

MEDIATING ADOLESCENT-CAREGIVER CONFLICT: GUIDELINES FOR SOCIAL WORKERS

by

Elize Maartens



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Supervisor: Dr L.K. Engelbrecht

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature



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Date

SUMMARY

An exploratory and descriptive research was conducted and the predominant research approach employed for this study is a qualitative research approach, however, elements of a quantitative research approach was included for the purpose of obtaining the goal of the research. The outcome of qualitative research is in the form of descriptive data in the participant's own words, thereby identifying the participant's beliefs and values that underlie the phenomena of adolescent-caregiver conflict. Consequently, this qualitative study is concerned with non-statistical methods and small samples that were purposively selected. However, some of the processed data were presented in a quantitative manner, by means of tables and figures.

By means of observation within the field of social work, it has been noted that there is an increasing need for intervention between adolescents and caregivers, as disputes occur increasingly between caregivers and their children, especially during the adolescent years. Social workers often take on the role of mediator, or use elements of mediation, acting as intermediaries and emphasizing collaborative and consensual processes when dealing with conflict. However, mediation has been utilized in many different situations and problems, but the social work profession has not kept pace with the rapid development of mediation as both a conceptual framework and a practice approach to conflict resolution in diverse settings. Therefore, in doing this research study, the researcher's motivation is to provide the necessary knowledge in this relatively new field by means of a theoretical framework and practical guidelines in using mediation.

The goal of the research is to gain a better understanding of mediating adolescent-caregiver conflict in order to provide guidelines for social workers. In order to achieve this goal the following objectives are devised: (a) to explore the nature of conflict in adolescent-caregiver relationships; (b) to describe theories, methods and processes of conflict and mediation in adolescent-caregiver relationships; (c) to investigate how social workers resolve conflict in

adolescent-caregiver relationships; and (d) to provide social workers with guidelines in mediating conflict in adolescent-caregiver relationships.

Further, ten social workers from BADISA were used for this study. The reason for choosing this particular organization is because the researcher is employed at one of the programmes of BADISA, and because of the accessibility to the organization in performing the research study.

This study proposes to equip social workers with the necessary skills and knowledge needed to take families through the process of preserving the intact family structure.

The results confirm and indicate that social workers deal with a high caseload of adolescent-caregiver conflict. Further, the results also confirmed that social workers had limited knowledge about mediation as a conflict resolution method and they would like to receive further training and knowledge in this area.

The primary recommendations to be made is that social workers need to be provided with relevant training and workshops regularly in the area of mediating adolescent-caregiver conflict; social workers need to consider the relevancy of the client's culture and socio-economic circumstances when mediating; and social workers need to use the method of mediation in conjunction with other relevant and currently used methods in social work with adolescents and caregivers who are in conflict, for the purpose of educating both parties on constructive conflict resolution.

OPSOMMING

'n Verkennende en beskrywende navorsingsontwerp is vir hierdie hoofsaaklik kwalitatiewe navorsing benut. Daar is egter elemente van 'n kwantitatiewe benadering by hierdie navorsing ingesluit om die doel van hierdie studie te bereik. Die kwalitatiewe navorsing is in die formaat van beskrywende data in die deelnemers se eie woorde, om sodoende die deelnemers se menings en waardes te identifiseer wat onderliggend aan die fenomeen van adolessent-versorger konflik is. Gevolglik is hierdie kwalitatiewe studie met nie-statistiese metodes uitgevoer en is deelnemers deur middel van 'n doelbewuste steekproef betrek.

Observasie in die maatskaplikewerk-praktyk toon dat dit kenmerkend is dat daar 'n verhoging in die behoefte vir intervensie tussen adolessente en hulle versorgers is, omdat daar 'n toename van konflik tussen versorgers en hul kinders, veral gedurende die adolessente jare is. Maatskaplike werkers neem dikwels die rol van bemiddelaar in, of gebruik elemente van bemiddeling, tree op as tussenganger en beklemtoon 'n medewerkende en 'n ooreenstemmende proses wanneer konfliksituasies gehanteer moet word. Bemiddeling word egter tans in verskillende situasies benut en ten opsigte van verskillende probleme, maar die maatskaplikewerk-professie het nie tred gehou met die snelle ontwikkeling van bemiddeling as beide 'n konsepsuele raamwerk en 'n praktykbenadering vir konflikoplossing in diverse omgewings nie. Die navorser se motivering vir die studie is dus om die nodige kennis in hierdie relatiewe nuwe veld te voorsien, deur middel van 'n teoretiese raamwerk en praktiese riglyne in die gebruik van bemiddeling tussen adolessente en hulle versorgers.

Die doel van die studie is om 'n beter begrip van bemiddeling van adolessent-versorger konflik te verkry ten einde riglyne aan maatskaplike werkers te stel. Om hierdie doel te bereik is die volgende doelwitte gestel: (a) om die aard van konflik in adolessent-versorger verhoudings te eksploreer; (b) om die teorieë, metodes en prosesse van konflik en bemiddeling in adolessent-versorger verhoudings te omskryf; (c) om te ondersoek hoe maatskaplike werkers konflik in adolessent-versorger verhoudings oplos; en (d) om

maatskaplike werkers met riglyne in die bemiddeling van konflik in adolessent-versorger verhoudings te voorsien.

Tien maatskaplike werkers van BADISA is by hierdie studie betrek. Die rede waarom hierdie spesifieke organisasie gekies is, is omdat die navorser 'n werknemer by een van die programme van BADISA is, en vir die toeganklikheid tot die organisasie om hierdie studie uit te voer.

Hierdie studie het ten doel om maatskaplike werkers toe te rus met die nodige vaardighede en kennis wat benodig word om gesinne deur die konflikbemiddelingsproses te neem ten einde die gesinsstruktuur instand te hou.

Die resultate van hierdie ondersoek bevestig en dui aan dat maatskaplike werkers 'n hoë gevallielading van adolessent-versorger konflik hanteer. Die bevindinge bevestig verder dat maatskaplike werkers beperkte kennis van bemiddeling as 'n konflikhanterende metode het en dat hulle verdere opleiding en kennis in hierdie area wil en moet opdoen.

Die primêre aanbevelings wat gemaak is, is dat maatskaplike werkers met die nodige en relevante opleiding en werkswinkels voorsien moet word in die area van bemiddeling van adolessent-versorger konflik; maatskaplike werkers moet die relevansie van die kliënt se kultuur en sosio-ekonomiese konteks in ag neem gedurende bemiddeling; en maatskaplike werkers moet konflikbemiddeling saam met die primêre maatskaplikewerk-metodes benut. Die doel van adolessent-versorger bemiddeling behoort te wees om beide partye in die konstruktiewe hantering van konflik op te voed.

RECOGNITION

Sincere appreciation is expressed to the following persons and institutions:

- My study guide and mentor, **Dr L.K. Engelbrecht**, for his patience, endurance, and encouragement in assisting me with this journey.
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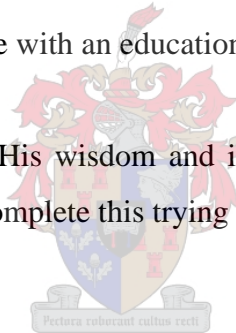


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CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR STUDY

In the general sense, conflict is part and parcel of people's daily lives. Living and experiencing fast rate changes personally, in the immediate environment where people live and function, as well as globally often places humans in a position of constant adjustment to these changing elements. For some people change is welcomed, for others it can be very stressful, causing strain to be placed on other systemic levels in which the person is functioning. Coulsen (1996:2) states that where change occurs it can create stress. In cases where strain occurs, it can very often be coupled with tension and in some cases result in conflict.

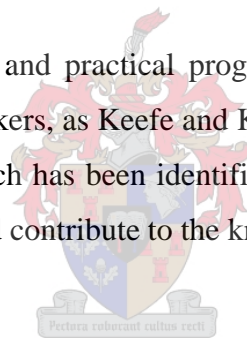
Irving and Benjamin (2002:3) further states that conflict features globally, across all cultures, in all different contexts, and has been recorded to have taken place in the past and is most likely to take place in the future. With this in mind, Moore (in Irving & Benjamin, 2002:3) suggests that the commonality of conflict is entrenched in dissimilarity. More specifically conflict is also ingrained in relationships where there are different feelings; where the parties have different principles and morals; where different information is given or a lack of information is given; where the parties concerned have differing ambitions and interests; where there is an imbalance of power relations; and where there are different mental and emotional states within the individuals concerned (Moore in Irving & Benjamin, 2002:3). Taking these different elements into consideration, conflict is foreseeable when humans bring these dissimilarities into their relationships.

With this in mind, social workers are often confronted in assisting clients to find solutions to problems or resolving conflict between different parties, for instance between a parent and child, between couples, family disputes, between community members (Kruk, 1998) and so forth. When looking at managing and resolving conflict, there are different practice methods

that can be used in different situations, such as negotiation, arbitration and mediation (Kruk, 1998:2). Social workers often take on the role of mediator, acting as intermediaries and emphasizing collaborative and consensual processes when dealing with conflict (Kruk, 1998:2).

However, over the past two decades, mediation has been utilized in many different situations and problems, but social work education and the social work profession have not kept pace with the rapid development of mediation as both a conceptual framework and a practice approach to conflict resolution in diverse settings (Kruk, 1998:2). Therefore, in doing this research study, the researcher may provide the necessary knowledge in this relatively new field to provide a theoretical framework and practical guidelines in using different methods of resolving conflict.

Also, from this study a theoretical and practical program can be composed to the further training and equipping of social workers, as Keefe and Koch (1999:33) also considers conflict resolution as a field of practice which has been identified as underdeveloped in social work. The findings may be informative and contribute to the knowledge base of other human service organizations.



Further, certain skills and knowledge are needed in optimally utilizing the different methods, such as mediation and negotiation, in different contexts. Mediation can be used in an array of different fields of practice and can be personalized according to the distinctive characteristics of the disputes and conflicts (Kruk, 1998:15). Therefore, mediation is a very useful social work practice model and its potential for application should be expanded on as well as with other methods (Kruk, 1998:15).

In other words, by understanding the actual nature of conflict resolution and the role it plays at any given time, social workers can clarify their roles and effectively apply a significant body of intervention skills (Mayer, 1995:613). Knowledge of different intervention skills and

conflict resolution methods empowers social workers to work more informed and effectively with their clients.

By means of observation within the field of social work, and established research findings such as Allison (2000), Erikson (1968), Lingren (1995), and Seidman, Lawrence and French (2004), it has been noted that there is an increasing need for intervention between adolescents and caregivers, as disputes occur increasingly between caregivers and their children, especially during the adolescent years. Kruk (1998:98) argues that conflict between the adolescent and their caregivers is reflective of the adolescent's healthy assertion of their individuality and independence.

Furthermore, specific focus will be drawn to mediation as a conflict resolution method, because it is useful in application to adolescent-caregiver conflict. Much of literature refers more specifically to family mediation; however, it can be applied to the context of the adolescent-caregiver relationship. Kruk (1998:98) further describes mediation as one of the methods that can be used as an alternative to placing the child or adolescents in foster care with grandparents, other family members or even in children's homes, which often happens if caregivers view the adolescent to be the problem and if the caregiver do not have the necessary skills to resolve conflict. Therefore, this study proposes to equip social workers with the necessary skills and knowledge needed to take families through the process of preserving the intact family structure (Kruk, 1998:97).

1.2 PROBLEM STATEMENT

Literature such as Allison (2000), Erikson (1968), Lingren (1995), and Seidman *et al.* (2004), confirms that there seems to be a tendency for conflict to arise and increase between the adolescent and caregiver. The developmental phase of adolescence often involves the adolescent striving for autonomy and the developmental phase of adulthood is often a time that involves various sources of stress that contributes to the occurrence of conflict between these two parties. In many cases caregivers and adolescents are ill equipped to resolve conflict. Assistance is therefore needed in the form of a mediator serving as a third party, such

as the social worker that can intervene and help the conflict resolution process along. Social work as a profession has however not kept pace with the rapid development of the field of mediation and therefore, need to be given guidelines as to utilizing this effective and practical method (Kruk, 1998:2).

1.3 AIMS OF STUDY

The goal of the research is to gain a better understanding of mediation of adolescent-caregiver conflict in order to provide guidelines for social workers. In order to achieve this goal the following objectives are devised:

- (a) To explore the nature of conflict in adolescent-caregiver relationships;
- (b) To describe theories, methods and processes of conflict and mediation in adolescent-caregiver relationships;
- (c) To investigate how social workers resolve conflict in adolescent-caregiver relationships;
- (d) To provide recommendations in mediating conflict in adolescent-caregiver relationships;

1.4 CLARIFICATION OF KEY CONCEPTS

For the purpose of this study, the following concepts will be defined in order to ensure a common ground of understanding is established, as these different concepts will be used throughout the study: (a) social work; (b) conflict; (c) conflict resolution; (d) caregiver; and (e) adolescent.

1.4.1 Social work

The International definition of social work describes the social work profession to promote:

“...social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” Hare (2004:406).

Social work is therefore, about empowering vulnerable individuals and disadvantaged communities, by means of sharing knowledge, experience and skills, so that these individual's basic needs are met, so that they are able to function independently, and so that they are referred to relevant resources in order to make their own decisions. In relation to mediation, social work particularly promotes empowerment of individuals through the education of conflict resolution and communication skills, and enhances their well-being in that individuals learn new effective ways of engaging with one another during conflict.

1.4.2 Conflict

Fisher, Ludin, Williams, Abdi, Smith and Williams (2000:4) define conflict as a relationship between two or more parties (individuals or groups) who have, or think they have, incompatible goals. Boardman and Horowitz (in Keefe & Koch, 1999:34) specify these incompatibilities to be within behaviours, cognitions (including goals), and/or affect among individuals or groups that may or may not lead to an aggressive expression of this social incompatibility. In other words, incongruity of diverging perceptions, opinions and values takes place between the parties involved.

Since the phenomenon of conflict is such a central point of discussion in this study, it would be necessary to elaborate more on the intensity and range that conflict can take. There are at least two continua that progressively describe the intensity of conflict. On the first continua discussed by Keltner (in Hocker & Wilmot, 1995:21), the intensity and range of conflict can be seen as firstly a mild difference, secondly a disagreement, thirdly a dispute, fourthly a campaign, fifthly litigation, and lastly a fight of war. The other continua described by Boulding (in Vayrynen, 1987:319) includes (a) union, (b) integration, (c) cooperation, (d) alliance, (e) mutual adaptation, (f) negotiation and exchange, (g) mediation, (h) arbitration, (i) threat systems and deterrence, (j) limited war, and (k) war of extermination. In other words, there is a spectrum that ranges from complete oneness and unity to total destruction with one another (Hocker & Wilmot, 1995:21).

However, most of people's everyday behaviour oscillates somewhere in the middle of the range of mediation, negotiation, exchange, mutual adaptation, and cooperation (Hocker & Wilmot, 1995:21). Nevertheless, it may be difficult for the caregiver and adolescent to resolve conflict if they do not have the necessary skills, knowledge and experience of this midrange of possible interactions. It is in this area of teaching skills and transferring knowledge where the social worker can intervene and empower the adolescent and caregiver.

1.4.3 Mediation

Mediation is an extension of negotiation, and mediation cannot take place without negotiating procedures. Mediation is a shared conflict resolution process whereby two or more parties in dispute are assisted in their negotiation by an unbiased and objective third party (Kruk, 1998:4). The third party or social worker aims to bring a power balance between the adolescent and caregiver, and assist them to reach consensus and an acceptable settlement of the issues in dispute (Kruk, 1998:4).

Further, it is important to understand that mediation does not include therapy (Umbreit & Kruk in Kruk, 1998:98). According to Umbreit and Kruk's parent-child mediation model (1998), therapy and mediation should not occur simultaneously during sessions; however, caregivers and adolescents can be referred for counselling or therapy if there are unresolved emotional issues that cause them to not progress to a resolution in mediation. In some cases, after an agreement has been reached, the parties concerned may still choose to go for counseling (Umbreit & Kruk in Kruk, 1998).

1.4.4 Caregiver

According to the definition in the New Dictionary of social work (Terminology Committee, 1995:6), a caregiver is a person who is responsible for providing care for another person. For the purpose of this study, when reference is made to the caregiver, it also represents biological parents, relatives, foster parents or any adult that takes the responsibility of caring for the young person.

1.4.5 Adolescence

Chaplin (1985) states that adolescence is the stage “between puberty and maturity” and that the estimated ages are 12-21 for girls, who mature earlier than boys, and 13-22 for boys (Chaplin, 1985:13). However, according to the Oxford Advanced Learner’s Dictionary (2000), it states that adolescence takes place between the ages of 13 and 18 and that it is a time when a child develops into an adult (Oxford Advanced Learner’s Dictionary, 2000:15). On the other hand, the South African Constitution of 1996 in Section 28(3) defines a child as anyone under the age of 18 years (in Bezuidenhout & Joubert, 2003:7). For the purpose of this study, words such as “adolescent” and “child” will be used interchangeably.

1.5 DELIMITATION OF THE RESEARCH AREA

The research area of this study has been delimited to BADISA, a non-profit organization and which is also a joint ministry of the Dutch Reformed Church (Western and Southern Cape) and the United Reformed Church of South Africa (Cape Synod). This study is further targeted at five of the BADISA branches or programmes in the Western Cape. The reason for choosing this particular organization as the target group is because the researcher is employed at one of the programmes of BADISA, and because of the accessibility to the organization in performing the research study.

There are a total of 24 branches or programmes in the Western Cape, of which a total of 39 social workers, are employed at the respective branches. These BADISA programmes are specifically only referring to those who have the word “BADISA” in the name of the organization, and not those programmes who are also affiliated to BADISA, and do not have the word “BADISA” in their name.

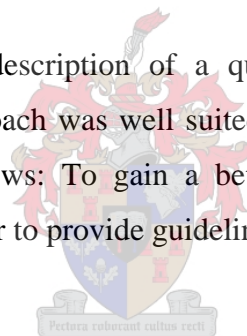
1.6 RESEARCH METHODOLOGY

1.6.1 Research approach

The predominant research approach employed for this study is a qualitative research approach, however, elements of a quantitative research approach was employed for the

purpose of obtaining the goal of the research. According to Fouche and Delpont (2002:79) the qualitative approach aim to understand social life and the meaning people attach to everyday life. In a broad sense, qualitative research refers to research that obtains participant accounts of meaning, experience or perceptions. The outcome of qualitative research is in the form of descriptive data in the participant's own words, thereby identifying the participant's beliefs and values that underlie the phenomena. Consequently, a qualitative study is concerned with non-statistical methods and small samples often purposively selected (Fouche & Delpont, 2002:79). However, as mentioned before, some of the processed data were presented in a quantitative manner, by means of tables and figures. According to De Vos (2002:364) sometimes it is necessary to combine the two approaches, and within these study small elements of the qualitative approach, such as indicating percentages and so forth, is included to give an overview of the "quantity" involved.

In view of the abovementioned description of a qualitative approach to research, the researcher concluded that this approach was well suited for realizing the goal of this study. The latter was formulated as follows: To gain a better understanding of mediation and adolescent-caregiver conflict in order to provide guidelines for social workers.



1.6.2 Research design

As indicated by Strydom (2002:213) exploratory and descriptive research is conducted to gain insight into a situation, phenomenon, social setting or relationship, community or individual. The necessity for this kind of study develops from a lack of basic information on a new area of interest, or in order to become acquainted with a situation so as to formulate a problem or develop a hypothesis. The answer to a "what" question would, constitute an exploratory study. In general exploratory research has a basic research goal, and researchers frequently use qualitative data (Fouche, 2002:109).

On the other hand, with the descriptive research design, focus is drawn on the "how" and "why" questions, which are evident throughout the study (Neuman in De Vos *et al.*,

2002:109). Descriptive research also allows for both a qualitative and quantitative research approach.

1.6.3 Research method

In the following sub-sections with reference to the research method employed, the literature study, population and sampling, methods of data collection, methods of data analysis, method of data verification, ethical considerations, and limitations of study, will be discussed.

1.6.3.1 Literature study

At the outset, the researcher conducted an extensive literature study on all the most current theses, dissertations, journals and books by means of the university library and the Internet (Strydom, 2002:212). The researcher endeavoured in making use of a range of different sources available and that which could be accessed. This was done in order to establish a reference framework from which to proceed with the research and to form a basis for comparison of the research findings.

According to Fouche and Delport (2002:127), it is necessary to conduct a literature study in order to gain a clearer understanding of the nature and meaning of the research field. Furthermore, Mouton (2001:87) points out that a literature study aims to avoid duplication and suggest possibilities in the research field to explore. Both local and international literature was utilized in order to gain an understanding of mediating adolescent-caregiver conflict.

1.6.3.2 Population and sampling

When referring to the universe in a study, it refers to all probable participants who possess the attributes in which the researcher is interested (Strydom & Venter, 2002:198). Therefore, with reference to this study, the universe is the 38 social workers from the respective 24 BADISA branches. Stoker (in De Vos, 2002:200, 201) provides guidelines as to choosing the sample size, from which a population of 38 participants, a sample size of approximately 25 participants can be chosen. However, because of the qualitative design of this study and the vast amount of data to be collected and analysed, ten social workers from five BADISA

branches are selected, so that the sample will be representative of the universe and so that conclusions can be drawn about the population from which it is drawn (Reid & Smith in De Vos, 2002:201).

With reference to the procedure of drawing a sample from the universe, non-probability sampling are utilized and specifically, a purposive sampling technique rather than random sampling methods. Qualitative researchers seek out individuals, groups and settings where specific processes being studied are most likely to occur (Strydom & Delpont, 2002:334). The researcher purposively sampled ten social workers from a specific region that is easily accessible and is homogenous in the type of areas the clients live in, in other words, the clients all live in rural areas.

1.6.3.3 Methods of data collection

- **Preparation for data collection**

Following the written permission from the Director of BADISA to conduct this study was granted, a literature review was done. The researcher began the process of data collection by making contact telephonically or in person with the potential participants at their offices. During this contact, the researcher introduced herself to the potential participants and explained the purpose and procedures of the research study. The researcher then established their readiness to participate in the research study. Permission was verbally obtained to willingly participate and appointments were scheduled with all 10 participants.

- **Research instrument**

Data was collected by means of a semi-structured interview with the aid of an interview schedule. This qualitative method was chosen in order to identify participants' experience in their own words (Richie & Lewis, 2003:36, 37). All the interviews were conducted in the home language of the participant (either Afrikaans or English) and audiotape with the consent of the participants (Greeff, 2002:302-303).

The researcher made use of a semi-structured interview schedule that included questions that were contained in an interview guide with a focus on the issues to be covered. Questions about each issue were asked in an open-ended, closed-ended, and multiple-choice manner.

