MENTAL HEALTH PROBLEMS AMONG SINGLE MOTHERS: IMPLICATIONS FOR WORK AND WELFARE REFORM[1]

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ABSTRACT

The 1996 welfare reform bill changed the nature of public assistance from an open-ended entitlement to a transitional program with work requirements and time limits. The emphasis on self-sufficiency and the expectation of work is based on the assumption that poor single mothers are similar in their status and functioning to the rest of the population. However, we find that their psychological status is quite distinct. Findings indicate that 17 percent of all single mothers, 22 percent of women receiving welfare and 20 percent of non-working single mothers, had experienced a psychiatric disorder within the past year. Logistic regression results reveal that having a psychiatric disorder is associated with a 25 percent lower likelihood of working. Mental health problems may prevent women from undertaking the tasks necessary to find employment, or women with these problems may lack the self-confidence needed to take on new challenges. Even after obtaining employment, mental health problems can play an important role in welfare and self-sufficiency outcomes. Our findings suggest that mental health problems among single mothers deserves greater attention as a barrier to self-sufficiency, and highlights the need for more effective intervention and treatment efforts to improve economic and social outcomes.

INTRODUCTION

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) focuses on moving women "from welfare to work" by ending entitlement to cash assistance and requiring work in exchange for time-limited assistance. After two years of receipt (or fewer at state option) recipients must participate in work-related activities.[4,5] After two years of receipt (or fewer at state option)[6] families will be ineligible for federally-funded cash aid.

Central to the political debates surrounding welfare reform is the idea that welfare recipients should be expected to work. The passage of work requirements and time limits indicates a clear shift in welfare policy from income maintenance to emphasizing work and self-sufficiency. Underlying this shift is the notion that since the majority of American mothers work, poor, single mothers should also be expected to participate in the labor force. This argument implicitly assumes that welfare recipients are similar in their status and functioning to the general population. Given recent changes in welfare, and the need to move women off welfare and into employment within specified time-limits, identifying the potential employment barriers that these women face is crucial.

While differences in the personal characteristics of welfare recipients was well-known to policy experts and program officials in the AFDC program, variations within the caseload received little attention. Because the traditional AFDC system effectively provided open-ended assistance, heterogeneity was of little concern. The advent of time-limits and work requirements, however, has forced researchers and program administrators to confront the great variations in personal problems and circumstances. The sharp caseload reductions experienced across the country, make it likely that those remaining on the rolls experience multiple difficulties that hinder their ability to achieve self-sufficiency, even during a robust economic recovery.

When examining employment barriers, the traditional focus has been on structural barriers, including access to child care, transportation costs, the availability of jobs paying a living wage, racial barriers and welfare disincentives. Discussions of individual barriers to self-sufficiency are often limited to demographic factors, such as the lack of schooling, job training and work experience, and have made little mention of psychological difficulties (Olson & Pavetti, 1996).

Yet mental health problems appear to be an important barrier to self-sufficiency, and the existence of these problems may prevent some women from leaving welfare for work in a timely manner. A growing body of research suggests that mental health problems profoundly impact social functioning (Tweed, 1993), and result in lower rates of labor force participation, reduced work hours and lower earnings (Bland, Stebelsky & Newman, 1988; Ettner, Frank & Kessler, in press; Jayakody, Danziger & Kessler, 1998; Kessler & Frank, 1996). Despite the lack of focus on the mental health problems of welfare recipients, recent research indicates that these women may experience higher levels of psychiatric distress than individuals in the general population, and that these problems may affect their economic self-sufficiency. Because psychological factors play a potentially critical role in the success of welfare reform efforts, we focus on the mental health of women, and more specifically, the mental health of single mothers. Mental health problems are a potentially important function of welfare receipt and female labor supply that have been overlooked.

