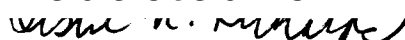


## AN ABSTRACT OF THE THESIS

Corinne M. Corson for the degree of Master of Science in Human Development and Family Studies presented on January 18, 2001. Title: Health, Well-Being, and Financial Self-Sufficiency of Low-Income Families in the Context of Welfare Reform.

*Redacted for Privacy*

Abstract approved:



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Leslie N. Richards

The Personal Responsibility and Work Reconciliation Act of 1996 brought several changes to the welfare system. Among these changes are lifetime limits for receiving welfare benefits, and work requirements intended to foster economic self-sufficiency in welfare recipients. In the past few years, it has been acknowledged that there are challenges and barriers to the latter requirement such as quality affordable childcare, transportation, and the availability of suitable jobs. Also needing to be addressed are the health concerns of family members that may also present as a challenge or barrier to attempts to obtain and maintain economic self-sufficiency. This study examined how health functions as a challenge or a barrier to economic self-sufficiency in a low-income rural population.

The sample consisted of 73 families enrolled in the Rural Families Speak Project, a multistate collaboration examining the effects of welfare reform on the well-being of low-income rural families. Mothers are the primary respondents to semi-structured interviews consisting of open-ended questions and fixed choice survey measures. Using qualitative research methods, and guided by an ecological

perspective that considers multiple levels of influence on individuals and families, interviews were analyzed for thematic content having to do with health, well-being, mental health, and experiences with and perceptions of welfare. Quantitative findings are reported well.

Findings indicated that health interferes with economic self-sufficiency in several ways. Adult health problems can limit or preclude the ability to find and keep work or acquire an education, as well as require out of pocket expenditures when adults are uninsured or underinsured. Child health problems can affect families in the same ways, and by limiting or interfering with the child's own education. Furthermore, welfare and other social agency policies may impact the health of low-income populations through the reduction of services.

Socioeconomic position can influence health outcomes through several different means, including access to and availability of health care, public and private social relationships, exposure to adverse conditions at home and in the workplace, social deprivation, and the social milieu. It is suggested that welfare policymakers consider these factors and adopt an ethic of care when making welfare policy decisions.

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Health, Well-Being, and Financial Self-Sufficiency of Low-Income Families in the  
Context of Welfare Reform

by

Corinne M. Corson

A THESIS

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Master of Science thesis of Corinne M. Corson presented on January 18, 2001

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Corinne M. Corson, Author

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# HEALTH, WELL-BEING, AND FINANCIAL SELF-SUFFICIENCY OF LOW-INCOME FAMILIES IN THE CONTEXT OF WELFARE REFORM

## CHAPTER 1

### INTRODUCTION

Changes in welfare policy throughout the 1990s, more commonly known as welfare reform, have led to a core focus on personal responsibility with the expectation that such responsibility will lead to economic self-sufficiency. More specifically, job search and work requirements are promoted as a means of fostering and improving economic self-sufficiency among economically disadvantaged individuals and families. Despite the worthiness of this goal, and the likelihood that economically disadvantaged individuals and families desire to be self-sufficient, there are factors—barriers and challenges—that must be considered when promoting and implementing programming that supports such goals. Factors that are consistently acknowledged and addressed are the need for sufficient and appropriate job opportunities, for skill development and enhancement in the economically vulnerable, and for both adequate and accessible transportation and childcare services, particularly in rural locales where resources are typically more limited (Cottle, 1996; Pantazis, 1997; Porterfield, 1998; Zedlewski, 1998). Health concerns are also mentioned, yet perhaps the significance of the challenge and barrier that health places between economically vulnerable families and self-sufficiency is underestimated. Examining this significance, as well as looking at the specific ways

in which health and well-being factors serve as a barrier to self-sufficiency, specifically in rural low-income populations, is the primary goal of this research.

With the focus on personal responsibility, one would assume that health is an individual issue, with any problems corrected by personal choices and behavior. What is often overlooked is the contribution of Western oriented political, economic, and social system philosophies and practices to individual health status. Indeed, several authors have noted this connection, contending that poor health and disease are consequences of lower socioeconomic status (Brunner, 1997; Krieger, 1999; National Center for Health Statistics, 1998; New York Academy of Sciences, 1999; Pincus, 1994; Wilkinson, 1997). What is created is a vicious cycle in which illness and disease are fostered in economically vulnerable populations as a result of living in a society that has such distinct divisions, and therefore privileges, among the classes. This same system, however, demands these individuals be self-sufficient—a sometimes difficult or impossible feat because of the barriers and challenges health problems create. Thus, a secondary focus of this research is to illustrate how the health and well-being of economically underprivileged individuals is affected by their social standing.

Before continuing, definitions of both health and self-sufficiency are necessary. According to the World Health Organization, health “is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (<http://www.who.int/aboutwho/en/definition.html>). Thus, for purposes of this study, when referring to health, both mental and social well-being will be taken into

account along with physical health. Social well-being will be indicated by depression levels and life satisfaction.

