

Poverty, Mental Health, and Women: Implications for Psychiatric Nurses in Primary Care Settings

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Poverty is one of the most consistent correlates of depression as well as other mental health disorders. Although poverty has negative health outcomes for men and women, the greater burden falls to women. Thus, the focus of this article is on the experiences of women and the complex intersection between the social and economic correlates of poverty and mental illness. A case study is presented that illustrates these intersections. The article concludes with suggestions to improve the mental health of poor women. J Am Psychiatr Nurses Assoc, 2007; 13(5), 267-274. DOI: 10.1177/1078390307308310

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Poverty is one of the most consistent correlates of depression (Belle & Doucet, 2003). Recent research has demonstrated that life circumstances often concomitant with poverty (e.g., living in disadvantaged neighborhoods, reduced access to educational and employment opportunities, perceived neighborhood disorder, food insecurity) also have negative effects on mental health and that these effects occur above and beyond the effects of personal poverty (Stafford & Marmot, 2003). Although poverty has negative health outcomes for both men and women, the greater burden falls on women, who will be the focus of this article. Specifically, this article will describe factors that practitioners need to be aware of and sensitive to when providing mental health care to poor women. The relative contribution of these factors will vary across individuals and across phases of the life cycle. The article will conclude with a case study from clinical work that illustrates the interaction of these factors on one woman's mental health and emotional well-being.

SOCIAL AND ECONOMIC CORRELATES OF POVERTY

In 2005, there were 37 million people living in poverty, giving the United States a poverty rate of

12.6%. Nearly one fourth of Black and Hispanic women lived below the poverty threshold (DeNavas-Walt, Proctor, & Hill-Lee, 2006), with female-headed households reporting even higher poverty rates. Black (39.2%) and Hispanic (39%) families reported similar poverty rates that were higher than rates reported by White families (27.1%; DeNavas-Walt et al., 2006). Furthermore, as women age, they are at increased risk for living in poverty compared to their male counterparts; 19% of women 80 and older live at or below the poverty line (Sevak, Weir, & Willis, 2003/2004). Despite these figures, the full extent of economic hardship faced by women is not fully captured, because the official poverty threshold is extremely low. According to the Department of Health and Human Services (<http://aspe.hhs.gov/poverty/07poverty.shtml>), the 2007 poverty guideline for a family of four was \$20,650; for a family of three, \$17,170; and for a family of two, \$13,690. Families with incomes even \$1.00 higher than these figures are not included in the official poverty population figures. The number of poor and nearly poor women in the United States is a significant public health issue with important mental health consequences.

It has long been accepted that poverty is a major risk factor for depression among women (Belle & Doucet, 2003). The relationship between poverty and depression has been studied with low-income women in various life circumstances and across the life span.

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Research has consistently demonstrated high levels of depression in low-income mothers with young children (Chung, McCollum, Elo, Lee, & Culhane, 2004; McLennan, Kotelchuck, & Cho, 2001; Siefert, Bowman, Heflin, Danziger, & Williams, 2000; Siefert, Finlayson, Williams, & Delva, 2007); homeless women (Bassuk, Weinreb, Buckner, Brown, Salomon, & Bassuk, 1996); and women experiencing food insecurity (Siefert, Heflin, Corcoran, & Williams, 2001).

Living in poverty also has an indirect effect on depression because being poor often places poor women in unsafe and vulnerable positions. Poor women report higher rates of physical and/or sexual abuse and posttraumatic stress compared to more privileged socioeconomic groups of women (Bassuk et al., 1996). Moreover, they experience more uncontrollable life events in the context of ongoing, chronic deprivation (Ennis, Hobfoll, & Schroder, 2000). Although the above are serious correlates of poverty, other factors associated with poverty are equally detrimental to women's mental health but have been less studied in poor individuals. Based on my clinical experience, the following four factors also play a critical role in the mental health of poor women: lack of social supports, residing in a disadvantaged neighborhood, and physical and mental comorbidities above and beyond depression.