BLAMING THE VICTIM

A long standing controversy in poverty research has been the debate over individual responsibility versus structural barriers as the root cause of welfare dependency. Many

researchers have been cautious about discussing the psychological status of welfare recipients fearing this lends credibility to the individual responsibility argument. Indeed, many sought to emphasize the similarities between welfare recipients and the general population –"the poor are just like you and me, they just lack money". This was a rational course of action for supporters of expanded social provision in a society with a tenuous commitment to redistributive concerns. Many believe highlighting the psychology of the poor as distinctive constitutes "blaming the victim", and directly leads to arguing that poverty and welfare receipt results from poor motivation, the lack of adherence to middle-class social norms and values, and a general "culture of poverty"(Moynihan, 1965). Yet, pointing out the mental health problems of welfare recipients does not negate that societal factors may be the ultimate cause of these problems, and that the lack of opportunities and structural barriers impact not only poverty outcomes, but mental health outcomes as well.

FAMILY STRUCTURE, POVERTY AND MENTAL HEALTH

Several lines of research suggest that welfare recipients will have high rates of mental health problems. Women receiving welfare may be at a particularly high risk of experiencing mental illness because of the established relationships between 1) poverty and mental health, 2) family structure and mental health, and 3) welfare receipt and mental health. By focusing on the context of welfare recipients' lives, and by discussing the relationship between mental health problems and a variety of demographic factors, we hope to make clear why mental health problems are important to consider and why recipients' themselves are not necessarily at fault for the existence of any mental health problem, poverty or welfare receipt.

The relationship between mental health and poverty is well established, showing that individuals in lower socioeconomic groups experience higher rates of psychiatric problems. While this relationship is widely recognized, the direction of causation is still debated. Some believe this relationship results from the "social selection" of the mentally ill into lower socioeconomic (SES) strata, while others argue that lower SES produces mental disorders (Bruce, Takeuchi & Leaf, 1991; Hunter & Macalpine, 1963; Eisenberg & Lazarsfeld, 1938; Dohrenwend & Dohrenwend, 1969; Feather, 1990; Dohrenwend et al., 1992; Jayakody, Danziger & Kessler, 1998; Kessler, 1982). Regardless of the direction of causality, studies examining the prevalence of mental disorders by socioeconomic status find that individuals in the lowest social class are two and one half times more likely to have mental health problems than individuals in the highest social class (Neugebauer et al., 1980) and that prevalence rates decline monotonically with socioeconomic status (Kessler et al., 1994).

Family structure has also been identified as an important factor related to mental health outcomes, with single motherhood emerging as a powerful predictor of poor mental health (Burgos, Lennor, Bravo, & Guzman, 1995; McLanahan, 1985). Single mothers demonstrate higher levels of psychiatric symptomology than other categories of women (Belle, 1980; Bennett, 1987; Burgos et al., 1995; Hall, Williams, & Greenberg, 1985; McLanahan, 1985; Weisman, Leaf & Bruce, 1987), and are particularly at risk for experiencing depressive symptoms (Burgos et al., 1995; Hall et al., 1985). Again, the direction of this relationship is unclear. While some believe that poor mental health results from financial insecurity and the greater number of daily stressors that single mothers experience, others believe that childbearing and/or marital disruption result from mental health problems (Hall et al, 1985; Pearlin & Johnson, 1977; Belle, 1982; Makowsky, 1982).

The lives of welfare recipients have been described as "perilous" (Salomon et al., 1996, pg. 521), filled with constraints and challenges (Brown et al., 1975; Dohrenwend, 1973; Pearlin & Johnson, 1977; Makowsky, 1982) which create chronic stress. In this context, it is difficult to imagine why single mothers would not have high rates of mental health problems. The stressful life events, limited social and economic resources, and other demographic disadvantages that accompany single parenthood, poverty and welfare receipt provide compelling explanations as to why welfare recipients have higher rates of psychiatric distress. Others believe that psychological problems result from women's stigmatizing and humiliating experiences with the welfare system (Jarrett, 1996; McLoyd & Wilson, 1991; Goodban, 1985; Nichols-Casebolt, 1986). The current policy climate of impending time-limits calls for greater attention to be paid to the context of mental health problems among welfare recipients and the potential barrier these problems pose for work and self-sufficiency.

