Abstract

Title of Document:	LOW-INCOME MOTHERS' MENTAL HEALTH IN THE CONTEXT OF FAMILY COMORBIDITY
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The present study utilized longitudinal ethnographic data from the *Welfare, Children, and Families: A Three-City Study* to analyze how low-income mothers construct meaning of and cope with mental health problems. The study focused on a subsample of 20 mothers with one or more mental health problems. Findings demonstrated the importance of family relationships and family comorbidity. Mothers often attributed mental health problems to problematic family relationships. Mothers also emphasized their children's health and well-being in assessing their own health. Their ability to care for their children shaped how they viewed themselves. A related feature of mothers' experience of mental health was cumulative disadvantage. Almost all of the mothers linked their mental health to one or more aspects of poverty. Finally, mothers employed a multiple strategies to cope with mental health problems, with mental health

treatment being one strategy. Implications for research, policy, and clinical work were discussed.

LOW-INCOME MOTHERS' MENTAL HEALTH IN THE CONTEXT OF FAMILY
COMORBIDITY

By

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Background

Research has established that socioeconomic status (SES) is linked to health over time, and the gap between high and low SES groups begins before birth and persists across the lifetime (Kaplan, 2009). Longitudinal data have demonstrated the effects of cumulative disadvantage, which posits that disadvantage early in life affects physical and mental health later in life, in part because those who experience disadvantage in childhood are likely to accumulate additional risk factors that continue to exacerbate their disadvantaged status (Shuey & Willson, 2008). The associations between SES and health over time are sufficiently large that one could justifiably argue that it is not only socioeconomic status that is stratified, but health is as well (Pearlin, Schieman, Fazio, & Meersman, 2005). Although health inequalities have been acknowledged and studied for decades, their causes are still not entirely clear.

With regard to mental health in particular, numerous studies have documented that psychological distress and a range of mental health diagnoses occur at higher rates among low-income versus higher-income individuals (Kessler et al., 1994; Pratt, Dey, & Cohen, 2007). Moreover, children of parents with mental health problems are at increased risk of psychiatric disorders themselves (e.g., Hammen & Brennan, 2003; Lieb et al., 2002; Turner, Beidel, & Costello, 1987). Other research had indicated that most people with mental health problems do not receive treatment, and the treatment gap is greater among the economically disadvantaged compared to their more advantaged counterparts (Wang et al., 2005). This pattern is problematic for a number of reasons, not least of which is the association between untreated maternal mental illness and impaired maternal functioning (Swartz et al., 2005) as well as poor outcomes for children receiving

psychiatric treatment (Brent et al., 1998; Cobham, Dadds, & Spence, 1998). In a related vein, an understudied factor linking poverty and health is family comorbidity, or the co-occurrence of physical and/or mental health problems in two or more members of a family. Very little is known about the prevalence of family comorbidity or how it influences family relationships, treatment-seeking, or health outcomes.

One overarching limitation of much of the research on health inequalities across the life course is that it has tended to utilize epidemiological and survey approaches. While such approaches provide important insights into how risk factors at the individual level influence health, they miss much about the day-to-day processes and contextual factors that work together over time to shape the health and treatment-seeking behaviors of those living in poverty (Burton & Bromell, 2010).

Given the limitations of the current research, both in terms of methodology and the gaps in understanding why health and treatment disparities persist, it is important to explore further the factors contributing to low-income mothers' decisions about how and whether to seek out mental health treatment, as well as what other coping strategies they utilize. Although survey data along with a handful of ethnographic studies shed some light on the instrumental and perceptual barriers that keep low-income mothers out of treatment (e.g., Anderson et al., 2006; Copeland & Snyder, 2010; Padgett, Patrick, Burns, & Schlesinger, 1994), there is a dearth of information about how these barriers play out over time. More specifically, very little research has been undertaken to understand the process of how such barriers interact with family comorbidity and cumulative disadvantage.

The present study utilizes longitudinal ethnographic data from the *Welfare, Children, and Families: A Three-City Study* (hereafter referred to as the Three-City Study) to begin to fill in some of the above gaps in knowledge. The ethnographic data from the Three-City Study offer detailed accounts of 256 low-income mothers' and families' lives over a period of six years, as well as retrospective data that cover mothers' histories. To date, only one study (Burton and Bromell, 2010) has conducted an analysis of mothers' mental health using these data. That study revealed a high prevalence of mental and physical health problems across the sample. The aim of the present study was to focus on a subsample of the mothers in order to explore in greater depth the context, meaning, and process by which low-income mothers address mental health problems.

Literature Review

The below review explores several bodies of research that are relevant to the present study. First I summarize what is known about the mental health of low-income mothers, including the increased risks facing single mothers and mothers on welfare, as well as the effects of maternal mental health problems on poor families. Next, findings from a study (Burton & Bromell, 2010) that was foundational to the current research, which analyzed maternal health in the Three-City Study ethnography, are recapped. Then the evidence for the association between health and poverty, and in a related vein for the accumulation of disadvantage over time, is reviewed. The next section of the literature review explores the understudied concept of family comorbidity. The final two sections cover related topics of barriers to mental health treatment and coping strategies employed by low-income women.

Mental Health of Low-Income Mothers

Psychological distress and numerous mental health diagnoses including anxiety, substance use, and depressive disorders, have been found to occur at higher rates for low-income versus higher-income individuals (Kessler et al., 1994; Pratt, Dey, & Cohen, 2007). Both the National Comorbidity Study (NCS) and the Epidemiological Catchment Area Study (ECA) have shown that individuals with lower socioeconomic status are more likely to suffer from mental health problems than those of higher SES (Loprest & Nichols, 2008). Yu and Williams (1999) analyzed data from the ECA and found that those in the lowest quartile were 2.86 times more likely to have a mental health problem than those in the highest socioeconomic quartile. Their analysis of the NCS found that people making less than $20,000 annually were 1.92 times as likely to have a mental disorder compared to people making $70,000 or more per year.

Several studies have demonstrated that low-income women, and particularly women on welfare, have disproportionately high rates of mental health disorders in comparison to all women. For instance, Loprest and Zedlewski (2006) found that 24 percent of women nationally who received welfare and 13 percent of low-income mothers who had never received welfare had mental health problems. A study by Loprest and Nichols (2008) analyzed the 2002 National Survey of America's Families to understand the impact of mental health problems and treatment on low-income mothers' employment. They found that although almost one-fourth of low-income mothers were in poor or very poor mental health, less than one-tenth of the mothers received any mental health treatment in the past year. Low-income mothers in very poor mental health were also found to be significantly less likely than other low-income mothers to work.

Single mothers. Among low-income mothers, single mothers have been shown to be at greater risk than partnered mothers to experience mental health problems. One study found that 75 percent of a sample of low-income single mothers with young kids suffered from mild to severe depression (Peden, Rayens, Hall, & Grant, 2004). Seifert, Bowman, Heflin, Danziger, and Williams (2000) reported that more than 25 percent of mothers who had been or were currently on welfare met diagnostic criteria for major depression. Coiro (2001) found that depression symptoms were as high as 40 percent for black single mothers.

Research has also demonstrated that factors which might protect mothers from mental health problems are in shorter supply for low-income, and especially single mothers, than they are for their wealthier and partnered counterparts (Broussard, 2010). For instance, one study found that low-income single mothers reported less contact with family and friends and perceived less social support than mothers who were married (Cairney, Boyle, Offord, & Racine, 2003). Single mothers also tended to find that social and instrumental support was inconsistent and came with expectations of reciprocity when it was provided by family and friends who were also low-income (Henley, Danziger, & Offer, 2005).

Other research has focused on the mental health impacts of parenting for low-income mothers. Various studies have found that parenting is particularly stressful for single mothers for a variety of reasons, including their inability to complete their education, increased financial pressure and time constraints, childcare difficulties, and limited access to health care (Ross, Mirkowski, & Goldsteen, 1990; Simon, 1995).

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Effects of maternal mental health problems on poor families. When problems such as those mentioned above are combined, as they often are for low-income mothers, the likelihood of poor mental health increases (Broussard, 2010). Research has indicated that the mental health of low-income mothers affects families in several ways. One way is that mental illness acts as a significant barrier to stable employment (Jayakody & Stauffer, 2000; Corcoran, Danziger, & Tolman, 2004). A panel study that followed current and former public aid recipients in Michigan over a four-and-a-half-year period found that "poor health is the rule, not the exception" (Corcoran, Danziger, & Tolman, 2004, p. 32). Corcoran and colleagues found that over the four waves of the study period, 44 percent of the women interviewed met the DSM-III R criteria for depression and 35 percent met the criteria for post-traumatic stress disorder at least once. More than 60 percent reported some type of mental health problem at least one time, and nearly 85 percent had a mental or physical health problem at some point during the study. Also striking was that over 37 percent indicated having a child with a health problem. All such problems were found to be significantly associated with length of employment. Women who had a mental health problem at either three or four waves of the study worked an average of 5.4 fewer months than women who never met the criteria for a mental health problem; physical impairments at three or four waves were associated with 4.7 fewer months of employment compared to women who never indicated impairment; and women who had a child with a health problem at three or four waves reported working 9.1 fewer months than women who reported no child health problems. The study authors noted that additional research and policy work needs to focus on the processes by which family health problems keep women from establishing more stable employment.

In addition to considering the impact of mental health on employment, research has also explored the ways in which poverty and maternal mental health interact to influence child development. It is well established that poverty is negatively associated with children's academic achievement, cognitive functioning, and social development (Duncan & Brooks-Gunn, 1997; Duncan, Brooks-Gunn, & Klebanov, 1994; Liaw & Brooks-Gunn, 1994). Studies have also found connections between poverty and poor mental health among children and adolescents (McLeod and Shanahan 1996; Tracy et al., 2009; Zilanawala & Pilkauskas, 2011). A smaller number of studies have attempted to elucidate the connections between maternal mental health, poverty, and child development. For instance, Petterson and Albers (2003) used data from the National Maternal and Infant Health Survey to examine whether maternal depression mediated the relationship between material hardship and child outcomes. They found that moderate and severe maternal depression in the context of poverty was associated with children's developmental delays; chronic maternal depression had the most deleterious consequences for development. In a review of the literature on postpartum depression and child development, Murray and Cooper (1997) reported that depressed mothers tended to be less responsive, more hostile and critical, and less competent compared to non-depressed mothers, and such behaviors adversely affected child development outcomes. The same review noted that the effects of maternal depression were more severe in samples drawn from more disadvantaged populations, both in terms of disturbed mother-child interactions and impaired child development. Research on parenting practices of mothers living in poverty have found that those who were experiencing high psychological distress often displayed parenting behaviors that were harsh and

inconsistent (Longfellow, Zelkowitz, & Saunders, 1982; Arditti, Burton, & Neeves-Botelho, 2010), although mothers living in contexts of persistent disadvantage often demonstrated advocacy/caring behaviors in addition to harsh and inconsistent ones (Arditti, Burton, & Neeves-Botelho, 2010).

On the whole, the body of research on maternal mental health and its effects on families is relatively small and much of it, with very few notable exceptions (e.g., Arditti, Burton, & Neeves-Botelho, 2010), has relied on survey data, which provide little insight into the day-to-day contextual processes that influence family well-being. The studies have also tended to focus on a single mental health problem like depression, limiting our understanding of the influence of broader mental health problems. Another important limitation of many of these studies was that they failed to consider how families are affected by the accumulation of disadvantages over time.

Previous Analysis of Maternal Health in the Three-City Study Ethnography

Given that the focus of the present study is on the mental health of a subset of mothers who were part of the Three-City Study ethnography, it is important to review Burton and Bromell's (2010) findings as they analyzed the full set of ethnographic data to explore how cumulative disadvantage, childhood illness, and family comorbidity shaped the 256 mothers' mental and physical health in later life. The authors consulted data about the mothers' employment and education histories in order to understand first of all the role of cumulative disadvantage. Data included information about school performance, factors that helped or hindered them as they pursued education as adults, lifelong work histories, job characteristics, and the influence of their own and their dependents' health on educational and work experiences. Grounded theory analysis

suggested that the mothers' early educational experiences were linked to a series of disadvantages that affected the current and later-life health of the mothers and their families. In turn, their own and their families' health problems interfered with mothers' attempts to hold steady jobs and provide for their families. By the end of the Three-City Study period, 72 percent of mothers who had been employed in some capacity during the study "lost their jobs trying to keep their children well" (p. 255). The inability to maintain stable employment further exacerbated health problems as it meant losing the possibility of work-related health benefits.

Findings in the area of individual and family comorbidity were also striking. Individual comorbidity refers to the presence of two or more physical and/or mental illnesses in a person, whereas family comorbidity refers to the co-occurrence of one or more physical and/or mental health problems among two or more members of a family. Burton and Bromell (2010) generated health data through mothers' descriptions of physical and mental illnesses they experienced as children, health problems currently affecting them and their children and how those problems were being treated, any mental or physical health diagnoses they or their children had received, and information about their parents' health. Eighty percent of the mothers reported individual comorbidity, meaning they were currently suffering from two or more chronic physical and/or mental health conditions. Common physical ailments included severe arthritis (44%), neurological disorders (42%), cardiovascular disease (36%), and morbid obesity (35%). Common mental health problems among the mothers were depression (69%) and anxiety disorders (67%). In terms of children's health, 72 percent of the children in the sample were identified as having two or more physical and/or mental health conditions. Common

conditions included ADHD (47%), asthma (45%), severe periodontal and dental disease (27%), obesity (24%), and anxiety disorders (13%).

Given the high rates of individual comorbidity, the study authors examined rates of family comorbidity and found that two or more family members had chronic physical and/or mental health problems in 68 percent of families. Only in 11 percent of families were there no chronic health problems reported for any family members. The profiles of comorbid families were often extreme, with mothers and children simultaneously experiencing severe and multiple health problems. The most pressing issue related to comorbidity was the way the mothers tended to neglect their own health needs in order to meet the health and economic needs of their families. The authors explained the importance of family comorbidity in the following way:

> Without a better understanding of family comorbidity we risk underestimating the scope of hardships that poor health causes in poor families. How do sick parents with multiple sick children manage their own care and the care of their kids? What does managing the care of others while also "working sick" mean for parents' employment and their ability to secure job-related family health insurance? What implications do the hardships related to family comorbidity have for individual family members' health in later life? We argue that exploring family comorbidity is essential to any study of the relationship between poverty, childhood illness, cumulative disadvantage, and health in later life (Burton & Bromell, 2010, p. 238).

Burton and Bromell (2010) discovered in their review of previous research that reference to the construct of family comorbidity was "notably lacking…except when

inferred in studies of family health insurance" (p. 237). Thus it is not surprising that the studies reviewed below (see Family Comorbidity) make no mention of the construct.

The Health-Poverty Association

Taking a step back, there is a vast body of research demonstrating that people with low incomes have poorer health and mortality outcomes than those who are more economically advantaged. The health gap between rich and poor begins before birth and increases throughout the lifetime (Kaplan, 2009). An analysis of a nationally representative sample of children born in 2001 found that children born to poor mothers were more than twice as likely as those born to non-poor mothers to be born with low birth weights (Nepomnyaschy, 2009). Even by nine months of age, measures of social-emotional development, cognitive development, and general health seem to be worse for children in poor families (Halle et al., 2009). By age 3, children in families living in poverty are two-thirds more likely to have asthma compared to children in families above 150 percent of the poverty line (Brooks et al., 2001). In adulthood, the effects of poverty on health are equally stark. Data collected by the Commission to Build a Healthier America demonstrated that two leading causes of death in the U.S., diabetes and heart disease, are 50 to 100 percent more common among poor adults than among the affluent (Kaplan, 2009). As was mentioned above, numerous mental health diagnoses occur at higher rates for low-income versus higher-income individuals (Kessler et al., 1994; Pratt, Dey, & Cohen, 2007). Among the elderly, living below the poverty line predicted having a higher number chronic health conditions compared to those living above the poverty line (National Center for Health Statistics, 2006).

Potential causes for the health-SES association. A number of factors partially

explain the link between socioeconomic status and health. Risky health behaviors like

poor diet, cigarette smoking, and physical inactivity have been tied to poor health

outcomes as well as to poverty (National Center for Health Statistics, 2006; Adler et al.,

1994), although studies have found that such behaviors only account for a small portion

of poverty's relationship to health (Adler et al., 1994). Differential exposure to

environmental risk factors, and especially to multiple such risk factors over time, sheds

further light on the relationship between health and socioeconomic status (Evans &

Kantrowitz, 2002). It has been well established that the poor tend to live and/or work in

environments that pose greater risks to their health (Kaplan, 2009). The poor have greater

exposure to lead, pesticides, and air pollution – all of which are associated with poorer

health. The jobs that are often held by the poor are more likely to lack basic benefits such

as sick leave or time off to care for a sick family member; these jobs are also more likely

to be unsafe and to lead to injuries and disabilities (Acs & Nichols, 2007).

Another important factor to consider in examining the link between health and

poverty is stress. An analysis of data from the Americans' Changing Lives study found

that negative life events and other stressors were related to socioeconomic status, and the

number of negative life events had a positive association with mortality (Lantz, House,

Mero, & Williams, 2005). It goes without saying that families in poverty often live with

both acute and chronic stress, such as material hardship, dangerous work and living

conditions, under-performing schools for their children, and the like. The effects of such

stress on a person's health are profound; they negatively affect the brain and

physiological systems, and have been found to contribute to chronic and acute diseases (McEwen & Lasley, 2002).

Differential access to quality health care is another factor at play in the relationship between socioeconomic status and health. In 2011 in the United States, an estimated 21.3 percent of persons aged 18 to 64 lacked health insurance; among poor adults in the same age group, the rate was 40.1 percent (Cohen & Martinez, 2011). It is not only access to care but also quality of care that is cause for concern. According to the 2007 National Healthcare Disparities Report (Agency for Healthcare Research and Quality, 2007), the quality of health care given to poor people was worse than the care given to their richer counterparts.

The neighborhood context is an area that has received growing attention in recent years. In various studies, disorder, poverty, and instability at the neighborhood level have been linked with poor physical and mental health. For instance, a random assignment experiment examining the long-term effects of moving from a high-poverty neighborhood to a lower-poverty neighborhood found that physical and mental health improved for those who moved, even though economic self-sufficiency was unaffected (Ludwig et al., 2012). The authors concluded that residing in a distressed neighborhood had significant adverse impacts on the health and well-being of low-income families. Another study looked specifically at the relationship between perceptions of neighborhood characteristics (such as drug selling, vandalism, and vacant housing) and depressive symptoms and found that, after adjusting for symptoms at baseline, perceptions of the neighborhood predicted depressive symptoms in a follow-up survey nine months later (Latkin & Curry, 2003).

Health effects of poverty over time. Not only does the research suggest that poverty, through various pathways, influences physical and mental health, but it also appears that the health effects are enduring, even if income increases later in life (McDonough, Sacker, & Wiggins, 2005). The timing, duration, and frequency of economic hardship have also been found to matter for health outcomes (Carr & Springer, 2010). Long spells of hardship tend to have more negative health consequences for children than short-term or single spells, and hardship in adolescence tends to be especially damaging for mental health and the effects often persist into adulthood (Sobolewski & Amato, 2005). It has also been shown that poverty tends to persist across generations; for example, a study using data from the National Longitudinal Survey of Youth found that one of three adults whose parents had incomes in the bottom quintile of the income distribution also ended up in the bottom 20 percent as adults (Mazumder, 2008). Similarly, an analysis of data from the Panel Study of Income Dynamics found that individuals who were born to parents whose income placed them in the bottom 20 percent had less than a one in six chance of reaching the median household income by middle age (Hertz, 2006). A study by Scaramella, Neppl, Ontai, and Conger (2008) demonstrated how poverty in one generation could affect well-being in subsequent generations: the authors found that poverty in the course of a grandparent's childhood predicted earlier childbearing among parents, which was in turn associated with harsher parenting of and problematic behaviors among grandchildren.

The research reviewed to this point leads to several important conclusions. First, the relationship between poverty and health is complex. No single factor can explain the link, but rather poverty negatively affects mental and physical health through a number of

different mechanisms. Second, process matters. Important processes are at play at various

levels from family to neighborhood and beyond, though these processes are not well

understood. Third, paying attention to time is essential. Poverty and health play out in

complex ways over the life course and across generations. Below I explore in greater

depth the theme of time and how disadvantage accumulates over time.

Cumulative Disadvantage

A growing body of research is using cumulative disadvantage theory to explain

how inequality in achievement or status develops over time (Shuey & Willson, 2008).

This concept was introduced in relation to the Three-City Study above. The theory

highlights the impact of cumulative stressors and losses on human development. Whereas

individuals who start life in a favorable relative position tend to maintain their advantage

and experience further gains over the life course, those who face disadvantage in

childhood are likely to accumulate additional risk factors that, over time, exacerbate their

disadvantaged status and lead to the deterioration of health (Shuey & Willson, 2008;

Walsemann, Geronimus, & Gee, 2008).

To better understand how cumulative disadvantage could play out, Burton and

Bromell (2010) provided a helpful description of the cumulative disadvantage process as

it relates to education, employment, and health. Research has demonstrated how factors

such as low birth weight, poor nutrition, mental disorders, and chronic diseases can lead

to academic deficiencies and lower academic attainment (Case, Fertig, & Paxson, 2005).

Poor educational performance at a young age has been found to decrease the likelihood of

completing high school and, thus, impacts the attainment of a college degree. Lacking a

college degree severely limits one's employment opportunities (Ross & Wu, 1996), as

demonstrated by the finding that low-income mothers with low educational attainment

often work in jobs that are low-paying, unstable, offer irregular hours, and provide few if

any benefits (Lein, Benjamin, McManus, & Roy, 2005). Not only are mothers affected by

such inadequate employment conditions, but their children suffer as well; children of

parents working non-standard hours are at greater risk of having emotional and social

problems (Strazdins et al., 2006). Women are often forced to leave their jobs when they

or their children are sick or when they must attend to other responsibilities to care for

dependent family members. Without work stability in the early adulthood years, low-

income mothers are less likely to accumulate the resources associated with good health

later in life (DiPrete & Eirich, 2006).

   Effects of cumulative stress. Sociological research of stress exposure also points

to the importance of considering cumulative disadvantage when studying the health of

different groups. Thoits (2010) reviewed sociological stress research from the past four

decades and discovered that when negative events, traumas, and chronic strains are

measured comprehensively, they substantially damage mental and physical health.

Stressors were found to proliferate across the life course and across generations,

expanding health gaps between the advantaged and the disadvantaged. Moreover, the

review suggested that differential exposure to stressors was a critical pathway by which

gender, racial, and socioeconomic inequalities in health were produced; females,

members of racial/ethnic minority groups, and the poor faced significantly more

cumulative burdens and had more chronic difficulties compared to other groups. The

review also found that negative impacts of stress on health were reduced when

individuals demonstrated high levels of self-esteem, mastery, and/or social support.

Role of cumulative childhood adversity in later mental health. Other studies have looked at ways in which experiencing specific adversities in childhood or adolescence specifically impacted mental health in later life. Living in a poor household or losing a parent through divorce or death has been associated with the earlier onset of psychological disorders and with an increased risk of psychological problems in adulthood (Gilman, Kawachi, Fitzmaurice, & Buka, 2003; Luo & Waite, 2005). Family disadvantage also influences the types and amount of resources that may be available to cope with adversity, and exposes children in those families to inequalities like overcrowded classrooms and under-qualified teachers (Darling-Hammond, 2004), harsher punishments like suspension or expulsion (Skiba, Michael, Nardo, & Peterson, 2002), and being tracked into remedial or vocational education classes (Darling-Hammond, 2004). Exposure to this sort of inequality in childhood may shape one's view of the world and one's responses to events in the future, in some cases leading to higher rates of psychological problems that set the stage for later social, health, and economic disadvantage (Neighbors & Williams, 2001). Schilling, Aseltine, and Gore (2008) analyzed data from a study that conducted two waves of structured interviews over two years with a probability sample of adolescents and young adults in the Boston area. The authors found that respondents with the greatest cumulative adversity had disproportionately poorer mental health in terms of behavioral and emotional functioning because of both the severity and number of adversities to which they were exposed. Severe adversities (e.g., sexual abuse, being involved in a life-threatening accident, etc.) were more common among low-SES youth and their families and were found to be

"embedded in a range of lesser-impact but potentially harmful exposures" (p. 9), such as

having a parent lose a job.

Trajectories of depressive symptoms. Walsemann, Gee, and Geronimus (2009)

used the National Longitudinal Survey of Youth to investigate ethnic differences in

trajectories of depressive symptoms and the extent to which background disadvantage

could account for these differences. Hispanics and blacks experienced higher levels of

symptoms when compared to whites, but the size and significance of the disparity varied

over the life course. Hispanics and blacks reported more disadvantage than whites in

terms of family background, education, and adult socioeconomic status; the

disadvantages accounted for 40 percent of the Hispanic-white disparity and roughly half

of the black-white disparity in depressive symptoms among young adults. The authors

concluded that "it is not just differences in static dimensions of social class (e.g., income

at one point in time), but it is also the cumulative effects of economic disadvantage" (p.

94) that account for disparities in depressive symptoms over time. They warned that over-

reliance on cross-sectional studies could mask important relationships between

depressive symptoms, race/ethnicity, and economic disadvantage.

Family Comorbidity

As I introduced above, another important consideration when exploring the

mental health of low-income mothers is comorbidity, or the co-occurrence of two or more

physical and/or mental health problems. Comorbidity at the individual level appears to

affect a large number of the U.S. population, particularly among low-income populations

(Danziger, Kalil, & Anderson, 2002; Muehrer, 2002). Evidence has suggested that mental

and physical disorders are reciprocally related and may each increase the risk of the other

(Muehrer, 2002). Further, the costs of health care have been found to be higher for people with comorbid physical and mental health problems compared to those without comorbidities (Muehrer, 2002). A concept that is less commonly employed than individual comorbidity is family comorbidity, which refers to the co-occurrence of one or more physical and/or mental health problems among two or more members of a family. Both concepts were given attention in the study by Burton and Bromell (2010), which was highlighted previously. Below I review several other studies that do not explicitly employ the term, "family comorbidity," but they nevertheless shed some light on the ways in which maternal mental health problems shape and are shaped by multiple illnesses within a family.

Olfson, Marcus, Druss, Pincus, and Weissman (2003) examined cross-sectional data from the Medical Expenditure Panel Survey, which estimates health care service use and expenditures. Their analyses revealed that children of depressed parents were roughly two times as likely as children of non-depressed parents to suffer from a variety of mental health conditions, and they were nearly three times as likely to use mental health services. The authors argued that clinicians and researchers need to pay attention not just to the familial nature of mental health problems, but also to family patterns of seeking treatment. They also noted that it remains unclear exactly *how* parental depression is connected to child mental health problems and treatment-seeking, again demonstrating the limitations of cross-sectional data for understanding process.