LACK OF SOCIAL SUPPORT

Findings in the social support research suggest that social support is a critical buffer for stressful life events and a major predictor of emotional and physical well-being (Thoits, 1984, 1995). However, the majority of studies have focused almost exclusively on middle-class Americans and the working poor, and our knowledge of how social support processes are altered by poverty is limited (Bassuk, Mickelson, & Perloff, 2002). Although research is just beginning in this area, what we know at this point is troubling. Research suggests that the informal support of female extended kin and nonkin networks that have traditionally helped women survive poverty has eroded (Roschelle, 1997). Support systems in entire communities have crumbled as a result of poverty, violence, drugs, and inadequate housing (Bassuk et al., 1996; Roschelle, 1997). Poor families no longer have social resources to share, because many face the same scarcity of resources. Because of this, poor women no longer depend on kin and nonkin for instrumental support but do express greater expectations of professionals to provide tangible assistance. Bassuk et al. (2002) found that

receiving instrumental support from professionals was predictive of high levels of depression and anxiety, suggesting that women in need of instrumental support were severely economically, socially, and emotionally depleted and their situations were more desperate than in the past. Another troublesome finding of the research on social support and poor women is the relationship between conflict and adverse mental health outcomes. Bassuk et al. (2002) found that conflict with kin, especially the mother, was highly predictive of depression. However, because the analyses were based on cross-sectional data, directionality of the relations could not be determined (i.e., depressive symptoms may contribute to conflicting interactions with family members). One surprising finding from the study by Bassuk et al. (2002) was the importance of sibling support and, to a lesser degree, support from the mother in predicting positive mental health outcomes. However, it has also been reported that kin support carries a sense of obligation and the potential for judgment and that under certain conditions, it might actually add to the burdens of women and increase depressive symptoms (Aranda, Castaneda, Lee, & Sobel, 2001; Weissman, 1987).

RESIDING IN DISADVANTAGED NEIGHBORHOODS

Poorer people tend to live in neighborhoods of concentrated poverty where access to quality education, employment opportunities, and adequate housing are limited, while at the same time, social disorder (delinquency, drug use, public intoxication), refused services (e.g., credit card applications, taxi service, and food delivery), and chronic stressors linked to economic insecurity are high (Cutrona, Russell, Brown, Clark, Hessling, & Gardner, 2005). Neighborhoods high on economic disadvantage offer few economic opportunities and few role models for economic success, which undermines optimism and belief in personal mastery. Neighborhoods high on social disorder make it difficult to establish supportive relationships with neighbors, they prevent a sense of predictability, and they offer threats to physical safety (Cutrona et al., 2005). Furthermore, stressors associated with neighborhood disorder influence depressive symptoms, independent of household income (Schulz et al., 2006). When negative life events occur in this context, their impact is often intensified because the worldview of the victim probably offers little hope for assistance from others and little experience with personal efficacy (Cutrona et al., 2005, p. 12).

African Americans are more likely than Whites to live in neighborhoods with high concentrations of poverty and segregation in which they are exposed to a range of social and physical stressors that erode health and in which they experience reduced access to resources necessary to sustain health (Schulz et al., 2006).

PHYSICAL AND MENTAL HEALTH COMORBIDITIES

There are few diseases that are specific to the poor; however, poorer persons experience disease at an earlier age and have increased mortality across all major causes of death than those who are not poor (Fiscella, 2003). Poor or nearly poor women are more likely to report fair or poor overall health, limitations in activity, and various chronic disease states such as arthritis, asthma, diabetes, hypertension, obesity, and/or osteoporosis. Additionally, poor or nearly poor women are more likely than high-income women to report lack of health insurance, dissatisfaction with their health plan when insured, and not having a usual source of care (National Healthcare Disparities Report, 2005; Making the Grade on Women's Health, 2004).