IMPLICATIONS FOR WORK AND SELF-SUFFICIENCY

The inter-related conditions of poverty, single-motherhood and welfare receipt frame the experiences of single mothers and place them at considerable risk for mental health problems. Recent studies have begun to document the prevalence of mental health problems among the welfare population, highlighting their potential importance. These estimates tend to vary because of the different mental health measures used and because of varying sample characteristics. While several demonstration programs relied on the Center for Epidemiological Studies Depression (CES-D) scale, recent studies are increasingly using diagnostic criteria (DSM-III-R or DSM-IV) established by the American Psychiatric Association (American

Psychiatric Association, 1987). DSM definitions provide a widely recognized and accepted definition of what constitutes a psychiatric disorder.

An evaluation of the New Chance demonstration program, designed to increase the educational and employment outcomes of young mothers, documented that 53 percent of their applicants were at risk of depression (Quint et al., 1994), measured using the CES-D. The JOBS program evaluation, which used 4 items from the CES-D, reports that 42 percent of their mothers, more than twice as many as in the general population, were assessed to have high levels of depressive symptoms (U.S. Department of Health and Human Services, 1995). Relying on DSM-III-R criteria, a study of welfare recipients in Michigan reports that 27 percent experienced major depression within the past year (Danziger et al., 1999). Nationally representative data from the National Household Survey of Drug Abuse, using DSM-III-R criteria, reports that 20 percent of women receiving welfare had experienced a psychiatric disorder within the previous year (Jayakody, Danziger & Pollack, 1999).

These prevalence rates have important implications for welfare reform. Women with these problems may have difficulty making the transition from welfare-to-work and achieving self-sufficiency. For example, mental health problems may place women at a greater risk for sanctioning, due to non-compliance with work requirements and other regulations. Mental health problems may also prevent women from finding and maintaining employment, increasing their risk of reaching the 5-year lifetime limit on federally- funded cash aid. Because of the potentially important role that mental health problems play in the success of welfare reform, we seek to further examine its role by 1) highlighting how prevalence estimates differ by family structure, poverty and welfare receipt, and by 2) examining the relationships between mental health problems and the work efforts of single mothers.

DATA

We analyze data from the 1994-96 National Household Survey of Drug Abuse (NHSDA), an annually repeated, national cross-sectional survey of the civilian, non-institutionalized population. Appropriately weighted, the NHSDA is representative of the national population.

A new questionnaire was used in 1994 and thereafter, which retained the core questions from previous surveys, and introduced a series of new measures focusing on mental health. These new measures used the short-form of the University of Michigan-Composite International Diagnostic Interview (UM-CIDI) to generate information on psychiatric diagnoses. The UM-CIDI is a non-clinically administered psychiatric diagnostic interview that was originally used in the National Comorbidity Survey (NCS) (Kessler et al., 1994). Field tests of the CIDI conducted by the World Health Organization documented high reliability and validity with diagnoses. The CIDI generates psychiatric diagnoses according to both the DSM-III-R and the ICD-10 diagnostic systems (Wittchen, 1994) and provides a widely recognized and accepted definition of psychiatric problems. The NHSDA collected information on four mental health problems that meet DSM-III-R criteria (American Psychiatric Association, 1987): major depression, generalized anxiety disorder, panic attack, and agoraphobia.

A limitation, inherent to the cross-sectional nature of the NHSDA, makes it difficult to untangle the simultaneous causal pathways by which mental health problems both influence and reflect adverse family circumstances and poor economic outcomes. Mental health problems may trigger prolonged welfare receipt and adverse economic outcomes. However, poverty, family

dislocation and welfare dependence can also stimulate depressive symptoms and other mental health problems.

Despite this limitation, the NHSDA's rich data provide a valuable benchmark between mental health problems and economic conditions. Although we can not untangle issues of simultaneous causation, the associations we document are important for public policy. Prolonged welfare dependence and poverty aggravate existing mental health problems, and thereby become barriers to self-sufficiency even among individuals who display few prior risk factors for diagnoses. At the same time, individuals who enter welfare with existing mental health problems are likely to experience prolonged spells.