Swartz and colleagues (2005) assessed the rates of and relationships between maternal and child mental health illness, utilizing data from a study that conducted structured interviews with mothers who brought their 6- to 17-year-old children to a

pediatric mental health clinic. Sixty-one percent of the mothers met diagnostic criteria for a current mental health problem, most commonly depression and/or anxiety. Two-thirds of those mothers were not receiving mental health treatment, which is significant given that prior research has demonstrated an association between untreated maternal mental illness and poor outcomes for children who are receiving psychiatric treatment (Brent et al., 1998; Cobham, Dadds, & Spence, 1998). Children of mothers who met diagnostic criteria for a mental health problem scored significantly higher on measures of externalizing and internalizing symptoms compared to children of mothers with no diagnosis; this finding is notable as it indicates that maternal psychiatric illness predicts higher symptom burden even among a sample of children being seen at a mental health clinic. Other findings included that mothers with one or more diagnoses showed markedly impaired functioning across multiple domains, were more likely to experience partner abuse, and indicated having less social support than mothers with no diagnosis. The authors concluded that "these mothers experience a range of difficulties that might have an impact on their capacity to optimally manage children suffering from their own psychiatric illnesses" (p. 1081).

The last study to be mentioned in this section was conducted by Lloyd and Rosman (2005), who used a case study to explore ways in which having a child with special needs affects low-income mothers' well-being and functioning, and relatedly to examine the patterns and effects of interacting with a range of service providers and systems. They noted that having a child with special needs and living in poverty were both associated with negative mental health outcomes for mothers. They pointed out that very little is known about the daily experiences of women who fall into both categories,

nor has research given sufficient attention to the ways a mother's mental health influences and is influenced by her children's development. Some research has suggested that low-income mothers of children with special needs engage in a variety of caregiving activities that are often undertaken in isolation and without respite, which results in high levels of physical and emotional stress (Lloyd, 2002).

The case study family analyzed by Lloyd and Rosman (2005) was a composite of families that took part in a qualitative study of low-income women with special needs children. The case study highlighted three themes related to mental health outcomes for this population of mothers: lack of adequate resources, excessive hassles associated with service utiLisation, and stress associated with maternal employment. Regarding resources, the case study demonstrated how families of children with special needs face time and economic resource demands not typically encountered by families who do not have special needs children, such as having to pay for in-home care, transporting children to and from multiple appointments, and arranging for child care for other siblings while going to treatment for the child. The second theme emphasized that "these families live at the intersection of both poverty- and disability-related services" (p. 189). They therefore deal with a large number of service providers representing different service systems, increasing the opportunities for hassles related to lack of coordination among providers and the fact that each system has its own norms, rules, and lines of authority. The impact of interactions with multiple service providers/systems on mothers' mental health and family health more broadly is unclear. The final theme illustrated by the case study is that of high levels of stress associated with employment. The stress results from several factors, most notably from difficulties finding appropriate child care and maintaining a

stable and consistent work schedule given the unpredictable health needs of their children.

As Burton and Bromell (2010) noted, the literature on family comorbidity is under-developed. The few studies cited above are also limited, whether due to the cross-sectional rather than longitudinal nature of the data or to the lack of diversity in the sample. There is a clear gap in the literature both in terms of family comorbidity overall as well as the way family comorbidity interacts with maternal mental health specifically. Burton and Bromell's (2010) study suggested that one effect of family comorbidity is that it might lead mothers to neglect their own health needs to meet the health and economic needs of their families; this area of inquiry needs more attention. Next I discuss other potential barriers to mental health treatment for low-income mothers.

Barriers to Mental Health Treatment

Fragmented mental health system. Recent events have generated interest in improving mental health treatment in the United States (Carroll, 2012). Such calls for improvement in treatment are not new. In 2003, the President's New Freedom Commission on Mental Health published a report detailing major barriers to mental health care in the U.S., the most significant being fragmentation and gaps in caring for children and adults with severe mental health issues (Hogan, 2003). The report identified 42 federal programs that might be accessed by people with mental illness, many of which are administered by different agencies at the state and local level, and each of which has different eligibility requirements. As a result, mental health care is scattered, and it is most often left to families to coordinate services (Hogan, 2003).

It should be noted that although the mental health care system is fragmented and in need of reform, important and positive changes in the system have occurred since the mid-1980s (Wang et al., 2005). Examples include advances in treatment, the launching of community-based programs that promote awareness and help-seeking for various mental disorders, delivery of mental health treatment in primary care settings, and the development of evidence-based guidelines to improve quality of mental health care. Nevertheless, U.S. survey data analyzed by Wang and colleagues (2005) indicated that the majority of people who had a mental illness – close to 60 percent – were untreated or inadequately treated based on evidence-based treatment guidelines. Only 28 percent of those with mental illness were treated by a mental health specialist; others were treated by general medical providers, human service providers, or alternative medical providers. Unmet treatment need appeared to be greatest among traditionally disadvantaged groups including racial or ethnic minorities, the elderly, those without insurance, and those with low incomes (Wang et al., 2005).

In summary, much research paints a grim picture of mental health treatment in the U.S. Among those who access treatment, there is a good probability they will not receive services that exceed a minimal threshold of adequacy. Those with severe mental illness who manage to obtain services encounter a system that is fragmented, confusing, and frustrating. But the fact remains that most people with a mental health condition do not receive treatment, and the gap is greater for disadvantaged populations compared to those who are economically resourced. This pattern can be partially explained by the lack of economic resources and health insurance, shortage of available services, and instrumental challenges faced by low-income populations (Anderson et al., 2006; Copeland & Snyder,

2010), but such explanations do not tell the whole story. In order to better understand what keeps some women from entering the mental health system, it is helpful to review several ethnographic studies that elucidate low-income mothers' perceptions and experiences of mental health and mental health treatment.

Perceptual barriers to treatment. Copeland and Snyder (2010) analyzed interviews with low-income African American mothers bringing their children for behavioral health treatment at a community mental health center. Of the 64 women who were initially interviewed, half of them screened positively for some level of anxiety or depressive disorder and were given a referral for treatment. Follow-up interviews were conducted with those 32 women in order to explore factors that might keep women from attending to their own mental health needs. Several themes emerged from the analysis as being important factors to consider for engaging low-income African American mothers in mental health treatment. An obvious barrier that was identified is that of economic stress. Less obvious was a concern among mothers that they could lose their children. Many of the mothers in the study reported feeling that "if they opened up and shared their difficult life experiences, the system would remove their children" (pp. 85-86). Thus "they feared the system and constantly referred to it as something to be avoided at all costs" (p. 85). Another common barrier to treatment was negative perceptions of the mental health system. Some mothers reported believing that clinicians would be ineffective because of a lack of first-hand knowledge of the difficulties the mothers faced. Others were concerned that they would be hospitalized and/or immediately medicated if they sought help for their mental health problems. A final theme that emerged was about violence and survival; a substantial number of women in the study had histories of

physical and/or sexual abuse, which previous research has associated with a decreased likeliness of seeking mental health help (Brown & Keith, 2003). More broadly, a desire to protect and care for their families combined with chronic life stressors like violent relationships were found to divert mothers' attention away from their own mental health needs.

Ward, Clark, and Heidrich (2009) undertook an exploratory qualitative study of African American women's beliefs about and strategies for coping with mental illness. They interviewed 15 women from a range of income levels, eight of whom reported being diagnosed with a mental illness. The women believed that factors such as discrimination, oppression, and racism can cause depression; they also expressed a belief that mentally ill African Americans are often hospitalized or even sent to jail. The authors noted that there was some research to support such a belief; significant disparities in rates of hospitaLisation for mental disorders have been found between African Americans and whites (Wisconsin Minority Health Program, 2004). Some of the women also demonstrated a lack of awareness and even denial of mental illness in their community. Nevertheless, most believed that mental illness was treatable with counseling and could also be helped by prayer and support networks. Through these interviews, various barriers to treatment were identified, including lack of knowledge about where to obtain mental health services, as well as perceived stigma and discrimination against those with mental illness.

Leis, Mendelson, Perry, and Tandon (2011) analyzed data from focus groups held with clients and home visitors from two Baltimore-based perinatal home visiting programs. Thirty-eight clients – all low-income African American women – participated

in one or more of five focus groups, which were designed to learn about women's perceptions of mental health and related services. The authors reported that the women's perceptions were largely negative. The women believed psychotherapy was ineffective, and they described mental health providers as being emotionally detached and uncaring. Interestingly, although the focus group facilitators did not ask questions about psychotropic medications, clients brought up the topic; they indicated beliefs that such medications do not work, cause unwanted side effects, and are overprescribed. Multiple clients were concerned that side-effects would interfere with caring for one's baby.

A qualitative study that specifically examined low-income African American women's perceptions of treatment of panic disorder (Johnson, Mills, DeLeon, Hartzema, & Haddad, 2009) found major barriers to treatment included fear of social stigma, lack of information, and fear of confiding in others about panic symptoms. In addition to these barriers, women faced challenges within their social networks as well, such as stigma related to mental illness, lack of acceptance about the use of psychotropic medications, and perceptions that personal/spiritual weakness had caused symptoms. Moreover, none of the sample members reported having developed effective relationships with mental health providers.

A study by Anderson and colleagues (2006) held qualitative interviews with 127 low-income mothers who initiated behavioral health treatment for their children at one of four community-based mental health centers. All of the mothers in this ethnically diverse sample met the diagnostic criteria for one or more anxiety and/or mood disorders. Of the 127 mothers, 29 had seen a mental health specialist; 15 of the 29 women had been prescribed psychotropic medications by a psychiatrist. Twenty-nine additional mothers

had been prescribed psychotropic medications by a gynecologist or primary care physician. The authors' analysis revealed that although nearly all the women agreed with their mental health diagnosis, most did not believe that treatment was necessary or beneficial. In part this discrepancy was due to how the mothers perceived the causes of their distress; most viewed their distress as an expected response to extreme stressors like current and/or past abuse, stress related to managing a behaviorally disturbed child, and daily hassles of poverty. Thus it is unsurprising that most of the mothers reacted negatively to a treatment referral, given that "they perceived that the clinical system would focus on creating internal changes, a focus that made little sense to them when they perceived their distress to be caused by external pressures. Relief would come with a change in life circumstances, not medication or 'talk therapy'" (p. 934). Another reason women gave for reacting negatively to a mental health treatment referral was that they feared having professionals judge them to be inadequate. Yet another factor contributing to low treatment-seeking was the mothers' interactions with their children's service providers were often negative; the interviewees reported that few of the clinicians appeared interested in the mothers' input about the child or in the mothers' problems or burdens. Not only did such interactions decrease mothers' trust in the mental health system, but they also decreased mothers' participation in their children's treatment. One last finding that should be highlighted was that there were very few differences between the white mothers' and minority mothers' stories; the authors reflected that "any possible differences might be obscured by the overwhelming nature of the poverty and/or class issues that dominate the reports of both groups" (p. 939).

Overall, a strength of the body of research examining barriers to mental health treatment for low-income women is that it is qualitative and provides a deeper understanding of women's experiences compared to survey data alone. A weakness is that most of the studies lacked diversity in their samples; additionally, most of the studies interviewed the women at just one point in time, thus they tell us little about what, if anything, changes over time as women consider mental health treatment.

Coping and Mental Health Treatment-Seeking among Low-Income Women

The research examined above highlights a number of perceptual and instrumental barriers to mental health treatment. A related but distinct field of study focuses on the coping behaviors employed by low-income women, one of which is mental health treatment-seeking. Lazarus and Folkman (1984) defined coping as an individual's pattern of responses to stressful circumstances. More specifically, coping involves cognitive and behavioral strategies to manage stress. In order to cope successfully, a person might utilize strategies for avoiding the problem as well as for actively dealing with the problem (Roth & Cohen, 1986). Thus coping efforts range from ignoring the problem to seeking professional help. Below some of the literature about how low-income women deal with mental health problems is explored in greater detail.

Racial/ethnic differences in coping. There is evidence of racial/ethnic differences in coping with mental health problems; for instance, African Americans have been shown to rely on informal coping mechanisms such as family, friends, church, and neighbors (Abrams, Dornig, & Curran, 2009; Matthews & Hughes, 2001), and to be more likely than their white counterparts to believe that family problems ought not be discussed outside the family (Alvidrez, 1999). Treatment-seeking behaviors were found

to be markedly different as well: even among those with identical health insurance coverage, African Americans and Latinos were less likely than European Americans to engage in outpatient mental health treatment (Padgett, Patrick, Burns, & Schlesinger, 1994).

Ennis, Hobfoll, and Schroder (2000) used questionnaire data from a sample of 1,241 African American and European American women who were pregnant and who visited one of two low-income health clinics. The researchers sought to understand how both chronic and acute economic hardship affect depressed mood and the use of different coping resources. They found that economic stress impacted mood almost exclusively through acute material loss rather than through chronic poverty. For the African American women in the sample, social support had a stress-buffering effect on material loss; in contrast, mastery – defined as the extent to which individuals perceive their goal to be in their control – acted as a greater buffer for high material loss among the European Americans. The authors noted, however, that social support and mastery were both found to be important buffers of stress for blacks and whites alike.

Active versus avoidant coping. In a cross-sectional analysis of a probability sample of 810 low-income women, Rayburn and colleagues (2005) examined relationships between trauma, depression, active and avoidant coping styles, and mental health service seeking. Traumas including living in a homeless shelter, childhood sexual abuse, physical violence in the past year, and death of a family member or close friend were related to avoidant coping strategies (e.g., making oneself feel better by eating, drinking, or smoking; sleeping more than normal; taking it out on others), which in turn increased the risk for experiencing depressive symptoms. Major physical violence in the

29

past six months was found to significantly predict clinical depression. Active coping like learning about the problem, talking to someone, and making and following a plan of action, predicted mental health service seeking for women who had experienced one or more traumas.

Social support and extended kinship networks. The notion of utilizing social support was mentioned above as one strategy for coping with mental health problems. The role of social support in the lives of low-income mothers has been explored extensively in the literature. Although most of this body of research does not specifically address mental health, it is nevertheless helpful to highlight findings about some of the processes that occur within low-income families as mothers seek out support.

De Souza Briggs (1998) conceptualized social support as ties that help individuals to cope or to "get by" with life's demands (p. 178). Such ties typically comprise relatives, close friends, and neighbors. They provide emotional support as well as instrumental assistance like occasional help with child care, a ride, or a small loan during an emergency. Some research (e.g., Hogan, Eggebeen, & Clogg, 1993) has noted that reciprocity is a critical component of social networks, especially in contexts in which resources are scarce. When expectations for reciprocity are unmet, tensions often increase and relationships may dissolve. Roschelle (1997) found that, in spite of highly valuing family, economic hardship prevented many black and Latino families from participating in social support and exchange networks.

Dominguez and Watkins (2003) utilized Three-City Study ethnographic data to identify issues that influence low-income mothers' use of family members as sources of social support. Unlike previous research, they found that many more factors than

economic constraints were at play in mothers' decision-making about who to turn to for

social support. Factors included accessibility, interpersonal dynamics, reciprocity, and

trust. Some women attempted to rely instead on an institution-based network when

friends and family were unable to provide adequate support, but they did so only when

concerns about confidentiality, competence, and being able to reciprocate "on their own

terms" (p. 123) could be established. This often proved difficult due to the fact that

nonprofit institutions were limited by budgetary constraints, narrow understandings of

reciprocity, and shifting policies that made them unstable bases of support. On the whole,

the authors found that the mothers they studied tried "to protect their own money, time,

and emotional reserves to minimize the costs of relying on others" (p. 129).

Partner relationships. Another body of research has focused more specifically

on low-income mothers' partner relationships and the support they may or may not

receive from those relationships. Numerous studies have shown how mothers often turn

to men for instrumental assistance and financial resources in particular (e.g., Gibson-

Davis, Edin, & McLanahan, 2005; Mincy, Garfinkel, & Nepomnyaschy, 2005; Roy, 1999).

Some research has suggested that low-income mothers may face considerable risk in

seeking the involvement of unmarried, nonresident fathers. For instance, Wilson and Brooks-

Gunn (2001) analyzed data from the Fragile Families study and found that unmarried fathers,

compared to their married counterparts, were more likely to have physically abused mothers,

used illicit drugs, drunk, or smoked. Other studies have found low-income women are more

likely to be abused by their partners than are other women (Tolman & Raphael, 2000; Waller

& Swisher, 2006). Not surprisingly, qualitative research indicates that abuse is one reason

some low-income women choose not to marry the father of their children (Edin, 2000), as

they wish to protect not only themselves but also their children. In addition to the risk of

abuse, there is also the risk that mothers may lose resources or not obtain the resources they seek because many low-income fathers are obligated to more than a single set of children (Roy, 1999).

Even in spite of these risks, mothers have shown they are willing to carve out various roles for fathers and other men to play in their children's lives. Roy and Burton (2007) also drew on the Three-City Study ethnography to discover how mothers negotiated connections with men including biological fathers, boyfriends, kin, and non-intimate friends for the purpose of improving their children's opportunities. Roy and Burton found that mothers recruited men for three primary supports: material support, child care, and emotional support/guidance. They also found the process of recruitment was often exhausting and, confirming other research, sometimes put mothers and children at risk for gaps in resources or for abuse. In this sense, the process of coping (seeking out instrumental and emotional support) could be expected to place families at risk for even greater harm and might exacerbate already existing mental health problems.

Effects of poverty-related stress on coping. The above summary explained how low-income mothers often have to negotiate complex relationships to obtain the support they need to "get by." This focus on "getting by" suggests that poverty could hinder some mothers' capacity to employ a broader range of coping strategies such as mental health treatment. Wadsworth (2012) provides a helpful summary of research that demonstrates more specifically how poverty-related stress contributes to mental health problems and affects how and whether people engage in mental health services. Poverty-related stress varies widely from exposure to violence to hunger, from illness to being unable to pay one's bills. Poverty has been found to amplify other stressors' effects (Almeida, Neupert, Banks, & Serido, 2005), often causing people who live in poverty to be overwhelmed by

seemingly minor events. Economic stress acts as a catalyst for various problems within

families, a process that has been conceptualized by the "Family Stress Model" (Conger &

Elder, 1994). The model posits that low family income and adverse financial events

generate economic stress for the family (Conger, Rueter, & Elder, 1999), which leads to

parental distress and (in cases where two parents are present) inter-parental conflict; such

distress and conflict lead to parenting problems that may compromise children's

psychological functioning. At the same time, children's behavior and emotional problems

create further turmoil in families and continue the cycle of family stress.

Another concept Wadsworth (2012) summarized is allostatic load, a term coined

by McEwen and Stellar (McEwen, 1998) to describe the cumulative wear and tear the

body incurs as a result of "repeated, excessive activations and inefficient down-regulation

of the stress response systems" (Wadsworth, 2012, p. 19). Allostatic load may lead to

physical and mental health problems over time, and it has been associated with a reduced

ability to learn and/or implement new material (McEwen, 1998). Wadsworth concluded

that low-income individuals with mental health problems may need help learning how to

regulate their stress response system before being able to engage in other coping

strategies like problem solving, healthy distraction, and active acceptance.

Coping with mental health problems in the context of IPV. I conclude this

review of the literature on mental health and coping strategies of low-income women by

looking briefly at the intersections of poverty and intimate partner violence (IPV).

Goodman, Smyth, Borges, and Singer (2009) argued for the importance of considering

IPV in any exploration of low-income women's mental health. The authors cited a host of

studies indicating that household income is perhaps the most significant correlate of IPV,

and the lower the income, the greater the likelihood that there will be violence (e.g., Cunradi, Caetano, & Schafer, 2002; Vest, Catlin, Chen, & Brownson, 2002). Longitudinal studies have indicated that financial strain and employment instability increase women's subsequent risk of abuse, even when researchers control for violence at baseline (Benson & Fox, 2004). Both poverty and IPV have been associated with mental health problems such as PTSD, anxiety, and depression (Belle & Doucet, 2003; Coiro, 2001; Coker, Weston, Creson, Justice, & Blakeney, 2005). The high co-occurrence of poverty and IPV suggest that the mental health effects of each condition could magnify each other, although Goodman, Smyth, Borges, and Singer (2009) noted that "just how the impact of one condition interacts with the impact of the other remains virtually unstudied" (p. 315). The authors proposed that women dealing with IPV in the context of poverty employ what they term "survival-focused coping," which is about "surviving in the short-term, meeting basic needs, and keeping oneself and one's loved ones as safe as possible" (p. 318). The authors noted that more research is needed to further explore how the effects of IPV and poverty combine to shape women's mental health and their options for addressing mental health problems.

The above research has suggested that low-income women employ a range of coping strategies, some of which are "active" while others are "avoidant." It appears that conditions of chronic poverty and traumas like IPV may severely limit women's ability to regulate stress and seek out assistance. However, it remains unclear why some women, in spite of extreme difficulties, make the decision to pursue mental health treatment while others do not. Another gap in the literature, mentioned previously, is how family comorbidity affects coping strategies including treatment-seeking.

Summary

One overarching finding of the literature review is that the effects of maternal

mental health on the family are not well understood, particularly in the context of

cumulative disadvantage and family comorbidity. Also understudied is the influence of

family comorbidity on maternal mental health and coping. In fact, there is a dearth of

research of any kind on family comorbidity, making this an important subject for future

research. Although a handful of ethnographic studies have explored barriers to mental

health treatment, more research is also needed to understand how such barriers play out

over time.

Theoretical Foundation: Life Course Approach

The theoretical foundation for the present study is the life course framework. This

framework recognizes the importance of taking a systems approach to studying how

individuals and families both shape and are shaped by social structures and relationships.

The life course approach emphasizes dynamic change over time and offers the

opportunity to consider the impact of cumulative life experiences as well as the timing of

important experiences earlier in life (George, 2002). Specifically, the approach provides

the four following concepts for examining the ways in which change occurs across the

life course (Elder & Giele, 2009):

- Location in context: People are born into a specific historical time and geographic

  community, each with a particular set of experiences and range of opportunities.

  According to the life course paradigm, "developmental processes and outcomes

  are shaped by the social trajectories people follow," and these trajectories

represent "the interplay of human lives with historical times and places or ecologies" (Elder, 1995, p. 107).

- Linked lives: The life course framework acknowledges individuals' social embeddedness and interdependence. The notion that mothers are "counted on" by their children, for instance, and that they experience a resulting sense of significance, is an expression of linked lives (Elder, 1995). The concept also recognizes that, within families, a change in one person's life (e.g., a parent losing a job) often ripples into the lives of other family members (e.g., a child having to switch schools, or a spouse having to take up another job) (Roy & Moser Jones, 2012). Zooming out, networks of families and friends also shape the health of network members (Smith & Christakis, 2008).

- Agency and personal control: To some extent, people select themselves into situations and roles, and in so doing, they construct their life course and identity within given social constraints. This aspect of the life course approach recognizes that people are often planful and make choices that offer the chance for them to control their lives (Elder & Giele, 2009). These choices are affected by contextual factors like the situation and interpretations of the situation, the individual's prior experiences, and his or her personality (Elder, 1995). In addition to the individual level, the family acts as an active agent of change, negotiating events and taking charge of the destinies of family members in addition to reacting to circumstances around them (Bengston & Allen, 1993).

- Timing of and adaptation to major life events: The timing of a life transition or event matters for the meaning and effects that transition or event will have (Elder

& Giele, 2009). For instance, adverse events or exposures may be especially harmful at certain sensitive or critical periods of development (Fine & Kotelchuck, 2010). Also important is how individuals and groups coordinate their responses and mobilize resources to adapt to and shape concrete external events and transitions (Elder & Giele, 2009).

Each of the above factors applies to the full life span – in other words, health and development are lifelong processes that cannot be fully explained by restricting analysis to any one life stage (Elder & Giele, 2009). Rather, health develops across the lifetime and is even shaped by events that occurred prior to birth (e.g., mother's childhood health), thus early experiences must be considered when attempting to understand adaptation in later life. Along these lines, the life course can be conceptualized as a lifelong phenomenon of "intertwining cumulative processes" (O'Rand, 2009, p. 123), in which the experiences and events that occur early in life have important consequences for later experiences and events, as well as for how individuals manage them. An important effect of this complexity is the "emergence, persistence, and widening or narrowing of inequality in different aspects of well-being – social, economic, physical, and psychological" (O'Rand, 2009, p.124).

Epidemiologists have employed life course concepts to explore social, biological, and environmental risk and protective factors of health and health disparities; often such factors do not have immediate impact on health but rather unfold over decades or generations (Roy & Moser Jones, 2012). Similarly, medical sociologists have utilized a life course framework to inquire about the connections between past stressors and present health (Pearlin, Schieman, Fazio, & Meersman, 2005). In summary, a growing number of

health-related research perspectives are using life course concepts to address two key questions: 1) Why do disparities in health persist for certain population groups? and 2) What factors influence the capacity of families and individuals to achieve optimal health and well-being? (Fine & Kotelchuck, 2010)

The present study is primarily concerned with the second question mentioned above; specifically, the aim is to draw on life course concepts of time, timing, linked lives, adaptation, agency, and context, to explore how low-income mothers with mental health problems address those problems and what role family comorbidity plays in mothers' efforts to achieve health and well-being for themselves and their families.

Research Questions

Building on the foundational assumption that low-income mothers and their families are embedded in particular social and historical contexts, the present study seeks to explore how low-income mothers interact with and adapt to their contexts as they cope with mental health problems. Specifically this study asks the following questions:

- How do low-income mothers experiencing individual and family comorbidity cope with mental health problems?

- How do mothers seek out mental health treatment over time? Within which family and community contexts do they do so?

The analyses offered by this study will increase understanding of the ways in which mothers' mental health and their coping play out over time, shape and are shaped by the daily routines of families, and interact with children's and other family members' health. An implicit question is whether, when, and how "coping" includes mental health treatment-seeking as one strategy. Although many previous studies have examined

families and poverty longitudinally, very few have utilized qualitative methods and a diverse sample to study low-income mothers in the context of families over a timespan of several years.

Methods

To investigate the coping and help-seeking behaviors of low-income mothers with mental health problems, this study uses ethnographic data from *Welfare, Children, and Families: A Three-City Study*. This study was a multisite, multi-method, longitudinal project aimed at examining how welfare reform impacted the lives of low-income Latino, white, and African-American families with young children (Winston et al., 1999). The Three-City Study focused on three large cities – Boston, Chicago, and San Antonio – in which welfare reform efforts at the federal, state, and local levels were expected to significantly affect the lives of low-income parents and children. There were three major components to the study: a longitudinal household survey of a random sample of 2,402 families, an embedded developmental study that involved 700 families, and an ethnographic study of 256 families and their neighborhoods. Although these 256 families were not part of the survey sample, they resided in the same neighborhoods and had comparable demographic characteristics to those in the survey sample (Winston et al., 1999).

Sample

Recruitment of families into the ethnography occurred between June 1999 and December 2000 (Burton & Bromell, 2010). Families were recruited from public assistance agencies, neighborhood community centers, formal childcare settings, and churches. Out of the 256 participating families, 212 were selected because they had a

child 2-4 years of age; the remaining 44 ethnography families were selected specifically because they included a child (0-8 years) with a disability, as one aim of the study was to increase understanding about how welfare reform affected families with disabilities (Burton & Bromell, 2010). However, analyses later revealed that the families included as part of the disability sample "were not qualitatively different from the families enrolled in the study without prior knowledge of their health conditions" (Burton & Bromell, 2010, p. 240).

