.

**A Social Worker Responds**

The first step in treatment involves having a physician rule out any biological factors which may lead to symptoms which, in Kelli’s case, would cause her to appear intoxicated when she is not, such as a petit mal seizure. Assuming no medical condition exists that would better explain Kelli’s actions; the next step involves assessing the behavioral, emotional, and situational factors to formulate a diagnostic picture. In the U.S., social workers routinely diagnose clients. Diagnosing serves two purposes: 1) to provide accurate documentation supporting the existence of a condition which justifies treatment and the need for insurance reimbursement, and 2) to develop a treatment plan which prioritizes her treatment needs, Kelli’s court-ordered treatment for alcohol is the first condition which must be addressed.
Diagnostic formulation in the U.S. relies on the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth edn., Text Revision, American Psychiatric Association [DSM-IV-TR], 2000), which establishes standardized criteria for diagnosis based on observed and reported symptoms. Kelli’s symptoms suggest a diagnosis of Alcohol Abuse and Depressive Disorder, Not Otherwise Specified.

Created using the diagnoses above, Kelli’s treatment plan should prioritize the alcohol abuse treatment because it is the reason for her referral. Kelli’s use of alcohol at the age of 13 (the minimum legal age for alcohol consumption in the U.S. is 21) indicates that she may be using alcohol to dull emotions she is unable to process. It also points to a lack of parental supervision which could indicate parenting problems. Teaching Kelli to communicate her feelings in pro-social ways will likely reduce her need to internalize negative feelings which may contribute to alcohol use. She, like many teenagers, clearly did not consider the consequences of driving after using alcohol.

The social worker would likely address the alcohol abuse through cognitive behavioral therapy (CBT). CBT, a therapeutic modality which seeks to restructure dysfunctional thoughts and feelings, as well as subsequent feelings and behaviors which result in undesirable consequences (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006), can help Kelli to conceptualize the way in which her behaviors led to the legal trouble she is currently experiencing. The social worker also should explore patterns of alcohol use in the home as Jessie may be using alcohol to self-medicate her own depression.

In evaluating Kelli’s depressive disorder, it is important to note the tendency of alcohol to heighten depressive symptoms. Kelli’s status as a teenage mother, as well as the depressive symptoms exhibited by her biological mother, are strong indicators that the depression itself was present prior to the time she began consuming alcohol. Although Kelli is the client, the social worker should explain the symptoms and genetic components of depression to Jessie with a recommendation that Jessie may wish to be evaluated herself if she has concerns. Such a referral will likely help Kelli indirectly. Research shows a correlation between improvement in depressed children and concurrent maternal treatment (Swartz et al., 2008). In addition, alleviating depressive symptoms will allow both women to more effectively attend to Zach’s needs.

Kelli has also expressed feelings of isolation and being overwhelmed in her role as a mother. Referral to a program for adolescent mothers would benefit Kelli by exposing her to other young women who have developed skills to manage the stressors of teen parenting. Teen group meetings would connect her to potential support networks and friendships. The programs which would assist Kelli are often small private non-profit charitable entities which offer parenting classes and other health services at low or no cost to the client. Further, such programs can help Kelli to obtain health insurance for her and her child through Medicaid, a state-run program, partially subsidized by the federal government, which assists low-income populations with medical needs, free birth control, and food vouchers. She is not entitled to any government-subsidized financial support because she is under the age of 18.

Kelli will need to complete her high school education if she wishes to obtain a job which can provide an appreciable level of financial support for herself and her son. Some programs offer on-site day care for children while teen mothers attend classes. Alternately, many school districts offer classes on the internet which allow teen mothers to complete their education at home.

Kelli’s case is one that social workers in the U.S. encounter often. The long-term ramifications of teen pregnancy to both mother and child include higher rates of poverty, alcohol and drug abuse, as well as a higher incidence of child abuse. Giving Kelli, her child, and her mother education and resources can minimize their stress, increase functioning, and potentially improve family interaction patterns for future generations.

**Teenage Parents: A Social Worker from the U.K. Responds**

By Emma Kelly

**Prevalence and Incidence**

The United Kingdom (U.K.) has the highest teenage pregnancy rate in Europe (UNICEF 2001), with a conception rate in 2009 of 38.2 per 1,000 girls aged 15–17 and an under-16 conception rate of 7.5 per 1,000 (Office of National Statistics, 2011). In 1998, the government set up a Teenage Pregnancy Unit to
tackle the problem and published the “Teenage Pregnancy Strategy.” The strategy aimed to halve the rate of teenage pregnancies by 2010, and in doing so reduce the range of negative outcomes associated with teenage pregnancy. Ten years on, some progress has been made with a reduction of 13.3 per cent in teenage pregnancies (Department of Education, 2010).

**Country Policies**

Social work responses to children and families in England are determined by The Children Act 1989, which is legislation that prescribes action from point of recognition through to Court-sanctioned involvement and long-term state care of children. Anyone under the age of 18 is covered by the Act, although resource constraints mean that young people between the ages of 15 and 18 are less likely receive support from state Children’s Services (Rees, 2010). The social work role is to work with other agencies to “safeguard children” and “promote their well-being” (Department of Children, Schools and Families, 2010, p. 34). Despite this emphasis on prevention, social work practice in England has long been criticized for only responding to child protection crises rather than earlier intervention work (Laming 2003; Munro, 2011). U.K. social services are stretched due to high referral rates, lack of local resources to support families, poor leadership, and under-staffing (Laming 2003; Munro 2011).

Evidence indicates poorer outcomes for teenage parents and their babies, including higher rates of infant mortality and post-natal depression. Teen parents are also less likely to finish their education and more likely to live in poor housing and have poor health outcomes than their peers (Department of Education, 2010). Coordinated between government departments but delivered locally, the Teenage Pregnancy Strategy aims to counteract some of these negative outcomes (Department of Education, 2010). The multiple strands of the strategy target have increased public and professional awareness and improved sexual health services for young people, as well as free support programs for teenage parents.

**A Social Worker Responds**

A case such as Kelli’s would only come to the attention of a U.K. social worker if there were substantial concerns about the risk to Zach; otherwise the case would be managed by what are known as “universal services” (i.e., services available to all in England and Wales). If Kelli was 15, then a referral to social services would be automatic. But given that she is 16, the Youth Offending Service (YOT) would oversee her court ordered treatment and may decide to manage the case with only health care services. In England, you cannot legally drive until you are 17, so it is possible that Kelli would be facing criminal charges for driving without a license and insurance.

Assuming that Kelli and Zach are referred to Children’s Services, the first action for a social worker would be to check the details of the referral with the referrer, in particularly checking that Kelli was informed of the decision to involve social workers. This open communication regarding referrals is important to build trust with Kelli. A social worker would then arrange to see Kelli and Zach to complete the “Initial Assessment.” This step is the first in a comprehensive assessment process that is set out in the government guidance “Framework of Assessment of Need of Children and Their Families” (Department of Health, 2000). The assessment is based on theories of child development and the ecological model (Jack, 1997) and is commonly referred to as the “triangle” since information is gathered in three domains: the child, the family, and socio-environmental factors.

During the initial assessment, which must be completed within ten days, the social worker would visit Kelli, see Zach, and speak to any other agency involved in their care such as health visiting services. Given that Kelli lives with her mother, it is likely that Jessie would be interviewed, too. If the father of the child has parental responsibility for Zach, which is a set of rights acquired generally at birth, then he should also be interviewed despite being in prison. Part of the social work task would be to distinguish between risks to Kelli and risks to Zach. Clearly, Kelli is ambivalent about being a mother, which is reflected in the paradox of giving up school to care for Zach and then acquiring a part-time job.

On completion of an initial assessment, the social worker has a number of options, including closing the case with no further action, continuing to work with the mother and child, or referring to another agency
for support such as HomeStart (an NGO that arranges for volunteers to visit vulnerable parents at home). Assuming that the needs and risks are significant enough to warrant continued social work intervention, the next step would be to undertake a “Core Assessment.” This is a far more detailed assessment, which takes place over 35 working days and involves all agencies that have contact with the family as well as Kelli.

During the assessment process, the social worker would identify Zach and Kelli’s needs, as well as any potential risks, before making a plan for intervention. Although care plans should be needs-led, the reality is that planning is limited by the availability of local resources. There is also likely to be a mismatch between what a social worker thinks Kelli and Zach need, what Kelli wants, and what can actually be provided. Two core issues need to be addressed: the attachment between Kelli and Zach, and Kelli’s drinking. Both issues potentially place Zach at risk of “significant harm,” which is the legal threshold for child protection intervention in England (Brayne & Carr, 2010).

Kelli clearly has concerns about her parenting, as well as misplaced expectations about her baby’s behavior. To counter this, the social worker would refer Kelli to parenting classes. These classes are commonly held in Children’s Centers, which are non-therapeutic centers located in the heart of communities across England. Children’s Centers provide a range of services, such as childcare, to parents in a geographically-defined area and are generally free of charge. In addition, the social worker would consider if there are other local support groups for teenage parents.

Given Kelli’s concerns about her family history of mental health issues, the social worker should also refer Kelli to Child and Adolescent Mental Health Services to receive free psychotherapeutic support and possibly access Parental Infant Psychology Services, which offer support in building the attachment between mother and child. The timing of these different referrals and services would need to be managed by the social worker to avoid overloading Kelli.

Notably, Kelli’s cooperation with the social worker is voluntary since the support would be offered under Section 17 of The Children Act 1989 which supports children in need. If the social worker and team manager decided that the risks were increasing, then more formalized child protection procedures would be instigated. These procedures could range from a Child Protection Case Conference, where issues of risk and welfare are managed in a multi-agency context, to court proceedings to remove Zach from the home if necessary.

Finally, Kelli would receive support in returning to education or taking up some form of training or employment. This support would be achieved by government childcare funding especially for teenage parents. Recent research found “that 73 per cent of teenage parents said they could not have gone into any learning without Care to Learn support and 75 per cent gained a full or partial qualification from their course” (DoE, 2010, p. 37).

Perhaps the greatest surprise about the English social work response to Kelli is that she may not receive social work input at all despite her and Zach’s obvious needs. Kelli and Zach would only receive a service if there were concerns about risk and “significant harm.”

