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**CWS1017W:**  
***Family Centered***  
***Case Planning***

**Transfer of Learning**  
**Day One**

**2025**

# TOL DAY ONE MATERIALS

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Self-Awareness Exercise

Fact Sheet: Dynamics of Domestic Violence

Fact Sheet: Substance Abuse

Fact Sheet: Mental Health Concerns

## TOL: Part One

### Self-Awareness Exercise

All of us have values, ethics, ideals, and principles that form the framework for our lives. The following seven questions will help you sort through these values in the context of your relationships with men.

1. A motto is a creed that summarizes our approach to life. It often has to do with work ethics, values about life, belief systems, or even a favorite saying. It could be positive or negative. If your father had a motto, what would it be? \_\_\_\_\_

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2. Who were important men in your life when you were growing up? What was your relationship with them like?

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3. What did these important men teach you about what men are like? \_\_\_\_\_

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4. If your father was active in your life as you were growing up, what did he teach you that you can embrace? What did he teach you that you want to discard? \_\_\_\_\_

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5. If your father was not active in your life as you were growing up, how did his absence shape and form who you are today? \_\_\_\_\_

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6. Think about the role your father played or is playing in your life in general. What impact does it have on your work? \_\_\_\_\_

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7. What has been the most surprising aspect of this exercise? \_\_\_\_\_

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## TOL: Part Two

Directions: Read the following three Fact Sheets:

- Handout F-1 Dynamics of Domestic Violence
- Handout F-2 Substance Abuse
- Handout F-3 Mental Health Concerns

As you review the Fact Sheets:

- **Highlight facts, discriminating dynamics, and any other information** that sets that particular issue apart from the other two issues
- Prepare to share your response to the following question with the group: **What is one thing that you learned from reviewing the Fact Sheets that was new or especially applicable to your work?**

Doing so will assist you in forming an accurate hypothesis of your group's assigned issue, i.e. Substance Abuse, Domestic Violence or Mental Health. We will confirm your group's hypothesis during break out discussions on Day Two of training.

## FACT SHEET:

### Dynamics of Domestic Violence

#### ***DESCRIPTION***

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

#### ***Specific Age, Gender, Cultural Features***

Domestic violence crosses ethnic, racial, age, national origin, sexual orientation, religious and socioeconomic lines. It is the leading cause of injury to women in the United States, such that they are more likely to be assaulted, injured, raped or killed by a male partner than by any other type of assailant. It is estimated that as many as four million instances of domestic abuse against women occur annually in the U.S. About one-fourth of all hospital emergency room visits by women result from domestic assaults.

Domestic violence is far more likely to be an issue of control than of anger. It is clear that the most dangerous time for a woman is when she is leaving or has just left an abusive partner and that partner is losing control of her. Her chances of being killed are increased dramatically.

This violence takes a devastating toll on children who are exposed to violence in the home. Approximately 2.4 million children are abused by their parents each year. Children whose mothers are victims of wife battery are twice as likely to be abused themselves as those children whose mothers are not victims of abuse. When children witness violence in the home, they have been found to suffer many of the symptoms that are experienced by children who are directly abused.

There are cultural considerations in domestic violence assessment and services. Codes of conduct and beliefs regarding traditional relationships between partners, the expectation that women be subservient to men, and prohibitions against involving “outsiders” in family business can all discourage a victim from disclosing the abuse. Furthermore, the victim may fear being shamed in the eyes of her community and may fear there will be gossip about her.

### ***Indicators of Domestic Violence***

The following behaviors should be considered an indication for a referral for services:

#### **Physical Harm:**

- Punching, hitting, slapping, kicking
- Burns
- Threatening with a weapon
- Mutilation of the victim
- Rape, forcing unwanted sex
- Forcing victim into pornography or sex in front of children
- Physical restraints, being tied up

#### **Emotional Harm:**

- Isolation from family and friends
- Embarrassing, name-calling, harassing the victim
- Threatening the victim or children
- Sleep deprivation
- Mutilating/killing pets, destroying objects
- Following or stalking
- Using children to spy on or assault the victim
- Degradation in front of children, belittling
- Control of victim’s friends, phone calls, clothes, whereabouts

**Economic Harm:**

- Not letting the victim get/keep a job
- Forcing the victim to ask for money
- Withholding money, information about money
- Stealing from the victim
- Ruining credit
- Sabotaging public assistance
- Withholding documentation/verification