The researcher conducted the interviews according to the guidelines given by Greeff (2002:303). First, the participant was made to feel comfortable and at ease. Then the researcher facilitated and guided him/her through the interview. The researcher did not necessarily ask every question on the schedule depending on the flow of the conversation, but obtained a watchful balance by not deviating too far from it. Participants had the opportunity at the end of the interview to ask questions regarding any uncertainties or express any feelings caused by the interview.

1.6.3.4 Methods of data analysis

Data analysis, according to De Vos *et al.* (2002:339) is the process of structuring and assigning meaning to the mass of collected data. This process is described as “...messy, ambiguous, time-consuming, creative and fascination...” (De Vos, 2002:339). Qualitative data analysis does not progress in a linear way; it rather occurs in analytic circles by searching for general statements about relationships among categories of data (De Vos *et al.*, 2002:340; Tutty *et al.*, 1996:90).

When the data collection process reached the point of data saturation, the process of data analysis began. First the tape-recorded interviews were transcribed. Subsequent to reading the transcriptions, the main findings were extracted manually, and the data was then sorted according to categories and themes (Oppenheim, 1992:261). The various categories and themes together with a few illustrative quotations from the raw data were turned into a report (Oppenheim, 1992:261). The researcher then summarized and interpreted the data in the research report by comparing it to existing data from the literature review. Finally, the data was presented in narrative, tabular or figure form (De Vos *et al.*, 2002:339-344).

1.6.3.5 Methods of data verification

When considering the method of data verification, the generalizability, reliability, and validity of the interview findings is ascertained (Kvale, 1996:88). Each of these three elements to data verification will be briefly discussed.

- **Generalizability**

Generalizability refers to questioning the research results in terms of whether it can be generalizable (Kvale, 1996:231). The findings from the participants in those specific areas can be compared, similarities and differences can be found, and generalizations can be made to this specific target group. Naturalistic generalizations can be made in this study, as the participants have developed personal experience, knowledge and expectations in their field of work (Kvale, 1996:232). The findings of a self-selected sample as in the case of this study, however, cannot be statistically generalized to the population at large (Kvale, 1996:233). Social workers that identifies with the content of mediation procedures and problem formulation, could use this study as a guideline, however, they would not be able to generalize it to all different contexts.

It is generally been the researcher who builds up and argues for the generality of his or her findings by means of assertational logic or by statistical procedures (Kvale, 1996:234). When looking at targets of generalization, three questions are asked: looking at “what is”, “what may be” and “what could be” (Kvale, 1996:234, 235). The “what is”, refers to basically attempting to establish the typical, the ordinary, the common – in other words, one seeks to maximize the fit between the what is found in research, and what takes place more broadly in a society, such as South Africa. The “what may be” does not look at generalizing what is, but what may be. The “what could be” refers to situating situations that is believed to be the preconceived ideals and studying them to see what goes on there (Kvale, 1996:234, 235).

- **Reliability**

Reliability refers to the consistency of the research findings (Kvale, 1996:235). Leading questions for instance are used in qualitative interviews to determine the reliability of the interviewees' answers (Kvale, 1996:286). Also, by repeating a question in different versions and each time getting the "same" indirect answer can also test the consistency of the participants' responses (Kvale, 1996:152). Therefore, one wants to see how consistent the findings of the research are within other areas or contexts.

- **Validity**

Validity means whether an interview study investigates that which it intended to investigate (Kvale, 1996:88). Validation includes both inspecting the end product as well as controlling the quality of knowledge throughout the stages of the research (Kvale, 1996:236). The validity with respect to the design refers to whether the design employed produced knowledge that is beneficial to the participants and the concerned organization, and at the same time reducing consequences that may be harmful (Kvale, 1996:237). Validity with regards to the interview concerns the trustworthiness of the research findings and the quality of the interview itself, with specific reference to cautious questioning as to the meaning of what is being said and continuously verifying information gained from the participants (Kvale, 1996). Validation with regards to transcribing, involved translating the oral data to written language (Kvale, 1996). All information obtained during interviews were recorded on a dictaphone, and transcribed word for word on to the computer. Validity with regards to reporting concerns the question of whether the main findings are reflected clearly and is a valid account in the report (Kvale, 1996). All the data was summarized and thematized according to the information that is necessary to meet the objectives of this study.

1.6.3.6 Ethical considerations

As a registered social worker, the researcher was bound by the ethical code of social workers (Tutty *et al.*, 1996:40-43). According to De Vos (2002:351) ethics are defined as:

“Ethics is a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the

most correct conduct towards experimental subjects and participants, employers, sponsors, other researchers, assistants and students.”

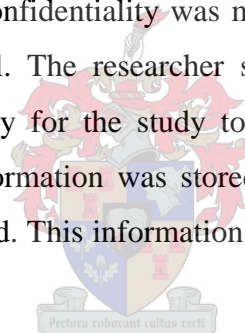
In agreement with the above, the following ethical conditions were relevant to be considered in conducting this study:

- **Informed consent**

Participants were provided with sufficient information about the study to allow them to decide for or against participation. The participants were not coerced in any way. Participants gave verbal consent to participate in the study.

- **Confidentiality**

The researcher ensured that confidentiality was maintained by keeping all information about participants confidential. The researcher solicited and recorded only personal information that was necessary for the study to achieve its purpose further ensured confidentiality. The study information was stored in a safe place where participants' identities would not be revealed. This information was accessible only to the researcher, and the supervisor.



1.6.3.7 Limitations of the study

The participants had limited knowledge about mediation and the process of it, which limited the usefulness of the responses to the other questions that were raised during the interview and presented on the interview schedule. Further, interviews took place during the participants' working day, which limited the time for the interviews. In order to compensate for these limitations the following was considered: the fact that the participants had limited knowledge about mediation, gave the researcher understanding into what methods they use in practice and identifies the needs for further training in this area, which is part of the aim of this study – gaining a better understanding of mediation and how it is used in practice. Social workers that identifies with the content of mediation procedures and problem formulation,

could use this study as a guideline, however, they would not be able to generalize it to all different contexts.

1.7 PRESENTATION OF STUDY

The research report will include several chapters. Chapter one will outline the research proposal and serve as an introduction. Chapter two will present an overview of the nature of conflict in adolescent-caregiver relationships. Chapter 3 will focus on the employment of mediating conflict in adolescent-caregiver relationships within the social worker's context. Chapter 4 will delineate the sample and instrument for survey as well as the results of the survey. Finally, chapter 5 will be a presentation of the conclusions and recommendations.

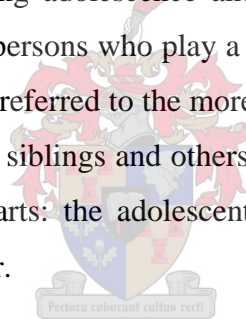


CHAPTER 2

THE NATURE OF CONFLICT IN ADOLESCENT-CAREGIVER RELATIONSHIPS

2.1 INTRODUCTION

In order to explore the nature of conflict in adolescent-caregiver relationships it would be of great value to briefly unwrap the complexities surrounding the life cycle stage of adolescence and adulthood in this chapter. The life stages of adolescence and adulthood according to Erikson's psychosocial stages (1968) will be discussed, because caregivers usually fall within the life stage of adulthood, and primarily because this theory lays specific emphasis on the role of the social environment during adolescence and adulthood. The social environment specifically refers to the significant persons who play a role or have an impact on the lives of people, such as parents or otherwise referred to the more inclusive concept of caregivers, then also the influence of peers, teachers, siblings and others with whom we interact. This chapter will be presented in three major parts: the adolescent, the caregiver, and the relationship between the adolescent and caregiver.



Within the first part of the discussion of adolescence, a brief discussion will be made of the life cycle stage of adolescence and the roles the adolescent plays. Within the second part of the discussion of the caregiver, specific reference will be made to the life cycle stage of adulthood and how this stage may impact the relationship with the adolescent, and then also a discussion on the roles of caregivers will follow. Within the final section on the relationship between the adolescent and caregiver, focus will be drawn to the different sources of stress experienced by the adolescent and caregiver, different factors that may contribute to adolescent-caregiver conflict, and the areas of conflict in adolescent-caregiver relationships. For the purpose of this study, as mentioned before, the caregiver represents the person, who is the lawful guardian, or person(s) who is responsible for the adolescent by private

arrangement, foster parent(s), or any guardian of the adolescent, such as an aunt, uncle, grandparents and so forth who takes responsibility in caring for the adolescent.

2.2 THE ADOLESCENT

For the purpose of this study, the developmental changes during adolescence will be discussed in the following section, because these developmental changes may be factors that impact the adolescent's relationship with the caregiver, as well as with the wider social environment.

2.2.1 Developmental changes during adolescence

There are many different changes that take place during adolescence, such as physical development, cognitive development, morality and spirituality, emotional development, self and identity formation, changes in family relations with caregivers and siblings, and peer relations, sexuality, education and work (Dacey & Kenny, 1997). Specifically linking to the aim of this chapter, which is the nature of conflict in adolescent-caregiver relationships, the areas that will be focused on is: changes in interpersonal relationships with caregivers, changes in interpersonal relationships with peers, cognitive development, and moral development. Each of these specific areas is chosen as they play a big part in the context of where conflict may take place between the adolescent and caregiver.

With reference to the section on interpersonal relationships with caregivers, focus will be drawn to identity formation and decision-making, and increase of conflict. Thereafter, changes in interpersonal relationships with peers/friends will be briefly discussed. In the area of cognitive development, the discussion will be centred on value systems and egocentricity.

2.2.1.1 *Changes in interpersonal relationships with caregiver(s)*

The life cycle stage of adolescence is very often associated as a time of *change* and *crisis*. With reference to the first, Seidman *et al.* (2004:236) describe this change taking place in the adolescent's development in the area of their biology, the maturing of their emotions, cognition, and in their interpersonal relationships.

With reference to interpersonal relationships, in some instances the word “crisis” can be connoted with calamity and tragedy. However, when Erikson (1968:16) refers to adolescence as a time of “crisis”, he describes it more as an essential “turning point, a crucial moment, when development must move one way or another”, gathering together sources for development, healing, and for advanced separation. It is a stage in the adolescent’s life that is necessary, in order for the adolescent to move into the next phase of adulthood. The adolescent needs to discover those resources and persons with whom they can identify and utilize for further growth. It therefore, depends on the way in which the time period of adolescence is perceived and experienced – either as a time of crisis and conflict, or as a time where turning point takes place for further growth and maturity.

- **Identity formation and decision-making**

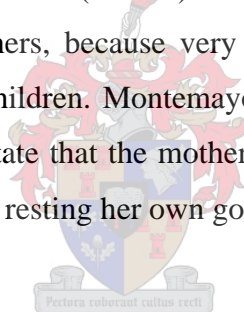
Erikson (1968) further explains that adolescence is a time for the individual where he or she is at war with him or herself, and in their bewilderment rebels and “war on their society” (Erikson, 1968:17). Therefore, according to Erikson (1968:17) the period of adolescence and young adulthood can be assigned to a time of normative identity crisis. This war on society may therefore, represent the various positions that adults in general uphold in society, such as caregivers. In search for their identity, they tend to inquire more as they aspire to become more autonomous and independent, and make choices for themselves (Seidman *et al.*, 2004:237). Various topics of discussion may be debated or even argued about, as a result of the adolescent not taking everything at face value and seeing themselves as entering the world of adulthood. The struggle takes place where the adolescent yearns to make decisions about family matters, develop independence, and on the other hand, also preserve the protection that the family offers (Seidman *et al.*, 2004:237). Therefore, part of this struggle for the adolescent and their caregiver is to negotiate and reach equilibrium between these two aspects.

Lingren (1995:2) adds that conflict between caregivers and adolescents generally increase amid the phase of childhood and during the onset of adolescence; while in the majority of families, the recurrence of conflict and the magnitude of it remains relatively at a low level.

Lingren (1995) further states that very often it is typical that conflict occurs in the area of negotiating their relationship with one another, where caregivers persist in trying to socialize their children, and do not see the warning signals of a breakdown in their relationship with their adolescents. According to Lingren (1995:2) it is very important for the adult to involve the adolescent when family decisions need to be made as well as when boundaries and rules are set, especially when it affects the life of the adolescent. When the caregiver involves the adolescent in decision-making and rule-setting, it teaches the adolescent about responsibility and enlarges their mind to other perspectives and other people's world views.

- **Increase of conflict**

Other research as stated by Allison (2000:1) has also indicated that conflict increases between caregivers and adolescents at some stage in middle school years and revolves around the daily happenings of life in a family. Allison (2000:1) also adds that conflict manifests more between adolescents and their mothers, because very often the mother is the person who spends more of her time with the children. Montemayor and Hanson (in Laursen, 1995:67) concur with this argument as they state that the mother is the main manager for responsibly socializing the children, unavoidably resting her own goals very often in straight opposition to the goals which the adolescent holds.



On the other hand, one also needs to consider in cases where the caregiver is other than a biological parent, such as, an aunt, uncle, or grandparent and the relation that the caregiver has to the adolescent can possibly also contribute to the type of conflict that occurs between the caregiver and adolescent.

2.2.1.2 Changes in interpersonal relationships with peers/friends

Beyond the context of the adolescent and caregiver relations, the adolescent's focus and loyalty very often lies more with their peers. The adolescent experiences on his own and together with his peers these developmental changes; these experiences direct towards different patterns of common communications with the peers and caregivers in the spaces in which the adolescent exist (Seidman *et al.*, 2004:237). Although adolescents place more

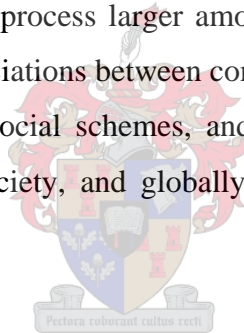
importance on building and maintaining relationships with their friends or peers, and spend much of their time in school, sport and hobbies, studies from Greenberg, Siegel, Leitch, Hunter, Youniss, Siddique & D'Arcy (in Noller & Callan, 1991:63) have shown that the family context in which the adolescent finds him or herself, has a far greater impact than those contexts which are mentioned before.

2.2.1.3 Cognitive development

In the following section on cognitive development specific focus will be drawn to a brief discussion on value systems and the aspect of egocentricity within the adolescent.

- **Value systems**

With specific reference to the cognitive development that takes place during the phase of adolescence, the adolescent start to process larger amounts of information, start to think in abstract terms, comprehend the associations between conceptual or theoretical principles, start to explore political, religious and social schemes, and they start to critically evaluate the prevailing value system in their society, and globally if they are exposed to it (Louw & Edwards, 1997:511).



Above these aspects of cognitive development, something that is of particular concern for this study is that through logical thought processes, adolescents are able to distinguish contradictions and double standards in people's reasoning and behaviour (Louw & Edwards, 1997:511). Within the context and relationship between the caregiver and adolescent this often results in conflict, for instance, when standards and rules are expected to be followed, which the caregiver do not adhere to themselves.

- **Egocentricity**

When adolescents become involved in high risk behaviour, such as, smoking, using drugs and alcohol, and partaking in sexual activity, it can very often be accounted for the egocentricity of the adolescent. Egocentricity refers to adolescents perceiving that they are "unique and invulnerable" (Louw & Edwards, 1997:511). In other words, the adolescent feels that he or

she is invincible and that the consequences of partaking in high risk behaviour will not affect them. These perceptions are directly linked to part of the processes of cognitive development. Conflict may result between the adolescent and caregiver if the adolescent becomes involved in high risk behaviour and does not see the consequences of their behaviour.

2.2.1.4 Moral development

During adolescence, moral development and more specifically, moral reasoning is a task that is very important. In this process of developing moral reasoning, the adolescent gains knowledge of beliefs that allows them to determine whether particular conduct patterns are of a right or wrong nature (Louw & Edwards, 1997:512). The pace at which this moral development is taking is decided upon the social context (Snarey, 1985). Kohlberg (1985) states that if one had to compare individuals from multifaceted urban cultures to those from primitive rural cultures, higher levels of moral reasoning would occur sooner in the urban cultures than within the rural cultures. In the same way, persons from higher socio-economic strata display higher levels of moral reasoning than those from lower socio-economic strata (Kohlberg, 1985).

Nonetheless, even if the adolescent can distinguish between right and wrong, has certain strong beliefs about certain behaviours (such as taking drugs), and has a sense of moral reasoning, does not necessarily determine how the adolescent will behave. Very often conflict occurs between the principles of the adolescent and the pressures within the environment that challenges their beliefs. These challenges are powerful influences which can override an individual's moral judgment, such as, conformity to the normative attitudes of the peer group, submission to those who are in power positions, and identification with group ideology (Louw & Edwards, 1997:515).

2.2.2 Adolescent roles

The roles of the adolescent are very closely linked to the caregiver's roles, which will be discussed further on. The adolescent's roles are a response to the roles that the caregiver has to undertake. The adolescent's roles are as follow: to learn society's values and attitudes and

their behaviour needs to reflect these; accept the discipline of their caregiver and be obedient; meet some of the caregiver's emotional needs; cooperate; preserve unity within the family structure and lessen tensions between family members; and carry out chores assigned to them by their caregivers (Kadushin, 1988:11).

Kadushin's (1988) work is classical and is still relevant today as there is no other more current literature available in the area of parental and children's roles. The purpose of including a discussion on adolescent roles and later a discussion on caregiver roles is because there are general acceptable expectations and obligations that caregivers and adolescents have towards each other. When these expectations and obligations are not met, conflict or strain within this relationship and other relationships can occur.

2.3 THE CAREGIVER

Aspects of the life cycle stage of adolescence have been discussed in the first part of this chapter. The second part of this chapter will take a closer look at the life cycle stage of adulthood, with specific reference to Erikson's (1968) perspective on the psychosocial crises during adulthood. Particular reference is made to adulthood in this chapter, as the caregiver usually falls within this stage of the life cycle. A brief discussion of the caregiver roles will also be included in this part of the chapter.

2.3.1 Psychosocial crises during adulthood

Erikson (1968) divides the life cycle stage of adulthood into three stages, namely early adulthood, middle adulthood, and late adulthood. Within each of these stages, there are different tasks to be performed or a different psychosocial crisis to be faced (Louw & Edwards, 1997:500). The caregiver can fall into any one of the three stages. Adults are more likely to have children or have the responsibility of taking care of children within early adulthood and middle adulthood. However, the caregiver within this study represents and includes a wider spectrum of persons, such as grandparents, uncles and aunts, which may fall within the late adulthood stage.

2.3.1.1 Early adulthood

Erikson's (1968) psychosocial stages with specific reference to the three adult stages mentioned above can be explained in terms of two bipolar ends that the adult may experience. Within the early adulthood stage (approximately 20 to 40 years), the young adult is supposed to form a meaningful relationship with another person, where intimacy can be experienced. On the other side of the pendulum is isolation and loneliness, which can be experienced when the adult has not formed a meaningful relationship with another (Louw & Edwards, 1997:501). This psychosocial crisis of intimacy versus isolation is important to consider for instance when children are born outside of wedlock where there was a lack of commitment within the relationship between the adults and where children are born out of casual sexual relations where there is no meaning and intimacy within the relationship. If for instance the adult did not experience intimacy and meaning in a relationship with another person during this stage, it may result in them having difficulty in connecting and forming meaningful relationships with their children and later adolescents.

2.3.1.2 Middle adulthood

Further, within the middle adulthood stage (approximately 40 to 65 years), Erikson (1968) argued that adults needed to rear children, become involved with work and with their society, in order to experience generativity. On the other side of the pendulum, Erikson argued that stagnation and self-centredness could develop if the adult did not involve themselves in these areas. Finding a balance between these three areas can also be challenging. This psychosocial crisis of generativity versus stagnation is important to consider, because many adults do not have the opportunity or are prepared to rear children and may not see the value of this experience. This may be problematic when adults are forced into the role of caregiver due to unplanned pregnancies, taking the responsibility of caregiver of children when the biological parents have passed away or have deserted the children and so forth. Neugarten (1968) have argued that the societal culture and social clocks very often guide and place expectations on adults to conform to specific milestones for this stage of adulthood, which may cause stress for those who are out of synchronization with the developmental guidelines provided by the social clock.

2.3.1.3 Late adulthood

In the final stage of late adulthood (approximately from 65 years of age), Erikson (1968) argues that there should be at a point where they can reflect and review their lives and should feel a sense of satisfaction of what they have achieved and accomplished that will develop integrity within them. On the other side of the pendulum, despair may be experienced if the adult has not achieved their ideals and dreams. This psychosocial crisis of integrity versus despair is important to consider, especially in cases where adults within this winter stage of their lives are forced into a caregiver role for various reasons and situations, which can sidetrack and delay the actual and usual process that they should go through. This may cause conflict within the caregiver-adolescent relationship.

Taking the above aspects into consideration of the stage of adulthood, it is clear that adults cannot be regarded as a homogeneous group as perhaps adolescence can be regarded, because within each of the three stages in adulthood, the adults have a much more diverse range of experiences than do children and adolescents (Louw & Edwards, 1997:524). Adults also make sense of these experiences in different ways to adolescents. These diverse range of experiences or otherwise referred to by Schlossberg (1987) as life events shape adults' lives and the way they develop as adults. Schlossberg (1987) refer to these specific life events as being family life, education, work, marriage, divorce, remarriage, changes in health, and death of a loved one.

2.3.2 Caregiver roles

A role is a responsibility that is performed, a position that is taken, and a behaviour that is performed out of obligation to another's expectation that he or she has of the person concerned (Kadushin, 1988:11). The general expectations that are laid upon caregivers in relation to the adolescent in performing acceptable roles are: the role of financial provider; provider of emotional needs; role of stimulator of normal intellectual, spiritual and social development; provider of socializing the adolescent; role of disciplinarian; role of protector; role of maintaining interaction between family members; role of providing a permanent place

of dwelling; and role of intermediary between the adolescent and the human race. It can be noted that there are many roles for which the caregiver needs to take responsibility. If the caregiver did not receive proper education through role modelling of his or her own caregivers and from the wider community as a child, it can spill over into tension, misunderstanding and conflict within the current adolescent-caregiver relationship.

2.4 THE ADOLESCENT-CAREGIVER RELATIONSHIP

There are different factors that may impact or have an effect on the adolescent-caregiver relationship and these factors needs to be considered. In the following section, the sources of stress that adolescents and caregivers can experience within their relationship are outlined; however, the different sources of stress discussed are not all inclusive. There may be other sources of stress. Some of these sources of stress can be considered as social and/or external environmental factors to contributing to conflict in adolescent-caregiver relationships.

2.4.1 Sources of stress in the adolescent-caregiver relationship

In conjunction with the developmental changes that take place during the stages of adolescence and adulthood, one needs to consider the sources of stress that adolescents and caregivers generally experience. Newcomb and associates (in Dacey & Kenny, 1997:356) categorized seven different key sources of stress experienced by adolescents and/or caregivers: family and/or parental problems; accident, illness, or loss of a loved one; engagement in sexual practices; autonomy; becoming involved in deviant behaviour; moving house, town, or school and/or caregiver changing work; and distress. Each of these sources of stress experienced by the adolescent and/or caregiver will be discussed briefly. Sources of stress discussed by other authors will also be included.

