Psychiatric Disorders and Substance Dependence among Unmarried Low-Income Mothers

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The study reported in this article examined the prevalence of mental health disorders and the sociodemographic factors associated with having a mental health disorder in a probability sample of 185 African American and white single mothers. Logistic regression analyses revealed that race (being white) and being on welfare were associated with increased risk of having a mental health disorder, when controlling for other sociodemographic variables. The association of welfare status and psychiatric disorders highlights the need for access to mental health services for this population. Implications for low-income women making the transition from welfare to employment are discussed.

Key words
low-income women
mental health
substance dependence
welfare

Welfare mothers experience more psychological distress and psychiatric disturbances than other groups (Bassuk, Buckner, Perloff, & Bassuk, 1998; Berton & Staab, 1996; Tolman & Rosen, 2001). Jayakody, Danziger, and Pollack (2000) analyzed data from the 1994 and 1995 National Household Survey on Drug Abuse and found that 19 percent of welfare recipients met the criteria for one of four DSM-III-R psychiatric diagnoses included in the survey. This is important because disruptions brought about by mental health disorders have been associated with lower rates of labor force participation and a drop in income (Ettner, Frank, & Kessler, 1997).

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (P.L.104-193) transformed welfare from an entitlement program to a temporary program that restricts the length of time during which welfare benefits can be received. PRWORA established a maximum 60-month lifetime limit for receipt of federal benefits (Temporary Assistance for Needy Families [TANF]) and mandated that recipients be involved in work-related activities within 24 months of receiving benefits. Welfare policy now emphasizes rapid labor force participation. However, if mental health and substance-related disorders are barriers to work, then the welfare recipients experiencing these problems may be at risk of losing benefits and suffering severe material hardship for themselves and their families.

The present study draws from a general community sample of adults living in the Detroit metropolitan area in 1995. Measures in the data set yield psychiatric diagnoses for five disorders: (1) major depressive episode, (2) panic disorder, (3) generalized anxiety disorder, (4) alcohol dependence, and (5) drug dependence. The psychiatric diagnoses examined in this study are limited to the ones measured in the Detroit Area Study (DAS). The study addressed three questions: (1) What is the prevalence of five mental health disorders in a probability sample of African American and white single mothers? (2) What sociodemographic factors are associated with a higher

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probability of having a mental health disorder? (3) Controlling for sociodemographic factors, is welfare receipt associated with higher prevalence of mental health disorders?

Research on Mental Health Disorders and Substance Use

Major Depressive Episode

The fundamental feature of major depressive episode (MDE) is either depressed mood or loss of interest or pleasure in all, or almost all, activities, and related symptoms, for at least two weeks. High rates of depression are disproportionately common among poor people (Bassuk et al., 1998; Dooley & Prause, 2002; Olfson et al., 2000), and psychopathology is more prevalent among the lowest social group than among the highest (Belle, 1990; Kessler et al., 1994). High levels of depressive symptoms are prevalent among women who lack employment, friends, and child care and among women experiencing stressful economic problems (Jackson, 1999; Lennon, Blome, & English, 2002). Belle reported that nearly one-half of a sample of low-income mothers of young children had high levels of depressive symptoms; those who had extremely low income, were unemployed, or were single were most likely to show symptoms of depression.

The association between depression and welfare reliance has been established. An evaluation of 790 participants in an employment training program for welfare recipients found that 42 percent met the criteria for clinical depression, more than twice the proportion in the general population (Moore, Zaslow, Coiro, Miller, & Magenheim, 1995). An examination of the National Longitudinal Survey of Youth revealed that 42 percent of welfare recipients interviewed in 1992 were at risk of depression. In contrast, only 20 percent of those who did not receive welfare reported such high levels of depressive symptoms (Steffick, 1996). Krinitzky (1990) found that low-income welfare mothers were significantly more distressed and depressed than low-income non-welfare mothers.