Sample

Our sample consists of 4,423 single mothers living with their own minor children (See Table 1 for a demographic description of the sample). Because of their small sample size, we exclude widowed mothers and women who are Native American and Asian American. We also exclude disabled and retired mothers and full-time students so that our sample could approximate the women who are required to work under welfare reform. To the extent that mental health problems cause women to leave the labor force and define themselves in the more socially acceptable category "disabled", this exclusion understates the negative effects of mental health problems. Because the 1994-1996 surveys used the same questions for the outcomes of interest, and because the annual surveys yielded demographically similar cross-sections of single mothers, we pooled the data. Additionally, all these annual surveys were conducted prior to the passage of welfare reform legislation.

Statistical Methods. We begin by comparing the overall prevalence of psychiatric disorders across different categories of mothers: married versus unmarried mothers, single

mothers by income level, and single mothers by welfare receipt and employment status. The NHSDA employs a complex survey design, including unequal selection probabilities, stratification and clustering. All analyses are appropriately weighted and the standard errors have been recalculated to account for design and sampling effects.

We next use a logistic regression model to examine the relationships between mental health problems and work. The logistic regression model provides a convenient way to explore patterns in the data, controlling for the standard socio-demographic factors associated with work. The logistic regression model is based on our sample of all single mothers, which includes welfare recipients and non-recipients. Simultaneous causation and omitted variables may be operative, thus questioning the interpretation as a causal model. Given the nature of the available data, we interpret our results cautiously, noting that simultaneity and omitted variables may influence the estimated coefficients.

RESULTS

We first examine how mental health prevalence rates differ across different groups of women in order to establish a context for discussing mental health problems among welfare recipients. That is, given the established relationships between mental health problems and family structure, poverty and welfare, it should be no surprise that rates of psychiatric illness are higher among the most economically and socially disadvantaged women. The first comparison examines the impact of family structure (Table 2). As expected, single mothers show significantly higher rates of most disorders. Among both married and single mothers, depression is the most common disorder experienced, with 8 percent of married mothers and 10 percent of

single mothers experiencing this condition within the previous year. Overall, 17 percent of single mothers had experienced one of the four disorders examined.

Next, we compare prevalence rates among single mothers by economic level, dividing the sample into those with personal incomes of $20,000 or more and those with personal incomes below $20,000 (See Table 3). Strong differences in prevalence rates by income level are evident, with poor economic resources being highly correlated with poor mental health. Low-income single mothers have rates of psychiatric disorders that are significantly higher than higher income single mothers (19 percent versus 15 percent, respectively). Prevalence rates among single mothers were also found to vary substantially by work and welfare status. Table 4 indicates that 22 percent of women receiving welfare had experienced a psychiatric disorder in the past year, a rate significantly higher than the 15 percent experienced by non-recipients. Table 5 presents estimates by employment status, indicating that 20 percent of non-working single mothers had experienced one of the four disorders examined. These prevalence rates illustrate how women facing multiple economic and social disadvantages have higher rates of mental health problems. Regardless of whether mental health problems are a cause or consequence of these disadvantages, Tables 2 through 5 indicate the high prevalence of mental health problems among a group of women increasingly expected to work and become self-sufficient.

We next examine whether, after controlling for relevant socio-demographic characteristics, mental health problems are associated with a lower probability of working. Table 6 presents the results from this logistic regression model. Work is defined as either full- or part-time employment. In examining the impact of psychiatric disorders, we control for the standard characteristics associated with employment. Results indicate that having a psychiatric

disorder in the past year is associated with a 25 percent lower odds of working , even after relevant socio-demographic variables (e.g., marital status, education, race) have been controlled. To further illustrate the associations between psychiatric problems and the probability of working, predicted probabilities were calculated from the regression results in Table 6. These estimates were then modified by psychiatric disorder status. The baseline case corresponds to an African American, never married single mother, aged 25, with 2 children who is in excellent or very good physical health, living in an urban area in the Northeast. Separate probabilities are calculated for women with a high school education and those without a high school degree.

Figure 1 illustrates how the probability of working differs by education and the presence of a psychiatric disorder. Among high school dropouts, having a psychiatric disorder is associated with a 5 percentage point decrease in the probability of working. High school graduates with a psychiatric disorder experience a 7 percentage point decline in their probability of working. While psychiatric disorders are significantly associated with work outcomes, it is important to note that education, a standard demographic characteristic associated with work, has a much larger impact. Among those with a psychiatric disorder, having a high school education increases the probability of working by 20 percentage points. Although not as large in magnitude as education, mental health problems are an important factor differentiating single mothers who work from those who do not. Given the emphasis on work and self-sufficiency in the current political context, these results suggest that mental health problems may be an important source of variation between women who are able to achieve self-sufficiency and those who do not.

