Mental Health, Welfare Reliance, and Lone Motherhood

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ABSTRACT

This paper explores the life circumstances and mental health experiences of welfare-reliant lone mothers, utilizing data from the *Lone Mothers: Building Social Inclusion* project, a Canada-wide research program. On the basis of qualitative interviews conducted with 43 welfare-reliant lone mothers living in Toronto, Ontario, we examine the conditions of their lives and the ways in which mental health, poverty, and single motherhood intersect. These intersections reveal the problematic nature of the traditional mental health system's response to these women. Required is a broader understanding of the ways that impoverished lone mothers' mental health is structurally situated, and requires population-based rather than individualized responses.

Keywords: lone mothers, mental health, single mothers, poverty, welfare, health

RÉSUMÉ

Cet article examine les situations et le vécu par rapport à la santé mentale des mères seules bénéficiaires d'aide sociale. Des données provenant d'un programme de recherche pancanadien, *Lone Mothers: Building Social Inclusion*, sont utilisées. Sur la base d'entrevues qualitatives avec 43 mères seules bénéficiaires d'aide sociale habitant Toronto (en Ontario), nous examinons les conditions de leurs vies et les interactions entre la santé mentale, la pauvreté et le fait d'être mère seule. Ces interactions revèlent les problèmes que suscitent la réponse à ces femmes de la part du réseau traditionnel de la santé mentale. Il faudrait mieux comprendre les façons dont la santé mentale des mères seules appauvries se situe dans les structures sociales, et la nécessité des interventions davantage au niveau de la population qu'au niveau de l'individu.

Mots clés : mères seules, santé mentale, pauvreté, aide sociale, santé

Mental Health and Lone Mothers

According to the World Health Organization (WHO) (Herrman, Saxena, & Moodie, 2005), mental health is considered "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to

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his or her community" (p. 2). The WHO makes an important distinction that mental health is more than the absence of illness, and more than the absence of psychological, social or behavioural issues. This distinction is important because it recognizes the ways individual mental health and well-being are bound to the larger social conditions and contexts that surround individuals. Some social conditions associated with diminished mental well-being include: material and social deprivation, lack of appropriate social support systems, and the lack of appropriate community resources (Polakoff & Gregory, 2002; Subramanian, Belli, & Kawachi, 2002). The WHO (2001) describes the connection between mental health and poverty as complex and a vicious cycle owing to the ways poverty, its associated stresses and material and social deprivation can predispose individuals to mental distress. Additionally, having a debilitating mental disorder can result in an individual being unable to work, and therefore, at-risk for further deprivation.

For welfare-reliant lone mothers, the stresses and demands of lone mothering add another dimension to an already complex picture of poverty and mental health. An examination of the literature reveals that lone mothers living in poverty are twice as likely to meet the criteria for a diagnosis of clinical depression (Coiro, 2001; Crosier, Butterworth, & Rodgers, 2007; Peden, Rayens, & Hall, 2004; Siefert, Heflin, Corcoran, & Williams, 2001). The prevalence rate for depressive symptoms can be from 40 to 60 percent among low-income single mothers (Coiro, 2001; Peden et al., 2004). When compared with the general population, the prevalence rate for lone mothers reporting depressive symptoms is two to three times greater, while the rate for lone mothers receiving social assistance is three to five times greater than that of the general population (Samuels-Dennis, 2007). When compared with partnered mothers, single mothers may experience diminished mental health caused in part by the contributing factors of financial hardship and the perceived lack of social support (Crosier et al., 2007). For those on social assistance the associated stress, stigma and scrutiny as well as prolonged exposure to life stressors and persistent poverty exacerbate mental health issues (Caragata, 2008a; Coiro, 2001).

Mental health issues among lone mothers are implicated as a barrier to employment and contribute to their reliance on social assistance (Coiro, 2001), while the stress and conditions of living in poverty are implicated in causing, or at the very least, compromising mental health to the point where employment may be difficult to secure and maintain (Zabkiewicz, 2010). However, exempting poverty as only a personal experience of underemployment or unemployment does not accurately reflect the ways its causes and conditions are structural. Claiming that poverty results from a lone mother's inability to work because of mental health problems fails to consider the ways in which the stress of living in poverty may exacerbate mental health issues. From a feminist perspective, such views fail to acknowledge women's continued and disproportionate burden for providing caring labour.