Generalized Anxiety Disorder

Excessive anxiety and uncontrollable worry about a number of events or activities characterize generalized anxiety disorder (GAD). Community prevalence studies based on DSM-III diagnoses have reported current prevalence of GAD ranging from 1.2 percent (Robins & Reigier, 1991) to 6.4 percent (Uhlenhuth, Balter, Mellinger, Cisin, & Clinthorne, 1983), and lifetime prevalence between 4.0 percent (Wittchen, Essau, Vonzerssen, Krieg, & Zaudig, 1992) and 6.6 percent (Robins & Reigier). Analyzing National Comorbidity Survey (NCS) data, Wittchen, Zhao, Kessler, and Eaton (1994) found that respondents who met the criteria for GAD suffered substantial interference in their lives and felt the need to seek professional help. They reported that women were twice as likely as men to have GAD. In the NCS, GAD was relatively rare, with a current prevalence of 1.6 percent; lifetime experience of GAD was 5.1 percent of the population ages 15 to 45. Danziger et al. (2000) found that, compared with the NCS estimate for general population, 7.3 percent of welfare recipients met the screening criteria for GAD.

Panic Disorder

Panic disorder is characterized by discrete periods of intense fear or discomfort combined with four other symptoms—shortness of breath, dizziness, trembling, and so forth. The rate of 12-month panic disorder in the NCS for women was 3.2 percent (Kessler et al., 1994). In a sample of low-income women in an urban general medicine practice, 9.2 percent of the women met the criteria for panic disorder during the preceding month (Olfson et al., 2000). Several studies have shown that panic disorder is more common in women than in men and that women are more likely than men to suffer a recurrence of panic symptoms after remission (Kessler et al., 1994; Yonkers et al., 1998).

Alcohol and Drug Dependence

Evidence of habitual use or a clear sense of need for drugs or alcohol characterizes substance dependence. Studies on the prevalence of substance abuse disorders among low-income women have found that the percentages were relatively small and consistent with the general population (Danziger et al., 2000; Grant & Dawson, 1996). Low-income samples drawn from high-risk nonwelfare populations (that is, homeless people, victims of violence, and so forth) do reveal higher rates of substance use, abuse, and dependence. For instance, Bassuk et al. (1996), in a sample of sheltered homeless mothers, found the alcohol and drug abuse and dependence rate to be 41.1 percent. In addition, studies that examined drug use and welfare receipt in a multivariate context found that use of drugs (marijuana and cocaine) in the preceding year was associated with welfare receipt in the subsequent year (Kaestner, 1998). However,

caution should be used when interpreting substance dependence problems based on household surveys because of probable underreporting of drug and alcohol use (Johnson & Meckstroth, 1998).

A number of studies have found that alcohol and drug use negatively affect employment and earnings (Berger & Leigh, 1988; Kaestner, 1998; Wickizer, Campbell, Krupski, & Stark, 2000). Most studies, however, have focused on men's employment and have not examined the effect of substance use on employment of single mothers. At the programmatic level, workfare programs designed to implement PRWORA have struggled with the employability of substance abusers because of drug-testing requirements for employment and disruptions in work attendance and performance brought about by substance use (Suffet, 1999).

This review of the literature suggests that psychiatric and substance dependence disorders have not been systematically examined in a low-income female population receiving welfare. This study addresses this omission by evaluating the prevalence of five psychiatric disorders, and the effect of these disorders on welfare receipt.

METHOD

Sample

The data came from the 1995 Detroit Area Study (DAS), a multistage area probability sample consisting of adult respondents, 18 years of age and older, residing in Wayne, Oakland, and Macomb counties in Michigan, and the city of Detroit. Face-to-face interviews were completed with 1,139 respondents between April and October 1995. Interviews were conducted by University of Michigan graduate students in a research training practicum in survey research and by professional interviewers from the Survey Research Center at the University of Michigan. The response rate was 70 percent. Race was measured by respondent self-identification. African Americans were oversampled; the final DAS sample included 520 white, 586 African American, and 33 Asian, American Indian, and Hispanic individuals.

