Pryce – Welcome to the Florida Institute for Child Welfare Podcast. This series is Child Protection Caseworker Support. I am Jessica Pryce, your host, on each episode we will explore topics that are relevant to child welfare professionals, we will directly from people who work every day to make a difference in the lives of children and families. It is our goal that this podcast is accessible, informative, and supportive. So, if you know someone who works in child welfare, be sure to share this podcast with them.

Today on the Florida Institute for Child Welfare Podcast we are discussing Depression. Our goal is to help child welfare professionals identify and help their clients who are suffering with depression. Since much of the work of a child welfare professional is not in a therapeutic setting, tips are provided for how to support families and connect them to the most effective resources. There is also a discussion around the importance of partnership between our mental health providers and child welfare professionals. Our guest today is Kim Purinton, the clinical training manager at sunshine health. Let’s get started.

Hi Kim, thank you for being here.

Kim – sure, thank you for having me.

Pryce – The first thing I wanted to do is kind of introduce you to our listeners. Could you tell us what you do, where you’re from, and kind of how you got into your position and into this work?

Kim - So I’ve been in social work, in the social work field for about thirty years now. And so, I’ve had myriad positions, but really the breadth, the breadth of what I have worked in, has been with children and families. Mainly in the realm of being a social worker in the school system for about seventeen years. And I got my LC- LCSW, my licensed clinical social work license back in 2004 and after that began a small private practice. So, currently I’m the clinical training manager for Sunshine Health and child welfare specialty programs based in Sunrise, Florida. And, what that means is I get the great privilege of working with strangers that train providers that work with kids in the child welfare system, training them on topics that are clinically based around trauma, brain science attachment, resiliency attachment pieces, so we can basically serve those that serve our children. So, thank you for asking, really happy to be here.
00:02:35 Pryce – Okay, the first thing I wanted to talk about Kim if you don’t mind is just especially people who aren’t clear about what depression really is and some people use it colloquially “I’m depressed. I’m sad.” What are kind of the clinical mile markers for when a person is depressed?

Kim – Sure, so I’m gonna talk about two different things. We’re gonna come out strong with that clinical definition and maybe some signs and symptoms. And then I also wanted to kind of talk about a lesser known definition that I thought was really appropriate for this for this discussion. So first of all, the DSM or the Diagnostic and Statistical Manual really quantifies mental depression as this as a as a mental depressive disorder really is clinical depression. It’s a very common and serious mood disorder in that just as people are different; so are feelings of depression. They may be different from person to person. But the actual symptoms of a depression diagnosis, those are the same, but they also always are typically they will manifest differently. They’ll present differently between people that that are experiencing depression. Also, some of those who suffer with depression experience persistent feelings of sadness, hopelessness, some may lose interest in activities that they might’ve once enjoyed. And also, aside from those emotional problems caused by depression individuals can also present with even physical symptoms that can range from digestive issues, even chronic pain. One of the big Hallmarks of this though is that the symptoms must be present for at least two weeks and they must cause that individual, that person’s clinically significant distress or some type of impairment in social, occupational, some other important area of their functioning.

00:04:33 Pryce – So, what you just said is really interesting to me because I used to be a CPI, a child protective investigator, and when I think about the moms that were on my caseload, I didn’t see a lot of what you just said. And I’m curious what your thoughts are about people who are functionally depressed. Because we know what we see, and the result of that it’s- you know you don’t want to be presumptuous and say, “are you depressed?” But, I’m just curious what your thoughts are about those that don’t present with these you know certain issues, but they have a lot of reasons to be depressed and they’re pushing it down.

00:05:07 Kim – Absolutely. Well, and I think a lot of times it goes back to knowing your caseload and taking the time as much as you can because it’s not- you don’t always have the luxury of time to create a historical relationship with someone. But, looking, and if you know that someone is acting outside their normal, that is probably one of the the chief indicators that something is off. And it could be that it’s depression, it could not be; but it’s that willingness for a PI, a case manager to just kind of stay with it if they suspect that there’s something off. That they’re seeing some of these changes, especially distraction, agitation, asking those questions to see if they can get to the to the meat of it.
Pryce – No, I like that a lot. As you’re working your case plan paying close attention to the parents and what they have been saying and seeing if things starkly change. I think that’s really good advice for frontline workers, and when I think about my time in the field, I did not have information about how to engage with a parent who is depressed. And you know, we’re kind of trained to come in, gather facts, and go make a decision; but I think with the way Florida is changing we are trying to have that engagement piece and really understanding our clients at a deeper level.

