

Understanding Disability, Inclusion and Social Activity Participation

Randy Johner

Volume 19, Number 2, October 2011

URI: <https://id.erudit.org/iderudit/1086902ar>

DOI: <https://doi.org/10.7202/1086902ar>

[See table of contents](#)

Publisher(s)

Réseau International sur le Processus de Production du Handicap

ISSN

1499-5549 (print)

2562-6574 (digital)

[Explore this journal](#)

Cite this article

Johner, R. (2011). Understanding Disability, Inclusion and Social Activity Participation. *Développement Humain, Handicap et Changement Social / Human Development, Disability, and Social Change*, 19(2), 81–95.
<https://doi.org/10.7202/1086902ar>

Article abstract

As the recognition of social inclusion intensifies worldwide, it is important to broaden our understanding of various linkages between disability and social deprivation. This paper examines the links between disability and specific social relations/emotional activities which are important to well-being, quality of life and inclusion. Using a stratified randomly-selected sample of Saskatchewan single mothers (n=370), this paper compared social relations/emotional activity participation among single mothers with a disability and single mothers without a disability. Overall, study results indicate that single mothers with a disability, particularly those of Aboriginal ethnicity, were socially deprived. Increased income resources and focussed service-provider interventions are necessary in order to equalize access for social relations/ emotional activity participation needs of this population of single mothers.

Understanding Disability, Inclusion and Social Activity Participation

RANDY JOHNER

Social Work Department, University of Regina, Canada

Article hors thème • Open Topic Article

Abstract

As the recognition of social inclusion intensifies worldwide, it is important to broaden our understanding of various linkages between disability and social deprivation. This paper examines the links between disability and specific social relations/emotional activities which are important to well-being, quality of life and inclusion. Using a stratified randomly-selected sample of Saskatchewan single mothers (n=370), this paper compared social relations/emotional activity participation among single mothers with a disability and single mothers without a disability. Overall, study results indicate that single mothers with a disability, particularly those of Aboriginal ethnicity, were socially deprived. Increased income resources and focussed service-provider interventions are necessary in order to equalize access for social relations/ emotional activity participation needs of this population of single mothers.

Keywords : single mothers, disability, social inclusion, social deprivation, social relations activities

Résumé

À l'heure où le concept d'inclusion sociale se voit graduellement reconnaître mondialement, il est important d'approfondir notre compréhension des différents liens existant entre le phénomène du handicap et celui de la déprivation sociale. Cet article examine les types de relations sociales / activités émotionnelles considérées importantes au bien-être, à la qualité de vie et à l'inclusion sociale par les personnes ayant des incapacités. Au moyen d'un échantillon aléatoire stratifié de mères célibataires habitant la province de Saskatchewan (Canada), il compare les niveaux de relation sociale et d'activités émotionnelles entre celles ayant et n'ayant pas d'incapacités. Les résultats de l'étude indiquent que les mères célibataires ayant des incapacités, tout particulièrement celles d'origine amérindienne, sont déprivées socialement. L'article conclut que l'accès à des revenus plus importants et des interventions ciblées de la part des fournisseurs de services sont nécessaires, afin d'offrir des opportunités égales chez les mères célibataires.

Mots-clés : mères célibataires, handicap, inclusion sociale, déprivation sociale, relations sociales

Introduction

In Canada, 14.3 % of the Canadian population or 4.4 million Canadians reported living with a disability (Statistics Canada (a), 2007). Although there has been much research that has examined disability, inclusion and social participation in Canada, there is still limited research in the province of Saskatchewan, which has specifically examined disability, inclusion and social activity participation in single mothers; specifically those social activities which citizens feel comprise essential roles, relationships and activities within the realm of social necessities of life (Durst & Bluechardt, 2001). Evidence suggests that social relations/emotional activities are central to well-being and inclusion (Diener & Deligman, 2002; Pantazis, Gordon & Townsend, 2006; Ryan & Deci, 2000).

The author believes that it is important to question whether or not single mothers with a disability have the freedom through equal access to participate in social relations/emotional activities. From a social justice perspective, this means that if single mothers with a disability do not have equal access, then society must equalize environmental conditions that single mothers do not have control over, and access to conditions which enable single mothers to realize their social needs and goals. When considering social relations/emotional social needs, the author anticipated that single mothers with disabilities would not have the same freedom through equal access to participate in social relations/emotional activities that single mothers without disabilities have. Social relations activities include basic activities which encompass interpersonal interaction and enhance psychological well-being such as maintaining friends (i.e. visiting/ having a meal in a restaurant). Therefore, the aims of this study were to deepen the understanding of disability and social relations/emotional activity participation among Saskatchewan single mothers, to identify differences with respect to specific social relations/emotional activities Saskatchewan single mothers (disabled/non-disabled) participated in, and to provide policy and service-provider suggestions with regard to disa-

bility, wellbeing and inclusion. The present paper fills a gap in our understanding of the valuation of specific social relations/emotional activities among single mothers with a disability; this is important because social relations/emotional activities are linked to well-being, quality of life and to social inclusion in a broader context (Gannon & Nolan, 2007). Indicators within the "functional" dimension of social inclusion are often referred to as "ability to participate" (Schookner, 2002) and would include social relations/emotional activities such as interacting with family, friends, and community members.

The format of this paper includes a number of sections. In the Background section of this paper, the author describes :

- 1- various theoretical models of disability;
- 2- various understandings of social inclusion;
- 3- social activity participation and its link to social deprivation.

The Background section is followed by the Methodology section which includes a description of the sample, the measurements and the data analysis techniques. The Results and Discussion sections follow the Methodology section. The last section includes the overall Conclusions and Policy/Service-Provider Suggestions.

Background

- Disability

There are numerous models of understanding disability. For example, if one looks at disability from the perspective of a Medical Model, disability is essentially perceived as a health and welfare issue. In this model, organizations generally founded by non-disabled people administer to creating caring environments for diverse groups of disabled people, with interventions based on assessment, diagnosis and labelling. Dependencies are created with resulting dis-empowerment and exclusion from mainstream society (Advancing the Inclusion of Persons with Disabilities, 2009).



