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## Introduction

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**S**ocial workers are challenged to meet the mental health needs of women at a time when women are taking on increased responsibilities in both the home and workplace. In accepting this challenge, social workers must provide women, especially low-income women, with the most effective practice possible. Given that effective practice relies on knowing which psychosocial interventions have been proven to work, social workers require knowledge about which interventions bring about the most positive, measurable changes in the lives of low-income women, regardless of etiology. Those insights have particular policy, practice, and research implications for those concerned about the well-being of all women, particularly when one considers that women are the primary consumers of mental health services.

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### Explaining Women's Poverty

One definition of poverty suggests simply that individuals are in poverty when they lack necessities, including food, shelter, medical care, and safety (Bradshaw, 2007). Even though some argue that basic needs are relative to each individual (Sen, 1999), others perceive poverty as simply a matter of inequality (Valentine, 1968). However, the most typical definition of poverty is the statistical measure known as the *poverty line* that Orshansky created in 1963 for the Department of Agriculture. In 2000, the poverty line for a family of four was \$17,500 (United States Census Bureau, 2000), though Quigley has noted that this measure of poverty is problematic inasmuch as it fails to account for the various views of family, cash income, work-related expenses, and regional differences in the cost of living (Bradshaw, 2007). Regardless of definition, the theories used to explain poverty are perhaps more important than definition to our text.

The cumulative and cyclical interdependencies theory of poverty provides an explanation of why a disproportionate number of women live in poverty in the United States. The theory builds on the following traditional theories of poverty: Individuals are inherently to blame in some way for living in

poverty (Bradshaw, 2007; Gwartney & McCaleb, 1985; Maskovsky, 2001; Weber, 2001); cultural belief systems support subcultures of poverty (Asen, 2002; Chaturvedi, Chiu, & Viswanathan, 2009; Lewis, 1998); economic, political, and social distortions or discriminations result in poverty among certain groups (Abramovitz, 1996; Alinsky, 1945; Blank, 2003; Chubb & Moe, 1996; Jencks, 1996; Quigley, 2003); and geographical disparities, such as rural versus urban circumstances, account for poverty (Goldsmith & Blakely, 1992; Pruitt, 2007; Weber & Jensen, 2004). The cumulative and cyclical interdependencies theory of poverty posits that these various explanations of poverty are interconnected and linked.

This interdependency theory of poverty explains how women become disadvantaged in the midst of poverty, and in turn, become psychologically disabled at the individual level. When women lack opportunities to be self-sufficient, this circumstance results in little, if any, motivation and often in depression in individuals (Bradshaw, 2007). Most important, the theory allows for the possibility that if any of the links between individual, cultural, socio-economic, and geographic aspects of poverty are broken, then the poverty cycle can be broken as well. This can be accomplished by identifying elements of self-sufficiency and addressing them via income and economic assets, education and skills, safe housing, access to health care, social services, close personal ties, or personal resourcefulness and leadership skills (Miller, Mastuera, Chao, & Sadowski, 2004).

## Women in Poverty

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Nearly 60% of Americans who live in poverty are women (Cawthorne, 2008). While poverty rates for men and women are the same in childhood, the rates increase for women in the childbearing years and in old age (Weiss, 2009). Interestingly, the gap between the rates of poverty for women (13%) and men (11.1%) is greater in the U.S. than in any other country in the Western world, and this gap is reflected across ethnic groups. A quarter of Black women and nearly a quarter of Latina women are poor, and both groups of women are twice as likely as White women to live in poverty (Cawthorne, 2008; United States Census Bureau, 2008). The following rates reflect poverty among married and unmarried women with and without children: married women with dependent children (54%); single women with dependent children (26%); single women with no children (12%); and married women with no dependent children (Cawthorne, 2008; Weiss, 2009).

The number of single mothers has increased significantly since 2000 (Weiss, 2009). This trend does not take into account the number of unmarried mothers who are close to being in poverty or who have inadequate incomes that fall above the poverty line. Women are paid less than men, are segregated into lower-paying occupations, provide more unpaid

caregiving than men, bear the costs of raising children, and are often pushed into a cycle of poverty due to domestic and sexual violence. As a result of these long-term circumstances, one in five women living in poverty are elderly women 60 years of age and older (United States Census Bureau, 2008; Weiss, 2009).