Case Study #5: Infidelity in a Partnership

By Zoe Lewis & Roberta Erwin

John and Mary are a couple in their early 30s who have been married for seven years. They have one child, who is six months old. They are seeking couples therapy to mend a recent rift in their relationship. Two months ago, John was caught by a police officer having sex with a prostitute. Mary learned of his infidelity when he contacted her from jail. John insisted that this was the first and only time he had ever engaged in extramarital sex. Mary, however, suspected that he was hiding other secrets. She sought out the advice of a social worker, who recommended that the couple seek couples therapy. John initially protested, claiming that he had learned from his mistake. He adamantly expressed his love for Mary and devotion to their marriage, claiming that the recent birth of their first child had left his wife so uninterested in sex that he had been forced to seek sexual gratification elsewhere. Mary acknowledged her lack of libido since giving birth three months ago, but said she was still passionately in love with her husband. She said she felt deeply hurt by his betrayal but was willing to work on their relationship, provided that he commit to monogamy and agree to see a couple therapist. John agreed to be monogamous but doubted the value of therapy,
arguing that they could solve their own problems. He insisted that his renewed commitment would end their conflict. Three weeks later, his wife caught him in their bed with another woman. They decide to see a social worker.

**Infidelity in Partnership: A Social Worker from Ghana Responds**

By Peter Dwumah & Lisa Salma Abubakar

**Prevalence and Incidence**

While infidelity occurs in Ghana, it is difficult to obtain data on its occurrence. This is because infidelity is viewed as a moral issue rather than a criminal and legal one. When it occurs, it is not reported to institutions such as the Department of Social Welfare.

**Country Policies**

There are no government policies relating to infidelity in Ghana. Bigamy is deemed as criminal when the marriage is contracted under ordinance and the culprit can be prosecuted in the courts. Marriage under ordinance is one of the forms of contracting a marriage legally in Ghana. This event is where the customary practices are performed and the couple also registers their marriage at their local Marriage Registry. This kind of marriage is monogamous. A partner can only remarry after a divorce has been granted. There is also marriage under customary law. Here, marriage is more of a union between two families than between two individuals. Three elements of this marriage are the consent of families of both partners, payment of a bride price or dowry, and a marriage ceremony. This form of marriage can be polygynous. There is no limitation on the number of women a man can marry if the marriage was contracted under customary law. Ghanaian society also recognizes marriage under Mohammedan ordinance in the Islamic tradition. The last kind of marriage is one contracted under customary law.

Ghana is a country in West Africa which was called the Gold Coast under colonial administration. It was colonized by Britain in 1902. It gained its independence on March 6, 1957 under the leadership of Dr. Kwame Nkrumah, who became the first president of the country.

Social work as a profession in Ghana began with the development of a social welfare system by the colonial administration of Ghana. There were no social workers in traditional Ghanaian societies. Before colonialism, social problems were solved within the context of traditional systems. These traditional systems were characterized by the extended family with strong family ties, which assured the security of its members. Social problems were solved for the individual by the extended family and society as whole. This orientation of group responsibility, being “my brother’s keeper,” was a value in traditional Ghanaian society.

However, Ghanaian society is not static. Societal changes have occurred as a result of colonialism, formal education, foreign religions such as Christianity and Islam, and technology. The British colonialists brought in what they called “social work” to help solve the problems due to the capitalist economy and broken-down extended family systems. Social work, which is viewed as a helping profession, is a young profession in Ghana and not well established yet. Social work in Ghana seeks to help and empower vulnerable groups in society such as children, women, the aged or the elderly, and persons with disabilities.

The Department of Social Welfare is the government institution which utilizes social workers in Ghana. The Department of Social Welfare runs three main core programs: Justice Administration, Child Rights and Protection, and Community Care. Within the Child Rights and Protection program, workers assume responsibility for adoptions, child welfare services, marriage reconciliation, child custody cases, and rehabilitation of street children. The functions performed under Justice Administration include assisting juvenile delinquents to adjust into society, providing vocational skills or training to illiterate and out of school youth, providing welfare services for prisoners and discharged prisoners, providing care and shelter for juveniles on remand, and placing abandoned and orphaned children for adoption. Within the Community Care program, the Department provides residential care for the destitute, registers persons with disabilities.
A Social Worker Responds

A basis of healthy marriages is the ability to trust your partner. Thus, infidelity is an issue that threatens marriages. The social worker in the case of John and Mary would need to first identify the problem. Identification of the problem means understanding the issue or the occurrence that needs to be addressed. This assessment would be done by interviewing both of them, first separately and then together. Through the interaction with the couple, the social worker would be able to appreciate the views of the clients in relation to the issue. In this case of infidelity, the social worker would be able to ascertain the views of John and Mary in relation to the issue. He/she would then help them decide what they want to do. Social workers should not prescribe solutions, but instead help the clients arrive at legally acceptable ways of addressing their issues. Sincerity of the couple is important if the social worker were to be able to help. In other words, the couple has to be honest and state what they really think or feel. This information would be very helpful to the social worker in devising appropriate interventions. He/she can then propose a visit to the couple to provide support in addressing the problem.

The lack of interest in sex acknowledged by Mary may be because of the fear of becoming pregnant again. The social worker could inform the couple about available family planning methods including the use of condoms, pills, injections, a vaginal ring, intrauterine devices, the diaphragm, or hormonal implants. With the exception of condom usage, the main issue of concern for these approaches in Ghana is the fear that it may have an impact on the couple’s ability to bear children in the future. The couple would be encouraged to use any of the methods that serve their purpose to reduce the likelihood of pregnancy. The social worker can educate the couple about dealing with their fears. The interview with Mary would help the worker to understand the cause of her lack of interest in sex. On this basis, he/she would assist Mary to develop an interest in sex again, by educating her on the implications of her behavior. The implications of Mary’s lack of interest in sex include the extra-marital affair of John, the possibility of contracting sexually transmitted infections such as HIV, and tension in the marriage and its effects on the child’s upbringing. Mary could also be referred to a medical doctor to help her deal with the problem of lack of libido.

The social worker would help Mary through counseling to let go of her sense of betrayal by John. Depending on the severity of the impact of the infidelity on Mary, there may be referrals to other professionals who may be of help such as psychologists.

The social worker would also educate John on both the health and economic effects of engaging in acts of infidelity since it has implications for John himself as well as the marriage. She/he would help John develop a consciousness about the effects, such as contracting sexually transmitted infections and creating tension in the home which impacts on a child’s psycho-social development. The social worker could also help John to appreciate the marital institution as well as maintaining the sexual sanctity of marriage, which could be done through education. An appropriate understanding of marriage would reduce the tendency of engaging in extra-marital affairs that have the potential of ruining the relationship and negatively impacting the child and other people. However, it is important to note that even though a social worker can counsel Mary and John, they are more likely to work through their conflict using elders in their extended family or religious leaders in their community.

Infidelity in Partnership: A Social Worker from Austria Responds

By Michael Klassen

Prevalence and Incidence

In Austria, less tolerant attitudes towards infidelity exist than in other countries, which may be traced to Christian Catholic teachings on marriage and sexuality. In the 24 largely Western and industrialized
countries in the 1994 International Social Survey Program, most people stated that extramarital sex was “always wrong” (Widmer et al., 1998, p. 352). Sixty-seven per cent of Austrian respondents condemned extramarital relations as being always wrong, a figure comparable to other conservative Catholic populations in Europe such as in Spain (76 per cent), Italy (67 per cent), and Poland (74 per cent). On average, only 4 per cent of respondents believed that extramarital sex was “not at all wrong.” Moral judgments in most European countries clearly continue to support sexual exclusivity between husbands and wives.

**Country Policies**

Most European countries, including Austria, have decriminalized adultery. Most couples who marry in Austria do so with the expectation of fidelity. Infidelity in partnership is often seen as a breach of trust and commitment that had been made during the act of marriage. Infidelity in partnership can be emotionally traumatic for both spouses, and often results in divorce. Children of divorcees in Austria are more likely to have social problems and end up in poverty. If infidelity in partnership leads to divorce, it also carries higher financial burdens in Austria since living expenses and taxes are generally cheaper for married couples than for divorced couples.

Social work in Austria is considered an independent discipline which is focused on uncovering, explaining, and solving social problems in the society. Social work has been taught in professional schools for over 60 years, but only recently (from the beginning of the twenty-first century) was social work education at Bachelor’s and Master’s levels established across the country. Notably, there is still no Doctorate in Social Work in Austria. Thus, social workers seeking a doctoral degree have to enroll in other related PhD programs such as sociology, political science, or psychology. Social workers in Austria are particularly skilled in problem analysis and the case analysis below is presented to illustrate this. The counseling described here would likely be provided in Austria by social workers as well as professionals from other disciplines such as psychiatry or psychology. Professional fields for social workers in Austria typically include the following areas: work with youth and families, work with the elderly, work in education and other professions, work with delinquency and rehabilitation, work in health care (disabilities, addiction, psychosomatic, and chronic problems), provision of basic welfare services, and/or work with immigrant issues and integration services.

**A Social Worker Responds**

Systems theory plays a major role in Austrian social work practice. There are two system-theoretical approaches that are prevalent within the German-speaking academic community of social work. First, there is Niklas Luhmann’s theory of social systems (Luhmann 1987, 1997), and second is Mario Bunge’s systems theory with Silvia Staub-Bernasconi (1995, 1998, 2000), Werner Obrecht (2000), and Kaspar Geiser (2000). In Austria, the social systems theory as developed by Mario Bunge (1996, 1998) is considered to be the most appropriate approach within the theoretical and practical fields of social work.

Bunge describes a social system as “a concrete system, which is composed of social animals. These animals (a) share a common environment and (b) interact with others members of the system in cooperative ways. A human social system is a social system which is composed of human beings and their artefacts” (Bunge 1996, p. 271). This systems theory approach provides the foundation for understanding the case analysis.