Approaching this issue in terms of population health is valuable for understanding the ways mental health, gender, and poverty are interrelated. Within this approach, attention is paid to the following interrelated conditions: socio-economic status, gender, social capital and inclusion, education, and employment. These conditions underlie health and well-being and inequities in these may place some individuals or subgroups of the general population at a disadvantage for attaining and maintaining optimal health (Denton, Prus, & Walters, 2004; Federal, Provincial and Territorial Advisory Committee on Population Health, 1999; Wanless, Mitchell, & Wister, 2010; Wilkinson & Pickett, 2006). Financial instability and poor health, including poor

mental health, are understood as inherently bound to one another (Denton et al., 2004; Subramanian et al., 2002; WHO, 2001).

Mental health is understood, not as the absence of illness, but rather as a resource or a capacity for individuals to act on and respond to the conditions of their lives (WHO, 2001), including the capacity to adapt to, respond to, or change adverse conditions. For welfare-reliant lone mothers, as one of the fastest growing population groups in Canada, living under conditions of perpetual poverty can pose severe material, psychological, and social restrictions to their capacity to take agency in their lives and ultimately to adapt and respond to the adversity they face. For instance, at a practical level, poverty can mean the inability to purchase the material things or services that promote health (Subramanian et al., 2002). Subsequently, rather than focusing solely on the individual, a population health approach aims to implement strategies, policies and practices that focus on improving the underlying social conditions and factors considered determinants of health and the interaction between them (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999; Populations Health Development Division, 1998). For lone mothers, this could mean the implementation of strategies and practices that focus on improving the inequalities they experience as a population subgroup defined by poverty, gender, and lone parenthood.

The paper next discusses the life circumstances of lone mothers in Canada, and the changes in welfare systems and the labour market that have exacerbated the poverty experienced by welfare reliant lone mother-led families. This is followed by a brief review of the issues associated with women's child-rearing labour roles. Following a description of the methodological approach utilized in collecting the data examined here, we discuss lone mothers' mental health issues, their experiences and the intersection of poverty, in addition to lone mothering and mental health, all of which strongly argue for a population health approach.

Lone Mothers, Welfare, and Work

The conditions low-income single mothers persistently face include a lack of material resources to meet their basic needs for safe and affordable housing, nutritious food, basic transportation, and medical and dental care (Caragata, 2008b; Children's Aid Society of Toronto and the Centre for Urban and Community Studies, 2001; McIntyre & Tarasuk, 2002). In addition, single mothers face multiple barriers to accessing mental health services including: a lack of affordable child care; high transportation costs; the stigma associated with getting help; and the current welfare environment that requires individuals to look for work or be in training or volunteer programs, regardless of health needs and family roles and responsibilities (Coiro, 2001; Froehlich, 2005).

Claiming that poverty is caused by a lack of employment fails to consider what the structurally disadvantaged groups, such as lone mothers, face in the labour market (Froehlich, 2005; Siefert et al., 2001; Sorensen, 1994). The trend over the past ten years for lone mothers has been toward temporary, precarious work, low-waged and without benefits. These circumstances, which mirror broader changes in the labour market, are magnified for the lone mother without access to affordable and flexible child care (Caragata, 2003; Zabkiewicz, 2010). Furthermore, Canada has one of the highest gender wage gaps among the Organization for Economic Cooperation and Development (OECD) countries and the training provided to those on social assistance is minimal and oriented to the "shortest route to work" (Breitkreuz, 2005; Conference Board of Canada, 2007;

Peck, 2005). Thus, employment sustainability is very difficult to achieve for a low-skilled sole support parent. Welfare-reliant lone mothers and their children were hit hard by the changes to welfare programs that, in most Canadian provinces, reduced benefit levels and tightened eligibility along with eliminating the special provisions once available to sole support parents. During the recession of the early 1990s, social assistance receipt in Canada skyrocketed, with 3.1 million individuals receiving assistance in 1994, many of them in lone mother families (Finnie & Irvine 2008). The 1996 replacement of the Canada Assistance Plan (CAP) with the Canada Health and Social Transfer (CHST) reduced federal-provincial transfers for social assistance, and also freed the provinces from restrictions on program design. As a result, all provinces subsequently instituted changes aimed at reducing welfare "dependency," with the three most aggressive reformers being Alberta, Ontario and British Columbia (Finnie & Irvine 2008; Sceviour & Finnie 2004). The changes in Canada included the introduction of "workfare" in most provinces including Ontario (Bashevkin, 2002).