00:06:32 Pryce – So Kim, I wanted to ask you if you have any information or advice to caseworkers about what they could be doing when they get on the scene with a parent or when they meet a parent for the first time. Do you have any type of even if it’s an analogy or a thought process that they can take in with them?

Kim – Well first of all, the best thing that a case manager a caseworker can do is look at every encounter as an opportunity, okay? And I know sometimes that might fall on very tired ears that have very heavy caseloads, so sometimes that’s a tall order. But the best thing that that you can do is come in hoping you can bring fresh eyes and fresh ears to the situation and keep in an open mind with the goal of “how can I help the person I’m about to meet work with to fan the flame of their motivation and their clarity about what their potential is, okay?” And so with that and yes I - you know I have got a an analogy that I’ll use that some of your listeners might have heard of protective factors and risk factors. And, one thing that help has helped me in the past and going to these opportunities is me knowing and also sharing with the person that I’m working with that there are these two truths, right? So, you’ve got one side, you’ve got truth number one, which may be what has caused them to be in this type of depressed. And we don’t know if they’re depressed or not, but in a way acting in a way that might seem sad or low energy, some things that might be concerning to a case manager. So, those truths could be what has happened to them, what people have said about them, labels that people have put on them, them remembering their past choices that might not have worked out so well, past failures, labels that they might put on themselves. So, they could be operating from that one truth base, and as a caseworker to go in, the best thing that we can do is help remind them that although there is this truth there is also another truth. There that the truth number one where I would start, where I have started with folks is: let’s just acknowledge that you are here present and ready to participate in this healing process, and in this process, because this person doesn’t have to you know, or they could be there in person, but not being given themselves. So, really our job is to go in and help fan the flame of their understanding that although there’s this one truth that really seeks to undermine their resiliency. There’s this other truth where, just like I just said, the resiliency fact where they’ve got you know they’re present, they’re ready to participate, they may have you know cleaned the house,
getting ready for the visit. They may have enacted or gotten some folks together to form even a- somewhat of a support system for themselves. So, really the best thing initially that a case manager can do is to go in and acknowledge and also help try to set the pace and lead that person into this other truth, this also truth where they can remember the resilience-y factors and the things that they’re working so hard for that it makes a difference.

00:09:57 Pryce – I really like that, especially because a truth will be that we are in your life now. There is an open case. You probably don’t want me to come to your house every month or every two weeks, but I’m here and that’s a truth, and it it’s not great, but there’s also that other truth that you are actively involved in this process and you’re present. I really like that. Thank you. And I also wanted to ask you Kim, in some areas of the country neglect comprises fifty percent of the cases that we get at DCF (Department of Children and Families) and in some areas, it’s seventy percent. So, I kind of wanted to talk to you and hear from you about the relationship between a mother and their child. And what if what if a mother is depressed, can that lead to neglect? And you know, what can we do really about that as frontline caseworkers and case managers?

Kim – It can have you know, research shows us that moms that are depressed have- there are other risk factors not only for the mom, but also for their child. Such things as they are you know if we got a mom who is carrying, who is pregnant she, she’s almost three and a half times more likely to deliver prematurely and almost four times more likely to deliver a low-weight-birth baby - a low-birthweight baby. She’s also less likely to breastfeed or breastfeed as long as recommended if that’s protocol for mom. But really, overall some of the impact, the real significant impact that moms that are suffering with depression or having experiencing depression that their babies or young kids that they want to be close to mom, and when mom’s depressed, they can have real significant issues. Trouble feeling close to their child.