Social work’s focus is on social problems, their determinants and consequences (Geiser, 2000; Obrecht, 2000; Staub-Bernasconi, 1995, 1998). Social problems imply that either the problem itself has a social dimension, such as unemployment or isolation, or the problem results from a social mechanism, such as unequal access to education or the result of repression. Pursuant to Staub-Bernasconi (1983, 1995, 1998) and Geiser (2000), the following problem dimensions can be identified: (a) skills and accoutrement problems (being “equipped” with a certain wealth, health, race, gender which might worsen certain social problems); (b) inter-exchange problems (problems between individuals); (c) power problems; and (d) socialized values (criteria problems). These problem dimensions are described in depth and applied to the case below.

Skills and accoutrement problems are connected with the different participation of individuals in health-related, medical, mental, social, and cultural resources of society. Staub-Bernasconi (1998b) specifies several
dimensions of skills and accoutrement which are relevant for this case. First, Staub-Bernasconi identifies
the physical accoutrement, with attributes like health, integrity, sex, age, or skin colour. In the given case,
there is certainly a problem in sexual needs as perceived by John and as experienced by Mary. Staub-
Bernasconi also identifies the socio-economic (education, work, income, property) and socio-ecological
accoutrement (accoutrement of the particular context, for example of the specific housing area). In terms
of the socio-economic accoutrement, John's sexual contact with a prostitute and another woman may be
driving financial resources away from his family.

Staub-Bernasconi defines the symbolic accoutrement as the ability to use terms, statements, and state-
ments-systems. In this respect, a social worker could analyze the fact that John apparently succeeded in
convincing his wife by arguing that the couple could solve their own problems without professional help.
Staub-Bernasconi also defines the accoutrement with decision-making and responsibility. A social worker in
the counseling setting could address this issue by asking clients questions pertaining to who makes decisions
in the family, how that is done, and what responsibility means to both of them?

Regarding inter-exchange problems, Staub-Bernasconi (1995) asserts that these are “problems of
asymmetry, give and take, and therewith inter exchange relationship which is not based on mutuality”
(p.106) [translated by the author]. The problems described in this case are certainly inter-exchange
problems. The relationship of John and Mary is not based on mutuality since John did not seek a conversa-
tion with Mary about his sexual needs before the infidelity and therefore did not give her a chance to deal
with the situation on a mutual basis.

Regarding power problems, individuals stand both within a social system and between social systems, in
vertical and hierarchical relationships respectively. The availability of powerful resources is, together with
the roles and social positions of the resources, crucial to determining whether they stand in a position of
power or of powerlessness (Geiser 2000). In the case of John and Mary, much intrafamilial tension arises due
to John’s infidelity. It seems that John is in a more powerful position in the family since initially he was able
to persuade Mary not to seek professional advice while proceeding with his infidelity. It is also important
to determine whether Mary is financially dependent on John since this could also be a power issue, as John
controls financial resources and Mary may not be able to leave him.

Regarding socialized values and criteria problems, all human beings are able to process, in a cognitive
manner, their real existence, so that they can create their individual and common perception of the “good”
as the favored state. These perceptions or semantic systems are values. Values can become part of a culture
or sub-culture if they are shared by all, many, or some people.

John claims a right for himself to be an autonomous person with his own sexual needs. This value appears
to be in conflict with the value of a monogamous relationship. A social worker may emphasize in a counseling
session the existence of these needs (autonomy vs. relationship), which might seem incongruent but can be
resolved in other ways such as infidelity. Challenging the non-fulfilment or disrespect of already existing
criteria and accordant norms such as fidelity in partnerships, a social worker would point at infidelity in a
partnership as disrespect for already existing criteria for trusting couples’ lives. The value of John's autonomy
and freedom would probably be of no relevance to Mary if she decides to engage in similar behaviour. A social
worker would share this insight with John in order to achieve his understanding of the situation of Mary.

All these analyses could be undertaken by a social worker within counseling sessions with a hope that
insight and understanding of underlying issues of infidelity in the partnership will result in a resolution of
the problems.

Case Study #6: Physical Violence within a Marriage

By Moises Prospero

Sara and Ron live in a working class neighborhood with their three children, ages three, five, and nine.
They are both employed and have grandparents assisting with childcare while they work. Although this
helps financially, they struggle to pay the monthly bills. The couple recently bought a new family van, but
shortly after the purchase Ron received a pay reduction at work due to company hardships.

Sara and Ron get along fairly well with the neighbors who also have children approximately the
same ages. At least once a month, they invite three other families to join them for an all-day cookout in
their backyard, where they eat different dishes that each family contributes, and drink beer and liquor. Occasionally, Sara has a bit too much to drink and begins to pick on Ron for not having a better job to buy "good stuff" like their neighborhood friends. He generally ignores her but gets visibly agitated when she makes fun of him in front of his friends.

One evening, Ron gets home from work before Sara and begins to listen to the phone messages. The second phone message is for Sara from a man named George, stating that he has to cancel a scheduled lunch. Ron gets angry that Sara is having lunch with another man and confronts her as soon as she walks into the house. She tells Ron that George is a coworker and they were planning to have a working lunch for a project that they are both responsible for completing. Ron does not believe Sara and starts yelling at her and accusing her of infidelity. Sara gets angry and starts yelling back at him, telling him that he is exaggerating and he should go and pick up the kids from their grandmother's house before it gets too late. Ron yells at Sara, "You are a whore and I'm sure that you are having sex with the whole neighborhood!" Sara yells back at him, "If I am having an affair, it's because I want to be with a real man who can give me what I need, what I deserve!! You are a loser Ron, that's why I don't ever want to have sex with you." Ron grabs Sara by the shoulders, faces her, and yells at her to shut up, but she continues to ridicule him in his face. Ron throws Sara to the couch and is about to leave the room when she grabs a small lamp and throws it at him, hitting him on the head and the lamp falls to the floor and breaks. Sara chases him to the bedroom where Ron tries to slam the door behind him but instead the door hits Sara in the face and she gets a bloody nose. Sara continues calling him a loser and Ron continues calling her a whore. Sara begins to slap and scratch Ron and he again grabs her and throws her to the floor. Sara gets up and charges at Ron. Ron punches Sara in the face, and then jumps on top of her to hold her down. Suddenly, they hear loud knocks on the house door. It is the police. The neighbors had heard the fighting and called the police. This is not the first time Sara and Ron had had loud yelling arguments, but it was the first time that they actually became physically violent.

Physical Violence in a Marriage: A Social Worker from Mexico Responds

By Isabel Teresa Molina

Prevalence and Incidence

By 2003, there were only ten shelters for female victims of family violence and their children (CIMAC, 2003). In 2010, three years after the Live a Life Free from Violence Act (LGAMVLV) was implemented and two years since its regulatory framework was approved, there are only 14 shelters (CIMAQ, 2010) for female victims of family abuse. Adult male victims cannot stay in these shelters.

Due to international migration dynamics and an increasing divorce rate, over 35 per cent of Mexican households are headed by a female parent. Mexico is a developing economy with high female labor force participation with 43 per cent of women involved in 2009 (World Statistics Pocketbook, 2010). Single female parents and their children are easy targets of abuse by temporary step-parents. There are no studies addressing the etiology and epidemiology of these cases.

Country Policies

The Mexican Constitution (1917) and the Federal Civil Code (1928) give equal rights and authority to men and women in the household. This legal equality does not reflect social and economic differences between men and women. For the most part social and economic inequality prevails, giving a better economic and social position to men.

LGAMVLV was enacted in January 2007 (Diario Oficial de la Federacion, 2007), and the regulatory framework to enforce the law was officially published on March 11, 2008 (DOF, 2008). It is likely that new social services to prevent, treat, eliminate, sanction, and eradicate family violence will emerge in the near future. For now, family violence is a private matter, in which victims need to develop their own strategic
Cases Studies and Analyses for the Web

and coping mechanisms. The National System for Integral Family Development (Sistema Nacional para el Desarrollo Integral de la Familia) is a public institution of social assistance whose goals are strengthening and developing the welfare of Mexican families, and which has the responsibility of providing protection for vulnerable family members. The Social Welfare Law (Ley de Asistencia Social, 2004) states that “individuals and families, beneficiaries of the social welfare system, based on their abilities, will participate in the social welfare processes of training, rehabilitation, and integration. Other family members are co-responsible for this participation and its benefits” ().

A Social Worker Responds

It is difficult to imagine this hypothetical case as a typical domestic violence situation in Mexico. Social and economic gender asymmetries, favoring males, are the typical situations in Mexico. Men are more likely than women to display violent and antisocial behaviors in Mexico, including drinking and being physically violent against their partners in heterosexual intimate relationships. Individual, nuclear, and extended family, as well as socio-political and institutional responses are framed by these asymmetries. These responses favor women and children above men when it comes to intervening to protect them from their male partners, but equally prevent victims from laying legal charges for fear of retaliation by male aggressors. Gender roles and social norms in Mexico would not allow Sara to drink in front of Ron and their children, and make fun of Ron’s low income in front of his friends. Typically in Mexico, if Sara were frustrated by Ron’s lower income, it would be more likely that Ron will become aggressive to Sara. If she should make fun of Ron in front of their friends, he would be socially justified to retaliate and become abusive toward her.

It would be possible for her to become capable of making more money than Ron, in which case she would be careful not to boast about it, for similar reasons explained above. It is dangerous for a woman in Mexico to make fun of her intimate male partner. In an extreme case, she could become verbally abusive with him, but not in public. If she does not respect his masculinity in public, she would be increasing the likelihood of him becoming physically violent with her, in addition to him cheating on her to reaffirm his masculinity. Thus a case in which she hits him intentionally with a lamp, and he then hits her unintentionally with the bedroom door is not typical in Mexico. In addition, when a marital dispute evolves into violence that is audible and visible to neighbors, it would be uncommon for those neighbors to call the police. Family violence in Mexico has been normalized and often is invisible.

Similar to the U.S. family violence dynamics, a limited number of family violence cases can be considered intimate terrorism cases (Johnson, 1995, 2000). Nevertheless, family violence in Mexico, while not fatal in all cases, has pervasive and traumatic consequences, and can be hierarchical. It runs from older males to younger females and younger males; and from mothers and fathers to children. Sometimes there is physical violence from children to parents, when the latter are dependent and have a history of being violent toward their children.