**Other indicators that you may see:**

- Bruises, cuts, swollen eyes
- Wearing unseasonable clothing to cover injuries
- Wearing dark glasses indoors
- Perpetrator is overly affectionate toward unresponsive victim
- Children repeating negative terms the perpetrator uses in reference to the victim
- Perpetrator will not allow the victim to be interviewed alone

**Services**

Through the Family Violence Prevention and Services Act, the Administration for Children and Families (ACF) is responsible for several activities which address domestic violence. Grants are provided to state agencies, territories and Indian Tribes for the provision of shelter services to victims of family violence and their dependents and for related services, such as alcohol and substance abuse prevention and family-violence prevention counseling. The National Resource Center on Domestic Violence (800-537-2238) provides information and resources, policy development, and technical assistance designed to enhance community response to and prevention of domestic violence.

There are many community-based services throughout Virginia that address the immediate needs of families involved in violence. Child Welfare professionals have collaborated with advocates from the domestic violence community to develop protocols for joint cases. Professionals from both areas believe that the first priority is always safety of children. Workers should consult and collaborate with local advocates for guidance in working with this complicated and often dangerous family dynamic.



Anger management and couples counseling have not been found to be effective services in reducing the violence. Batterer intervention programs are most often based on the need to alter the batterer's thought processes that include the need to control their partners and their negative views of women. These are learned behaviors.

While it is not the role of the child welfare worker to advise an adult victim of domestic violence to leave an abusive partner, the worker must consider the safety of the child and the mother, whether she stays or leaves. The worker can open up discussion regarding domestic violence by using the following non-judgmental statements. These statements are intended to inform the suspected victim that you are aware that there may be a problem with domestic violence, you are open to discussing it, and that there is help available. The victim may not enter into a discussion with you at first; however, as you demonstrate your trustworthiness she may open up about it later. It is essential that all your communication be non-judgmental and non-blaming.

- Violence is against the law.
- You deserve to be safe.
- I'm concerned for your safety.
- I'm concerned for your children's safety.
- There are ways to plan for safety.

***Regarding the development of case plans:***

There are sometimes conflicting priorities in families where there is domestic violence. Protecting children is always the first priority but to do that, there are options. For example, it may be necessary to develop two case plans. One reason this is done is to make the batterer accountable for his own objectives/activities. Objectives may include cessation of verbal, emotional, physical, and sexual abuse; cessation of interference with their partner's efforts to parent children safely; and compliance with protection orders and other court-ordered mandates, including those imposed by probation, parole, and perpetrator intervention programs.

Another reason for separate case plans is for issues of safety and confidentiality. If the mother and child are in a shelter or if there is danger in the batterer knowing the mother's activities, the plans should be separate.

## ***Assessment Interviewing Questions***

Because of the high percentage of women visiting emergency rooms due to partner abuse, the American Academy of Family Physicians has developed three brief screening questions to detect partner abuse. While these would not be the only questions asked by workers in child protection, they may provide some initial assessment data. It should also be noted that similar assessments should be made throughout the life of the case as victims may not initially trust the worker or may fear for their lives or the lives of their children if they tell.

### Initial screening questions may include:

- “Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?”
- “Do you feel safe in your current relationship?”
- “Is there a partner from a previous relationship who is making you feel unsafe now?”

### Additional questions may include:

Has your partner ever:

- Kept you from seeing your family or friends?
- Followed you to see where you go?
- Accused you of being unfaithful?
- Controlled your money?
- Called you a degrading name?
- Made threats to you or to the children?
- Made threats to commit suicide?
- Been violent outside the family?
- Threatened to report you to CPS/Social Services or to take away the children?
- Is the abuse happening more often than usual?
- Is the abuse getting more severe?

Additional information may be found in Child Protection in Families Experiencing Domestic Violence, published by the U.S. Dept. of Health and Human Services, available through Child Welfare Information Gateway at [www.childwelfare.gov](http://www.childwelfare.gov)

***Virginia Family Violence and Sexual Assault Hotline***  
**800.838.8238**

*Adapted with permission from The Field Guide to Child Welfare – Volume II. J.S. Rycus, Ph.D., R.C. Hughes, Ph.D., Child Welfare League of America Press, 1998. Caseworker Core Module VI: Case Planning and Family-Centered Casework. Written by IHS for Ohio Child Welfare Training Program FINAL – July, 2008.*

## **FACT SHEET:**

### **Substance Abuse**

#### **Description**

The abuse of drug and alcohol by parents has become an increasingly frequent contributor to child maltreatment. The risks to children can be quite high.