Self-sufficiency is a little more difficult to define, with a wide range of contextual meanings. For this research, self-sufficiency will refer to a family's ability and capacity to sustain themselves adequately financially, according to federal poverty guidelines, which are often argued as being extraordinarily low (Edin & Lein, 1997; Rank, 1994; Seccombe, 1999).

The research was guided by an ecological theoretical perspective, which looks at the nature of interactions between people and their immediate and more removed social and physical environments. Although there are several variations regarding the ecological approach, the work of Urie Bronfenbrenner (1977) was used to guide this research. Using his approach, the individual can be seen at the center of several concentric circles. The innermost circle, in which the individual is embedded, is the microsystem. The microsystem refers to interpersonal interactions within specific settings that are immediate to the individual. These include, for example, interactions within the family, the workplace, or school.

The next circle out is the mesosystem, which refers to interactions and connections among major settings; or, according to Bronfenbrenner (1977), it is "a system of microsystems" (p. 515). The mesosystem is followed by the exosystem, which refers to other social systems that, while not necessarily immediately encompassing individuals, may affect them in a variety of ways. This system includes such structures as the neighborhood, work environments, mass media, government

agencies, and so on. The final level of influence on individuals is the macrosystem, which surrounds, permeates, and influences all other contexts in which the individual exists and is affected by. The macrosystem does not refer to a specific context in which the individual functions and exists, but rather to the cultural, political, social, educational, and legal systems that drive how the more concrete systems manifest in a particular society.

Each of these contexts is defined from the view of the individual at the center; and though it appears as if each system is separate from the others, they are more correctly looked at as an intermeshed network of systems, each affecting the other. Thus, the individual is not only part of the microsystem and connecting mesosystem, but also the macrosystem and exosystem (Bronfenbrenner, 1977).

Though all realms of the ecological model are covered, this research is situated primarily in the macrosystem and microsystem points of view, though the exosystem and mesosystem come into focus when considering the communities and geographic areas in which families live. The microsystem is represented through the presentation of the actual experience of individuals attempting to attain self-sufficiency. In other words, though it is probable that individuals desire and are capable of taking care of their families, health and well-being concerns and problems exist. Indicating what these problems are and how they affect the lives of low-income rural families is the primary intent of this research. Thus, the overarching question guiding this research asks, how does health affect the ability of low-income rural families to obtain and maintain economic self-sufficiency?

## CHAPTER 2

### REVIEW OF THE LITERATURE

#### Welfare Reform

In 1996, President Clinton signed the Personal Responsibility and Work Reconciliation Act, more commonly known as welfare reform. The signing of this Act established Public Law 104-193, which brought an end to traditional welfare, better known as Aid to Dependent Families and Children (AFDC). In its place the Temporary Assistance to Needy Families (TANF) program was created. Different from AFDC, which was a federal entitlement program, the decisions regarding the administration of TANF have devolved to states. While cash grants are still given, there is flexibility from state to state regarding how the allotted funds will be most useful for a particular individual or family. In some instances, help may be given with transportation, clothing, childcare, training, and other areas that can help facilitate employability (Pantazis, 1997; Seccombe, 1999).

Although states now control benefits distribution, states are required to function within certain federal parameters. Two commonly known parameters are work requirements and lifetime limits. According to current law, there is a lifetime limit on receipt of TANF benefits of no more than five years. States may individually choose how to distribute funds within this five-year period, and they may set the state limit to fewer years (Pantazis, 1997; Seccombe, 1999). Moreover, all recipients who are

able bodied must work after two years of receiving TANF benefits (Pantazis, 1997; Seccombe, 1997).

How states go about encouraging TANF recipients to work is variable. Several policies are typically applied, including incentives such as maximum benefit levels and retainment of a greater share of earnings without losing TANF benefits (Zedlewski, 1998). A second method is to apply sanctions; wherein the amount of benefits a family receives is reduced according to their refusal to work.

Despite what appear to be good intentions to impel and assist vulnerable families with endeavors to become economically self-sufficient, there is cause for concern given the new welfare policies. Though time limits present unique concerns in and of themselves, there are as many or more reasons to be concerned about work requirements and the implications they have for vulnerable families. Pantazis (1997) noted in reference to welfare reform work requirements, "Meeting the work requirements of the new law is a fundamental problem that could hinder the successful implementation of the program (para 13)." She mentioned concerns about the availability of sustainable jobs, particularly local publicly subsidized jobs for which welfare recipients are qualified.

Others (Cottle, 1996; Porterfield, 1998; Zedlewski, 1998) have also expressed concern about the availability of jobs and some of the proposed options for addressing this issue. Cottle asks where the jobs will come from and at what cost. Can offering incentives to private businesses that furnish jobs to welfare recipients be an effective option? Cottle indicates that even if the private sector were willing to



furnish these jobs, the “natural job creation process” cannot provide enough jobs to employ the additional workers who have been and will be entering into the system (para 10). Given the circumstances, as Pantazis mentioned, there is a necessity for the creation of publicly subsidized jobs. And of course, the issue with this option, as with any other, is funding.