Social workers’ interventions with family violence are almost nonexistent in Mexico, and family violence crimes are mostly accounted for by Amnesty International studies (2008), pieces of news published by a national women’s non-governmental news organization, Comunicación e Información de la Mujer A.C. (Women’s Information and Communication Civic Association, CIMAC), obituaries, the red crime page, or in hushed tone conversations. Political and social attention to intimate partner violence has emerged recently in Mexico for political reasons. In fact, due to the feminine vote, Ernesto Zedillo, PRI candidate, became the country’s first female president in 1994 (Molina, 2009).

Since men and women are responsible for reducing the level of violence in their intimate relationships without secular intervention, couples tend to resort to consultation with their extended families and religious leaders, often seeking advice from Catholic priests. The Catholic hierarchy is not homogeneous. In some states, like Oaxaca and Morelos, Liberation Theology priests have contributed to women’s empowerment, whereas conservative priests, in states like Jalisco and Guanajuato, promote the submission of women to men’s authority. Few couples will seek professional assistance from a counselor or psychologist. Social work agency professionals in Mexico seldom provide mental health services (Viñas-Velásquez & Fernández de Juan, 2007). They are mostly case managers in charge of determining applicants’ eligibility for social assistance/services, working at the Integral Family Development agency.
(DIF), and more recently in the National Women’s Institute. Contrary to the family phenomenon of mobility in more high income countries, few Mexican individuals move to cities far from their extended family residences. This limited family mobility allows men and women to contact their elders for advice and support. Intimate partner violence can be significantly reduced if it is disclosed to an older family member. A case such as the one described here would most likely follow this pattern—partners are advised to reconcile their differences, forgive, and respect each other. If a case developed to include police intervention, police officers would not enter the house. They would verbally admonish both partners to stop fighting, advise them (especially the woman) that they can go to the local DIF if they cannot handle the matter peacefully, and leave the couple alone. Members of the extended family would be involved, and partners would try to stop insulting each other and having outbursts of physical violence. In cities and rural areas in Mexico, it is typical for extended family members to assist with childcare so that physically capable male and female adults can contribute to the support of the extended family. Mexican society and the Mexican government are family-oriented. Family homes are considered private spaces, into which the police cannot enter without a warrant except in the case of a flagrant crime. Family disputes are considered to be private matters, regardless of the Mexican government’s adherence to multiple international treaties to protect women, elders, and children. Shame and guilt form a dense barrier to social workers’ interventions in family disputes. Only if one of them decided to go to DIF local offices would a social worker become involved in counseling either or both of them to make changes in their behavior for the sake of keeping the family together. Most cases go judicially unreported, and thus are not prosecuted.

Physical Violence in a Marriage: A Social Worker from Botswana Responds

By Tobokane Manthai

Prevalence and Incidence

There is a lack of data on various forms of violence (World Statistics Pocketbook, 2010), but domestic violence against women remains an issue of concern. The national police force is training officers to be more responsive in handling domestic violence problems. Although the government is tougher in dealing with criminal sexual assault, societal attitudes toward other forms of domestic violence remain lenient. Half the murders of women are linked to histories of domestic violence and human rights activists estimate that six in ten women are victims of domestic violence at some time in their lives. Rape is another serious problem, and the government acknowledged in 1999 that, given the high incidence of HIV and AIDS, sexual assault has become an even more serious offense. Police are rarely called to intervene in cases of domestic violence. Reports of sexual exploitation, abuse, and criminal sexual assault are increasing, and public awareness is growing. Under customary law, and in common rural practice, men have the right to “chastise” their wives. Women in Botswana do not have the same civil rights as men. A woman married in “community of property” is held to be a legal minor, requiring her husband's consent to buy or sell property, apply for credit, and enter into legally binding contracts. A 1999 study of rape by the Botswana police revealed that laws do not address the issue of marital rape.

Country Policies

According to UN Botswana (2000), development policies, such as the 1996 National Policy on Women in Development, the National Gender Program, and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), continually support initiatives empowering communities to address women’s issues and promote a sense of ownership and gender mainstreaming activities. In 1996, the government promulgated the National Policy on Women in Development aimed at addressing the situation of women in Botswana through an integrated and multi-sectoral approach. It focuses on elimination of all negative economic and socio-cultural practices as well as inappropriate
laws that maintain forms of inequality and inequity between women and men. The Revised National Policy on Education (1994) provides that all children should have access to ten years of basic education (UN Botswana, 2000).

The Constitution and penal code of Botswana forbid discrimination based on color, race, nationality, or creed, but do not mention discrimination based on gender. In fact, political, social, and economic opportunities for women are restricted by a number of laws and customs. For example, women married under either common law or customary (tribal) law are subject to practices in which wives assume a legal status equivalent to the husband's child. Essentially, this means that a woman may not make a legally binding agreement without her husband's consent or assistance. Traditionally, males have a mutual obligation to support and provide for their families whilst wives are domestic “keepers” and child care providers. Since marital problems are considered to be an issue to be dealt with between the husband, wife, immediate family members, or the clan, the police are reluctant to intervene. Usually problems are settled through the extended family, and as a result, few cases of domestic violence ever go through the legal system.

**A Social Worker Responds**

When a case is reported to authorities, a multi-agency response is usually planned in domestic violence cases. Traditionally, it may be possible to persuade the violent partner(s) to leave the family home for a time while an assessment is undertaken and interventions are planned (wives/women are usually sent back to their birth families whilst the issue is being attended to and only come to their husband’s/in-law’s home for hearings). The social worker works with both families to amicably address the matter at hand.

Social workers share responsibility with other service providers in addressing the matter to ensure collaborative and coordinated responses among family, community, and legal system and to obtain precise information about the predictability of domestic violence in the family. Some social work interventions fail to address domestic terrorism and are criticized for the lack of informed decision-making regarding cultural and gender differences. Furthermore, the social service system has been condemned for lack of collaborative approaches to challenge and reshape solutions to a particular context of culture and community in which the case is addressed. Holistic communal/professional approaches are designed to (a) make the best of local experience and knowledge, and (b) help social workers realize their political, economic, and community goals in addressing domestic aggression.

My professional reflections about previous cases of domestic violence indicate that more attention needs to be concentrated on understanding the dynamics of domestic violence. The focus should be on the factors that perpetuate domestic violence, the availability of support resources, and the clear and consistent documentation of experiences/cases as reported by survivors. These guidelines would help professionals develop pragmatic and responsive treatment plans to combat domestic violence in a culturally appropriate manner.

Tribal definitions, understandings, and approaches create difficulties for intervention in family violence in Tswana (local culture) communities. There are two elements of domestic violence inquiry. First, there are the structural arrangements whereby public sector institutions operate as systems of social control to protect and address inequalities that exist in the society. Second, there are the family/communal/kinship structures that need to be taken into account. The latter are comprised of men and women who, by virtue of their marital and social status, have the capacity to protect and preserve peace and tranquility within marriages. Although this may be a representative manner of equally involving men and women, large gender and power disparities exist whereby males are more influential than females in making decisions to address the matter at hand. Mediation is done through a series of family, community, and legal consultations to resolve domestic violence. Women are usually blamed for minimizing whilst males are known for magnification of the issues at hand. These behaviors are believed to stem from the socialization of women to be submissive, and from traditional sayings like “women should be seen, not heard,” whereas “men are allowed to moderately chastise their wives and children as a form of discipline.” There is no defined measure of “moderate” in such instances.

The case of Ron and Sara combines concerns for the safety of the children; learned behaviors by the children that mirror both parents’ violence towards each other over time; power and control issues; societal, institutional, and structural demands and influence; and structural contribution to the reported domestic
abuse. A social worker would engage with both parents, in conjunction with the legal system and the law enforcement agency (police), for assessment, with the main objective of prioritizing the issues and protecting the vulnerable (in this case, the children). Contact would be made with the paternal grandmother (who is the regular caregiver and close relative/family member) to understand the family dynamics and clarify the details. It is imperative that the social worker not compromise the children's safety or that of other intervening parties.

The social worker's duty is to work with health and education services. Information would be obtained from the children's schools by contacting guidance and counseling teachers and interviewing the children. Ideally the children would be seen in school away from the home environment and without the parents.

Decisions and interventions depend on the responses from the children and the parents. The decision as to when to involve caregivers needs to be carefully considered. Children may experience emotional harm at some level and they may also be at risk of physical harm. The social work professional conducts a safety assessment. If parents do not require support in safeguarding their children, then child protection procedures may not be necessary since family interaction and relationships will be assessed and monitored.

Moreover, both parents can equally seek support to change their behaviors from various organizations such as Childline Botswana (where parents who believe that their past trauma/violence experiences may affect their parenting skills seek assistance, and/or where children may be customarily or statutorily placed in foster care or in residential care) and/or The Women's Shelter (a place where abused women and their children are given temporary refuge). Based on the available information to make early judgments without compromising the safety of the children, and while considering the best interest of the children and preserving families before placing any family member in the above mentioned organizations, the social worker often makes discretionary decisions.

Social work professionals assess, observe, and watch for signs of distress. They also provide empathy, use active listening, and communicate with minimal criticism and judgment. The professional would work with Sara and Ron to offer some form of (usually brief/solution-focused) counseling using the contemporary human behavior theoretical approaches (this may be individual/family/group counseling) and provide services to the children as well.

**Case Study #7: Parenting Disruptive Children**

By Joanna E. Bettmann

Joseph and Eva have two sons (Sam, age seven and Henry, age 12) and stay in a rural area. They live in a farmhouse with Eva's mother and father. Everyone helps out on the farm because it is difficult and exhausting work. The business is constantly on the edge of financial collapse as market costs for goods keep changing. Joseph's family, including his three sisters and their families, live in the next community, where they also have farms and small businesses. All the families spend a lot of time together. Joseph and Eva's children love being with all their cousins, aunts, uncles, and grandparents.