Our study focused on a subsample of the larger DAS sample that met criteria for inclusion in the study. A sample of 185 African American and white unmarried mothers ages 18 to 49 was selected for the current study. Respondents were grouped by welfare status: Aid to Families with Dependent Children (AFDC, $n = 90$), and non-AFDC ($n = 95$). AFDC status was defined by whether the respondent or a member of the respondents' household received AFDC in the past year. Because of the small number of Asian, American Indian, and Hispanic respondents in the study, analyses included only the African American ($n = 150$) and white ($n = 35$) respondents.

Measures

Age, marital status, family income, education, and neighborhood crime were sociodemographic control variables used in the analyses. Respondent age was categorized into three groups: (1) 18 to 27 years; (2) 28 to 37 years; and (3) 38 to 49 years. Marital status was assessed by a series of dummy variables for cohabitating (people who were living with a partner for at least six months), never married, or widowed/divorced/separated. Family income was assessed using four categories: (1) less than $10,000; (2) $10,000 to $19,999; (3) $20,000 to $29,999; and (4) $30,000 and above. Educational status was coded 0 for non–high school graduate and 1 for high school graduate. A single-item self-report of problems with muggings, burglaries, assaults, or other problems in their neighborhood was used to measure neighborhood crime. Response categories ranged from 1 = never to 5 = very often.

Mental health status was assessed by the presence of three clinically significant emotional disorders and two substance dependence disorders in the year before the interview: MDE, GAD, panic attack, alcohol dependence, and drug dependence. In addition to the five disorders, an "any disorder" variable was computed for respondents who had any of the five disorders.

The measurement of these disorders was based on the definitions and criteria specified in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders, Third Edition—Revised* (DSM-III-R) (APA, 1987). The psychiatric diagnoses were operationalized in screening versions of the World Health Organization's (WHO) Composite International Diagnostic Interview, Version 1.0 (CIDI) (Kessler, Andrews, Morczek, Ustun, & Wittchen, 1998; World Health Organization, 1990). The CIDI is a structured interview schedule designed to be used by trained nonclinician interviewers to assess the prevalence of specific psychiatric disorders (Robins et al., 1988). WHO field trials (Wittchen, 1994) and other methodological studies (Blazer, Kessler, McGonagle, & Swartz, 1994; Wittchen) have

documented good test–retest reliability and clinical validity of these CIDI diagnoses.

Analyses

The data were weighted to take into account differential probabilities of selection and to adjust the demographics of the sample to those of the area from which they were drawn, for nonresponses as well as for age, gender, race, education, and income. These weights were designed to improve the overall representativeness of the sample and ensure that the results were generalizable to the female adult population of the Detroit metropolitan area.

Descriptive analyses were used to present differences by AFDC and non-AFDC status and by race on the independent variables and the five DSM-III-R disorders. A series of two nested models was tested using logistic regression. The dependent variable used in the logistic regression analyses was "any disorder." The first of the three models included the demographic covariates (that is, age, marital status, family income, education, and neighborhood crime). Race was added in the second model and AFDC status in the third model. Race by AFDC interaction was also tested.

Results

Significant differences were found between AFDC and non-AFDC mothers in partner status, age, race, and family income. Among women on AFDC, more than half (65.1 percent) had never been married (Table 1). Women on AFDC were four times as likely to have family income of less than $10,000 compared with their non-AFDC counterparts (61.1 percent versus 15.0 percent). Women on AFDC were more likely to be younger; most of the AFDC mothers (54.8 percent) were from 18 to 27 years of age. White mothers were more likely to be non-AFDC mothers than on AFDC (51.6 percent versus 30.6 percent).

Mothers from AFDC households did not differ significantly from non-AFDC households on any of the five disorders, but they were significantly more likely to have at least one of the five disorders. Major depression was the most common mental health disorder in both samples (Table 2).