Although poverty has been documented as one of the most consistent correlates of depression, women also suffer an additional burden of other mental illnesses that have significant health and social consequences. These include schizophrenia, schizoaffective disorder, bipolar disorder, anxiety disorders, and some personality disorders. Although there is no evidence to suggest that poorer women are at greater risk for the development of severe mental illnesses, there is evidence to suggest that over time, the associated disabilities often lead to poverty and homelessness (Collins, Geller, Miller, Toro, & Susser, 2001) in addition to social isolation and loneliness (Chernomas, Clarke, & Chisholm, 2000). Despite being at great risk for depression and other mental health etiologies, poor women rarely receive mental health services of any kind (Coiro, 2001).

In summary, the evidence linking poverty and adverse mental health outcomes in women is compelling. Poverty and its sequelae contribute directly and indirectly to depression and other mental health disorders. Poor women lack adequate kin and nonkin social support, and when that support is conflicted, there are even worse mental health outcomes. Furthermore, the combined effect of being poor in a poor, disadvantaged,

and dangerous neighborhood may have the most negative mental health consequences for women, especially for African American and Hispanic women who are disproportionately poor. A case study based on my clinical experiences will be presented that illustrates the complex interaction between poverty, gender, mental health, and neighborhood disadvantage.

PRIMARY CARE SETTING

I work as a psychiatric nurse practitioner at a primary care center for the uninsured in Detroit. Detroit's population is predominantly African American (81.5%; U.S. Census Bureau, 2000) and the city has the most segregated neighborhoods in the United States (Darden & Kamel, 2000). In 2005, Detroit had the second highest rate of poverty in the nation (31.4%; DeNavas-Walt et al., 2006). The primary care center is located on the east side of Detroit. This area has the highest poverty level in the city of Detroit, and most surrounding census tracts qualify as medically underserved areas (MUAs). The vast majority of patients who come to the primary care center are African American (94%) and women (67%) with incomes at or below the federal poverty level (80%).

The primary care center has implemented several services to increase access to health care and to encourage greater adherence to treatment. For example, transportation is provided to and from scheduled appointments; laboratory work is conducted on site; prescription medications are provided; patients receive assistance with completing forms for the patient assistance programs (PAP); there is a patient educator on staff; referrals for more complex testing are provided at no cost to the patient; and on-site psychotherapy is conducted by me and another experienced, PhD-prepared nurse practitioner (NP). Patients who express or exhibit signs or symptoms of mental distress are referred to the psychiatric NPs. A continuum of psychiatric and mental health services is provided: individual, couple, and family therapy as well as group therapy for adult incest survivors and for those dealing with grief and bereavement related to death. In addition, a fiber-arts (e.g., crochet) group was started in the spring of 2006 as adjunct therapy that has practical application. It offers a structured learning experience in such a way that the learner experiences self as competent and achieves a sense of mastery out of which comes self-knowledge and self-awareness. As noted earlier, neighborhoods high on economic disadvantage offer few opportunities for success, which

undermines optimism and belief in personal mastery (Cutrona et al., 2005).

A CASE STUDY

Eunice, 42, was diagnosed with major depression 3 years ago. (This case is a composite based on clinical experience and illustrates many of the correlates of poverty and mental health.) She first came to the health center following an acute reaction to steroid treatment for asthma that resulted in an emergency hospitalization during which she was in a coma for almost 2 weeks. During the hospitalization, she suffered a cerebral vascular incident (CVA), with residual weakness in her lower extremities. Eunice was subsequently diagnosed with diabetes mellitus and is taking relatively large doses of Humulin 50/50 each day. Although Eunice has a glucose meter and test strips from the health center, she is inconsistent in checking her blood sugars and frequently does not eat. Eunice's family history of trauma and alcohol and substance abuse may be contributing factors to her low level of self-care.