Burton and Bromell (2010) reported that all the families' incomes were at or below 200 percent of the federal poverty line at the time they enrolled in the ethnography. Forty-two percent of the mothers were of Hispanic or Latino ethnicity, 38 percent were African American, and 20 percent were non-Hispanic White. The majority of the mothers (58 percent) were under 30 years of age at the time of enrollment and nearly half (49 percent) were receiving public aid through Temporary Assistance to Needy Families (TANF). Of those mothers who were receiving TANF, one-third were also working. The 256 mothers in the ethnography were responsible for a total of 685 children, of whom 53 percent were younger than 4 years of age. Three-quarters of the mothers cared for two or more children; 23 percent of the mothers were responsible for four or more children.

Most of the mothers (58%) indicated they were unmarried and not cohabiting at the time of recruitment into the study, but Burton and Bromell (2010) report that the mothers' relationships were more fluid and complex than was initially understood. The authors therefore classified mothers' relationship histories into one of three categories: sustained, transitory, or abated. Forty-five percent of the women were classified as having sustained unions, meaning "as adults, they had been in 1 or 2 marital or

cohabiting unions lasting 3 or more years" (p. 243). Thirty-seven percent of the women fell in the category of transitory unions, defined as "being involved in sequential short-term partnerships with different men, or mothers having long-term involvements with men that cycled between living together and breaking up (usually in 3–6 month intervals) and living with other men during the break-up periods" (p. 243). Finally, 18 percent had abated unions, meaning they were not in a serious relationship during the study and had not been married or cohabiting for at least one year before they enrolled in the study.

As the literature review mentioned above, Burton and Bromell (2010) found a high number of physical and mental health problems among the sample. They reported that 80 percent of the mothers in the ethnography suffered from a chronic physical and/or mental health condition. Common physical ailments included severe arthritis (44%) and cardiovascular disease (36%). Common mental health problems among the mothers were depression (69%) and anxiety disorders (67%). Of the 256 mothers in the sample, 205 of them reported having two or more physical and/or mental health problems. Of the children, 72 percent were identified as having two or more physical and/or mental health conditions, most commonly ADHD (47%), asthma (45%), severe periodontal and dental disease (27%), obesity (24%), and anxiety disorders (13%). In 68% of the families, two or more family members had chronic physical and/or mental health problems.

The present study focused on a subsample of 20 of the 256 mothers, which allowed a more in-depth exploration of the mothers' experiences of mental health. To select the sample, first a single city—Chicago—was chosen in order to limit contextual differences between mothers in different locations. Including mothers from one city allowed the study to "hold constant" important geographical variables such as the mental

health system as well as state- and local-level policies affecting public assistance. Next, case profiles and family timelines were consulted (see Data Analysis section below) to identify mothers who met the following conditions: 1) there was the presence of a mental health diagnosis and/or the experience of significant symptoms of mental health problems, 2) complete data for the family were available, and 3) the data included extensive information on mental health. Finally, I purposefully looked for diversity of subsample members to ensure representation of African-American, Latino, and White families. Through this process, 20 mothers and families were identified for inclusion in the subsample. (See Appendix A for demographic characteristics of the subsample and Appendix B for brief summaries of the mothers.) The mothers ranged in age from 16 years to 50 years, with an average age of 31. They had between one and eight children, averaging 3.3 children. Just over half of the mothers (55%) were African American, 35% were Latino, and 10% were Caucasian. Eighty-five percent of the mothers reported accessing some sort of mental health treatment at some point in their lives (discussed further in Chapter 3).

Data Collection

The ethnographic data on mothers and families were gathered and analyzed through a method of structured discovery. Ethnographers interviewed and observed the respondents, focusing on topics of interest while maintaining enough flexibility to uncover unexpected findings and relationships between variables (Arditti, Burton, & Neeves-Botelho, 2010). In addition to conducting interviews, ethnographers used participant observation to learn more about context and relationships; they accompanied mothers to places like welfare offices, doctor's appointments, and work, as well as being

present during extended conversations and attending family functions (Roy & Burton, 2007). In most cases, one ethnographer remained with each family for the entire study (Burton & Bromell, 2010). Ethnographers met with their families one to two times per month for the first 12-18 months of the study and then twice a year through 2003. Respondents received department or grocery store vouchers for participating in the study.

The primary data sources for this study were transcripts of all tape-recorded interviews and ethnographers' field notes about participant observations and interviews. Interviews covered such topics as education and work histories, health and health care access, intimate relationships, family routines, neighborhood context, and support networks (Roy & Burton, 2007). Regarding health, mothers were asked to describe the physical and mental illnesses they experienced as children, as well as any current health problems affecting them and their children that a physician or mental health specialist had diagnosed and/or treated. Gathering accurate data on the health of mothers and their families was only accomplished after months of in-depth discussions with and observations of mothers, as well as verification of their health problems by physicians, social workers, therapists, or other family members (Burton & Bromell, 2010). With regard to mental health, most of the mothers reported diagnoses received by a mental health professional, but the diagnoses often varied over time as the mothers and their children were seen by different health professionals. Burton and Bromell (2010) note that a number of factors could affect the diagnoses received, including the amount and accuracy of information provided, as well as the progression of family members' illnesses over time. In their study, the authors chose to use conservative descriptions of

mental health conditions, guided by the *DSM IV* definitions of mental health disorders (American Psychiatric Association, 2000).

Data Analysis

The Three-City Study research team conducted two initial waves of coding soon after data were collected. In each of the three cities, ethnographers assigned bucket codes to their field notes and transcribed interviews and observations; these documents were then entered into a qualitative data management software application (nVivo). Data were then sent to researchers and qualitative data analysts at Pennsylvania State University for a second wave of coding. Here the data were organized into case profiles for each family.

The present study utilized grounded theory methods to conduct three phases of coding of complete datasets for each family in the subsample. The three phases of coding were open, axial, and selective (LaRossa, 2005). The first phase of coding was open coding, which involved a "line-by-line" breakdown of the data (Daly, 2007). In this phase, the goal was to identify concepts and formulate categories based on the contextual experiences provided by research participants (LaRossa, 2005). Through the process of reviewing transcripts and field notes from interviews and observations, I developed an initial set of codes to describe the phenomena discussed or observed which then guided further exploration of the data. In this phase, codes were developed deductively and inductively: deductive codes arose from what I knew to be relevant from prior research, whereas inductive codes emerged directly from participants' experiences (Daly, 2007). Examples of codes in this first phase included substance use, child illness, and mothers' relationships with extended kin.

The second phase of analysis was axial coding. This phase involved looking for conceptually-similar codes, or categories. In this phase, characteristics of each category were defined to distinguish it from the others (Daly, 2007). Through the process of axial coding, I looked across cases to identify patterns among the mothers. A few examples of patterns included active and avoidant coping, abuse suffered in childhood, and mental health treatment-seeking during pregnancy.

The third and final wave of analysis was selective coding. The purpose of this wave was to develop a theory about how the various categories related to one another. At this stage the researcher selected what was determined to be the most important categories, patterns, and relationships between the categories to describe a theory about how they hold together. In selective coding, a "central category" was thus developed that was able to explain the interrelating characteristics of supporting categories (Daly, 2007). In this phase, codes were tied together into more abstract concepts that became the underpinnings of grounded theory. For instance, codes such as "substance use," "prayer," "isolation," and "talking to friends" were categorized into a code called "coping." Codes including "relationships with extended kin," "mother guilt," and "intimate partner violence" were tied together into a category called "family system."

Data Quality

A variety of measures helped to ensure the credibility and dependability of the data (Lincoln & Guba, 1985). First, there was prolonged field engagement (Roy & Burton, 2007). In most cases, the ethnographer was racially matched with the family and the same ethnographer remained matched with a family for the study's six years, allowing for the development of strong relationships (Burton & Bromell, 2010). In

addition, the study design included repeat coding techniques and cross-checking of data, obtaining consistent input from more than 200 ethnographers, research scientists, and qualitative data analysts (Burton & Bromell, 2010). Finally, there was triangulation through multiple methods of data collection and multiple data sources (Roy & Burton, 2007).

Reflexivity

There are a number of ways in which my personal experience and background have affected the approach to this study. My work experiences have cultivated a deep respect for families living in poverty and a desire to understand and change the systems and circumstances that have allowed poverty to persist across generations. After obtaining a Master's degree in public policy, I spent several years in Baltimore researching and advocating for policies and practices to benefit families affected by welfare reform. I then spent eight years with an international relief and development organization, supporting programs aimed at empowering families—and particularly women—in some of the world's most economically deprived regions. Through these work experiences, I have seen first-hand some of the many faces of poverty and I have wrestled with the complexity of addressing poverty's root causes and lasting consequences.

Most recently, I have spent the past two years as a Couple and Family Therapist Intern serving a largely low-income community. In that time, I have become more intimately acquainted with the linkages between poverty and mental health. Since leading an 8-week therapeutic group for women—all of them mothers—a year ago, I have come to believe that we in the mental health field need to better understand how low-income

mothers navigate the mental health system and make decisions about whether or not to seek treatment for themselves, especially if their children are also in need of some sort of treatment.

An implicit challenge I have faced in all these experiences is that I am coming from a position of privilege: I grew up in a middle-class family; I am white; I have obtained a graduate degree. I have no frame of reference to understand what it would be like to be unable to feed my children, to wonder if my lights will be shut off tomorrow, or to have to stay with an abusive partner because the alternative is homelessness. What I do have in common with the groups I have served and advocated for, and what I have drawn upon over the course of the present study, is that I am a woman and a mother. I understand, at least in part, how women in this society and across the world still struggle to have their voices heard, that there are still ways in which women are considered to be (perhaps ever-so-slightly) "less-than" men. And I understand a mother's passion for her children – her willingness to sacrifice anything to protect and care for them. In these and other ways, I feel a deep empathy for the women and families who are the focus of this study. I hope to do justice to their stories and the lessons they have to teach.

Results: Chapter 1: Low-Income Mothers and the Perceived Meaning of Mental Health

In this chapter, I broadly describe various ways in which the low-income mothers talked about, experienced, and attempted to make sense of their mental health. The data illustrate a complex array of issues shaping and being shaped by low-income mothers' mental health. For instance, one cannot discuss a mom's depression without also talking about her child's health, her relationship with her extended family, her partner relationships, and her experience of poverty over time. Thus cumulative disadvantage and family comorbidity are two concepts that I will introduce here and return to in later chapters. In this chapter, I utilize the stories of two mothers in the sample who offer particularly rich insights into the varied trajectories low-income mothers may follow as they seek to construct meaning in their mental health and adapt to life circumstances over time. These two women illustrate the difference between treatment and non-treatment and embody most of the themes I touch upon in this thesis. Case studies are especially helpful for this chapter as the fuller context helps one grasp how mothers come to construct their mental health.

Before introducing the two cases, it is worth noting several overarching themes. First, descriptions of mental health problems varied even when the primary diagnosis -- commonly depression -- remained the same. Second, mothers often ascribed their mental health problems to problematic or stressful relationships, and they encountered their mental health problems in the context of these relationships. Finally, mental health problems were also attributed to and experienced within contexts of ongoing poverty.

Descriptions

The mothers in my sample described their mental health using a broad range of terms and descriptions, from the highly clinical to the informal and colloquial. For instance, Wendy, a mother whose story we will learn more about later in the chapter, closely identified with the diagnosis of dysthymic disorder, while another mother, Ashley, remarked, "I'm a loony bin." Other more informal labels employed by the mothers included "mood swings," "nervous breakdown," "low self-esteem," "mental breakdown," and "letting emotions rule my life." At the same time they used a range of descriptions, there was commonality: all 20 mothers described what they experienced as "depression," and 15 of them (75%) received that diagnosis from a health care professional. A quarter of the mothers mentioned anxiety attacks in addition to depression. Eleven of the 20 mothers (55%) mentioned using drugs, alcohol, or cigarettes to help them cope with stress, and four of them (20%) had been in drug or alcohol treatment one or more times.

Clearly, depression was a common thread running through each case. The term was something of a catchall description for how the mothers experienced a wide variety of symptoms such as loneliness, isolation, worry, guilt, insecurity, and anger. Although the term depression was applied broadly, it is important to note that for several of the mothers, depression was just one of multiple mental health diagnoses that were employed. Nevertheless, it is noteworthy that depression was the most prominent term utilized by mothers throughout the interviews.

For some of the mothers, receiving a mental health diagnosis from a health care professional helped them to move toward solutions. It seemed as if the label defined the

issue and provided motivation and structure for seeking help. Wendy's experience fell within this category, and is noted below.

Conversely, a couple of others in the sample described turning to negative coping strategies such as drugs when they lived without a clear name for their mental health problem. For instance, Tammy gave the following description of herself before being diagnosed with depression:

I had got so depressed with myself that I didn't comb my hair, I just sat, I just sat in the window. My mother dies, I lost my job, stuff just, you know the ball just stopped. Stuff just happened for three years. My son went to jail, he got six years. Jerry got sick, almost…you know, stuff just happened back to back for three years.

Tammy said she did not know she "had depression" or how to deal with her problems. Someone gave her drugs which made her feel good, and then "where something would happen I'd go get high."

Mothers also used depression as a descriptor to help them understand their behaviors, such as pushing people away or choosing not to talk to others. Sharon said, "Sometimes I don't feel good. Sometimes I be depressed…So when I be depressed I don't say nothing to nobody. I don't talk to people when I'm depressed. Just like to be alone."

Two of the mothers (10%) perceived they had a mental health problem when they "had to ask for help," which was something they would rather not have done. For others, the requirement was more extreme: it was when they considered thoughts of injuring or killing themselves that they decided there was something wrong. Seven mothers in the

sample (35%) reported considering or attempting suicide. Pam talked about knowing she was depressed because she,

> entertain[ed] the thoughts of bodily harm to [my]self…Have I ever tried to kill myself? That is not a question that somebody can really give the right answer. But to answer, yeah. Usually they will ask you have you entertained the thought? Yes, I have. Have you acted on that thought? Of course. Did I succeed? No. What made me not succeed? I thought about it, it wouldn't have benefited me to kill me and the other person lived.

Another mother, Tammy, expressed her suicidal tendencies more succinctly: "I just didn't care what happened. I didn't care. I wished I was dead half of the time."

Describing mental health problems helped the mothers summarize in a word or a few words the multitude of challenges they faced and the complex feelings and behavioral responses triggered by those challenges. Ashley, the mother who called herself a "loony bin," never received a diagnosis of clinical depression but she nevertheless referred to herself (in addition to being a "loony bin") as depressed. When asked to describe her overall mental health, Ashley responded:

> It sucks. Sometimes I feel A-Okay. Sometimes I feel sad. Sometimes I feel just tired. Sometimes I just feel that I'm not doing a good job as a mother and a provider. Sometimes it's just so overwhelming. But I get over it.

The mental health diagnoses and descriptions the mothers used, most often depression, encapsulated a great deal and their meaning varied from mother to mother. As the above quote from Ashley suggested, issues of relationships and resources were centrally important for many of the mothers. I turn to these two topics next.

Relationships and Mental Health Problems

Several patterns emerged regarding how the mothers understood the causes of their mental health problems, which I will explore in the two case examples below. As a general overview, virtually all the mothers viewed relationships with extended kin, children, and partners as primary causes of their mental health issues. Common relationship-oriented explanations mothers gave for their mental health problems included learning their partners were cheating on them, being physically and/or verbally abused by partners, separation from partners, children acting out, facing an unexpected pregnancy or pregnancy of which the father was unsupportive, feeling taken advantage of by others, and feeling isolated or ignored by others. In a related vein, family comorbidity figured prominently into mothers' understanding of the causes of their mental health issues, both by predisposing them to problems and by creating turmoil and stress at having to care for afflicted family members. Seven of the mothers (35%) explicitly mentioned that mental health problems "[ran] in the family," 13 mothers (65%) cited child physical and/or mental health issues as a source of stress, and four (20%) mentioned other family comorbidity challenges such as having a husband with a significant physical or mental health impairment or a parent with a disability requiring their support.

Five mothers in the sample (25%) traced their mental health problems back to childhood or adolescence, each of them relating the problems to difficult events or circumstances such as child abuse or homelessness, and/or to troublesome relationships such as having a distant or abusive mother. For the remaining 15 mothers (75%), there was no mention of mental health problems occurring prior to adulthood, and in those cases a particular event or cascade of events (almost always related to one or more

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significant relationships as discussed above) was cited as triggering the mental health problem.

Although this will be a central topic in the next chapter, it deserves mention here that the mothers commonly focused on their children when speaking about their mental health, whether referring to how their children "caused" mental health problems, or to the ways their children suffered the consequences of the mothers' mental health problems. Ruth, for example, referred to having taken out her "moods" on her oldest daughter, Heidi, about whom she said things would have been "a lot better without." When asked about her own mental health, Ruth focused on Heidi, saying her mental health was "a lot better when Heidi is not around. It's good when she's not here; when Heidi is here, I'm yelling at her all the time."

Other common expressions of poor mental health included pushing people away and wanting to be alone, becoming overwhelmed and (in seven cases, or 35%) suicidal, and feeling unable to care for oneself or for others, particularly one's children. Moreover, mothers described feeling profoundly isolated, as if they had nowhere and no one to turn to. There was a tension between needing help from others but not wanting to ask for help, whether out of fear of being taken advantage of, a desire to protect one's children, or for some other reason.

Cumulative Disadvantage and Mental Health Problems

In addition to attributing mental health problems to relationships including partners, children, and extended family, mothers also commonly cited financial stress and a lack of resources as contributing to their mental health concerns. Sixteen of the mothers (80%) explicitly linked various components of cumulative disadvantage – including

joblessness, homelessness, inadequate education, living in poor neighborhoods, being unable to provide for their children, the stress of being a single mother, and general "money problems" – to their mental health. Most of the mothers grew up in poverty and lived with the consequences of poverty in their own lives. While grappling with these personal consequences, they now faced the reality of raising their children in poverty. The mothers expressed wanting more for their children, and they experienced guilt and emotional turmoil as they discovered the severe limitations of their options. Briana talked about facing disappointment as a single, unemployed mother to two children and pregnant with a third:

> When I was having my girls, I was so excited….but I did not want to be a single parent. Not with three kids. It's hard enough with two. Now, here come another, and I ain't even ready for it…My plan was to be working by now, but now I gotta wait til at least the baby is born….".

Later when Briana yelled at her children, she apologized to the ethnographer, saying:

> I'm not usually like this. I just don't have any patience lately. I really love them. I love them a lot. My nerves is just…I just ain't got no patience. Things'll be better. They got to. I have to get a job. I'm tired of this. This why I ain't got no patience. Between having another baby and no job…

The mothers' stories made apparent that cumulative disadvantage and its impact on mental health affected the mothers' relationships and the roles they played in those relationships. This appeared especially clear in situations of family comorbidity in which mothers had to weigh their own needs against those of their children and other family members. Given the limited resources available for addressing mental health issues, it is

perhaps unsurprising that in many instances the mothers chose not to seek treatment for themselves. I will return to this topic in the third chapter when exploring coping strategies.

This overview of the three broad themes around mothers' perceptions of mental health also demonstrates their interrelation. It is difficult to talk about one without also talking about the others. At this point, it is instructive to trace the three themes – labels, relationships, and cumulative disadvantage – through two case studies that illustrate the themes in unique ways. These two mothers offer two very different examples of how mental health problems are perceived, labeled, and addressed in the context of complicated family and intimate relationships and cumulative disadvantage.

Case Example 1: Lisa

Lisa was a 23-year-old African-American mother whose daughters were 4 and 5 at the date of enrollment in the study (2/2000). Lisa's husband physically and emotionally abused her; midway through the study, Lisa filed for divorce. She grew up in an impoverished family and experienced ongoing abuse by her mother until moving out, first to a homeless shelter and then to her own low-income apartment. Lisa was diagnosed with depression and had taken medication for it, but when she lost Medicaid coverage at the end of the study, she stopped taking the medication. Lisa reported gaining confidence and finding meaning through her job. As a young mother, she struggled to balance the desire to be in relationship with (and have the support of) others, even as she desired to protect herself and her children from being hurt. This ongoing tension played a part in her relationships with her ex-husband, her mother, and other extended family members, and it formed a key feature for Lisa's experience of mental health.

"My mind was so messed up": **The role of cumulative disadvantage.** Lisa grew

up in public housing with her mother, younger sister, and several extended family

members. She believed that she stopped learning in the third grade, which is when her

experience of abuse began. Her mother inflicted most of the abuse, but sometimes one of

her mother's boyfriends gave Lisa a beating. Lisa recalled how the abusive situation at

home made her middle school years particularly difficult, as her mother would sometimes

"give me a beating right in front of school," making Lisa a "target" for other kids. Lisa

remembered being so distracted by her home life that she found it difficult to focus at

school:

> My mind was so messed up. You know, [the teacher would] be talking and I'd just
>
> drift away. That's it. [Ethnographer: Were there other things that you thought
>
> about, like, during school or things that start after?] Umm, probably who's going
>
> to beat me up or whatever. That was on my mind. But you have to remember, I
>
> was sick. You know?

Lisa accrued many absences from school because her mother often wanted her to

stay home. She gave Lisa "guilt trips," accusing her of letting other things (e.g., attending

school) get in the way of her relationship with her mother. Lisa said her mother "used

[my sister and me] as a crutch." By staying home from school, Lisa fell behind in her

classes and exposed herself to more frequent abuse. In addition to regular beatings, Lisa's

mother prostituted Lisa out at age 13 and would sometimes kick her out of the house,

leaving her to live on the streets.

The theme of cumulative disadvantage further emerged as Lisa talked about how

her mom was abused by her own mother. Lisa's mother gave birth to Lisa when she was

just 16 years old, and Lisa said "things did not work out" for her mother. She relied on

public assistance while Lisa was growing up, first on Aid for Families with Dependent

Children (AFDC), and then on Supplemental Security Income (SSI) benefits for Lisa's

"mental depression" when Lisa was around age 13. She recalled attending counseling at

the time, but rather than counseling being an opportunity for Lisa to talk to a trusted

adult, Lisa's mother attended sessions with Lisa, making it impossible for Lisa to express

her real feelings or to reveal the abuse she was enduring. Here she expressed the isolation

she experienced at that time:

> I had one counselor at that time, when my mom was trying to put me on
>
> SSI…And, umm, I had to go through these therapy things, cause then school had
>
> a counselor, so umm I went through that…And she [would say], "You have to
>
> listen to your mother." Because my mom would be there and speak for me. And I
>
> could not bring her stuff out, what she was doing to me…But them counselors,
>
> they never played no important part in my life. [Ethnographer: Did you ever get
>
> the chance to talk about it? Did you ever find anybody you could talk to about it?]
>
> No.

Lisa's mother and other family members moved to Milwaukee when Lisa was 17,

at which time Lisa lived in homeless shelters for about a year while waiting to be

assigned her own public housing unit. At the time she was pregnant and being treated for

depression. She and the father of her child eventually moved in together. When Lisa

became pregnant with her second daughter only a few months after giving birth to her

first, she recalled that she was in a "state of denial," experiencing another episode of

depression due to the unplanned pregnancy.

In the health interview five years later (August, 2000), Lisa described her overall mental health as "okay," saying she had been "happy" in the last year because she was "finally finding" herself and "it's good to know yourself." She said she was learning what made her happy and how to cope with everyday life. However, the ethnographer noticed "dozens of small, thin cuts on her arm…She's self-mutilating." Here we see a paradox between Lisa describing herself as "happy" and "finding herself" on the one hand, while on the other hand dealing with limited resources and strategies to cope with ongoing stressors. One of the greatest stressors she faced at the time (and throughout the course of the study) had to do with her children: she desired to protect them, felt guilty about raising them in poverty, and feared being like her own mother. In August of 2000, she discussed how she desired to be closer to her family of origin but feared it would put her children in danger. She did not want their childhood to be abusive like her childhood experience. Two years later (October, 2002), Lisa remarked that she felt "trapped in public housing" and feared her daughters would live their entire lives in public housing as she had. She said, "when you live in the projects all your life, that's where you gon' live." Lisa spoke in the same interview regarding how she was fighting "so hard" not to be like her mother.

"They were trying to label my baby": **Family comorbidity.** In addition to the guilt related to raising children in poverty, Lisa struggled to deal with her daughter, Julie's, behavioral and physical health problems. In January of 2001, Lisa received a referral to bring Julie to a speech therapist, because the childcare center director suspected she was acting out due to speech incomprehensibility. Although speech therapy helped, in May of 2003 Julie started acting out again following Lisa's separation from her

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husband. Lisa believed "they were trying to label my baby" with a behavioral disorder, to which Lisa was resistant as she feared Julie being singled out and treated differently in the classroom.

Lisa pointed out how on top of Julie's father leaving, her regular teacher was also out on maternity leave so she had five different teachers in the past school year, each with different expectations. Initially the marital break-up "didn't faze" Julie, so Lisa did not understand where her daughter's outbursts were coming from. But she realized that "you can only whoop a child so much" before concluding that "something is really wrong," and eventually Lisa could see how "everything [Julie] was used to was gone."

"Everybody just keep on using me": **Isolation and relationships.** A recurring theme throughout Lisa's story consisted of complicated relationships which both contributed to and were affected by Lisa's mental health. Lisa described in an early interview (May, 2000) feeling like her generous nature caused her to be taken advantage of by neighbors and friends:

> If you stay to yourself, than you don't have no problems as far as people
> borrowing. I have a big heart and they try to misuse that…[I don't] too much
> socialize with too many people no more…It's not good being friends because a
> friendship is a give and take thing and I always found myself being the one to
> give, give, give.

In August, 2001, Lisa talked about feeling as though she had no one to depend on when she was in need and this caused her to feel "depressed and alone." She gave the example of needing money to buy her daughters' school uniforms. When she told her mother about the need, her mother offered to sell drugs to get the money. Lisa said she

did not want her mother's "dirty money." Her husband's response when Lisa felt

depressed was to "have faith," but Lisa believed he provided very little actual support,

especially when it came to caring for the children. The complicated relationship Lisa had

with her mother and other family members was further evidenced in October of 2002,

when Lisa reported that both her mother and her grandmother were ignoring her, telling

her they were "too busy" to call. Lisa told the story of how she lent money to her aunt,

who had a history of drug abuse:

> I can tell you, this was me trying to buy friends again. I was like, "Well, what
>
> you need? I'll send you whatever you need." She like, "I need some money to do
>
> a, b, and c." So I sent her a $50 money order. She was like "Can you send it
>
> Western Union?" I said 'I'll see." I couldn't send it Western Union 'cause I didn't
>
> get my paycheck and I had money just to get a money order. She didn't even say
>
> thank you…That's it. I have to learn not to use my emotions. You know, I have
>
> to learn how to pray about that...You know, from Albert on down, everybody just
>
> keep on using me, because I let them.

Reminiscent of when Lisa was a child, her mother still (in 2002, when Lisa was

26) accused Lisa of being "too busy for me." Lisa explained, "I'm trying not to let

depression sit in on me, and she's like, 'Since you don't have time to talk to me, I'm not

gon' call you anymore.'" Lisa wished she could tell her mother, "'I'm your daughter.