In the last six months, things have become strained. Sam is having a difficult time at school and he has begun acting out at home. Instead of playing nicely with his cousins, Sam recently gave his cousin Edward a black eye after a particularly rough children's game. He often tells his mother that he won't follow her rules, waiting until his father arrives and sets very firm boundaries about bedtime, homework, dinner, chores, etc. Sam used to be a very easy child to get along with, but recently he has been starting fights at school, with his cousins, and with his brother. He barely follows house rules and his parents are confused. Sam’s older brother Henry is a very compliant child, and Sam used to be like that but not anymore. Now he shouts at people and occasionally is rough with his mother. Sam’s parents are worried that his aggression and acting out seem to be getting worse.

Sam’s parents have asked for guidance from their parents, their minister, and their aunts and uncles, but Sam has not responded well to anyone's advice. Sam’s parents and grandparents come to the social worker’s office asking what they can do with their disruptive child.
Parenting Disruptive Children: A Social Worker from Germany Responds

By Mareile Nganunu-Kroening & Katrin-Maria Berger

Prevalence and Incidence

Different forms of behavioral problems in children are quite common in Germany. A study conducted in 2004 shows that approximately 13–17 per cent of children and youth in Germany experienced behavioral problems that were regarded as critical (Losel, 2004).

Country Policies

Whilst Germany is regarded as one of the richest economies/nations in the world, it was not spared by the recent global economic crisis. Germany is a “Sozialstaat” (social welfare state) where basically the government takes major responsibility/guardianship for the welfare of its people. Provision of socio-economic assistance entails an extensive grant and financial support system that is expensive and always victim to cutbacks in national and local spending. On the other hand, in a context of relatively high unemployment rates as well as other global influences, availing and financing social services become increasingly important as a vast number of people require such services.

The legal foundation for social service provision in Germany is provided in the “Sozialgesetzbuch,” a law specifically governing matters of social service provision. Although the profession of social work is still viewed as the domain of those lacking in academic powers, the number of professionals acquiring specialized qualifications and their participation in multidisciplinary work groups has led to greater acceptance in recent times.

A Social Worker Responds

A German family in the given case scenario is unlikely to initiate any call for assistance, but is more likely to not do anything or to simply play down the behavior as part of puberty. At most, the parents may consult a parenting manual. The family may seek a referral from the family doctor to a psychologist in order to attempt to establish through tests whether there is any psychological/medical cause for the described behavior. In Germany it is the office of the Allgemeiner Sozialdienst (ASD) (governmental social service department) that provides counseling, information, and referrals to children, youth, and parents in problem situations. ASD workers are accessible in different localities and assistance can be sought telephonically or through direct contact.

If it opts to voluntarily seek assistance, this family can make use of a specialized service called “Erziehungsberatung” (parenting counseling), which is one of the services offered by ASD. This service is advertised through the internet and invites families to seek free, confidential, psychological counseling for any parenting difficulties experienced. The counseling would guide parents on how to build better relationships with their children, sensitize them about children’s specific developmental needs, and guide them as to how to manage challenging behavior, helping them to foster healthy social behavior in their children and to discipline them appropriately.

The clients in this case can also go to the ASD (during office hours) and apply for more in-depth and long-term assistance for a maximum period of two years. In more serious cases, longer periods of time may be approved. The worker initially establishes whether there is any concern about the immediate safety of the child. If there is, information will be passed on to the relevant sources, which is the respective social worker’s employer or another specified ASD worker. In such cases, removal of the child and alternative placement will be considered, but as it is an expensive option this is often avoided. If there is no such concern, different options for help are considered.

One of these is “Sozialpädagogische Familienhilfe” (social-educational family assistance) which is offered if the family system is causing or sustaining the problem. This service is usually offered by non-governmental
service providers to whom this mandate is outsourced and who are obliged to report to the ASD at regular intervals. It is social workers, social education workers or educationalists who conduct this type of work. Often families prefer to approach these professionals directly as they fear that the ASD might remove the child from their care. This measure is granted for a certain number of hours during which the worker helps the family to identify sustainable solutions to their problems. Reports are written every six months and these determine continuation or termination of assistance. The approach is child-centered, systemic, and resource oriented.

During assessment conducted by two ASD workers it is important to establish whether the problematic behavior is a consequence of family interaction and therefore requires systemic help, whether it is symptomatic and needs to be treated medically, or whether its cause lies outside the family. He/she would look at the family system with the child at its center but take note of the child's multileveled environment. The worker would formulate child friendly goals and objectives and establish a working relationship with the young person. Sessions would take place two or three times a week, and would also include roundtable discussions with concerned parties.

However, it is thought that this case would probably not qualify for family assistance, unless the school or other institutions outwardly complain about the behavior of the child. The case may possibly be granted “soziale gruppenarbeit” (social group work), which is also most commonly offered by a non-governmental service provider. This measure entails work with a group of children/youth where social behavior is learned and practiced, and healthy social habits acquired. Two social workers or social education workers facilitate this group work, and the training takes place once or twice a week for two to three hours in the afternoon. If there is a case where a young person has serious individual problems, or where the family no longer has any influence over them, then this person can be accommodated individually through a measure called “Einzelfallhilfe” (case assistance).

Parents would also be encouraged to enroll their children in supervised spare-time activities, many of which are available in different forms. Such peer activities would also help the child to operate effectively and independently in a social context which, in the case of an isolated farming family, is important.

Parenting Disruptive Children: A Social Worker from Botswana Responds

By Ivy Gosego Mmeanyana

Prevalence and Incidence

Many Botswanan families face problems with children of Sam's age and older. There are no exact statistics to show the prevalence of disruptive children because it is a household issue, and as a result cases are seldom reported. However, in one agency that deals with children and their families, it is shown that behavioral problems make up 21 per cent of the cases received (Childline Botswana Annual Report, 2008/2009). There is also evidence, even though it has not yet been documented, that there are a significant number of disruptive children in the society. The Government of Botswana was at one point worried about the moral fiber that seemed to have been lost which led to a commission on moral decay being formed in 2008.

Country Policies

In the traditional Tswana family support system there has always been a protocol of communication whereby, when a mother has a problem with one of the children, she would tell the child's father and the issue would be discussed among the nuclear family, failing which the extended family or the village leadership would be delegated to do so. Nowadays the traditional support system has, to some extent, broken down and professional social work has been established in the state and non-government community.

In dealing with cases of disruptive children in families, social workers are influenced by culture, social work theories, and state policies. Policies related to child welfare in Botswana include the Children's Act of 2009, No. 8, the Adoption of Children Act 1952, 28:01 (in the process of amendment), and the National
Plan of Action for Orphans and Vulnerable Children (2010–16)—all of which focus on the best interest of the child.

A Social Worker Responds

In Sam’s case, a social worker would start by obtaining the client’s personal information and data on the presenting problem from the parents, the child, and later the school, close relatives, siblings, and friends to support a systems approach to the matter. After a close assessment of Sam’s behavior, a social worker would identify major factors that could help in understanding the issue. According to Erickson’s stages of development, Sam is at the industry versus inferiority stage. Children at this stage become aware of themselves as individuals (independence) and may work hard at being responsible and “doing it right.” In addition, they recognize their cultural and individual differences and form moral values. To express their independence they may, like Sam, become disobedient, using “back talk” and being rebellious, hence the need for parents to reinforce good behavior and challenge that which is negative. Furthermore, at this stage there should be encouragement and praise for accomplishments at school and home. With Sam’s current behavior, it is difficult to keep showering him with praise, and inevitably he will receive punishment, be ridiculed, and compared negatively to other “good children” such as his brother or a friend. This results in Sam feeling inferior and hence, to regain his power, he may act aggressively towards other children and his mother whom he feels has less power. However, he may obey his father, whom he perceives as a dominant force. Sam’s behavior may also be seen as a sin by the family’s pastor who may influence Sam to ignore his approach as it adds to his feeling of inferiority.

The family’s economic downturn has had a negative effect on Sam and his environment. It is inevitable that the elders in the family and in the community are stressed, and the child has picked up this tension causing him to feel angry, guilty, and distressed as suggested by his aggression and refusal to perform home chores. He may not know of other ways of reacting to the tension he is feeling because he is a child and, unlike adults, has limited methods of responding to stress.

In many cases in Botswana, especially in rural farming areas, parents usually have a closed communication pattern with their children. This pattern could mean that children talk only when talked to, and the necessity of discussing issues with a seven-year-old like Sam is out of the question. This failure to explain issues results in children being confused and not knowing who to turn to when they are hurt or when they see their parents under stress: “mogolo ga a bodiwe a o tsogile” which denotes that a child cannot ask an adult how they are. Another important point is that Sam gives respect to, or fears, his father more than his mother. This feeling can mean that there is a gap or lack of consensus between mother and father of which Sam is taking advantage.

Intervention related to the child’s developmental stage will include an explanation to the parents of what the child is going through and sharing of information on how to handle a child at Sam’s level of development. The parents will be encouraged to give praise in appropriate measure and to set clear limitations and consequences for behavior. A social worker would also discuss this issue with the teacher at school and suggest that he/she incorporates Sam’s issue in one of the class lessons. This exploration would be done as a general topic so that he does not feel that the teacher is talking about him.

The child may also receive training in social skills to help him to gain new problem-solving and coping abilities, accept failure or rejection, learn how to manage anger more effectively, and better relate to others even in times of frustration. There are games that are usually played to encourage good social skills—for example, “follow the leader” and “Yo na ke mang?” (Who is this?). In the game of “follow the leader,” 12–15 children make a circle and the leader runs in the middle of the circle performing acts like dancing, laughing, or making faces with the other children following suite. If anyone fails, they take the center spot and do the same until everyone has taken part. In this game, the children take turns at introducing one another, helping them to learn to follow rules and better understand and tolerate others. The teacher will observe Sam’s cooperation during the games and report to the social worker on his progress.

As communication between parents and child is not positive in this case, the family and the social worker will work on improving the situation. The parents have to revisit their parenting skills and ensure that they both agree on how they will raise their children and their consistency in dealing with both children.

Parents will also be empowered to more openly communicate with their children. If they know that lack of openness is somehow linked to Sam’s disruptive behavior, the parents are likely to start talking to him
and including him in relevant decision making. Consequently, if Sam understands his parents’ situation, he is more likely to listen, be cooperative, and return the favor by talking with them rather than acting out.