Before the coma, Eunice worked full time in the health care field. Although her pay was less than \$12.00 per hour, she was able to pay her bills and go to the movies and/or dinner occasionally. However, since the CVA and the resultant health problems, Eunice has not been able to work. She has applied for Social Security disability twice but has been denied both times and has had no income since the hospitalization. She was living with her sister, but they were evicted from the home they had lived in for more than 12 years. About 2 years ago, when neither Eunice nor her sister were able to maintain the mortgage payments and were in foreclosure, they signed over the deed to their home to a "mortgage company" that stated that it would pay off the arrears on the outstanding mortgage and prevent the foreclosure. Eunice and her sister then rented the house with the understanding that they would be able to purchase the house back from the mortgage company in the future. Of course, this did not happen, because they were victims of a predatory "foreclosure rescue" real estate scam that has been going on across the nation for the past few years. Although Eunice and her sister have reported the scam and the legal authorities agree that they were scammed, it was too late. They were evicted in February 2007. Since then, Eunice has been living between friends, and her sister has moved out of state to live with her son.

Eunice's childhood and adolescent years were difficult. She was sexually and physically abused by family members and lived in foster care for several years.

She has resumed a relationship with her biological mother and maternal grandparents, but the relationships are conflicted. They rarely contact her and never remember her on her birthday or on holidays. Eunice has never married, nor does she have children. She dropped out of high school, although she did receive her GED and attend community college, but she was unable to continue because of insufficient funds.

When I began seeing Eunice for individual therapy, she was extremely depressed (tearful, sad affect, sleep disturbance, nightmares) and isolative (stayed in bedroom, would not talk to anyone or answer the phone), heard voices, was unable to go out in public without experiencing severe anxiety, and believed that people were "looking at her." During this time, her physical health problems were worsening, and she was seeing several specialists for her complex health needs. Eunice did attend weekly individual therapy and participated in a fiber-arts group, in which she did very well. Eunice was able to attend and actively participate in these therapeutic interventions because she was in a familiar and safe environment where she could trust that people would not hurt her. Because of Eunice's unstable housing situation and lack of a permanent address, she has not been back to the center since February 2007. Her whereabouts are unknown, and her physical and mental health status is in jeopardy.

This case study illustrates the tremendous challenges that poor women with depression experience. Eunice has experienced and continues to experience many of the correlates of poverty and mental health discussed above. Eunice is a woman of color who grew up poor. She had inconsistent access to quality education, moved frequently between family members and foster care, and experienced interpersonal trauma and family conflict. Although becoming a certified nursing assistant (CNA) was a major accomplishment, it is an entry-level position that typically pays low wages with few, if any, benefits. Because of her unstable medical problems and associated disabilities, Eunice is incapable of performing the responsibilities of a CNA and has no other marketable job skills. Although Eunice applied for Social Security Disability and is appealing the denial, the process may take up to 2 years. In the meantime, she has no income and no hope of gaining employment. In addition, Eunice is now homeless, moving between friends and acquaintances and most likely staying in disadvantaged neighborhoods. This is problematic for several reasons. First, she lost her primary supportive relationship when her sister moved out of state. This was a critical loss for Eunice because

sibling support is predictive of positive mental health outcomes (Bassuk et al., 2002). Second, many of the households where Eunice is staying are also poor with limited financial and social resources. Because of this, it is unlikely that she can depend on them for support (Bassuk et al., 2002). Although Eunice exemplifies the type of woman most in need of instrumental support from professionals (women severely economically, socially, and emotionally depleted; Bassuk et al., 2002), she is unable to access that support because of frequent moves, lack of transportation, and inability to maintain a working phone. Third, living in households where supportive relationships and a sense of predictability are difficult to establish could exacerbate Eunice's other psychiatric comorbidities (e.g., auditory hallucinations, panic attacks, and social isolation) and result in poor health outcomes (Collins et al., 2001).

Despite the challenges of poverty, living in disadvantaged neighborhoods, multiple medical problems, and depression, Eunice's natural gifts include a high level of intelligence, humor, and kindness. One could say of her that she has a "large heart." Eunice is talented, with three-dimensional thinking (high mechanical and technical abilities, as reported by her textile instructor). Yet, Eunice's talents are being wasted, and her full potential may never be realized as she continues to struggle with poverty, poor health, unstable housing, and a lack of viable resources to develop the skills necessary to overcome poverty. Even more sobering is that Eunice is not unique among poor women. A vast majority of poor women have skills and abilities that could make a significant contribution to society if they were not burdened by trying to survive.