2.4.1.1 *Family and/or parental problems*

Parental and/or family problems are chosen to be discussed as a primary source of stress, because this is the area in which the child or adolescent as well as caregiver spends much of their time. In many cases, there are marital problems between the parents and/or caregivers, or the home may be headed by a single parent, and/or the caregivers are in conflict about

parenting style or discipline. These are strains that directly affect the adolescent and/or children, as they are exposed to these conflicts or stresses on a regular basis. The home should be a place where the child feels safe and where there is a general sense of harmony within the home (Newcomb & associates in Dacey & Kenny, 1997). When the caregivers in the home struggle to resolve conflict, this behaviour is modelled for the children in the home and the way in which conflict is resolved or unresolved between the caregivers can in turn be internalized within the adolescent's frame of reference. The adolescent's frame of reference may then also influence the way he or she resolves conflict in their relationships with significant others.

Muncie (1999:191) also concurs that very often when difficulties start to occur during the adolescent stage, it very often can be connected to stressful circumstances, such as marital disharmony or parental authoritarianism, which also links to the parental style that will be briefly discussed at a later stage.

2.4.1.2 *Death, accident or loss of loved one*

Death, an accident or loss of a loved one is a source of stress included, because these events are a part of life, and it is something that every person has to face at some point of their lives. The adolescent and caregiver may experience a great deal of stress in cases of death of a loved one, being in an accident, or if one of the family members fell ill, that might result in extra responsibility being placed on the adolescent, and being deserted by a parent or caregiver. With reference to the latter, of being deserted by a parent or caregiver, presents as a definite strain as it may result in losing trust in a loved one and increasing loneliness, which is very much part of what adolescents experience on a continued basis (Konopka, 1997:12). The outcome of losing a loved one or any one of the above mentioned examples are angst, bitterness, anger towards themselves, towards God or other parties involved, a loss of hope, a decrease in energy levels, feelings of discouragement, and experiencing difficulties in solving problems (Roestenburg, 1999:133).

Every adolescent and/or caregiver in very different contexts, with reference to culture, spiritual upbringing, morals and values and so forth, grieves the loss of significant others in many different ways. In some instances, it needs to be considered that adolescents and/or children, as well as caregivers are not always given the opportunity to move through their own grieving process or stages of grieving as outlined by Kübler-Ross (1969), and these may result in unresolved issues that may spill over into other areas of functioning in their lives. The caregiver is not able to move through the grieving process, because of the pace, demands and responsibilities that life places on them. These unresolved issues or pains may form blockages to everyday interactions and even in the level of intimacy with significant others.

2.4.1.3 Engagement of sexual practices

The engagement of sexual practices is a source of stress that needs to be discussed, because this is one of the areas which affect adolescents considerably with regards to their increasing interest in this area specifically during this phase of their life. During the phase of adolescence, the adolescent often starts to become interested in the opposite sex. Very often adolescents are pressured at school, or more specifically by their peer group to start dating and/or be in a relationship with the opposite sex. In some cases their may even be confusion about sexual orientation, and decisions around having sex – these may all serve as sources of stress for the adolescent, especially when the adolescent is not completely and correctly informed by trusted sources (Newcomb & associates in Dacey & Kenny, 1997:356). Adolescents do not always feel at liberty to ask caregivers questions they have about sexuality, especially in cases where they do not have a trusting relationship with their caregivers and where much conflict takes place within the home. However, there may be other reasons for feeling that they cannot approach their caregivers with sexuality related issues, such as the concept of the “generation gap” (Noller & Callan, 1991:26), which is discussed at a later stage.

2.4.1.4 Autonomy

Autonomy is a source of stress that needs to be discussed as adolescence is a stage in life that is characterized by the onset of it. The adolescent strives to be independent, but with it comes

extra responsibility, and with extra responsibility comes growth and growth can sometimes be painful. Becoming more independent and autonomous, can become a source of stress, because they are moving into a sphere of uncertainty, not always knowing what the consequences may be of their actions. In the sphere of uncertainty, feelings of insecurity and fear may contribute to the source of stress (Dacey & Kenny, 1997:210).

Minuchin (in Dacey & Kenny, 1997:217) adds that very often conflict occurs during adolescence because the caregivers are not flexible in meeting the adolescent's need for autonomy. Eccles, Wigfield, Buchanan, Reuman, Flanagan and Mac Iver (in Stewart, 2001:125) recapitulate the predicament of adolescence as being a time where the adolescent on the one hand, wishes to be under less control from the caregiver. On the other hand, the adolescent does not want total freedom and risk losing the emotional attachment of the caregiver. As an alternative, the adolescent wishes for a steady increase in the opportunity in independence, joint-decision making, and the joint-setting of rules (Eccles *et al.*, in Stewart, 2001:125).

2.4.1.5 *Involvement in deviant behaviour*

Involvement in deviant behaviour is a source of stress that needs to be discussed, as it links to extreme cases where other sources of stress may drive the adolescent to the extent of becoming involved in deviant behaviour. This may result in conflict between the adolescent and caregiver. Not all adolescents possess the skills and capacity to deal with stress effectively. In cases where adolescents become involved in deviant behaviour, such as vandalism, stealing, lying and/or coming into contact with the law, these instances can very well serve as a source of stress for them. Executing and/or participating in these deviant behaviours, very often is a search for individuality and complying with pressure from peers. However, inherently the adolescent is aware of the consequences and outcome of his or her behaviour if he or she has been raised with society's general norms and values (Dacey & Kenny, 1997:356, 357). This awareness of the consequences of their deviant behaviour comes into conflict with their moral reasoning, if this has been developed, which in turn may result in stress within the adolescent. Very often adolescents become involved in deviant behaviour,

such as stealing, just as a means of survival, particularly in the poor communities. The adolescent's need to survive overrides their moral reasoning.

Deviant behaviour can also be perceived as high risk behaviour. In cases of high risk behaviour, such as coming into contact with the law, use of and/or selling of drugs, engaging in promiscuous behaviour, and so forth can be understood in relation to Jessor's (in Davis, Tang & Ko, 2002) psychosocial framework. Jessor (in Davis *et al.*, 2002:609) proposes a model that includes five interconnected spheres of protective and risk factors: the genetic make-up; the environment where the person is socialized; the way the individual perceives his or her environment; the individual's conduct; and personality traits of the individual. In the following sub-section the protective and risk factors to engaging in high risk behaviour is outlined separately, as well as the factor of after-school supervision.

- **Protective factors to engaging in high risk behaviour**

Jessor (in Davis *et al.*, 2002:610) includes factors which may protect the adolescent from participating in high-risk behaviour. These are: having a high level of intellect, support networks within the community or socially, growing up in an affirmative family atmosphere, having good access to resources in the community, being raised with good values, and experiencing a good quality education and school environment.

- **Risk factors to engaging in high risk behaviour**

Jessor (in Davis *et al.*, 2002:609) further explains the factors which may increase the likelihood of adolescents engaging in risk behaviour and they are: harmful influence from the family, conflicts that take place within the family and peer contexts, poor quality of life as a result of poverty, having a low sense of worth and self-respect, and performing poorly academically. With specific reference to the point of poverty, an argument can also be made that poverty may be a factor that may increase the likelihood of adolescents participating in high risk behaviour. However, according to Roestenburg's (1999:129) research, it showed that some families had the capacity to function as a powerful emotional place of safety, regardless of living in poor conditions. Participants in his study had the opinion that it did not

depend on the family's income, their position in employment, the amount of food they had, or whether they lived in a house or shack, but it depended largely on the family's "socio-emotional capacity" (Roestenburg, 1999:129). The issue of a lack of after-school supervision can also be related to adolescents becoming involved in deviant behaviour, which leads to the following sub-section.

- **After-school supervision**

Added to these factors of involvement in deviant behaviour, Stewart (2001:123) states that particularly girls, more than adolescent boys, who take care of themselves in the afternoon after school due to caregivers working, tend to be involved in more problem behaviours; have increasing conflict with caregivers; have feelings of rejection from their caregivers; interact more with deviant friends; and have low self-esteem. These findings show the importance of adult supervision and care after school.

2.4.1.6 Relocation

It is essential to look at relocation as a source of stress, as it is often evident in the South African context where a migrant labour system exists. This may be a source of stress for the caregiver and adolescent. Relocation being a source of stress refers to instances where adolescents can be faced with a new environment, such as moving into a new home, town, or when they go to High school. It can become very stressful in finding their way around the school premises, making new friends, getting used to new teachers and so forth. It can also be stressful for the caregiver in adjusting to a new environment, perhaps a new surrounding and predominant culture, language and it can be a challenge to make new friends.

Another source of stress related to the adolescent with reference to relocation, specifically in the South African context, is the state of uncertainty and change adolescents are experiencing in preparing for the present career realities and high unemployment rate in the country (Borgen & Amundson, 1998:14). High school learners, who come to the end of their school career, may find it a very daunting experience of entering the labour market or gaining access

to tertiary institutions, particularly when they have to venture out of home and into unfamiliar territory.

2.4.1.7 Distress

It would be of use to discuss distress as a source of stress, because it encompasses different aspects which may be experienced by many adolescents, which in turn may have an effect on their relationship with their caregiver(s). Dacey and Kenny (1997:356) has referred to distress being experienced when for example the adolescent's skin often breaks out with pimples, hormonal changes take place, when excess weight is gained, when they perform poorly at school, and when they may have suicidal thoughts. Adolescents are very often focused on their outward appearance, and a skin outbreak or gaining weight is therefore, a great source of concern and stress.

The nature of adolescence and adulthood, and the various sources of stress outlined above need to be taken into consideration as it set the context in understanding the type of conflict that may take place between adolescents and caregivers. It also needs to be considered, because according to McCubbin, Needle and Wilson (in Noller & Callan, 1991) in cases where adolescents continuously experience an increase in stressors in the family context, adolescents are more susceptible to getting involved in drinking, smoking or drugs than other adolescents (McCubbin *et al.* in Noller & Callan, 1991:133).

2.4.2 Factors that contribute to adolescent-caregiver conflict

Before discussing the various areas in which conflict can take place between caregivers and adolescents, it should be noted that there are various factors that contribute to conflicting situations between caregivers and adolescents and these need to be outlined first. For the purpose of this study, specific reference will be made to the following factors: closeness and cohesion; early childhood experiences; economical position; social and cultural context or environment; adaptability; punishment and/or discipline; family violence and/or physical abuse; substance abuse; and communication. The reason why these factors are specifically

chosen for this study is because it directly relates to the objective of this study and to endeavour in making it relevant to the South African context.

2.4.2.1 Closeness and cohesion

Noller and Callan (1991) outlines various factors that can affect the adolescent-caregiver relationship. One of the first factors discussed by above authors is closeness and cohesion. The characteristics of a close family and the signs of emotional distance will also be covered in this section. Every parent or caregiver has his own style of parenting and each family functions in different ways to others. There are different styles of parenting, such as authoritarian style, permissive style, authoritative style as outlined by Baumrind (1991), as well as the way a family functions. In considering the styles of parenting and the way a family functions, one needs to consider different factors such as the *closeness* that is shared between the family members, as well as the *cohesion*, structure and organization of the family (Noller & Callan, 1991:65,66).

With reference to cohesion, it suggests that members of the family are permitted to state their opinion, thoughts and feelings in a safe environment. Therefore, when caregivers do not create an environment of closeness and support to the adolescent, and discourage the adolescent to advance towards independence, growth stagnates and conflict can very well occur.

Laursen (1995:56) based his research on the basis that conflict which occurs interpersonally varies according to the relationship in which it occurs and the level of attachment between the participants. If one expands on this perspective, Collins and Laursen (in Laursen, 1995:56) further explain that conflict can be viewed as a “microcosm” mirroring larger patterns of social interaction. In other words, when reflecting on disputes, insight may be gained into the characteristics of and the course that social relationships take (Laursen, 1995:56).

- **Characteristics of a close family**

According to Kelley, Berscheid, Christensen, Harvey, Huston, Levinger, McClintock, Peplau, and Petersen (in Laursen, 1995:56) the characteristics of a close family is when relationships between the caregivers and adolescents are mutually supporting, included, and when reciprocally satisfying interactions take place. Furthermore, regular and varied social interaction takes place between close family members, which can very well increase the rate of disagreements, because the more they spend time with one another, the more chances the family members have to differ (Berscheid, Snyder & Omoto in Laursen, 1995:56). On the other hand, there may also be signs of emotional distance, which will be briefly discussed in the following sub-section.

- **Signs of emotional distance**

Lingren (1995:2) agrees that caregivers and adolescents often turn out to be more physically and psychologically distant from each other during the adolescent stage. Indications of whether this isolation has taken place between them, is a decrease in emotional closeness and warmth, disagreement between the adolescent and caregiver increases, and adolescents tend to spend more of their time with peers (Lingren, 1995:2). Very often, but not in all cases it is because the caregivers are emotionally unavailable to their adolescents (Lingren, 1995:2), either due to over-commitment to work, their lack of knowledge in how to relate on an emotional level with their adolescent, or may not have the capacity or ability to meet the emotional needs of the adolescent.

The importance of family attachment and connectedness according to Stewart (2001:124) is that it serves as a shielding factor in opposition to emotional suffering and the potential for suicide, the occurrence of interpersonal violent behaviour, the use of substance use, and somewhat premature sexual activity. In many cases when fathers are not part of their daughter's lives, or when their relationship is cold and distant, studies have shown that these girls experience relatively early pubertal timing and development, and father-substitutes can sometimes meet these needs (Vanderbilt University, 1999; Grandon, 1995).

2.4.2.2 Early childhood experiences

Early childhood experiences ties in closely with the aforementioned aspect of closeness and cohesion. Depending on the type of experiences or the things that happened during the adolescent's childhood, will largely impact not only on the development of the child into a young adult, but also on his or her relationship with his or her parent or caregiver (Braun, 1996:6) and other significant persons in the child's personal world. Specific reference will be made to childhood experiences, such as not being raised by biological parents and sexual abuse and/or incest.

- **Not being raised by biological parents**

In cases where the child was raised by caregivers other than their biological parents and later reunited with their parents raises concerns of adjustment of new family practices and/or relating with one another (Ramphela, 2002:73). Feelings of rejection and being deserted may be built up during the childhood years and may lie dormant within the adolescent. These underlying feelings of anger, fear, rejection and abandonment may be projected onto the caregivers in times of conflict or used to manipulate the caregivers into making decisions that will be to the adolescent's own advantage. Caregivers may also experience feelings of guilt, for the time they left their children in other people's care, which in turn makes them vulnerable to being manipulated by their adolescent(s). In addition, caregiver's childhood experiences in relation to who raised them also have an impact on the way they may care for the adolescent and view their role as caregiver.

- **Sexual abuse and incest**

Another negative experience during childhood that may have an impact on the adolescent-caregiver relationship is if sexual abuse and incest occurred during the childhood years of the adolescent and/or caregiver. The way the child responds to, deals with, and makes sense of this negative experience(s) has a great impact particularly in the area of relationships and how they perceive relationships and how they interact with adults (Bezuidenhout & Joubert, 2003:134). In cases where the sexual abuse or incest continues during the childhood years into adolescence, these children often run away from home and/or become involved in crime

in various forms, such as prostitution and petty theft in order to stay alive (Bezuidenhout & Joubert, 2003:134).

2.4.2.3 Economical position

The ideal is for families to be close-knit and supportive of one another. However, what needs to be considered is that Galvin, Byland and Brommel (2004:16) and Roestenburg (1999:128) state that the unity of a family and the way they relate with one another can be influenced by the economical pressure placed on the life of the family, especially when looking at the South African context. Results in a study done by Roestenburg (1999:128) showed that the only way of survival for some families is to over-commit themselves to their jobs. As a result, the quality and time spent together as a family suffers in the long run. Along with the financial pressures of survival and the demands from society that change on continuous basis, caregivers are very often unequipped to supervise and manage the behaviour of their children and/or adolescents (Roestenburg, 1999:128).

In addition, the interpersonal relationship between the caregiver and adolescent is very often affected by the context of the migrant labour system. Looking more specifically at the African culture in South Africa, not referring to a specific language or clan group, very often mothers have to leave their children with relatives to be raised, because of the migrant labour system (Ramphela, 2002:65). In these cases, the fathers may work away from home in the urban areas, and there comes a stage where these wives decide that it is more important to secure their marriages by moving to their husbands, partners, or the father of the children, and leaving their children behind with relatives. As a result, children grow up without the instruction and love from their mothers (Ramphela, 2002:65). A dear price is paid where these children receive a limited amount of emotional nourishment (Ramphela, 2002:66). By the time the home is secured with the child's parents in the urban area and the child returns to his or her parents, much time has been lost and the attachment between child and parent has weakened. This in itself may lead to problems of adjustment, communication and relating with one another (Ramphela, 2002:73). The child or adolescent may experience confusion in the way the parenting styles differ from that which he or she experienced in his or her initial upbringing.

2.4.2.4 *The cultural context and/or environment*

According to Mead (in Louw & Edwards, 1997:505) it is important to consider the cultural and social environment in which the adolescents find themselves, as it contributes to determining the experience and behaviour of adolescents. The cultural and social environment refers for instance to the religion and/or spiritual beliefs, morals and values, ethnicity, traditions and practices of the adolescent and wider community (Galvin *et al.*, 2004:19). Also, according to Stewart (2001:119), when studying adolescent development, it has become increasingly important to gain an understanding into the context adolescents are finding themselves in socially, and the impact this has on their development. This understanding of the adolescent's social context also needs to be weighed up against the social context in which the caregiver has been accustomed to in his or her past or way of upbringing.

The argument that there is an increase in defiance and conflict during adolescence cannot be universal or be generalized to all different contexts and/or cultures. Children, who have been raised in a society of Western practices, can very often be socialized under the propagation of free speech, individualism, and independence. These notions encourage a culture that may clash with previous generation's socialization of submission, dependence and conservatism. Although South Africa has adapted many Westernized and Euro-centric practices and beliefs, South African citizens are constituted out of many different culture groups, represented by many different families, who socialize and parent their children in many different ways (Bezuidenhout & Joubert, 2003:2, 3). The way children are socialized and raised has a part to play in the adolescent's development and in due course in his or her behaviour or interactions with significant others.

In support of this notion of taking into consideration the societal norms and diverse value systems in South Africa and abroad, it helps to understand the impact it has on the functioning of adolescents and their caregivers. Davis *et al.* (2002:610) supports this notion as they discovered the differences in values contrary to traditional Western values, in their study of Chinese adolescents in Hong Kong. In the Chinese society, children are expected to be obedient to the instructions of their caregivers, the children need to show respect at all times,

and not challenge their parents on any decisions that they make, which is referred to as “filial piety” (Davis *et al.*, 2002:610).

In addition, much emphasis is placed on achieving academically, more so than on achieving in the area of sports and art. Much like South African adolescents, Chinese adolescents in Hong Kong have been raised in a society where many different cultures are practiced, based on Western values as well as traditional Chinese values (Davis *et al.*, 2002:610). As a result, there may be values of the family and of the society at large that are contradictory and in conflict with one another, which may in turn add to present struggles and conflict within the adolescent-caregiver relationship.

2.4.2.5 Family composition

With reference to family composition, one needs to also consider the different contexts in which the adolescent may find him or herself. Very often divorce and remarriage occurs and new families are constituted. New siblings and a new father or mother is added to the adolescent’s world. In instances where adolescents are involved in remarried families, Carter and McGoldrick (1999:420) state that it is harder for family integration to take place. This process of unsuccessful family integration can result in conflict between the adolescent and caregiver(s).

Therefore, according to Sekhukhune (2004:51), the children and/or adolescents possibly will come into the stepfamily with distrust and the expectations of problems, because the stepparent is more likely to withhold from playing and interacting privately with the children and/or adolescents, than in the case of biological fathers. This new environment in which the adolescent enters is uncertain and may conjure up fears and insecurity.

2.4.2.6 Adaptability

Noller and Callan (1991) further explains the variable of adaptability that is needed within the family context. During adolescence as mentioned before, much negotiation takes place, particularly with reference to the rules and routines of the family. Very often the caregivers

may resist making changes in the rules and routine, fearing that they may lose control of their adolescent(s) (Noller & Callan, 1991:66). However, what needs to be considered is the family's ability to fine-tune to the needs of the adolescent rather than to be unbending and unyielding (Noller & Callan, 1991:67). The adult and adolescent therefore, need to be sensitive and flexible to the changing needs of the family system or between the caregiver and adolescent. Each adolescent is unique and has very different needs compared to the next. The caregiver may therefore, experience resistance or conflict if they do not modify their approach and way of child-rearing according to each child's needs.

2.4.2.7 Punishment and/or discipline

The quality of the adolescent-caregiver relationship can also be negatively affected by the degree of punishment and/or discipline that takes place within this relationship. Very often in the context where the level of discipline is high and the adult behaves in a restrictive and unfair manner towards the adolescent, in many cases it can generate rebellion, hostility and conjure up fear within the adolescent (Baumrind in Noller & Callan, 1991).

On the contrary, where there is a lack of discipline, it very often results in the adolescent regarding their caregiver(s) in a negative manner and having very little respect for them (Balswick & Macrides, Middleton & Putney in Noller & Callan, 1991:68). Discipline and rules set boundaries, which in turn creates an environment where the adolescent feels safe. Therefore, careful consideration needs to be taken to the degree of discipline exercised on each individual child and/or adolescent. The factor of punishment and/or discipline ties in closely with the different care giving styles or parenting styles practiced in different homes.

2.4.2.8 Family violence and/or physical abuse

In extreme cases where family violence takes place, anger and resentment within the adolescent can occur and be aimed towards the caregiver, and the adolescent may even attempt to find ways for retribution (Dreikurs & Sotz in Noller & Callan, 1991:68). According to Sekhukhune (2004:51) violence and abuse occurs more in the context of stepfamilies than in traditional families. When physical abuse takes place on a regular basis

within the home, it may very often result in the adolescent experiencing low self-esteem, passivity, poor social relationships, deficiency in the area of giving empathy, getting involved in the abuse of alcohol and drugs, thinking of taking their own life, and/or getting involved in delinquent behaviour and even murder (Garbarino & Gilliam in Noller & Callan, 1991:68). The atmosphere of the home may very often be tense, family members may fear for the next abusive episode and as a result “walk on eggs”. A relationship that is based on fear is an unhealthy relationship and produces negative thought patterns and ways of living.