Even though most women on welfare live in poverty, many women with children who are underemployed, as well as many women who are unemployed without children, live in or near poverty. In addition, many unmarried women who are widowed, divorced, separated, or never married are on their own (Weiss, 2009), and these groups of women comprise three fourths of women who live in poverty. The rate of poverty among this group of women is 20.8%, compared to the 6.2% rate of poverty among married women. In sum, based on the poverty line, many women are at or near poverty, and nearly half of those women are unmarried.

Pruitt (2007) noted that poverty in rural areas is a serious problem for female-headed households. In 2003, 36.3% of families headed by females in rural areas were living in poverty, compared to 28.9% of families headed by females in urban areas. In rural areas, single female heads of households with children are more likely than single female heads of households without children to live in poverty. As a result, the children in these households are twice as likely to live in poverty as children who live in suburban areas, and thus the cycle of poverty will likely continue, especially for females.

Several authors have presented the faces of women who live in poverty. Berrick (1997) described the lives of five women on welfare. For example, she described Darlene, a woman on welfare who had become immobilized by deep depression that kept her from wanting to wake up in the morning, primarily because she feared social contacts with social workers, her children's teachers, social workers, and other parents (Berrick, pp. 94–95). Connelly (2000) provided a glimpse of the lives of homeless women with children and how they negotiated daily living without a home. Raphael (2000) told the story of Bernice, a woman from a violent background who became the victim of domestic violence. Ehrenreich (1996) presented the face of many women underemployed in the secondary labor force. She stated:

When poor single mothers had the option of remaining out of the labor force on welfare, the middle and upper middle class tended to view them with impatience, if not disgust. The welfare poor were excoriated for their laziness, their persistence in reproducing in unfavorable circumstances, their presumed addictions, above all for their “dependency.” Here they were, content to live off “government handouts” instead of seeking “self-sufficiency,” like everyone else, through a job. They needed to get their act together, learn how to wind an alarm clock, and get to work. (Ehrenreich, 1996, p. 220)

## Poverty and Women's Mental Health

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A mental disorder is a state of emotional and psychological well-being in which an individual is unable to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life (American Heritage Dictionary, 2000). The National Institute of Mental Health (NIMH) National Advisory Mental Health Council's Workgroup on Basic Science placed emphasis on gender differences in the developmental, social, and environmental contributions to mental health (National Institute of Mental Health, 2004). Equally important, however, is the connection between poverty and women's mental health.

Belle (1990) highlighted the association between poverty and women's mental health, particularly the association between poverty and depression. Estimates suggest that between one fourth and one third of women on welfare experience some combination of post-traumatic stress disorder (PTSD), depression, generalized anxiety disorder (GAD), or substance abuse or misuse (see Anderson & Gryzlak, 2002; Coiro, 2001; Danziger, Kalil, & Anderson, 2001; Lens, 2002; Meara, 2006; Montoya, Bell, Atkinson, Nagy, & Whitsell, 2002). More recently, Cook et al. (2009) found that among single mothers on welfare, 61% of mothers reported a lifetime rate of any disorder listed in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*; 46.8% of mothers reported at least one disorder in the past 12 months. The lifetime and 12-month rates for specific disorders were substance use disorder (SUD; 29.1%, 9%), mood disorders (28.8%, 20.1%), and anxiety disorders (47.1%, 39.0%).

Similarly, in the National Household Survey of Drug Abuse (NHSDA), 19% of welfare recipients met the criteria for depression and had used illicit drugs in the past year (Jayakody, Danziger, & Pollack, 2000). Barusch, Taylor, Abu-Bader, and Derr (1999) found that nearly 43% of welfare recipients scored positively for clinical depression, 15% scored positively for PTSD, and approximately 7% scored positively for GAD. In another study, welfare program directors surveyed believed that 65% of recipients needed substance abuse treatment (Cordozo & Sussman, 2001).

Wenzel, Tucker, Hambarsoomian, and Elliott (2006) examined violence among 869 women randomly selected from shelter settings and low-income housing in one California metropolitan county. They found that 23% of women in shelters and 9% of women in low-income housing reported experiencing physical violence. For sheltered women, the perpetrators were especially diverse, including sexual partners and family members, as well as strangers; furthermore, the violence was severe. The researchers suggest that impoverished women should be screened specifically for safety. Goodman, Smyth, Borges, and Singer (2009) highlighted that intimate partner violence (IPV) and poverty intersect to shape women's mental health and ways of coping.