The changes made to social assistance clearly had a disproportionate effect on women because their sole caregiving responsibilities makes their "exits" from social assistance much more difficult and they thus endure long spells on welfare at very low benefit rates (McMullin, Davies, & Cassidy 2002). Job training and education programs, where offered, are geared primarily to the "shortest route to work" and hence fail to adequately equip lone mothers who seek to enter an already precarious labour market so as to earn a family wage. Furthermore, increased public discourse attributing irresponsibility and wilful dependency has promoted a view that lone mothers have babies in order to get welfare, and that they are welfare "scammers" (McCormack, 2004). This has created a social environment often hostile to the needs of these families.

Women's Caring Labour

Caring labour is systematically and routinely unacknowledged and unvalued, and represents a disproportionate share of the work of women (Bezanson, 2006; Orloff, 2001, 2006; Lewis, 2001). Lone mothers' work associated with provisioning is monumental in scope. These women are in a league of their own when it comes to their ability to juggle bills and scrape together a small income from a variety of sources. Supplying the family with food requires trips—often by foot to avoid transportation costs—to food banks and grocery sales. Sometimes in order to make ends meet they borrow money from family and friends. Ingenuity and creativity are augmented by sheer tenacity as lone mothers go about trying to meet their families' needs.

In addition, traditional affective care work, described by many lone mothers as a joy, can also be demanding when she is stressed, exhausted and without respite. It is clear too, from the interview data from the *Lone Mothers: Building Social Inclusion* project, that an important determinant by which mothers remain on social assistance likely has to do with the needs of these women's children. Children with chronic medical conditions and special needs are just some of the additional demands many of the women interviewed were coping with. Despite women's near-equal labour force participation, the model of the "male breadwinner" continues to inform our social structures. The model has shifted—not to a gender neutral or gender positive one where both marketplace and care work are acknowledged—but to extending traditional male patterns of paid work to women alongside their on-going, unacknowledged, and unpaid care work (Bezanson, 2006; Korteweg, 2006).

We have described several broad structural and social conditions that are negatively affecting the mental health and well-being of lone mother-led families. Enduring poverty as a consequence of poor employment

training, lack of affordable child care, inadequate welfare benefits, and a precarious labour market are issues well beyond the scope of mental health service providers. But these same service providers must witness these intersecting traps and experience the frustration of offering, at best, band-aids for the too frequent mental health issues occurring in these families. Thus, a complex approach to understanding mental health and poverty is necessary, and in the case of lone mothers, understanding the relationship between mental health, welfare-reliance and poverty, and single motherhood as intersecting, interlocking, and mutually bound experiences.

METHODOLOGY

Lone Mothers: Building Social Inclusion is a community/university research alliance involving academic researchers from five universities across Canada with non-profit community organizations, all of whom share an interest and concern for the circumstances of impoverished lone mothers. A major aspect of the initiative was a combined focus on research and advocacy, and the grounding of the work in a feminist, participatory methodology. This is reflected in the recruitment of lone mothers on social assistance who joined the project as research assistants (RAs). Eight women were active as RAs, advocates and overall peer advisors to the project. These women were also interviewed by academic partners as part of the longitudinal panel described below.

A longitudinal panel of about 110 lone mothers in Toronto, St John's, and Vancouver, Canada was established, with interviews occurring every 6 months over a 3-year period. All of the women were on social assistance at the point of selection and each had at least one child living with her. Lone mothers on social assistance, who were selected and trained as RA's as described above, conducted the majority of the interviews. Women researchers, including academic partners, project staff or doctoral student research assistants, conducted remaining interviews.