In addition, when conflict takes place between caregivers, it may have harmful effects on the children. Amato (in Noller & Callan, 1991) provides two reasons. Firstly, it is harmful because the habitual disputes that take place between the caregivers result in creating a stressful and uncomfortable atmosphere within the home. Secondly, the discontented and unhappy marriage often spills over into the adolescent and caregiver relationship, bringing into being a worsening in their relationship as well (Amato in Noller & Callan, 1991:77). Therefore, the emotional climate of the home sets the stage for the kind of interaction that may take place between the family members.

2.4.2.9 Substance abuse

Looking more specifically at a local human service organization’s statistics (BADISA, 2006) taken from reported cases, needs assessments, and general observation over the past two years, the country side of the Western Cape is characterized by social problems such as poverty, unemployment, family violence, crime, child abuse and a high rate of substance abuse. How these social problems are interrelated is not at this point debated, but reflects a picture of dysfunctional homes or families and communities. The abuse of alcohol and drugs is a common occurrence in many of the rural dysfunctional homes.

For the purpose of this study, there are two contexts within which substances are abused – caregiver(s) abusing substances and adolescents abusing substances. Each of these two contexts will be discussed. The way adolescents think and behave is often reflected by the habits and value system of their caregivers (Langone, 1995:91). Adolescents repeat what they

learn and/or see from their caregivers and/or role models – whether these role models are a negative or positive influence. In other words, if the caregiver abuses alcohol or other substances, it creates a culture, norms, or way of behaving for the adolescent (Langone, 1995:91). These norms created within the home and community comes into conflict with societal norms and may cause conflict within adolescent-caregiver relationship, especially when the adolescent does not want to conform to or accept the caregiver's way of living. The adolescents that do not conform to this way of living try to rise above these challenging circumstances.

Further, adolescents are very often susceptible to the influences of their elders and the caregivers therefore, have a responsibility to educate and guide the adolescents. When caregivers neglect this responsibility, respect is lost in this relationship which limits interaction and communication between them. It may very often be difficult for caregivers to provide the necessary guidance and education to their adolescent when the caregiver has no other frame of reference than that which he or she has learnt during his or her childhood. The caregiver's frame of reference may not always be correct or in line with society's current norms and values.

On the other side, in cases where caregivers do not abuse any substances, and the adolescent starts to explore and later abuse substances, it may be perceived as rebellious behaviour (Langone, 1995:93). Out of this behaviour evolves bad habits, which are self-destructive and breaks down self-worth. Although adolescent substance abuse is perceived as rebellious behaviour, there is usually in most cases underlying problems, unresolved issues, or unmet needs that hide behind this behaviour, particularly when this behaviour continues over a long-term. In cases where alcohol or other substances is used over a short-term, it can be viewed as experimental use, as they begin to discover how the substance can alter their mood and state of feeling (Muisener, 1994:5).

2.4.2.10 *Communication*

Communication is a factor that needs to be discussed, because no relationship can exist without the component of communication, whether it is verbal or non-verbal. Communication is either limited or enhanced by the type of relationship between two or more persons. For example, as mentioned in the previous section above, when adolescents lose respect for their caregivers, because the caregivers disregard their responsibility to educate, lead and discipline, it restricts meaningful communication between caregivers and adolescents.

- **The creation of meaning through communication**

Each adolescent-caregiver relationship is unique in the way they communicate, and the way their communication adds meaning and value to their relationship (Galvin *et al.*, 2004:1). The meaning of their communication is co-created and negotiated; however, when the adult and adolescent do not hold the same meaning, misunderstanding can possibly occur (Galvin *et al.*, 2004:26). These misunderstandings and even conflict may occur as a result of the fact that each person perceives the world through their own “glasses” (Galvin *et al.*, 2004:26). In other words, these glasses represent the age of the person, their gender, their beliefs and morals, and culture (Galvin *et al.*, 2004:26). Each person has his or her own unique pair of glasses which is in turn affected by other people’s different pair of glasses. These glasses filter information that are spoken, heard, smelt, felt, tasted or seen and creates meaning. The way in which language is spoken, body language is displayed and the meaning attached to words also creates different perceptions. These meanings and perceptions are co-created between family members or between the adolescent and caregiver over time.

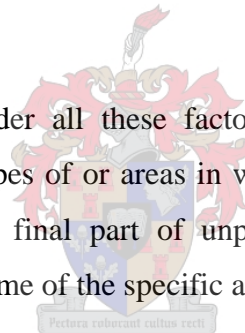
When there is lack of communication and interaction between family members and more specifically caregivers and adolescents, it is difficult for the family system to be structured and within their relationship there may be very limited set of meanings (Galvin *et al.*, 2004:31). The concepts of cohesion and adaptability discussed earlier form a background to perceiving in which ways communication takes place within the family or between the caregiver and adolescent. A pattern of limited communication within the relationship concerned may also inhibit future opportunities where the adolescent has the need to disclose

personal issues or concerns (Galvin *et al.*, 2004:144). The issue of trust and closeness within this relationship is also at the core of a meaningful communication within this relationship, which leads to the following sub-section of adolescent-caregiver self-disclosure.

- **Adolescent-caregiver self-disclosure**

Self-disclosure within the adolescent-caregiver relationship takes place when personal issues are shared and they take the risk of being vulnerable to each other and counting the cost involved (Galvin *et al.*, 2004:145). In other words, self-disclosure within this relationship will more easily take place when both parties find these encounters satisfying and when value is added to it (Galvin *et al.*, 2004:147). Self-disclosure will not easily take place if trust, closeness and respect is absent in the adolescent-caregiver relationship. Communication within this relationship will be surfaced and their level of intimacy may be poor or even non-existent.

It is therefore, important to consider all these factors discussed above as a context or background to understanding the types of or areas in which conflict can take place between caregivers and adolescents. In the final part of unpacking the complexities around the adolescent-caregiver relationship, some of the specific areas of conflict will be discussed.



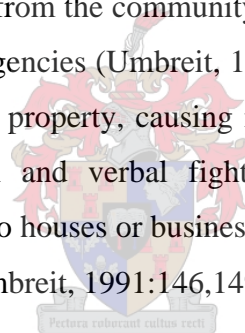
2.4.3 The areas of conflict in the adolescent-caregiver relationship

In the following section a discussion will be made of the areas of conflict in adolescent-caregiver relationships, in other words, the type of conflict that can take place between these parties. The social worker is faced with and has to deal with many different conflicting situations when families need assistance and intervention. With particular reference to conflict that take place between caregivers and adolescents, various authors and practitioners such as Merry (1987); Merry in Umbreit (1991); Coulsen (1996); Galambos and Almeida (1992); Lung (2000); Laursen (1995); Leviton and Greenstone (1997); and Noller and Callan (1991) have discovered different types of conflict or conflicting situations. In the instance where professional intervention is needed or applied, it very often occurs when caregivers feel that they cannot control the behaviour of the adolescent. This leads to a discussion on the

behaviour and the type of conflict that may occur within this particular relationship, which is of importance to the social worker who needs knowledge in this area.

In cases where caregivers feel they have little control over their adolescent children, the behaviour of the adolescent can be characterized as being disobedient, rebellious, and undisciplined. Very often the adult or caregiver has tried many different ways and methods of dealing with the problem, but instead has caused greater harm to their relationship. The fruit of rebellious and disobedient behaviour are breaking house rules, running away from home, staying absent from school, coming in conflict with the law, stubbornness, truancy, and where drug abuse is involved and so forth (Merry, 1987; Merry in Umbreit, 1991; Coulsen, 1996).

What also needs to be considered is that the source of referrals to social workers not only come from the parties concerned or from the community, but also from system referrals, such as from police, courts, and related agencies (Umbreit, 1991:146). These may include cases of harassment, adolescents vandalizing property, causing noise within the community, disputes around issues of money, physical and verbal fights between adolescents and/or with caregivers, breaking and entering into houses or businesses, theft, and criminal mischief being some of the most general crimes (Umbreit, 1991:146,149).



Further, various authors such as Galambos and Almeida (1992:737) found in their research that conflict between caregivers and adolescents occurred in five domains: duties around the house, the way they dress, good manners, money matters, and alcohol and/or drug usage. Lung (2000:1) discovered that Chinese Americans experienced more conflict with their caregivers over issues pertaining to familial respect, and homework or leisure time. On the other hand, Laursen (1995: 55) has categorised these different types of conflict into themes of responsibilities, school, and autonomy that centre between the caregivers and adolescents and peer group.

Laursen (1995:59) listed twelve practical day to day areas of conflict issues that may take place between caregivers and adolescents, which are very similar to Leviton and Greenstone's

(1997:52-54) list of areas of conflict: independence and the need for privacy; performance at school; sexuality and dating; choices of friends; taking responsibility and completing domestic tasks; morals and values; transportation to and from social activities or using their parent's vehicle; use of pocket money and respect for possessions; privileges of television and the use of the telephone; criticism; differing opinions; and irritating behaviour. With specific reference to the conflicting issue of transportation to and from social activities or using their parent's vehicle may not be applicable within the context of the poorer communities, as caregivers do not have the financial means to own a vehicle. Within this context, the adolescents walk to and from social activities, which brings the whole aspect of safety into the argument.

Taking into consideration that not all adolescents are rebellious and are disobedient towards their caregivers, conflict and problems are inevitable to occur between the two parties concerned. Caregivers and adolescents have differing attitudes and therefore, consider that even the closest caregiver and adolescent will have differences of opinions (Noller & Callan, 1991:26). These differences in attitudes are sometimes referred to as the generation gap, which basically is disparities in the area of the clothes the adolescent wears, the way they look, the friends with whom they socialize, their responsibilities and the way they work with money (Noller & Callan, 1991:26).

2.5 CONCLUSION

Taking into consideration all the different behavioural problems that can be presented to the social worker, there are far reaching factors and aspects as outlined before that can be drawn upon to gain understanding and to plan an intervention strategy. The following aspects and factors need to be taken into consideration such as the various adolescent developmental changes, the psychosocial crisis that caregivers go through during adulthood, and aspects around the adolescent-caregiver relationship. Most importantly, as a starting point it is important to contextualize every situation according to that specific family's situation, circumstances and frame of reference, and not to generalize theories of adolescence and adulthood to all contexts. Also, it is important that no behaviour should be looked upon in

isolation to a wider context, as there are always contributing factors that impact on each individual's way of thinking, feeling and behaving.

In the following chapter, a presentation will be made of the broad phenomenon of conflict and how it can be mediated in adolescent-caregiver relationships. From this discussion, guidelines will be extracted for social workers that may be utilized and applied in their daily work with adolescents and caregivers. Specific discussions will be held around the theory of the conflict cycle between adolescents and caregivers, and mediation as a method and strategy of conflict resolution in adolescent-caregiver relationships. The need for a discussion on this is to explore how the social worker will go about effectively empowering families and more specifically adolescents and caregivers to resolve conflict.



CHAPTER 3

EMPLOYMENT OF MEDIATING CONFLICT IN ADOLESCENT-CAREGIVER RELATIONSHIPS

3.1 INTRODUCTION

The broad phenomenon being studied is conflict and how it can be mediated in adolescent-caregiver relationships and from this guidelines will be extracted which social workers may use and apply in their daily workings with individuals. In the previous chapter, more was focused on the adolescent and adulthood stages of the life cycle and the nature thereof, the adolescent-caregiver relationship and the factors that contribute to conflict within this relationship, as well as the areas in which conflict can take place in the adolescent-caregiver relationship.

In order to give social workers guidelines in working with conflicting relationships between caregivers and adolescents, a broader view and understanding needs to be gained in the area of theories and strategies utilized by social workers, the process of conflict resolution and how mediation can be used by social workers to resolve conflict. The focus areas of theories and processes of conflict serve as an essential starting point in gaining practical guidelines for social workers. In this chapter, more specifically will be looked at the following areas: the conflict cycle; integrated conflict theory; the systems theory in terms of conflict; strategies utilized by social workers in general; culture and mediation; and the process of adolescent-caregiver mediation.

3.2 CONFLICT CYCLE

The conflict cycle needs to be discussed as a starting point, because mediation needs to be understood in the context of the cycle that conflict generally takes. The conflict cycle forms a frame of reference for understanding conflict resolution and how mediation as a conflict resolution strategy can penetrate the sequence of conflict or understand the route conflict

normally takes. The conflict cycle gives one the opportunity to look at a conflicting situation or event and analyze the interactions that have taken place in this case, between the adolescent and caregiver. More specifically, the adolescent's feelings, behaviour and reaction to the caregiver and other significant persons in the environment is analyzed (Long, Wood & Fecser, 2001:23). In cases where these conflicting situations produces actions and reactions that continuously feeds on one another and the cycle does not discontinue, a crisis may occur, which is usually the point at which the social worker may intervene or may become involved. The conflict cycle is however, not a predictor of the process that conflict normally takes, as every human being responds, thinks and feels differently in a particular context. The conflict cycle serves as a theory and a way to understand conflicting situations or events between adolescents and caregivers.

The conflict cycle starts with a stressful event. Before a caregiver or an adolescent allows themselves to engage in a conflict cycle, one needs to assess both the caregiver's and the adolescent's private logic, which consists of the concept that they have of themselves, their irrational beliefs, and their self-fulfilling prophecy (Long *et al.*, 2001 23). Their own unique private logic governs their way of thinking, feeling and behaving. Both the caregiver's and adolescent's self concept and belief system may very often be distorted and misinformed, which can negatively influence the way they engage with each other for instance. The crisis continues as the adolescent's feelings and emotions intensifies, such as feelings of anxiousness, fear and embarrassment, which leads to the adolescent's observable behaviour, such as becoming aggressive towards the caregiver and/or swearing. This leads to the caregiver reacting in response to the adolescent's negative behaviour, shouting and/or hitting the adolescent, which in turn does not resolve the conflict and may result back again into a stressful event (Long *et al.*, 2001:25). The conflict cycle is diagrammatically represented in Figure 3.1 below.

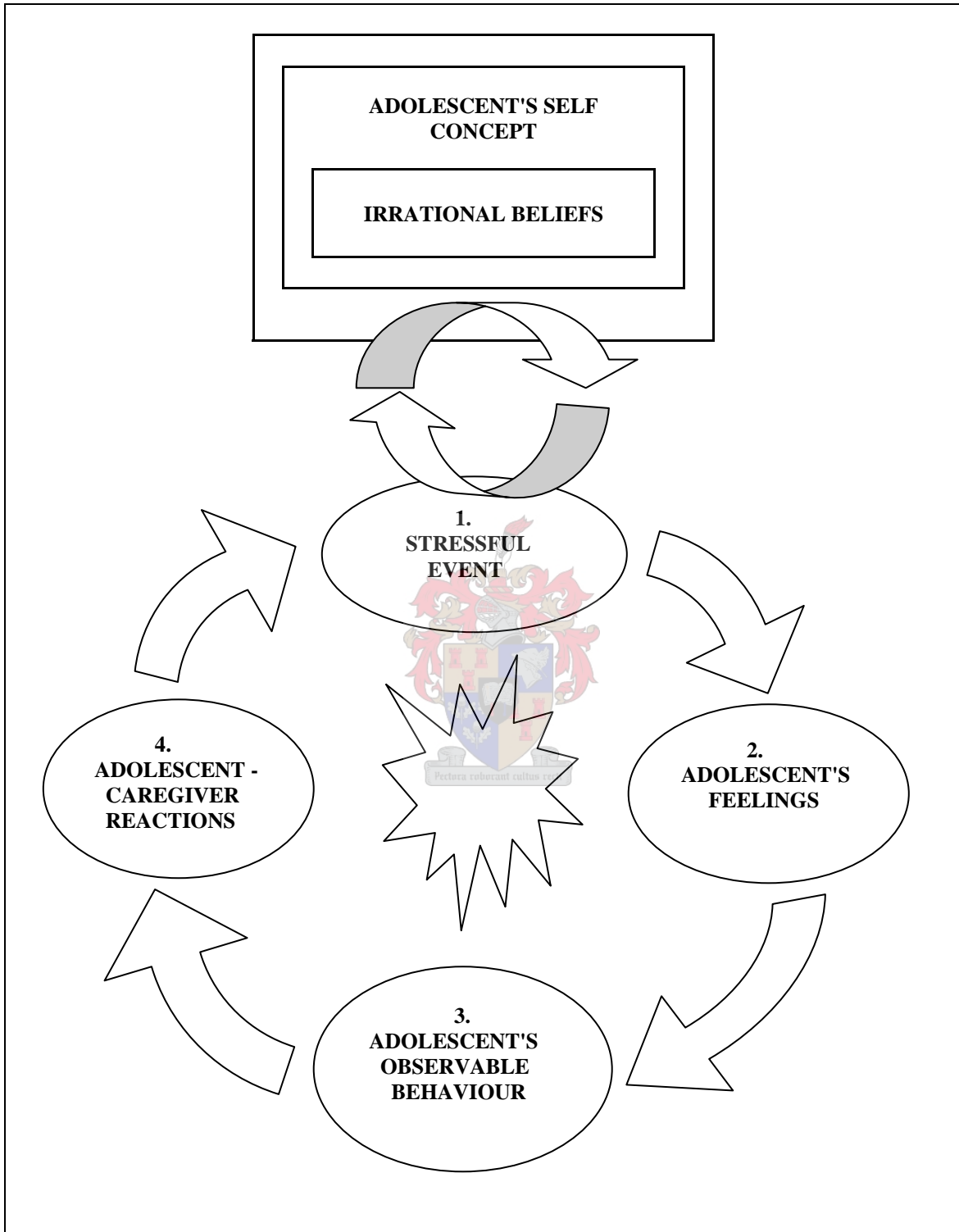


Figure 3.1: The conflict cycle
 (Adapted from Long *et al.*, 2001)

In order to discontinue the cycle, the adolescent and caregiver needs to recognize that the cycle is occurring. Once this recognition has taken place, the content and process can then be analyzed, which will allow the social worker and/or the parties concerned to plan ways to intervene (Long *et al.*, 2001:24). The social worker can also explain the cycle to the adolescent and caregiver diagrammatically so that they can visually see the conflict cycle trap that they have engaged in. On the other hand, when the cycle prolongs and is uninterrupted, the cycle may lead to another cycle and the latter cycle may lead to another and so forth. Each cycle may become more intricate and involved and the process may be driven by emotions and not by rational thinking and processing (Long *et al.*, 2001:25, 26). When irrational thinking and processing as well negative behaviour, such as outbursts take place, people can get hurt and relationships can be scarred. Therefore, the sooner the cycle and process is interrupted, the better the chances are from them hurting each other emotionally and/or physically.

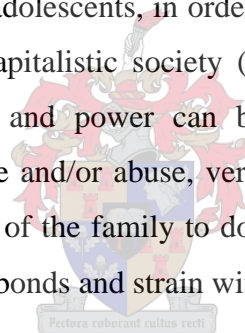
3.3 THE INTEGRATED CONFLICT THEORY

Conflict is a phenomenon that needs to be understood and explained in terms of various theories. The reason why conflict occurs or takes place in adolescent-caregiver relationships are explained in terms of a theory or a formal set of ideas (Oxford Dictionary, 2000:1241). With reference to adolescent-caregiver relationships, the integrated conflict theory has been included in this study as it gives a comprehensive account of why conflict may occur in this relationship. This theory is also particularly relevant to the context of adolescents and caregivers living in rural areas such as the Western Cape where a large group of the caregivers work seasonally on farms.

Colvin and Pauly (in Joubert & Bezuidenhout, 2003:110) developed an integrated conflict theory from the Marxist theory and they explored family relations within the context where the caregivers worked in a forceful environment of capitalism, which in turn resulted in a family environment that was forceful. A capitalist society and/or environment is one in which employers exploit their employees (Haralambos & Holborn, 1995:10). One social group therefore, gains at the expense of another. Conflict of interest occurs between the two social

groups, and this must ultimately be resolved, since a social system containing such contradictions will not survive if it does not change. The contradictions that occur in such a social system are that the wages that workers receive is well below the value of the wealth they produce (Haralambos & Holborn, 1995:10). Marx (in Haralambos & Holborn, 1995:10) claimed that the workers therefore, had no ownership of the wealth.

Negative relations in the workplace in terms of power imbalances between employer and employee create tension and estrangement in the home setting. Caregivers experience frustration and resentment in the workplace and in turn transfer these feelings onto family members (Joubert & Bezuidenhout, 2003:110). Caregivers have a lack of power and voice in the workplace, for instance in the present day context of farm workers in the rural areas as mentioned previously, which may result in them exercising this excessive power and control over their partners, children and/or adolescents, in order to compensate for the lack of power they have in the workplace in a capitalistic society (Joubert & Bezuidenhout, 2003:110). Ways in which excessive control and power can be exercised are through aggressive behaviour, such as physical violence and/or abuse, verbal abuse, withholding finances from their partners, and forcing members of the family to do things that they may not usually do. This may result in weakened family bonds and strain within the home environment.



Adolescents as well as children may not always understand the frustration and strain that their caregivers are under, and especially why the coercive behaviour on the part of the caregiver occurs. In many of these cases, adolescents resort to expressing their own frustrations and hopelessness through acts of crime and/or aggressive behaviour as a way to seeking positive rewards that are not otherwise within reach (Joubert & Bezuidenhout, 2003:110). The integrated conflict theory is useful in that it contextualizes the adolescent-caregiver relationship in a capitalist society and includes the influences that the working environment may have on the family relations, particularly where there are power imbalances.

In the following section, attention will be drawn to a discussion of the systems theory as a way of analyzing and understanding the phenomenon of conflict. Before doing so, the

phenomenon of conflict needs to be analyzed and understood in terms of the systems theory and why conflict occurs.

3.4 THE SYSTEMS THEORY IN TERMS OF CONFLICT

When analyzing the concept of conflict, the systems theory serves as a framework for understanding conflict in the family unit, and for the purpose of this study, conflict in the adolescent-caregiver relationship. According to the systems theory, the adolescent and caregiver cannot and should not be analyzed as separate entities and as functioning separately. When looking at the adolescent-caregiver relationship, it should be regarded as a complex and dynamic system, and part of larger systems, such as the family unit, the community, the society, and the global system. Everything that takes place, such as dialogue, behaviour and transactions between adolescent and caregiver, as well as events in the personal life of the adolescent and caregiver, has an effect on each other, and has a ripple effect on the larger systems (Broderick, 1993).

The systems theory implies with specific reference to conflict that some types of conflicts may be useful for a human system; in other words, it should not be one's aim to eliminate all conflict (Yanoov, 1992:40). The reason for this is that according to the systems theory, it is argued that all change and growth will be accompanied by elements of conflict. This change and growth can be referred to physical, emotional and cognitive changes taking place within the adolescent and caregiver respectively as discussed in the previous chapter. The change and growth within the adolescent-caregiver relationship can also refer to external and environmental changes that have an impact on their relationship and functioning.