Children of alcoholic mothers may be born with fetal alcohol syndrome, which is characterized by growth deficiency, learning disabilities, behavior problems, and various degrees of mental retardation. Infants whose mothers used crack cocaine during pregnancy are likely to have neurological, behavioral, and other developmental problems.

Children with substance-abusing parents are also at risk of physical abuse, neglect, and sexual abuse. As an example, it has been estimated that up to 75% of all incest incidents involve use of alcohol on the part of the perpetrator (Thompson, 1990).

Problems with substance abuse exist in an estimated 40% to 80% of the families of children confirmed by CPS as victims of abuse and neglect (CWLA, 2001).

Drug abuse can be defined as the use of a drug for other than medicinal purposes, which results in the impaired physical, mental, emotional, or social well-being of the user, or others who are dependent upon the user. Commonly abused drugs are alcohol, prescription drugs, sedatives, stimulants, marijuana, narcotics, inhalants, hallucinogens, phencyclidine, cocaine, methamphetamine and crack. These drugs affect the user's feelings, perceptions, and behavior by altering the body chemistry. Users often experience these physiological changes as mildly to intensely pleasurable - altering mood, reducing anxiety and depression, and creating feelings of euphoria sometimes referred to as a "high."

With some drugs, continued use sufficiently changes the body chemistry to increase tolerance. The user then requires increasing amounts of the drug to produce the same effect. The user may also become physically and/or emotionally dependent on the drug to function. This dependence, also referred to as addiction, makes it extremely difficult to control or stop use of the drug. Withdrawal can cause a wide range of unpleasant, painful, and potentially dangerous physical and psychological symptoms.

Clearly, not all persons who use drugs or alcohol are drug dependent. The scope, frequency, and circumstances of parents' drug or alcohol use will determine the ultimate risk to their children. Drug use can be limited in scope and frequency, more or less controlled, and it may not significantly affect the user's functioning or parenting ability. However, for many people, recreational use of drugs and alcohol can be a "slippery slope," quickly becoming more chronic and serious, leading to abuse or addiction. This is particularly true of crack cocaine, a highly addictive substance. Zuckerman (1994) states that while becoming addicted to alcohol, heroin, or intranasal cocaine may take years, with crack cocaine this progression from recreational use to addiction can occur within weeks or months of first use.

### **Effects on Parenting**

Parental substance abuse is associated with a more than twofold increase in the risk of exposure to child physical and sexual abuse (Walsh, 2003). The Welfare League of America reports that children raised by parents who abuse alcohol and other drugs are almost three times more likely to be abused and more than four times more likely to be neglected than other children (CWLA, 2001).

Once addicted, the user has a "chronic, progressive disease in which there is a loss of control over the use of, and a compulsive preoccupation with, a substance, despite the consequences" (Zuckerman 1994). The addict's primary goal is to maintain use of the drug. Pervasive disruption in all aspects of the addict's life—physical, psychological, economic, familial, interpersonal, and social—is a common result. The effects of substance abuse on parenting can be pervasive. Since addicts consider their own needs first, their children's needs for basic physical care, nurturance, and supervision are often not met, placing them at high risk of harm. According to Zuckerman (1994), the "primary relationship of mothers addicted to crack is with their drug of choice, not with their child."

Howard (1994) reports that mothers who are dependent on crack were found to be significantly less sensitive, responsive, or accessible to their children and without exception their children exhibited insecure attachments. Secure attachments were seen only in children whose mothers had been sober for at least six months prior to the testing procedure.

It is important to stress that in spite of the potentially serious outcomes of parental drug use for children, most drug addicts do not intend to harm their children, nor are they deliberately indifferent to their needs. They frequently exhibit extreme shame and guilt about the problems their drug use causes their children (Schottenfeld, Visarello, Grossman, Klerman, Nagler, & Adnopoz 1994); and they often devise complicated strategies to protect their children from the effects of their drug use (Kearney, Murphy & Rosenbaum 1994).