Table 1. Descriptive Statistics for Unmarried Mothers Ages 18 to 49 (Weighted)

Variable	Total (N = 185)	AFDC (n = 95)	Non-AFDC (n = 90)
Age (%) (years)			
18–27	32.1	54.8**	12.3
28–37	30.3	31.8	29.1
38–49	37.6	13.4	58.7
Partner status (%)			
Never married	44.6	65.1**	26.7
Cohabitating	15.2	11.2	18.7
Family income (%)			
Less than $10,000	36.5	61.1**	15.0
$10,000–$19,999	19.2	14.9	23.1
$20,000–$29,999	16.0	8.1	23.0
$30,000 and over	28.3	16.0	39.0
Race (%)			
White	41.8	30.6*	51.6
Black	58.2	69.4	48.4
Education (%)			
High school graduate	80.5	76.9	83.7
Community stress			
Neighborhood crime (mean)	3.2	3.2	3.2
Welfare status			
AFDC household (%)	46.6		

*$p < .05$. **$p < .001$.

Table 2. AFDC Status and Psychiatric Disorders among Unmarried Mothers Ages 18 to 49 (Weighted), in Percentages

Disorder	Total ($N = 185$)	AFDC ($n = 90$)	Non-AFDC ($n = 95$)
Affective disorder			
Major depression	22.8	30.0	15.6
Anxiety disorders			
Panic disorder	7.8	10.0	6.5
Generalized anxiety	3.2	5.0	2.2
Any anxiety disorder	10.6	15.0	6.7
Substance dependence			
Alcohol dependence	5.2	10.0	2.2
Drug dependence	0.9	0	2.2
Any substance dependence	5.7	10.0	2.2
Range of disorders			
0 disorders	66.5	52.5	78.3
1 disorder	27.4	40.0	17.4
2 or more disorders	6.1	7.5	6.1
Any disorder	33.5	47.5*	21.7

*$p < .05$.

For both samples, respondents who had a disorder tended to have only one of the five disorders measured.

Because of the small sample size of the individual disorders and the lack of significant bivariate results, we examined the associations among race, AFDC status, and psychiatric disorders using the composite "any disorder" variable rather than the individual disorders. We did not use a count of the disorders because most respondents had only one disorder. Table 3 presents the associations among race, AFDC status, and having any of the five psychiatric disorders. In model 1 (sociodemographic controls), none of the covariates was significantly related to having any one of the five disorders, and covariates were only marginally related with marital status and education. Model 2 (sociodemographic controls, race, and AFDC status) suggests that AFDC status is related to having any disorder and that the likelihood of having a disorder is three times greater if the mother receives AFDC. The coefficient for race is also significant and suggests that the likelihood of having any mental health disorder is more than two and a half times greater for African American women than for white women. The second logistic regression model explains 15 percent of the variation in the dependent variable. The race by AFDC interaction was tested and found insignificant.

Discussion

The data suggest that AFDC mothers differed significantly from their non-AFDC counterparts on their demographic measures. These differences were similar to earlier studies of welfare populations in that AFDC mothers were more likely to be younger, poorer, and of color (Blank, 1997). When evaluating psychiatric disorders by AFDC status, there were no significant differences on the individual disorders, but AFDC mothers were significantly more likely to have any of the disorders during the past year. The multivariate analyses revealed that race (being white) and receiving AFDC were associated with increased risk of having a mental health disorder during the past year when controlling for other sociodemographic variables.

Limitations

A number of limitations of the analyses should be noted. First, the sample was drawn in 1995 before changes in welfare policy were implemented on a national level. In Michigan, however, where the sample was drawn, spring of 1995 brought some of the first implementations of welfare reform in the United States. Welfare recipients who did not cooperate with employment and training expectations had their grants and food stamps reduced by 25 percent. After 12 months of noncooperation, recipients had their cases closed. Coupled

Table 3. Logistic Regression Coefficients and Odds Ratios for the Association among Race, AFDC Status, and Any Psychiatric Disorder in Unmarried Mothers Ages 18 to 49