Not only are there real concerns regarding the availability of jobs, and of jobs that pay a sufficient wage to adequately support families, there are real concerns regarding the barriers and challenges individuals and families must face to find and keep a job. As previously mentioned, there are concerns about who will watch the children of recipients while they engage in workforce activities. There are also concerns, particularly for rural families, about how workers will get to work. Previous research specific to rural women who receive welfare benefits has indicated that certain supports are needed in order to encourage them to get work and continue working. Such supports include living-wage jobs, and both childcare and transportation assistance (Porterfield, 1998). Yet what about health problems? How can they be, and do they need to be addressed by current welfare policy?

### Determinants of Health

Though health is often thought of as an individual experience and thus an individual responsibility, fostered or hindered by individual actions, it is, in reality, the result of much more. When a broader view of health and well-being is acknowledged, we realize that who we are and what we experience in life is affected

by our surroundings and the contexts in which we live and act. We are much more than biological events influenced only by genetics and individual behaviors.

According to Hughes (1992), health and well-being are affected by biological, psychological, *and* social dimensions. Moreover, he contended that the effects of health and well-being are “profoundly interpersonal” with illness a shared, communal experience (p. 123).

Health is determined by a meld of several different factors (Brown, 1998; S. Khanna, personal communication, Spring, 2000). One factor is biology, and includes disease etiology, the pathogenic process, and preventative and curative medical (not limited to Western allopathic medicine) treatments. Ecological factors, such as the physical environment, food, pollution, and population contribute to health. Sociocultural influences also determine health, and consist of worldview, group behavior, ethnomedical beliefs, and individual behavior. Lastly, political and economic ideologies and forces, including access to resources, resource allocation, regional interests, and decisions made on either an individual or group basis affect health. These health determinants represent both macro- and microlevel influences.

When looking at health, it is necessary to look at all of these factors as a whole, as creating a division among them leads to a false understanding of what determines health. With that understanding, this research more specifically looks at the effects to the latter two mentioned determinants—sociocultural influences and political/economic ideologies—on the health of rural low-income families. While the sociocultural standpoint emphasizes individuals’ experiences within their specific

culture and/or subculture, beliefs, values, individual ideals and practices; the political ecology view is more a theoretical orientation that focuses on specific historical processes and social stratification from a global position (Brown, 1998). Whereas sociocultural influences would be more concerned with ethnic differences, the political economy is more a reflection of the functions and effects of the World Bank and nation-state influences.

### The Social, Political, and Economic Dimensions of Health and Well-Being

The connection between health and well-being and cultural, political, and economic philosophies is apparent in the literature. With the goal of determining the effect of income disparities on health, Kennedy, Kawachi, Glass, and Prothrow-Stith (1998) analyzed state data from the 1993 and 1994 behavioral risk factor surveillance system. They found that, when controlling for personal characteristics, such as age, sex, race, health insurance status, household composition, and income, those living in states with the greatest income disparities were nearly one-third more likely than those living in states with lesser income disparity to report fair or poor health.

In a subsequent study (Fiscella & Franks, 2000) designed to examine the connections between income inequality, self-rated health, and mortality, it was found that, indeed, income inequality does have a small but significant effect on self-rated health and depressive symptoms but not on morbidity and mortality. Individual

income, however, had a larger effect on all variables, including depressive symptoms, severity of biomedical morbidity, self-rated health, and mortality.

A press release prepared to summarize data from the 1998 annual Health and Human Services Report to the President and Congress also indicates that health is related not only to income, but also education (US Department of Health and Human Services, 1998). In fact, for all health indicators reported, each incremental increase in either income or education showed an increase in the likelihood of being in good health. For instance, less educated adults are more likely to die at a younger age than those with more education; and, adults with less education are more likely to have higher death rates from all leading causes of death. Additionally, although cigarette smoking declined overall for adults between 1974 and 1995, those with the least education were over two times as likely to smoke as those with the most education.

The health of children is also affected by socioeconomic status (US Department of Health and Human Services, 1998). Key indicators of health, infant mortality rates and low-birthweight rates, were elevated when infants were born to mothers who were less educated. Lead exposure and excessive amounts of blood lead levels were found in children from low-income families. Acquiring access to health insurance and health care is also more difficult for low-income individuals; and children from low-income families without health insurance were more likely than low-income children with insurance to have no regular source of health care.

These disparities appear to be enduring as a 1994 report found similar results (US Department of Health and Human Services, 1995), with the conclusion that education is of vital importance to general health status and well-being. Health disparities reported in *Health, United States, 1994* included a significantly greater likelihood for pregnant women without a high school education to smoke than those who were college graduates, a decline in infant mortality and low birthweight as the mother's educational level increases, a lower vaccination rate for children from low-income families than those of middle or higher income families, and less health care provider contact for children who were considered poor or near poor than nonpoor children.