In this regard, Goodman et al. (2009) proposed that poverty *does* contribute to IPV, despite the attempt of those involved in the early domestic

violence movement to portray IPV as a classless phenomenon. Poverty contributes to IPV primarily in that poor women are more likely than middle- to upper-class women to remain financially dependent on an abusive partner. Reciprocally, IPV contributes to persistent poverty inasmuch as it often leads to mental health-related unemployment and homelessness. Taken together, the mutually reinforcing effect of IPV and poverty results in stress, powerlessness, and social isolation for women, a context in which women must cope very differently than other battered women (Goodman et al., 2009).

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2008) noted that cultural disparities place certain groups of women at even greater risk of poor mental health, particularly due to the lack of economic resources. Women from ethnic minority groups often face racism, discrimination, and violence in their social environments, and those women who have recently come to the United States as immigrants or refugees are at risk of mental disorders due to the additional stresses and traumas that are related to acculturation and assimilation expectations. Also, women from ethnic and cultural minority groups may not seek help for mental health problems because of the stigma attached to mental illness within their cultures.

Several researchers have found that stress among low-income women is associated with mental health problems (Vandergriff-Avery, 2002; Vogel & Marshall, 2001). In the National Survey of American Families (NSAF), parents in stressful family environments were four times more likely than other parents to report symptoms of mental health problems, and low income in families is highly associated with stress (Moore & Vandivere, 2000). The dual role of breadwinner and nurturer undoubtedly places stress on women, particularly those making the transition from welfare to work and who have joined the ranks of the working poor (Cancian, 2001). Sadly, public policy leaders have disenfranchised poor women, especially those in rural areas, from meaningful discussions about the challenge of both working and caring for children (Cancian, Haveman, Meyer, & Wolfe, 2002; Cocca, 2002; Lens, 2002; Pruitt, 2007).

Due to mental health problems, some women on welfare who want to be employed may be unable to understand or conform to the instructions of agencies, or be able to find and keep a job (Cordoza & Sussman, 2001, p. 5). If they do find jobs, the disorders may interfere with interpersonal relationships and functioning in ways that cause them problems in the workplace (Cordoza & Sussman, 2001). This may be especially true for many women whose mental or learning disorders go untreated or undertreated prior to their entering the labor force. The stress of trying to be effective in the workplace may be amplified when women must assume the roles of breadwinner and nurturer.

Ultimately, mental illness and psychological distress can impact the daily functioning and work life of individuals with these conditions. Symptoms

such as severely depressed affect, low energy, feelings of hopelessness and worthlessness and suicidal thoughts can make functioning in the work place, even at a basic level, extremely difficult for a person suffering from clinical depression. Other disorders, such as anxiety related conditions, post-traumatic stress disorder and obsessive-compulsive thinking can make regular work environments intimidating, and even overwhelming. A person with a psychiatric illness often feels challenged by even the most fundamental tasks, such as getting out of bed in the morning, tending to personal activities of daily living and parenting. These struggles often preclude seeking work outside the home, and certainly constrain work performances and impair long-term consistency and effectiveness (Cordozo & Sussman, 2001, p. 1).

## **Poor Women, Mental Health, and Social Work Practice**

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Many authors have focused on topics that range from men's abuse of women to poverty among women (Abramovitz, 1996; Amott & Matthaei, 1996; Burden & Gottlieb, 1987; Davis, 1994; Gutierrez & Lewis, 1999; Hanmer & Statham, 1989; Loseke, 1992; Roberts, 1998; Stout & McPhail, 1998; Van Den Bergh, 1995; Van Den Bergh & Cooper, 1986; Van Wormer, 2001; Van Wormer & Bartollas, 2000). However, few authors have focused on the mental health of poor women. As a result, much more information is needed to understand how social workers can practice more effectively with poor women.

First, the literature suggests that the most prevalent disorders among low-income women are PTSD, depression, GAD, and SUD. Given the fact that low income and gender are predictors of borderline personality disorder (BPD) and the lethality of this disorder is so great, this disorder is also important to consider when practicing with poor women. The evidence also indicates that these particular disorders often exist in combination, and as such, it is plausible, for example, that low-income women may use substances to treat symptoms of other mental health disorders. By comparison, eating disorders are not prevalent among low-income women.