You should know when something wrong. Don't give up on me like that.'" She thought,

"When people are trying to change their life, you should have patience with them." So in

this way, Lisa's relationship with her mother made it difficult for Lisa to move away

from depression. Her ability to address her mental health was closely related to and at times hindered by her interactions with her mom.

As with most of the mothers in the sample, Lisa's partner was another source of significant mental and emotional turmoil. Lisa met her husband, Albert, shortly after breaking up with an abusive boyfriend. She said that early on in the relationship he was "always there for me," but by August of 2000 she described him as being "distant" because he knew "all of my secrets." He became increasingly physically abusive over the course of the study, and in December, 2001, Lisa kicked Albert out of the apartment after he hit her several times in front of the children. When he publicly hit her in the apartment lobby, the on-duty security guard called the police.

In April, 2002, Lisa reported that she was pressured into participating in marital counseling with the assistant pastor at their church. In counseling, she felt like Albert and the assistant pastor/counselor were "ganging up on her" by giving her Bible verses which emphasized women's submission and men's dominance. After describing the physical abuse she endured, the assistant pastor responded, "Well, it's not like he hit you in the face or nothing." In striking similarity to her experience in counseling as an adolescent, this encounter with supposed counseling left Lisa feeling profoundly alone. By October, 2002, she had made the decision to end the marriage, but still struggled to protect herself and her children from Albert's abusive behavior. For instance, she attempted to file a protective order but was told, "That's your husband…and you don't have no marks." Lisa reflected, "So I actually have to get beat up and I feel like that, I really been through it girl." Her conclusion was that "the only thing I can do for protection is pray." Albert also wrought emotional havoc on Lisa through his behaviors with the children. He

showed up to scheduled visits late or not at all, and when he was with the kids, he told them lies or details about Lisa's past that she believed were inappropriate to be shared. Lisa viewed this as his way of asserting control, and she worried at how deeply it hurt the girls.

"Last year, I would have been trying to kill myself": **Sources of strength.** In October, 2002, as the end of her marriage was certain, Lisa felt depressed and suicidal. She said, "Last year, I would have been trying to kill myself or something like that…I'm not at the point no more where I would try to take some pills and stuff like that." Two major sources of support stood out, one of which was her work and the friendships at work which Lisa cultivated. The second was support she received from members of her old church.

As early as February, 2001, Lisa declared feeling "transformed" by work, and noted she had more confidence and did not feel the need to take her anti-depressant when she worked. More than two years later, in April of 2003, Lisa talked about feeling even stronger thanks to her co-workers who provided support to leave Albert. Lisa said they helped to bring her out of her "shell" and to strengthen her self-esteem.

Religion played a more complicated role in Lisa's life, providing a source of empowerment and strength, but also (as seen above) working against her as she endeavored to leave her abusive husband. Throughout Lisa's story, the importance of prayer and reading the Bible was discussed. Also in evidence was the strong support provided by a network of people alongside her. The role of religion will be explored further in Chapter 3.

Case Example 2: Wendy

Wendy, a 25 year-old African-American mother, had a son of five when she entered the study (8/2001). She divorced midway through and moved back in with her parents. Wendy described dealing with depression her whole life, which others in her family had also experienced along with other mood and substance use disorders. She first entered the mental health system at age 17 when she attempted suicide, an act she attributed to her mother being "unaffectionate and overbearing." After being hospitalized, Wendy saw a counselor and psychiatrist for almost three years and she went back into counseling after her son was born, as she dealt with panic attacks in addition to depression. Wendy said she learned various coping techniques in therapy and that her self-esteem improved as a result. Her relationship with her mother began to change towards the end of the study as Wendy was able to shift the ways in which the two of them interacted.

"I can never make mom happy": **Experience of depression in adolescence.** Wendy was unique among the mothers in the sample for the depth of information she shared about her experience of depression as an adolescent. Her insights were helpful windows into the relationship dynamics that other members of the sample hinted at enacting with their mothers as well. For Wendy, her relationship with her mother was a central contributing factor to her depression. She described past bouts of rage wherein she put holes in the wall of her parents' house "to relieve tension." Wendy moved out of her family's house at age 17 to live with Matt (whom she would marry three years later). The two struggled financially and lived in a rat-infested apartment. They were evicted and spent a night at a shelter, and when Wendy's mother found out she forced Wendy to

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return home. Wendy viewed the relationship as controlling and said it made her depressed and suicidal.

I had been dealing with depression my whole life, undiagnosed...I would have bouts of rages.... [My mother] was very emotionally closed off. So she would say things that were emotionally hurtful to me but I was unable to hurt her back. So I jumped on her. And that 's the philosophy, I can't hurt you emotionally so [I] hurt you physically but I need to fight back, you know. And so there was all this dynamics going on between us and the bottom line was I can never make mom happy. And with kids I've learned that no matter what else is going on there's inherent need in children to make their parents happy. To please their parents and they're hard-wired. It's in their genes, it's genetic. I'm convinced. They must make mom and or dad happy. That's part of their, that's their purpose in life. And I could not no matter... She one of those impossible to please people. I simply could not make her happy…I had really worked up in my mind that she really did not want me. She did not want me for whatever reason could not or did not have an abortion... So I was going to make mom happy. I was going to do for her what she could not or would not do 18 years ago…This is what I really believed and I'm thinking this is my last effort to make mom happy cause nothing else works, so this is go to be what it is. And I really thought I was doing her a favor. Do you know after my brother broke down the door and his momentum knocked me over and the pills fell into the toilet and I'm just sitting there emotionally catatonic. She came into the room and said, "Why do you always have to cause trouble?" And he

was there, that was a witness. And if I had had the strength, I think I'd still be in jail for Murder 1. I'd killed her right there on the spot.

Although the relationship between Wendy and her mother was of pivotal importance to Wendy's mental health as she was growing up, Wendy came to believe there was a strong biological component to her depression as well.

[M]any times people that have not dealt with [depression] on a first-hand basis or [with] someone very close to them will have the idea, "Well just cheer up. Snap out of it," you know...Everybody gets depressed and everybody gets blue and everybody gets down but when it crosses a line into being a clinical condition, when you're just not able to pull yourself up out of it…And part of what I learned in the counseling that I had is that it's best to look at depression and other mental illnesses like it as a…physical illness that has emotional symptomatology. Depression is a physical illness in many ways, whether it is brought on by some events in your life or rather it is...from a chemical, biochemical imbalance that was there originally…But it's still a physical illness except the symptoms are manifest in your emotional state, rather than in physical problems. So...I can no more snap myself out of sleeping all day and up all night... And crying spells for no reason and this disembodied sense of guilt.

Wendy's way of speaking about depression was more sophisticated than many of the mothers in the sample, perhaps in large part because she participated in more therapy than most of the other mothers. Her observations provide a sense of the range of the data in terms of how mental health is described and understood.

"I've never really been depression free": **Ongoing mental health issues and**

perceived contributing factors. Wendy's understanding of her own mental health

evolved as she moved into adulthood. In January 2001, at age 26, she began seeing a

counselor at her university while struggling with guilt associated with not staying at

home with her four year old son. She worried that she wasn't "doing my child justice"

and viewed the guilt as contributing to depression and panic attacks.

> I've never really been depression free. It's come and gone and I think the term for
>
> it now is...umm...dimorphic disorder? No, that's not it. Dysthymic disorder. I've
>
> been in counseling at Chicago State since January, when I was dealing with
>
> anxiety attacks and pressure from school and financial problems at home. So I
>
> started seeing a counselor over there. I told her I was dealing with this depression
>
> and these issues and I described to her the way it felt. And that's when she first
>
> gave me that term, dysthymic disorder. Then I looked up the little DSM-IV
>
> handbook that I had to buy for my Abnormal Psych class I had last semester. And
>
> I looked it up and that was the description that it gave. And I said, "Wow, that
>
> sounds exactly right."

Again, even as Wendy acknowledged the potential role of biology, she also

interpreted her depression and anxiety as stemming in part from circumstance. At this

time her circumstances included guilt related to not being a stay-at-home mom, school

pressure, and chronic financial problems. In October, 2001, the weight of financial stress

once more became apparent. Wendy spoke of the "catch-22" of receiving public

assistance. Wendy was the only person in her family to have applied for public

assistance, which she initiated when she became pregnant. As a full-time student as well

as a mother, the welfare office informed her that by quitting school to get a full-time job, her son would be eligible for an early education program. To Wendy, she was being asked to choose between her son's education and her own. Even if she obtained full-time work, she risked losing her medical assistance. In her view,

the purpose of the welfare reform was not to eliminate poverty but to get people off of welfare. Any job is better than no job. The minimum wage is $5.15/hour. That is $9888/year but the poverty line for a family of 3 is $13000, which is not enough to live. You could work 56 hours a week and still not make enough to make ends meet. Maybe I should kick my husband out, leave my job and have about four more babies with different guys. I am being penalized because I married my child's father before I got pregnant. I realized that I should never have told them I was married.

In a later interview (March, 2002), Wendy hypothesized that financial problems were actually hiding the "interpersonal problems between me and Matt," which eventually ended the marriage. She explained,

The financial problems were never going to end the marriage because no one blamed the other. We saw the way the world worked and it just wasn't fair…There were systematic procedures and systemic institutions in place to basically create that economic glass ceiling.

Wendy's husband also struggled with mental health issues that Wendy linked to abuse he suffered as a child. Wendy and Matt met when Wendy was a teenager and her self-esteem was "very low" because she felt "unloved" by her mother. Matt's family was "extremely dysfunctional." Once when he was four, his father threw him into a wall. In

another incident, Matt's brothers babysat him by tying him to a chair and leaving him in a closet for eight hours. He was now claustrophobic and severely obese. Wendy reported that once he "got married, knocked me up, and had a family, he wasn't going to work no more." She believed overall he "has a lot of unresolved issues regarding his childhood," and these issues placed a high strain on their relationship.

"Two-steps back": **Regulating relationships and establishing identity.** By March of 2002, Wendy had left the marriage and moved back in with her parents. She said there were "a hundred little things wrong with him and a hundred little things that had changed about me." Ultimately, she decided the marriage was not good enough to keep her there and her self-esteem had improved to the point where she believed she could be happier without him. She spoke of taking back "some of the power I didn't know I'd given up." Part of taking back her power included becoming involved with another man. While still married to Matt, Wendy engaged in an affair with a married man.

After moving back into her parents' home, Wendy described being in the "two-steps back stage" of life and trying to move forward. She found that the changes she had made in herself had affected the ways in which her parents dealt with her. When she first moved back into the house, her parents were "still reading from the old book on how to interact with me," and she told her mother she was not the same person she used to be. She declared that she was "someone they've never met before." Although Wendy described "reverting back to old behaviors" at times, she also spoke of having more "close" conversations with her mother at that time compared to when she was a teenager. She attributed this development to learning how to care less about whether her mother

"passes judgment," having recognized that she (Wendy) had reached the point where she was also an adult. As I will explore further in Chapter 3, therapy played a significant role in Wendy's journey to change the dynamics of her relationship with her mother.

Conclusion

In this chapter, I have presented how low-income mothers talk about, experience, and construct meaning around their mental health. The construction of meaning is closely linked with relationships – particularly with partners, extended kin, and children. It is also intertwined with the mothers' experience of poverty and disadvantage over time. This chapter presented a window into these important themes. Focusing on two women's stories provided an opportunity to understand the depth and complexity of how mental health is experienced and understood by low-income mothers. Lisa's and Wendy's stories were each unique and demonstrated important differences related to family and economic background, as well as to mental health treatment. Lisa had a much more pronounced history of cumulative disadvantage than Wendy, which affected the amount of family support the mothers received. Another difference was that Wendy obtained substantial mental health treatment, whereas Lisa's experience of counseling was extremely limited and largely negative. Although Wendy considered her mother to be controlling and the cause of her depression when Wendy was an adolescent, she believed the skills she learned in therapy helped transform her relationship with her mother so she could relate to her more as an adult. Lisa, on the other hand, relied primarily on the support of friends and church members, work, and her faith to cope with her depression. Her mother's ongoing involvement with drugs and overall erratic behavior made it difficult for Lisa to rely on and substantially invest in that relationship.

Moving forward, I broaden the scope of the study to draw on the rich variation of experiences found across the sample. In the next chapter, I expand on the theme of relationships and the related concept of family comorbidity to better understand how mental health plays out in the context of complex family systems. The third chapter focuses on how mothers cope with and address their mental health problems.

Results: Chapter 2: The Role of Family and Partner Relationships in Shaping Mothers' Mental Health and Responses to Mental Health

In the previous chapter, I examined how mothers perceive and construct meaning around their mental health. One prominent finding was that mothers often attributed their mental health problems to and experienced them within complex and stressful relationships. The finding was illustrated in two case studies. In this chapter, I report in greater depth on the role that family and partner relationships played in shaping mothers' mental health and responses to mental health. In particular, I draw on data from across the sample to explore how mothers' mental health was shaped by processes that occurred in their relationships with their children, families of origin, and current and former spouses or boyfriends.

This chapter attends to four processes that occurred within families and that were meaningful for mothers' mental health. To start with, mothers spoke of experiencing guilt associated with motherhood and especially balancing the demands of motherhood in the context of poverty, which I call the *"bad mom" phenomenon*. Another important process was that of mothers desiring to *protect and advocate* for their children and other family members. Mothers often undertook such protecting and advocacy behaviors to the detriment of their own well-being. At other times they were unable to protect their loved ones, which created emotional dissonance and turmoil. Closely related was the process of *family comorbidity management*, as mothers negotiated their own health issues while dealing with family members' health problems. Lastly was the process of *distance regulation with parents and partners.* Mothers invested significant effort regulating distance within complex, unstable, and unreliable relationships, yet they also relied heavily on these relationships for emotional and/or financial support.

The "Bad Mom" Phenomenon

The most pronounced theme that emerged in the realm of family and relationships was feeling guilty about being a "bad mom." Fifteen of the twenty mothers (75%) reported experiencing guilt about taking out their frustrations and anger on their kids, passing "issues" onto their kids, past mistakes, raising their children in poverty, or simply "not doing a good job." These mothers commonly expressed feeling overwhelmed at the reaLisation that their options were extremely limited, sometimes leading them to turn to drugs, alcohol, or even considering suicide to escape their difficult circumstances. As I will describe later in the chapter, other responses to feeling guilty and overwhelmed included increased protective and caring behaviors, relying on children for assistance, harsh or neglectful parenting, and looking to unsafe or unreliable relationships for assistance.

"Taking out" feelings on children and not having enough time. Elana, a 30-year-old Latino mother of two sons (aged 6 and newborn) and two daughters (aged 3 and 1), classified herself as a "bad mother" because she "went through a depression" when her husband left her for a period of time and she said she took out her anger and frustration on her oldest child. Also contributing to her view of herself as a "bad mother" was an incident in which her husband physically abused the oldest child. Elana was held responsible for the abuse because she had custody when the incident occurred. Moreover, Elana said her job kept her from "cooking, feeding, and spending time with her family," which further left her feeling inadequate as a mother. She had to work because her husband's job paid too little to support the family, and it caused her guilt that she was unable to be present with her children more often than she was. Elana's predicament

reflected one that many of the mothers experienced: they worked very hard to provide for their families and they felt like bad mothers in the process of doing so. The struggle to provide, especially when partners were unable or (in other cases) unwilling to contribute significantly, often led to problems within relationships and created additional stress that made parenting all the more difficult, leading to even more feelings of being a "bad mom."

Fear of passing problems onto children. The sense of being a "bad mom" was closely connected to the themes of cumulative disadvantage and family comorbidity. An example is Brenda, a single, 25-year-old African-American mother to an infant daughter and two sons (aged 4 and 9), one with autism and the other with a developmental delay. Brenda remarked that she could see in her sons what she "didn't do right" and she was trying to "hurry to work on myself so I can get it right." Brenda expressed concern that she could not "work on" her children when she was so "messed up" herself. She compared herself to her own mother, who she said "was finished raising me when I was old enough to stay home alone." Brenda wanted to be a more active parent and better example so her children would avoid making the same "mistakes" she made, such as getting pregnant at the age of 15. Brenda attributed many of her "mistakes" to the neglect and poverty she experienced as a child. She was keenly aware that she was caught in poverty just as her mother was. Brenda did not want to allow her emotional problems to keep her from being a better mother to her young children, who clearly needed her.

Victoria, 35, expressed similar fears and guilt about passing along her emotional problems to her five children (aged 3-16). Victoria moved with her husband and four younger children to the U.S. from Mexico when one of her sons was extremely ill. The

doctors in Mexico could not figure out why and the family had exhausted all their resources. Victoria said her son's health problems caused her a great deal of emotional and financial stress. She was so worried about her son's health that she "neglected taking care" of her husband and the other children, which caused her to feel guilty.

At the same time as her son was ill, Victoria's mother was also sick and hospitalized. Victoria was unable to help her siblings care for their mother as much as she would have liked, which further added to the feelings of guilt. Victoria described her mental state as worried, tense, and depressed. She believed her children suffered the most from her high level of stress because she would yell at them as she had "no patience." Victoria also feared transmitting her "insecurities" to her children and described how she wanted to encourage them to try new things more than she did. Another source of guilt was that her oldest son still lived in Mexico and Victoria was unable to help him financially. In both instances – as Victoria encouraged her children to try new things and build their confidence, and desired to better support her children financially – the underlying theme was that of a mother who wanted to be able to provide her children with more options than she had.

Guilt about raising children in poverty. Many other mothers experienced the same sense of shame, blame, and guilt. Another Latino mother, Sofia, age 36 with two children (and a third born midway through the study), talked about how she felt guilty that her children had to "endure economic hardship along with me." She regretted being unable to meet their most basic needs because of extreme poverty. At one point she left one of her children with her mother in Mexico in order to avoid paying for child care, but she "missed him too much" and brought him home. She felt that even though they would

be poor, it was better for them to be together. Yet she still suffered emotionally from raising her children in difficult circumstances.

Not surprisingly, mothers commonly reported their feelings of guilt and shame were mixed with being intensely overwhelmed. Ashley, a 27-year-old African-American mother who was introduced in Chapter 1, spoke about how this combination of guilt and being overwhelmed made it difficult for her to do anything more than she was doing. In other words, it left her feeling stuck. Ashley had four children (aged 3 to 7). When asked to describe her mental health and the causes of stress in her life, Ashley responded:

> It sucks. Sometimes I feel A-Okay. Sometimes I feel sad. Sometimes I feel just tired. Sometimes I just feel that I'm not doing a good job as a mother and a provider. Sometimes it's just so overwhelming. But I get over it….Kids get on my nerves because they being hot headed and I don't know why and I want to crack them upside the head. Man is being hard-headed. I don't know why and I want to crack him up alongside his head. I'm telling ya, y'all can kiss my butt and I'm gonna leave. I keep threatening, I keep saying I'm gonna run away. Mom don't go. I'm leaving ya.

Ashley referred to multiple stressors in this quote: the feeling of "not doing a good job" as provider or mother, being overwhelmed, her kids getting on her nerves, and her "man" (fiancé) being "hard-headed." She then spoke of threatening to "run away," though it is unclear whether this threat was ever made in seriousness. Whether or not she would have actually left her family, the intensity of her feelings was apparent.

In some cases, the sense of being overwhelmed was so great that it caused mothers to consider suicide. An example is Frida, a 26-year-old African-American

mother of a four-year-old girl. Frida's husband suffered from a slipped disk that eventually caused him to lose his job, which exacerbated the family's already precarious economic situation. Frida talked about how she was extremely overwhelmed by her responsibilities and she felt inadequate to meet them:

I was feeling it, I was feeling the anger, the hostility, I didn't wElana come home to my family, I didn't want to be a mother anymore, I didn't want to be a wife, I didn't want to be bothered with anybody, I got to a very depressed place and I used to cry, and I was like, this is not me, I used to be a happy, fun-loving person getting along with everybody, you know….It's been many a time I was like, maybe I should take these pills and my family can collect insurance and they can pay off these bills or whatever, maybe they're better without me, you know, it's been a lot of that going on.

Guilt about past mistakes. Another common pattern in this sample of low-income Chicago families was that mothers felt guilty for mistakes they made in the past and the impact mothers perceived those mistakes had on their children's behavior. Pam, for instance, a 42-year-old African-American grandmother, was helping to raise her son's child because her son was incarcerated for murder. At the age of 13, Pam was having sex with a man whose child she babysat and she became pregnant. When her son was between the ages of 3 and 7, she was involved in prostitution and selling drugs to make ends meet. In helping to care not only for her grandson but also for her niece's child, Pam was "trying to make up for mistakes" she believed she made with her own child.

Tammy, a 38-year-old mother, experienced guilt for reasons very similar to Pam's, also related to how things had turned out for one of her children. A single mother

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to eight boys, Tammy's oldest son was in jail for drug dealing. Tammy said he started selling drugs when she lost her job and was no longer able to give him money for babysitting the younger children. She felt responsible because she "could not buy him shoes and other things his friends had," and she believed that was why he turned to selling drugs. In an interview that took place roughly a year later, Tammy mentioned that she preferred to "work a day job any day than work nights with boys," because she had learned that when she was working nights, her oldest son was out "running with gang members." Tammy felt stuck, however, because in order to receive public assistance she was told she had to work:

> And then you aid is put you under pressure now- if you don't work you don't get nothing. See don't have no choice but to work. Your kids at home raisin' themselves. That's why society is so fucked up.

Tammy seemed to have been in a bind common to many of the mothers. When she was working, her son was spending time with gang members. When she lost her job, according to Tammy's understanding of how events unfolded, he started selling drugs because he needed money. Tammy felt guilty and responsible for both situations, and she wanted to do a better job with her younger children.

Tammy faced additional and significant stressors at the time she was dealing with the incarceration of her oldest son, including the death of her mother and significant illness of another son (to be discussed further in the section on Family Comorbidity, below). She struggled with drug and alcohol addictions that brought the Department of Child and Family Services (DCFS) into her family's life and caused her to fear that her children might be taken away from her. Tammy's children "hardly went to school" one

year because Tammy's job required her to leave the house early in the morning before her children left for school, therefore they would often simply stay home and watch television. The same year, three of her children were hit by cars and sustained minor injuries, which led DCFS back into Tammy's life. Tammy chose to quit her job because she worried a social worker would come to her house while she was working and discover her children were unsupervised. She explained, "I left my job to be a mother. I left my job to be a mother. A full-time mother." Quitting her job meant her children would go to school more regularly, but it came at the cost of lost income. Tammy described going through a period of depression after leaving her job:

> I was frightenin' myself, my inner side was fighting the outer side because the other body didn't want to quit working cause it was used to working and providing different. But my inner side was telling me, money ain't everything. Your kids need you right now…I don't want to quit working. I ain't gonna have no money. I ain't gonna have no cigarettes.

Tammy described an inner battle that many low-income mothers fought. She wanted to prioritize being at home for her children and she faced pressure from DCFS to do so, but that meant sacrificing her job and some of the independence she enjoyed. It meant her options might be even more limited, which could be expected to have further deleterious consequences for her mental health.

Advocacy and Protection

The mothers' accounts suggested that they undertook advocacy and protective behaviors on behalf of their children and other family members, in spite of or perhaps in response to feeling like they were "bad mothers." Mothers often undertook such

behaviors to the detriment of their own well-being. In this section, I highlight these behaviors and, where appropriate, the barriers that kept mothers from being able to carry them out. I show how the experience of wanting to protect and care for their families but being unable to do so created internal dissonance for mothers, serving to exacerbate or even trigger mental health problems.

Advocacy in schools. Given the large number of mothers who had children with physical and/or mental health problems, it was quite common that they worked to ensure their children received appropriate services, particularly in the school system. I introduced Brenda above and mention her again now because of her efforts to make certain her sons – one with autism and the other with a developmental delay – were properly treated. Her older, autistic son was placed in special education and Brenda had to go through "hell and high water" to have him labeled as what he really was. She did not want her younger son to "have a record attached to him," so she chose to avoid special education for him and instead sought out resources to hire a tutor. There behaviors are notable when considered in light of Brenda's concern that she might be too "messed up" to "get it right" with her own children.

There were many other examples of mothers advocating for their children in the schools. Ana Maria, a 32-year-old Latino mother to three children (aged 2 to 13), found she had to be proactive to ensure her bilingual children received fair and equal treatment. Ana Maria explained, "The teachers in our area have no idea how to treat or teach children that are bilingual. I had to pull [one of my children] from one school and re-enroll him in another." Victoria, who (as I detailed above) moved with her family from Mexico to the U.S. when one of her children was very ill, frequently interacted with her

children's teachers and principal with the help of a bilingual coordinator. For instance, when she learned one of her son's teachers was "gruff" and called the students "dummies," she spoke to the principal and had her son switched to another classroom. Carla, a 30-year-old Latino mother of three (aged 4 to 8), was working as a teacher's aide at her children's school. When funding for aides was cut, she continued volunteering because she believed it helped her children.

Emphasizing education. In addition to advocating for their children at school, almost all of the mothers advocated for and emphasized the importance of education for their children. Tammy, introduced earlier in the chapter, said:

> I always tell my boys the longer you stay in school the better job you will get and the better your life will be…I don't really expect them to go to college, least get me a high school diploma and then you can get a job…They gotta take care of me. They gotta learn. They got to give me the money back. You can't take care of me if you can't read and write.

Ashley, another mother presented above, echoed the importance of education and said she would kick her children out of the house if they dropped out of school. As long as they were in school, she planned to allow them to live at home. Mariana, a 16-year-old mother with two children under the age of two, also spoke about her desire for her children to be better off than she was, but her greater desire was for her children to be happy. She said of her daughter:

> I hope that whatever it is that she is doing when she is twenty, she is being safe, she is being responsible as she is doing it, she is enjoying it and it is something she wants to do. I just hope she is not just out there wasting her life and just

bumming around…As long as she ain't gang banging, drug dealing or locked up, she is fine.

María's primary fear was that her daughter would end up pregnant at the age of 15 like Mariana had done, but Mariana said if that happened she would support her daughter.

Providing financially and sacrificing for children. Another common type of protective behavior mothers practiced or desired to practice was to provide financially for their families and especially their children. What was surprising given the often extreme poverty in which these families lived was that several of the mothers mentioned having savings set aside for their children. Mariana, for instance, had a savings account and a life insurance policy. Elana reported having an interest bearing savings account as well as some bonds "for the children." Ana Maria started a college fund for all three of her children.

More common than being able to set money set aside was mothers' willingness to sacrifice their own well-being to ensure other family members' needs were met. Gloria was one example. A 41-year-old Latino mother to four children (aged 4 to 12), Gloria would often run out of food before she had money to buy more, at which times she would skip meals or eat less so there would be enough food for the children. She made sure her children never had to skip meals or eat less due to a lack of food.

Similar stories of sacrifice were heard as mothers spoke about what they gave up for their partners. For instance, Victoria reported that she woke up in the middle of the night to prepare her husband's breakfast and pack his lunch. On the other hand, she "did not really do anything" to keep herself healthy other than take vitamins. She said the only rest she ever received was at night, but this rest she sacrificed to make her husband's

meals. Several mothers offered similar accounts of sacrificing for the sake of their partners, often with the implicit underlying expectation that this was what women did for their partners.