If one examines disability from a Human Rights and Development Issue perspective, then one recognizes and acknowledges that people with disabilities are citizens with the same rights, needs and responsibilities as citizens without disabilities. Therefore, this perspective focuses on providing resources to disabled people which will make certain that each person "will have equal opportunities for participation in society" (South Africa's Integrated National Disability Strategy, 2009, p. 3). This perspective focuses "on the removal of barriers to equal participation and the elimination of discrimination based on disability" (South Africa's Integrated National Disability Strategy, p. 3).

A "Social" Model of Disability, The World Health Organization Model of disablement, which underlies the new International Classification of Functioning, (World Health Organization, 2001), and the Quebec Model (Fougeyrolas, Cloutier, Bergeron, Cote, & St. Michel, 1999), the new paradigm of the National Institute on Disability and Rehabilitation Research (National Institute on Disability and Rehabilitation Research, 1999) all recognize that an individual's functioning in society is inextricably linked to her impairment (s) and her environment (social, political, cultural). The complex interaction between one's impairment and one's environment influences the quantity (and quality) of completing daily tasks (Dijkers, Yavuzer, Ergin, Weitzenkamp, & Whiteneck, 2002). In other words, an individual's impairment, completion of daily tasks, and mobility in conjunction with her environment will affect her participation in social relations/emotional activities (Dijkers et al. 2002).

This paper recognizes that a single definition of disability is unrealistic given the multiple and complex interactions which impact a person's social activity participation in society. Implicit within this understanding of disability, is the recognition that what is actually disabling for persons with impairments is the lack of societal recognition of the equal rights, needs and responsibilities of these persons. The international measure of disability, "*International Classification of Functioning, Disability and Health*", recognizes that disability is much more than a

biological or medical condition, and embraces the notion of societal impediment as the disabling factor rather than the impairment or condition (World Health Organization (WHO), 2009).

- Social Inclusion

It has been argued that the world-wide prominence of the construct of social inclusion may be linked to factors such as globalization, violence from war-torn countries, rising immigrant populations, increasing gaps between rich and poor in developed countries, and globalization of news (i.e. awareness of wide-spread acts of terrorism) (Everett, 2009). In France, Stiglitz, Sen, and Fitoussi (2009), found that traditional measures of Gross Domestic Product (GDP) do not adequately measure quality of life and social and economic well-being. Stiglitz et al. (2009) suggest that additional measures which are directly linked to social inclusion should include both subjective and objective measures, such as education, personal activities including work and social connection such as participating in relations/emotional activities.

In a developed country such as Canada, the prominence of social inclusion is linked to an increasing gap between the rich and poor. For example since 1989, in the province of Saskatchewan, the incomes of the top 10% of the population rose by 66% while those incomes of the poorest rose only by 30% (Douglas & Gringrich, 2009). In addition, more than 45% of Saskatchewan Aboriginal children live in low-income families and over 41% of children in Saskatchewan single mother families live in poverty (Douglas & Gringrich, 2009). In this paper, poverty is recognized as the core of material and social deprivation. Poverty is linked to disability through associated factors such as malnutrition, poor health services, sanitation and unsafe working and living conditions (Mont, 2007). The presence of disability/functional limitations can snare individuals into a life of poverty because of the barriers involved in participating in social activities, and all other aspects of life (Mont).

Social inclusion as a construct is often construed as "self evidently desirable and unquestionable" (Spandler, 2007, p. 1). To further complicate matters, the construct of social inclusion is also intrinsically linked to quality of life and social and economic well-being. In a Government of Canada report, *Advancing the Inclusion of Persons with Disabilities* (2009), readers are cautioned to remember that,

Inclusion means different things to different people. Individuals choose to participate in society in different ways. Each person with a disability is unique, with needs, goals and challenges that are influenced by many things, such as gender, type and severity of disability, stage of life, family, community and culture. As a result, there is no single way of measuring the extent to which people with disabilities are fully included in Canada (p. 6).

There are many examples of definitions of social inclusion. Lloyd, Tse, and Deane (2006) define social inclusion as "being able to rejoin or participate in leisure, friendship and work communities" (p. 1) with indicators of social inclusion including, "employment, education, participation in leisure/social activities, access to health services, health insurance, security/welfare support and community services" (p. 2).

According to Toye and Infanti (2004), the construct of social inclusion encompasses multiple deprivations, transcends poverty and social exclusion, and provides linkages with social (social relations), human (education, health) and financial (income, earnings) capital as well as to other social determinants of health. Social determinants of health include the following factors : income, social supports, education, employment and working conditions, social and physical environments, healthy child development, personal health practices, individual capacity and coping practices, biology and genetic make-up, health services, gender, ethnicity and culture (Population and Public Health Branch, 2001). The experience of exclusion and resultant lack of social and economic need fulfillment deepens as the inter-relationships

among multiple determinants of health are also considered.

Lastly, Shookner's (2002) *Dimensions of Social Exclusion and Inclusion* framework informed the methodology in this paper. Shookner's framework appears to resonate with Maslow's (1943) hierarchy of needs : physiological, safety, love/belonging, esteem and self-actualization in the sense that social and economic inclusion is dependent on the fulfilment of these needs that Maslow identified (Jeannotte, 2008). In Shookner's framework (see Table 1), the following dimensions of exclusion/inclusion are recognized : cultural, economic, functional, participatory, physical, political, relational and structural.

These dimensions overlap and interact with one another in complex ways. In this framework, social inclusion is conceptualized as multi-dimensional and transformative. For example indicators of exclusion within the *functional* dimension are referred to as "Disability" and include restrictions based on limitations, overwork, time stress, and undervaluing of assets available. In contrast, indicators of inclusion within the *functional* dimension are referred to as "Ability to participate" and include opportunities for personal development, valued social roles, and recognizing competence.