DISCUSSION

The 1996 welfare reform bill emphasizes self-sufficiency and the expectation of work, based on the assumption that poor single mothers are similar in their status and functioning to the rest of the population, and therefore can and should support themselves and their family. As Tables 2 through 5 illustrate, however, their psychological status is quite distinct. Among the four disorders examined, 17 percent of all single mothers, 22 percent of those women receiving welfare, and 20 percent of non-working single mothers had experienced a DSM-III-R psychiatric disorder within the past year.

While these rates may seem high, actual prevalence rates are probably higher. That is, the NHSDA likely under-estimates psychiatric prevalence rates among this group of women. The NHSDA examined only four disorders—major depression, generalized anxiety disorders, agoraphobia and panic attacks; the full extent of psychiatric disorders would be much higher if the NHSDA had measured additional disorders. Data from the National Comorbidity Survey[7], which contains information on over 10 psychiatric diagnoses, indicates that almost 40 percent of single mothers had experienced a psychiatric disorder in the past year.

Post-traumatic stress disorder (PTSD) appears to be one condition not included in the NHSDA that may be particularly relevant for the welfare population. Many poor, single mothers experience traumas, such as rape, domestic violence, and sexual molestation; traumas which place them at a greater risk for PTSD. Among participants in a welfare-to-work program in New Jersey, 22 percent reported having been raped; 55 percent had experienced domestic violence; and 20 percent had been sexually molested as a child (Curcio, 1996). NCS results indicate that 14 percent of single mothers had experienced PTSD in the previous year and 15

percent of welfare recipients in a Michigan sample were suffering from PTSD (Danziger et al., 1999).

As our regression results indicate, the likelihood of working is 25 percent lower for those with a psychiatric disorder. As mentioned earlier, the cross-sectional nature of the data prevents us from disentangling the causal direction of this relationship. One possible interpretation is that having a job reduces the probability of having a mental health problem. This intpretation suggests that the lack of employment, possibly combined with the stigma of welfare receipt, results in a greater likelihood of mental health problems. An alternative interpretation suggests that mental health problems may prevent women from undertaking the tasks necessary to find employment, or women with these problems may lack the self-confidence needed to take on new challenges. Even after obtaining employment, mental health problems can play an important role in welfare and self-sufficiency outcomes. Some women may succeed in obtaining employment, but have difficulty keeping their jobs or performing effectively on them because of a mental health condition. For example, major depression, the most prevalent psychiatric disorder examined, is defined as a negative mood state so extreme that it interferes with daily functioning and productive activity (American Psychiatric Association, 1987). Mental illness effects health, physical functioning, self-care, productivity and social functioning-- with the amount of the impairment being statistically comparable to that associated with chronic medical conditions (Wells et al., 1989). In the most severe forms, these problems can make job search and work participation impossible.

Psychiatric problems could also play a role in the success of education and job training programs. Many welfare recipients obtain employment or slots in job training programs only to lose those positions due to confrontations with co-workers and supervisors, lateness and similar

violations with workplace norms. We suspect that mental health problems play an important role in these difficulties since those suffering from mental health problems are more vulnerable to interpersonal problems and irritability and experience diminished social functioning (Schless, Schartz, Goetz, & Mendels, 1974; Tweed, 1993).

CONCLUSION

The current results are based on data collected prior to the passage of welfare reform. Under the old AFDC system, differences in the personal characteristics of welfare recipients was of little concern. With time-limited assistance, however, researchers and program administrators are increasingly focusing on individual characteristics to determine those most likely affected by time-limits. The traditionally recognized characteristics of those likely to hit time-limits include individuals who began receipt: without a high school degree or GED, without prior work experience, under age 25, never married, and having a young child (Moffitt & Pavetti, 1999; Duncan et al., 1997). In addition, mental health problems appear to be another important barrier to self-sufficiency.