Other research has also shown a relationship between child health, family income, and parental education (Flores, Bauchner, Feinstein, & Nguyen, 1998). This research examined not only the influence of both income and parental education on children's health and use of health care services, but also ethnicity. The results found that children in certain minority group populations (Native Americans, Blacks, and Hispanics) had the poorest health compared to Asian/Pacific Islanders and Whites. Likewise, children from the former groups were also the least healthy, with fewer doctor visits, and excessive intervals between visits. Differences remained even after adjustment for income and parental education, indicating that ethnicity, indeed, is an important factor in regard to health status.

Whether it is the disparity in individual income or the effects of income inequalities that most affects the health of individuals is a point for further

investigation and analysis. How income disparities and inequalities work to affect personal health, however, is of interest. Adler, Boyce, Chesney, Folkman, and Syme (1993) looked at the mechanisms through which socioeconomic status (SES) work to affect the health of individuals. By conducting a meta-analysis of existing literature, they concluded that while health status is negatively impacted by lack of access to and availability of health care and health care insurance coverage, there are several other ways in which SES works to promote health disparities among classes.

Although individual health behavior appears to be ultimately responsible for health status, at least according to the health messages conveyed by Western society that emphasize personal rather than collective responsibility and action, there are additional factors that influence health status. For example, those of low SES are more likely to be exposed to potentially harmful environmental conditions, both at home and at the workplace. Such conditions include exposure to disease causing agents, including stressful social events such as crime (Adler et al., 1993). Not only can exposure to such agents directly affect health, it can create and exacerbate psychological responses (stress) that also contribute to disease. Moreover, the ability to mediate stress in a healthful manner can also be a function of SES, with those in the lower strata experiencing more difficulty. When children from families with a lower SES, and therefore fewer resources and coping mechanisms, are exposed to stress early in life, lasting effects on health can result. Adler et al. assert that “exposure to greater stress in childhood reduces the likelihood that children will develop ‘resilience’ and increases the chances that they will develop depression and

helplessness, characteristics that have been linked to increased risk of disease” (p. 3143).

Pincus (1994) argued similarly saying that it is not so much whether individuals have access to health care that influences their health status, but rather formal educational level that influences a multiplicity of “behavioral, psychological, and cognitive mediators” that influence health (para 14). Such mediators include anxiety, depression, learned helplessness, self-efficacy, health locus of control, health knowledge, social support, and more. All of these mediators can influence participation in certain health risk behaviors, such as smoking, poor diet, and lack of exercise.

The participation in these risk behaviors is equated with an individual’s social milieu (Pincus, 1994). Engaging in health risk behaviors may eventually be reflected as risk factors such as high blood pressure, obesity, disease manifestations, and so on. According to Adler et al. (1993), both the behaviors and the risk factors are associated with SES, with those of a higher SES less likely to participate in risky behavior. Why those of a higher SES are less likely to participate in risky behavior is not discussed by Adler et al., but it can be surmised that those in the lower SES strata are less likely to be educated about the health consequences of behaviors, and have fewer resources, both material and physical, to correct certain health behaviors. For instance, fitting in time for exercise or purchasing fresh, healthy foods are extravagances when one’s time and resources are consumed with simply trying to make ends meet.

Another argument is that, as opposed to direct physical consequences of lower material standards such as inadequate housing, poor diets, and so on, health is more a product of both indirect and direct psychosocial pathways related to social position (Brunner, 1997; Wilkinson, 1997). Wilkinson contended that the indirect effects of psychosocial stress lead to an increased exposure to behavioral risk factors, such as smoking and drinking, similar to Pincus's (1994) social milieu; whereas the direct effects are physiological and result from chronic mental and emotional stress from being at the bottom of the division of the classes. Indeed, Wilkinson noted that in societies that are more egalitarian, where there is more social cohesion, there is better overall health, and both social support and social integration have been found to benefit health. When individuals feel out of control and insecure, have fatalistic attitudes, lack self-esteem, suffer from job insecurity and real and perceived financial strain, and must endure stressful life events and limited healthful social connections, health suffers.

An in-depth explanation of the biological processes that take place, linking the circumstances noted directly above to health status, is beyond the scope of this paper and are not yet fully understood. Brunner (1997) does summarize the supposed process in relation to the "flight or fight" response mechanism that is a process of human evolution. When the "flight or fight" mechanism is frequently activated, or is activated for a prolonged period of time, as it typically would be for someone suffering the stresses and emotional consequences of income disparity and/or inequality, specific neuroendocrine hormones, such as adrenaline and



cortisol, are released and circulate throughout the body. They prepare the body for physical exertion. When that exertion does not take place, the chemicals continue to circulate in the body, creating potentially negative effects leading to disease.

### Health and Work

Welfare reform policies are asking a vulnerable population, already negatively affected by their social status, to be more financially responsible for themselves and their families. But can they?