The deleterious effects of drug use on parenting are pervasive. Heavy use of drugs and alcohol typically interferes with thought processes, judgment, organization, and self-control. Substance abusing parents are often disorganized in their thinking and actions, they lack follow-through in all their activities, and their parenting responses are unpredictable and inconsistent (Howard 1994). In addition, blackouts, binges, and drug or alcohol-induced stupors, which are common with heavy substance abuse, can create very dangerous situations in which children are left totally unsupervised, placing them at high risk of harm. In fact, Zuckerman [1994] contends that "if the mother is addicted, the child's safety can be assured only if an adult who does not use drugs is in the household and is willing to take care of the child, or if the mother is actively involved in treatment that regularly monitors the child."

Methamphetamine use sometimes results in delusions, which can put the children and caseworker at risk of harm. Furthermore, "meth labs" are dangerous for children. The volatile chemicals used to produce "meth" can combust, causing the home to burst into flames. There are often "booby traps" and guard dogs protecting the property, which can pose a safety risk for children.

## **Difficulties with Identifying Substance Abuse**

In spite of high correlations between substance abuse and child maltreatment, substance abuse in maltreating families is not always identified. Many caseworkers are not aware of the signs and symptoms of substance abuse or addiction, and they may be uncomfortable asking the pointed questions necessary to determine the scope of drug or alcohol involvement. Denial is also a typical symptom of addiction. Substance abusers often deny that they use drugs or alcohol, or they may contend that their drug use causes no problems for themselves or their children.

In addition, research by Kearney, et al. (1994) suggested that mothers on crack devised many strategies to hide their drug involvement, to shield their children from drugs and the drug life, and to make up for crack's negative effects on mothering. These strategies included keeping children physically apart from cocaine by never using the drug in front of the children; hiring babysitters or leaving children with relatives prior to using the drug; or waiting until the children were asleep or safely situated. Mothers also made certain their appearance did not reveal their drug using status when they visited schools or other child-related settings, and they lied to agency officials or family members about their drug use. Most women described how they separated family money from drug money to assure that their children's needs were met. As their crack use became more frequent, they reported paying all their bills as soon as their paychecks or welfare checks arrived, because any unspent money was vulnerable. As a result, many of the mothers were able to hide the fact of their drug use from family, friends, and the community.

However, these compensatory strategies eventually broke down for almost 70 % of the mothers in the study. Many were unable to reduce or stop drug use, and they eventually exhausted their emotional and financial resources. Many of the mothers then voluntarily entrusted the care of their children to family members, or their children were removed by protective service agencies. The mothers appeared to be more readily accepting of placement of their children if they themselves made the placement arrangements, than if the child protection agency removed their children without their consent. Drug use often escalated after placement of the children, reportedly as they now had no mothering responsibilities, and as an attempt to deal with the pain and sadness of losing their children.

## Indicators of Substance Abuse

Because there are a wide variety of substances used, and an equally wide variety of indicators and symptoms, it is usually not possible for caseworkers to accurately diagnose which drug is being used or to what degree. Users may also concurrently use more than one substance. Anyone suspected of drug abuse or addiction should be evaluated by a professional in the field of substance abuse.

The most common general indicators of substance abuse are: altered mood states (euphoria, anxiety, irritability, excitability, sluggishness, or depression); changes in appetite and sleep patterns; temperamental or erratic behavior; poor memory and judgment; confusion and inability to concentrate; moodiness and restlessness; lack of concern about personal appearance; lack of attention to the environment; and clumsiness and coordination problems.

Caseworkers should become familiar with the dynamics of commonly abused substances in order to recognize when substance abuse is a contributor to maltreatment. Additional information is provided in the *Field Guide to Child Welfare*, including descriptions and indicators of alcohol abuse, inhalants, cocaine and crack, stimulants, depressants, narcotics and hallucinogens.

## Prognosis for Treatment

Currently, the prognosis for the treatment of substance abuse is quite equivocal. Different treatment programs report widely differing degrees of success with addiction to different drugs. Further, the need for drug abuse treatment far exceeds the availability of treatment resources. For example, in 1990 it was estimated that of the 105,000 pregnant women who needed drug treatment annually, only 30,000 received it (Nunes-Dinis & Barth 1993).

The prognosis for treatment of crack cocaine addiction is, at present, limited. Howard (1994) reports that most of the mothers in their study continued to use drugs, despite efforts by program staff to help their clients identify, enter, and stick with drug treatment. Only 15% of the mothers in the study remained abstinent for one year. Besharov (1994) concurs, suggesting that with crack cocaine addiction, "relapse is the rule, not the exception," and treatment success is defined as successfully increasing periods of remission, and controlling the damage done during relapses, rather than achieving permanent abstinence.