Feeling powerless to protect families. Throughout the mothers' stories, in addition to accounts of sacrifice, advocacy, and protection, there were also descriptions of mothers feeling powerless to protect their families or to improve their circumstances. A case in point was when Ana Maria's husband left her when she was six months pregnant with her first child. She became homeless and begged her husband for financial assistance but he refused. Ana Maria applied for public housing but was wait-listed, so she would wait with her newborn at McDonalds until all the customers left. Then she would pull out a blanket and pillow and go to sleep on the floor. Ana Maria did not want to go to a shelter because she believed they were too dangerous, and could not go home because her stepfather was an abusive alcoholic from whom she wanted to protect her child.

The notion of needing to protect one's children from other family members such as grandparents appeared several times in the data. Mothers also mentioned avoiding or ending romantic relationships because of their children. Susan, a 50-year-old Caucasian woman who adopted four severely abused children (aged 4 to 20), said a man had been "sweet to her" but she would not consider getting into a relationship because her children's safety was her first priority. Susan felt that "dating would not be fair to them." Another example came from Sofia, who said she almost married a man but decided not to because one of her daughters strongly objected to the marriage. Although Sofia wanted to

remarry someday, she said she was committed to taking her children's feelings into account.

I have shared previously how the mothers were not always able to shield their children from harm, and this was also true when it came to protecting children from mothers' partner relationships. Ruth, a 43-year-old mother of four kids (aged 4 to 17), all from different fathers and all with significant mental and physical health problems, had a live-in boyfriend who she learned was sexually molesting her two youngest children. All the men Ruth had been with before him had physically abused her, and Ruth herself had been investigated by DCFS more than once for child abuse. She described the anguish of wanting the best for her children but realizing she had contributed to their suffering, in part through her decision to be in unsafe relationships:

> It was my fault maybe, I especially am sorry for ruining my kids' life and my low self-esteem I did have, what I tried to do was since Heidi [oldest child] didn't have a father, and Carly [second-born] didn't have a father, I tried to make sure that there was a man in my life that loved me and respected me and loved my kids. When my kids need a father figure, I try to find one. Every time I did, it was an abusive one or an alcoholic one. I'm sorry for putting Carly through hell, like I went through hell.

I will return to Ruth's story later. For now, suffice it to say that the experience of wanting to keep their children safe but being unable to do so could be expected to create internal dissonance in the lives of the mothers, serving to exacerbate or even trigger mental health problems.

Harsh and neglectful parenting. In addition to efforts at advocacy and

protection, the data also demonstrated that a few mothers displayed harsh and/or

neglectful parenting behaviors. A young African-American mother named Kara (age 21)

who had two young sons was often "rough" with her older son. The ethnographer

reported Kara "would sometimes smack his butt or yank his arm" and generally gave the

impression she "lack[ed] some maturity as a mother." At the same time, Kara advocated

for her son if she thought he was not getting what he needed from teachers or other

caregivers. Kara would not hesitate to confront people about the way they treated her son,

telling them, "Don't talk to my child in any kind of way." This combination of struggling

on behalf of one's children and struggling with or against one's children was a common

occurrence in the mothers' stories.

Briana, a highly stressed 25-year-old single mother I referred to in the first

chapter, had three children under the age of 6. The ethnographer often observed Briana

spanking her children, for instance when they would go someplace without her knowing

where they were. Once the ethnographer arrived for an interview and found the two

youngest children, a toddler and a newborn, had been left alone for an unspecified

amount of time. A year later, just before Briana went to jail for a drug-related offense, the

ethnographer learned from another study participant that Briana had left her children

home alone for several days. Eventually the oldest daughter went downstairs and told the

apartment complex security guard that she was hungry, at which time Briana's mother

picked up the children.

Ruth also exhibited harsh parenting throughout the study and with all of her children. She shared the following story of losing her temper with her second-oldest daughter:

> They had to solder this back together again. I got real mad at Carly, I went way out of control, I banged my knuckle on a glass table, and I busted my knuckle. I got mad, I just got fed up with Carly, she wasn't listening, just "boom, boom, boom," I didn't feel nothing. But my kids said go to the hospital. They told me, take the ring off, get it cut, or lose my finger, to get my knuckle into place. Back to the jewelers, they didn't charge me nothing.

Ruth spoke of her struggle to "control" her 8-year-old son Tim, who was diagnosed with ADHD and oppositional defiant disorder (ODD). He often did not want to take his medication, which sometimes led him to do things like run into the street into oncoming traffic. Ruth recalled a recent instance of her power struggle with Tim:

> One day he got me so pissed, Monte [current boyfriend] told me to calm down. I held Tim down, sat him in the chair, and held his nose [closed, so he couldn't breathe through it]. I made sure he took it, held his nose until I was sure it went down. He likes to play games. I cracked him in the head, and Monte told me I shouldn't have done that. I think it was Monday. I got really mad because he refused to take it, because he wasn't getting his way he decided he wasn't going to take it. And I cracked him in the head, yes, I do hit him…I have to, I have to show them who the boss is, I'm not playing games.

Although Ruth's story may be an extreme example, I will return to it in the section below on Family Comorbidity because it illustrates the volatile ways in which

mothers' mental health problems, children's mental health problems, and cumulative disadvantage often interact. Mothers with inadequate resources who experienced histories of violence and/or other hardships may have exercised harsh or otherwise negative parenting strategies for a variety of reasons. Reasons included asserting power when they felt they had none, attempting to protect their children from immediate harm, and apparent lack of knowledge about other parenting strategies. From the literature review, another reason may have had to do with allostatic load. Mothers like Ruth likely experienced excessive cumulative wear and tear on the body as a result of "repeated, excessive activations and inefficient down-regulation of the stress response systems" (Wadsworth, 2012, p. 19). As I wrote above, allostatic load may lead to physical and mental health problems over time, and it has been associated with a reduced ability to learn and/or implement new material (McEwen, 1998), which would help to explain why Ruth might have a difficult time "learning what she's supposed to be learning" in therapy (as I will discuss in the next chapter).

Family Comorbidity Management

The majority of the mothers (65%) cited family health issues as a source of significant stress. In this section, I highlight ways in which mothers negotiate their own mental health issues as they deal with their other family members' physical and mental health problems.

Negotiating multiple child health problems. Tammy, introduced previously, was mother to eight boys (the oldest of whom was incarcerated) with multiple physical and mental health conditions. All the children had asthma and one son had Rheumatic fever which for a time required daily appointments with doctors and physical therapists.

Tammy reported being "physically and emotionally wiped out" by her son's illness and she relapsed into drug addiction when her son's sickness worsened. Three of her other children had "anger management" problems and were on medication for ADHD. Tammy referred to one of them as "the most evilest kid" and enrolled him, and eventually the other two, in counseling. At the same time, Tammy felt responsible for their behavioral difficulties because she worked two jobs while she was pregnant with them and believed they did not get enough sleep in the womb. One of Tammy's friends told her,

> I see why you get drunk when you get home. I don't know how you can work
>
> and have seven boys [living at home with you]. I watched two of your kids for
>
> just one day and they drove me crazy, they hyper.

In Tammy's case, her children's physical and mental/behavioral health problems placed a great deal of pressure on her and contributed to her own mental and behavioral health issues. She sometimes blamed the children (for being "hyper" or one of them for being "evil") and sometimes blamed herself (for working and "causing" the behavior problems in the first place).

Ruth likewise experienced the strain of family comorbidity. Ruth herself was diagnosed with depression and panic disorder. She also had hearing and vision problems, back problems, asthma, uterine fibroids, thyroid problems, and dental problems. Ruth's oldest daughter (Heidi, 17 years as of time of enrollment in the study) had a history of suicide attempts, ADHD, and health problems linked to her reproductive organs, possibly due to an untreated sexually transmitted disease. Her 13-year-old daughter, Carly, who had been in foster care since the age of 9, was diagnosed with bipolar disorder. Ruth's 6-year-old son, Tim, had a hearing impairment, ADHD, and ODD, and her 4-year-old

daughter, Sandy, had a host of physical health problems including anemia, asthma, vision problems, and vaginal problems linked to sexual abuse trauma.

Not surprisingly, Ruth spent a considerable amount of time attempting to manage her own and her children's health conditions. It was common for Ruth to have to reschedule one child's psychiatric evaluation, for instance, to deal with another child's optometrist appointment. Ruth had to make decisions about what counselor to see based on whether the office was "kid-friendly" and whether she could schedule everyone's appointments for the same day. The constant pressure of having to track and cope with her children's health problems could be expected to weigh heavily on Ruth, leading to greater mental health problems of her own on the one hand, while diminishing the time she had to deal with her own problems on the other hand.

As was already suggested above, Ruth's perception of how her children were doing was wrapped up in whether or not she was able to "control" them. She said, "Heidi's out of control, there's nothing we can do about her. I don't know about Sandy [the youngest] yet, I don't think she is." Ruth decided she wanted to have her son Tim hospitalized because she wanted to "get his behavior under control." She continued,

> [Tim's] not listening to nobody…He's at a stage where he mocks you, where he wants to swing, just wants to do what he wants to do. [His counselor and I] want to talk to find out why he is the way he is, he's got a lot of anger in him…He don't care what we say. He's like Heidi.

Ruth at times blamed the children for their behavior and at other times blamed the men she was seeing, who would "fight constantly" with the children. She periodically reported having "nervous breakdowns" or "anxiety attacks" and sometimes the

paramedics would be called. They once cautioned her to "quit acting and scaring the children," but she responded, "I can't stop this…"

It bears repeating that Ruth's case was extreme and complicated. Nevertheless, it demonstrated how family comorbidity and cumulative disadvantage often placed extraordinary pressure on low-income mothers, and perhaps in particular on single mothers. Mothers such as Ruth struggled not only to provide for their families, but also to manage the complex illnesses of multiple family members – in some cases, while also dealing with the courts and child protective systems. The overall lack of financial resources and social supports available to these mothers left them with extremely limited options. Mothers' sometimes less than ideal responses to the pressures they experienced – whether ambivalence about being home with their children, threats to leave, or tendencies to blame others for their problems – could be viewed as understandable.

Negotiating system of care. In notable contrast to Ruth was Susan, a 50-year-old adoptive mother of four. Susan also suffered from depression in addition to several physical health conditions including obesity, hypothyroidism, hypertension, kidney stones, dental problems, and vision problems. Her children came from abusive homes and suffered from multiple physical and mental health problems as a result, including ADHD, fetal alcohol syndrome, and anxiety. When Susan adopted her first child, Cayla, for the first few years she was in and out of the home which made things "very unstable." Susan described this time as "the most neurotic, awful, terrible period of my life. It was awful." At that time, Susan and Cayla started seeing a therapist, which Susan described as a very positive experience. Susan had this therapist built into the adoption settlement to work with the other three children as well. She said that the therapist provided "continuity

within the context of our family" and helped Susan with personal issues, parenting problems, and various issues with the children. Nevertheless, she noted that when things were bad, it was difficult for her to pay attention to her children's individual needs. She felt the best she could do was what was best for the "group as a whole." She said,

It becomes less and less critical what you Sally Jones, or you Alexa, or Garth, or you Justin need because I may only be able to do this, which is in the best interest of the whole family. And I'm sure that's the case for many families, but it became a constant thing, and I don't think anybody was getting their needs met.

Susan faced a number of challenges caring for her children. One was obtaining proper school experiences for Garth, who was six years old when the family entered the study and who suffered from ADHD, fetal alcohol syndrome, and anxiety, and was a year behind in school. Susan fought and succeeded in having him placed in special education. Another challenge was managing her three younger children's diets; while Susan had to feed the two boys a lot of food to keep up with the fast metabolisms they had as a result of ADHD medications, her daughter Alexa (age 5) was overweight and had anxiety about food access due to her experience of being denied food as a very young child. Alexa would confuse healthy restriction with Susan withholding food from her. Yet another challenge Susan mentioned was accessing psychiatric care for her children. Although a family therapist was woven into their adoption agreement, the children had to remain on a waitlist for a year before they were able to see a psychiatrist.

Susan noted that the stress and depression she experienced caused her to became "unilaterally labile, and to be provocative and angry, or angry and reactive. And that has been a huge problem for me, you know, from a professional perspective." Susan received

significant financial support from her parents, who would also occasionally keep the children to give Susan a break. This sort of instrumental assistance was extremely important to Susan.

Family comorbidity and financial strain. Susan was unique in that she was financially better off than other mothers in the study, in large part because she had regular employment and the support of her parents. Virtually every other mother in the sample lacked adequate financial resources. Brenda's financial situation was more representative of the rest of the sample. Brenda's oldest child was autistic and asthmatic and her middle child had a speech impediment and developmental delay. Her youngest child had to repeat kindergarten. Brenda was only comfortable allowing family members to watch her children. She often had to miss work when her children were ill and nobody was available to care for them, which caused her to lose several jobs. The job loss further exacerbated the difficult financial situation of the family.

Nicole, a 27-year-old African-American mom to four children (aged 3 to 9), also struggled financially and the situation was made more difficult by one of her children's health issues. Nicole described her first three kids as "perfect," while she described her youngest, Wesley, as "bad." It is unclear whether the "bad" label or Wesley's behavior was related to his physical health, but he also had problems with bronchitis that developed into asthma. Nicole had to pay $75 out-of-pocket for treatment and she said she had been unable to do laundry after that because she did not have any more money.

An even more extreme case of financial and emotional distress that was exacerbated by a child's illness was found in Victoria's story. Victoria moved her family to the U.S. to treat her son's illness. She explained:

Last year was a very difficult year for me...My son's illness led us to take the

decision to immigrate to the U.S. because the resources that we had in Mexico

vanished. We no longer had access to health care, we spent our small savings

consulting doctors, on medications, and in treatment.

As I mentioned above, witnessing her son's long illness caused immense psychological

distress for Victoria and affected her overall mental health. She felt tense, anxious, and

reported "panicking" whenever any of children exhibited even minor symptoms of

illness. At the same time, being constantly preoccupied with her son's illness made it

difficult for Victoria to focus on the rest of her family's needs, which contributed to

feelings of guilt and inadequacy.

Taking care of extended family members. Family comorbidity came up not just

in mothers' relationships with their children, but also in their relationships with extended

kin. Sharon, a 34-year-old African-American mother to five children (aged 2 to 15), had a

number of health problems individually and within her family. She suffered from

diabetes, vision problems, asthma, alcoholism, and depression. Her diabetes was so

severe that it caused her to quit the GED program in which she was enrolled. Sharon's

father also had diabetes and was morbidly obese, making it difficult for him to "get

around." Sharon would check on him every day, which took considerable time and was

an emotional drain.

There were several accounts of mothers linking the physical impairment of

extended family members to their own mental health. One mother, Elana, connected the

stress in her life directly to her mother's health. Though Elana wanted to return to work

after her child was born and she was even offered three different jobs, she also desired to

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take care of her mother who had been diagnosed with Lou Gehrig's disease (ALS), and so she turned down the job offers.

The mothers shared many instances of comorbid mental health problems in their extended families, particularly substance use disorders such as alcoholism, which they believed played an important role in shaping their own mental health in later-life. Because in most of these cases there was also some level of abuse and/or neglect, mothers described these relationships as being complex and they felt the need to regulate emotional and physical distance with these family members. Therefore I have included them in the next section.

Distance Regulation with Parents and Partners

For several mothers in the sample, extended kin networks acted as drains and as forces of substantial stress. For instance, Elana considered her husband Juan's family members to have a negative effect on her mental wellbeing. Juan's brother told him he should abandon Elana a few years before and continued to push this idea as years went by. In response, Elana would never permit the brother inside of her house. Another mother, Victoria, expressed very clearly a sentiment that others shared but did not necessarily articulate when she said that living with family was "the saddest and most troublesome thing one can do." Having lived with her sister and cousin at various times, she said those relationships were marked by conflict.

In spite of conflict, complex histories, and unreliability of relationships with family members, mothers reported turning to those relationships for assistance because they had few other places to turn. Two relationships mothers spoke of the most were with their own mothers and with intimate partners.

Relationships with mothers. Roughly half of the mothers spoke about having complex relationships with their moms that involved painful conflict, whether spoken or unspoken. Briana, one of the young single mothers I wrote about previously, told of how the help she received from her mother had receded over an eight-month period and Briana was eventually expected to repay her mother for any child care support her mother provided. Tensions increased when Briana's mother reported Briana to DCFS because her house was "filthy," but Briana knew they were coming and cleaned her home so the charges were determined to be unfounded. Even after this event, Briana reported going to her mother for money to cover unpaid bills. Her mother would also buy food for Briana in exchange for food stamps.

Brenda said she felt tightly bound as to what she communicated to her mother. She believed help with the children might not be forthcoming if her mother perceived a critical word coming from Brenda. In a very real way, conflict altered what resources were available to the mothers.

The conflict between Ana Maria and her mother was more overt. Ana Maria's mother moved out of their house after being severely assaulted by Ana Maria's stepfather. When the stepfather started "taking it out" on Ana Maria, she moved out as well against her parents' wishes. Even though Ana Maria was in college and "working hard," her parents accused her of "being too free and sleeping around." Ana Maria was extremely hurt by these comments and said in response, "so I got pregnant." After this rupture in the relationship, she and her mother never recovered their closeness. Ana Maria lost what was an unreliable source of comfort and support, unreliable in part because her mother was living in poverty and suffering extreme abuse at the hands of her

husband. It is noteworthy that Ana Maria believed the conflict with her mother was at least partially responsible for pushing her into a relationship and early pregnancy with Jesus, which by her own account greatly contributed to her emotional distress (as well as exacerbated her poverty).

Another complicated mother-daughter relationship was found in Mariana's story. At 16, Mariana was the youngest mother in the sample but she bore many responsibilities. When the study began, Mariana and her infant child lived in an apartment with Mariana's mother, while Mariana's toddler lived with her paternal grandmother. Mariana wanted to move out and live with a friend because she "had problems" living with her mother, but her mother relied on Mariana to cover the rent because Mariana earned more than her mother did. Mariana said she was more of the "adult" in the relationship. She explained how a year earlier, her mother had been living with a cousin but they were evicted. Then the cousin and the cousin's family moved back to Puerto Rico where the in-country family had to provide for all of their needs. Mariana wrapped up the story by saying, "You see, my whole family is messed up. It's not like anyone can help me."

Mariana's father was not engaged in her education in her early years, but she remembered her mother being very involved until Mariana reached the third grade. She recalled how her mother went to her first day of school with her, kept in touch with her teachers, and participated in bake sales and school festivals. But as Mariana began the third grade, her mother started to withdraw as she not only started working, but she also had remarried to an abusive man. Mariana concluded, "She didn't really have the time or the energy to be going to school." In this context, Mariana had to grow up quickly. She

worked from a very young age in order to support not only herself, but her entire family as well. She summarized her relationship with her mother in the following way:

> I no longer need her approval, it's just like, I'm going back to school and that's the way it is. So she's not really involved in anything. She just goes along with what I do. She has no other choice. I mean, we don't live together. She may have custody of me but she no longer makes my decisions for me...I think it's mainly because she realized that although I am only 16 years old and she may be 39 years old, we're both equals in that we are both mothers...she knows that I am looking at things in a different perspective, so she lets me go ahead and use my own good judgment to do what I want to do.

Mariana expressed compassion and concern for her mother, recognizing that she lived a difficult life punctuated by poverty and abuse. But she also was annoyed and repelled by the reality that her mother was "in a mess." The ethnographer noted that interviews with Mariana often included "issues" about her mother's unreliability and irresponsibility, and the history between her with her mother caused Mariana to not want to "depend" on anyone.

Sharon said her mother paid little positive attention to her in childhood, a fact she attributed to her mother's alcoholism but that was likely also related to poverty more broadly. Sharon reported that her family was on public assistance her whole life, "'cause we were poor," and her mother had no education. Her parents separated when she was very young. Sharon recalled, "She wouldn't go up to the school for me, wasn't there for me like I am for my daughter." In her adolescent years Sharon began skipping school, became pregnant, and eventually dropped out of school altogether, events that Sharon

linked to her mother's absence. During a year in which Sharon was using drugs, she sent

her children to stay with her mother, who by this time was living in Mississippi. It is

noteworthy that although Sharon held her mother partially responsible for some of her

difficulties, she nevertheless turned to her mother for assistance with her own children.

Whether she did so because there was nowhere else to turn or because she still trusted her

mother was unclear. Regardless, Sharon's account provides a stark portrait of the ways

in which health disadvantages accumulate in a family over time. Sharon experienced both

physical and emotional health problems that affected her education, her job prospects,

and her ability to provide and care for her children. From what information is provided,

her parents faced similar challenges and were unable to prevent those challenges from

being passed down to their daughter.

Pam's account shares features that are similar to Sharon's, including chronic

poverty, alcoholism, teenage pregnancy, and school dropout. Pam said her first taste of

alcohol came at age seven. She related memories of stealing her mother's beers while her

mom was diverted by a card game. More directly, she recounted that her mother used to

put her to sleep by giving her alcoholic drinks. School was a struggle for Pam when

young, as her mother worked while trying to care for the six children in the house. Pam

would often hear her mother crying because she needed help around the house, and Pam

remembered times when her mother would ask about her homework but was too tired to

actually check it. At age eleven, Pam's mother became ill. It was during this time that

Pam's sisters began having children. Pam found herself caring for both her mother and

for the new infants in the house. This scenario contributed to Pam "running the streets

and doing a lot of bad things," and by age 14 she was pregnant with her own child,

David. Pam's mother became David's primary care provider because Pam was selling drugs and engaged in prostitution.

The above examples have shown how mothers' relationships with extended kin, and especially with their own mothers, played an important role in shaping mothers' mental health. Several mothers spoke of how their own mothers were unavailable or became less available over time because of poverty and/or abuse, which led mothers in the sample down destructive paths and often into destructive relationships. Unstable relationships with their mothers also diminished what was typically an important source of support to help the mothers care for themselves and others, further exacerbating their emotional distress.

Partner relationships. Mothers' partner relationships were similarly complex and often unreliable, and yet they were frequently sources of support mothers turned to when there were few or no alternatives. One prominent theme that emerged in the analysis of mothers' partner relationships was abuse. Six of the mothers (30%) reported being physically and/or verbally abused by their spouses or boyfriends, in some cases continuing a family history of abuse. For instance, I shared Lisa's story in the first chapter. Another example was Pam, who was helping to raise her grandchild because her son was in jail. She said that if she had known Frank, her common-law husband, was going to be abusive, she would never have gotten involved with him. She said she was "too far gone" to do anything about the abuse. She expressed the belief that women who fail to leave an abusive relationship within the first year are unlikely to ever leave. Pam was depressed over the relationship and said she was "ready for it to end" but she had a difficult time ending it. When Frank would become violent, it was because he was

frustrated Pam was "telling the truth" or when "he can't get his way." She said she would usually not fight back or defend herself, feeling like she made things worse by saying what she wanted to say. Over time, Pam's grandson stayed with her less often because she did not want him to witness the fights between her and Frank. By the end of the study, Pam was making Frank sleep on the floor in hopes that he would "eventually leave." Pam seemed to feel as though she had little power to control the relationship directly so she did so in subtle ways, for instance by keeping quiet or making Frank sleep on the floor. As a result, she spent less time with her grandson. She did not say this explicitly, but there is some indication that Pam felt guilty for in effect allowing an abusive relationship to come between her and her grandchild. By failing to more overtly push away one person (her partner), she pushed away another (her grandson).

In some cases, mothers stayed with abusive partners because they were afraid of losing their children if they left. This scenario was true for Carla, whom I mentioned briefly above. She met her husband, Andrew, at work and he told her that her boyfriend was not treating her well. He started helping Carla with her first child, they soon moved in together, and then they married one month later. After six years of marriage, Carla described their relationship as being very tense. Andrew was drinking alcohol and had become violent towards her and the children. Carla no longer wanted to be with him and believed "life would be better" if she left him as there would be less conflict in the home. At the same time, she was afraid he would fight for custody of the children and she would not be able to protect them, so she chose to remain with him. Although Carla's situation was different from Pam's, the common strand is that both of them believed their options were so limited that staying with an abusive partner was preferable to leaving.

Also found in a few mothers' stories was that they found themselves in a series of abusive relationships. Ruth, for example, suffered extreme and repeated abuse in relationships with her husbands. When she was 23, her first husband beat her in front of his relatives, who "didn't say anything about it." She described how "He beat me, stomped on me, he pulled me by the hair, he threw me into the wall." Ruth was pregnant at the time but had a miscarriage as a result of the abuse. Ruth left him after this event, but her future relationships were also violent. Her second daughter's father, for instance, was an alcoholic who was abusive to Ruth and her first daughter. Her youngest child's father was physically and mentally abusive; not only did he assault Ruth, but he also attempted to kidnap her son. He was incarcerated for four years for battering Ruth. Her two oldest daughters witnessed the violence that left Ruth hospitalized for two days.

Ruth recognized the pattern of violence but said her intention had been to find men who "loved me and respected me and loved my kids." She went on, "When my kids need a father figure, I try to find one. Every time I did, it was an abusive one or an alcoholic one." Ruth resolved not to let it happen again as she declared, "I'm not no man's punching bag no more." In spite of her personal resolution, her oldest daughter, Heidi, was already in an abusive relationship of her own. Ruth hoped her other children would not follow in their footsteps. In this account and in several other mothers' stories, it is striking how patterns of abuse permeated and repeated themselves in families. Mothers spoke of how their mothers were abused by husbands, and in Ruth's case the pattern was continuing into the next generation. In addition to representing one reason mothers had to invest energy to regulate distance within relationships, the pattern also

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seems to represent another facet of the "bad mom" guilt so many of the mothers experienced.

It was not only violence that caused mothers to work hard at regulating distance within their relationships, but it was also the fact that their partner relationships were generally complex and fluid, often making them unreliable and unstable. For instance, when 27-year-old Nicole entered the study, she was cohabiting with her partner, Warren, who had moved in again after the two were estranged over a battering incident. Warren was the father of Nicole's youngest child. He had cheated on Nicole and fathered children with multiple other women, including one child who was born while he was living with Nicole. Warren was in and out of jail, which his mother called "his second home." Interestingly, an ex-lover with whom he had a child would sometimes help Nicole by taking care of Nicole's youngest son for weeks at a time. Warren was not the only partner involved in Nicole's life. When the father of her three oldest children learned she was dating someone else, he became jealous and wanted to get back together with her. When she refused, he "became vindictive" and reported her to DCFS for a fictitious charge.

Nicole's partner relationships were complex in that multiple partners and children were involved, there was abuse and infidelity, and unlikely bonds of support emerged (for instance, between Nicole and her boyfriend's ex-lover). Moreover, the partner relationships were fluid in the sense that Nicole moved in and out of them in a way that appeared on the surface to be haphazard, but her behaviors may have been attempts to adapt to an unpredictable environment. Nicole grew up with an abusive mother and learned early on that she could "trust nobody," a belief that her intimate relationships

seemed to confirm. The stress her relationships caused her, as well as her inability to trust others to help her, were primary contributors to Nicole's depression.