- Social Activity Participation

In this study, social activity participation was understood as fulfilling needs and goals (i.e. personal, professional, public) while in contact with family, friends, community and others in society (Dijkers, Whiteneck, & El-Jaroudi, 2000). This study also incorporated the British Poverty and Social Exclusion (PSE) Survey's (Pantazis, Gordon, & Levitas, 2006) understanding of social deprivation and its link with social activity participation which was construed for measurement purposes into two sub-categories : economic and social deprivation. Economic deprivation included needs related to diet, health, clothing, housing, household facilities, environment and work; social deprivation included needs related to family activities, social support and integration, recreation and



TABLE 1 : DIMENSIONS OF EXCLUSION AND INCLUSION

INDICATORS OF EXCLUSION	DIMENSION	INDICATORS OF INCLUSION
Disadvantage gender stereotyping, historic oppression Cultural deprivation	Cultural	Valuing contributions recognition of differences, valuing diversity, positive identity
Poverty inadequate income for basic needs, participation in society, stigma, deprivation, devaluation of care giving	Economic	Adequate income for basic needs and participation in society, capability for personal development, value and support care giving
Disability restrictions based on limitations, overwork, time stress, undervaluing of assets available	Functional	Ability to participate opportunities for personal development valued social roles, recognizing competence
Barriers to movement, restricted access to public places, lack of transportation	Physical	Access to public places and community resources, access to transportation, resources and capacity to social participation
Marginalization silencing, barriers to participation, institutional dependency, no room for choice, not involved in decision-making	Participatory	Empowerment freedom to chose, contribution to community, access to programs, resources and capacity to support participation, involved in decision-making, social action
Denial of Human Rights restrictive policies and legislation, short-term view, blaming victim	Political	Affirmation of Human Rights enabling policies and legislation, social protection for vulnerable groups, removing systemic barriers
Isolation segregation, distancing, competitiveness, violence and abuse, fear, shame	Relational	Belonging social proximity, respect, recognition, co-operation, solidarity, family support, access to resources
Discrimination racism, sexism, homophobia, restriction on eligibility, no access to programs, barrier to access	Structural	Entitlements access to programs, transparent pathways to access, community capacity building

Adapted from Shookner (2002)



education (Townsend, 1993). Economic and social needs or deprivation are not mutually exclusive, and factors within these sub-categories of deprivation interact with each other. In addition, determining the causal relationship between economic and social needs and disability is very complex, "with all these outcomes being-interlinked and each affecting and potentially affected by disability" (Gannon & Nolan, 2007, p. 1430).

Specific social relations/emotional activities from the British PSE Survey (Pantazis, Gordon, & Levitas, 2006) which were utilized in this study were :

- 1- an evening out with your own friends or relatives every 2 weeks;
- 2- having a meal in a restaurant once a month;
- 3- some type of leisure activity such as biking, walking or swimming;
- 4- a holiday away from home for one week of the year, not with relatives;
- 5- celebrations on special occasions such as birthdays and Christmases.

In the PSE Survey (Pantazis, Gordon, & Levitas), respondents (n=1,534) identified these activities as either necessities or desirable for well-being and inclusion in society.

Identified as necessities of life were some type of leisure activity (79%), celebrations on special occasions (83%), and a week's holiday (56%). Activities which were identified as desirable more than necessary for well-being and inclusion were a night out every 2 weeks (76%) and a meal in a restaurant (71%).

Methodology

The data for this paper was taken from a study which was a multi-method study, mostly quantitative methods, completed in two stages. In the first stage, a focus group and interviews of Saskatchewan single mothers informed the study instrument (self-administered questionnaire) (See Author, Maslany & Jeffery, 2007). In the second stage of the study, a province-wide self-administered survey was conducted (See Author, Maslany, Jeffery, & Gingrich (2009) for full study details). Ethics approval for

this study was granted from the University of Regina, Research Ethics Board. This paper focuses on data from that study which specifically pertains to disabled/non-disabled Saskatchewan single mothers and their participation in specific social/relational activities; data which has not been previously shared or discussed in the literature.

- Sample

In this study, Saskatchewan single mothers, those with a disability and those without a disability were compared, first in relation to socio-demographic characteristics, and then in relation to participation in social relations/emotional activities. This study's stratified randomly-selected sample consisted of 370 Saskatchewan single mothers, living off-reserve, aged 18-59 years with at least one dependent child less than 18 years of age.

In order to ascertain the sample representativeness (i.e. do the characteristics of the sample accurately reflect the characteristics of the population?), the author examined the factors of self-rated health, numbers of friends, and employment status because these personal characteristics are linked to social inclusion, well-being and disability (Advancing the Inclusion of People with Disabilities, 2009, p. 73). The Canadian report, "Advancing the Inclusion of People with Disabilities", (using 2006 Census data), indicated that 54% of male and female adults (15 years and over) with disabilities in Canada rated their health as good, very good or excellent, 24.8% rated their health as fair, and 12.9 % rated their health as poor. Men were more likely than women to rate their health as very good or excellent (26.5% versus 22.0%); a trend which was similar across all age groups. In the 2006 Census, respondents were asked, "In general, would you say your health is... poor, fair, good, very good or excellent." In this study, 58% of Saskatchewan single mothers with disabilities rated their health as good, very good or excellent, 29.6% rated their health as fair, and 10.4% rated their health as poor.



In the Canadian Report, "Advancing the Inclusion of People with Disabilities" (2009), (using 2006 Census data), the number of close friendships for women with disabilities (15 years and over) was 0 friends (6%); 1 or 2 friends (18.2%); 3-5 friends (28.1%), and 6-10 friends (16.0%). Respondents were asked, "How many close friends do you have, that is, people who are not relatives, but who you feel at ease with, can talk to about what is on your mind, or call on for help... none, 1 or 2, 3 to 5, 6 to 10, 11 to 20, more than 20?" In this study, 8.9% of Saskatchewan single mothers had 0 friends that they could count on; 29.3% had 1 or 2 friends, 46.3% had 3- 5 friends, and 15.5% had 6 or more friends. According to Statistics Canada (b) (2007), just over 50% of Canadians (15 years and over; male/female) who reported having a disability are employed. In this study, 53.3% of the single mothers with a disability indicated that they were employed by others.

In light of the differences observed between the study respondents (disabled) and the variables of perceived health, numbers of friends that one can count on in times of need, and employment status, the author suggests caution not to over generalize to the general population of single mothers with a disability. This study's strengths include the randomization process which should somewhat minimize selection bias and the use of a comparison group (single mothers without a disability). Study weaknesses include small sample size ($n=370$), correlational cross-sectional nature of study (cannot determine causality), and a selective response rate which is non-random, as those with some interest in the topic of inclusion/exclusion are more likely to respond to a self-administered survey. In addition, this study did not measure factors which are linked to persons with a disability such as lack of transportation and restricted access to public places (Durst & Bluehardt, 2001), low income and vulnerability to violence (Advancing the Inclusion of Persons with Disabilities, 2009; Hague, Thiara, & Mullender, 2010) and lack of childcare which is linked to single mother status (Levitas, Head, & Finch, 2006).