	Model 1		Model 2		
Variable	*b*	*SE*	*b*	*SE*	Odds Ratio
Age (years)					
(18–27)					
28–37	–.19	.46	–.03	.48	.97
38 and over	–.39	.50	–.12	.54	.88
Partner status					
(Divorced/separated/widowed)					
Never married	–.49	.41	–.56	.43	.57
Cohabitation	–1.50	.85	–1.65	.86	.19
Family income					
(less than $10,000)					
$10,000–$19,999	–.46	.49	–.38	.52	.68
$20,000–$29,999	–.26	.53	.19	.56	1.20
$30,000 and over	–.43	.51	–.12	.59	.88
Education					
(High school graduate = 1)	–.77	.46	–.70	.47	.50
Community stress					
Neighborhood crime	–.10	.14	–.09	.15	.91
Race					
(black = 0)					
white =1			.95*	.45	2.59
Welfare status					
AFDC household			1.04*	.46	2.84

NOTE: Items in parentheses are reference variables.
*$p < .05$.

with the more stringent PRWORA mandatory work requirements, Michigan saw its TANF caseload decline by 39 percent between fiscal years 1995 and 1998 (Plimpton & Greenberg, 1999).

It is important to note, however, that although this sample was drawn when the AFDC rather than the TANF program was in place, the relationship between welfare status and psychiatric disorders is likely to be stronger in the TANF context. Recipients who leave welfare are less likely to have psychiatric disorders than those who remain on welfare (Danziger et al., 2000; Meckstroth, Pavetti, & Johnson, 2000). Psychiatric disorders can be barriers to employment or may result from the increased vulnerability that results from material hardship and relative economic deprivation (Johnson & Meckstroth, 1998). For this reason, we believe our analyses and conclusions are relevant for a TANF population.

Second, the sample of white AFDC recipients was too small. Research with larger samples is important to substantiate the link between welfare status and psychiatric disorder. Finally, by calling attention to the increased prevalence of psychiatric disorders in welfare households, we may further stigmatize poor people and contribute to the victim blaming that has historically dominated the political debate about welfare (see Blank, 1997).

Implications for Women Moving from Welfare to Work

Although mental health disorders are not the primary cause of poverty, there is a need for services for this vulnerable population. The elevated rates of mental health disorders during the past year for welfare recipients indicate that it may be useful to develop appropriate screening procedures for mental health and substance abuse problems as part of welfare-to-work programs. Treatment interventions may help to ensure a smoother transition for welfare recipients attempting to sustain employment. Respondents with the most severe mental illnesses may be eligible for supplemental security income (SSI). Yet, many participants with

less intrusive disorders may not meet the criteria for SSI but may be unable to sustain employment because of a mental health disorder.

Access to services is of particular concern for respondents who attempt to make the transition from welfare to employment and find that they no longer have health insurance. Although many states have made Medicaid available to recipients who are employed, the benefits are usually offered for a limited time. Along with the decline of welfare caseloads since the passage of the PRWORA, there has been a decline in Medicaid enrollment (Chavkin, Romero, & Wise, 2000). Recent research has concluded that former welfare recipients are not likely to maintain health insurance. Reporting on 1,004 women who left welfare between 1995 and 1997, Garrett and Holahan (2000) found that only 36 percent of the women received Medicaid, 23 percent obtained private or employer-sponsored health insurance, and 4 percent had health insurance from another source. More than one-third (41 percent) of women who had previously received welfare were unemployed in 1997. The Surgeon General's report on mental health in the United States (U.S. Department of Health and Human Services [DHHS], 1999) concluded that the disparity in insurance coverage for mental disorders contrasted with other illnesses is among the primary reasons for people not seeking needed mental health care.

PRWORA has greatly increased the complexity of rules surrounding Medicaid, and it is possible that many eligible women do not receive benefits because of a lack of understanding of the rules. The absence of insurance could have a negative effect on women who need mental health and substance abuse services. Community mental health and substance abuse resources that require minimal or no payment are scarce, which means that many women forgo treatment (DHHS, 1999). Policies and interventions that address mental health and substance abuse problems could facilitate PRWORA goals to help women make successful transitions from welfare to work. Research is needed to examine whether receiving adequate mental health and substance abuse services ameliorates the effects of these problems and increases the likelihood of maintaining employment. **HSW**

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