A different sort of complexity was found in Ashley's partner relationships. Ashley was representative of a number of mothers for whom financial considerations were an explicit (but not necessarily primary) factor in their choices about partners. Terrence was the father of Ashley's four children, who Ashley said she considered marrying but was hesitant because he was not financially stable. She nevertheless put her low-income housing situation in jeopardy by allowing him to live with her although his name was not on the lease. At one point during the study, Ashley started dating another man but said her family and Terrence "became alarmed" by the behavior of her "other boyfriend." Her mother and Terrence called a family meeting to talk about the issue. Terrence did not want "his children living in a bad environment and he ordered Ashley to "leave the man alone." After the family meeting, Ashley continued to contact the other boyfriend, but he was soon imprisoned. Ashley viewed his imprisonment as a "heavenly intervention," saying she would not have been able to cut off contact with him had she not been forced to do so. Several months later, Ashley and Terrence decided to get married. Ashley felt ready because "he finally got a good job" and was able to contribute to the family regularly. This example illustrates the importance mothers placed on finances and a potential partner's ability to provide, but it also shows how mothers might sacrifice stability and put themselves at risk for the sake of a relationship.

As has already become clear, one factor adding to the complexity of relationships was infidelity and having multiple partners. Roughly one-quarter of the mothers discovered their partners were cheating on them and three others said they had cheated on

their partners. For Ana Maria, learning of her husband's affair triggered a depression. Although they separated for a time, they still lived together because Ana Maria could not afford to pay rent by herself. She was also afraid Jesus would take the children from her. Ana Maria described being at the point where she could not take any more stress. She said she was "about to explode" and when that happened she thought about "stupid alternatives such as committing suicide." When she talked about suicide, she also mentioned "taking the children" with her, believing that if she were not alive nobody else would take care of them.

By the close of the study period three years later, Ana Maria learned Jesus was having another affair and she felt depressed and humiliated. She secluded herself from family and friends and said she was "trying not to hit bottom" because she needed to maintain her employment. She still felt she could not leave him because she needed his help paying the bills.

Balancing partner and family relationships. One last example demonstrates not only the complexity of mothers' partner relationships, but also the considerations involved in balancing the amount of time and energy invested in partner relationships versus relationships with children and extended kin. When Sofia divorced her first husband, both Sofia and Elisa experienced depression and went to counseling. Although Elisa's father was asked to remain involved in her life, he did not. I noted previously that Sofia chose not to remarry at one point because her daughter Elisa strongly objected. Later on in the study, however, Sofia met a significantly younger man named Isaac who soon moved in with Sofia and her children. Sofia became pregnant with Isaac's child. She believed having him move in was "the only way to form a family" and it also benefited

everyone financially because they had another adult to help pay the bills. The move was difficult on the children, especially Elisa, who threatened to move out. Sofia said she was not willing to give up the relationship and she told her daughter, "If that's what's going to make you happy, go ahead my child." Sofia figured her children were "aging quickly" and would "soon be moving out of the house," and Sofia knew she did not want to be alone in the future. Over time the children "grew to love" Isaac and even started calling him "Dad." Sofia said her life had improved both emotionally and financially.

One consequence of Isaac moving in was that Sofia's sisters, with whom she had been very close, stopped speaking to her. Sofia and her family were Jehovah's Witnesses and her sisters did not approve of Sofia's relationship with Isaac – that he was younger and that they were cohabiting and having a child outside of marriage. When she and Isaac married, they resumed their relationship with Sofia although it was not as close as before. However, the marriage only lasted a few months; Sofia kicked Isaac out when he became involved with the 18-year-old daughter of the family renting out Sofia's basement. This transition was again very difficult on the children as they had grown attached to him. Elisa started having trouble in school and Sofia's son Alex, who "used to be very well-behaved," started acting "aggressive and bitter." He told his teachers that his "father" had left the family and that his mother did not have enough money for food. Sofia decided shortly after the break-up that they would all move back to Mexico to live with her mother for at least six months because Sofia needed "the support and comfort" of her mother. One positive was that Sofia's sisters became more communicative and supportive once the marriage ended.

Several things stood out in Sofia's experience. One was the way she benefited from her relationship with Isaac. For a time, there were emotional and financial benefits, and her children eventually appreciated having a father figure in the home. But the transitions were challenging for the kids and created tension between Sofia and her daughter especially, as well as between Sofia and her sisters. Getting closer to one person meant pushing others away. In the end, Isaac proved to be unreliable and he failed to provide consistent child support, so the emotional and financial benefits of the relationship were short-lived. Moreover, the dissolution of the relationship created further complications for the children, causing behavior problems and challenges in school. These events culminated in Sofia's decision to move back to Mexico, where she hoped her mother's support would help her to heal.

Conclusion

This chapter has shown that many of the mothers experienced guilt associated with being a "bad mom," and they were weighed down trying to protect, advocate, and provide for their children and other family members, many with physical and mental health problems, with very limited resources.   Mothers also evidenced unstable, unreliable, and generally complex relationships with extended kin and partners. Affairs, abuse, and feelings of being "stuck" were common. All of these factors contributed to a context of high stress and often low support for mothers. In the third and final chapter, I explore how mothers attempted to cope with mental health problems that were shaped by these complex relational contexts.

Results: Chapter 3: Mothers' Coping Behaviors

In this chapter I examine the various strategies mothers employ to cope with their mental health problems. My framework is based loosely on that used by Roth and Cohen (1986), who explained that people cope successfully by utilizing strategies for avoiding problems/threats as well as for actively dealing with or approaching the problems or threats. As this chapter will demonstrate, a broad range of strategies were applied by the mothers. Common avoidant coping mechanisms included substance use and abuse, taking out their problems on and blaming other people, not thinking about problems or the past, keeping their problems to themselves, and isolating themselves from other people. Other avoidant behaviors that will not be discussed in detail but that were mentioned in the data included turning to food for comfort, sleeping more than usual, watching television, and (in one case) cutting. Mothers also used active coping strategies such as talking to friends and family members, turning to religion and prayer, and seeking out mental health treatment. The last section of the chapter is devoted to exploring barriers to successful coping, including instrumental and perceptual barriers to mental health treatment, family comorbidity-related barriers that demand a constant focus on others, and a lack of social support.

Avoidant Coping

Substance use and abuse. Eleven of the mothers (55%) indicated using drugs, alcohol, or cigarettes to help them cope with stress. Sharon drank and used drugs before going into treatment, and then she was sober for two years until she resumed drinking midway through the study. She told the ethnographer, "Well I don't drink all the time. I just wanted a drink because I was feeling down, you know…It always helps the problem

a bit. Wish I never did it. Don't want to start back the way I was." She said that she could "always stop" and that she would not let her drinking get out of control. This pattern of quitting drugs and then returning to or taking up drinking was common.

Pam, whose mother would sometimes give her alcohol to put her to sleep, reported using cigarettes and alcohol. She claimed that using the substances "don't lock me into the depression…I do alcohol 'cause I like to." However, she also noted that sometimes drinking and smoking caused stress or caused the problems that caused the stress. She said, "It's all one package. It can't be separate." Pam started smoking when she was 15. Although she wanted to stop, she said did not know how she would. She prayed daily that she would not pick up a cigarette, "but it keep happening." Pam could go several days without drinking but thought the pressure to stop entirely would probably be overwhelming.

Pam had previously been addicted to heroin. She started using at the age of 14 and said she "liked it ever since. But thank the Lord, by the good grace of His guidance, I have been clean 10 years." She decided to go into a treatment program to "get clean" because she "was tired of spending my money and waking up sick. Point blank." She noted how in order for her to give up the heroin, she had to be committed to quitting in both her head and her heart. However, she said was not committed "in her heart" to quitting drinking.

Another mother who had been to rehabilitation for drug addiction but who still drank was Tammy. I wrote in a previous chapter that Tammy became addicted to drugs and had a "breakdown" when her mother passed away. Tammy said that she did not know she "had depression and did not know how to deal with it," so she turned to drugs.

Someone she knew gave her drugs and then "where something would happen I'd go get high." She received treatment at a women's clinic and said it helped her "dig down deep" and learn how to cope. However, she did not provide any details about what those coping strategies were. Rather, the coping strategy Tammy mentioned applying often by the time she entered the study included going to her room, locking the door, and drinking "half a pint of alcohol." Once Tammy was drunk when the ethnographer stopped by and Tammy recalled that her mother "used to be drunk all the time." Tammy said she had been "busy and stressed" and that she "needed to take a day" for herself and "get drunk." At a separate interview, Tammy indicated that she took Prozac at one point to treat her depression but she stopped taking it. Instead she dealt with her depression by "getting drunk and going to sleep." For Tammy and several other mothers, alcohol offered a powerful escape from depression and stress, one that they were unwilling or unable to give up even after going through treatment for drug addiction. This could be a result of the social acceptability (and legality) of alcohol use as opposed to illicit drugs. Yet as Pam pointed out, drinking created stress of its own and contributed to problems that created more stress, so this particular coping strategy was not successful in the long-run.

Taking it out on others. Another common avoidant coping technique was taking out one's problems and negative emotions on other people, for instance by fighting with them or blaming them for their problems. Kara offered one example. She was known in her community as a "fighter" and as someone who used her strength to "bully" people. She said she had to learn to be tough to defend herself, especially since she and her son experienced spells of homelessness and would sometimes sleep in the hallways of apartment buildings because they had nowhere to go. The pattern of fighting started at a

young age. Kara was kicked out of high school for fighting, which she said was because kids were "picking on" her siblings and cousin. For Kara, fighting others was partly about coping with negative feelings, but it was also about protecting people she cared about.

More common to mothers than fighting was blaming others for their problems. I referred to Ruth's story several times in the previous chapter to highlight challenges related to family comorbidity and parenting. I return to her story now because she often took out her stress on her children and blamed others for her problems. Ruth lost custody of two of her daughters; her first-born child, Heidi, was briefly placed in foster care when she was young, and her second-born, Carly, had been removed from the home four years before the study began and was still in foster care at the end of the study. Ruth described what happened with Heidi:

> I abused my kid, I pounded her head on the table when she was young, because of me being with Cameron [then Ruth's husband] for so many years, he was a sugar daddy to Heidi, every time she wanted something she got it from him so she was spoiled by him. She thought she was going to get away with the same thing he was doing to her, I couldn't put up with it. So I pounded her head on the table…When I asked for help, there was no one there to help me out, the only way they'd help me was taking my kid. Like it is now with Carly.

In addition to taking out her stress on her children, Ruth also blamed others for hers and her children's problems. For example, she blamed Heidi for the fact that Carly was taken from her. Ruth also had a difficult time accepting responsibility for the abuse her children endured at the hands of her live-in boyfriend, Les, and tried to push the blame onto the Department of Child and Family Services (DCFS):

Unstable environment, because a man molested my kids, and it's my fault? It
ain't my fault, I know it ain't my fault. I trusted him and he loved me and loved
the kids. He loved them too much. What he couldn't get from me he tried to get
from them. I couldn't have sex. In a way, it was my fault, in a way it's more
DCFS's fault. They knew I was going to school, I needed someone that DCFS
could approve on babysitting for my kids. Everyone knew who was babysitting
for my kids; it was my boyfriend.

Mothers such as Ruth were in challenging positions of being victims themselves (of
abuse, of conditions of irreversible poverty) but also of coming to terms with the fact that
their children had been (or were at risk of being) victimized as well, sometimes directly
by the mothers and sometimes indirectly because mothers failed to protect them. It seems
that by denying some of the responsibility and/or by focusing on others and taking out
frustrations or feelings on other people, they were shielding themselves from being
overwhelmed by "bad mom" guilt.

Isolating and keeping problems to themselves. In contrast to mothers who in a
sense "acted out," there were also examples of mothers who kept their feelings to
themselves. Ana Maria considered herself to be "mentally unhealthy" and said she dealt
with her mental problems by "remaining quiet" and "not complaining" when she disliked
something. Her reasoning was that it was preferable to avoid confrontations with people
because "nothing really changes" even when she would tell someone what was bothering
her. However, she recognized the problem of keeping everything to herself was that she
accumulated the negative feelings and then she would "explode." Often the ones who
"paid the consequences" were her children because she became "tough" with them.

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A similar avoidant coping strategy was not talking about one's problems, which commonly led mothers to isolate themselves. For example, Pam's ethnographer stated that Pam refused to discuss her son's incarceration. It was only when the ethnographer investigated on her own that she learned he was serving a 55-year sentence for murder. Throughout the interviews, Pam hinted that there were certain events she would rather forget. She said she was not "too keen on pinpointing exact dates" and that she "chose not to remember" some things. She also described herself as a "loner," saying she had associates but not friends because she did not want people "in her business."

Avoiding painful memories or relationships may have been an adaptive response that enabled Pam and other mothers to function rather than be overcome by shame, trauma, fear, or guilt. The difficult relationships and experiences of Pam and others might explain their tendency to avoid and isolate. One experience Pam mentioned was caring for her friend's daughter for two years while her friend was incarcerated for drug-related charges. When the child's mother was released from prison and she retrieved her daughter, Pam was devastated, in part because the child's mother continued using drugs. She shared this as one reason for not wanting to get too close to people, because "it hurt so badly" when the child was taken from her. Presumably, losing her son to jail was another painful experience.

Elana was another mother who isolated herself from others in response to depression she suffered as a result of her mother's death. She stopped going to church because she had a difficult time accepting that "God did not stop" her mother's death. She also spent less recreational time with her family, saying she would not "have fun with the family out of respect" for her mother. For Elana, isolating was a sign of respect

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for her mother. For Pam and several other mothers, isolating and keeping their feelings to themselves was more about protecting themselves from experiencing additional pain. In both cases, it seemed the women were at risk of closing themselves off from receiving outside assistance to process negative emotions. Whether or not that assistance was truly available or trustworthy is unclear.

Active Coping

Although mothers shared accounts that they avoided talking about or directly dealing with their problems or pasts, there were also instances in which mothers reported that it was important to address their problems by talking about them and/or by taking time to focus on themselves rather than others. Lisa asserted, "You'll never get your problem solved if you can't face it." She said that almost everyone she knew in her apartment building used "something" to cope with their problems or to "fit in," but they were not successful in dealing with their problems. Lisa spoke from experience, given that she had a history of drug and alcohol use. As I will discuss below, her job and religious affiliation later became more effective coping strategies for Lisa. Nevertheless, she continued to demonstrate a combination of active and avoidance coping behaviors, as she was the mother whom the ethnographer observed to be cutting herself.

Talking to friends and family. Although in the last chapter I devoted considerable space to the complexities and challenges posed by families, it was also the case that the majority of the mothers had some friends and/or family members who provided important emotional support to help them cope with mental health problems. Ashley illustrated this point well when she said she "could not make it" without the help she received from her family and friends. Another mother, Gloria, experienced severe

depression when her husband left her while she was pregnant with their fourth child. She stopped eating and relied on her sisters and close friends to help her get through the difficult time. Gloria explained,

> My friend would tell me, "Don't be dumb. Look, eat." She would take me to the hospital, she would bring me home, and she would always attend to me. "No look, when you have the baby, I'll be with you." And when I had the baby she was with me, in the birth, when they assisted me...She went straight from work to the hospital. One time she didn't go to work because she was waiting until I gave birth.

At one point Gloria applied for housing assistance and was given the opportunity to move into a subsidized apartment 10 blocks away, but she chose to remain in her building where all her sisters resided. She said she did not want to give up the support and closeness she enjoyed with them so nearby. The support she received from friends and family members alike was a critical component of Gloria's coping.

Susan, the adoptive mother of four children, received support from other adoptive parents as well as from her therapist. Susan relied on her mother to manage her finances, which included paying her bills and overseeing her bank account. Susan said she also received emotional support from friends she met through work situations, with whom she spoke on a daily or weekly basis, and from sisters whom she called at least every month.

Although to this point I have focused on active coping strategies as being totally separate from avoidance coping strategies, in practice most of the mothers evidenced both types. This was particularly true when it came to talking about their feelings versus keeping their feelings to themselves. For instance, Frida sometimes avoided talking about

what was bothering her, while at other times she would "talk out her problems" or write in a journal. Frida said that when she became angry, she felt the need to "get away from" others by going to her room, listening to music, or going for a drive. Her husband was sometimes able to help Frida manage her anxiety by talking through her concerns with her. Frida offered the example of how she yelled at her daughter for "perpetually asking me to do things while my husband was sitting in the next room playing video games." She and her husband discussed the situation and concluded Frida's irritability stemmed from menstrual cramps. In addition to talking about her problems with her husband, Frida turned to her mother, aunt, grandmother, and brothers for emotional support.

Frida mentioned being concerned that she became angry "without provocation" and she wanted "to talk to a psychiatrist to see if I'm all together." She believed she needed "a psychological evaluation to make sure everything is fine." Frida was prone to depression but said she did not always recognize when it occurred. During those times she would stop answering the phone and she would avoid people when angry with them. However, she also revealed that she kept a journal of her thoughts when she was upset, a more active strategy which she said she learned from the *Oprah Winfrey Show*.

Exercise, making time for oneself, and related strategies. In addition to talking about their problems with friends and family, mothers found ways of making time for and caring for themselves through exercise, taking time away from their children, and the like. Sharon reported that she sometimes relieved stress by taking long walks, going to the movies, or enjoying a long bubble bath. Ashley said she tried to "get away as much as possible." She further explained:

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I try to leave this house as much as possible. If I can I will go to other places like to get away from the kids and stuff. I'll go like out of town or stuff like that. I do pedicures. You know I just try to keep myself up and myself healthy. If I keep myself up then I can keep myself happy.

Given the financial difficulties most of the mothers experienced, it is likely that they had few resources to regularly go out of town, to the movies, or the like. This reality is a reminder of the ways in which poverty limits mothers' coping mechanisms.

Susan also recognized that she needed a break from her children, as well as from work. She felt breaks were important at least every three months. While she would have liked to have taken a week off from work, she was not usually able to do that. She was able to take a day off and drop her children at daycare. She would then spend the day "getting things accomplished." She described those breaks as a "time when I can hear myself think again." Susan also acknowledged it was important for her to take care of herself physically, declaring, "You know if I don't take care of myself, I'm not going to be able to take care of my kids and take care of all the things that I need to take care of. So it is important to me to do that." At the same time, she struggled to keep herself healthy as she suffered from multiple illnesses, some of them related to obesity. Susan believed there were many things she "should be doing" for herself such as being more physically active and "having peaceful moments" at the start of the day. Between taking care of her children and her house, she found there was not enough time for everything.

Gloria was another mother who tried to find ways of making time to focus on herself. She explained how she would tell her children to give her space and time alone:

When, when I feel, like depressed, what I want is...I don't want to hear noise. I tell

my daughters, "You know what? I feel bad." The food is ready; I heat it up for

them. "I'm going to lie down for a little while, I don't want to hear noise, please.

Do your homework and I'll check over it in a while." I go to my room for a while.

I concentrate on myself in what I do. I lock myself in, I sleep for a while, and then

later I come back out as if nothing [happened]. Then I talk with the kids. The kids

are also calm because they know that I feel bad. I tell the oldest. "Eat, the food is

ready. Heat up the tortillas in the microwave. I feel very bad. Serve yourselves."

And that's it. What I do is I go to my room, I lock myself in. I relax because that's

what they've told me to do. I turn off the light. And that's it. Later I'm, I'm more

relaxed. I come back out. I talk to my kids, I see their homework. There, they've

done. Then I...I relax by myself, in order to not scream, to not make them...think

that something is wrong. That's what I do.

Gloria found a way of being alone that did not require additional resources, it rather

called on her children to take care of themselves for the evening. She believed this

strategy worked for her and her family.

Religion, prayer, and spirituality. Fourteen of the mothers (70%) stated that

religion, prayer, and/or spirituality helped them cope with their mental health problems.

Lisa, for instance, relied heavily on her faith and prayer life, as was indicated in the first

chapter. She viewed her prayers as "conversations with God" and said they helped her to

concentrate and feel better. Lisa also credited the church with helping her to stop

drinking. Going to church "kept [her] mind occupied" and she was able to give up

alcohol within a month of attending church. What helped her to give it up was learning

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that her "body was a temple for the Lord" and that she needed to "teach the younger women how to be sober." Lisa summarized, "Church plays a big role in my life," adding that "once you get a relationship with God, everything else falls into place." Because of Lisa's involvement with the church, many of the women in her building would come to her for advice. She said she knew if she did not rely on God, she would "be out there in the world, probably doing what they doing in order to make it, to cope with life."

At the same time that religion provided a source of strength and empowerment for Lisa, there were also ways in which it worked against her as she attempted to overcome hardships she had endured throughout her life. As I wrote in Chapter 1, Lisa was pressured by her pastor to attend marital counseling and to remain in a physically and mentally abusive marriage. Lisa felt as if the pastor and Albert, her husband at the time, were "ganging up on" her. The pastor frequently cited bible verses emphasizing the submission of women and dominance of men. The pastor also insinuated that Albert was justified in "taking it" when Lisa did not want to have sex. Although she felt as though she was doing something wrong by "disobeying God's words" and committing a sin, Lisa went through with the divorce.

Tammy's involvement with religion was more straightforward than Lisa's. She reported drawing strength from her religious affiliation, stating, "I wake up and the first thing I do is say my blessings at the church, right across the street." When asked if she ever had to worry about not having enough food to feed her family, she replied, "No, my God ain't gonna let me have a hungry day." She mentioned that she had "hungry days" in the past but that it had been more than three years since she had one. Similarly, Ashley said that in addition to taking walks every day to keep healthy, she relied on prayer.

Stress from her children and from concerns about money was "so much I just wElana blow up," but she said she prayed and "everything works out."

One other example of a mother who relied on her faith is Gloria. She said that after giving birth to her son, she would still think about her ex-husband and would smoke cigarettes and drink beer. She explained:

I would go to sleep like that, because I couldn't even sleep. It would take one [beer] to get me to sleep. But I wouldn't let my daughters see me drink one. Then I said, "Why am I doing this?" I went to church and I asked God, "My God, take this away. I can't sleep. I'm thinking about my daughters' dad. I don't want to think about him anymore. Take that away from me." And it worked, thank God. I went to church and I asked God. And he took all that away from me...I said, "No more." Because you start with only one and then I said, "What if my children find out or something? I don't want them to find out about this."

The data offered numerous such examples of mothers relying on their faith to help them overcome difficult circumstances such as addictions, shortages of food or money, and separations from partners. Beyond the importance of faith, mothers also relied on networks of church members to listen to them, offer advice, provide instrumental assistance, and the like. The finding that 70 percent of the mothers relied to some extent on faith and faith practice to aid in their coping suggests that mental health workers and other helping professionals ought to take into account the potentially significant role played by the faith community.

Finding purpose and confidence through work. Another coping strategy mentioned by several mothers was finding meaning and purpose through work. For

instance, Lisa talked often about "being transformed" by her job. She felt she gained confidence and valuable skills at work. She also said she felt "better emotionally" when she worked, and the difference was significant enough that she did not believe she needed to take her depression medication when she was working. Part of what Lisa loved about her job was that she was "able to help others," which seemed to give her life and personal experience a sense of purpose. She described working with a teenage girl who was associating with an older man, which caused Lisa concern that the girl might start selling her body. She said the scenario was very common. Lisa recalled how when she was 12 years old, a deacon wanted to "date" her, and she drew on this experience in her work with the teenage girl. She concluded, "I been there. So I feel like, 'I can stop you from going out and being in the street, selling your body.'"

Ashley also gained confidence from working. When asked in a follow-up interview if she had done anything to improve her self-image, she replied:

> Yeah. I got a job. After a while I got a job. So, it took me a long time to say I am worthy of myself. I don't care what people think of me otherwise because what's the problem, the root of my problem I got rid of him so get the hell out of my house, don't come back. I said it. I didn't need him. I found that I don't need a man to make me happy. I don't need somebody to tell me that you're doing a good job. I don't need a man to tell me do this, do that…I depend on myself. I take care of myself. I take care of my kids. I don't need a man to do everything for me and stuff like that so I'm cool.

For Ashley, a job helped her to discover that she could take care of herself and be happy without a man telling her she was worth something. She found that moving towards self-

sufficiency was an important step in improving her self-image. Clearly, the dynamic of work and contributing to one's family and (in some cases) community played an important role in mothers' self-assessments.

Mental health treatment-seeking. In addition to the coping strategies covered to this point, seventeen of the mothers (85%) also sought out some sort of mental health treatment at some point in their lives. For some of them, it was short-term or only in childhood or adolescence, while for others it extended over a period of months or even years. In the final section of this chapter, I explore barriers to effective mental health treatment. Here I describe general patterns of treatment-seeking and how mothers decided to enter into treatment.

As I have written, Wendy was one mother whose experience of treatment was extensive. At the age of 17, she spent 11 days in a mental institution after attempting suicide. This experience was not a positive one on the whole because Wendy did not feel like she was treated in a straightforward or respectful manner. She was upset, for instance, that she did not know exactly what her diagnosis was or what the treatment plan would be:

> I don't even think I was given a point blank diagnosis. I think I just...I was on the antidepressant so I figured all right, I must be depressed, right. But I was never told I had a major...I looked up and there's all these different terms. There's major depressive this and that and the other. And partial recovery, and full recovery and this and the other. I was never given any of that. Again, the informed patient. They didn't even want to tell me the medication they were putting me on. So, I

was never given a full diagnosis. I was never given... sat down and have

something explained to me like they assumed that I'd be able to figure it out.

Wendy was placed on Prozac and continued to receive outpatient therapy for just

less than three years. She returned to counseling with a psychologist at the Chicago State

University at the age of 26, "when I was dealing with anxiety attacks and pressure from

school and financial problems at home." This experience was much more positive than

her first one. Wendy reported being "very happy" with the services she received, saying

"I've made tremendous progress..." She believed there were "deep-seated personal issues

of self-esteem that I've come a long way working through." Among the things Wendy

credited her therapist with teaching her were relaxation techniques and "tools to take a

clear assessment" of and cope with her life. At the same time Wendy returned to therapy,

she also started seeing a psychiatrist to get back on an anti-depressant. Below is what she

shared about her experience with the medication:

> Now [the psychiatrist] put me on Zoloft. The side effects from that were too
>
> extreme. The headaches were too bad. And actually, the psychologist told me that
>
> she has yet to run into anybody that was put on Zoloft that didn't have a problem
>
> with it... Umm I've been getting regular migraine headaches since I was 13 years.
>
> And since... during that time I've learned that I'm very susceptible to headaches.
>
> So any circumstance that is likely to cause a headache, I'll get one... Guaranteed.
>
> So when she told me there was a possibility of headaches, I knew I was going to
>
> get headaches…I was still getting up and functioning even though I was in
>
> pain…But it was still too much...So I had to stop [the Zoloft].

Wendy was scheduled to return to the psychiatrist three weeks later but there was no information about whether she tried a different medication. On the whole, Wendy's first encounter with mental health treatment was negative but her later experiences with the psychologist and psychiatrist were very positive. Her extensive involvement in therapy and her general interest in psychology developed in Wendy a sophisticated understanding of mental health that made her unique among the mothers in the sample.

Another mother who entered the mental health system at a young age was Mariana, but her perspective and way of talking about it was quite different from Wendy's. Mariana started experiencing anxiety symptoms in the fifth or sixth grade, which she described as "I would just start shaking and I would get really dizzy and just fall out." She saw a doctor after her mother noticed she was spending a lot of time in her room. Mariana was told:

> It had, you know, a lot to do with my nerves, but also because we thought it had
> to do with some girls in school that were bothering me. And so, I went and I
> started getting medicine for it and calmed down, but like a couple years later, it
> was just like, you know? I would get really depressed or I would get, you know,
> and so she decided to just continue giving me the medication, 'cause I just, I feel
> real sad all of a sudden.