In Toronto, 42 lone mothers on social assistance were interviewed in the first round of panel interviews, 37 in round two, 34 in round three and 29 women in round four, over a 4-year sequence. Interviews were transcribed, stripped of identifying information and coded according to a descriptive coding tree developed collaboratively by several research partners. NVivo software was used to assist with data analysis. Data was summarized and shared with our Toronto group of lone mother research assistants as a check on our categories and resulting analysis. The Toronto panel was purposively selected to represent the spectrum of poor lone mothers living in the city. The participants were Canadian-born and immigrant, including aboriginal and racialized women. They varied in age, education, neighbourhood, and number of children. Of the 42 panel participants, 9 were recruited through welfare offices, 22 from grassroots community organizations, 5 through snowball sampling where a participant referred someone. For 6 participants, the source of the referral is unknown.

The ages of the participants are quite varied with five between 16 and 20, eleven between 21 and 30, fifteen between 31 and 40 and eleven over 40 years old. Of the 42 lone mothers, seventeen have 1 child, twelve have 2 children, five have 3 children and eight women have 4 or more children. Overall, these mothers are sole parenting 85 children, 27 of them pre-schoolers. It is interesting to note that the number of children in each household fairly closely parallels the data for Canadian women overall (Statistics Canada, 2007), contesting the idea that women on social assistance have significantly more children.

Twenty-five panel participants are Canadian-born, six are from the Caribbean, three are from Africa, and two are from each of Latin America, Europe, the Middle East, and Asia. Among the 17 women who are immigrants, 10 had been in Canada for more than 10 years. The women's levels of education reflect a wide range: 4 have completed college or university, 5 have some college or university, 9 completed high school, and 15 have completed some high school. The level of education was unknown for 8 participants. Six women had been receiving assistance for less than 1 year, eleven between 1 and 2 years, eleven between 2 and 5 years, and eight women have been receiving welfare benefits for more than 5 years. Most of these 42 women were not simply sole support parents; they were also negotiating and managing their children's relationships with their fathers, yet one more example of their unacknowledged care work.

This article is based on the analysis of qualitative data collected in the first and last rounds of 43 semi-structured interviews in Toronto, Ontario, as these interviews provided more health-related data. This analysis explores the mental health experiences of lone mothers reliant on social assistance and the ways their experiences intersect with poverty and with their status as single mothers.

FINDINGS

We proceed with a description of our data and its analysis framed in two ways. First, we describe the mental health issues in the lives of the lone mother research participants, as well as in their children's lives. Following this, we explore and analyse the intersections between mental health, welfare-reliance, and lone motherhood.

Mental Health Issues

Among the lone mothers participating in the longitudinal panel, the mental health experiences described are consistent with the general literature about the common mental health issues faced by lone mothers living in poverty, and specifically by those reliant on social welfare programs. For rounds one and four there were a total of 43 lone mothers interviewed. Almost half of the women, 20 (46.5%), experienced mental health issues. The range of mental health issues included: post-traumatic stress disorder, self-inflicted injury (i.e., cutting), anxiety, post-partum depression, and depression. The most common mental health experience was depression. It is important to note that for all of the women reporting mental health problems no women identified this as the precipitating reason for their application to social assistance. The precipitating reasons ranged from leaving abusive partners, separation or divorce from partners, to sudden unemployment. In addition, along the spectrum of mental health and well-being, the participants in this study also reported other stress related issues, such as high blood pressure, difficulty sleeping, as well as excessive worry and emotional and physical exhaustion.

Although these mental health experiences are not unexpected, their qualitative detailing is important. Moving beyond statistics, we can better understand the extent, severity, and depth to which the women experience these conditions. Also critical is the women's own accounting of their issues, symptoms and their self-management as well as any professional treatment received, its benefits and how it was accessed. Perhaps most importantly, this qualitative "window" enables us to see these mental health issues situated against their structural, community and familial backdrops.