There is an abundance of information regarding how work affects health, particularly women's health, both positively and negatively. On the one hand, waged work, for women, may lead to better mental and physical health, financial gains, and an opportunity to expand social networks and autonomy (Doyal, 1995; Kneip, 2000; Rodin & Ickovics, 1994). On the other hand, certain types of waged work may also contribute to poor health. Work where there is exposure to dangerous chemicals and industrial machines, as well as work that is menial and stressful where individuals feel as if they have no control, low-status, and limited social support, can create poor health (Doyal, 1995; Kneipp, 2000; Rodin & Ickovics, 1994). It is the latter type of work that is typically available for those receiving or leaving welfare (Kneipp, 2000), potentially further contributing to the poor health and well-being of this vulnerable population. Kneipp, in fact, found this to be the case when investigating the effects of moving from welfare to work on the psychosocial health of women included in the Washington State Family Income Study, a five-year

longitudinal panel survey. Psychosocial health was measured as self-efficacy, self-esteem, sense of control, and depression. Comparisons regarding the psychosocial health of women who had left welfare for paid employment to those who stayed on welfare consistently did not change from Year 1 to Year 2.

Harder to find are data on how health influences the ability to work. In interviews with 47 women receiving welfare benefits and living in small to mid-size Florida towns, Seccombe (1999) found that poor health was one reason women relied on welfare. Health concerns interfered with both the women's ability to look for and keep work. Furthermore, the type of work women with health problems such as depression, asthma, back pain, and cardiovascular concerns, can perform is limited. The women in Seccombe's study also mentioned that the health of their children limited their desire and ability to work. Women were afraid to leave their children who were ill or had emotional problems with unskilled childcare providers, a trait that Seccombe noted is applauded in middle class women but frowned on in low-income women.

A study conducted by Heymann and Earle (1999) indicated that, in fact, mothers who had received welfare benefits were more likely to have at least one child with a chronic health problem. After leaving welfare for work, mothers had less time to care for their sick children because they were less likely to receive paid sick leave, vacation leave, and flexible hours than working mothers who had never received welfare reimbursements. The double-bind created makes it nearly impossible to enter

into and succeed in the labor force and meet the health and development needs of their children at the same time (Heymann & Earle).

Another study indicated that many mothers who have received welfare have drug and/or mental health (depression) concerns that affect their employability (Jayakody, Danziger, & Pollack, 2000). In order for them to acquire and maintain employment, they need to receive treatment to help them with their health and mental health problems.

A recent report presenting the findings of the long-term effects of Even Start Family Literacy programs also found that health concerns are a major challenge for low-income families attempting to acquire financial self-sufficiency (Richards et al., 2000). Not only was health affected by paid employment, the health status of either the adults or children in families ( $n = 29$ ) kept the adults from being able to work. Additionally, the high cost of uncovered medical expenses diminished the financial resources of some of the families. Medical problems faced were occupational injuries resulting in disability, cardiovascular disease, diabetes, back injuries/pain, and behavioral problems in children, such as Attention Deficit Hyperactivity Disorder (ADHD).

As already noted, Seccombe (1999) made mention of how the choices mothers who are receiving welfare make regarding the health and welfare of their families are often looked down upon, even if those choices are identical to ones applauded when made by middle-class women. It is clear that the former women are discriminated against because of their social standing. Though the specific focus of this thesis is

not necessarily on the effects of discrimination, one goal is to show that socioeconomic circumstances do affect health. It cannot be denied that such a connection is related to discrimination resulting from financial disparity and inequality, a reflection of a capitalistic economic structure that emphasizes the differences between “haves” and “have nots.”

### Chapter Summary

The Personal Responsibility and Work Reconciliation Act of 1996 made substantial changes in the welfare system. Whereas before, AFDC was a federally managed program; now, the control and management of its replacement, TANF, has devolved to the states. The federal government, though, is still responsible for allocating funds.

Along with changes in management, there are two important regulations of welfare reform: time limits and work requirements. These first few years after the implementation of welfare reform have revealed certain challenges or barriers to these regulations, such as lack of access to and lack of availability of affordable quality childcare, lack of appropriate job skills and living wage jobs, and lack of access to reliable transportation, particularly for those living in rural areas. One other challenge that needs to be discussed, however, is the health of these families and how it might affect the ability to find and keep work that sustains them.

Health is defined as not just physical well-being, but also mental and social well-being. There are several different determinants of health, not just individual behavior

and practices. These determinants include: biology, ecological influences, sociocultural influences, and political and economic ideologies. These determinants play into health via such means as resource and asset allocation, income distribution, education, ethnic status, and socioeconomic position.

Previous research (Doyal, 1995; Kneipp, 2000; Rodin & Ickovics, 1994) has shown that work, particularly menial, stressful work in which the worker has no sense of control, the kind most likely to be engaged in by low-skilled workers, affects health. There are data (Heyman & Earle; 1999; Richards et al., 2000; Seccombe, 1999) indicating that health can affect the ability to work, but they are more difficult to find. This deficit leads to the primary goal of this research: to show how health affects the ability of low-income rural families to obtain and maintain economic self-sufficiency.