We anticipate that mental health problems will play an even greater role in the new policy context. Welfare caseloads have declined substantially since August 1998, partly due to favorable economic conditions, and partly due to changes in program eligibility (Danziger, 1999). Dramatic reductions in welfare caseloads may indicate that the more able-bodied recipients have left welfare, leaving behind an increasingly disadvantaged group experiencing multiple barriers to self-sufficiency, including mental health problems. Initial evidence from the NHSDA confirms this suspicion. While 19 percent of welfare recipients in the 1994 wave had experienced a psychiatric disorder within the past year, 25 percent of welfare recipients in the

1997 wave had experienced a mental health problem (the NHSDA samples reflect the caseload drop witnessed nationally—34 percent of single mothers received welfare in the 1994 wave of the NHSDA, compared to 25 percent in 1997). This increasing prevalence of mental health problems in the post-reform caseload highlights the need to confront this individual barrier.

Despite its potentially important role, mental health problems receive little attention in welfare programs and regulations. For example, while screening for education and job deficiencies is routine, no systematic effort exists to identify mental health problems. Mental health screening instruments, such as the CIDI, provide a relatively easy and inexpensive tool for identifying psychiatric problems. Once trained, an individual can administer the CIDI without having prior clinical experience. After a disorder has been identified, the client can be referred to appropriate treatment services.

Additionally, few states recognize the existence of mental health problems as a qualifying criteria for exemptions and extensions from work requirements and time-limits. Exemptions effectively stop a recipients' time clock while extensions provide continued assistance to families that have exceeded their time-limit. Although the federal guidelines specify some criteria for exemptions[8], states have wide discretion in establishing their own rules. Only three states specifically mention mental health problems as an exemption qualifying condition. Both Alabama and Tennessee provide exemptions for individuals participating in mental health counseling, and Nebraska specifies that it will exempt if self-sufficiency is not possible because of the mental or emotional condition of anyone in the assistance unit (Gallagher et al., 1998). As more and more women approach their five-year time limit, other states may consider including mental health in their exemption and extension criteria.[9]

We are not suggesting that all women with mental health problems be excluded from work requirements and time-limits. After all, many women suffering from psychiatric disorders are employed and avoid welfare. Indeed, the current findings highlight a basic administrative question-- what problems should excuse some recipients from work requirements and other regulations imposed on others? Our findings suggest that more attention be paid to mental health problems among poor single mothers, and highlights the need for more effective intervention and treatment efforts to improve economic and social outcomes.

Without interventions that assist women with mental health problems, some of these women are likely to exhaust their time on assistance. While interventions to address educational and job skills deficiencies are commonplace (Gueron & Pauly, 1991; Olson & Pavetti, 1996), mental health treatment services in the context of welfare reform have received far less attention. Even intensive intervention efforts, such as New Chance, provided no explicit treatment for mental health problems (53 percent of their participants were at a high risk for depression).

Although psychiatric disorder prevalence rates are high, treatment for these problems appears low. Further analyses of the NHSDA reveal substantial differences between prevalence and treatment.[10] While 17 percent of single mothers had experienced a psychiatric disorder in the past year, 6 percent had received treatment for that problem. Among women receiving welfare, 8 percent had received treatment in the past year.[11] This gap between prevalence and treatment suggests that a portion of the caseload needs more up-front mental health treatment services than traditional welfare-to-work programs provide. The current substantial state surplus in welfare dollars provides a valuable opportunity to provide more extensive mental health screening and treatment services than those currently available.

The identification and treatment of mental health problems is clearly important for the success of welfare reform. In addition to being a barrier to self-sufficiency, psychiatric illness has important implications for more general social and family functioning. Improving the home environments of young children is a central, through occasionally overlooked policy goal. The psychiatric disorder prevalence rates we document have important implications for child well-being. High levels of depression, stress and other mental health problems constitute important barriers to effective parenting (Lyons-Ruth, Connell & Grunebaum, 1990; Simmons et al., 1993; McLoyd, 1990), and children of depressed mothers are at a greater risk for adjustment problems (Dodge, 1990; Downey & Coyne, 1990). Therefore, improving mother's mental health will benefit child outcomes through improvements in parenting skills.