- Measurements

In this study, disability was self-reported. Respondents were asked, "Do you have a long-standing illness, disability or infirmity. By longstanding, I mean anything that has troubled you over a period of time." Those respondents who answered "Yes" to this question were also asked, "Does this long-standing illness, disability or infirmity limit your participation in social activities?" In a social model of disability (Fougeyrollas et al., 1999), disability is understood as the linkage between one's functional status and the physical, cultural and political environments. Individuals with functional limitations would not be perceived as "disabled" if environments were designed for equal access via accommodation and supports which would allow those individuals to participate fully in society. Thus interventions are at both the individual and the societal levels.

Findings from the Canadian Community Health Survey (2005) indicated that for Saskatchewan women between the ages of 25-54 years, the rate of self-reported disability was 28%. In addition, almost all Saskatchewan women who reported having a disability stated that they had a physical or mental condition that was negatively linked to activity participation. In this study's sample (18-59 years), 33.2% of Saskatchewan single mothers indicated that they had a disability. Of those single mothers who reported having a disability, almost all of the single mothers reported that their disability was negatively linked to activity participation. Many of the study respondents voluntarily identified their physical or emotional impairment; these impairments included obesity, blood disorder, insomnia, depression, anaemia, chronic pain from violence-inflicted injuries (cuts from broken glass bottles), bi-polar disorder, diabetes, drug addiction, and cerebral palsy.

- Measurement of socio-economic characteristics included age ("What year were you were born in?");
- Aboriginal ethnicity ("Are you an Aboriginal person?" No=0; Yes=1);

- Education level ("What is the highest level of education that you have completed?" Basic education (up to 10 years)=1);
- Basic Education (up to 11 years)=2;
- Secondary Education-high school, vocational education or GED (12 years)=3;
- Higher or university level education (13 years or more)=4;
- Income ("On average, how much money before taxes is your current total monthly income?" (Please include child support payments and child tax credit));
- Health : All in all, how would you say your health is? Friends ("How many close friends do you have?... meaning people you feel at ease with, can talk to about private matters, and can call on for help?" 0, 1, 2, 3, 4, 5, 6, or 7 or more?);
- See or talk to friends ("How many of those friends do you see or talk to at least once every 2 weeks?" 0, 1, 2, 3, 4, 5, 6, or 7 or more?);
- Employment status ("Are you currently employed either full or part-time?" (No=0; Yes, self-employed=1; Yes, Employed by others= 2)).

Respondents were also asked to check the box, *Do*, *Don't do but don't want to do*, *Don't do and can't afford*, and *Does not apply*, that best answers their participation in the following common social activities :

- 1- an evening out with your own friends or relatives every 2 weeks;
- 2- having a meal in a restaurant once a month;
- 3- some type of leisure activity such as biking, walking or swimming;
- 4- a holiday away from home for one week of the year, not with relatives;
- 5- celebrations on special occasions such as birthdays and Christmases.

Data Analysis

In order to attain descriptive statistics and other analyses, the author used SPSS software (SPSS, Version 15.0, Chicago, IL.). All varia-

bles were first examined using standard univariate techniques (frequency distributions, measures of central tendency, dispersion). Bivariate correlational analysis (Spearman's correlation coefficient) was used to test for the relationship between personal socio-demographic characteristics and social activity participation. Chi-square tests were conducted for Non-Disability/Disability differences in the personal socio-economic characteristics of Aboriginal ethnicity, education level, employment status, self-rated health, and monthly income. The t-test (differences in means) was used to test for Non-Disability/Disability age in years, number of close friends one can count on in times of need, and number of close friends one see or talks to every 2 weeks. Chi-square tests were also conducted for Non-Disability/Disability differences and social activity participation. A p value of <0.05 was considered statistically significant in all analyses.

Results

Results in Table 2 indicate that Saskatchewan single mothers with a disability had poorer perceived health, were older, and had fewer close friends that they could count on in times of need (i.e. can talk to about private matters, can call for help). There was a significant association whether or not a single mother had a disability and self-rated health, ($\chi^2(4) = 75.01$, $p < 0.001$), Cramer's V = .452 (medium effect); single mothers with a disability (41%) had poorer self-rated health (poor/fair) than single mothers without a disability (7.9%). On average, single mothers with a disability (M= 1968, SE= .82) were older than single mothers without a disability (M= 1972, SE= .58). This difference was significant $t(377) = 4.1$, $p < 0.001$, which represented a small effect, $r = .20$. On average, single mothers with a disability (M=3.3, SE= .18) had fewer friends one can count on in times of need than single mothers without a disability (M=3.7, SE= .13). This difference was significant $t(366) = 2.1$, $p < 0.05$, which represented a rather small effect, $r = .10$.

Results in Table 3 indicate that Saskatchewan single mothers with a disability were less likely to have an evening out with relatives or friends



**TABLE 2 : SOCIO-DEMOGRAPHIC CHARACTERISTICS OF SASKATCHEWAN
SINGLE MOTHERS, DISABLED/NON-DISABLED**

Characteristic	Non-Disabled n= 247	Disabled n= 123	χ^2
Aboriginal Ethnicity	Percentage	Percentage	n.s.
Yes	41.7 %	43.3 %	
No	58.3 %	56.7 %	
Education			n.s.
Basic-up to 10 years	9.5 %	11.0 %	
Basic-Completion of 11 years	6.3 %	3.1 %	
Secondary Education-12 years	31.7 %	39.4 %	
Higher or university level-13 years	52.4 %	46.5 %	
Employment Status			n.s.
Not Employed	33.6 %	39.8 %	
Yes, self-employed	5.3 %	4.9 %	
Yes, employed by others	61.1 %	55.3 %	
Self-rated Health			p<0.001
Poor	0 %	10.4 %	
Fair	7.9 %	29.6 %	
Good	39.7 %	42.4 %	
Very Good	33.3 %	15.2 %	
Excellent	19.0 %	2.4 %	
Monthly Income (Before Taxes)			n.s.
Under \$800	10.1 %	8.9 %	
\$800-\$1000	13.0 %	13.8 %	
Over \$1000 & up to \$1200	11.7 %	13.0 %	
Over \$1200 & up to \$1500	12.1 %	15.4 %	
Over \$1500 & up to \$2000	17.8 %	17.1 %	
Over \$2000	35.2 %	31.7 %	
	Mean (Standard Deviation)	Mean (Standard Deviation)	t-test
Year born			p<0.001
	1972 (9.2)	1968 (9.3)	
Number of close friends			p<0.05
	3.7 (2.1)	3.3 (2.0)	
Number of close friends see or talk to every two weeks			n.s.
	3.3 (2.0)	3.0 (2.1)	