## CHAPTER 3

### METHODS

In response to changes in welfare policy and concern for how these policies might affect economically vulnerable families living in rural areas, several researchers from universities with Agricultural Experimental Stations (AES) formed the NC-223 regional research project. The first official meeting of this group took place in 1998 during which procedure and protocol development was initiated. In 1999, pilot data from participating states were collected, and procedures and methods were refined. This project eventually took on the name of “Rural Families Speak,” to which it will be referred from here on. This study will use a sub-sample, 73 cases, of first year (Wave I) data collected for the Rural Families Speak Project.

Rural Families Speak is a multistate collaboration designed to examine the effects of welfare reform policies on the well-being and functioning of rural, low-income families over time. This project uses a triangulation of methods design in which both qualitative and quantitative data were collected. Examining the connections between socioeconomic and sociocultural influences on the health and well-being of families falls outside the bounds of conventional quantitative research, making the need for qualitative methods critical in order to provide a description of the experiences of participants regarding how their health affects their lives, not just a quantification of health problems. Such a method provides for a much richer

description of the lives of participants as multiple dimensions of well-being can be examined and assessed.

The Rural Families Speak Project was designed to include data from multiple different states and regions of the country. Currently, 15 states are participating, representing all regions of the United States. Participating states include California, Colorado, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, Ohio, Oregon, and Wyoming. Figure 1 gives a pictorial illustration of states included in the Rural Families Speak Project.



Figure 1. States Participating in Rural Families Speak Project

The multistate design allows for a more comprehensive analysis of the different regulations and provisions across states resulting from the devolution of welfare.

This is a five-year project. Year One (1999) consisted of method development and pilot data collection. Years Two (2000), Three (2001), and Four (2002) are for data collection, and Year Five (2003) will be devoted to analysis.

There are three main objectives to the Rural Families Speak Project. One is to track over time the individual and family circumstances, functioning, and well-being of low-income families with children in each participating state. The second objective is to track over time the changing welfare policies in each participating state, and the community environments in which these low-income rural families with children live and function. The third objective is to identify and analyze the ways in which the interaction of each of the above factors, that is, changing welfare policies, community contexts, and the individual functioning of rural low-income families effect the well-being and functioning of the study families. The current study was concerned with objectives one and three.

### Community Selection

Participant recruitment was based on rural-urban continuum county codes developed by Butler and Beale (1994) of the United States Department of Agriculture (USDA) Economic Research Service. According to this system, which uses the 1993 definition of metropolitan and nonmetropolitan counties determined by the Office of Management and Budget, counties are classified on a continuum of



zero to nine. Counties with a classification of zero are central counties of metro areas with a population of one million or more. Counties with a rating of nine are completely rural or fewer than 2,500 urban population and not adjacent to a metro area (Butler & Beale, 1994). States participating in the Rural Families Speak Project have recruited participants from counties meeting the rural-urban continuum codes of six, an urban population of 2,500 to 19,999 that is adjacent to a metro area; or seven, an urban population of 2,500 to 19, 999 that is not adjacent to a metro area.

Rural families were targeted for this project because they face unique concerns and problems. Rural communities are typically faced with high numbers of families in or near poverty. Moreover, rural families and communities must confront factors such as geographic distance and transportation needs, limited access to and availability of employment and educational opportunities, as well as potentially limited and inaccessible private, non-profit, and public social supports.

### The Sample

Originally, it was agreed that each participating state in the Rural Families Speak Project would recruit at least 30 participants in each state. Due to funding concerns, it was agreed during the second year that states must have a minimum of 20 participants to be included, though recruiting 30 or more participants remains desirable. Thirty participating families from each state were chosen as a manageable number for a longitudinal qualitative study and allows for analysis of quantitative factors both within and across states. States may include families from either one or

two counties meeting the Butler and Beale (1994) rural-urban county codes of six or seven.

The primary qualifying criteria for inclusion into this study were eligibility for food stamps and having at least one child under the age 12 at the time of recruitment into the study. In order to examine day care arrangements, families with a preschool child were given preference. Other low-income families, those who receive Women, Infants, and Children (WIC) benefits were also eligible or, families with incomes up to 200% of the federal poverty line at the time of entry into the study. Each state selected participants who represent the racial and ethnic diversity of low-income rural population in that state, with both Latino and African Americans targeted and represented in certain states (Michigan, Oregon, California, Louisiana, and Kentucky). Due to the unique and complicated circumstances of Native Americans in regard to tribal benefits and services, they were not intentionally targeted for recruitment, though they are minimally represented in this study. Study families were recruited from a variety of sources, such as state and non-profit service agencies (*e.g.*, Head Start, Adult and Family Services, community outreach programs, jobs programs), the school system, and word of mouth. Mothers of low-income families were the primary respondent and were asked to participate in an in-person interview lasting between two to three hours.

Data reported for this study are from 73 rural, low-income families living in California, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, Ohio, and Oregon. Forty-four families (68%) were classified

as living in poverty according to the 2000 federal poverty guidelines. A total of 40 (56%) mothers reported not having a partner; of those, 26 (74%) were classified as living below the poverty threshold. Eighteen (60%) of those living with a partner fall into this same category.