The single most common reason offered for the severity of lone mothers' mental health issues relates to the chronic, unrelenting, and survival-driven nature of their lives, a consequence of both poverty and sole caregiving. The following excerpts describe the mental health impact of having to manage the stress of living in poverty:

> Julie: There's always this, sort of, under-the-surface layer of stress and I used to take it out in strange ways like obsessive-compulsive ways. I would find I would worry too much and I would get sick. Or I would have to clean too much, or all of these things and I guess—what ended up happening is I became so overwhelmed… I mean, there's always something that you can't clear up whether you have debt you really want to clear up, but you just can't. It's an unbelievable juggling act. It's a juggling act, absolutely. And it's like, always having to keep track or a tally of where and how it goes. It's just unbelievable, it is, and it doesn't help the obsessive-compulsive disorder. It can trigger it, kind of, because it's all numbers and adding, and that was part of my OCD [obsessive compulsive disorder]. So I have to be really very careful.

> Kayla: I have kids to deal with and finances and everything and so, I was stressed out. My midterms were coming up. I missed midterms 'cause I had the girls and so, like I was just crashing. That's why I went to my doctor; I felt like I was just going to crash. There's too much. I was overwhelmed with everything. I'm seeing a counsellor about my depressive episodes but for a while it was touch and go, 'cause I felt like every two or three steps forward I can take four to five steps back.

> Jessica: It's just like it all stems together. If I'm stressed out at home, there are certain things I can't deal with, to make me come to school on time. I can't do good in school so I'm stressing out about school. Also, I'm strapped financially so it's hard there. I always have to think about what I need to buy and if I have money. My bank account's always in overdraft. I got a credit card but I need to get rid of it because it's killing me now. When I can't afford to get something I'll put it on my credit card and eventually it just adds up.

Anne speaks to the life-draining stress that she experiences and its consequences in terms of her mental health:

> Financial stress, the stresses of being single with children, trying to hold a full-time job, even a 12-hour-a-day job, having four kids at home, making sure they have what they need and I have what I need. That's stresses to me. I'm now on [disability benefits or pension] for mental health issues, stress-related issues.

As can be expected based on findings from the literature review, many of the women interviewed struggle with depression. Rose describes her circumstance rather matter-of-factly. It is just one more complication in an already complicated life and seeking out treatment can be just one more unsustainable demand:

> I go through depression. I went and saw a psychiatrist once. I know I need to go and seek professional help that way. I didn't like that psychiatrist so I just never went back to him.

Brenda lived with an addiction for many years and is now sober. She was one of the fortunate to continue to have access to treatment. She also acknowledged important differences in mental health responses between grassroots or non-governmental organizations (NGOs) versus traditional professional addictions and mental health services and expressed a belief that nonjudgmental NGOs were more helpful in her overcoming her addiction. About the traditional professionalized approach, Brenda shares:

> I still go for drug counselling, and I've been going for seven years. Before that I was going to the [mental health and addictions facility]. Now I don't really go for drug reasons, I go just to learn, to educate myself. It's all learning about how your mind and body think, and choices, learning about yourself.

On the other hand, Brenda speaks to the enormous contributions made by grassroots NGOs who often offer group-work, many from a self-help and mutual support orientation:

> With [community agency for women in conflict with the law]—that's walk-in. It's there on the corner. Many years I walked by that place and I never knew what it was and one day I picked up the phone and I talked to somebody and I was crying, "I have to quit my drugs." It was that first step and they were there to support me 100%. They didn't say, "Don't do drugs," they're there to support you no matter what. If you relapse or anything, they're still there to give you a pat on the back. That's one thing I like about [community agency for women in conflict with the law], they're there to help you. The [traditional centres offering addictions counselling and mental health services] they say, "No, you're not allowed to have that, no, you can't do that." A lot of people fail because they're pressured. Just having somebody say "no"—they're going to go do it.

From a mental health perspective, it is the response and messages of unconditional acceptance and support, rather than messages about compliance, that can be experienced as the most helpful.

The place of abuse (such as a history of childhood abuse or intimate partner violence) in creating trauma, depression, and on-going mental health issues appears to be inadequately acknowledged. Interview respondent after interview respondent speaks to the mental health legacy that derives from their abuse experiences. The following excerpts describe that legacy:

> Madison: It's just my own personal anxieties I wish to hopefully resolve maybe one day. This has kind of been ongoing issue since I was a teenager. That's one of the reasons why I left home because I got so many anxieties. I almost got to the point I hated my parents so much, like it's either you kill me or I kill you.

