

Fact Sheet:

Mental Health Concerns

The following information is adapted from the *Field Guide to Child Welfare* (Rycus and Hughes, 1998.)

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 may have 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 criteria. 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, zero indicates no problem, one indicates a mild problem with severity or frequency, two indicates a moderate severity or frequency, three indicates extreme severity or frequency. In general, open-ended questions are preferred, as that allows the individual to explain whatever is troubling him/her. 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?”

“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?”

“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 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 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. BPD is a contributor to child abuse and neglect. People with BPD have considerable difficulty in the following areas:

Interpersonal Relationships

Individuals with BPD 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 teenaged 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 their lives.

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 BPD are impulsive and engage in self-damaging acts, such as suicide gestures, self-mutilation, and may 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 and 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 BPD may like the caseworker and emotionally cling to him/her one day (when the 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.