It is further argued that all conflicts seem to comprise at least four basic parts: duration of tension or pressure, personality and/or ideology of the participants, distribution of power or resources, and styles of decision making. These four parts are pieces of a broad components-system-environment model (Yanoov, 1992:40). Each of the four components is concurrently making an impact on the other three components and they influence one another. Therefore, the interaction that takes place between them should be applicable to any type or size of

conflict. There may be other components operating, however, the following four components that will be discussed are usually present in every conflict (Yanoov, 1992:41).

3.4.1 Duration of tension/pressure

The first part of the components-system-environment model is the duration of the pressure or tension in the conflict (Yanoov, 1992:41). Conflicting situations or events can either be short or long in its duration. In order to establish whether the conflict is short or long, the history and duration of the conflict between the caregiver and adolescent needs to be delineated for intervention to be effective. Conflicts that are short-lived are generally settled easily; whilst longer lasting conflicts are more difficult to deal with. The reason for this being is that when tension and pressure lasts over a long period of time, crisis may occur. The systems involved in a crisis may experience feelings of inadequacy and helplessness to resolve the conflict, however slowly but surely recovery may start to take place.

Further, crisis periods that are short in duration very often confirm to be helpful to the growth of the caregiver-adolescent system and may generate new solutions to problems that already exist (Yanoov, 1992). On the other hand, crisis periods that are long in duration can become complicated and result in the breaking down of mental health. In situations such as these, the persons involved may feel exhausted, cope poorly, and create more tension for themselves and in their environment (Yanoov, 1992:41). Individuals who experience constant tension may often hold the view that the world is against them and as a result discard the middle ground. As the cycle continues and tension escalates, the individual's system becomes further closed and they depend upon a coercive style of decision-making within the system, such as forceful and threatening behaviour. If the adolescent and/or caregiver do not experience relief from the tension, burnout may result, one or both parties may depart from the environment, or one or both may provoke the conflict to a point of violence.

3.4.2 Personality and/or ideology of the participants

The second part of the components-system-environment model of conflict that needs to be considered is the personality and ideology of the adolescent and caregiver (Yanoov, 1992). In

the instances where conflict persists continuously between the adolescent and caregiver, it often results in each creating boundaries between them that become increasingly impermeable. When boundaries are impermeable, it makes it difficult to mediate, negotiate or resolve conflict. When these persons or systems become closed, each has a tendency to hold extreme opinions and perceive the world in dichotomous categories. In other words, the adolescent or caregiver's ideology about the world becomes compartmentalized. There is only one way and no other alternatives to the solution and other persons involved must either choose if they are for or against the person. Closed-minded adolescents and/or caregivers have a tendency to dominate decision-making and see the world in tidy compartments and may then exclude others as undeserving of consideration. In either case of the adolescent holding a great amount of power through manipulation for instance, or the caregiver holding power through authority and position for instance, may cause frustration when efforts are made in trying to resolve the conflict in which they are participating. They may also rationalize the use of violence against the opponent who is persistent (Yanoov, 1992:41).

3.4.3 Distribution of power/resources

The third part of the components-system-environment model of conflict is the distribution of power and resources (Yanoov, 1992:42). When conflict occurs there is a struggle for power and resources. In other words, each person's sense of power and their resources are under threat. Each is competing for power, influence, or for the control of resources. Power arrangements can be either shared, or one of the parties may have most of the power and the other party may have very little power. Intervention takes place at the point where there is an imbalance of power. If the adolescent and/or caregiver foresee no hope in their situation or future, such as in the context of disadvantaged groups in society, the alternative of violence may be taken.

3.4.4 Styles of decision making

The fourth and final part of the components-system-environment model of conflict to be discussed is the styles of decision making utilized by the adolescent and caregiver (Yanoov, 1992:42). In the field of management, it is learnt that there are at least three styles of decision

making and they are denial, coercion and cooperation. However, denial is from a fairly closed system and makes it almost impossible to try and resolve a situation from this standpoint.

The coercive style of decision making has the characteristics of the one exploiting his or her power by dominating and forcing the other do as they say. The one who has been dominated may feel resentment towards the other and this may increase the intensity of the conflict. This style of decision making may generate feelings of suspicion, hostility and disrespect on the part of the one who has been coerced (Yanoov, 1992). The result is somebody wins and the other loses. In other words, there is no action taken for both caregiver and adolescent to gain mutually (Crawley, 1995:39).

Further, communication between the caregiver and adolescent for instance, is one-sided and obedience is expected when orders and instructions are given. The caregiver expects little or no opposition from the adolescent for instance. This type of decision making style can be useful when order needs to be reinstated quickly within the home subsequent to the start of a serious crisis (Yanoov, 1992).

On the contrast, the cooperative style includes both caregiver and adolescent to participate in making the decisions. Decisions are made democratically and power is equally shared (Yanoov, 1992:43). The two parties involved tolerate and co-exist with one another. The different options and solutions to the problem are equally weighed up against each other and together both caregiver and adolescent negotiate the best possible solution. Communication is therefore open and has a two-way flow. Consistency in joint-decision making over a period of time results in a trusting relationship and benevolence (Yanoov, 1992:42). This style of decision making can be very empowering as the power balance is equal and knowledge is shared and gained through the experience.

This leads to the following question on how conflict can be resolved or more specifically which strategies social workers can utilize in the process of resolving conflict. The following section discusses three strategies of resolving conflict: avoidance, negotiation and mediation.

Within each strategy discussed, the benefits and shortfalls of using these methods will be included.

3.5 STRATEGIES OF CONFLICT RESOLUTION

Strategies utilized by social workers need to be included in this study, because there are many different ways of resolving conflict. People have different ways of resolving conflict – some of these ways are not always beneficial for all parties, but it may work for the person in that particular context. The social worker needs to have a clear understanding of the different ways people generally resolve conflict and what the benefits and shortfalls are of using the different strategies. However, for the purpose of this study, focus will only be drawn to three particular strategies to resolving conflict, as these three strategies are mostly utilized by social workers as specialized strategies, and to relate to the specific aim of this chapter. The three strategies are avoidance, negotiation, and mediation – the latter being the focus of this chapter.

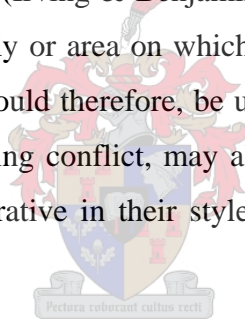
3.5.1 Avoidance

As already mentioned in the previous chapters, conflict arises in most relationships. In most cases people deal with conflict in an informal manner (Moore, 1986). When conflict arises, people very often avoid confronting the issue or talking about the problem, particularly when they characterize conflict as or when their perception of conflict is negative (Irving & Benjamin, 2002:4). People, who avoid each other as a result of conflict, may do so because they believe that they have no power to bring about change, or they may doubt that a change for the better is possible (Moore, 1986:4). Some people detest the hassle of confronting another about an issue that troubles them. It may cause discomfort for the person who is confronting as well as for the person who is being confronted; not knowing what the outcome or response of the other person will be, can become disconcerting for him or her.

Further, very often adolescents use avoidance or intimidation as a means to resolving conflict, because they do not have the necessary skills and cognitive development to effectively resolve conflict (Umbreit, 1991:142). Other possible reasons why adolescents use

intimidation and avoidance as a means to resolving conflict, is because it is their way of surviving and protecting themselves, particularly in an environment where adolescents lack protection, guidance and care from their caregivers and the community. Adolescents in these circumstances have to fend for themselves.

When conflict is avoided in the family system or between caregivers and adolescents for instance, this type of behaviour may be characterized as a warning of dysfunction (Barsky, 2000; Reiss, 1981) within this family system or within this particular relationship. The reason for this being is because this avoidance strategy serves to perpetuate grievances and reduce opportunities for repair to take place within this relationship (Irving & Benjamin, 2002:4). Sequentially, the focus of therapeutic intervention can be on avoidance and why it is occurring within this relationship. However, avoidance may be fixed standards and rules of behaviour of certain cultural groups (Irving & Benjamin, 2002). Confrontation may then not always be the best technique to apply or area on which to focus during intervention in such instances, and cultural sensitivity should therefore, be upheld and respected. The implication of caregivers and adolescents avoiding conflict, may also mean that they are unassertive in voicing their opinions and uncooperative in their style of resolving conflict (Galvin *et al.*, 2004:236).



3.5.2 Negotiation

Negotiation is a conversation that takes place voluntarily between two or more parties to inform and teach each other about their interests and needs, to exchange information, and to brainstorm a solution that will meet the needs of all the parties involved (Girard & Koch, 1996:152). When there is a conflicting situation between two or more parties, negotiation techniques helps the parties to form a dialogue about their concerns and may help increase the likelihood of the parties understanding each other's points of view (Koch & Martinezin in Keefe & Koch, 1999:40). The parties' concerned need to be interdependent of one another, relying on one another's collaboration and they must be able to influence one another (Moore, 1986:11). They need to find an area of consensus or point on which both parties agree. In

other words, the relationship between the parties concerned needs to be based on mutual respect for each other's needs and interests.

The social worker is not always present while negotiation takes place: the social worker's role is to coach and assist the adolescent and caregiver to be fully prepared, by demonstrating effective communication skills and by introducing the negotiation process (Keefe & Koch, 1999:40). The social worker can also help the adolescent and caregiver to reflect and analyze that which occurred during the negotiation session. In this way, both adolescent and caregiver can learn from their experience, evaluate that which went well, that which could have been done differently, what they learnt from the experience, and plan future negotiations (Keefe & Koch, 1999:42).

Negotiation is not the only means to resolving conflict or bringing about change to a system and efforts may not always be successful; choosing negotiation is a deliberate and premeditated choice (Anstey, 2002:68). Negotiation is different to informal discussions and problem solving in that negotiation is intentional and the process is structured (Moore, 1986:6). Negotiation can be used in place of or in conjunction with other strategies of conflict resolution when disagreements need to be resolved (Anstey, 2002:8).

3.5.3 Mediation

Mediation is often the next step after negotiation, particularly when direct negotiation has failed and communication between the caregiver and adolescent for instance, has been broken (Fisher *et al*, 2000:117). Assistance is therefore needed and a third party, such as the social worker can intervene and help the conflict resolution process along. Mediation is an extension of negotiation, and mediation cannot take place without negotiating procedures. Mediation is a shared conflict resolution process whereby two or more parties in dispute are assisted in their negotiation by an unbiased and objective third party (Kruk, 1998:4). The third party or social worker aims to bring a power balance between the adolescent and caregiver, and assist them to reach consensus and an acceptable settlement of the issues in dispute (Kruk, 1998:4). In bringing a power balance between the two conflicting parties, the weaker party gains voice

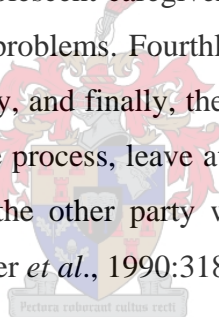
within the system and structure of an agreed upon mediation (Keefe & Koch, 1999:37). The more powerful and stronger party is therefore placed on an equal footing with the less powerful and weaker party.

Mediation allows for a shift from a focus on position to a consideration of mutual interests (Keefe & Koch, 1999:37). Each party gets the opportunity to express his or her interests and concerns, which creates an atmosphere of equality and initiates the search for shared interests. The social worker organizes and facilitates the process by which the caregiver and adolescent make their own decisions and determine the outcome, in a way that satisfies the interests and needs of both the adolescent and caregiver (Kruk, 1998:4). The mediating process therefore has clearly structured and defined stages, which will be discussed at a later stage. The social worker directs the process, but the caregiver and adolescent decide upon the outcome (Kruk, 1998:5).

The mediation process purposes to minimize obstacles that may obstruct communication, allows different alternatives to be explored, and it aims to attend to the needs of both the adolescent and caregiver (Mayer, 1995:619). Mediation is an empowering intervention strategy, in that the parties concerned are aided in solving their own problems and learning the skill of communicating during conflicting times (Mayer, 1995:619). If social work is done from a developmental and empowerment perspective, mediation is then a natural step for social workers to take on this role as mediator and is a valuable addition to the services offered to the clients (Mayer, 1995; Lombard, 1992). Social work executed from a developmental and empowerment perspective is when persons are respected, given their right to self-determination and empowered with skills to handle future problematic situations. In the same way, mediation is a method used by social workers to empower the adolescent and caregiver with skills and knowledge to resolve future conflicting situations. Mediation is so very often integrated into intervention with clients, but social workers do not necessarily identify or recognize that they act as mediators and are not always fully equipped in practicing mediation.

Centering more on the parties concerned, adolescents have the potential to become parents or caregivers when they are older, which gives more reason for conflicts to be resolved between them and their own parents. Unresolved conflict and not learning how to effectively resolve conflict may have a secondary effect of increasing the likelihood that they will become abusing caregivers or make the same mistakes as their caregivers (Stahler, DuCette & Povich, 1990:317). Mediation is therefore, a very valuable learning experience for all the parties concerned, as it equips and teaches both caregiver and adolescent to explore options for progressive communication and change in their behaviour (Cordes, 1983).

The benefits of utilizing mediation as a method of conflict resolution is firstly, that it is a very brief intervention – the intervention may usually take between two to three hours. Secondly, it can make a fairly instant impact by targeting the evident problems that might be predominantly unstable within the adolescent-caregiver relationship. Thirdly, the mediating process may also address underlying problems. Fourthly, the process educates the caregiver and adolescent. Fifthly, there is privacy, and finally, the caregiver and adolescent has control of the process in that they can stop the process, leave at any point of the process, and decide on what can and cannot be said to the other party when the social worker has to relay information (Umbreit, 1991:143; Stahler *et al.*, 1990:318).



On the other hand, some limitations of mediation are firstly, that the social worker cannot force the parties concerned to participate and compel them to find a settlement; secondly, it is not a binding contract; thirdly, it has weak closure, in that there are no legal requirements that binds them; fourthly, the adolescent and/or caregiver can abandon the process at any time; fifthly, the participants may not always have the emotional and intellectual capacity to negotiate – particularly in cases where they are uneducated; and lastly, it is not applicable in all contexts (Umbreit, 1991:143; Coulsen, 1996:24; Irving & Benjamin, 2002:5).

Mediation is chosen as the primary focus of all the different strategies to resolving conflict when adolescents and caregivers are in conflict, because of its usefulness in social work practice and for the purpose of this study. Mediation is a specialized form of practice and

literature, such as (Umbreit, 1991:143; Coulsen, 1996:24; Irving & Benjamin, 2002:5) specifically refer to the specialized field of family mediation which is of relevance to the context of this study. The process of mediation will be discussed further on in this chapter. In the following section mediation will be discussed in terms of the context and/or culture in which it takes place.

3.6 CULTURE AND MEDIATION

It is important to consider the subject of culture in conjunction with mediation, particularly in the context where social workers are faced directly and indirectly with people and communities from a multi-cultural society in South Africa. There are two questions to consider when looking at the subject of culture in conflict and mediation. The first question to consider is if culture plays a role in conflict and if it does, in what kind of ways it plays a role. The other area of concern for the social worker is what it means to be a culturally competent and culturally sensitive social worker during mediation. These two questions will be discussed in the following two sub-sections. Before doing so, the complex nature of culture needs to be outlined.

Culture needs to be seen from two different perspectives simultaneously, in order to present a clearer view of this complex subject. The two perspectives are “internal” and “external”. Culture viewed from an internal or subjective perspective, can be universally understood as a set of beliefs, values, attitudes, language, and behaviours that are mutually shared by a group of people that are set apart from and unique from all other groups (Alba, 1985; Duryea, 1992; Hofstede, 1980; Yinger, 1985). The outside perspective refers to those aspects that are characteristic of a group and that can be viewed from the outside, such as their religion, race, dialect or language, marriage customs, food preference, dress code, traditions and practices, shared history, and so on (Irving & Benjamin, 2002:319).

In bringing both perspectives together, it is clear to see that culture influences, shapes the way, and determines how people relate to one another; what we think and feel about life, death, and illness; what we eat and how we clothe ourselves; in which ways people celebrate

special occasions, how rituals are practiced and holidays are celebrated; and how we work (McGoldrick, 1988:69).

3.6.1 The role culture plays in conflict

Each family unit produces their own culture of conflict, complex set of ideas, language, values, behaviours, norms, attitudes, and rules that powerfully influence how the members of the family unit think about, feel and respond to conflict (Cloke & Goldsmith, 2000:19). The social experiences that take place between family members over a period of time shape the cultures of conflict; it sets boundaries for what can be expected to happen from ourselves and from others during conflict (Cloke & Goldsmith, 2000). The cultures of conflict in families or within relationships also gives an indication of what kind of behaviour during conflict is acceptable and what is not (Cloke & Goldsmith, 2000). In other words, the cultures of conflict in these particular relationships produces verbal and non-verbal rules about what can and cannot be said and done during conflict (Cloke & Goldsmith, 2000). There is a great amount of pressure placed on the individuals to respond and react to conflict in expected ways (Cloke & Goldsmith, 2000).

Further, the external culture of society portrayed and communicated through popular audio, visual and written media, such as television, movies and newspapers enhance, accentuate and trivialize the attractiveness of using aggression during conflict (Cloke & Goldsmith, 2000). As society is increasingly exposed to these ideas, people's threshold of acceptance for violent behaviour is lowered, their ability for resolving conflict is undermined, and they become increasingly addicted to the adrenaline rush of aggressive behaviour, or may become more avoidant and fearful (Cloke & Goldsmith, 2000:21). Aggressive behaviour becomes the norm and within the adolescent-caregiver relationship, this kind of behaviour may be exercised during conflict as a result of society's culture that has desensitized the harmful effects of violence.

There are many detrimental effects that this aggressive method of conflict resolution has on those that are exposed and influenced by it. Some of the effects are losing their ability to feel

empathy for others who are in distress, an absorbing fear for violence, feeling anxious about being socially accepted, an anesthetizing submission to behaviours that are unacceptable, doubting people's worth, circumventing intimacy with others, a recoiling into accommodating behaviour, and ultimately an assault on the soul (Cloke & Goldsmith, 2000:21).

Furthermore, a culture ecosystem has been created based on miscommunication and conflict, where a lot of time is spent and ensnared in disputes with others, people get confused about messages that are brought across ambiguously and the parties involved try to make their feelings and needs understood (Cloke & Goldsmith, 2000:21). The social worker's task is to help and educate individuals to recognize and discharge these cultural messages, encourage and empower them to embrace a culture of discourse-sharing, peacemaking, resolution and transformation (Cloke & Goldsmith, 2000:21, 22). The adolescent and caregiver have a unique culture and their culture determines how they resolve conflict. The social worker needs to explore their present way of resolving conflict and reflect on whether their way of resolving conflict is working for them. Conflict resolving strategies and ways of engaging cannot change and evolve, unless the adolescent and caregiver comes to the realization and admits that their way of handling conflict is not working.

3.6.2 Cultural competence and sensitivity during mediation

As mentioned before, South Africa is a country that is multi-cultural and rich in diversity, which is all the more reason why social workers need to be educated and equipped in being culturally competent and sensitive during service delivery. There are basically two approaches or models to cross-cultural practice that has developed over time and they can be placed on either side of a continuum. Each will be broken down to its basic characteristics. On the one side of the continuum, there is the cultural literacy model as proposed by Benjamin (1996) and Roberts (1990) and they tend to do the following: the social worker should be treated as an expert; it needs to be assumed that the social worker has superior knowledge over their clients; culture should be regarded as a system that is all the same; the client needs to be essentially considered as a member of a cultural group; this model advances culture-specific

clinical techniques; and from this model it is not required of the social worker to examine him or herself (Irving & Benjamin, 2002:320).

On the other side of the continuum, there are the phenomenological models as proposed by Dyche and Zayas (1995) and they tend to do the following: this approach treats the practitioner as learner; believes that the social worker will approach the adolescent and caregiver from a position of curiosity and naïveté; assume that life experiences serves as a function for parties concerned to internalize more than one culture; essentially consider the uniqueness and individuality of the adolescent and caregiver; advance process-oriented clinical techniques; and requires the social worker to continuously reflect and critically evaluate their thought processes and the way they intervene with their clients (Irving & Benjamin, 2002:321).

In looking at these two approaches to cross-cultural practice, one should not see them at opposite ends on a continuum, because in practice it should be difficult to find social workers that perform these models in its purest form (Irving & Benjamin, 2002). To a certain extent, social workers use experience and knowledge when they can and/or else depend on process-oriented techniques (Irving & Benjamin, 2002). Consequently, there is a need for a more integrated approach.

Tsang and George (1998) have presented an integrated framework that includes and highlights four elements. The first element is attitude. In order for a social worker to be culturally competent during service delivery, he or she needs to possess an attitude that includes a concern for fairness and justice in society, understand the importance of difference between the adolescent and caregiver and being receptive to it, an eagerness to learn from the adolescents and caregivers, and the motivation to be critical and reflective of themselves as social workers. The second element is knowledge. The practitioner needs knowledge of the content of specific cultures, be familiar with the systemic context of culture, the salience of the internalized or self-identified culture, and the way in which adolescents and caregivers behave and react to each other in the context of cross-cultural communication. The third

element is skills. The skills the social worker needs relates to their ability to control their own emotional responses, they need to acknowledge that the service that is being delivered occurs within the context of a specific organization, they need to utilize the relationship and communication skills, and use specific change strategies. The final element is research. There needs to be a feedback loop linking process-oriented and change strategies and outcome effectiveness data (Tsang & George, 1998:73-93). When all these elements are brought together, it forms an integrated approach on cross-cultural practice in general and in adolescent-caregiver relationships. In essence, culture provides the context and way in which mediation takes place between the social worker, adolescent and caregiver.

In the following section, a closer look is taken into what one wants to achieve when using mediation between the adolescent and caregiver, in other words, the goals of adolescent-caregiver mediation.

3.7 THE GOALS OF ADOLESCENT-CAREGIVER MEDIATION

It is necessary to look at the goals of adolescent-caregiver mediation, as it serves as a yardstick for what one wants to achieve. There are two main goals of adolescent-caregiver mediation. The first primary goal of adolescent-caregiver mediation is to facilitate a process where resolution is found in their conflict and a fair and definite agreement is obtained to which both parties believes their needs have been met and to which both caregiver and adolescent can adhere (Umbreit & Kruk in Kruk, 1998:97). The secondary goal is that a positive change needs to be attained in the adolescent-caregiver relationship and also in the dynamics of the family system. This change occurs once the adolescent and caregiver has learnt new ways of engaging, communicating or negotiating with one another in times of conflict and disagreement; mutually suited solutions are searched together through dialogue and discourse-sharing. Both parties need to take responsibility for the problem at hand and the social worker therefore, needs to empower the adolescent and caregiver to take ownership of the conflict and determine an outcome (Umbreit & Kruk in Kruk, 1998:100).