> Pauline: Being a [First Nation] residential school survivor has kind of left me struggling with what they call post-traumatic stress disorder and that kind of brings me where I'm at today. Being on Social Services has not been easy right from the start. But it's gone from, like, bad to worse actually. My post-traumatic stress disorder, I didn't know what that was, but that kind of really affected me when they started talking about residential school stuff. You know what I mean? I kind of blocked that. Post-traumatic stress disorder is trauma from when you're a child, when you block it out and then it hits you later in life.

> Janet [English is her second language]: Well, I would say my biggest stress is having to leave my husband. Even today, I think it still stresses me out. Because there was violence involved, not towards the kids but towards me. He was very controlling. So that was really stressful. That was very, very stressful. I thought I would lose my mind, seriously. Because of my situation with my husband and everything, I don't know, emotional, I've been through so many things. So, I don't know, I think sometimes that I'm not that strong any more. I get too much tired, I get headache, I get nervous or some small stuff give me my heartburn. It was like my life with my husband was so stressful and then it's not too easy to get over it and, like, I gotta have my daughter. Like, I'm happy to have her to encourage to do better, you know. But it's always stress. My life with my health, the doctor told me, it's coming from my mind, is more stress. She offered me, I don't know, a pill. I didn't take it. I wanted to improve by myself to see if I'm strong enough to help myself. I never ever take the anti-depression pill.

> Chrissy: Well, I'm going through a really personal tough time with their father [due to the stress associated with leaving the relationship but having to continue contact for access and child support]. It's taken a toll on my whole psyche. I'm dealing with it the best way I can, without having to go and have that help. It would be nice to have someone to talk to, just to say, "Hey, look, I'm not crazy, right?"

Many women report having experienced post-partum depression, often undiagnosed and untreated until very late.

> Tara: When I had [son's name] I had like a post-partum depression but now I'm okay. That was, I think, about 2 years. I was raising two kids, I was going through a divorce or a trial separation, so everything was so hard, and I'm alright now. I went to a psychiatrist, [which wasn't helpful] and then finally I talked to a different doctor and it was a lady doctor; she understood me better. She said that you had a child and she asked me a couple of questions and then she said this may be a depression and she sent me to a psychiatrist,

> and he diagnosed it. [After the baby was born] it was so depressing, just taking care of a child. I love my child of course, but it's just that the whole world was away and I felt depressed about that because I was always working, always going out. Suddenly it was dark, empty, just with a little baby. It's just—it was too much for me.

Latoya too suffers from post-partum:

> Well, I didn't really ask my doctor, but my social worker exposed that I probably still have post-partum [depression]. Sometimes I cry and I'm like, "Oh, this is so hard, I have no one to turn to."

Ahmed sums up her experience of trying to get help:

> Yes, yeah and no one cares, everybody just smile, oh, it's like you know. They don't see you from inside, they see you from outside. It was hard, but now I'm okay.

While qualitative research does not lend itself to generalization, and cause and effect is difficult to establish through any research approach, the types of mental health issues which are so common among the lone mothers interviewed suggest that they are, at least in part, derived from the stressful contexts in which these lives are being lived. Even post-partum depression, revealed by many of the mothers and often diagnosed well after the fact, was seldom treated and very often lingered beyond its usual term. The vast majority of the mental health issues these lone mothers report are stress and depression—in concert with telling that they cannot afford to feed their children adequately, have few social contacts, little social or recreational activity, struggle to decide whether they can afford either internet access or cable television, and continually juggle unpaid bills and rent arrears capped off by frequent demands for documentation from social services. Depression under these circumstances is a reasonable response, which is no less real or debilitating.

Intersections between Mental Health, Welfare Reliance, and Lone Motherhood

It is at the intersection between mental health and mothering that the women in our project find the endurance to "push on" because of the demands and the stress of carrying sole responsibility for their children and families. Often their health needs come second. For instance, Ann describes how she places her children's health needs before her own,

> Yeah, I was very down [with physical and emotional health issues] because I was having problems with the father. And stuff like that. Lots of problems, you know. I don't know, I just focus on my kids more, to be honest. I have to focus on them and I'm starting to be selfish and just trying to focus on myself, you know. 'Cause, like, with health, too. I have lots of problems. My hair is falling out; my skin is breaking out a lot… I haven't been to the doctor because I have to be taking my kids to the doctor all the time and this year I had to take them to the doctor a lot. No, no I have no time for myself. I'm sick; my skin is breaking out; I don't go to the doctor. I have no time.