TABLE 3 : SOCIAL ACTIVITY PARTICIPATION (%) OF SASKATCHEWAN SINGLE MOTHERS, DISABLED/NON-DISABLED

Social Activity	Group	Do	Don't Do and Don't Want to Do	Don't Do Because Can't Afford to	Does Not Apply	χ^2
Evening out with relatives or friends every 2 weeks						p<0.05
	Non-Disabled	54.8%	7.9%	30.7%	6.6%	
	Disabled	39.2%	8.0%	48.0%	4.8%	
Meal in a restaurant once a month						n.s.
	Non-Disabled	74.0%	3.7%	19.9%	2.4%	
	Disabled	68.8%	.8%	27.2%	3.2%	
Leisure activity like biking, walking, swimming						n.s.
	Non-Disabled	86.3%	5.8%	5.4%	2.5%	
	Disabled	79.4%	7.1%	9.5%	4.0%	
Annual one week holiday without relatives						n.s.
	Non-Disabled	27.4%	4.1%	62.7%	5.8%	
	Disabled	18.3%	4.8%	72.2%	4.8%	
Celebrations of special occasions						n.s.
	Non-Disabled	95.9%	.8%	2.4%	.8%	
	Disabled	95.2%	.8%	3.2%	.8%	

every 2 weeks than Saskatchewan single mothers without a disability. There was a significant association whether or not a single mother had a disability and going out for an evening every 2 weeks, ($\chi^2(3) = 11.22, p < 0.05$), Cramer's $V = .175$; single mothers with a disability (48%) were less likely to go out for an evening with friends or relatives because they couldn't afford to when compared to single mothers without a disability (29.2%). Overall, 77.2 % of single mothers (disabled/non-disabled) could not go out for an evening every 2 weeks because they could not afford to do so.

Results from Table 4 indicate that for single mothers with a disability there was a significant relationship between an evening out every 2 weeks with friends or relatives and Aboriginal ethnicity, $r = .21, p < 0.01$; education, $r = -.20, p < 0.05$, income, $r = -.21, p < 0.05$; number of friends one can count on in times of need, $r = -.37, p < 0.01$; and how many friends one sees or talks to every 2 weeks, $r = -.36, p < 0.01$. In other words, for single mothers who had a disability, the factors of Aboriginal ethnicity, low educational levels, low income levels, few friends, and few friends one sees or talks to every 2 weeks were linked to their non-participation in the social activity of an evening out every 2 weeks with friends or relatives. For



TABLE 4 : CORRELATIONS BETWEEN VARIABLES, NON-DISABLED & DISABLED
 (*P< 0.05 (ONE-TAILED); ** P<0.01 (ONE-TAILED))

	1	2	3	4	5	6	7	8	9	10	11	12	13
Non-Disabled (n = 247)													
1. Year born	----	-.10**	-.23**	-.49**	-.05	.09	.07	.12	.09	-.07	-.05	-.03	-.41**
2. Aboriginal	.10	----	-.26**	-.30**	.07	.16**	.04	.08	.12*	-.10	-.10*	-.02	-.20**
3. Education	-.23**	-.26**	----	.46*	-.16**	-.21**	-.00	-.06	-.09	.06	.04	.01	.30**
4. Income	-.48**	-.30**	.46**	----	-.12*	-.30**	-.05	-.20**	-.10	.16**	.08	.07	.55**
5. Evening out	-.04	.07	-.16**	-.12*	----	.29**	.18**	.28**	.10*	-.22**	-.36**	-.35**	-.18**
6. Meal out	-.09	.165**	-.21**	-.30**	.29**	----	.06	.22*	.15**	-.17**	-.17**	-.13*	-.20**
7. Leisure	.07	.04	-.00	-.05	.18**	.06	----	.20**	-.01	-.20**	-.06	-.06	.05
8. Holiday	.12*	.08	-.06	-.20**	.28**	.22**	.20**	----	.04	-.214**	-.17**	-.21**	-.04
9. Celebrations	.09	.12*	-.09	-.10	.10*	.15*	-.01	.03	----	-.03	-.08	.02	-.15**
10. Health	-.07	-.10	.06	.16**	-.22**	-.17**	-.20**	-.22**	-.03	----	.24**	.29**	-.00
11. Close friends	-.05	-.11*	.04	.08	-.36**	-.17**	-.07	-.17**	-.08	.24**	----	.88**	.14*
12. See Friends	-.03	-.02	.01	.07	-.36**	-.13*	-.06	-.21**	.03	.29**	.88**	----	.09
13. Employment	-.41**	-.20**	.30**	.55**	-.18**	-.20**	.05	-.04	-.15**	-.00	.14*	.09	----
Disabled (n = 123)													
1. Year born in	----	.25**	-.07	-.26**	-.03	-.09	-.04	.02	-.07	.09	-.01	-.11	-.26**
2. Aboriginal	.25**	----	.12	-.39**	.21**	.02	.05	.15*	.11	.05	-.03	.01	-.29**
3. Education	-.07	-.12	----	.47**	-.20*	-.20*	-.12	-.21**	.00	.23**	.21**	.08	.34**
4. Monthly Income	-.26**	-.38**	.47**	----	-.21**	-.03	-.10	-.08	.03	.22**	.12	.05	.59**
5. Evening out	-.03	.21**	-.20*	-.21*	----	.19*	.21**	.37**	.14*	-.04	-.37**	-.36**	-.06
6. Meal out	-.09	.02	-.20*	-.03	.19*	----	.24**	.32**	.11	-.16*	-.14	-.15	-.14
7. Biking, etc.	-.04	.05	-.17	-.10	.21**	.24*	----	.26**	.19*	-.20*	-.19*	-.18*	.01
8. Holiday	.02	.15*	-.20**	-.08	.37**	.32**	.26**	----	.16*	-.20*	-.24**	-.22**	-.09
9. Celebrations	-.07	.11	.00	.03	.14*	.11	.19*	.16*	----	-.00	-.02	-.00	.19*
10. Health	.09	.04	.23**	.21**	-.04	-.16*	-.20	-.20*	-.00	----	.31**	.22**	.03
11. Close friends	-.01	-.03	.21**	.12	-.37**	-.14	-.19*	-.24**	-.02	.31**	----	.82**	.13
12. See Friends	-.11	-.00	.08	.05	-.36**	.15	-.18*	-.22**	-.00	.23**	.82**	----	.02
13. Employment	-.26**	-.29**	.34**	.58**	-.06	-.14	.01	-.09	.19*	.03	.13	.02	----