IMPLICATIONS FOR PSYCHIATRIC NURSES IN PRIMARY CARE SETTINGS

The review of literature and the case study suggest several areas in which the mental health needs of poor women can be more effectively addressed. First, although traditional mental health services (e.g., therapy, psychopharmacology, cognitive behavioral therapy, education) are necessary, they are not sufficient when working with poor women. Psychiatric nurses need to ask more detailed questions about women's housing situations and the neighborhood context in which they live. For example, if the utilities are turned off for nonpayment or if the woman feels physically unsafe because of delinquency or drug use in the neighborhood, she may have only a partial response to treatment,

because the contributing factors to depression (e.g., social disorder, economic insecurity) have not been addressed. I worked with one woman who stayed awake all night and slept all day. Despite trying different medications and therapeutic interventions, nothing helped. I had been asking the wrong questions; she wasn't sleeping at night because of gang and drug activity next door and the need to "protect her house and self"—she slept when they slept.

Second, when working with poor women, it is important to explore the various dimensions of social support (instrumental, emotional, conflict) they receive from kin and nonkin and the impact of that support on their mental health. Research by Bassuk et al. (2002) identified the importance of sibling support and, to a lesser degree, support from the mother as highly predictive of mental health outcomes. However, we also know that conflict with one's mother is a strong predictor of depression. Thus, it will be important to understand the nature of kin relationships that are helpful versus harmful as we work with women to build networks that will sustain them. Beeber and Canuso (2005, p. 773) developed five questions that might help psychiatric nurses in this effort: (a) Who helps you get the day-to-day things you need in life? (b) If you had an emergency, who would you call on for help? (c) Who would lend you money or keep your child(ren) if you needed it? (d) Who gives you advice that is useful? and (e) Who understands your private worries and feelings?

Third, psychiatric nurses who work with poor women also need knowledge about social service agencies in their practice area and what services are offered. We need to be aware of the application process for the various assistance programs (e.g., utility payments, Medicaid, Supplemental Security Income [SSI], and Bridge Card) so that when our women seek assistance, they take the necessary documentation with them and the process is facilitated. We need to cultivate collegial relationships with people who work in these agencies as well as with organizations that offer legal assistance, housing, clothing, food, baby and child supplies, and medical equipment, supplies, and medications. Another important contact is local churches: Many have food pantries or soup kitchens and offer clothing, temporary shelter, and some financial resources. These resources are available in most communities; however, they are often "unknown" because many are grassroots efforts.

Fourth, psychiatric nurses need to think "outside the box" when offering therapeutic interventions. As noted earlier, neighborhoods high on economic

disadvantage offer few opportunities for success, which undermines optimism and belief in personal mastery (Cutrona et al., 2005). If women are without a sense of competence and self-knowledge, traditional mental health services may have a limited impact because poor women often feel that nothing will change or that they do not have the power to make change. One example of a nontraditional intervention was the fiber-arts group (crochet) we started as adjunct therapy. This group was not seen as "therapy," because many women who participated were not depressed or in therapy. In many ways, this group helped Eunice feel "normal" and offered her an opportunity to successfully complete crochet projects and to achieve a sense of personal mastery.

The fifth suggestion is for primary care providers to screen for depression in their female patients, particularly those who are poor. Despite the high prevalence of depressive symptoms and major depressive episodes in women, depression continues to be underdiagnosed and undertreated by primary care and other nonpsychiatric practitioners, who are, paradoxically, the providers most likely to see these women initially (Agency for Health Care Policy and Research Depression Guidelines Panel, 1993; Padgett, 1997). However, screening alone will not be useful if there are few resources for treatment of these women. One viable solution to treatment is the movement toward the integration of mental health services into primary care settings, which is gaining momentum in the United States. Because psychiatric nurses have traditionally worked collaboratively, this paradigm shift positions us to be at the forefront of this movement and to assume leadership roles within this new model of service delivery.