By the time she entered the study, Mariana was still taking medication "for [her] nerves and stuff" when needed, but she said she was uncertain exactly what medication she was being given. She recalled, "First they were giving me like Prozac and God knows what else…And then, umm, he just currently changed this. I don't even know what he's giving me right now." Mariana's view of treatment and her seeming unconcern about

what medication she was being given stood in stark contrast to Wendy's insistence on understanding the details of her treatment. Nevertheless, Mariana showed initiative by requesting to see a mental health care professional at the hospital when she was pregnant with her daughter and experiencing depression again. Right after giving birth was the last time she saw a mental health professional, though it is unclear for how long she saw the clinician.

Mariana's story exemplifies a typical pattern in which mothers sought out mental health treatment during difficult life stages such as pregnancy. Also common was for mothers to receive mental health treatment in the context of drug and alcohol addiction treatment. Pam was one such mother. She described what led her into rehabilitation for her heroin addiction and what treatment was like for her:

> I got tired of mother fuckers riding around in new cars and shitting houses and diamond rings on their fingers and I was spending $200 or $300 with them every day and I ain't got nothing and the next morning I am sick as a dog, ain't got food to eat and running around here trying to find some money for the dope veins…I have 15 years on the drugs. I am blessed with it today…I was on methadone for 2 years. [I would] go to groups, participate in the clinic, would have to be there every day like certain times, it was like a job, you have to keep your mind occupied and busy to stay clean. It worked for me, it doesn't work for everybody.

While Pam was in rehab, she saw a psychiatrist, was diagnosed with depression, and started taking medication for it. As of 2001, Pam reported she was no longer seeing a psychiatrist but was still taking the anti-depressant. By 2003, she had stopped taking the anti-depressant because she said it made her feel more depressed. The topic of medication

and its perceived effectiveness was an important one for many of the mothers. I will return to this subject in the next section of the chapter.

As I stated previously, Tammy went through treatment for drug addiction as well. She had outpatient drug treatment and then checked herself into inpatient treatment after her youngest child was born. After leaving the clinic, she periodically visited her counselor there, whom she said helped her "dig down deep" and teach her how to cope. She also met with a psychiatrist who prescribed Prozac for her depression, but she eventually stopped taking it for reasons that were unclear. After that, she relied on alcohol to help her cope with depression, although she mentioned having the option of seeing a counselor who would be paid for through public aid.

The mothers' stories revealed a back-and-forth movement between active and avoidant coping. Especially for the mothers with a history of addictions, there seemed to be a perpetual struggle to find balance between approach and avoidance. Part of the reason may have been that therapy and/or medication offered only imperfect or partial solutions to their varied problems that were rooted largely in cumulative disadvantage and the strain of family comorbidity management.

For a couple of the mothers, mental health treatment helped them to deal with problems related to couple relationships. Frida, who I referred to earlier as desiring a "psychological evaluation to make sure everything is fine," experienced panic attacks and had been given medication to help treat them "when I really can't breathe and am really out of it." Eventually she was able to see a therapist. Below she explained what led her to enter therapy:

[My husband and I had] gotten to the point where I was really angry, I was going through a lot of emotional things where I really wanted to give up, where I wanted to get in my car and go…I was feeling it, I was feeling the anger, the hostility, I didn't wElana come home to my family, I didn't want to be a mother anymore, I didn't want to be a wife…I'm going crazy, it's been many a time I was like, maybe I should take these pills and my family can collect insurance and they can pay off these bills or whatever, maybe they're better without me, you know, it's been a lot of that going on...

Frida's emotional and marital problems were wrapped up with financial problems. Therapy helped her realize that a lot of her anger stemmed from the fact that her husband was in school and not working. She said, "I felt that he is my security and when you're not working and you're just going to school and there's bills, where's my security at, where's my Superman?" In therapy, Frida learned what she needed to communicate to her husband and what they had to plan out together to ameliorate the situation:

And so sometimes you have to explain to him it's not necessarily that you're doing it, but this is how it makes me feel, and it's a lot of stuff that he has to understand, not saying that you do it, it's just how I perceive it, and he understood that we had to work through it, so now it's more like, I don't blame you, but you need to get a job. I gave him not necessarily an ultimatum, 'cause we don't do that, but we've made a plan.

Thus therapy helped Frida to sort out the various concerns and stressors she was facing and to communicate more clearly with her husband so he could be a better support to her.

Therapy did not change her financial situation, but, as Frida noted, it encouraged her and her husband to make the necessary plans so they could make things better.

To close the section on patterns of mental health treatment-seeking, it deserves mention that two mothers referred to receiving and being pleased with counseling services at the same agency, *Mujeres Latinas*. One of them was Sofia, who said she and her daughter were in therapy after Sofia separated from her husband, "because she would cry and I would cry." Below is how Sofia described their four months with *Mujeres Latinas*:

> We'd have group counseling, just women with the same problem, like me. And my daughter would also go talk with someone. So, we were both going for a while. It really did [help me]... The one that took care of my case…she was the one that helped me…to get out of depression. She gave me advice, she looked for alternatives for me.

More analysis is needed to better understand treatment-seeking patterns by race and ethnicity. In this sample, these two mothers were the only ones to mention an agency by name and it happened to be the same one – one that served Latino women in particular.

Although research has suggested that groups such as Latinos, African-Americans, and the economically disadvantaged in general are less likely than their white or wealthier counterparts to pursue mental health treatment (e.g., Anderson et al., 2006; Wang et al., 2005), the above accounts paint a more nuanced picture. Mothers accessed mental health treatment in a variety of ways and for an assortment of reasons. Some entered through drug and alcohol treatment, while others found psychologists and

psychiatrists who were made available at schools and hospitals. Some of them entered therapy at their mothers' urging, while a few started treatment because their relationships were falling apart. Others went because of depression triggered by pregnancy or separation. Some mothers accessed mental health care at multiple points in time and/or for a period of years, while others only participated for a brief interval. I stated above that the majority of the mothers accessed some sort of mental health treatment. Next I look at what kept mothers from entering treatment or from viewing treatment more positively, as well as other barriers to successfully coping with mental health problems.

Barriers to Successful Coping

Mothers experienced multiple and varied barriers to successful coping, including instrumental and perceptual barriers to mental health treatment, constant pressure to focus on others due to family comorbidity-related issues, lack of social support, and desiring but being unable to employ active coping strategies.

A prominent theme in the data was the difficulty some of the mothers had accessing mental health treatment over time. Among the instrumental barriers they faced were lack of access to transportation, no child care, and a lack of insurance. For other mothers, barriers were perceptual in nature. Many of them had negative views of therapy and/or medication or they had experienced therapy in the past and did not find it valuable.

Perceptual barriers to treatment. Sharon reported that she went to a counselor for three months but did not like attending the sessions so she stopped going. In a separate interview she indicated she had also seen a counselor while she was in treatment for drug addiction and that it had helped. As I stated in the section above on substance use, Sharon used drugs and alcohol and was sober for two years after going through

rehab, but she later started drinking again. She believed she could "always stop." The trajectory of Sharon's experience may be an example of the inadequacy of short-term therapy or simply the probability of relapse in addiction. It also seems likely that a negative experience in therapy decreases the likelihood of taking that route in the future.

Lisa was one mother who faced a combination of barriers to mental health treatment. As I described in Chapter One, Lisa was subjected to regular physical and emotional abuse from her mother while growing up. It was difficult for Lisa to keep friends, as her mother would make her feel guilty for putting friends before family. In high school, when Lisa saw a counselor, her mother sat in on the sessions, forcing Lisa to hide the extent of her problems at home. Lisa was not in therapy at the time of the interview and said that she had never found anyone to speak with about her problems. However, when Lisa became pregnant with her second daughter only a couple of months after giving birth to her first, she became very depressed and was prescribed an antidepressant by her doctor. She remained on the antidepressant for several years but found even more positive effects for her mental health came from her job. She said that when she worked, she did not feel the need for her depression medication. Lisa eventually stopped the medication for good when she stopped receiving Medicaid and was unable to afford the out-of-pocket costs. Lisa stated she "no longer ha[d] anything to be depressed about," and the idea of having to pay for the medication herself made her think, "I'll be better."

Perhaps a negative view of medication acted for Lisa as a perceptual barrier to adequate mental health treatment, or perhaps she truly did not need the anti-depressant. It certainly seemed as though the lack of health insurance (and the resultant high cost of

medication) became a barrier. For other mothers, negative perceptions of medication and of therapy overall were more overt. After Pam's father passed away, she felt herself "slipping into a depression." Her primary care doctor referred her to a therapist, and although her previous experience with counseling left her averse to the therapeutic process, she consented to see him once. Pam described the therapist as a "talker," which she said was a good thing because it meant he would not be "quick to want her to take medicine." She felt she was "already taking enough medicine," joking that someone could come to her house to get well because she had so many different pills. Although she had taken anti-depressants in the past, she stopped because she perceived, "They don't make you feel better. They make you depressed." She did not say whether she herself experienced becoming more depressed after taking the medication, or if this sentiment was something she had heard other people express.

Pam also spoke negatively about her involvement in treatment for drug addiction. She complained that she would sometimes see the counselors themselves purchasing drugs right outside the treatment center, where drug dealers would congregate. Though she did overcome her heroin addiction, she said it was "because of me and God, not them." She declared her determination to quit heroin stemmed from being tired of "all the stealing, lying, hoeing, and other things" she did in support of her habit.

Several other mothers had similarly negative perceptions of mental health treatment and especially of medication. Nicole's doctor recommended that she take medication for her depression but she did not want to because she heard that "it could make you go even crazier." She also talked about disliking group therapy because she did not want "everybody knowing [her] business." While her perceptions of group therapy

came from personal experience, her fears about medication stemmed from information she had received from her doctor.

Ashley also received negative messages about medication from a doctor (this time, a psychiatrist), and this on top of her unsatisfying encounters with psychiatrists turned her off of mental health treatment. She initially agreed to see a psychiatrist at her mother's urging. Her mother was concerned about "some incidents" that occurred in Ashley's childhood. Ashley saw one psychiatrist one time but did not like the person so switched to a different doctor. She saw the second psychiatrist twice and then stopped going. Ashley reasoned:

> All he's gonna tell me is how does that make you feel. If I knew how it made me feel then I wouldn't be here with you. [Therapists] don't do nothing but ask you the same questions and they don't give you the answers that you need.

The psychiatrist told Ashley that anti-depressants could make her feel sick for a week, which was another factor in her decision to not take the medication for her depression:

> I don't want to take some medicine that's going to make you nauseated for a whole week. Makes you sick then after a while, after riding it out, some weeks later then it better. I ain't taking medicine that's gonna make me sick. I'm already sick, why would I want to take some medicine that's gonna make me sick. No, I didn't take that medicine. I got over it.

Ashley made up her mind that "that pill does not do anything for you," and that therapists were unhelpful. She told the ethnographer that she still needed help but she refused to seek it. Her account raises questions about what, if anything, the mental health professionals could have done differently in their first sessions to let Ashley know they

better understood where she was coming from and what she was going through. Alternatively, what sort of mental health treatment would have given Ashley the "answers" for which she was searching, or the patience to find them? Her case suggests at the very least that clinicians need to be profoundly sensitive to the lens through which low-income populations may view therapy, a topic to which I will return in the discussion section.

Brenda was one mother who explicitly acknowledged the stigma towards mental health treatment that existed in the African American community. She was prescribed medicine for depression but chose not to take it. She related how she never fully recovered from the pain of the breakup with her first child's father. Brenda said she had not "been right" since then and that her "spirit was broken." Although she did not know what to do about it, she firmly believed medication was not the answer. She perceived medication to be a "crutch." More broadly, Brenda experienced "a lot of stress, tension, and issue" but "not a lot of time to think about it to try to sort it out." One challenge was the unspoken rule that people would not talk about their troubles. Brenda shared this insight about the general stigma in the African American community of talking about one's problems: "A lot of people do stuff they don't talk about, especially black people...Now a white person will run to a therapist in a minute."

In addition to holding negative opinions about medication and therapy generally, two mothers made negative assessments of drug and alcohol treatment. Briana said she was considering entering a drug treatment program because she felt she was smoking too much marijuana and wanted to stop before she started looking for a job. Her mother had also been "nagging" her to go. However, Briana was only willing to attend a program if

they provided her with bus fare. She also did not believe that treatment was a pressing issue because she "ain't gone that bad." Briana said she already knew about the repercussions of drug use and felt her time would be better spent looking for a job than sitting in rehab.

Instrumental barriers to treatment. The barriers that kept Briana out of treatment were both instrumental (transportation costs) and perceptual (she was not that far gone). Briana was sent to jail midway through the study for a drug-related offense. The data did not indicate that she ever went into treatment.

An instrumental barrier to treatment that two different mothers cited was childcare. Ana Maria was one of those mothers. After finding value in therapy four years prior to the study, Ana Maria stopped attending sessions due to being unable to find or afford someone to care for her children during session times. She reported that therapy had helped her discover her "inner power" and taught her about changing the negative situations of her life. She also said she learned about having a "better perspective of the alternatives" to her current life conditions. At the time of the interview, Ana Maria said she felt "miserable." Although she knew what she "ought to do" to improve her mental health, the reality of her situation appeared to lack options. When Ana Maria's husband cheated on her, they separated but were still living together because she could not afford to pay rent due to her part-time work status. She believed having a therapist to talk to about her problems would have helped because it had helped in the past, but she saw no way of making it happen.

Several mothers had difficulties accessing treatment because of cost, including a lack of health insurance or simply the unavailability of affordable services. I mentioned

earlier, for instance, that Wendy had to drop out of treatment at one point because her father lost his insurance. Lisa too stopped taking her anti-depressant in part because she lost her Medicaid. In a related vein, another challenge that was mentioned was that of finding mental health services that were in relative proximity to mothers' homes or places of work so that mothers could avoid taking too much time out of their day to access help. One question raised by these varied accounts was whether mental health professionals who came into contact with the mothers possessed a clear understanding of the structural challenges faced by this population. It seems likely that clinicians who do not fully appreciate and take into account the logistical difficulties low-income mothers face as they attempt to access treatment will be less successful in treating or retaining these women as clients.

Family comorbidity-related barriers. Given the large number of mothers whose children had physical and/or mental health problems, it is not surprising that a major barrier mothers faced in successfully coping with their own mental health problems was being focused on other family members and their health concerns, as has been demonstrated in this and previous chapters. A couple of examples further illustrate the point. Victoria never sought treatment for her depression because she was too preoccupied caring for her sick child and worrying about her sick mother. She said she "neglected" her own needs and "did not take the time" to take care of herself, which left her feeling more tense, worried, and depressed.

Ruth has already served as an example of family comorbidity-related challenges, and I draw on her story once again because she expended a great deal of energy treating her children's health conditions, but often it seemed as though she did not have a choice.

Ruth and her children had a family counselor, Stephen, whom she was able to see on her own only "rarely." She reported, "The only time I talk to Stephen alone is when Heidi is home watching Tim, or I get done with court…" Later Ruth indicated feeling under-supported and misunderstood by the counselor: "Every time I go to counseling, they tell me I'm not learning what I'm supposed to be learning, [but] he's not teaching what he's supposed to be teaching me." Periodically throughout the study, Ruth talked about being expected (usually by DCFS) to attend parenting classes and counseling to find out how to help her children "get along better with one another," but it is unclear whether she was ever able to address her own issues in counseling, that is her mental health issues concerns from her children's.

I mentioned in the last chapter that the concept of "allostatic load" might be especially relevant to Ruth's case. Ruth's extensive history of abuse coupled with extreme family comorbidity make it likely that she experienced repeated and excessive activations of the stress response systems. Perhaps she never learned how (or it was never safe) to effectively down-regulate. As I wrote above, allostatic load has been associated with a reduced ability to learn and/or implement new material, which would help to explain why Ruth was not learning what her counselor wanted her to learn. It was not mentioned in the data what the counselor attempted to teach Ruth. The literature (e.g., Wadsworth, 2012) would suggest Ruth needed help learning how to regulate her stress response system before she would have been able to engage in coping strategies like problem solving, healthy distraction, and active acceptance. If the counselor was not trained appropriately, he might not have known how to help her to deal with the extreme level of past and present stress she felt.

Limited social support. The data suggested that another barrier mothers faced as they attempted to cope with mental health problems was limited social support. Although mothers indicated that talking to family and friends helped them to cope, many also said they felt taken advantage of and thus they reduced their interactions with other people. For instance, Lisa said her neighbors would often come over to borrow food because they knew she had a "generous nature." She explained, "If you stay to yourself, then you don't have no problems as far as people borrowing. I have a big heart and they try to misuse that." After attempting to befriend some neighbors, she came to believe it was best to keep her distance, reporting that "it's not good being friends because a friendship is a give and take thing and I always found myself being the one to give, give, give." Nevertheless, Lisa did not seem to want to end her friendships entirely because she valued the little attention she received. As with the process of distance regulation mothers undertook with parents and partners (as detailed in Chapter 2), a similar process was observed here. Although friends, neighbors, and extended kin were imperfect supports at best, they offered some measure of support that Lisa was reluctant to give up.

Other mothers reported similarly low levels of social support but less hesitation than Lisa to sever ties. Pam stated that she felt like people took advantage of her. She said she gave more than she received, for instance to her niece, for whom she provided child care support. Tammy described relationships with people who "always want something for nothing," claiming that people were "selfish" and they asked her for help "all the time." Briana complained about all of the people who were "in her business" since she went to jail that she "stopped associating" with people and stayed in the house. She said people acted like they wanted her to improve her life, but once she started trying to do so

they were "hating on" her and "being jealous and unsupportive." Such mothers seemed to be more likely to isolate themselves as a result of a lack of social support, but perhaps they were also less likely than mothers such as Lisa to be taken advantage of again.

In support of the notion that mothers isolated themselves, a few of them explicitly admitted that they were loath to ask for help. Nicole said she experienced a lot of stress due to raising kids with very little money or outside assistance. She managed by "hanging and talking" with her friends, but she also stated that she could "trust nobody." Brenda also thought she would be better off if she had more assistance but she considered herself to be a private person and she did not like to ask for help. She believed friends and associates perceived that she had her "stuff together," and perhaps she was reluctant to dispel that perception.

While a few mothers made a deliberate decision to avoid reaching out and asking for assistance, others lacked significant support because they had moved as adults and their family and/or friends lived elsewhere. Sofia, for example, moved to the U.S. from Mexico and felt that she did not have anyone in the U.S. with whom she could share her problems or who could help care for her children. Victoria had also emigrated from Mexico and cited as a primary source of stress the fact that her mother and first-born son were still there. Like Sofia, she could think of nobody who helped her by offering advice, listening to her problems, or taking care of her children. Victoria said she felt "deep nostalgia" for her home in Mexico and for the family she left behind there. She also admitted, "For me it is difficult to ask for help, not because I do not need anything but because I would feel bad if they tell me no."

Another reason mentioned for lacking support was that of being surrounded by people who were in situations just as difficult as theirs were. Ana Maria noted that although there were women around her with whom she had a lot in common, it was unhelpful because they were not positive role models. Virtually all of the women in her neighborhood were depressed and had financial and marital problems. She observed a lot of domestic violence as well, stating that most of the men treated their wives like "dogs." Ana Maria said she wished she knew a woman who "persevered against many obstacles and made it," and who could advise her about how to be successful.

Desiring but failing to employ active coping strategies. Mothers in the sample commonly talked about things they thought they "should have been doing," or wanted or intended to do to deal more effectively with their stress and issues. For instance, I wrote above that Susan believed she should be more physically active, take more time away from the kids, spend time with friends, have "peaceful moments" at the start of the day, and read at night. But the responsibilities of caring for her children and her house made it difficult for her to meet these standards. As another example, when Ruth was asked what she did to handle her stress, she answered that she took a walk at night, saying "I've got to get out of here, I wish I could get away a few days without the kids around me but my responsibility is my two little kids.' When questioned about how often she goes for walks, Ruth responded, "I barely do it." She could recall having taken two walks in recent memory. A more commonly employed stress-relieving strategy was smoking, which Ruth wanted to give up but found difficult. She said, "I could [quit] on my own as long as the kids don't aggravate me." Ruth also considered other self-care strategies, but could not find ways around barriers to those either: "I want to go to sleep at night, take a

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bath or shower, but I can't until Heidi's home, pounding on the window like a maniac."
Again Ruth seemed to blame others (in this case, her children) rather than actively seek
out ways of changing her situation. It was unclear if this was because she did not know
how to seek out more active strategies or because she had tried and failed many times
before.

Brenda said she was "always trying to get rest, relaxation, and time" for herself
but "never quite ma[de] it." Instead she took "mini-breaks from the world" to smoke a
cigarette and drink a cup of coffee. She would do this when she got "really excited and
stressed out." Another activity Brenda wanted to do to relieve stress was to read, but she
said she "can't keep in focus." She used to buy a lot of self-help and "free your spirit"
books but thought she got "over-involved" in them. As was mentioned earlier, Brenda's
most common coping mechanisms were cigarettes and alcohol.

Conclusion

Mothers employed multiple strategies to deal with their mental health problems.
Most mothers mixed active and avoidant coping strategies. The large majority of them
sought out mental health treatment at some point but they also expressed skepticism
about both medication and therapy. On the other hand, there were reports of positive
experiences mothers had in treatment, too. Among the barriers mothers faced to treatment
and effective coping in general, many were related to focusing on others. Several mothers
articulated clear ideas of what they "should" be doing to cope more successfully with
their stress but they had a difficult time following through. Potential reasons include that
their mental health issues kept them from doing so, they lacked the space or time, or their
addictions were more powerful forces in their lives.

Discussion

The chief aim of this study was to utilize longitudinal ethnographic data to explore how low-income mothers experience and cope with mental health problems. The results confirmed much of what previous research has found about the high incidence of mental health problems among low-income populations (Kessler et al., 1994; Loprest & Nichols, 2008; Pratt, Dey, & Cohen, 2007; Yu and Williams, 1999). Findings about coping also agreed with earlier studies (Abrams, Dornig, & Curran, 2009; Matthews & Hughes, 2001; Roth & Cohen, 1986), as the mothers in this study employed a broad range of coping strategies including avoidant and active strategies. Avoidant coping mechanisms included substance use and abuse, taking out their problems on and blaming other people, not thinking about problems or the past, keeping their problems to themselves, and isolating themselves from other people. Examples of active coping included talking to friends and family members, turning to religion and prayer, and seeking out mental health treatment.

I explored the various factors mothers considered when making decisions about whether or not to seek mental health treatment. Reinforcing previous qualitative research (Anderson et al., 2006; Copeland & Snyder, 2010; Padgett, Patrick, Burns, & Schlesinger, 1994), this study found that mothers faced a number of perceptual and instrumental barriers to mental health treatment. Among the instrumental barriers they faced were lack of access to transportation, no child care, and a lack of insurance. Mothers were also under constant pressure to focus on others due to family comorbidity-related issues and lack of social support. For other mothers, barriers were perceptual in

nature. Many of them had negative views of therapy and/or medication or they had experienced therapy in the past and did not find it valuable.

Also as expected, mental health problems were exacerbated by conditions of ongoing poverty, which mothers identified as a source of constant stress. Mothers commonly cited financial stress and a lack of resources as contributing to their mental health concerns. Sixteen of the mothers (80%) explicitly linked various aspects of cumulative disadvantage – including joblessness, homelessness, inadequate education, living in poor neighborhoods, being unable to provide for their children, the stress of being a single mother, and general "money problems" – to their mental health. Most of the mothers grew up in poverty and lived with the consequences of poverty in their own lives. Five mothers in the sample (25%) traced their mental health problems back to childhood or adolescence, each of them relating the problems to difficult events or circumstances such as child abuse or homelessness, and/or to troublesome relationships such as having a distant or abusive mother. At the same time as most grew up on poverty, they all now faced the reality of raising their children in poverty. Poverty seemed to be a direct as well as indirect source of stress, as financial problems not only caused worry in and of themselves but they also contributed to relationship tension, which increased mothers' stress even more.

In addition to attributing the causes of their mental health problems to poverty, virtually all the mothers viewed relationships with extended kin, children, and partners as primary causes of their mental health issues. Common relationship-oriented explanations mothers gave for their mental health problems included learning their partners were cheating on them, being physically and/or verbally abused by partners, separation from

partners, children acting out, facing an unexpected pregnancy or pregnancy of which the father is unsupportive, feeling taken advantage of by others, and feeling isolated or ignored by others.

Contributions to Research

This study makes three major contributions to existing research. First is that even in the face of significant barriers, many low-income mothers engage in mental health treatment. In spite of both perceptual and instrumental barriers, 85 percent of the mothers in my sample received some sort of mental health treatment at some point in their lives. This finding suggests that this particular group of low-income mothers had at least minimal access and openness to mental health treatment. Important times of transition or entryways into treatment for mothers included the death of a parent, depression around pregnancy or childbirth, distress around couple relationships, problems with children's behavior, and substance use difficulties (which sometimes led to the involvement of courts or child protective systems). Some mothers reported that treatment taught them how to cope with stressful circumstances, developed their self-esteem, and gave them tools to be better mothers. For these mothers, therapists also served as important sources of emotional support. Such testimonies offer insights into the differences therapy could make in the lives of low-income mothers and their families. For instance, having a therapist to provide regular and safe emotional support might make it easier for mothers to move away from unsafe or unstable relationships, which could have substantial benefits for children and mothers alike. Previous studies (e.g., Roy & Burton, 2007) have shown that mothers sometimes rely more heavily on institutional support when their kinship networks offer inadequate resources. There are benefits and drawbacks to such

reliance, as institutional support is not guaranteed. Nevertheless, in some cases it may pose less of a risk than unsafe family or partner relationships.

For the women in the sample, the question remains as to whether treatment was of adequate length or effectiveness. Many of the mothers reported going to a counselor only a few times, for instance, and then stopping because of instrumental barriers such as child care or cost, or because they did not find it helpful. Further research is needed to better understand what kept mothers who entered treatment initially from continuing, as the Three-City Study data did not provide detailed answers to such questions. Research is also needed to identify strategies for clinicians to reach low-income mothers in need of mental health care, particularly those who are going through times of transition or difficulty as such as the types experienced by mothers in this study.

Another major contribution of this study is that it allowed a much closer look at the process of how mothers managed family comorbidity. As described in Chapter 1, family comorbidity figured prominently into mothers' understanding of the causes of their mental health issues, both by predisposing them to problems and by creating turmoil and stress at having to care for afflicted family members. Seven of the mothers (35%) believed mental health problems "[ran] in the family," while 13 mothers (65%) cited child physical and/or mental health issues as a source of stress. Four mothers (20%) mentioned other family comorbidity challenges such as having a husband with a significant physical or mental health impairment or a parent with a disability requiring their support.