Mental health problems may be an important barrier to employment for some single mothers. Regardless of whether mental health problems are a cause or consequence of economic disadvantage, it is clear that a substantial minority of the current caseload suffers from psychiatric disorders. The context of welfare reform has focused on the barriers to self-sufficiency and we have focused on women's mental health within this paradigm. We have also considered how family processes and child well-being are impacted by mother's mental health. These findings highlight the need for more effective mental health screening and treatment services to improve economic and family outcomes. Aside from these effects, effective treatment services are needed to address an important source of anguish for a subgroup of single mothers.

ENDNOTES

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[4] Federal law defines work-related activities as unsubsidized employment, subsidized private or public employment, work experience, on-the-job training, job search and job readiness for up to 6 weeks, community service, vocational education for a maximum of 12 months, provision of child care to TANF recipients, job skills training, education directly related to employment, and high school education or its equivalent.

[5] Work requirements represent more of a continuum from the old AFDC system rather than a new development because under AFDC non-exempt recipients were required to participate in Job Opportunities and Basic Skills (JOBS) training. Although a major change is that PRWORA eliminated the AFDC exemptions (primarily for caretakers of young children) from JOBS participation.

[6] Twenty-two states have established time limits shorter than 5 years; Connecticut has adopted a 21-month time limit, and for some recipients in Texas eligibility ends after 12 months.

[7] Unfortunately, the NCS does not contain a measure of welfare receipt, preventing a more detailed assessment of psychiatric distress among welfare recipients.

[8] Federal exemptions include: families that do not contain an adult receiving assistance; months of assistance received by an adult as a minor child not the head of household or married to the head of household; and any month that the family lived on an Indian reservation or Alaskan Native village with unemployment above 50 percent.

[9] Several other states have more general categories for exemptions and extensions that could potentially include mental health problems. For example, 30 states provide exemptions for disability. In addition to physical disability, states may include mental illness or mental disability as part of this exemption criteria.

[10] The NHSDA has two questions about mental health treatment services. The first asks about over-night hospital stays ("During the past 12 months, how many different times have you stayed overnight or longer in a hospital to receive treatment for psychological or emotional difficulties?" and the second about outpatient services ("Have you received treatment for psychological problems or emotional difficulties at a mental health clinic or by a mental health professional on an outpatient basis in the past 12 months?". Participation in either is treated as receiving treatment.

[11] The difference in means for treatment between recipients and non-recipients is not significant.

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TABLE 1. Demographic Characteristics of the NHSDA Single Mothers Sample

	Proportion	Mean
Unweighted sample size	4,423	
Race/Ethnicity		
White	53.4	
African American	32.5	
Puerto Rican	2.8	
Mexican American	7.7	
Other Hispanic	3.6	
Age		32.1
Education		
Less than high school	25.6	
High school graduate	39.1	
Some college	23.3	
College graduate	12.0	
Work status		
Currently working	26.3	
Currently not working	73.7	
Welfare Receipt		
Does not receive welfare	70.0	
Receives welfare	30.0	
Number of children under 12		1.45

NOTE: Based on weighted data. Work status includes both full- and part-time work.

TABLE 2. Prevalence of Psychiatric Disorders Among Mothers by Marital Status

	Married Mothers With Children	Single Mothers With Children
Unweighted sample size	6,906	4,423
Psychiatric Disorders		
Major depression	0.08	0.10**
Generalized anxiety disorder	0.02	0.03
Panic attack	0.04	0.05**
Agoraphobia	0.02	0.03**
Any disorder	0.13	0.17***

NOTE: The information on married mothers (n=6,906) is from the same NHSDA survey years and employs the same sample restrictions as the single mothers sample. Based on weighted data. * indicates a significant difference between the means of married mothers and unmarried mothers; *p<.05; **p<.01; ***p<.001

TABLE 3. Prevalence of Psychiatric Disorders Among Single Mothers by Income Level

	Personal Income $20,000 or Above	Personal Income Below $20,000
Unweighted sample size	806	3,617
Psychiatric Disorders		
Major depression	0.08	0.11*
Generalized anxiety disorder	0.02	0.04*
Panic attack	0.04	0.06
Agoraphobia	0.01	0.04***
Any disorder	0.15	0.19**