00:11:46 Pryce – So, I’m really glad you brought up the what could happen when a mother gives birth and I was listening to a podcast the other day and I’m not sure if you are familiar with the term matrescence. I just learned it. And Dr. Alexandria Sax is leading the podcast and she talks about you know, that we have the term adolescence that really odd season for teenagers, and matrescence is that odd season for new moms. And again, going back to when I was in the field, I wish I would have known that seventy to eighty percent of new moms likely will experience the baby blues. So, when I had a case with a newborn, it never dawned on me that perhaps this mother is dealing with the baby blues or perhaps this mother is depressed. My- as you wrote in on, okay, there is a presenting issue, child maltreatment, and I think that that’s going to be important for our listeners to know. That there could be a host of other things going on when there’s a brand-new baby. And Dr. Sax often says, “with the birth of a baby, there is the
birth of a mother.” Even if you have multiple children, you’re birthing a different type of mom and you’re becoming a mom and DCF might be at your door, but I hope that DCF and our CBC’s (Community-Based Care) and our frontline workers can start to think about “okay, I’m here for a particular reason, but there could be a host of other things happening in this person, in this mom right now.” So, I’m glad you brought up the maternal kind of health piece.

00:13:12 **Kim** – Sure. And I think that even speaks back to the work that we’re privileged to do. You know, I know that we don’t feel like you know it’s a privilege every day, sometimes it feels like it’s work, but I think along with that I think of prevention, right? That just kind of comes up to me and you know as much as we can get in to fan the flame of the mom’s resiliency fire or letting her - helping her to focus on what’s going well. That’s the best thing that that we could really do to offer and I love that that how do you say that again, the matern-?

**Pryce** – The matrescence.

**Kim** – The matrescence, right. And pro- so, really just to help mom prepare for that because, like you said, the baby blues, it’s very common. It’s you know, it’s something if it lasts longer than two weeks, we’re really then you’re not looking at baby blues anymore pers se, but a lot of it does mimic, could look- be a precursor to post-partum, it could be a precursor to other depressive disorders; however, it could just be mom’s tired and needs some good nutrition.

**Pryce** – Matrescence.

**Kim** – Right! That’s matrescence! So, if we can if we can go in and help prepare, right? You know and no, nobody’s ever really prepared, but if we can help a little bit, that would be that would be great thank you.

00:14:31 **Pryce** – And I know that you are a clinician, and when I think about PI’s (Protective Investigators) they’re not exactly clinicians, but I think they do clinical work, but I wanted to talk about the referral process, you know when we do have those identifying moments when this mom seems depressed or you know, as a PI what is the best route when it comes to helping that mom? Because we don’t have that ongoing clinical relationship.

**Kim** – Sure. I’m reaching back into the archives of when you know when I was a a case manager, I worked with the actu- one of the things I wasn’t - didn’t share, but it’s pertinent was I used to work very early on in in the NICU (Newborn Intensive Care Unit) with moms that had just delivered, children that were exposed to the HIV virus. And this is way back in the day before there were heal pricks in the NICU you know and having to go in and share some tough news, right, with a mom. That you know that not only there’s this health complication, but we need to move quickly and assist the child with this swell to antibody concerns. So, remembering myself as like a twenty-two-year-old caseworker going in that had not gotten a
masters, not a clin- so yeah and I think what you said is so pertinent. Our frontline folks go into these moments where ready or not, here we come, right? And so, the best thing that I was able to do was really nothing that had to do with my skillset, was really to understand what are my available resources? I was in a hospital setting, so I said “okay, you know what’s the best- you know who’s the- what’s the best referral I can make?” And I started- this was- was it before cellphones? It might have been before cellphones! So I had my rolodex of folks that I could call to send a referral out. When I came to the to the height of my aptitude or the end of what I felt I could expertly assist mom with, I wanted to have a good referral at the ready, and part of the work that, help be the foundation for my courier and that season was creating relationships with those referrals. So, if it was an email- I don’t even know if we we’re emailing then, but it was an email; if it was a phone call; or even to go by and see that that really was one of the foundational elements of knowing where and when I needed to refer and to whom. And then that follow up was really really important. And to let mom know that there might be other people that I would bring alongside to help her as her team. Her team of support for that.

00:17:17 Pryce – I like that, and I know from your notes, and we talked before the podcast, we talked about trauma. And when it comes to being a frontline worker, we do go in with the history on the family if there is a history, you know we have if they’ve been in our system before. And we can look at, perhaps, domestic violence and different trauma related, you know mile markers. How does trauma relate to depression? Is there multi-generational trauma, is there multi-generational type of - is the likelihood that you’ll be depressed greater if you’ve had certain traumas?