single mothers without a disability, there was a significant relationship between an evening out every 2 weeks and education, $r = -.16, p < 0.01$; income, $r = -.12, p < 0.05$; health, $r = -.22, p < 0.01$; number of friends one can count on in times of need, $r = -.36, p < 0.01$; how many friends one sees or talks to every 2 weeks; and employment status, $r = -.18, p < 0.01$.

In other words, for single mothers who did not have a disability, the factors of low educational levels, low income levels, poor self-rated health, few friends, few friends one sees or talks to every 2 weeks, and lack of employment were linked to their non-participation in the social activity of an evening out every 2 weeks with friends or relatives. For disabled/non-

disabled single mothers, low income and low educational levels (indicators of material deprivation), were linked to not going out for an evening every 2 weeks. For single mothers without a disability only, lack of employment (indicator of material deprivation) was also linked to not going out for an evening every 2 weeks. For single mothers with a disability only, Aboriginal ethnicity was linked to not going out for an evening every 2 weeks.

When we examine only the significant personal socio-economic characteristics of self-rated health, age, and number of close friends (see Table 2) and participation in the only significant social activity, an evening out every 2 weeks with friends or relatives (see Table 3), results



from Table 4 indicate that for single mothers with a disability, there was a significant relationship between an evening out every 2 weeks with friends or relatives and number of friends that one can count on in times of need, $r = -.37$, $p < 0.01$. For single mothers without a disability, there was a significant relationship between an evening out every 2 weeks and self-rated health, $r = -.22$, $p < 0.01$ and number of friends that one can count on in times of need, $r = -.36$, $p < 0.01$. In other words, for disabled/non-disabled single mothers, having few friends (an indicator of social deprivation), was linked to not going out for an evening every 2 weeks.

For single mothers without a disability only, poor self-rated health was linked to not going out for an evening every 2 weeks. As noted previously, single mothers with a disability had poorer self-rated health than single mothers without a disability. Canadian evidence indicates that a sense of community belonging or inclusion is linked to perceived physical and mental health; those with higher perceived health were more likely to have a higher sense of wellbeing and inclusion than those with lower perceived health (Shields, 2008). In addition, dimensions of social connections and relationships have been found to promote individual well-being (Stiglitz, Sen, & Fitoussi, 2009).

Discussion

This study's cross-sectional findings for single mothers with and without a disability were consistent with Pantazis, Gordon and Levitas (2006) cross-sectional findings from the Poverty and Social Exclusion (PSE) Survey ($n=1,534$ households), which examined what percentage of the adult population participated in common social activities as one aspect of social deprivation. Although this cross-sectional study utilized fewer and rather simplistic measures for material deprivation and personal socio-economic characteristics, our social relations/emotional activities and response categories (see Table 3) were identical to those used in the PSE Survey. Findings from the PSE Survey indicated that population groups such as single mothers (53%), were much more likely to not participate in social activities such as

have an evening out particularly due to low income, than were single women and partnered mothers (Levitas, Head, & Finch, 2006).

This study's cross-sectional findings for single mothers with and without a disability were consistent with the Toronto Social Services' 2003 Survey findings of single mothers on Ontario Works ($n=801$) indicated that 4 out of 5 of these single mothers who received social assistance had not had a night out with friends in the past month; 71% of these single mothers indicated that they had not had an evening out in a month because they could not afford to do so. In the Toronto Social Service's Survey, respondents were not asked whether or not they had a disability, although they were asked if they felt isolated and lonely (findings/percentages not stated).

This study's findings for single mothers with a disability (see Table 3) were also consistent with findings from the PSE Survey (Pantazis, Gordon, & Levitas, 2006) which indicated that those individuals with mental health impairments (44%) did not have an evening out because they could not afford to (Payne, 2006). Single parents (over 25%) were more likely to suffer from depression or poor well being than other population groups (Payne). The PSE Survey used the short version of the General Mental Health Questionnaire (GHQ-12) which is used in general populations to measure symptoms of mental ill health, particularly depression. In the PSE Survey, this instrument was used as an "indicator of poor well being" (Payne, 2006, p. 289).

In addition, this study's findings for single mothers with a disability were also consistent with several other studies which examined social inclusion and disability in diverse populations. Gannon and Nolan's (2007) study of the impact of disability transitions on social inclusion used data from the Living in Ireland Survey, 1995-2001 ($n=2727$ adults). Respondents were asked, 'Whether he or she had an afternoon or evening out in the last fortnight, for entertainment, something that cost money; and if not what was the main reason, didn't want to; full social life in other ways; couldn't afford to;



can't leave children; illness; or other. Their study found that having an evening out every fortnight, was the only social activity that was significant even when they controlled for age, gender, and educational attainment. Those who reported a disability were 19 percentage points less likely to participate in an evening out every fortnight than those who did not report a disability, particularly those individuals who were elderly (65+ years) and for women. Other categories of social activity participation in their study included numbers of friends/relatives one talks to or meets and membership in a club or organization. In the Living in Ireland Survey, disability is measured with the following question : "Do you have any chronic physical or mental health problem, illness or disability?" Respondents are also asked if they have a chronic or mental health problem, illness or disability, does their impairment limit their daily activities (severe, some or no limitations).