NOTE: Based on weighted data; * indicates a significant difference between the means of low income single mothers and higher income single mothers.; *p<.05; **p<.01; ***p<.001

TABLE 4. Prevalence of Psychiatric Disorders Among Single Mothers by Welfare Receipt

	Does Not Receive Welfare	Receives Welfare
Unweighted sample size	2,651	1,772
Psychiatric Disorders		
Major depression	0.09	0.13**
Generalized anxiety disorder	0.03	0.04
Panic attack	0.05	0.07*
Agoraphobia	0.02	0.06***
Any disorder	0.15	0.22**

NOTE: Based on weighted data; * indicates a significant difference between the means by welfare receipt; *p<.05; **p<.01; ***p<.001

TABLE 5. Prevalence of Psychiatric Disorders Among Single Mothers by Work Status

	Working Full- or Part-Time	Not Working
Unweighted sample size	1,831	1,786
Psychiatric Disorders		
Major depression	.08	.12*
Generalized anxiety disorder	.02	.04
Panic attach	.04	.06
Agoraphobia	.02	.05***
Any disorder	.15	.20**

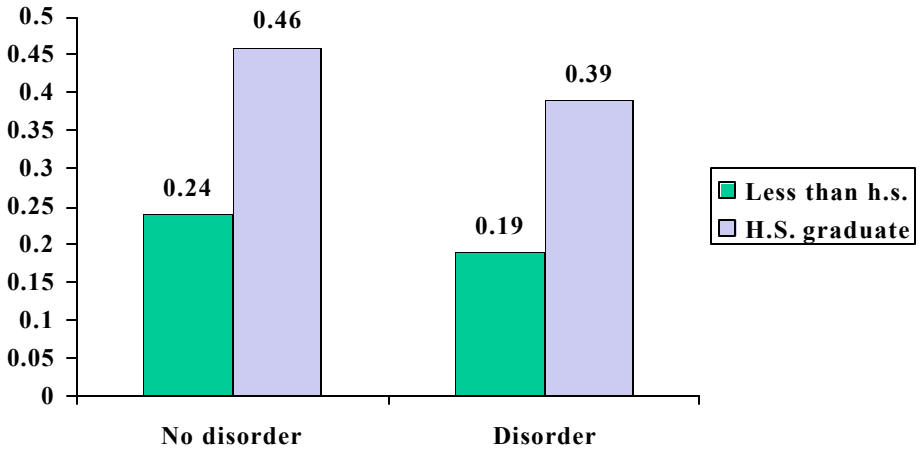
NOTE: Based on weighted data; * indicates a significant difference between the means by work status; *p<.05

TABLE 6. Logistic Regression Results: Mental Health Problems and Work

	B	s.e.	odds ratio
Constant	-1.04	.37	
Psychiatric disorder[1] (none=0)	-.29**	.09	0.75
Race/Ethnicity (White=0)			
African American	-.46**	.13	0.63
Puerto Rican	-.78**	.27	0.46
Mexican American	-.03	.18	1.03
Other Hispanic	-.34	.11	0.71
Marital Status			
Never married (div/sep=0)	-.36**	.11	.070
Education (less than high school=0)			
High school graduate[2]	1.01***	.13	2.73
More than high school	1.43***	.14	4.18
Age	.04***	.01	1.04
Number of children under 12	-.34***	.05	0.72
Excellent/very good health (other=0)	.38**	.12	1.47
Rural (urban=0)	-.30	.19	0.74
Region (Northeast=0)			
North central	.57**	.23	1.76
South	-.04	.23	1.95
West	-1.04**	.36	0.96

[1] Includes major depression, generalized anxiety disorder, agoraphobia, and panic attack.
[2] Includes those who received a GED.
*p<.05; **p<.01; ***p<.001
Model Π^2 (15)=971.89; Regression is weighted.

Figure 1. The Probability of Working



NOTE: Baseline probability is for an African American, never married single mother, 25 years of age with two children under 12, in excellent or very good health, and who lives in an urban area in the Northeast.