Kim – And you know there’s- this is such a rich topic, and I know we’ve - we don’t have a year to talk about it, but the answer’s you know, yes. It’s definitely, that is a real marker for if you’ve had trauma in your past, and some of your listeners may have heard of the ACE (Adverse Childhood Experiences) study. Which is on adverse childhood experiences. And, the crux of that you know that could a whole podcast onto itself. But basically, what look that was a person’s different traumas that they have experienced before they were turned eighteen, give them a certain score. And the higher that score is it really does, research bares out, that it can provide complications for that individual both in the physical and you know emotional realm. That they, things such as even has been linked to cancer and heart disease and even yes even mental health disorders, depression being one of them. And so, those are real important. I think a good psychosocial you know, assessment or a good history. And again, I think it’s that piece of being prepared prior to going in. If there is a history you know, for if there is something to read you know, I know it’s not always easy you know because time is such a resource, it’s scarcity. But to read and be prepared prior to the opportunity really, going in
to meet with mom at that first time is to kind of get that understanding because not only are we going in to see what’s that impact on relationship between mom and baby, but we’re also our chief goal is “how can we shore up the resilience and the strength in that mom?”

00:19:28 **Pryce** – Got it. And Kim, I have one last question if you don’t mind. I remember you mentioned you were in private practice when you are a licensed clinical social worker and I hear a lot from my work that there’s a disconnect between clinicians and our child welfare workforce. So, if a mom is sitting in a room with a therapist, perhaps sitting in with you, some therapists don’t really know a lot about our practice model, don’t know about certain child maltreatment issues, don’t know about present and preeminent danger that a child might be in. So, because of that disconnect, kids are re-abused and some of these kids are-end up you know, dying. So, I’m curious, when you were in your private practice, did you have information about child welfare in general when you were talking to a mom perhaps? In the back of your mind, were you thinking about the well-being of her child? Just curious how that was for you as a therapist.

**Kim** – Sure. Well, one of the pieces that I would know be- just as it would go, I would end up seeing youth that, may have been cutting or have suicidal ideation; other safety concerns. And I think that’s really what you’re speaking to. And so for me, and even really if it was a domestic violence, if I saw folks that were in there for marriage counseling, safety is always something that’s that foundational component. Because if you don’t ensure the safety of the folks, first and foremost, that’s your working with, and that equates to their children, making sure that the kids are in a safe and secure environment. You really can’t go forward with any other therapeutic intervention. And I think it just as a of a as a social worker, you know master’s level social worker, which is you know it’s a clinician, but we also have that background. I- to me it’s almost two people part of Maslow’s hierarchy of needs, right? You know, don’t talk to me about anything else if I’m hungry. My piece of that is if there’s some issue with safety and security, and permanency issues around that, that has to get addressed first, it really does. And it is actually very therapeutic because those activities- say if that was your goal. Even in therapy as a clinician, if I saw someone coming in for therapy, a child welfare goal, a safety or permanency goal, could actually also be a clinical goal as well. Because you’re looking at how to solve a problem, you’re looking at being solution oriented, you’re looking at what are some resiliency factors or support system, you’re helping the mom or whoever is around that child, or if it’s around a young mom that is suffering with depression that’s just given birth. You know, those pieces, you’re those can, those two can co-exist and sometimes both be the child welfare goal as well as the clinical goal. So for me in in practice, that was really pivotal; much on if I was working a case because we needed to bring resources in and make sure the safety and security, or if a presenting issue which we found out
later was not the issue, right, was more “clinical” in nature. You know, I would work it the same way, I really would.

**00:22:43** Pryce – And with that, I want to thank Kim again for being with us today. To learn more about Kim and the work that she does, please visit us at [WWW.FICW.FSU.EDU](http://WWW.FICW.FSU.EDU). We have also posted information and resources about depression. I end each podcast with a thank you to our child welfare community, we appreciate your commitment to this work, and we hope the podcast was helpful. I want to acknowledge Aaron Kudja, our podcast engineer, and Marianna Tutwiler, the producer of this series. Until next time, I am Jessica Pryce, and we are strengthening child protection by providing caseworker support.