Further, it is important to understand that mediation does not include therapy (Umbreit & Kruk in Kruk, 1998:98). According to Umbreit and Kruk's parent-child mediation model (1998), therapy and mediation should not occur simultaneously during sessions; however, caregivers and adolescents can be referred for counselling or therapy if there are unresolved emotional issues that cause them to not progress to a resolution in mediation. In some cases, after an agreement has been reached, the parties concerned may still choose to go for counselling (Umbreit & Kruk in Kruk, 1998).

In the following section, the process of adolescent-caregiver mediation will be discussed. Mediation has a structured process that serves as a guideline for the way in which the mediation procedure should follow, and the social worker should have knowledge of this process.

3.8 THE PROCESS OF ADOLESCENT-CAREGIVER MEDIATION

Different authors have included various stages during the mediation process. A comprehensive and integrated process will be outlined that may serve as a guideline to social workers in adolescent-caregiver mediation. The mediation process also provides the adolescent and caregiver a model from which to refer in future negotiations or in conflicting situations (Umbreit & Kruk in Kruk, 1998:100). Mediation therefore serves as an educative and empowerment function in that the adolescent and caregiver experiences the process of mediation and learns new skills in dealing effectively and constructively with conflict.

Before discussing the process of caregiver-adolescent mediation, one needs to briefly outline the conditions for almost all forms of adolescent-caregiver mediation. There are two core conditions. The first condition is that there needs to be an existing relationship between the adolescent and caregiver, they need to have common interests, and should be able to communicate their need to resolve the conflict (Umbreit & Kruk, 1998:106). It does not help if for example the adolescent and caregiver have been estranged from each other for a long period of time and because of emotional baggage are not prepared to or are too stubborn to admit the need for a resolution to the conflict.

The second condition is that the power should be relatively equally distributed between the parties concerned (Umbreit & Kruk, 1998). In other words, it will be difficult to utilize the method of mediation for example, where the caregiver has a very dominating nature and style of parenting and where the adolescent has very little voice; the caregiver may view the adolescent as the problem and not the problem being part of the system. The social worker therefore, needs to evaluate and assess these conditions in relation to the adolescent and caregiver's context before mediation can commence.

There are many different phases and stages in the process of mediation and different authors such as Umbreit and Kruk (1998); Zetzel and Wixted (1984); Umbreit, (1991); Girard and Koch (1995); Fisher *et al.* (2000); and Crawley (1995) use different terms, however, the content is basically the same. The adolescent-caregiver mediation process involves five main phases. The first phase involves the social worker setting the stage; the second phase involves the adolescent and caregiver defining the issues; the third phase involves processing the issues; the fourth phase involves resolving the issues; and the fifth phase involves the parties making an agreement (Zetzel & Wixted, 1984). Umbreit and Kruk (1998) has a more comprehensive and detailed eight distinct stages of the adolescent-caregiver mediation process to which this study will refer, namely: preparation stage; initial joint session; caucus or recess stage; initial private or joint negotiation stage; interim private or joint negotiation stage; final private or joint negotiation stage; concluding joint session stage; review, follow-up and post-hearing. A brief discussion of each of these stages will follow.

3.8.1 Preparation stage

Although the focus of this chapter has been on adolescent-caregiver conflict and the mediation thereof, it should not be taken for granted that the conflict is only limited to only one caregiver and adolescent; very often when there are other members of the family living together, they may too have a stake in the conflict and need to be included in the mediation process where possible (Umbreit & Kruk, 1998:109). Consequently, there may be a need for co-mediating this multiparty. If this is the case, the preparation stage is used for both

mediators to consult and decide on how the responsibilities of the whole process should be divided; reviewing the case and procedures; and this stage is also used for drawing up a schedule that is guided by time, and taking care of preliminaries, such as setting up the room, before the mediation begins (Umbreit & Kruk, in Kruk, 1998; Umbreit, 1991). However, it is important to realize that within the social work context in South Africa, there may not always be the luxury of having more than one social worker mediating. The reasons for this may be accounted for a lack of human resources, social workers may not always be available, or have the time to co-mediate with another social workers, because of high case loads. Social workers do however make use of their colleagues during family conferencing, in order to gain an outsider's objective perspective on the situation at hand. Family conferencing will not be discussed in this study.

3.8.2 Initial joint session stage

The initial joint session with the adolescent and caregiver consists of the social worker welcoming them, giving words of encouragement, introductions; stating the role the social worker will play; the process that will be followed and the expected duration (Girard & Koch, 1995; Fisher *et al.*, 2000; Crawley, 1995). Following this, the issue of confidentiality will be addressed and basic ground rules will be established, such as one person speaking at a time, respecting each other's opinions, honesty, not getting sidetracked from the actual problem, no name calling, and avoid blaming at all costs (Keefe & Koch, 1999:44).

Thereafter, each person gets the opportunity to give a general picture of the problem or their individual perceptions of how they see the problem (Keefe & Koch, 1999:44). Each person gets to hear the other version or perspective on the problem. In addition, each person is able to present his or her "wish list" or state their position on what they want. During this stage, it will become evident how the adolescent and caregiver communicate with one another, non-verbal messages that are conveyed, as well as how communication takes place with other members of the family present in the session (Umbreit & Kruk, 1998:110). In order for the social worker to maintain control over communication, it would be essential that adolescent and caregiver address the social worker directly and not to speak directly to one another

(Umbreit & Kruk, 1998). In this way, communication can be controlled and facilitated by the social worker. Before concluding this stage, the social worker needs to inform the parties that during recesses, the social worker will be using a short time to evaluate what he or she has learned from the discussion and will also use this time to prepare for the next stage of the process (Umbreit & Kruk in Kruk, 1998).

3.8.3 Caucus or recess stage

During the first stage the social worker should take notes while the parties have shared their stories. In this way, during the recess stage, the social worker can go over the information from the notes; briefly go over the details with their co-worker if their was one present; and plan a strategy that identifies the issues that may most likely be resolved through mediation, and whether the format of the following session will be joint or separate meetings (Umbreit, 1991; Umbreit & Kruk, 1998). If the parties concerned have made good use of joint sessions, this format should not be disrupted (Umbreit & Kruk, 1998).

3.8.4 Initial private or joint negotiation stage

In the case where this stage is held privately with one of the parties, the social worker would meet with the adolescent first and then with the caregiver (Umbreit & Kruk, 1998:111). The social worker needs to emphasize again that confidentiality will be held. Open-ended questions need to be asked and they need to be raised in a non-judgmental manner and tone; the most important issues and interests of each party are identified through probing, without falling into the trap of giving advice and counselling.

While giving the parties time to reflect on their interests, needs and issues, they also need to think about and identify possible changes that could aid in resolving the conflict (Umbreit & Kruk, 1998). In addition, the social worker needs to help each party to identify areas of agreement; from this different options can be generated, developed and explored (Keefe & Koch, 1999:44). This can be done by using hypothetical situations to test potential solutions. The social worker needs to demonstrate an attitude of optimism and hopefulness about the

prospect for change, and to reframe the problems in dispute in neutral terms (Umbreit & Kruk, 1998).

Further, the social worker needs to clarify with the adolescent and later also with the caregiver that which can be shared with the other party in the next stage and what he or she is willing to do to bring about change (Umbreit & Kruk, 1998; Keefe & Koch, 1998). In this way the social worker gives the adolescent or caregiver respectively the choice and power to decide on what should be shared and how it should be communicated. The adolescent also then takes responsibility for their part that he or she needs to play in resolving the conflict. The whole process during this stage in essence remains the same when the social worker meets with the caregiver.

If however, a joint session is held during this stage, it is important that each party gets the opportunity to speak without interruption and at some point during this stage, the social worker needs to caucus with each party to determine whether the joint format is working for him or her. This will ensure that each party feels that his or her perception of the conflict has been given attention (Umbreit & Kruk, 1998). Before moving to the next stage, the social worker needs to take a break in order to review and discuss the case with their co-worker (if there is one), and make the necessary changes in strategy, if needed (Umbreit & Kruk in Kruk, 1998).

3.8.5 Interim private or joint negotiation stage

During the interim private or joint negotiation stage, more information can be gathered, verbalized interests and concerns can be clarified, and negotiations can be initiated and movement can be made toward ultimate resolution (Umbreit & Kruk, 1998). If there is a need for private sessions, information is conveyed between the parties; and in joint meetings, the social worker needs to be careful in maintaining control of the process, and encourage the parties to openly speak to each other (Umbreit & Kruk, 1998). The concerns and interests that are laid out on the table need to be further bargained, constricted and reframed in a way that addresses the interests of both the adolescent and caregiver (Umbreit & Kruk in Kruk, 1998).

In starting this process, the parties need to start with a less complex issue, one that they can agree upon more easily (Shaw, 1989). If they experience success in resolving a particular issue, it will motivate them and predict future success on more intricate issues in dispute. Once all the issues have been identified, an agenda is established and the adolescent and caregiver gets the opportunity to make a list of options that they prefer for the resolution of the first issue in dispute; this is repeated for each of the identified issues on the agenda (Umbreit & Kruk, 1998). It is important to do reality testing of each of the options proposed by the adolescent and caregiver. The solutions that are agreed upon for each issue need to contain two elements. Firstly, it needs to contain a list of desired behaviours by the adolescent and caregiver or changes in behaviour that is expected from one another. Secondly, it needs to contain the consequences, the benefits and shortfalls, of non-conformity and conformity with the desired behaviours (Umbreit & Kruk, 1998:112).

3.8.6 Final private or joint negotiation stage

During the final private or joint negotiation stage the details of the agreement are worked out (Umbreit, 1991:144). In other words, the final terms of the agreement are constructed. If it is necessary, the social worker can recess to further reflect on the case. Subsequent to the construction of a possible agreement, a final session with both adolescent and caregiver is arranged (Umbreit & Kruk in Kruk, 1998).

3.8.7 Concluding joint session stage

During the concluding joint session, the social worker reads the agreement to both the adolescent and caregiver; after which each party signs the agreement and each receives a copy. This part of the process is optional, and the parties cannot be forced to sign a contract agreement, as this will be contrary to the basic principals of mediation where the parties are empowered and not coerced into making a final decision. The whole mediation process can serve as a model for resolving future conflict and the parties is given the opportunity to discuss how they will handle future conflict (Umbreit & Kruk in Kruk, 1998).

3.8.8 Review, follow-up and post-hearing

It is essential for the social worker(s) to reflect and evaluate the process and its results after the caregiver and adolescent have left. The social worker's thoughts and experience of the mediation needs to be documented by means of process notes. These process notes serve as record of the content of mediation, as well as a means to evaluate the work that the social worker has done. Following up the parties need to be planned and diarized advisably a month or two after the last contact. As new issues may have surfaced during this time, it can be helpful to them to have a follow-up session to assess how they have integrated and applied the skills they have learned in mediation process (Umbreit & Kruk in Kruk, 1998).

3.9 OTHER ALTERNATIVES TO MEDIATION

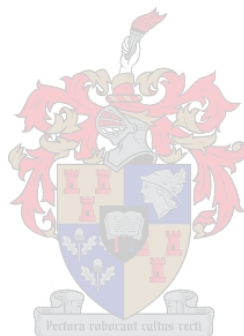
Within the specific area of adolescent-caregiver conflict, one of the most desirable alternatives to mediation is prevention (Umbreit & Kruk in Kruk, 1998:113). Very often by the time the family reaches out for assistance, their problems have escalated to such an extent, that it results in the mediation process being complex and intricate. Caregivers can be trained in helpful approaches in managing conflict well before their children reach adolescence.

In addition, statutory and therapeutic intervention remains as the main alternatives to mediation in the field of adolescent-caregiver conflict. Statutory intervention refers to children's court enquiries, where adolescents are removed from their caregiver(s) care, and placed into institutional care, such as a children's home or a school of industry, particularly in cases where the conflict has escalated to such an extent that the caregiver has no control over the adolescent's behaviour. However, when conflict between the caregiver and adolescent is still manageable, in its infant stage and relatively uncomplicated, mediation can be utilized in addition to therapeutic services (Umbreit & Kruk in Kruk, 1998).

3.10 CONCLUSION

At the core of social work, there is the drive towards justice, equality and empowerment of individuals. Conflict resolution strategies facilitate this process of bringing about justice, equality and empowerment and have also been part of social worker's intervention methods

and processes in dealing with people who are in conflict with one another. This chapter has attempted to present the theoretical background, methods and processes of conflict resolution in adolescent-caregiver relationships. This chapter has also focused on culture, what role it plays in conflict and how social workers can become culturally competent and sensitive in a diverse society such as South Africa. Specific focus was placed on mediation as a conflict resolution strategy, because of its usefulness in social work practice; it requires the participation of all the parties involved, which encourages taking responsibility and ownership; and for the purpose of reaching the objectives for this study. Consequently, this chapter gives practical guidelines to social workers in intervening with adolescents and caregivers who are in conflict.

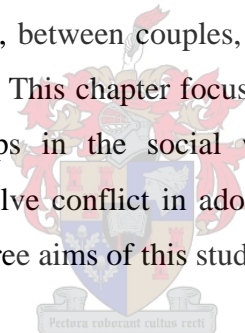


CHAPTER 4

SOCIAL WORKER'S EXPERIENCES IN WORKING WITH CONFLICTING ADOLESCENTS AND THEIR CAREGIVER(S)

4.1 INTRODUCTION

Literature (Coulsen 1996; Irving & Benjamin, 2002; Kruk, 1998; Keefe & Koch, 1999) confirms that conflict occurs in all different kinds of relationships, different types of contexts, takes place in diverse cultures, globally, has taken place in the past, and will most probably take place in the future. With this in mind, social workers are often confronted in assisting clients to find solutions to problems or resolving conflict between different parties, for instance between a parent and child, between couples, family disputes, between community members (Kruk, 1998) and so forth. This chapter focuses on exploring the nature of conflict in adolescent-caregiver relationships in the social worker's particular context; and to investigate how social workers resolve conflict in adolescent-caregiver relationships during intervention. These are two of the three aims of this study.



4.2 DELIMITATION OF THE INVESTIGATION

Following the written permission from the Director of a human service organization (BADISA), to conduct this study was granted, a literature review was done. Due to the difficulty and costs involved in including the universe of this study, a purposive sampling of 5 programs were selected that were in the same region of which included 10 social workers. The target group consisted of 10 social workers from the 5 programs, of which all 10 social worker were purposively sampled as participants (Strydom & Delpont, 2002:334).

4.3 GATHERING AND ANALYSING DATA

Data was collected by means of a semi-structured interview with the aid of an interview schedule. All the interviews were conducted in the home language of the participant (either

Afrikaans or English) and audiotape was used with the consent of the participants (Greeff, 2002:302-303).

The researcher began the process of data collection by making contact telephonically or in person with the potential participants at their offices. During this contact, the researcher introduced herself to the potential participants and explained the purpose and procedures of the research study. The researcher then established their readiness to participate in the research study. Permission was verbally obtained to willingly participate and appointments were scheduled with all 10 social workers.

Before each interview, participants were informed about the confidential nature of the tape recordings and transcripts of the interview. Participants had the opportunity to ask questions during and after the interview regarding any uncertainties, or express any feelings caused by the interview.

The process of data analysis began, once the data collection process reached the point of data saturation (Tutty *et al.*, 1996:92). First, the tape-recorded interviews were transcribed and translated. The data was then analyzed by means of identifying central and sub-themes for the study. These themes are presented as the results of this study and these will be subsequently discussed.

In the rest of the chapter, the data will be presented and interpreted by comparing it to existing data from the literature review. Where relevant, the data will be presented in narrative, tabular or figure form. It is important to note that due to the qualitative nature of this study, not all the participants answered all the questions, as the researcher merely guided the discussion. The researcher did however, try to incorporate all aspects of the research in the interview, but in some cases the flow of the interview did not allow for it.

4.4 RESULTS OF THE INVESTIGATION

4.4.1 The profile of participants in this study

Table 4.1 presents the profile of the participants that took part in this study.

Table 4.1: Identifying details of participant

The profile of participants in this study	
Criteria for participating:	Participants must be a social worker at selected programs
Number of participants:	Ten social workers of diverse ethnicity
Sex:	All females
Age:	From 23 to 55 years
Type of area they work in:	10 Rural areas
Language:	9 Afrikaans 1 English

The ten participants in Table 4.1 are all employed at the 5 different programs in a particular region in the Western Cape and each has different amount of years of experience in social work. However, the latter is not of importance for this study. The names of the towns where the study was undertaken will not be identified to ensure confidentiality of participants.

4.4.2 Knowledge about adolescent-caregiver conflict

The participants were requested to classify their knowledge about adolescent-caregiver conflict as one of the following: excellent, good, average, poor, or very poor. Six (60%) of the participants chose to classify their knowledge as average. Their reasons included mostly that they do not specialize in this field, that they work with other types of cases, and that they could do more research and receive more knowledge about this particular field.

The other four (40%) participants chose to classify their knowledge on adolescent-caregiver conflict as good. Their reasons included mostly that they get much exposure and experience in working with these types of cases where conflict occurs between adolescents and caregivers, particularly also within foster families; they also read up in literature and manuals about how to intervene and work with conflicting adolescents and caregivers.

The question regarding their knowledge about adolescent-caregiver conflict needed to be included, because if the participants had very little or did not have any knowledge in this area, limited information would then be gained from them. The responses from the participants to this question also give an indication of the high occurrence of participants dealing with adolescent-caregiver conflict.

With specific reference to the question on how many of the participants' current cases involve conflict between adolescents and caregivers, the average percentage of cases that involve adolescent-caregiver conflict within the participants' caseload is 41,3%, which can be regarded relatively high and indicates the need for more knowledge and experience in this particular area. Seven (70%) participants regarded their caseload of adolescent-caregiver conflict as high and provided various reasons as to why they thought their caseloads were regarded as high. Firstly, adolescent-caregiver conflict is something that would occur continuously throughout life, which corresponds with Lingren (1995:2) that conflict between caregivers and adolescents generally increases amid the phase of childhood and during the onset of adolescence. Secondly, there are always a group of adolescents that would have behavioural problems. Thirdly, participants experienced most of their cases involving foster parents who have problems with their foster children and it could be directly linked to the root of where the foster parents' initial motivation for foster care was for financial gain of the foster care grant. Fourthly, foster parents do not always know how to deal with the foster children. Lastly, the high occurrence of conflict occurs because of the caregivers' lifestyle of alcohol abuse, the lack of family planning that takes place, the high occurrence of non-committed fathers, and caregivers who have a lack of parenting skills. With specific reference to the latter of caregivers abusing alcohol also concurs with literature that it causes conflict

between the adolescent and caregiver, particularly when the adolescent does not want to conform to or accepts the caregiver's way of living (Langone, 1995:91).

Three (30%) participants regarded their caseloads of adolescent-caregiver conflict as low and provided various reasons as to why they regarded their caseload as low. One of the participants worked in a smaller area where the occurrence of adolescent-caregiver conflict is low; another participant did not experience these types of cases being reported frequently, as they perceived that the coloured community tends to resolve their problems on their own. This corresponds with Cloke and Goldsmith (2000:19) that each family unit and community at large produces their own culture of conflict, complex set of ideas, language, values, behaviours, norms, attitudes, and rules that powerfully influence how the members of the family unit think about, feel and respond to conflict.

Another participant experienced that their adolescent-caregiver conflict cases tended to be lower but more intense and complex in nature, because foster parents tended to wait a long period of time before they report the problems that they are experiencing with the adolescent, in other words, the caregiver or foster parent would report it when the problems and conflicting situations has escalated to a crisis point. This very much links with how the conflict cycle of Long *et al.* (2001:23) has accumulated over a long period of time between the adolescent and caregiver which produces actions and reactions that continuously feeds on one another and when the cycle does not discontinue, it often may result in a crisis.

4.4.3 Socio-economic status of clients

The participants described the socio-economic status of their clients in their working area as mostly a profile of sub-economic living, poverty, a high occurrence of unemployment and as seasonal working areas, which provides employment for basically 6 months of the year. One of the participants described the socio-economic status of their clients as having a high level of hardship that leads to alcohol abuse and in turn leads to poor relationships and is described as "a vicious cycle" as one thing leads into another and feeds into each other. Most of their clients work either on farms or in industries. Many are dependent on state grants, such as

foster care grants and pensions and their wages or income is minimal. These areas are further described as under-developed, the schools are small but it is the biggest infrastructure in these areas.

Therefore, most of the participant's clients live in poverty, as a result of unemployment and/or seasonal work. Most of these clients can also only work in factories or farms, because of their level of education received, which limits their income to a certain level. Alcohol abuse is also part of the vicious cycle and affects relationships with others. The socio-economic status of the participants' clients were considered in this study, as it is important to consider the context in which the participant's clients are living in, as the economical position of the family unit affects relationships and their way of living (Galvin *et al.*, 2004; Roestenburg 1999).

4.4.4 Culture of the clients

Participants were required to describe the predominant culture of the people who live in the area in which they work. The participants could answer according to their own understanding of the concept of culture. Most of the participants referred to their clients having mostly of the following characteristics and are categorized as follows:

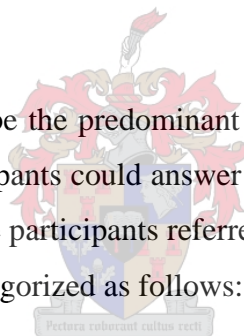


Table 4.2: Culture of the clients

CATEGORY	CONTENT
Race	Mostly black and coloured people; black people are moving into the coloured areas, because they work away from their own homes, which brings about culture differences and conflict.
Language	Mostly Afrikaans speaking and two participants worked with Xhosa speaking clients.
Relationship/ Marital status	Few of the participants' clients get married and many live in cohabitating relationships to financially support one another.
Recreation	Within these areas there are poor recreational services, the people are very sociable, they spend their time at shebeens, pubs taverns and sports grounds. They do not spend their time constructively, because they mostly drink with friends for relaxation.
Behaviour	A lot of alcohol abuse occurs within these areas, some of them abuse alcohol "because they are labourers...it is their only way out...it is there way of relaxation". Alcohol is also very accessible within these areas.
Morals/ Values	One of the participants believed that the value system differs between the black and coloured people in that "it is not wrong for coloured people to drink and get drunk".
Religion	In most cases, religion between the black and coloured peopled differs. In one of the areas there are many Rastafarians. There is also a high tendency for many of the foster parents and more specifically the women to be religious as they belong to and are involved in churches. These areas mostly represent a Christian culture as most of the people go to church – "half of them are religious, the others do not go to church".
Practices/ Customs	Ubuntu is developed more strongly amongst the black culture than amongst the coloureds. One of the examples described as a black cultural practice is when the black boys go into the bush for initiation to be regarded as a man – he then has more authority over relationships. In many of the cases the women take the leadership role and are the leadership figure.
Work	Some of the participants described the culture of the people as including the norm of where both parents are required to work either on farms or in factories.
Family ties	One of the participants described the culture of the area to include other family taking responsibility for other people's children; that there are strong family ties amongst the black people and believed that the coloured people do not have such strong family ties.