Parents and close relatives will be encouraged to display patience, firmness, and unconditional love and support to the children. A parent support group might be formed by the social worker to provide ongoing assistance even after termination of the case.

In rural areas or village settings in Botswana, a disruptive child might be disciplined physically by older family members or at the Kgotla (customary court), and social workers would get involved in a more superficial manner. In urban settings, a professional organization like Childline would offer counseling to the child and their family. There may be the use of play therapy to assess what the child is feeling, which will assist the social worker to deal with specific emotions and their root causes.

Case Study #8: Parenting an Adolescent

By Nicki Kartozian & Melissa Ward

Greg and Lucy come to the social worker's office after their 16-year-old daughter, Mary, has been in a physical fight at school and consequently expelled. They state that Mary has a history of defiant behavior. This event is not the first time the school has had to take corrective action. Mary has frequently had conflict with multiple teachers over the years. One of these conflicts escalated to the point where Mary needed to be physically restrained because she was trying to hit her teacher.

Greg remembers Mary's problems with aggression starting when she was around the age of 12. He says that she mostly made verbally aggressive remarks then, but that these have now progressed into physical violence with her siblings, peers at school, and occasionally teachers. The parents share that their attempts at punishing Mary have failed. They have tried taking away privileges, such as spending time with friends, but she disregards their rules and does whatever she wants. It seems to her parents that she does the exact opposite of what they want and expect from her.

An additional issue that the family reports is their lack of communication. Any attempts to talk with Mary about her behavior leads to yelling and screaming. Lucy admits that talking with Mary is extremely upsetting and that she often walks away when she can no longer deal with her daughter. She reports that she does not know what to do to control Mary's behavior or how they can return to having a healthy relationship with one another. Greg and Lucy are particularly concerned about Mary being home alone because of their work schedules. They are both working two jobs; therefore, there is little time to spend as a family and the time they do have is spent arguing and criticizing one another. Greg and Lucy's hope in attending family therapy is to gain more effective parenting skills and to improve the family relationships.

Parenting an Adolescent: A Social Worker from Botswana Responds

By Odireleng Jankey

Prevalence and Incidence

The incidence of children with defiant behavior is not clearly documented in Botswana. However, the Children's Act no. 8 of 2009 recognizes that there are children who are in conflict with the law. Mary's involvement in a physical fight with the teacher could be classified as an assault that may need police or court intervention, hence the expulsion of Mary from school.

Country Policies

In Botswana, the Revised National Policy on Education (1994) does not allow a child who has been expelled to be absorbed into any government school. In the context of Botswana, at the age of 16, young
people would probably be in their last year of a three-year Junior Certificate program with two years left to complete their secondary education and, if successful, they would be able to attend university or a college of further education. The options that parents of expelled pupils have are to send their child to a private school or, if this is unaffordable, it would be important to keep them engaged in constructive activities as several social work programs in Botswana have funding for out-of-school youth projects.

**A Social Worker Responds**

A social worker would look at Mary's defiant behavior from a family perspective which is in line with the Setswana culture of collective problem solving or *therisano* (consulting). What is being presented as a problem for Mary is a family (as opposed to an individual) issue. Interventions should be focused on the individual and the family. The initial phase of the assessment would be for the social worker to compile a family history to gain information that will be relevant for addressing the salient issues.

The worker would first see Mary alone to understand the problem of defiant behavior from her perspective. This activity would be appropriate in the Setswana culture because it would be considered disrespectful for Mary to talk to a third party about the shortcomings of her parents in their presence. Talking to Mary is of vital importance because, if she has felt judged, unaccepted, and uncared for by her parents, she might have become defiant and less open to considering options for change. As an intervention strategy, the social worker would engage Mary in self-assessment and the impact her behavior has on family relations. Counseling would be combined with active task-centered support and Mary would identify areas on which to work. The girl would also be given the opportunity to explore, discover, and clarify ways of living in harmony with the rest of her family.

When working with the family, the social worker would try to understand, from the family's vantage point, what happened when Mary was 12 years old. Greg remembers that he noticed Mary's aggression when she was that age. Though there is no reference in the case study as to what occurred at this time, they might have experienced a major transition that had not been resolved. Setswana culture is closed with regard to discussing marital issues outside the family and this could have been the start of Lucy and Greg's marital and financial problems. The social worker would explore how the family functioned before Mary was 12 years old. If the family had experienced good interpersonal relationships before that time, the worker would help the parents to determine what had worked for them in the past so that they could learn from and build upon it to accommodate a growing adolescent. This information is crucial to assess as Mary's behavior and environment are mutually interrelated.

The other issue that the social worker would explore and assess is that of financial difficulties in the family that have forced the parents to each have two jobs. The worker would assist them to deal with their financial issues by attending to budgeting and a work schedule that could assist both parents to have some time to spend at home with the family. The parents would be helped to appreciate that their continuous absence might be affecting their children, and that Mary is displaying a lack of constructive and disciplinary parenting through defiant behavior.

Another issue that the family would be assisted with is how to parent an adolescent. Aunts and uncles in the Setswana culture used to play the role of talking to adolescents. With industrialization and the breaking down of the extended family system, families are becoming more nuclear and parents of adolescents may not have the communication skills to effectively perform this role. Social work agencies such as the Botswana Family Welfare Association and the Girl Guides movement are assisting parents in this regard, and Mary could also be encouraged to participate in programs provided by these agencies. Adolescence is a stage of development characterized by storming, a quest for autonomy, and an understanding of self. Mary may be trying to understand this transition and the issues associated with it.

Her aggression may be coming from a lack of parental willingness to discuss issues such as her menstrual cycle, and hormonal and physical changes. Since the parents are continuously absent from home, Mary's defiant behavior could be related to the fact that she is seeking their attention. Engaging in physical fights with her teacher could also be an indication of a strained relationship between her mother and herself. Mary might be projecting feelings of aggression directed at her mother towards her teacher, who might be viewed as a mother figure. In Setswana culture “ngwana wa mosetsana molekane wa ga mmaagwe” means that a daughter should be her mother's friend and confidant. In Mary's case, a mother/daughter friendship
does not exist. Furthermore Greg and Lucy’s parenting behavior is demonstrated through controlling Mary. The social worker would assist them to explore alternative parental techniques. These interventions might include talking to her instead of shouting at her, giving her some responsibilities around the home that are age appropriate, and providing her with privileges over her younger siblings to recognize this transition.

It is apparent that family relationships are very strained. Greg and Lucy are always arguing and blaming each other. They could be assisted by their aunts and uncles to address their conflicts (although modernization and industrialization have interfered with this process). The parents may not have information on what to do in the absence of an extended family system that had previously assisted in conflict resolution, and the social worker would attempt to fill this vacuum. The aggression that Mary is displaying might be a result of learned behavior, in that Mary is modeling the aggression witnessed at home. The social worker would educate the parents on good communication skills, anger management, and conflict resolution in order for the children to model this behavior and learn new ways of relating to each other (given that behavior can be learnt and unlearnt). The social worker in this case should also address how Mary’s other sibling’s are coping with the continuous absence of parents, their arguing, and the tension at home.

It seems that Lucy is the one providing parenting and, therefore, constantly fighting with Mary. In Setswana culture, parenting is teamwork that requires both parents to participate. Furthermore the father is the authority figure and, in the absence of Greg’s parenting role, Mary may defy Lucy’s authority. The social worker would work with Greg to help him to participate in parenting, as well as addressing issues that may be preventing him from doing so.

**Parenting an Adolescent: A Social Worker from Ghana Responds**

By Peter Dwumah & Lisa Salma Abubakar

**Prevalence and Incidence**

It is important to state that, even though family conflict occurs in Ghana, children are generally not expected to challenge their parents or older people. People do not report these issues to appropriate bodies such as the DSW, which has been established to help the citizenry deal with life problems including the parenting of defiant young people, and thus precise information about prevalence and incidence is difficult to find.

**Country Policies**

The DSW is the government institution that is responsible for ensuring and supporting social work practice. The Child Rights and Protection program performs various functions including adoption, child custody, and rehabilitation of street children. The Justice Administration program includes assisting young offenders to adjust in society; providing vocational skills or training to illiterate and out-of-school youth; ensuring care and shelter for juveniles on remand; and placing abandoned and orphaned children for adoption.

There are no specific country policies on parenting. However, for cases of child abuse, the country has established the Domestic Violence and Victims Support Unit (DOVVSU) in the Ghana Police Service. There is also a Ministry of Women and Children Affairs.

**A Social Worker Responds**

In the case of Mary’s defiant behavior, the traditional Ghanaian system recognizes the training of family members as the collective responsibility of the entire extended family and the society. Any member of the family such as uncles, aunts, grandparents, nephews, and nieces, apart from one’s parents, was responsible for the conduct of members. Even beyond the family, any older member of the society could correct a person for wrongdoing.
Ghanaian society is, however, not static. Changes have occurred with the reduction of the role of the family and society as a whole in influencing peoples’ behavior and their general well-being. The British colonial government introduced what was termed “social work” to help solve the problems caused by a capitalist economy and the fractured extended family system. Modern social work is a young profession in Ghana and it seeks to help and empower vulnerable groups in the society including families.

Adolescence is a time of identity crisis and, at this stage, there is some level of pressure on the adolescent in decision making concerning life choices. Idealistic values take root; therefore, adolescence is a period in which the individual undergoes rapid social growth, learning how to apply several interpersonal skills in different situations. The young person must unlearn some of the values and interests of his/her childhood and replace them with those of an adult. The mode of child rearing is very important because it will have a marked influence on the child. In the traditional Ghanaian context, parents have a duty to stamp out “evil nature” and replace it with “good nature.” Therefore the child has no right to question what the parent says. Child rearing in Ghanaian society is generally authoritarian, and the use of force and strict discipline is applied, with the child having little opportunity to refuse or disagree with his or her parents. The latter thus expect total obedience from their children.