Wald (1994), however, cites a growing body of evidence to support the claim that the lack of success in treating crack cocaine addiction is at least partially related to the inadequacy of available treatment programs.



Substance abuse is difficult to treat because of the complexity of conditions and factors related to drug use. Several studies have noted the high percentage of drug-abusing mothers whose personal histories included physical and/or sexual abuse, neglect, drug use, violence, multiple separations, discontinuous relationships, and other physical and emotional hardships (Howard 1994; Kearney et al. 1994; Chavkin, Paone, Friedmann, & Wilets 1993, Grella et. al. 2005). It is posited that the euphoric mood and feelings of well-being that are typical effects of many drugs may be used as an antidote to anxiety, depression, hopelessness, and shame. However, the etiology of drug addiction is not that simple, and the effects of individual personality, physiological make-up, environmental factors, and social factors must be considered concurrently with the user's history.

The prognosis for individual drug users varies considerably, depending upon several factors: the type of drug used; the scope and frequency of drug use; the longevity of the user's habit; the degree of tolerance or dependence; the individual's personal and interpersonal strengths and resources; and the supportiveness of the user's family and social environment. The following "strength" conditions would in general, increase the likelihood of successful treatment. The "risk" conditions, in general, are likely to make treatment more difficult.

### **Strengths That Can Mitigate the Effects of Substance Abuse**

- Parents acknowledge their substance abuse, and fully understand the negative impact it has on their children.
- Parents are willing to engage in some form of substance abuse treatment, and attempt to remain involved in a treatment program. This may include self-help and peer-help organizations such as Alcoholics Anonymous and Narcotics Anonymous.
- Parents make alternative care-giving arrangements for their children when they recognize themselves to be incapable of providing proper care.
- Parents are willing and able to separate themselves from friends, family-members, spouses, or others who continue to use drugs and support their continued use by the parents.

- Parents have a strong support network of family and friends who do not use drugs and who support their attempts to discontinue drug use.
- Parents have a history of adequate social, occupational, and personal functioning prior to the onset of drug use.
- Parents are able to recognize when a relapse is likely and make plans for their children, call in friends or family members to provide care for the children, or seek help.
- Parents exhibit shame and distress about the effects of drug use on their parenting.
- Parents have a history of successful parenting prior to the onset of drug use and have a strong identity as a parent.

### **Conditions That Increase Risk of Maltreatment**

- Parents whose drug abuse seriously impairs their judgment, reliability, and ability to meet their children's needs.
- Parents whose involvement in a drug culture lifestyle places their children at continuous and serious risk of harm.
- Drug abusing parents who deny the existence of the problem, and refuse to consider treatment, or who verbalize a desire for help but never follow through.
- Parents with no history of adequate social, occupational, and personal functioning prior to the onset of drug use.
- Parents whose primary social contacts and support networks are also habitual drug users; parents with no social support network of non-using family or friends.
- Parents with little or no history of successful parenting prior to onset of drug use, and limited identity as a parent.

## **Services**

Highly specialized treatment must be provided to address the problems related to substance abuse. When substance abuse is a primary contributing factor to child maltreatment, little change in the home situation can be expected until the substance abuse problem has been dealt with and resolved. Additional information about self-help programs, pharmacological interventions, and multi-faceted approaches can be found in the *Field Guide to Child Welfare*.

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## **FACT SHEET:**

### **Mental Health Concerns**

#### **Depression**

A depressed parent may not have the emotional energy to attend to the children's needs. Depressed feelings and behaviors may be situational, of relatively recent origin, and may be in response to a traumatic loss. Clinical depression is more chronic, normally long standing, less related to situational causes, and often has a physiological basis. Depression can also result from taking certain medications, including those for treatment of high blood pressure. Depression can also occur post-partum. Some people who experience depression with psychotic features such as delusions. Depression can lead some individuals to commit suicide.

#### *Specific Age, Gender, Cultural Features*

The core symptoms are the same between children and adults. However, certain symptoms such as somatic complaints, irritability, and social withdrawal are particularly common in children; psycho-motor retardation, hypersomnia, and delusions are less common in pre-puberty than in adolescence and adulthood.

Studies indicate that major depression occurs twice as often in women as in men. Some women experience depression for a few days following the beginning of menses. Some women experience post-partum depression, usually within four weeks of the birth of the baby. The presence of delusions about the baby can result in the mother harming the baby. Women with post-partum depression often have severe anxiety and even panic attacks.