It was considered important to investigate the culture of the participant's clients as it set a context and profile of the clients with whom the participant's worked. It also gave the

researcher a clearer understanding of how the participant's viewed their client's culture and what the participants understood by the concept of culture.

The participants' views of their client's culture can be classified from both an internal or subjective perspective, as well as an outside perspective. On the one hand, the participants' views were internal or subjective, because their views of culture can be universally understood as a set of beliefs, values, attitudes, language, and behaviours that are mutually shared by a group of people that are set apart from and unique from all other groups (Alba, 1985; Duryea, 1992; Hofstede, 1980; Yinger, 1985).

On the other hand, their views were also from an outside perspective, because their descriptions referred to those aspects that are characteristic of a group and that can be viewed from the outside, such as their religion, race, dialect or language, marriage customs, food preference, dress code, traditions and practices, shared history, and so on (Irving & Benjamin, 2002:319). Therefore, the participants' views of their client's culture correspond with the way literature describes the different aspects of the broad concept of culture.

Two further and separate questions were asked regarding culture during the interview, which would link to the previous description and context that the participants gave of their client's culture. Participants were asked in the first question to say whether they thought culture played a role in conflict between adolescents and caregivers, and they were asked to state their reasons for their answer. Eight (80%) of the participants answered "yes" and their reasons were mostly related to: how "a culture of alcohol or drug abuse" is predominant in their areas that give rise to conflict; that parents are very often not married, that parents and children do not know how to deal with conflict; "the younger generation is more "hip" – not attached to their old traditions", because it does not get carried over by their caregivers, however, within the black community they are more attached to their traditions. Further, participants believed that culture plays a role in conflict when caregivers experience problems in adjusting to changing times and circumstances that are different to the times when they were growing up or when there are differences in backgrounds as to how they utilized their

leisure time. In many of the cases caregivers did not have the experiences of being a child, they may not know how a child should be and that is why basic childhood practices or child's play do not get passed over to the adolescent in their formative years. Furthermore, there is the culture and norm of where caregivers become physical or violent towards the adolescent during conflict "we hit it out of each other", because it is accepted to do so in their culture, and these practices gets carried over to the adolescent and to further generations. Another participant believed that culture plays a role in conflict in the way perceptions and beliefs about conflict is carried over from one generation to the next – whether conflict is seen as acceptable or something that is avoided.

On the other hand, two (20 %) participants answered that culture did not play a role in conflict and their reasons were that they believed that the culture between the child and caregiver is usually the same, and would therefore not usually invoke conflict between the caregiver and adolescent. The other participant believed strongly in Erikson's (1968) stages of development and stated that this theory did not refer to culture and how it could play a role in conflict.

The final question asked in relation to culture, was whether culture played a role in the way conflict is resolved between adolescents and caregivers. Most participants responded "yes" to the question if culture played a role in the way conflict is resolved between adolescents and caregivers. The participants' reasons referred mostly to: how values and norms of a culture determines how the caregiver and adolescent deals with conflict; the practices and methods of resolving conflict in their culture are carried over from one generation to the next generation; how the use of language and meaning shapes the way conflict is perceived; and how a lack of communication skills and conflict resolving skills that were never learned impacts on their culture. This coincides with Cloke and Goldsmith's (2000:19) argument that the way in which the people think, feel, and act towards conflict is very much influenced by a set of ideas, language, values, behaviours, norms, attitudes, and rules that have evolved in their culture. Also, the aggressive way in which conflict is so often resolved within these cultures, can very much be accounted for the norms that has developed within these cultures as a result of

society's culture that has desensitized the harmful effects of violence (Cloke & Goldsmith, 2000:21).

4.4.5 The caregiver(s) of the adolescent

In the study, the participants were asked to identify the primary and secondary caregiver(s) of the adolescent in the area in which they work. Some of the participants worked in more than one area, which resulted in more than one answer. The reason for including this question in this study was to determine whether there was more than one caregiver over the adolescent and whether the primary caregiver was someone other than the biological parent(s). In other words, the purpose of identifying the various caregivers over the adolescent was to help establish a clearer picture of the family structure in the participants' working areas, and to see if there is a pattern. The participants were also asked to provide reasons why they thought these persons take on the primary and secondary caregiver roles over the adolescent.

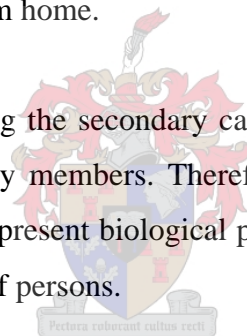
Two (20%) participants answered that the primary caregivers over adolescents are mostly foster parents representing aunts and uncles, because participants stated when foster care is considered, family are regarded first in order to maintain family ties; very often more than one family lives together in one home and somebody takes responsibility for the child; the child also normally goes to the person or family member from whom he or she receives love; family members also ask to be foster parents over the adolescents because they may feel sorry for them; it may be for economic reasons because they do not have the financial means to take care of the child on their own; and they may be dependent on the child support grant.

Four (40%) participants answered that the primary giver over the adolescent is the grandparents, because participants experienced that many biological mothers work away from home and then the grandmother is the closest person, or available person, or interested person, or one who can be trusted; the biological mothers often become pregnant too early in their lives and still want to continue living a "young life" and they do not want to give up their freedom; very often the grandmother takes the responsibility away from the biological mother, because the grandmother feels that the biological mother is not raising the children

properly and is perhaps neglecting them; in some cases parents have passed away; the parent and/or child has a bond with the grandparents; the adolescents sometimes live or have grown up with the grandparents or the grandparents live with them in the home; in many cases in the black community, when women get married, they move away from their family of origin and the children stay behind to be raised by the grandmothers; the mothers choose to be with their husbands and migrate where there is labour. The latter aspect corresponds with literature as to how the migrant labour system negatively impacts on the biological parents' relationship with their adolescent and is a source of stress for caregivers and adolescents (Ramphela, 2002:65).

Two (20%) participants answered that the primary caregiver over the adolescent is the biological mother; however, in the case where the biological parent(s) works, the grandparent(s) look after the adolescent during the day and at times when the biological mother or father socializes away from home.

Further, with reference to identifying the secondary caregiver over the adolescent is mostly grandparents, aunts and other family members. Therefore, one should not assume that the primary and secondary caregivers represent biological parents, and in these particular areas it is not a single person, but a system of persons.



Participants were also asked to identify the primary and secondary caregiver's age respectively according to the different age categories stipulated on the interview schedule. Some of the participants could not select one specific category and they therefore, generalized more or less between which ages the respective caregivers fall under.

On the basis of their generalizations it was found that most of the primary caregiver's age group falls between the ages of 41 and 50 years. This age group corresponds with the above-mentioned findings where the primary caregiver is mostly a maternal aunt – the biological mother's older sister.

On the basis of their generalizations it was found that most of the most of the secondary caregiver's age group falls between 51 and 60 years of age. This age group corresponds with the above-mentioned findings where the secondary caregiver mostly represents grandparents who generally fall within this age group.

The purpose of identifying the age group of the primary and secondary caregivers is to see the age difference between the caregiver in relation to the adolescent. The age difference between the caregiver and adolescent is relatively high, if one considers that an adolescent's age ranges between the ages of 13 and 18 years according to the Oxford Dictionary (2000) and if the caregiver's age falls within the 51 and 60 years range. The generation gap in itself as discussed in Chapter 2 has a great impact on the caregiver-adolescent relationship, which may also serve as a source of stress in this relationship (Noller & Callan, 1991:26). Adolescents may feel that their caregivers are "out of touch" with the changing times, that the caregivers come from another generational era, and do not understand the pressures that the adolescent faces.

4.4.6 Gender and prevalence of behavioural problems in adolescents

Participants were asked to identify whether behavioural problems occurred more within boys or girls or both within the area they work. Very often it can be assumed that behavioural problems occur more within boys. The purpose of this question was to test whether this is the case within these areas. Four (40%) participants answered that behavioural problems occurred more within boys; two (20%) answered more with girls; and four (40%) answered that behavioural problems occurred equally between both boys and girls in their area. Therefore, one cannot assume that behavioural problems occur more within boys.

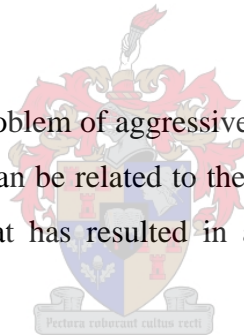
Further, the participants each identified several types of problems that are most prevalent within the gender they chose that is common in the area they work. The different problems will be listed in relation to the gender, which will give an indication of the types of problems that occur mostly in the participants' areas.

Behavioural problems that are more prevalent amongst the boys are:

- Peer pressure that pushes them in becoming involved in deviant behaviour
- Aggressiveness such as physical assault

With reference to the literature study in Chapter 2, the adolescent's focus and loyalty very often lies more with their peers and the adolescent places greater value on their relationship with their peers, in order to feel accepted as "part of the group" (Seidman *et al.*, 2004:237). This may very well be one of the many different reasons why adolescents allow peers to pressurize them into becoming involved in deviant behaviour. Other reasons provided by Jessor (in Davis *et al.*, 2002:609) as to factors that may increase the likelihood of adolescents becoming involved in high risk or deviant behaviour which are relevant and fitting to this study's context are: harmful influence from the family and poor quality of life as a result of poverty.

With reference to the behavioural problem of aggressiveness and sometimes assault that takes place on the part of the adolescent can be related to the conflict cycle that has continued and escalated over a period of time that has resulted in a crisis as discussed by Long *et al.* (2001:25) in Chapter 3.



On the other hand, a behavioural problem that is more prevalent amongst the girls is promiscuity. In many cases this can be related to the absent loving relationship that should exist between the father and daughter and not having a male role model in her life. In many cases when fathers are not part of their daughter's lives, or when their relationship is cold and distant, studies have shown that these girls experience relatively early pubertal timing and development, and father-substitutes can sometimes meet these needs (Vanderbilt University, 1999; Grandon, 1995).

Behavioural problems that are almost equally prevalent amongst boys and girls are refusal to attend school; experimentation with alcohol and/or drugs; and being rebellious and deviant towards caregivers. When adolescents become involved in high risk behaviour, such as,

smoking, using drugs and alcohol, and partaking in sexual activity, it can very often be accounted for the egocentricity of the adolescent. Egocentricity refers to adolescents perceiving that they are “unique and invulnerable” (Louw & Edwards, 1997:511). In other words, the adolescent feels that he or she is invincible and that the consequences of partaking in high risk behaviour will not affect them. Conflict may result between the adolescent and caregiver if the adolescent becomes involved in high risk behaviour and does not see the consequences of their behaviour.

4.4.7 Age group of adolescent’s development

Participants were asked to identify the age group of the adolescent’s development where conflict occurs mostly with their caregiver(s) in their working areas. Most of the participants categorized the age group between the ages of 12 and 15 years and the next highest age group selected are between 16 and 19 years. The outcome of this question concurs with other research as stated by Allison (2000:1) which indicated that conflict increases between caregivers and adolescents at some stage in middle school years.

4.4.8 Conflict between biological parents and adolescent

Participants were asked to identify with reference to their cases whether the adolescent that is raised by his or her biological parents, are more in conflict with the mother or the father. Eight (80%) indicated the mother to be the person with whom the adolescent had more conflict. The reasons the participants provided were mostly related to: the mother having more contact with the children, because the fathers often work away from home and the mother spends most of the time at home with the children; the children also tend to have a closer relationship with the mother; the biological parents are very often not married and they live together, which gives the mother more legal rights and power over the children – as a result the mother makes the rules, takes a leadership role and the father is uninvolved which in turn results in the children revolting against the mother. In cases where the mother is not home the grandmother ensures that the rules are obeyed.

The above responses of the participants coincides with literature such as Allison (2000:1) who states that conflict manifests more between adolescents and their mothers, because very often the mother is the person who spends more of her time with the children. Montemayor and Hanson (in Laursen, 1995:67) concurs with this argument as they state that the mother is the main manager for responsibly socializing the children, unavoidably resting her own goals very often in straight opposition to the goals which the adolescent holds.

On the other hand, two (20%) of participants stated that conflict occurred mostly between the adolescent and their father and their reasons were as follows:

- Because the father is absent, works away from home and tends to be home only over weekends, causes the adolescent to have conflict more with his or her father. The conflict occurs when the father is at home, but it affects the whole family.
- Very often the father has extramarital affairs and the adolescent therefore, becomes a support for the mother, and the mother tends to protect the adolescent during conflict. The mother does not agree with the father on matters.

Therefore, one can assume that in most cases the adolescent will have more conflict with his or her biological mother, however, not in all cases, and every adolescent is unique in their context and in their way of responding to their circumstances. Also, one needs to consider the closeness and attachment of the relationship between the adolescent and biological parent when reflecting on the conflict that takes place between them. In other words, when reflecting on disputes, insight may be gained into the characteristics of and the course that social relationships take (Laursen, 1995:56).

4.4.9 Adolescents raised by relatives

Participants were asked to give the different reasons as to why adolescents in particular cases are raised by a relative(s). The purpose of this question is to reinforce the notion that very often the adolescent is not raised by his or her biological parents, particularly where the socio-economic circumstances of the areas in which the participants work are poor. The different reasons are mostly related to the fact that many parents are not available, because they work

away from home, or the parents neglect the children and do not provide proper supervision for the children, which in some cases result in the children being placed in foster care in the aunt, uncles, or grandparent's care. Further, very often the parents are young and do not possess the necessary parenting skills, which leads to the grandparents taking on the roles of primary caregivers. In other cases the parents shift their responsibility on others, such as relatives, because they still want to live a young person's life and it is convenient for them. Furthermore, there may be the high rate of parents suffering from tuberculosis and HIV/AIDS, or in other cases the biological parents are deceased; and for practical reasons sometimes the relatives live closer to the school.

Another question was raised around the aspect of adolescents that were raised by their relatives. Participants were asked to describe the results when adolescents are reunited with their biological parents after they have been raised by relatives. Some of the participants did not see or experience this very often in their area, but experienced some cases where the adolescent had a better understanding for their biological parent(s) and offer their parents support or even fall into the lifestyle of the parents and live exactly like the parents do.

Other participants responded that adolescents being reunited with their biological parents could result in conflict, adolescents may ask themselves the question of "why now?" and may experience feeling of anger, rejection and mistrust; the adolescent may not accept the authority of their parents and become rebellious; and it may be difficult for them to relate with one another.

Therefore, in some of the cases where the child was raised by caregivers other than their biological parents and later reunited with their parents raises concerns of adjustment of new family practices and/or relating with one another (Ramphele, 2002:73). However, it cannot be generalized to all cases.

4.4.10 Factors that hinders communication between adolescents and caregivers

Participants were asked to discuss the kinds of factors that hinder communication between adolescents and caregivers. Communication is very much part of conflict or the lack thereof. One needs to therefore, consider the factors within these contexts that may hinder communication. Most of the participants' responses referred to the "generation gap" as to being a factor that hinders meaningful communication. In other words, caregivers and adolescents have differing attitudes and differences of opinions which basically are disparities in the area of the clothes the adolescent wears, the way they look, the friends with whom they socialize, their responsibilities and the way they work with money (Noller & Callan, 1991:26). Adolescents do not feel understood by the caregiver, because of the big age gap that lies between them and feel uncomfortable to talk to their caregiver about taboo topics such as sex, drugs and alcohol.

Other factors that hinders communication is the lack of communication skills; lack of knowledge of the adolescent's developmental phase; and that caregivers are too occupied with work and spend long hours at work – there is a lack of quality time spent together between adolescent and caregiver which very often results in an unattached and shallow relationship between them. Where there is a lack of communication and a lack of a relationship exists between the adolescent and caregiver, misunderstandings occur and conflict arises (Ramphela, 2002:73).

4.4.11 Sources of stress in adolescents and caregivers

Participants were asked to identify the sources of stress that adolescents and caregivers can experience individually and within their relationship. The leading sources of stress for the adolescent in the participants' working area are: peer pressure; alcohol and/or drug abuse within the home; and underachieving academically in relation to the school's requirements and standards.

The largest sources of stress for caregivers in the participants' working area are: a lack of financial resources: not being able to provide sufficiently; problems at work such as difficult working conditions and long working hours; and not knowing how to handle their children. All of the above mentioned list of sources of stress experienced mostly by adolescents and caregivers concur with the findings of various authors such as, Newcomb and associates (in Dacey & Kenny, 1997); Muncie (1999); Noller and Callan (1991); Jessor (in Davis *et al.* (2002); Laursen (1995); Lingren (1995); Galvin *et al.* (2004); Roestenburg (1999); Amato (in Noller & Callan, 1991); Langone (1995).

4.4.12 Factors contributing to conflict between adolescents and their caregivers

Participants were asked to discuss the factors that contribute to conflict between adolescents and their caregivers. The highest occurring factors identified by the ten participants were: caregivers that have a lack of knowledge, parenting skills and understanding in the area of communication, conflict resolution and the adolescent's developmental phase; caregivers who have a lack of education and adolescents that are more educated; and caregivers and adolescents in particular being exposed to social problems such as poverty, alcohol and drug abuse, and sexual promiscuity. The adolescent and caregiver is very much influenced by one another's behaviour and influences from society or the community or otherwise stated, the way adolescents think and behave is often reflected by the habits and value system of their caregivers (Langone, 1995:91). Adolescents repeat what they learn and/or see from their caregivers and/or role models – whether these role models are a negative or positive influence. In other words, if the caregiver abuses alcohol or other substances, it creates a culture, norms, or way of behaving for the adolescent (Langone, 1995:91).

4.4.13 How adolescents and their caregivers deal with conflict

Participants were asked to describe the ways in which adolescents and caregivers in their areas deal with conflict. All of the participants mentioned that the adolescents and caregivers do not deal with conflict for the following reasons:

- They shout and swear at each other;
- They do not have the skills to communicate through the conflict;

- They do not give each other the opportunity to talk and listen to each other;
- Caregivers give adolescents hidings;
- Caregivers take the adolescent's privileges away, such as no cell phones, television and friends;
- Caregivers complain to outsiders, such as teachers, social worker and police;
- Caregivers and adolescents hit each other or family violence takes place between caregivers;
- Caregivers and/or adolescents abuse alcohol as a means to escaping reality;
- Adolescent walks away from home, returns either late at night or after a few days.

From the above descriptions of ways in which adolescents and caregivers deal with conflict, it is clear that there is a lack of knowledge and skills in the area of constructive conflict resolution within the participants' working areas.

Participants were also asked at which point the social worker generally become involved between conflicting adolescents and caregivers. Most of the participants responded that the social worker becomes involved when it is reported by police, schools, neighbours of clients, people in the community, and from the parties concerned, which are concurrent with the findings of Umbreit (1991). The cases generally come under the social worker's attention when the problem has progressed to a point of crisis and where the caregiver has used up all of their own resources.

4.4.14 Issues and problems adolescents and caregivers argue about

Participants were asked to identify the different issues and problems that adolescents and caregivers argue about mostly. The issues and problems adolescents and caregivers argue about mostly are: wrong friends, peer pressure, adolescents who sleep over at friends without caregiver's permission; adolescents who roam the streets without informing and communicating with their caregivers; alcohol and drug abuse; and disobedience to house rules and disrespect towards caregivers. The issues and problems listed above, correspond to

literature such as Lung (2000); Leviton and Greenstone (1997); Laursen (1995); Galambos and Almeida (1992); and Noller and Callan (1991).

The various reasons provided by the participants as to why these issues and problems occur mostly between the adolescent and caregiver were as follows: the caregiver does not have a relationship with the adolescent; they do not spend enough quality time together; caregivers are uninvolved in the lives of the adolescent; a lack of parenting skills; there is no discipline and regulations; conflict takes place between the caregivers; financial stress; a lack of proper recreational activities in the community; adolescent is self-absorbed; life has no purpose for the adolescent and caregiver – they have no vision for the future; caregivers do not know how to adjust to the adolescent’s phase of development; alcohol abuse and family violence occurs regularly in the home; family practices get carried over from one generation to the next; it is the norm within the community and they are exposed to it daily; and poor communication. The reasons listed above coincide with literature such as Merry (1987); Merry in Umbreit (1991); and Coulsen (1996). Although there are many different issues listed above, it has become evident throughout the findings that a lack of parenting skills appears recurrently in most of the participants’ responses.

4.4.15 Employment of conflict resolution methods

Participants were asked to identify the method(s) of conflict resolution they employ mostly between adolescents and their caregivers. The participants’ responses were: mediation and family conferencing; educational methods and anger management; family discussions or meetings; family interviews; behavioural techniques; family meetings; and joint interviews. All of the above mentioned methods and techniques includes elements of mediation, but it seems as though the social workers use these elements unintentionally and not necessarily knowing the full process of mediation.

Following the question of the methods the participants employ during intervention with adolescents and caregivers, participants were asked to discuss the process of their method. From the participants’ responses, it was clear that most of the participants used elements or

parts of mediation, as presented in the previous chapter. The elements of mediation which the participants use and refer to are, bearing in mind that the responses below are representative of the total responses:

- the participants perceived themselves and/or social worker as a third and neutral party that facilitates the process;
- the social worker leads the adolescent and caregiver in understanding each other's view points;
- each person gets the opportunity to share how they experience the problem;
- caregiver and adolescent are seen separately;
- communication is done in a controlled environment where there is order;
- a solution needs to be reached at the end of the process and they need to make the decisions and take responsibility for the solution;
- a follow-up session is done to reflect on their progress.

The above list of elements of mediation used by participants in their different methods of conflict resolution are similar to that discussed in Chapter 3, by authors such as Fisher, *et al.* (2000:117) and Kruk (1998:4). However, the participants were not aware of or have a comprehensive understanding of the process of mediation; and how to utilize mediation solely and exclusively in specific situations. Most of the participants' process involved other elements that are not consistent with the process of mediation, such as: the length of their process is much longer, for example, a few weeks or even months, and they do not limit themselves to reaching a solution within two hours as prescribed by the process of mediation; and they include therapy in their process, which should not be included according to Umbreit and Kruk in Kruk (1998:98).

The process of mediation has a definite beginning and an ending, and it has different stages that represent different sessions with the different parties involved. The process starts with a preparation stage; follows onto initial joint session; caucus or recess stage; initial private or joint negotiation stage; interim private or joint negotiation stage; final private or joint negotiation stage; concluding joint session stage; review, follow-up and post-hearing

(Umbreit & Kruk 1998). These different stages basically involves the social worker setting the stage; the adolescent and caregiver defining the issues; processing the issues; resolving the issues; and the parties making an agreement (Zetzel & Wixted, 1984).