Lastly, findings from Durst and Bluechardt's (2001) study of Saskatchewan urban Aboriginal persons with disabilities indicated that one of the major barriers to participation in social and recreational activities was an indicator of material deprivation (low income). In Durst and Bluechardt's study, respondents (n=11) male/female who ranged from 20-50+ years were asked, "Do you participate in recreational or sports activities"? For Aboriginal persons with disabilities, provision of culturally relevant social activities was deemed to be essential for their well-being and sense of inclusion (Durst & Bluechardt).

Conclusions and Policy / Service-Provider Suggestions

This paper has endeavored to deepen the understanding of wellbeing and social inclusion by examining the link between disability and social activity participation in Saskatchewan single mothers. Overall, study findings indicated that there were imbalances or gaps in the social activity participation levels among single mothers with a disability compared to single mothers without a disability. Saskatchewan single mothers with a disability did not participate in an evening out every 2 weeks as often

as Saskatchewan single mothers without a disability. In addition, Aboriginal single mothers with a disability were less likely to have an evening out every 2 weeks than were Non-Aboriginal single mothers with a disability. This finding confirms research which identifies a "double stigma" or "compound disadvantage" for women who are disabled and of a "minority" ethnicity such as Aboriginal ethnicity (Hague, Thiara, & Mullender, 2010). Material deprivation (low income) was indicated by both groups of single mothers as the main reason for not participating in an evening out every 2 weeks (Durst & Bluechardt, 2001).

Although each single mother in this study would experience her disability in a unique manner, it was evident from this study's correlational findings that disability or impairment has an impact on social activity participation and is also linked to factors such as low income and Aboriginal ethnicity (Fougeyrollas, Cloutier, Bergeron, Cote, & St. Michel, 1999). For all single mothers with and without a disability, the numbers of friends that one has in times of need was also important to social activity participation. The finding that single mothers with a disability have fewer friends during times of need than single mothers without a disability was troubling. The author can speculate that choosing to have fewer friends would not be an option for most single mothers, particularly those with a disability; indeed, with the responsibilities of managing a household and raising children, more support rather than less support would seem desirable, even necessary, not only for the mother's well-being but also for the children's well-being. Single Aboriginal mothers with a disability, "lose out on both accounts" (Hague, Thiara, & Mullender, 2010, p. 8); they have fewer supportive friends in time of need which may also impact on their ability to participate in social relational/emotional activities than single mothers without a disability.

This study has generated important questions for further research : do single mothers with a disability have fewer friends (disabled/non-disabled) because of the disability and therefore less access to participate in social activi-

ties or because of other reasons like transportation issues (i.e. cannot afford transportation/ their friends do not have access to transportation and/or also have a disability which also restricts their participation and/or cannot access public buildings)? Are single mothers with a disability less accepted in public places (is single mother status and having a disability a double stigma) than single mothers without a disability and therefore reluctant to participate in social activities in the community? Are social activities culturally relevant and/or accessible (Durst & Bluechardt, 2001)? Wagner and Bailey (2005) suggest that "physical accessibility and physical integration alone do not ensure that [Canadian] individuals with disabilities will feel welcome and accommodated" (p. 2). Community awareness programs are necessary in order to combat stigma.

It is important that policy-makers and service providers focus on the heterogeneity of single mothers with disabilities (Gannon & Nolan, 2007) and its link to income levels, Aboriginal ethnicity, numbers of supportive friends, and social activity participation... in other words, their wellbeing and inclusion in society. Single mothers with a disability want to participate in the same social relations/emotional activities that single mothers without a disability want to participate in (Wagar & Bailey, 2005).

Increased financial resources and service-provider programs which focus specifically on ensuring meaningful social activity participation among single mothers with a disability should be a priority in our society. If low income inhibits many single mothers, with and without a disability, from participating in common social activities that they would like to participate in, policy-makers must ensure that these single mothers have an adequate income to do so. If single mothers with a disability do not have supportive friends to ease/facilitate participation in common social activities and/or cannot access culturally relevant activities, service-providers must ensure that necessary support/mechanisms are in place to facilitate their full inclusion in society.

It is vital for all of Canadian society to recognize that an individual's functioning in society is inextricably linked to her impairment (s) and her social, political and environment (Fougeyrollas, Cloutier, Bergeron, Cote, & St. Michel, 1999); and to embrace the notion of societal impediment as the disabling factor rather than the impairment (WHO, 2009). Canadian society must take steps at both the individual level (i.e. medical rehabilitation) and at the societal level (i.e. introduction of universal design to make infrastructure more accessible) to ensure that those with functional limitations would not be "disabled" in the sense of their full participation or inclusion in society (Mont, 2007). "We, the one's who are challenged, need to be heard. To be seen not as a disability, but as a person who has, and will continue to bloom. To be seen not only as a handicap, but as a well intact human being" Robert M. Hensel (born with spina bifida, Advocate for the disabled, international poet-writer).

References

- ADVANCING THE INCLUSION OF PERSONS WITH DISABILITIES (2009). Retrieved from <http://www.marchofdimes.ca/NR/rdonlyres/C8B5B6A1-4E40-440E-A000-DFC512C43B8E/0/aido4.pdf>
- CANADIAN COMMUNITY HEALTH SURVEY (2005). Retrieved from <http://www.statcan.gc.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=3226&lang=en&db=imdb&adm=8&dis=2>.
- DIENER, E., & SELIGMAN, M. (2002). Very Happy People. *Psychological Science*, 13, 81-84.
- DIJKERS, M. P. J. M., WHITENECK, G., & EL-JAROUDI, R. (2000). Measures of social outcomes in disability research. *Archives of Physical medical and Rehabilitation*, 81 (Suppl 2), S63-S80.
- DIJKERS, M. P. J. M., YAVUZER, G., ERGIN, S., WEITZENKAMP, D., & WHITENECK, G. (2002). A Tale of two countries : environmental impacts on social participation after spinal cord injury. *Spinal Cor*, 40, 351-362.
- DOUGLAS, F., & GINGRICH, P. (2009). *Child and Family Poverty Saskatchewan Report*. University of Regina : Social Policy Research Unit.
- DURST, D., & BLUECHARDT, M. (2001). *Triple Jeopardy*. University of Regina : Social Policy Research Unit.
- EVERETTE, B. (2009). Belonging : social exclusion, social inclusion, personal safety and the experience of mental illness. Retrieved from <http://www.mooodisorderscanada.ca/documents/Publications/BELONGING%20FINAL%20REPORT.pdf>