There are cultural differences in how depression is experienced and described. In some cultures, depression may be expressed in mostly somatic complaints, rather than feelings of sadness or guilt. For example, there may be complaints of "nerves" or headaches in Latino and Mediterranean cultures, weakness, tiredness or "imbalance" in Chinese and Asian cultures, or problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" in the Hopi (American Indian) culture.

***Diagnostic Indicators: Major Depression***

Symptoms include the following, which occur most of the day, nearly every day, for at least a two-week period.

*Mood:* depressed mood, including feeling sad, empty, tearful, hopeless and helpless either by self-report or observation by others, often expressed in adolescents as “I’m bored”;

*Loss of interest in activities:* markedly diminished interest or pleasure in all, or almost all, activities;

*Motivation:* general apathy, decrease in school or work performance, reduced attendance at school, failure to complete school or work assignments;

*Eating patterns:* significant weight loss when not dieting, weight gain, or change in appetite;

*Sleep patterns:* regular insomnia (inability to sleep) or hypersomnia (sleeps all the time);

*Activity level:* agitation and restlessness, or slow, lethargic motor activity; fatigue or loss of energy;

*Feelings about self:* feelings of worthlessness, or excessive or inappropriate guilt, such as, “I can’t do anything right,” “I’m so stupid”;

*Concentration:* diminished ability to think or concentrate; indecisiveness; children may daydream at school or show a decrease in attentive behavior;

*Suicidal thoughts:* recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, a suicide attempt, or a plan to commit suicide. Verbalizations may include: “I’d be better off dead,” “I should just off myself,” “I’m so stupid.”

## ***Treatment***

A variety of medications are used to treat depression. It is sometimes difficult to determine the optimal medications and dosages for some people, especially adolescents. Some medications do not take effect for approximately three weeks. Some individuals may become frustrated with this and should be encouraged to continue the medication as specified by the prescribing physician.

Some people are not helped by medication. A knowledgeable physician should monitor medication at least monthly.

Mental health counseling is usually also necessary to treat depression. The therapy may focus on a variety of issues, such as coping with the depression, and resolving emotional, social or life situations that may have contributed to the depression. Parents should be involved in therapy to understand and help the child or adolescent who has depression or bi-polar disorders, and to deal with the resulting difficult behaviors.

Individuals who show any signs of suicidal thoughts, such as talking about suicide, saying goodbye to friends and loved ones, or giving away possessions, should be seen immediately by a mental health professional to ascertain the risk of suicide and determine whether psychiatric hospitalization is necessary.

## **Bipolar Disorders**

Bipolar disorders (sometimes called manic-depressive disorder) combine manic and depressive behaviors. The cycling between manic and depressive behaviors can be quite lengthy, with several months of each type of episode or rapid cycling, with only hours of each type of episode.

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood
- Inflated self-esteem
- Grandiosity
- Decreased need for sleep
- More talkative than usual
- The subjective experience that the individual's thoughts are racing
- Distractibility
- Significant increase in goal-directed activity
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

Adolescents who experience manic episodes are more likely than adults to include psychotic features. Adolescents in manic episodes may engage in antisocial behavior (including aggression), school truancy, school failure, or substance abuse.

### ***Assessment Interviewing Questions***

Specific interviewing questions can be developed by formulating specific questions for each diagnostic criterion. Similar questions can be used when interviewing collateral contacts, or when interviewing a parent regarding his/her child. It is often helpful to ask the client to rate the degree of severity or frequency of the symptom (scaling questions). For example, 0 indicates no problem, 1 indicates a mild problem with severity or frequency, 2 indicates a moderate severity or frequency, 3 indicates extreme severity or frequency. In general, open-ended questions are preferred, as that allows the individual to explain whatever is troubling him. However, some clients, especially children, are not able to respond to open-ended questions, and require more specific questions in order to communicate with the worker.

The following are suggestions. Each worker should adapt these to the situation, the developmental level of the person being interviewed, and the worker's style.