Health information is based on the 73 mothers we interviewed about their own health, their partners' (n = 32), and their children's health (n = 148). The average age of the mothers at the time of the interview was 27; partners' average age was 31. Sixty-three children (45%) were less than 5 years of age, 62 (45%) were between five and 12 years, and 14 (10%) were 12 or older (ages were not reported for 9 children). These and other demographic characteristics of the sample are summarized in Table 1.

### Procedures

States have agreed to collect data on core variables with the provision for collecting additional state specific data. Families will be revisited each year of the project in order to get an update regarding their situations, perceptions, and experiences. Some of the interview content will change from year to year so as not to be redundant, and as a means of gathering data on a wide variety of subjects. Other questions and measures will remain constant to facilitate longitudinal analysis.

### Ethics/Informed Consent

Each participating state obtained approval from their university's Institutional Review Board before collecting data. At the opening of each interview, participants were informed that their participation in this project is entirely voluntary and the

Table 1. Demographic Characteristics of Sample

Characteristic	
<u>Age of Participant</u>	
Range	17-62
Mean	27
<u>Age of Partner</u>	
Range	22-55
Mean	31
<u>Marital Status</u>	
Married/Living with Partner	29
Single/Divorced/Separated	41
<u>Living in Poverty</u>	
With Partner	18
Without Partner	26
<u>Number of Children</u>	
Range	1-5
Mean	2.0
<u>Age of Children</u>	
Range	0-19
Mean	6
<u>Ethnic Affiliation</u>	
Hispanic/Latino	19
African American	12
Non-Hispanic White	35
Multi-Ethnic	4
<u>Mother's Educational Level</u>	
Less Than High School Diploma/Some High School	23
High School or GED	17
Specialized Technical or Vocational Training	9
Some College, Including AA Degree	19
College or University Graduate	3

Note: The 62 year old participant is a grandmother raising a grandchild.

information they provide is confidential. Each participant signed a written informed consent providing this information and procedures to follow if they have any questions and concerns. A copy of the Oregon Informed Consent can be found in Appendix A. Any written materials were provided in both English and Spanish and written at a literacy level appropriate to this sample population. To further address literacy concerns, an offer was made by the interviewer to read any written or survey measures to the participant. Interviews were conducted in the language of preference of the participants (English or Spanish). With the permission of participants, interviews were tape-recorded.

Participants were compensated for their time with some sort of a gratuity that varies from state to state. For example, mothers may have been offered a gift certificate to a local store or a cash incentive; children of participating families may have been offered a book or art supplies.

Participants were offered a choice regarding where the interview would take place, for instance, their home or a meeting room at their church or some other community agency. Open-ended interview questions were asked, with planned breaks incorporated in order to complete survey measures. Participants were informed that they could choose to complete the interview in two sessions in case fatigue was a factor.

Participants were informed at the time of initial contact that this is a multi-year project and that they will be asked to complete an in-depth, in-person interview for

each year of the project. To reduce attrition, several methods have been employed. At the initial interview, participants were asked to provide the name, address, and phone number of three relatives or friends who will always know how to contact them. They were also provided with contact information for the local project research office. In some states, a financial reward (typically ten dollars) is offered if they call with updated contact information each time they move. Families are also contacted on a regular basis, via state-specific project newsletters, greeting cards, or phone calls.

### Protocol and Measures

For Wave I of data collection, participants were asked about their current household composition; the community in which they live in; housing; employment and current work and sources of income; work history; attitudes about, experiences with, and knowledge of welfare and other community resources; transportation; childcare; family of origin; family schedules, well-being, and health; current levels of education and life skills; parenting; and their personal social support networks. Specific to this research were the open-ended questions that ask about the health problems of family members and how they may affect everyday family life. Questions asking about life satisfaction and social supports were also investigated in this analysis. Any other comments that respondents made having to do with health, mental health, well-being, and social support, regardless of where they occurred in the interview, were coded appropriately and were included in the analysis of health

constraints and challenges. A copy of the complete interview protocol can be found in Appendix B.

Descriptive analyses were also conducted on two quantitative measures, one describing the types of health problems participants and their families and the other addressing participant depression.

Health Survey. Health surveys collect data for both adults and children in the family. The adult health survey was completed for both mothers and their partners; the child health survey is filled out for each child in the family. The health surveys are similar to initial screening tools filled out upon the first visit to a health care provider. They ask for information regarding both medical and dental insurance, number of doctor and dentist visits in the past year, and number of days of school or work missed in the past year due to illness or injury. The health surveys also have a checklist of common medical problems experienced by the respondent and her family, as well as room to write in any health concern(s) not included on the checklist. The health surveys are included in Appendix C.

Feelings About How Things Are Going. The Center for Epidemiologic Studies Depression Scale (CES-D) was designed to measure depressive symptoms in the general population (Radloff, 1977). This assessment tool has been proven both reliable and valid in populations with differing demographic traits (Fava, 1983; Roberts, 1980; Roberts & Vernon, 1983; Wiessman, Sholomskas, Pottenger, Prusoff, & Locke, 1997). The measure was retitled “Feelings About How Things

Are Going” (Appendix C) in an effort to make it less intimidating. Participants were asked to report how often in the past week they experienced specific situations or feelings. Examples are: “I was bothered by things that don’t usually bother me.” “I felt that everything I did was an effort.” “I felt that people disliked me.”