- FOUGEYROLLAS, P., CLOUTIER, R., BERGERON, H., COTE, J., & ST. MICHEL, G. (1999). *The Quebec Classification : Disability Creation Process*. Lac St. Charles, Quebec : International Network on the Disability Creation Process.
- GANNON, B., & NOLAN, A. (2007). The impact of disability transitions on social inclusion. *Social Science & Medicine*, 64, 1425-1437.
- HAGUE, G., THIARA, R., & MULLENDER, A. (2010). Disabled Women, Domestic Violence and Social Care : The Risk of Isolation, Vulnerability and Neglect. *British Journal of Social Work*, July 7, 1-18.
- JEANNOTTE, M. (2008). *Promoting Social Integration - A Brief Examination of Concepts and Issues*. Experts Group meeting, Helsinki, Finland. July 8-10.
- MASLANY, G., & JEFFERY, B. (2007) A Pilot Study : Health, Social Exclusion & Single Mothers. *International Journal of Interdisciplinary Social Sciences*, 2, 455-463.
- MASLANY, G., JEFFERY, B., & GINGRICH, P. (2009). Exploring Links between Perceived Health, Social Exclusion, and Social Assistance in Saskatchewan Single Mothers. *Women's Health & Urban Life An International and Interdisciplinary Journal*, 8(2), 42-63.
- LEVITAS, R., HEAD, E., & FINCH, N. (2006). Lone mothers, poverty and social exclusion. In Pantazis, C., Gordon, D., & Levitas, R. (Eds.) (p.405-430). *Poverty and social exclusion in Britain*. University of Bristol : The Policy Press.
- LLOYD, C., TSE, S., & DEANE, F. P. (2006). Community participation and social inclusion : How practitioners can make a difference. *Australian e-Journal for the Advancement of Mental Health*, 5(3). Retrieved from <http://www.auseinet.com/journal/vol5iss3/lloyd.pdf>
- MASLOW, A. (1943). A Theory of Human Motivation. *Psychological Review*, 50, 370-96.
- MONT, D. (2007). *Measuring Disability Prevalence*. SP Discussion Paper. No. 0706. Retrieved from <http://siteresources.worldbank.org/DISABILITY/Resource/s/data/MontPrevalence.pdf>
- NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH (1999). Long-Range Plan for Fiscal Years 1999-2003. *Federal Register*, 64(234), 68575-68614.
- POPULATION AND PUBLIC HEALTH BRANCH (2001). *Key Learning Two from PPHB Atlantic's Work on Social and Economic Inclusion, 1998-2000*. Retrieved from http://www.hc-sc.ca/hppb/regions/atlantic/pdf/key_learning_two_e.pdf
- PANTAZIS, C., GORDON, D., & LEVITAS, R. (EDS.) (2006). *Poverty and social exclusion in Britain*. University of Bristol : The Policy Press.
- PANTAZIS, C., GORDON, D., & TOWNSEND, P. (2006). The Necessities of Life. In C. Pantazis, D. Gordon & R. Levitas, (Eds.) (p.89-122). *Poverty and social exclusion in Britain*. University of Bristol : The Policy Press.
- PAYNE, S. (2006). Mental Health, Poverty and Social Exclusion. In C. Pantazis, D. Gordon & R. Levitas (Eds.) (p.285-311). *Poverty and social exclusion in Britain*. University of Bristol : The Policy Press.
- RYAN, R. & DECI, E. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *American Psychologist*, 55, 68-78.
- SCHLEIEN, S. J., RAY, M. T., & GREEN, F. P. (1997). *Community recreation and people with disabilities : Strategies for inclusion*. Baltimore, Maryland : Paul 11 Brooks.
- SHIELDS, M. (2008). Community belonging and self-perceived health. *Health Reports*, 19(2), 51-60.
- SHOOKNER, M. (2002). *Dimensions and Indicators of Social Exclusion and Inclusion*. Retrieved from http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Inclusion_lens/inclusion_2002_e.pdf
- SOUTH AFRICA'S INTEGRATED NATIONAL DISABILITY STRATEGY (2009). Retrieved from <http://www.independentliving.org/docs5/SANatIDisStrat.html>
- SPANDLER, H. (2007). From Social Exclusion to Inclusion? A Critique of the Inclusion Imperative in Mental Health. Retrieved from <http://www.medicalsociologyonline.org/archives/issue22/spandler.html>
- STATISTICS CANADA (A). (2007). Census Snapshot of Canada-Families. *Canadian Social Trends*, 84, 39. Retrieved from <http://www.statcan.gc.ca/pub/11-008-x/11-008-x2007007-eng.pdf>
- STATISTICS CANADA (B). (2007). Table 202-0804-Families in low income, by economic family type, constant dollars, annual, Participation and Activity Limitation Survey 2006 : *An Analytical Report*, p.10.
- STIGLITZ, J. E., SEN, A., & FITOUSSI, J.-P. (2009). *Report of the Commission on Measurement of Economic Performance and Social Progress*. Retrieved from http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf
- TORONTO COMMUNITY & NEIGHBOURHOOD SERVICES (2003). *Social Assistance and Social Exclusion*. Findings from the Toronto Social Services' 2003 survey of single parents on Ontario Works. Retrieved from <http://www.toronto.ca/socialservices/reports.htm#e>
- TOWNSEND, P. (1993). *The international analysis of poverty*. Hemel Hempstead : Harvester Wheatsheaf.
- TOYE, M., & INFANTI, J. (2004). *Social Inclusion and Community Economic Development*. Pan-Canadian Community Development Learning Network project Framework. Retrieved from http://www.laidlawfdn.org/page_1069.cfm
- WAGNER, J., & BAILEY, M. (2005). The "I" in Inclusion : Individual Indicators of Inclusion across Quality of Life Domains. *Rehabilitation Review*, 16(6), 1-2.
- WORLD HEALTH ORGANIZATION (2001). *ICIDH-2 : International Classification of Functioning, Disability and Health*. Final draft, full version. Geneva : World Health Organization.
- WORLD HEALTH ORGANIZATION (WHO). 2009. Retrieved from <http://www.WHO.int/classifications/icf>