Second, individual predispositions to these mental health disorders must be taken into consideration. For example, in the case of PTSD, trauma may actually change the brain in a way that contributes to ongoing symptoms of PTSD, and as such, weight may be given to internal processes rather than external stressors. In the future, it may be that pharmacological intervention will account for more positive outcomes than psychosocial interventions for women who have experienced traumatic events, including childhood sexual abuse, domestic violence, and war experiences. As more research is conducted using technology, such as the use of magnetic resonance imaging, the

extent to which biochemical and genetic factors contribute to mental health disorders will determine the extent to which psychosocial versus pharmacological interventions are effective in addressing particular disorders and in what proportions.

Third, much more interest must be paid to the stressors that amplify and exacerbate women's predispositions, especially when one considers the ongoing impact of poverty on mental health. Among drug-addicted women, Kubiak (2005) explored the cumulative effect of women's exposure to stress and found that PTSD increased 40% with each trauma, and that adding chronic stressors increased the likelihood of PTSD. The results of one study indicate that among low-income African American women in an urban Midwestern county, IPV increased women's odds of receiving welfare benefits in a year whereby previous welfare receipt did not (Yoshihama, Hammock, & Horrocks, 2006).

Fourth, routine screening of low-income women who social workers perceive to be at risk of particular disorders seems warranted in order to identify the presence of mental health problems and needs in particular areas. For example, Pruitt (2007) noted the prevalence of depression among low-income women in rural areas. Clark et al. (2008) found that poor women who witnessed community violence in urban neighborhoods were twice as likely as women who did not witness such violence to experience anxiety as well as depressive symptoms. This may mean that social workers develop self-anchored screening measures that reflect the norms in particular areas (Jordan & Franklin, 2003).

Fifth, it is important for social workers to gain insight into the cultural and ethnic factors that affect the mental health of poor women. In this regard, how poor women from ethnic minority groups make sense of mental health problems in terms of causes may reflect the stigma and prejudice that exacerbate these problems. It is imperative to understand more precisely how mental health problems determine whether or not women seek help from formal versus informal caregivers. Perhaps most importantly, women from ethnic minority groups are likely to respond in unique ways to traditional and nontraditional screening measures and interventions (Bhui & Dinos, 2008).

Last, evidence-based interventions that focus on the mental health needs of all women are important in gaining insight into how programs and services can be developed that meet the mental health needs of poor women. While it is especially important to assess accurately the client's situation quantitatively, (Meyer, 1992; Jordan & Franklin, 2003), inferential thinking about and interpretation of data about the client are important skills that allow clinicians to determine the most effective treatment for particular clients (Meyer, 1992). Evidence-based practice (EBP) incorporates what social workers know from their experiences as clinicians and what consumers know from their own life experiences (Gambrill, 1999, 2001; Rosen & Proctor, 2002; Webb, 2001; Witkin & Harrison, 2001).

With this in mind, Gilgun (2005) proposed the following cornerstones of evidence-based practice: (a) what we know from research and theory, (b) what we learn from consumers of our services, (c) what social workers know from their own experience, and (d) what the consumer brings to the situation. In this context, we focus on what we know from the research and theory on treating the mental health disorders prevalent among low-income women. We assume that students who use this text will have a basic understanding of theories that explain mental health problems and of both qualitative and quantitative measures used in screening for mental health disorders, and are willing to use interventions that have been proven to work in addressing the mental health needs of individuals.

## Summary

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We noted that the cumulative and cyclical interdependencies theory explains women's poverty by linking the individual, cultural, socioeconomic, and geographic factors that contribute to poverty. We found that in order to reduce poverty, elements of self-sufficiency must be identified and addressed through income and economic assets, education and skills, safe housing, access to health care, social services, close personal ties, and personal resourcefulness and leadership skills. In this context, we noted the considerable numbers of women who live in poverty or near poverty, and how poverty contributes to mental health problems (specifically, PTSD, depression, GAD, SUD, and borderline personality disorder) among many women.

In the remaining chapters of this text, we examine those disorders relying primarily on the Ovid databases, using the Cochrane Central Registry of Clinical Trials, the Cochrane Database of Systematic Reviews, Medline, and Psych INFO. The descriptors used to identify salient literature varied by disorder but included *women*, *low-income women*, *poor women*, *etiology*, *prevalence*, *screening*, *assessment*, *evidence-based practice*, and *effective practice*. In addition, information was utilized that is available on the web-pages of the American Psychological Association, the National Institutes of Health, the National Institutes of Mental Health, and SAMHSA.