With regard to the defiant behavior of Greg and Lucy’s daughter, a social worker in Ghana would invite the parents and the child for an interview. The social worker would interact with the parents and with the child separately to establish what is happening in the family. On the basis of the information emerging from the interaction, the social worker would be able to devise an intervention strategy to help the family deal with the problem. If the problem appears to stem from the child, the worker would forge an agreement with Mary and her parents with regard to appropriate, expected patterns of behavior, and the child would give a written undertaking to behave in a positive manner. There would also be supervision of the girl by the social worker, both at school and at home. There could be regular visits during the initial stages of intervention, probably twice a week with frequency being reduced when there are signs of improvement. However, if the behavior continues, the social worker may use the justice system to address the situation, but most often probation would be recommended. This action would give Mary the opportunity to reform within her own environment, but she would have to adhere to strict conditions. If she violates these, she may be placed in an institutional setting or correctional home. If the parents are the main contributors to the adolescent’s behavior, then the social worker has to work with them to address the problem. This intervention would take the form of family therapy.

In the event that the parents do not cooperate, there might be the need for a Fifth Person Order, which relates to placing the adolescent with a different person who is interested and wants to help them reform. In the case of Mary, she would be removed from the problematic environment of the parents and placed in a more conducive setting which would be supervised by a social worker. In all the above scenarios, the school, which is also an important stakeholder in the life of the adolescent, would be involved in the supervision process.

References

Adoption of Children Act 1952, Botswana.
The Children Act 1989, United Kingdom.
SAMHSA, HHA, National Center for Child Traumatic Stress, University of California at Los Angeles and Duke University. www.NCTSNet.org


Demographic Overviews

Austria

Austria has a population of 8,364,095 people. The population composition of Austria based on age structure is: those aged 0–14 years make up 15 per cent of the population, 15–64 years make up 68 per cent, and the percentage for those 65 years and older is 17 per cent. The female population constitutes 51.2 per cent of the total population (The World Bank, 2011). The urban population is 68 per cent. Austria reports that 98 per cent of its population is literate (CIA World Factbook, 2011). The pupil to teacher ratio for primary education in Austria is one teacher per 12 students. Six per cent of the Austrian population lives below the poverty line (The World Bank, 2011).

Botswana

Botswana’s population is 1,949,780 with 63 per cent being 0–14 years of age, 33 per cent being 15–64 years of age, and 4 per cent being 65 years of age and older. Botswana is another young country age-wise with females constituting 50 per cent of the entire population (The World Bank, 2011). The percentage of the population that is literate is 81.2 per cent with the gross enrollment for primary education being 109 and the net enrollment being 86.9. The student to teacher ratio for primary education is 25. The gross secondary enrollment ratio is 82 and the gross tertiary enrollment ratio is 8 (The World Bank, 2011)—thus not many people are enrolled in higher education. Sixty-one per cent of the population lives in urban areas. The percentage of the population living below the poverty line is 30.3 per cent (CIA World Factbook, 2011).

Brazil

Brazil is the largest country in area and in population in Latin America with 3.3 million square miles and approximately 191 million people. Among these, 51 per cent are females, 84 per cent live in urban areas (most in cities alongside the coast), and 51 per cent are under 30 years of age (15 per cent under 10, 18 per cent under 20, and 18 per cent under 30 years). Although the illiteracy rate is on the decline it is still high (10 per cent), and only 30 per cent of the population has 11 years or more of education. Seven per cent of the population lives in poverty (U.S. $2 per day), 4 per cent live in extreme poverty (U.S. $1.25 per day), and 19 per cent live under U.S. $100 per capita per month. Unemployment is around 9 per cent, and despite the fact that women are better educated than men, the unemployment rate has a gender gap, with more females outside the job market than males. According to the World Bank, Brazil is a middle income country and is the eighth wealthiest economy in the world but still suffers from the problem of inequality as a wide gap exists between the rich and the poor (World Bank, 2011).

Bulgaria

Bulgaria’s population is 7,585,131. Of this figure, 13 per cent were 0–14 years, 69 per cent were 15–64 years and 17 per cent were over 65 years. The female population makes up 51.7 per cent (Worldbank, 2011). Seventy-one per cent of the total population lives in urban settings. The percentage of the total population living below the poverty line is 21.8 per cent. The percentage noted as being literate is 98.2 per cent. The gross enrollment ratio for primary education is 101, and the pupil to teacher ratio for primary education is one teacher per 16 students.
Canada

Most of Canada's current population of 34,030,589 lives within 100 miles of the border with the U.S. As compared to other developed nations, Canada has a relatively high average annual population growth rate of 0.794 per cent. The majority of the Canadian population (81 per cent) currently resides in urban settings (IndexMundi, 2011a; Statistics Canada, 2011). Canada is considered to have a young population, with a median age of 41 years. The current male/female ratio is estimated at 0.98 male(s)/female, with an overall life expectancy at birth of 81.38 years. The overall poverty rate in Canada has fallen from 15.7 per cent in 1996 to 10.8 per cent in 2005. The percentage of the Canadian population that currently lives below the poverty line is estimated to be 9.4 per cent (Statistics Canada, 2009, 2011; IndexMundi, 2011a and b). Canada has two official languages, English and French. In the 2006 Census, the Canadian Aboriginal population was counted at 3.75 per cent of the total population and it is estimated that, by 2031, approximately 28 per cent of the population will be foreign-born (Statistics Canada, 2011). Education is administered, supported, and managed by federal, provincial, and local governments, and the current literacy rates are 99 per cent for both males and females (IndexMundi, 2011a).

China

By July 2012, it is estimated that China's total population will be approximately 1.3 billion people. The age structure of the Chinese population is as follows: 0–14 years make up 17.6 per cent of the population; 15–64 years make up 73.6 per cent of the total population, and 65 years and over constitute 8.9 per cent of the total population (CIA 2012). Females constitute 48 per cent of the entire population (The World Bank, 2011). China's literacy rate is quite high at 92.2 per cent, and the gross enrollment ratio for primary education is 111 (World Bank, 2011). In 2010, the urban population of China was 47 per cent of the total population (CIA 2012). The percentage of people living below the poverty line is 2.8 per cent; however, The CIA Fact Book added this note: the 21.5 million rural population live below the official “absolute poverty” line (approximately U.S. $90 per year); an additional 35.5 million rural population live above that level but below the official “low income” line (approximately U.S. $125 per year) (2007) (The World Factbook, 2012, economy). In addition, according to UNICEF data, 16 per cent of the population lives below the international poverty line.

El Salvador

El Salvador is the most densely populated country of the Americas with a population of 6.2 million in a territory of 21,041 sq. km. (8,124 sq. miles). The Gross National Income per capita (Purchasing Power Parity) for El Salvador is U.S. $6,360, the third highest in Central America after Panama and Costa Rica. The national economy depends heavily on the Salvadorans living in the U.S. More than 20% of the families receive remittances. The national currency is the dollar. Life expectancy is 67 years for males, and 76 years for women. The adult literacy rate is 84%. Thirteen percent of Salvadorans live on less than U.S.$2 a day. Thirty-two percent of the population is between the ages of 0 and 14 years (World Bank, 2011).

Finland

Finland is a large but sparsely inhabited Nordic parliamentary republic with 5.3 million inhabitants. It has been a member of the European Union since 1995. Approximately 1.1 million people are under 18 years of age, but the number and proportion of children in the population is declining. In Finland, 41 per cent of families have children. The fertility rate is 1.8. Forty per cent of children are born to cohabiting couples. Slightly over three per cent of married or cohabiting couples divorce or break up each year. Nowadays, there is a diverse range of family arrangements in Finnish households.
Germany

The population for Germany is 81,879,976. Females make up 51.0 per cent of the total population figure (The World Bank, 2011). In addition to having the largest economy in Europe, Germany's population is also the second largest. It ranks as the 16th most populous in the world (Central Intelligence Agency [CIA] World Factbook, 2011). It is also densely populated with 229.4 inhabitants per square kilometer. Today's Germany is also significantly characterized by a large immigrant population, in that approximately 19 per cent of the country's residents are of foreign or partially-foreign descent. Of Germany's inhabitants, 13.3 percent are under the age of 15 years. The average national unemployment rate in 2010 was about 7.1 per cent, and the overall life expectancy in Germany at birth is 80.07 years. Ninety-nine per cent of Germans aged 15 and above are estimated to be able to read and write (CIA World Factbook, 2011).

In 2003, 12 per cent of the German population lived in rural areas and at the end of the twentieth century only 2.7 per cent of the German workforce was involved in agriculture, forestry, and fishery combined. Germany is an industry-based economy and its dependence on the agricultural sector is limited. Farming communities/families are under tremendous pressure of extinction as they are faced with increasing European competition (United Nations Secretariat, 2003).

Ghana

Based on 2009 data, Ghana has a population of 23,837,261 people, with 38 per cent of the population between 0–14 years, 58 per cent 15–64 years, and 4 per cent over 65 years. Females make up 49.3 per cent of the overall population figure (World Bank, 2011). The gross enrollment ratio for primary education is 105 (based on 2009 data) while the net enrollment is 76.5. The student to teacher ratio for primary education is 33. The gross secondary and tertiary enrollment ratios are 57 and 9, respectively (World Bank, 2011); thus not many people are enrolled in higher education. The percentage of the population that is literate is 57.9 per cent. Ghana's urban population is 51 per cent of the total population. The population below the poverty line is 28.5 per cent (CIA World Factbook, 2011).

Hungary

Hungary has a population of approximately 9,969,000 (Hungarian Central Statistical Office, 2011). In this Eastern European country, those aged 0–14 years constitute 15 per cent of the population, those aged 15–64 years 69 per cent, and those over 65 years 16 per cent. Females constitute 52.5 per cent of the entire population figure. The percentage for literacy is 99.4 per cent of the total population. Gross primary enrollment is 99. The percentage for net primary enrollment in Hungary is 89.7, and the student to teacher ratio for primary education is 10. The gross secondary enrollment ratio is 97 while gross tertiary enrollment is 65 (World Bank, 2011).