Several processes were involved in mothers' management of family comorbidity. First, mothers had to negotiate their own health issues while dealing with family

members' health problems. Focusing on the health of sick children, partners, or other family members frequently meant neglecting or ignoring their own mental (and physical) health needs. Focusing on those who were sick also sometimes meant paying less attention to those family members who were healthy, which resulted in mothers feeling guilty for being unable to meet everyone's needs. Second, mothers had to navigate doctors' appointments and care for sick family members while attempting to keep their jobs. This was not always possible, as for instance mothers often had to miss work when their children were ill and sometimes they lost their jobs as a result. Thus on top of the emotional strain of dealing with multiple health problems in the family, mothers had to negotiate the additional financial strain those health problems created. A third process related to family comorbidity involved advocating for children and family members to ensure they received necessary services. Advocacy efforts were undertaken with various systems, including schools, child protective services, counselors, and other health care providers.

The mothers' accounts demonstrated the tremendous strain that family comorbidity management placed on them. The pressure of having to negotiate other people's health problems weighed heavily on many of the mothers. Mothers reported that having to manage family comorbidity exacerbated or triggered their mental health problems, but at the same time it diminished the amount of time and energy mothers had available to deal with those problems.

Overlapping with family comorbidity management was the process of regulating distance within complex, often unstable and unreliable relationships primarily with their mothers and intimate partners. Mothers with histories of poverty and abuse invested

substantial emotional energy in regulating distance with these family members who tended to suffer from mental and/or physical health conditions of their own. Several of the mothers recounted stories of suffering severe abuse as children, a pattern that often continued in their partner relationships. Because mothers' options were extremely limited by cumulative disadvantage, they continued to rely on unstable and even unsafe relationships with partners and extended kin for emotional and/or financial support.

A third contribution is that the notion of being a "bad mom" emerged from the data as being linked to mothers' mental health. Although the "bad mom" concept is not new, to my knowledge it has not been specifically studied in conjunction with low-income mothers' mental health. For instance, Garey (1999) conducted qualitative research to explore women's identities as mothers and workers. She found that women constructed meanings of "working mother" that took into account cultural standards of what it meant to be a "good" worker and a "good" mother, but that were also shaped and often constrained by the resources mothers had at their disposal. Similar to the present study's results, Garey's research suggested that mothers often blamed themselves for their children's problems and they conceptualized themselves as "bad mothers" when they were unable to provide or be there for their children in ways they (and the dominant culture) believed they ought to be providing.

The present study adds something new to research such as Garey's by uncovering the ways in which low-income mothers' activities including protecting, providing for, and caring for their children took a substantial emotional toll on the women. When they were unable to adequately protect or provide for their loved ones, many of the mothers experienced emotional dissonance and turmoil. Seventy-five percent of the mothers

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reported experiencing guilt for various reasons including taking out their frustrations and anger on their kids, passing "issues" onto their kids, past mistakes, raising their children in poverty, or simply "not doing a good job." The guilt was related to cumulative disadvantage in that the mothers knew their options for changing the situation were extremely limited. This realization of being hemmed in fed back into their mental health problems as it sometimes contributed to their turning to drugs, alcohol, or even considering suicide to escape their difficult circumstances. The "bad mom" guilt was exacerbated when responses such as harsh or neglectful parenting were triggered. In other cases mothers responded by turning to unsafe or unreliable relationships.

Also interesting was that in addition to feeling guilty for how their children suffered the consequences of their mental health problems, mothers also commonly referred to their children as "causing" their mental health problems. Thus children were often placed in a paradoxical position of being both victims and perpetrators, of needing to be protected and needing to be controlled.

Theoretical Considerations

This study has drawn on the life course framework to consider the dynamic ways in which cumulative life experiences shape low-income mothers' mental health and their efforts to care for themselves and their families. In particular, the study has employed life course concepts of context, linked lives, agency and personal control, time, timing, and adaptation. Although these terms have not been used explicitly throughout, the concepts closely relate to the major themes that have emerged from the data. Below is a brief review of the life course concepts and how they relate to the study findings.

The first concept, location in context, states that people are born into a specific historical time and geographic community, each with a particular range of opportunities and experiences. The present study clearly showed how mothers' mental health was shaped by the contexts in which they lived and by their experiences of ongoing poverty. The mothers understood their and their children's opportunities were extremely limited and this understanding played a part in exacerbating mothers' distress. Mothers perceived, for instance, that conditions of homelessness, being raised and/or raising their children in public housing, and other unstable or unsafe conditions contributed to their mental health problems. The concept of location in context was thus closely related to the theme of cumulative disadvantage.

Also related to cumulative disadvantage was the concept of timing. The life course approach posits that the timing of a life transition or event matters for the meaning and effects that transition or event will have (Elder & Giele, 2009). The mothers' accounts suggested that the timing of events at certain points in the mothers' development – for instance the onset of abuse during childhood, the experience of one's mother becoming distant and/or unavailable as a young teenager, or a pregnancy in adolescence – was indeed centrally important in shaping the meaning mothers attributed to those events and also in shaping the mothers' mental health later on.

At the same time, this study found that the life course concepts of adaptation, agency, and personal control were highly relevant. Mothers were not mere victims of their circumstances, but they were rather dynamic participants in mobilizing resources to adapt to external events. In other words, they devised various strategies to cope with their circumstances. In a related vein, the concepts of agency and personal control came into

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play. These concepts recognize that people are often planful and make choices that offer the chance for them to control their lives (Elder & Giele, 2009). There were numerous examples of agency in the mothers' stories, for instance as the mothers accessed mental health treatment, advocated for their children in an attempt to take charge of their destinies, and sought out various supports for their families.

The life course concept that was perhaps most relevant to the present study was that of linked lives. This concept emphasizes how individuals are interdependent and socially embedded. The concept acknowledges that within families, a change in one person's life often ripples into the lives of other family members. Similarly, one family member's health may affect the health and well-being of other family members. The accounts of the mothers in the sample demonstrated how such interdependence could generate support for the mothers but could also create a great deal of strain and pressure when resources were limited. Mothers expressed the belief that family and partner relationships were often a cause of their mental health problems and yet they turned to those relationships for help in coping with their mental health problems. Mothers dealt with their own health problems in the context of multiple other family health problems, which sometimes meant they neglected their own needs to take care of family members. In this way, the theme of family comorbidity was closely intertwined with the concept of linked lives.

Methodological Considerations

The Three-City Study ethnography had a number of methodological strengths, without which it would have been impossible to learn about how these low-income mothers understood and coped with mental health problems. The ethnography provided

detailed reporting and observations of what mothers said and did in the context of their everyday lives across a variety of contexts (Burton & Bromell, 2010). It also utilized formal and informal interviews over a period of several years, which allowed ethnographers to *be there* with mothers in such a way that they could gather sensitive information as well as the context for that information. In other words, mothers were given ample opportunities to reveal information when they were ready and on their own terms (Burton & Bromell, 2010).

At the same time as there were significant strengths, this study had limitations. The primary limitation was that I did not collect the data myself and consequently I had no input into or control over what questions were asked or who was interviewed. Because the primary aim of the Three-City Study was not specifically to learn about low-income mothers' mental health, but rather was to broadly assess the well-being of low-income children and families after welfare reform, it was at times challenging to pull out and piece together appropriate information on mothers' mental health. Not all of the mothers in the study answered questions about their mental health, and therefore in addition to the decision I made to focus on a single location (Chicago), my sample was further limited to those mothers for whom sufficient information was available. Even out of the mothers I selected to include in the sample, some of them provided only very limited details about mental health symptoms, diagnoses, or treatment.

Another limitation of the study was that interviews were only conducted with mothers. There were no interviews with mental health professionals to gain their perspective on mothers' mental health conditions or course of treatment, for instance. Nor were there interviews with other family members to learn what influence maternal mental

health had on the family, or how they believed various family processes may have shaped the mothers' mental health.

Also important to highlight is that the Three-City Study ethnography concluded in 2003, making the data somewhat dated. In the ten years that have passed since then, numerous changes have occurred in our nation's economy, and in our welfare and health care systems and policies, all of which have affected low-income mothers and families. The recent economic downturn, for instance, has increased the economic distress of many low-income families and hampered parents' ability to invest in their children's education, nutrition, and health (Chaudry, 2010). On the other hand, a significant and potentially positive development occurred in health care policy with the passage of the Affordable Care Act, which was signed into law in 2010 and upheld by the Supreme Court in 2012 (U.S. Department of Health and Human Services, 2013). New studies will be needed to explore how these and other recent developments may shape the mental health of vulnerable populations such as low-income mothers. It is to the topic of future research that I turn next.

Implications for Research

Additional research is needed in several areas related to the current study. Most fundamentally, there is a need for a continued focus on low-income mothers' mental health issues and especially for utilizing ethnographic research to understand the processes at play for mothers and families. I believe there would be great value to further analyzing the Three-City Study ethnographic data, including cases from Boston and San Antonio. Much more could be learned by going into greater depth with an expanded number of cases and focusing on various aspects of mothers' mental health. For instance,

it would be worthwhile to conduct a more nuanced analysis of the role of partner

relationships or family relationships in shaping mental health. Also of value would be to

study how mental health shapes program use related both to mothers and children,

including housing, education, and health-related programs. The data could also be used to

study how mental health shapes mothers' employment and movement toward self-

sufficiency.

In addition to utilizing Three-City Study data, more ethnographic research is

needed to focus more specifically on low-income mothers' mental health issues, their

treatment experiences, and the interplay of mothers' mental health with the health of the

family. While the current study provided important insights, future ethnographic studies

could be designed to interview mothers in greater depth regarding a variety of mental

health-related topics. These would include such things as beliefs about mental health

treatment and where those beliefs came from, detailed descriptions about experiences

with mental health treatment, and the like. The inclusion of such an interview protocol in

an ethnographic study would add great value to the current knowledge about factors that

help or hinder low-income mothers as they attempt to address their mental health

problems.

Even more targeted research is needed to focus on the efficacy of mental health

treatment for low-income mothers. As the present study demonstrated, this population is

likely to make use of mental health care services. What is much less clear is which

treatments are most effective for treating which conditions. Studies are needed to

evaluate treatments for anxiety and depression, substance use disorders, PTSD and other

trauma-related conditions, and a host of parenting-, family-, and couple-related concerns that low-income mothers commonly experience.

Another direction for future studies is to further test the "bad mother" concept as it relates to maternal mental health. My research raised a number of questions about the concept that merit additional exploration. For instance, I found that some mothers seemed to overcome their mother guilt or to transform it into something else. More research is needed to understand in what contexts it is possible for mothers to overcome or transform their guilt. What factors help or hinder the process (e.g., therapy, social support, strong family relationships)? Furthermore, studies could look into differences between mothers who report feeling like "bad mothers" and those who do not. How are their experiences different and what if any protective factors can be identified among mothers whose mental health does not suffer from mother guilt? Future research could also examine the role of partners and extended kin in contributing to or alleviating the guilt, blame, and shame of low-income mothers.

As I alluded to above, it will also be important for researchers to examine the impact of the Affordable Care Act on low-income mothers' access to effective mental health care services. What difference if any will health care reform have on this population's ability to afford and navigate systems of care for themselves and their family members? How will it change the ways in which providers are held accountable for treatment? What changes might be made in agencies' coordination of services? It will be critical to track health care reform in order to ensure we know the answer to these and other questions.

Implications for Policy

As with much research before it (e.g., Kaplan, 2009; Loprest & Nichols, 2008; Pearlin et al., 2005; Shuey & Willson, 2008), this study found a clear relationship between cumulative disadvantage and poor health, including poor mental health. Eighty percent of the mothers in the sample linked their poor mental health to some component of cumulative disadvantage, such as unemployment, being unable to pay bills or otherwise provide for one's family, homelessness, and disadvantage and/or abuse experienced in childhood. As I described in the literature review, poor maternal mental health and poverty have also been associated with children's developmental delays (Petterson & Albers, 2003). Furthermore, child development outcomes have been found to be adversely affected by mothers' post-partum depression, with the worst outcomes found for children in disadvantaged families (Murray & Cooper, 1997).

Such findings strongly suggest the need for policies that promote structural changes to alleviate poverty and cumulative disadvantage. While a detailed discussion of such policies is beyond the scope of this study, I will highlight several promising approaches for supporting low-income families. I do so because I believe poverty alleviation is an essential mental health care strategy and ought to be elevated as a central component of U.S. mental health care policy.

Develop affordable child care options. The United States' antipoverty strategy has been based on the assumption that most adults are able to and should work, even if they have very young children. Cancian, Meyer, and Reed (2010) argue that in order for this strategy to be functional, policies are needed that help parents to balance their work and family responsibilities. The mothers in my sample certainly made this point clear as

they struggled to balance competing demands of jobs and being present for their children. This often involved managing their children's health conditions while also keeping themselves healthy enough to work. Many of the mothers in the sample had weak or unreliable social networks to support them in caring for their children, making help with child care all the more crucial. Affordable child care is therefore one necessary building block of an antipoverty strategy that is work-focused, whether by increasing the availability of child care subsidies, expanding Head Start and Early Head Start programs, or through other means (Cancian et al., 2010). For families that have children with physical and/or mental disabilities, the amount of child care subsidies may need to be increased (Lloyd & Rosman, 2005).

Create family-friendly workplace policies. In addition to affordable child care options, low-income parents need policies in the workplace that take into account their parental responsibilities. The Bureau of Labor Statistics (2007) reported that low-wage workers are the least likely of all workers to have workplace benefits such as paid sick leave and employer-sponsored health care. At a minimum, policies to expand paid and unpaid leave to cover a greater number of employers should be considered. In addition, the Unemployment Insurance system could be expanded to apply to more low-income workers such as those looking for part-time work and those who have had to leave work for family-related reasons (Cancian et al., 2010).

Reform child support policies. Many of the mothers in the sample received some amount of child support. The amounts varied widely and payments were unreliable, in part because it could be difficult to track down their children's fathers and in part because fathers experienced unemployment and/or also had other children to support.

Such challenges added to the financial stress of mothers. An important implication is that child support policies need to be reformed to focus more on the well-being of children and families and to take into account the realities of economic uncertainties and complex family dynamics (Cancian et al., 2010). Currently, the child support system acts more as an apparatus for government cost-recovery than as income support for low-income families (Cancian et al., 2010). According to the U.S. Census Bureau (Grall, 2011), in 2009 only 41.2 percent of custodial parents who were due child support payments received the full amount. The proportion of custodial parents who were due payments but received none was 29.2 percent. Cancian and colleagues (2010) recommend making the child support system more effective for mothers and children by allowing those receiving TANF cash assistance to also receive all child support payments without penalty, allowing them to keep past-due child support payments that are made, and eliminating any efforts to charge nonresident fathers for Medicaid birthing costs.

The child support system also needs to acknowledge that many nonresident fathers of low-income children are resource poor themselves and may find it difficult to offer substantial assistance. Policies therefore also need to address nonresident fathers' barriers to employment and support their efforts to work. Ideas worth considering include expanding access to programs such as the Earned Income Tax Credit, Medicaid, and job training to nonresident fathers who pay child support (Cancian et al., 2010).

Align workforce development policies to economic realities. A critical component of a cohesive antipoverty strategy is training and education to provide low-income workers with access to better-paying jobs. One projection has estimated that the economy will create 47 million jobs between 2008 and 2018, of which 64 percent will

require postsecondary education or training (Carnevale, Smith, & Strohl, 2010). Not surprisingly, the jobs that will be available to those with a high school education or less will likely be low-wage jobs, many of them part-time or transitional (Carnevale et al., 2010). To narrow the gap between the education and training requirements of many future jobs and the skill levels of many low-income job seekers, programs need to be created and/or expanded that would enable low-income populations to overcome various barriers to gaining required skills. Examples include: structured programs such as apprenticeships and paid internships that provide (and pay for) work experience and on-the-job learning; compressed and intensive occupational training programs that lead to postsecondary certificates that have clear labor market value; and training options that blend classroom, online, and work-based learning (Carnevale et al., 2010).

Support initiatives that target low-income children and youth. Aber and Chaudry (2010) wrote that public investments in children and youth are at their lowest when they matter most: before kids enter public school (ages 0-4) and after leaving public school before they are truly self-sufficient (roughly ages 17 or 18 to 21). Thus low-income children are already disadvantaged before they even enter school and the gap continues to widen during a key period of transition as young adults seek out employment. For these reasons, policymakers should prioritize early childhood education as well as postsecondary development. As I mentioned above, one important step is to expand such programs as Head Start and Early Head Start. Although Early Head Start expanded as a result of the $1.1 billion it received as part of the 2009 American Recovery and Reinvestment Act, Schmit and Ewen (2012) reported that as of 2010, fewer than 4

percent of eligible children age 3 and under were able to attend the program. Clearly, there is a great deal of room to grow.

Low-income youth also need investment in their development to help break the cycle of poverty. For young people with low skills and no interest in attending college, research suggests that effective programs are those that combine classroom study with direct work experience (Aber & Chaudry, 2010). I also agree with Carnevale and colleagues (2010), who argued that we ought to revive technical and career-focused education programs in high schools as alternative routes to further education or as pathways to industry-based certificates that enable students to secure employment after high school.

For youth who are college-bound, reforms are needed to increase access to Pell grants and to simplify the process by which students apply for financial aid. In addition, incentives should be made available to help disadvantaged students complete their degrees (Aber & Chaudry, 2010).

Implications for Clinical Work

In addition to advocating for policy changes to alleviate poverty, I affirm several opportunities mental health professionals have to improve their services to low-income mothers and families. Given that a large number of the mothers reported being dissatisfied with or having negative perceptions of mental health treatment, it is imperative that clinicians consider ways in which they can effectively reach this vulnerable group.

Adapt services to meet the needs of low-income clients. One implication of the present study is that traditional psychotherapy is likely inadequate to meet the multiple

and varied needs of low-income clients such as the mothers I wrote about. Attempting to fit this population into the traditional mold will face a greater likelihood of clients dropping out of treatment, often as a result of instrumental barriers. Therefore therapists working with this population need to be equipped to address a range of issues and offer practical support. Promising results have been achieved through a collaborative, interagency team approach utilizing a case manager (Sharlin & Shamai, 2000). Other adaptations to traditional therapy include making regular home visits, providing therapy in locations such as community centers, scheduling sessions in the evenings and on weekends, providing vouchers for transportation, and making child care available. Also of critical importance is training therapists about the concept of allostatic load and how to help clients to regulate their stress response system and develop effective coping strategies. As I discussed previously, allostatic load has been associated with a reduced ability to learn and/or implement new material (Wadsworth, 2012). Teaching clients to down-regulate is a necessary first step before they will be able to learn problem solving, healthy distraction, and active acceptance.

Address expectations and beliefs about therapy in the first session. In addition to instrumental barriers, a significant impediment for mothers in this study to entering or continuing in mental health treatment was the perception that therapy was or would be ineffective. An implication is that therapists must address client expectations and perceptions about therapy as early in the therapeutic process as possible. In this way, clinicians can take a non-defensive stance with clients, acknowledging that a lot of people are skeptical about therapy but that clients should feel free to ask any questions they may

have. Clinicians may also find it beneficial to explain that the role of the therapist is to collaborate with and act as a resource to clients, not to act as "expert."

Address social class in therapy. Much of the literature on treating low-income individuals and families has emphasized the need for therapists to address social class differences in therapy (e.g., Grimes & McElwain, 2008; Thompson, Cole, & Nitzarim, 2012). For instance, Thompson and colleagues (2012) interviewed low-income clients in therapy and found that social class was important in shaping their experience of therapy. Clients who described their experiences as positive attributed those experiences partly to the willingness of their therapist to discuss social class-related content in therapy and to understand the complexities of their stories as lower-class individuals. Other clients described their experiences less positively and reported that their therapist was dismissive of the impact of social class and/or that the therapist lacked awareness of social class.

Build on client strengths. Given the prevalence of advocacy and caring behaviors mothers in the study demonstrated, an important message for clinicians is that they should build on and help to develop family strengths. A strengths-based approach would be critical for therapists helping low-income mothers to process and sort through the "bad mother" guilt they experience. Such an approach would empower mothers and affirm the advocacy, care, and protecting behaviors they direct toward their children and others, while also focusing on reducing risky behaviors such as substance abuse and harsh parenting (Arditti et al., 2010).

Conclusion

It is fitting to end this study with a reminder to focus on strengths. Although the low-income mothers that have been the focus of this research faced tremendous

challenges, it would be unfair and short-sighted to overlook the great assets they and so many like them also possess. Keeping those strengths in mind helps us as researchers and clinicians to hold onto hope that health inequalities can be reversed, and that generations and communities need not be condemned to poverty. No doubt, our hope must also fuel action as we pursue effective strategies not only for improving the mental health of low-income mothers and families, but more fundamentally for alleviating poverty in our nation.

Appendix A: Mothers' Demographic Information Table

Pseudonym	Age	Race	# Children	Mental Health Treatment (Y/N)
Sharon	34	African American	5	Y
Kara	21	African American	2	Y
Lisa	23	African American	2	Y
Pam	42	African American	1	Y
Tammy	38	African American	8	Y
Briana	25	African American	3	N
Nicole	27	African American	4	Y
Amy	27	African American	4	Y
Brenda	25	African American	3	Y
Wendy	25	African American	1	Y
Vicky	26	African American	1	Y
Ruth	43	Caucasian	4	Y
Susan	50	Caucasian	4	Y
Mariana	16	Latino	2	Y
Ana Maria	32	Latino	3	Y
Elana	30	Latino	4	Y
Gloria	41	Latino	4	N
Sofia	36	Latino	3	Y
Victoria	35	Latino	5	N
Carla	30	Latino	3	Y

Appendix B: Descriptions of Sample Members

African-American Mothers

Sharon is a 34-year-old mother to three daughters (15, 10, 2) and 2 sons (12, 4). She has a long-term boyfriend who is also the father of most of her children. Sharon has a family history of alcoholism and a history of drug abuse. She dropped out of high school and became pregnant as teenager. She went to rehab and received counseling there.

Kara, 21, has two sons (age 3 and newborn) by different fathers. She has been homeless since age 14. Her older child sees a psychologist for aggression, anger, and depression later in the study and is eventually hospitalized. Colleen sees psychologist though it is unclear for what diagnosis.

Lisa, 23, has two daughters (5 and 4). She has a history of child abuse, homelessness, drug abuse, and depression (diagnosed). Her husband is abusive and she eventually divorces him. Lisa takes medication for depression but stops midway through the study.

Pam is the 42-year-old paternal grandmother and off-and-on primary caregiver to her five-year-old grandson, whose father is incarcerated for murder. Pam has a history of school dropout, teen pregnancy, prostitution, and drug abuse. She also has heart problems, migraines, and a family history of MS and diabetes. There is mention of domestic violence between Pam and her live-in boyfriend. Pam was on anti-depressants but stops taking them. She is resistant to therapy.

Tammy, 38, has eight boys ranging in age from 9 months to 17 years. Her oldest son is in jail for a drug-related offense. Her (common-law) husband is also in jail. Others of her children suffer from multiple physical and behavioral health problems. Tammy has a history of drug and alcohol abuse, for which she receives treatment.

Briana, 25, has two daughters (6, 2) and one son (newborn). She uses drugs and goes to jail midway through the study. Although she mentions experiencing depression, there is no indication that she receives mental health treatment.

Nicole is a 27-year-old mother to three sons (8, 6, and 2 years) and one daughter (7) years old. She has a history of child abuse and domestic violence (her ex-husband abused her). She was diagnosed with depression and went to therapy. Her children have physical and behavioral health problems.

Amy, 27, has three sons (6, 4, 3) and one daughter (7). She has diabetes and depression, and her children have asthma, obesity, and are at risk for diabetes. Her depression started during her first pregnancy but she did not like the process of therapy.

Twenty-five-year-old *Brenda* is mother to two sons (9 and 4) and one daughter (3 months). She suffered abuse by her boyfriend after the birth of her youngest child, for which her boyfriend went to jail. Two of her children have physical and behavioral health problems. Brenda's depression was so bad it was difficult for her to get out of bed, but she resisted treatment.

Wendy, 25, has a 5-year-old son. She and the father divorce midway through the study. Wendy attempted suicide at the age of 17. She has a family history of mood disorders and alcoholism. She receives extensive counseling for depression and panic attacks and takes medication.

Vicky, 26, is married and has a 4-year-old daughter. She notes that heart disease and obesity run in her family. She experiences social anxiety and depression and has had some therapy. An additional stressor is that her husband has a slipped disk; he loses his job as a result.

Caucasian Mothers

Ruth is 43 and has three daughters (17, 13, 4) and one son (6), all to different fathers. Ruth suffers from many physical health problems (hearing and vision, back problems, asthma, uterine fibroids, thyroid problems, dental problems) and has been physically abused by all the children's fathers. There is a family history of mental health disorders, including retardation, brain damage, and ADHD. All her children have been hospitalized at some point for mental health issues and they have multiple physical health problems.

Susan, 50, is the adoptive mother to two daughters (20, 5) and two sons (6, 4). In addition to depression, she has a number of physical health problems, including obesity, hypothyroidism, hypertension, kidney stones, dental problems, and vision problems. Her children experienced extreme abuse in their families of origin and suffer multiple physical and mental health problems as a result. Mother and children receive counseling.

Latino Mothers

Mariana, 16, has one daughter (1 year) and a newborn son. She traces her depression and anxiety back to the 5th or 6th grade and has been taking medication ever since. She considers her difficult relationships with her boyfriend and mother to be sources of depression.

Ana Maria is a 32-year-old mother to two sons (13 and 6) and one daughter (2) who separates from her husband (the children's father) midway through study. She traces her depression back to when she learned her husband was having an affair. In addition to depression, Ana Maria has arthritis and obesity. One of her children has scoliosis and another has behavioral problems. Ana Maria went to therapy for depression but had to stop going because she had no child care.

Elana, 30, has two sons (6 and newborn), and two daughters (3 and 1), and is married to the children's father. Her mother, to whom Elana was very close, died of ALS early in the study. Elana has depression, high cholesterol, and dental problems, but avoids going to health care professionals. Her youngest child also has health problems.

Gloria, 41, has three daughters (12, 10, 7) and one son (4). Born and raised in Mexico, Gloria dropped out of school after elementary school to get a job when her father left the family. She and her siblings moved to the US as young adults. Gloria's children have problems in school, one child has behavioral problems, and another has severe allergies and back pain. Aileen suffers severe headaches and has a history of depression that was severe enough to have threatened her last pregnancy. She has been treated for depression.

Sofia is 36 and has one son (5) and two daughters (10 years and newborn). She moved to the US from Mexico and has been divorced two times. One child is having problems learning and another is displaying behavior problems. Sofia and one of her daughters received counseling when her first husband left.

Victoria, 35, is from Mexico and has four sons (16, 6, 4, 3), and one daughter (7). Her oldest son still lives in Mexico. He has a different father than the rest of the children. Victoria is married to the father of the younger four kids. They moved from Mexico in July 2000 because of one of the children's health problems and the financial strain those health problems caused. The child's illness was difficult for Victoria emotionally but she never received any mental health treatment.

Carla is a 30-year-old mother with two sons and (8, 5) and one daughter (4). Her husband is the father of the daughter. Their relationship is reportedly tense and sometimes violent.

Carla used to smoke and drink but she quit, however her husband still drinks. Carla received treatment for depression.

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