Further, there are two main goals to the process of mediation. The first primary goal of adolescent-caregiver mediation is to facilitate a process where resolution is found in their conflict and a fair and definite agreement is obtained to which both parties believes their needs have been met and to which both caregiver and adolescent can adhere (Umbreit & Kruk in Kruk, 1998:97). The secondary goal is that a positive change needs to be attained in the adolescent-caregiver relationship and also in the dynamics of the family system. This change occurs once the adolescent and caregiver has learnt new ways of engaging, communicating or negotiating with one another in times of conflict and disagreement; mutually suited solutions are searched together through dialogue and discourse-sharing. Both parties need to take responsibility for the problem at hand and the social worker therefore, needs to empower the adolescent and caregiver to take ownership of the conflict and determine an outcome (Umbreit & Kruk in Kruk, 1998:100). The above explanation of the goals of mediation may differ from the process that is utilized in other methods chosen by the participants, as the participants' preferred methods and processes can sometimes occur over a long period of time. Mediation is an intensive but quick intervention method that aims to find a solution within the space of approximately two hours.

The fact that the participants did not have knowledge or a clear understanding of the full process of mediation, limited the usefulness of the responses to the other questions raised during the interview and presented on the interview schedule.

4.4.16 Benefits of using mediation

With reference to the question of what benefits there are in using mediation between adolescents and caregivers who are in conflict, the participants mostly referred to the following, bearing in mind that these are a summary and the central themes listed below:

- the social worker sets an example, is a role model and teaches on how to communicate meaningfully and listen to one another;
- the process of mediation helps the parties involved to understand each other's view points and why they behave in certain ways;
- it helps the parties to resolve conflict in a civilized manner;
- the parties involved need to make decisions regarding the way forward and take responsibility for their decisions;
- the social worker/mediator acts in a neutral and objective manner;
- new communication and conflict resolution skills are learned by the parties.

The above-mentioned benefits correspond indirectly to the findings of authors such as Umbreit (1991:143) and Stahler *et al.* (1990:318) with specific reference to the type of role the social worker plays during mediation and the responsibility that each party plays within the mediation process.

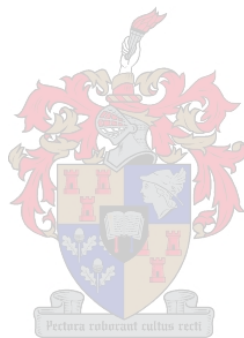
Further, when participants were asked how they experience working with conflicting adolescents and their caregivers, most of the participants experienced it as a challenge, and as a field in which they would like more knowledge and training. Some even experienced it stressful, especially being bombarded with so many different methods of conflict resolution, and not always being able to master or specialize in one method. Some also felt that the high case load prevents them from learning and applying new methods and skills of conflict resolution. It is therefore clear that there is a need for social workers to be further trained particularly in the area of mediating adolescent-caregiver conflict, because they do not have a comprehensive understanding of this method of conflict resolution.

4.5 CONCLUSION

Broadly, in this chapter the social worker's experiences in working with conflicting adolescents and their caregiver(s) were discussed. The delimitation of the investigation, how data was gathered and analyzed, as well as the results of the investigation were further discussed. The core findings are firstly, that there is a high occurrence of social workers

dealing with adolescent-caregiver conflict in their different working areas. Secondly, with reference to the socio-economic status of the participants' clients, most of the clients live in poverty, as a result of unemployment and/or seasonal work, which lead to other social problems, such as substance abuse and family violence. Secondly, most of the participants believed that culture plays a role in the way conflict is resolved. Thirdly, the adolescent is not necessarily raised by their biological parent(s) and in many cases the adolescent is then raised by maternal aunts, grandparents or other family members. Lastly, there seems to be a great need in the area of parenting skills and conflict resolution skills.

In the following chapter conclusions and recommendations regarding guidelines for social workers in using mediation between adolescents and their caregivers that are in conflict will be presented.



CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The exploration into mediating adolescent-caregiver conflict and providing guidelines for social workers, originated out of an identified need for a specialized social work intervention method. The aim of this chapter is to present the conclusions drawn from the findings of the study in order to make the appropriate recommendations. These recommendations will indicate general guidelines regarding mediation as a social work intervention with adolescents and their caregivers who are in conflict, and in doing so meet the final objective of this study: to provide social workers guidelines in mediating conflict in adolescent-caregiver relationships.

5.2 CONCLUSIONS

The following conclusions are based on the findings from the empirical investigation.

5.2.1 Knowledge about adolescent-caregiver conflict

The majority of participants regarded their knowledge of adolescent-caregiver conflict as average and they believed that they needed to learn more about this subject. From this finding, it can be concluded that an average level of knowledge leaves room for improvement in gaining more knowledge in this area.

5.2.2 Caseload of adolescent-caregiver conflict

The majority of participants regarded their caseload of adolescent-caregiver conflict as high. The other participants regarded their caseload of adolescent-caregiver conflict as low, because they worked in smaller areas, or did not have many such reported cases.

The **conclusions** that can be made are that most of the cases reported at the social worker's office are not necessarily reported as adolescent-caregiver conflict and the problems are

multi-faceted and complex. Further, cases of adolescent-caregiver conflict also get reported to other role players, such as schools, churches and the police. The participants' caseload with regards to adolescent-caregiver conflict that is indicated on their statistics may not be a true reflection of what the situation is within the community at large without the other role players' statistics within the community. Nevertheless, adolescent-caregiver conflict seems to be problematic in most of the participants' areas. Also, cases of adolescent-caregiver conflict are mostly reported when the situation has escalated to a crisis point.

5.2.3 Socio-economic status of clients

Most of the participant's clients live in poverty, as a result of unemployment and/or seasonal work. Alcohol abuse is also part of the vicious cycle of depleting their financial resources and has a negative impact on their relationships.

The **conclusions** can be made that the level of education of the participants' clients allows them to do general work on farms and in factories that are seasonal in these areas, which leads to minimal wages during certain months of the year. Minimal wages may lead to living in difficult conditions in poor communities that have limited resources, limited recreational facilities, and high crime rates. These are all conditions that give rise to the prevalence of stress and conflict within adolescent-caregiver relationships particularly in the context of South Africa.

5.2.4 Culture of the clients

When referring to the culture of the people with whom the participants work the majority of participants referred to race, recreational activities, behaviour and religion. Most of the clients are from a coloured racial group; most of the communities have a lack of positive recreational activities; a high rate of alcohol abuse takes place in these areas; and many of the people are religious. Further, most of the participants believed that culture plays a role in the way conflict is resolved.

Therefore, the following **conclusions** can be made that it is clear that alcohol and drug abuse is problematic within these communities and may be a way for the caregiver and/or adolescent to escape from conflict and/or stress in their lives, which in itself causes conflict between caregivers and adolescents. People who live in close proximity to one another in these poorer, lower socio-economic areas, tend to see, hear and learn from each other how to deal with conflict. Family violence, screaming, shouting, and fighting becomes the norm or an acceptable way of relating to one another, which is carried over from one generation to the next.

Further, it seems as though the younger generation does not value the traditions that are passed on by their caregivers, and caregivers do not take the time to explain and pass on these traditions to the next generation. The previous generations, with reference to the caregivers, had a different upbringing to the current generation of adolescents, and it is difficult for the caregivers to adjust to the changing times; they do not always understand these changes, which may cause conflict in the adolescent-caregiver relationship.

Lastly, within these particular contexts the caregivers have a lack of knowledge on how to resolve conflict, perhaps because of a lack of opportunities to receive education in the past. On the other hand, the adolescents are more educated than their caregivers in the area of communication and conflict resolution, as they are exposed to more information and instruction on these topics at school and through the media. As a result, the adolescents may have different expectations on how conflict should be resolved, which may in turn result in conflict when these expectations are not met.

5.2.5 Primary and secondary caregiver over adolescent

Most of the primary caregivers fall within the age group of 41 to 50 years of age, and they are mostly maternal aunts or the older sister of the biological mother. In many cases it is because of the biological parent(s) working away from home, who have passed away, are uninvolved in the life of the adolescent, has a lack of parenting skills, or do not want to take responsibility and care of their own children. Most of the secondary caregivers fall within the age group of

51 to 60 years of age, and it is mostly the maternal grandmother and/or grandparents, as a result of biological parent(s) working away from home, who have passed away, are uninvolved in the life of the adolescent, have a lack of parenting skills, do not want to take responsibility and care of their own children, and many of the grandparent(s) live in the same home.

It can be **concluded** that many adolescents were or are not raised by their biological parents and have to be raised by maternal aunts, grandparents or other family members, because of one of many reasons, such as in cases where the biological parents are working, where pregnancies were unplanned, where there is a lack of parenting skills, where the biological parent(s) abuse or neglect the children, amongst other reasons. Therefore, it was found that in most cases, there is more than one caregiver, who is not necessarily the biological parent(s), hence the terms primary and secondary caregivers are used in this study. The adolescent is cared for by a system of persons, and not necessarily a single person.

5.2.6 Gender, age, prevalence and types of behavioural problems in adolescents

The participants stated that behavioural problems occur equally between boys and girls. Therefore, it can be **concluded** that one cannot assume that behavioural problems occur more within boys, and that certain behavioural problems are associated more often with a specific gender. It can also be **concluded** that conflict may result between the adolescent and caregiver if the adolescent becomes involved in high risk behaviour and does not see the consequences of their behaviour.

5.2.7 Conflict between biological parents and adolescent

The participants identified the biological mother to be the person with whom the adolescent is more in conflict with than in comparison to the biological father, because of the following possible reasons: the biological mother is not married to the biological father, and in some cases the biological fathers does not live in the same home; the biological mother may be involved with another man; the biological father is absent as a result of long working hours and in some cases abuse alcohol during leisure time, is apathetic, or has deserted the family,

the father does not take responsibility for the children; the biological mother may take a leadership role in the home and take on the role as primary caregiver.

It can be **concluded** that in many cases the biological father has been emasculated and disempowered, as a result of the women taking over the roles of the biological father. The biological mother who takes on the leadership role perpetuates the passivity of the biological father, as she takes over his role and position within the home. The biological fathers become passive in their responsibility towards their children and have become accustomed to the biological mothers acting as the primary caregivers. As a result the biological mother takes on an extra load and can very easily burnout from over-involvement and trying to do everything on her own. The biological mother may take out her frustration on the adolescent and/or her husband, which may place strain on the adolescent-caregiver relationship.

5.2.8 Factors that hinders communication between adolescents and caregivers

The participants referred to the following factors that hinders communication between the adolescent and caregiver: there is no existing and close relationship between the adolescents and caregivers, which results in the adolescent not disclosing personal issues with their caregivers; there is a “generation gap” that exists between them; caregivers work long hours and spend very little quality time with the adolescents; adolescents are exposed to much more high risk behaviour than the caregivers were exposed during their childhood; caregivers do not understand the developmental phase which adolescents are going through; and caregivers have very little knowledge and skills in communicating meaningfully with the adolescent.

With regards to the findings it can be **concluded** that many of the caregivers in these areas do not possess knowledge and parenting skills in the areas of communication, conflict resolution, and the adolescent’s developmental phase.

5.2.9 Sources of stress in adolescents and caregivers

The leading sources of stress for adolescents in the participants’ working area are: peer pressure; alcohol and/or drug abuse within the home; and underachieving academically in

relation to the school's requirements and standards. The largest sources of stress for caregivers in the participants' working area are: a lack of financial resources which includes not being able to provide sufficiently; problems at work such as difficult working conditions and long working hours; and not knowing how to handle their children.

In relation to adolescents experiencing stress as a result of their peers that places pressure on them to become involved in high risk behaviour; the occurrence of alcohol and/or drug abuse within the home; and underachieving academically in relation to the school's requirements and standards, it can be **concluded** that there is an increasing likelihood for adolescents to engage in high risk behaviour because of the context of the participants working area, such as the harmful influence of alcohol abuse within the home; conflicts that take place within the family and peer contexts, poor quality of life as a result of poverty, having a low sense of worth and self-respect, and performing poorly academically.

It can also be **concluded** that the unity of a family and the way they relate with one another can be influenced by the economical pressure placed on the life of the family.

5.2.10 How adolescents and their caregivers deal with conflict

The majority of participants described the adolescents and caregivers in their areas as not dealing with conflict in that they shout and swear at each other; avoid the conflict by walking away; escape the reality of the conflict by turning to alcohol and/or drugs; family violence and physical abuse takes place within the home; and they do not listen to each other.

It can be **concluded** that there is a lack of knowledge and skills in the area of constructive conflict resolution within the participants' working areas.

5.2.11 Issues and problems adolescents and caregivers argue about

The majority of participants stated that the issues and problems adolescents and caregivers argue about mostly are: wrong friends, peer pressure, adolescents who sleep over at friends without caregiver's permission; adolescents who roam the streets without informing and

communicating with their caregivers; alcohol and drug abuse; disobedience to house rules; and disrespect towards caregivers.

It can be **concluded** that caregivers have little authority over their adolescents, that the adolescents do not consider and respect their caregivers; and that the adolescents' in these areas sense of belonging may lie more strongly with their peers.

5.2.12 Employment of conflict resolution methods

The majority of participants use a variety of methods to help resolve conflict such as family conferencing; educational methods and anger management; family discussions or meetings; family interviews; behavioural and incentive techniques; family meetings; and joint interviews.

It can be **concluded** that the participants in this study did not have a comprehensive understanding of mediation and the process it takes. The process of mediation has a definite beginning and an ending, and it has different stages that represent different sessions with the different parties involved. Further, there are two main goals to the process of mediation. Firstly, the goal of adolescent-caregiver mediation is to facilitate a process where resolution is found in their conflict and a fair and definite agreement is obtained to which both parties believes their needs have been met and to which both caregiver and adolescent can agree to. Secondly, a positive change needs to be attained in the adolescent-caregiver relationship and also in the dynamics of the family system. This change occurs once the adolescent and caregiver has learnt new ways of engaging, communicating or negotiating with one another in times of conflict and disagreement; mutually suited solutions are searched together through dialogue and discourse-sharing. Both parties need to take responsibility for the problem at hand and the social worker therefore, needs to empower the adolescent and caregiver to take ownership of the conflict and determine an outcome.

5.3 RECOMMENDATIONS

The following recommendations are based on the previous conclusions.

5.3.1 Knowledge about adolescent-caregiver conflict and continued education

It is recommended that social workers need to study recent published literature regarding adolescent-caregiver conflict during group supervision. Furthermore, it is recommended that management should provide social workers with relevant training and workshops regularly in the area of adolescent-caregiver conflict and mediation that can be used in conjunction with social work methods. Mediation can be used in many other contexts other than adolescent-caregiver conflict, such as in groups and in communities.

5.3.2 Awareness-raising on adolescent-caregiver mediation

It is recommended that social workers' intervention needs to include an element of prevention in terms of awareness-raising and education with regards to adolescent-caregiver conflict within the community at large, in order to have an impact on future adolescent-caregiver relationships and bring a reduction in high caseloads. It is further recommended that awareness promotion by social workers should take place at High schools and at farms or industries where caregivers work on the use of mediation to resolve conflict and to enhance the accessibility of social workers.

5.3.3 Socio-economic status of clients

It is recommended that social workers need to give attention during mediation to the living conditions that the adolescent and caregiver is living in and how it impacts on their relationship and life in general. It is further recommended that the basic needs, such as food, clothing, and shelter of the adolescent and caregiver needs to be addressed prior or in conjunction with mediation.

5.3.4 Culture of clients

It is recommended that social workers need to take into consideration the client's culture during assessment and during intervention when mediating. It is further recommended that social workers need to discuss and address the adolescent and caregiver's culture of communication, ways of resolving conflict, and traditions of their family and generations before them.

5.3.5 Primary and secondary caregivers of adolescent

It is recommended that mediation should not only include the adolescent and caregiver, but also the rest of the system of persons involved in the life of and who take or share responsibility for the adolescent.

5.3.6 Service delivery to adolescents and caregivers

It is recommended that intervention and service delivery should centre on both genders, when focusing on high risk adolescents. It is further recommended that biological fathers need to be included in the mediation process and empowered in terms of intervention through the process of mediation on how to communicate meaningfully with the adolescent and their partner within the home.

5.3.7 Situational analyses of adolescent-caregiver conflict cases

It is recommended that the social worker should determine the overall situation of adolescent-caregiver conflict in her area from other role players and network with other role players with regards to intervention and prevention.

5.3.8 Peer pressure and caregiver responsibilities

It is recommended that social workers need to focus on the influence of peers on the adolescent, and the caregiver's responsibilities towards the adolescent during the process of mediation and other intervention methods.

5.3.9 Employment of adolescent-caregiver mediation

It is recommended that social workers need to facilitate an approximately two hour process where resolution is found in their conflict and a fair and definite agreement is obtained – this process does not involve therapy. It is further recommended that the adolescent and caregiver has to learn new ways of engaging, communicating or negotiating with one another in times of conflict and disagreement and the social worker therefore, needs to empower the adolescent and caregiver to take ownership of the conflict and determine an outcome.

5.4 FURTHER RESEARCH

In the light of the results of this explorative investigation with regards to mediating adolescent-caregiver conflict, it is suggested that further research focus on the usefulness and effectiveness of mediation on the level of service delivery.



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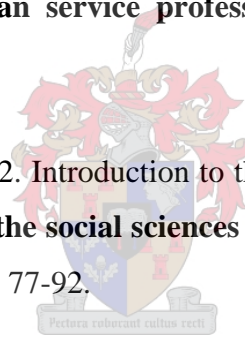
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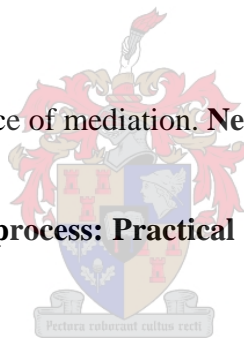
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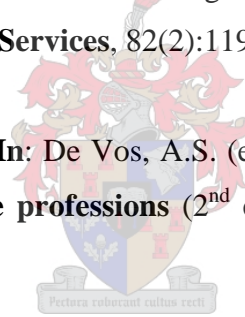
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ANNEXURE A

INTERVIEW SCHEDULE: ADOLESCENT-CAREGIVER CONFLICT

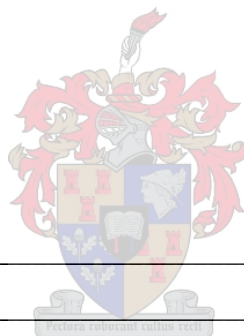
1. Do you work with adolescents and their caregivers?

Yes	
No	

2. Do you regard your knowledge about adolescent-caregiver conflict as:

Excellent	
Good	
Average	
Poor	
Very poor	

3. Why would you say so?



4. In what type of area do you work in?

Rural	Urban	Other (please specify)

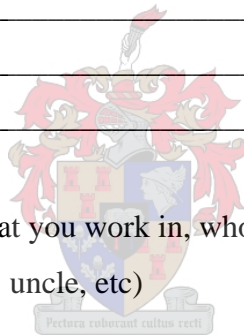
5. What is the socio-economic status of your clients in this area?

6. Describe the predominant culture of the people who live in the area in which you work.

7. How many of your current cases involve conflict between adolescents and caregivers?
Indicate either by percentage or approximate number of cases.

8. Would you regard this as high or low? Please explain.

9. Within the particular context that you work in, who is the primary caregiver(s)? (i.e. grandmother, grandfather, aunt, uncle, etc)



10. What would the reason(s) be for this?

11. Is there generally more than one person who acts as the caregiver?

Yes	
No	

12. If yes, who is the secondary caregiver mostly over the adolescent?

13. What would the reason(s) be for this?

14. What is the general age group of the primary caregiver(s) over the adolescent?

21 – 30 years	31 – 40 years	41 – 50 years	51 - 60	61 and older

15. What is the general age group of the secondary caregiver(s) over the adolescent?

21 – 30 years	31 – 40 years	41 – 50 years	51 - 60	61 and older

16. Do behavioural problems occur more within boys or girls in your area?

Boys	
Girls	
Both	

17. What are the types of problems that are more prevalent within this gender?

18. Between what age group of the child's development does conflict occur mostly with their caregiver(s) in your area?

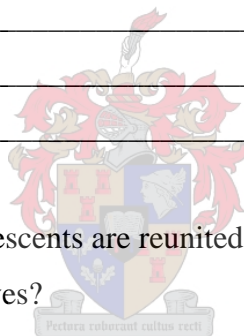
0 – 3 years	4 – 7 years	8 – 11 years	12 – 15 years	16 – 19 years	Other

19. In the particular cases where the adolescent is raised by his or her biological parents, with whom does the adolescent have conflict more? Choose one.

Mother	
Father	

20. Please explain your answer in question 19.

21. What are the results when adolescents are reunited with their biological parents after they have been raised by relatives?

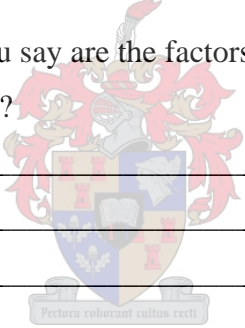


22. What kind of factors hinders adolescents and caregivers to communicate meaningfully?

23. What are the sources of stress that *adolescents* possibly can experience?

24. What are the sources of stress that *caregivers* possibly can experience?

25. In your opinion, what would you say are the factors that contribute to conflict between adolescents and their caregivers?



26. In what ways do adolescents and caregivers deal with conflict mostly?

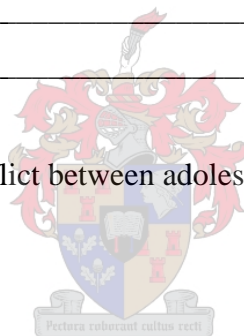
27. At which point does the social worker generally become involved?

28. What are the different issues and problems that adolescents and caregivers argue about mostly?

29. Elaborate why you think these issues and problems occur mostly between the adolescent and caregiver mentioned in your previous answer?

30. Does culture play a role in conflict between adolescents and caregivers?

Yes	
No	



31. Please explain your answer in question 30.

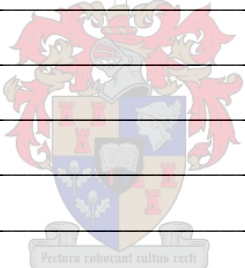
32. Does culture play a role in the way conflict is resolved?

Yes	
No	

33. Please explain your answer in question 32.

34. What method(s) of conflict resolution do you employ mostly between adolescents and their caregivers?

35. Please explain the reasons why you use this specific method of conflict resolution mostly.



36. Discuss the process that you follow in the method you mentioned above.

37. Does the above mentioned process involve elements of mediation? Why or why not?

38. What are the benefits of using mediation between adolescents and caregivers who are in conflict?

39. How often do you employ the method of mediation between adolescents and caregivers, for example, once or twice a week, or once or twice a month, etc.?

40. In what type of conflicting situations do you use mediation between adolescents and caregivers?

41. Do you see a difference between mediation and family therapy? Please explain.

42. What measures do you employ to prevent future destructive conflict from occurring between adolescents and caregivers?

43. How do you experience working with conflicting adolescents and caregivers?

44. Is there anything further that you feel is important?