In another instance, Monique describes,

> I go to therapy every Wednesday through [a local hospital treatment program for] trauma therapy, individual. My doctor—she recommended that to me and she connected me there because these three years dealing with the criminal and family court and immigration [after leaving a violent marriage] and two children affected by the abuse, it was very hard for me to deal with my issues.

The very life circumstances of the lone mothers we interviewed are highly complex. Their mental health issues occur in contexts where they are negotiating and managing an overwhelming number of complex

issues and they must deal with these single-handedly. From the immigration status issues that trap Kayla on assistance, to the needs of her children that Donna speaks to, these are only two of many complex situations that these mothers with few resources must handle.

> Kayla: I'm always stressed out. Always stressed out, because I have so much to deal with. I have my career, which I want to start and I can't start because of my [immigration] status. I have my school that I'm interested in but I can't go to because of my status. I can't work because of my status. I'm not supposed to be on welfare because I haven't got any status, but I'm applying for humanitarian—I'm on the humanitarian. I'm not supposed to be on welfare, but it's like, okay, I have two kids. How else am I going to survive? I'm not supposed to work illegally and I don't have a worker's permit. I'm not supposed to go to school, because I don't have a study permit, and I'm not supposed to be on welfare. So how am I supposed to survive? What am I supposed to do with my kids?

> Donna: [My son is] on medication for his ADHD [attention-deficit/hyperactivity disorder] as well. The medication has two side effects, which are loss of appetite—and my son is not very big to begin with. He's 38 pounds, and five years old. He's lost weight since the medication, so he's now on a special diet, with the PediaSure [a meal supplement] and extra food. He was never a picky kid to eat, and now he's so picky. He would eat anything, no problem, and now it's a struggle to get him to eat. If he hasn't had his medication, he'll eat, no problem but if he's had it he won't eat. I had to struggle with social assistance to give me extra money, because PediaSure is not covered. So I had to struggle with them for a couple of months. Three different times I had to get a doctor's form filled out for a special diet for him.

Social networks are often truncated for single mothers on social assistance as they have few opportunities to meet others, especially those who are outside of their socio-economic sphere. Thus, their opportunity to access and utilize social capital is severely constrained. Furthermore, families are often sources of stress rather than assets and resources, as Jessica explains:

> It's just really stressful to be with my family, the way they act and how they see things compared to what I see. According to them, they're always right, so there's no arguing. They're ignorant, so they make a lot of unneeded comments and whatnot.

Sophie has a son with some significant emotional and psychological problems and faces the stress of not being able to see his needs met in spite of her best efforts. Nevertheless she also appreciates how these challenges have made her a stronger mother:

> I have found fighting with the system is very difficult, concerning where my son is at. He's high risk. The system has failed, with whether it be family counselling… My son [name] was sexually assaulted when he was three and a half. I have fought with the system since then for help. They help you for a little bit then they throw you away. Then they send you to this place, then they send you to that place, then they send you to another place. If an organization is there to help you, they should stick to that until they know that you're ready to move on to the next step. I'm not sorry, because it makes me stronger as a mom.

However, pushing on at the expense of their own health needs can be problematic. For instance, without the financial means to hire a paid caregiver, without adequate or appropriate childcare or social supports to care for their children, some welfare-reliant lone mothers can find themselves forced to relinquish their care and parental rights to child protective services (Krane & Davies, 2000). Patricia shares her experiences of having child protective services involved in her life because of her mental health issues and disadvantages:

> I can't stand [child protective services]. I really hate them. That's why the three [children live with an extended family member]—for the first month or two months, all I did was—I slept. I was really depressed and I didn't do anything, like, I hardly visited the kids. I used to call them and stuff, but like, I was very

> depressed because of the situation with my baby's father, with my two daughters' father—it was like, you know, I was worn out. I was really worn out and I was so tired and stressed and depressed and I thought I was going to go into a nervous breakdown.