There are different models of collaborative services (e.g., coordinated, integrated, colocated), types of programs (targeted, nontargeted), and treatment modalities (specified, unspecified; Blount, 2003). Colocated services, in which both mental health and primary care are provided within the same practice location, is one model that positively affects access to mental health services (Blount, 2003), especially for poor populations (Lieberman, Adalist-Estrin, Erinle, & Sloan, 2006). Satcher (1999), in his report as Surgeon General on mental health, addressed the issue of access, stating that referral to mental health services is not an effective way to engage certain groups. He stated that some groups culturally do not define their psychosocial difficulties as reasons to go for mental health services and that this is a problem of the delivery system rather than a problem of the groups themselves.

Satcher concluded that for difficult-to-engage groups, locating mental health services in primary care settings will significantly increase access. A systematic review of 38 studies and follow-up reports offers support for Satcher's contention, concluding that collaborative practice is likely to be most developed when clinicians are colocated and most effective when the location is familiar and nonstigmatizing for patients (Craven & Bland, 2006).

Last, there is an ever-increasing need to advocate for public policies that improve women's educational and employment opportunities. Opportunities to earn a living wage could potentially increase women's access to health-enhancing resources such as health insurance, safe and adequate housing, and sufficient food. Improvement in women's household income could also reduce symptoms of depression by reducing financial strain and improving access to instrumental social support (Schulz et al., 2006).

DISCUSSION

Mental health services for poor and low-income populations are at a turning point in the United States. Federal funding for public mental health continues to shrink each year, and the monies that are available have been shifted to the most severely and persistently mentally ill. This trend is predicted to continue, with proposed cuts in mental health recovery and prevention programs for fiscal year 2008. According to Mental Health America (<http://www.nmha.org>), the Bush Administration proposes to cut Medicaid by \$25.7 billion over 5 years; this program is the single largest source of funding for mental health services. Other proposed budget cuts include suicide prevention by \$3 million, youth-violence prevention programs by \$18 million (20%), and post-traumatic stress disorder programs for youths by \$1.5 million. Even if a modified version of this budget is passed, decreased funding for public health insurances will continue to disproportionately affect poor and low-income populations, especially women.

The decrease in federal funding for mental health services seems counterintuitive in light of the finding that significant mental health disparities exist between racial minorities and non-Hispanic Whites (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services [DHHS], 2001). Minorities are less likely to receive mental health services, and when they do, they are likely to receive services of poorer quality (U.S. DHHS, 2001). Even when members of poor and low-income populations decide to seek mental health services,

they face many obstacles: long wait times for appointments, multiple intake appointments, fewer clinicians who are willing or able to provide services at lower rates of reimbursement (Lieberman et al., 2006), limited or no health insurance benefits (Carrasquillo, Himmelstein, Woolhandler, & Bor, 1999), cultural mistrust (Nickerson, Helms, & Terrell, 1994; U.S. DHHS, 2001), and perceived provider bias in the diagnosis and treatment of mental disorders (U.S. DHHS, 2001). For African Americans, there is a greater likelihood of seeking mental health services from religious sources (Brown, 2004) and informal community support than from professional mental health providers (Primm, Cabot, Pettis, Vu, & Cooper, 2002).

For psychiatric nurses who provide mental health services to poor and low-income women, this is the best of times and the worst of times. Women who experience mental illness or mental health problems have a tremendous number of treatment options and mental health resources available to them, yet the majority of poor and low-income women do not receive the care they need for a myriad of reasons. Some of these reasons are related to the complexity associated with mental illness, poverty, and race, whereas other reasons are related to how health care is delivered in the United States. It is crucial that psychiatric nurses provide leadership and vision during the transformation of the mental health system (American Nurses Association, 2007). Our clinical experience with poor and low-income women will bring a broader and deeper perspective to the table in terms of how the mental health system can be transformed to better meet the mental health issues of women who present with complex and diverse needs.

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