#### **Questions regarding depression:**

- *“Do you ever feel sad? If so, how often? How bad are these feelings?”*
- *“Do you ever have thoughts about killing yourself? If so, have you thought of how you might do this?” (Usually, having a specific plan and the means to carry out the plan indicates a higher risk of suicide. However, any thoughts of suicide should be taken seriously, and a mental health practitioner should see the person.)*
- *“How do you feel about yourself?”*
- *“How do you feel about the future? Or, “Do you ever feel as if there is no hope for you?”*
- *“Do you find that you have less interest in activities that used to interest you?”*
- *“Do you find that you have trouble concentrating?”*
- *“Is it hard to get motivated?” Or, “Is it hard to get things done?”*
- *“Are there any changes in your sleep patterns?”*
- *“Are there any changes in your eating habits?”*
- *“What about your activity level? Do you feel tired, restless, agitated?”*



Questions regarding manic episodes:

- *“How is your mood?”*
- *“Is your activity level unusually high?”*
- *“Do you find that you don’t need as much sleep as you usually do?”*
- *“How do you feel about yourself?”*
- *“Do you ever feel irritable?”*
- *“Do you find yourself thinking that you can do anything, that anything is possible?”*
- *“Does it seem like your thoughts are racing, and you can’t slow them down?”*
- *“Are you more talkative than usual?”*
- *“Are you more distractible than usual?”*
- *“Do you find that you must participate in activities that bring you pleasure, regardless of the consequences?”*

**Borderline Personality Disorder**

“Parents who have a personality disorder display dysfunctional patterns of behavior in all aspects of their lives” (Rycus, 1998 Vol II). A large number (but not all) individuals with Borderline Personality Disorder (BPD) were abused or neglected as children. Borderline Personality Disorder is a contributor to child abuse and neglect. People with Borderline Personality Disorder have considerable difficulty in the following areas:

***Interpersonal Relationships***

- Individuals with Borderline Personality Disorder have considerable difficulty forming and maintaining interpersonal relationships. “They fluctuate quickly between idealizing and clinging to another individual and devaluing and opposing that individual” (Sperry, 2003). They may develop relationships very quickly and intensely; however, these relationships are often shallow and unstable. Adults may have a long series of short term romantic relationships.
- They have an extraordinary fear of rejection and will make frantic efforts to avoid real or imagined abandonment. For example, they may engage in indiscriminate sexual affairs, they may have considerable difficulty allowing their teenage children to become independent, and they may depend on their children to meet their needs for love and affection.

- Casework with persons with BPD is often marked with significant difficulty in balancing a supportive/facilitative role with appropriate authority. Clients with BPD may be extremely demanding of caseworkers for attention and services. They may create some type of crisis to avoid closing the child protective services case in order to keep the caseworker involved in his/her life.
- Relationships between children and parents who have BPD are often disturbed, because children are not equipped to cope with the emotional neediness and fluctuations of intense mood.

### ***Behavior***

- People with Borderline Personality Disorder are impulsive and engage in self-damaging acts, suicide gestures, self-mutilation, have difficulty controlling their anger, and often provoke fights. They often work in jobs that are less than their intelligence and ability would warrant and may change jobs frequently.

### ***Emotional Functioning***

- They often have marked mood shifts and frequently, easily erupt into inappropriate and intense rage, and have difficulty controlling their anger. They may also have feelings of emptiness and boredom.
- People with BPD have an external locus of control and usually blame others when things go wrong. Their emotions often fluctuate between hope and despair since they feel powerless to change their circumstances. Additionally they often rely on manipulation of others to meet their needs, which further contributes to their inability to maintain relationships. They may, for example, make excessive demands of caseworkers.
- They tend to have rigid, rapidly fluctuating perceptions of others, as either “all good” or “all bad” and may intensely like someone one minute and intensely dislike them the next. For example, a client with Borderline Personality Disorder might see that a caseworker is doing something the person perceives as positive, but claim to hate the caseworker the next day (when the caseworker confronts the person, is unable to immediately meet his/her need, or otherwise frustrates him/her).

## ***Treatment***

It was once thought that treatment of BPD was largely ineffective. However, recent advances in mental health treatment and in the use of medications have resulted in better prognoses. An accurate differential diagnosis from a psychologist or psychiatrist, and a treatment approach tailored to the individual is critical to treating people with BPD.

*Adapted with permission from The Field Guide to Child Welfare – Volume II. J.S. Rycus, Ph.D., R.C. Hughes, Ph.D., Child Welfare League of America Press, 1998. Caseworker Core Module VI: Case Planning and Family-Centered Casework. Written by IHS for Ohio Child Welfare Training Program FINAL – July, 2000*

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