India

India has a population of 1,155,347,678, with 31 per cent being 0–14 years old, 64 per cent being 15–64 years old, and 5 per cent 65 years and older. The female population constitutes 48.3 per cent of the country (World Bank, 2011). Based on 2007 estimates, the percentage for literacy is 61 per cent (CIA World Factbook, 2011). The gross primary enrollment ratio is 117, and the net enrollment is 91.4. The gross secondary enrollment ratio is 60. Based on 2007 statistics, the gross tertiary enrollment ratio is 13 (World Bank, 2011). The urban population is 30 per cent. The population living below the poverty line is 25 per cent.
**Indonesia**

Indonesia's population is 239,870,937. The age structure of the Indonesian population is 0–14 years being 27 per cent; 15–64 years being 67 per cent; 65 years and over being 6 per cent. Overall, females constitute 50 per cent of the entire population. The population living below the poverty line is 13 per cent. The percentage of the population that is literate is 92 per cent. The urban population is 54 per cent of the total population. With respect to education, the gross enrollment ratio for primary education is 117 per cent with the pupil to teacher ratio for primary education is one teacher per 17 students (World Bank, 2011).

**Ireland**

Ireland has an estimated population of 4,450,446. The population composition is 21 per cent of the population being 0–14 years, 68 per cent being 15–64 years, and 11 per cent being over 65 years. The entire female population is 49.9 per cent. The gross primary enrollment ratio is 105, with the pupil to teacher ratio for primary education being one teacher for every 16 students (The World Bank, 2011). Ireland's urban population is 62 per cent of the total population. Ninety-nine percent of the total population is literate. Only 5.5 per cent of the population lives below the poverty line (CIA World Factbook, 2011).

**Israel**

Israel has a population of about 7.5 million, about 20 per cent of whom are Arabs (Palestinians) and the rest are mostly Jewish. About a quarter of the population (2.7 million) is less than 18 years of age, 10 per cent of whom are children under five. Israel is a highly urbanized country—only 8–9 per cent of the population lives in rural areas. The economic inequality in Israel is higher than in most modern countries, and the upper income quintile is about 7.5 higher than the lowest one (compared to a mean ratio of 4.9 for the European Union countries). If inequality is measured by the Gini coefficient, Israel (0.378) is very similar to the U.S. (0.381). The rate of poverty (less than 40 per cent of the median income) is 21 per cent, higher than all other OECD countries, and the rate of poverty for children is also higher at 29 per cent. Most children receive elementary and some kind of high school education. Thus, more than 75 per cent of 25–64 year olds have high school education.

**Japan**

In 2008, the estimated figure for Japan's total population was 127,692 million—22.1 per cent of this figure representing the 28 million people over 65 years. In contrast to this, Japan's young population accounted for 13.5 per cent of the entire population, or 17 million people. The population within the age bracket of 15–64, also referred to as the working population, made up 82 million or 64.5 per cent. The population estimates of 2009 revealed a continuing decline in the young (13.3 per cent) and working (63.9 per cent) populations. However, the population aged 65 and over is increasing (Ministry of Internal Affairs and Communications, Bureau of Statistics, 2009).

**Mexico**

Mexico has a population of 107,431,225. Twenty-eight per cent of the population is 0–14 years of age, 65 per cent is 15–64 years, and 6 per cent is over 65 years. It is a young country wherein females constitute 50.8 per cent of the entire population (World Bank, 2011). The net enrollment ratio for primary education is 98.1, which is the ratio of children of official school age who are enrolled in school (World Bank 2011). The student to teacher ratio for primary education is 28 students per one teacher. The gross secondary enrollment ratio is 90 and gross tertiary enrollment ratio is 27 (World Bank, 2011). Thus there are high rates of school enrollment at primary and secondary school levels. In regard to literacy, 86.1 per cent of the
population is literate. The urban population is 78 per cent of the total population. The population living below the poverty line is 18.2 per cent (CIA World Factbook, 2011).

Mongolia

In 2009, Mongolia had a population of 2,670,966 people. The age composition was 26 per cent aged 0–14 years, 70 per cent 15–64 years, and 4 per cent over 65 years. The percentage for females is 50.5 per cent (World Bank, 2011). Based on 2009 data, the gross enrollment ratio for primary education is 110 and the net primary enrollment ratio is 90.5. The student to teacher ratio for primary education is 30. The gross secondary and tertiary enrollment ratios, based on 2009 statistics, are 92 and 53 respectively (World Bank, 2011), which speaks to a large number of people accessing higher education. The urban population is 62 per cent of the total population. The percentage of the population that is literate is 97.8 per cent. The percentage living below the poverty line is 36.1 per cent (CIA World Factbook, 2011), indicating a relatively high poverty status for many in Mongolia.

The Netherlands

The Netherlands has a population of 16,574,989 (October 2010), of whom 8,371,513 are women and 8,203,476 are men. Young people under the age of 20 comprise 23.7 per cent of the population, numbering 3,928,334 in total. The country is very densely populated with 491 inhabitants per square kilometer. The proportion of people living in urban environments is 41.7 per cent, with 40.3 per cent residing in rural areas. Of the population, 379,000 people's highest educational level was elementary school, followed by 8,510,000 people who have completed some form of secondary schooling or vocational training, while 1,700,000 people hold Bachelor's degrees and 960,000 have postgraduate degrees at Masters or Doctoral level. The literacy rate in The Netherlands stands at 99 per cent. Almost seven per cent of the population lives below the so-called “low income border”, which denotes an income of €9,249 per year at the price level of the year 2000. About 2.3 per cent of inhabitants have lived below this level for more than four years (Central Bureau of Statistics [CBS], 2011).

New Zealand

New Zealand has a population of 4,315,800, with 20 per cent aged 0–14 years, 67 per cent aged 15–64 years, and 13 per cent aged 65 years and older. Females constitute 50.6 per cent of the entire population (World Bank, 2011). The percentage of the population that is literate is 99 per cent (CIA World Factbook, 2011). The gross enrollment ratio for primary education is 101, and the net primary enrollment is 99.5. The student to teacher ratio for primary education is 15 to one. The gross secondary enrollment ratio is 119 while the gross tertiary enrollment is 78 (World Bank, 2011). The urban population is 86 per cent of the total population. New Zealand uses the concept of equivalized income as a measure for determining the population that falls below the poverty line. It refers to the income that a household, taking into account its size and composition, needs in order to attain a given standard of living. In 2001 and 2006, the percentage below the poverty line was calculated in terms of people. In 1996 (when the calculations were based on households), the percentage of households that fell below the threshold was 13.9 per cent. In 2001, it was 15.0 per cent of the population; and in 2006, it was 14.96 per cent (Salmond, Crampton, & Atkinson, 2007).

Pacific Islanders

Over a million Pacific Islanders (including Samoans from American or Western Samoa) currently live in the U.S. (U.S. Census Bureau, 2006). These large population numbers pose opportunities for positive contributions to society as well as risk for low socioeconomic status, poverty, disease, under-education,
violence, substance abuse, and crime and delinquency (Kassebaum et al., 1995; Le, 2002). Notably, nearly 26 per cent of Samoans and 23 per cent of Tongans live below the poverty line in the U.S. (Ro, 2002).

**South Africa**

At present, the population of South Africa is estimated at around 49.9 million people, of which 51.3 per cent are female and 48.7 per cent male. Of these numbers, 32 per cent are children below the age of 18 years. The population is made up of a wide variety of cultures, languages, and religions. Africans make up 79.9 per cent of the population. White people follow with 9.2 per cent, colored people (mixed race) with 8.8 per cent, and the Indian and Asian population with 2.2 per cent. South Africa is a multilingual country. Since the democratic constitution came into effect in 1997, 11 official languages are recognized and given equal status. South Africa hosts a mix of religious beliefs. By far the largest religious group is Christian, which makes up about 80 per cent of the population. Most of these are Protestants, with 6 per cent being Catholic and mostly of Portuguese or Irish descent. Hindus form about 1 per cent of the population and Islam also has a presence (Statistics South Africa, July, 2010).

**South Korea**

As of January 2010, the population of the Republic of Korea (South Korea) exceeded 50 million people (Statistics Korea, 2011). Out of this population, 17 per cent are aged 0–14 years, 73 per cent 15–64 years and 11 per cent are 65 years and older with females constituting 50.5 per cent (World Bank, 2011; Statistics Korea, 2010). The urban population is 83 per cent of the total population. Households in the capital of Seoul occupy 47.9 per cent of the total number of households. The average number of household members was 2.69 persons. By 2010, two-person households emerged as the main type of household. Forty-seven per cent of households resided in apartments. This percentage exceeded the percentage of detached dwellings (39.6 per cent) for the first time (Statistics Korea, 2011). Ninety-seven per cent of the population is literate with the gross enrollment ratio for primary education at 105, a net primary enrollment at 98.8, and a student to teacher ratio for primary education at 24. The gross secondary enrollment ratio is 97, and gross tertiary enrollment is 98. Fifteen per cent of the population is living below the poverty line (CIA World Factbook, 2011). Since digital communication technology is highly advanced, computers are in nearly every Korean household.

**United Kingdom**

The population of the United Kingdom is 61,838,154. Based on age structure, 17 per cent of the population is 0–14 years, 66 per cent is 15–64 years, and 16 per cent is over 65 years. Females make up 50.9 per cent of the entire population (The World Bank, 2011). The gross enrollment ratio for primary education is 106, wherein the pupil to teacher ratio for primary education is one teacher per 18 students (World Bank, 2011). Ninety-nine percent of the population is literate. Eighty per cent of the country lives in urban settings. The population living below the poverty line is 14 per cent (CIA World Factbook, 2011).

**United States**

The U.S. has a population of 307,007,000. Based on age structure, 23 per cent of the population is 0–14 years, 67 per cent is 15–64 years, and 13 per cent is over 65 years. Females constitute 50.7 per cent of the entire population (World Bank, 2011). The urban population is 82 per cent of the total (CIA World Factbook, 2011). In terms of education, the gross enrollment ratio for primary education is 99, while the net primary enrollment is 92, and the student to teacher to ratio is 14. The gross enrollment ratio for secondary education is 94 while the ratio for tertiary education is 83 (World Bank, 2011). Ninety-nine percent of the overall population is noted to be literate. The population living below the poverty line is 12 per cent (CIA World Factbook, 2011).
References


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