Throughout the interviews, there was very little mention of reprieve, relief, or getting ahead, both financially and health-wise. The only consistent mention of relief was expressed through descriptions about their relationships with their children. Despite the barriers and scrutiny faced by low-income lone mothers, in their most challenging moments, they find the strength, hope, and courage to endure for the sake of their children. In this poignant description, Madison, who has a history of childhood abuse and experiences depression, explains the interconnection between her mental health, mothering, and lack of material resources,

> You know, if it wasn't for [my son] I would have absolutely no energy, like, none. If it wasn't for my son to ground me and put me in a good mood and make me realize he needs me… He's the only thing that kind of helps me out, actually. If it wasn't for [my son] I probably maybe go back into work at strip clubs. I'll probably do something like that to pay cash and, you know, don't really care. It's just a job, I need money. You know, I'm not thinking about the future right now and I'm having a hard time. You can't live day by day and that's what I'm doing. I'm just going day by day. Like I said, the only thing that wakes me up and gets me enthusiastic is just cooking for [my son] and playing with him and I just have that, that's just enough energy.

The linkages are clear, lone parenting is both an enormous demand and stressor and yet it is her son who keeps her moving forward with occasional enthusiasm, and yet the profound lack of material resources gives Madison little reason to feel hopeful and to plan for a future for her and her son. In this is revealed the intersection of mental health with being poor and a lone mother. In their relationships with their children, lone mothers move forward and go on emotionally because of their relationship with their children, and also for the sake of their children. These experiences challenge dominant "poor mothering" discourses and stereotypes surrounding lone mothers living in poverty. Often, as evidenced by our data, these strong mothering responses are made by women coping with debilitating mental health issues.

CONCLUSION

For the most part, North American responses to mental health problems are highly individualistic and narrowly psychological. Effective treatment must move away from its focus solely on the individual. Required is attention to the conditions in which people live and the stress on their health, including the stress on their mental health. Consequently, a more complex approach to understanding mental health and poverty is necessary, and in the case of lone mothers, understanding the relationship between mental health, welfare-reliance and poverty, and single motherhood as intersecting and interlocking experiences. Most often, while the context in which a mental health "problem" occurs may be acknowledged, it is seen as separate from the treatment response. The data from the lone mothers interviewed as part of this research suggest that an effective approach for lone mothers on social assistance, based on a health promotions strategy, would involve building community supports and working with social assistance delivery bodies to advocate for increased benefits, greater income security and appropriate auxiliary supports.

Such a "health enhancing" approach is required with particular attention paid to intervening with poverty and mental health simultaneously, while also providing adequate social supports for the lone mothering role (Crosier et al., 2007; Siefert, et al., 2001), such as affordable and accessible child care (Zabkiewicz,

2010). There has been an increasingly narrow focus on financial management so that the life circumstances of the recipient are, in a sense, beyond the worker's purview as long as she fulfills the ongoing eligibility rules. That she may see a counsellor or a psychiatrist will be her good fortune as most research participants found it difficult to access these supports. However, even if counselling is available, the "therapy silo" is as unlikely to appreciate her material and social disadvantage and its meaning, as the "welfare silo" is likely to intensify the relationship between deprivation and mental health.

Lone mothers are one of Canada's fastest growing population groups raising a significant percentage of Canadian children. While the job-getting aims of workfare may have required the disincentive of very low welfare benefits, it is perhaps time to appraise the overall cost-benefit of such a strategy. When lone mothers lament leaving an abusive partner where at least their material needs were met, when almost 60% of the lone mothers interviewed report high levels of stress or diagnosed mental health issues, the unacknowledged costs are indeed too high. For welfare-reliant lone mothers, policy and practice initiatives need to attend to, address, and support their mental health needs with consideration to their impoverishment (Siefert et al., 2001). As some argue, mental health is compromised not by individual characteristics, but rather by the depressing conditions in which lone mothers find themselves as they try to make ends meet on limited incomes at welfare rates that do not meet their basic needs (Coiro, 2001; Froehlich, 2005; Sorensen, 1994).

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