Respondents have the following choices: (a) rarely or none of the time, (b) a little of the time, (c) a moderate amount of the time, or (d) most or all of the time. Some items on the measure are reversed scored; a score of greater than 15 indicates risk for clinical depression.

### Coding and Analysis

Each state was responsible for collecting and preparing (transcribing interviews and filling in missing data from the quantitative measures) their data for analysis. Data were then sent to a central coding point, Oregon State University. A qualitative coding scheme was developed by the Oregon State University research team, under the direction of Dr. Leslie Richards. The tenets of grounded theory (Glaser and Strauss, 1967) and qualitative analysis techniques (Berg, 1997; Gilgun, Daly, & Handel, 1992; Strauss & Corbin, 1990) were employed to guide this process. Eighteen general codes were developed for the first round of data coding and include such items as childcare, family issues, housing, well-being, health, mental health, welfare, and community. A copy of the entire coding criteria can be found in Appendix D. The interviews were then hand-coded at Oregon State University, beginning with the entire team (six members) coding the same three



interviews for training purposes. Interviews were then individually coded, with every fifth interview being coded by two coders and then every tenth to ensure interrater reliability. Once the interviews were coded, they were entered into WinMax, a computer-assisted qualitative analysis program. This program assists with data management, data transfer, and data analysis.

Individual researchers on this project were interested in particular topics requiring further coding and analysis of data. Oregon State University provided the initial round of coding that is to remain unchanged; however, project members can request and retrieve coded segments having to do with a particular theme and further subcode those segments to suit their purposes. Additionally, a dataset for quantitative analysis was created by the Oregon State University research team.

For this thesis, coded segments having to do with health, mental health, well-being, welfare, and social support from agencies were examined and further sub-coded according to the research question at hand. What emerged were several themes regarding how health interferes with attempts to become economically self-sufficient. These themes include how the health of both adults and children interferes with attempts to find and keep work, and with educational attempts of both adults and children. The data also revealed that health insurance coverage, or lack of, can substantially affect both the finances and health of these families; and, that changes in welfare policy, particularly when services are cut, can make it more difficult for families to take care of their health. These themes will be addressed in-depth in the following chapter. Quantitative data were also used for descriptive purposes.

In presenting the data, I have for the most part used the exact quotes of participants, without correcting for grammar or word choice. Occasionally, I have edited quotes for readability by reducing the number of “false starts,” that is, sentences that begin but are not finished, or by leaving out a segment unrelated to the point I am illustrating. In addition, I have sometimes added clarifying information to a quoted segment using parentheses. When I need to alter or add to the words of participants to clarify what is being said, I have used square brackets. To protect the confidentiality of the members of this study, all names of participants, their partners, and their children have been changed in the presentation of the results. Names of towns, institutions, and businesses have also been altered or omitted.

## CHAPTER 4

### RESULTS

In this chapter, I will present the findings of my analysis regarding how health interferes with the ability of low-income families to pursue, obtain, and maintain self-sufficiency, an important consideration regarding current welfare regulations requiring workforce participation of families receiving benefits. The data revealed several ways, presented in the following text, in which health can function as a challenge or barrier to this endeavor. First, adult health problems, and how they can limit job seeking activities, participation in work, and the ability to keep work will be discussed. Then, how attempts to obtain more education and thus become more employable can also be foiled by the health status of adults will be presented. Descriptive statistics summarizing the number of health problems and most common health problems in adults will also be presented.

Next will be an examination of how the health problems of children can limit the work and educational pursuits of parents, as well as how child health can interfere with the child's own education. Once again, descriptive statistics summarizing the number of health problems and most common health problems in children will be presented. A discussion of how the lack of access to health care coverage presents a financial challenge to these vulnerable families will be presented next, followed by a discussion of how certain policies and practices influenced by welfare reform may also affect the finances and health of the participants in this study.

### Adult Health Problems

Given their relatively young age, mothers in this sample reported a high number of health problems. Mothers reported between 0-13 health problems, with an average of four health problems per mother, and only 11 mothers reporting no health problems at all. Table 2 shows the frequency of health problems experienced by mothers in this sample.

Table 2. Frequency of Health Problems in Mothers

Number of Health Problems	Number of Mothers	%
0	11	16
1	4	6
2	4	6
3	13	19
4	11	16
5	7	10
6	2	8
7	3	3
8	3	5
9	3	5
10	3	5
13	1	2

The most common health problems reported by mothers were: migraines/headaches (37%), allergies (27%), eye or vision problems (27%), back problems (27%), tobacco use (27%), and fatigue (26%). Figure 2 illustrates the most common health problems for mothers.

Partners had fewer health problems (an average of about 2.5, range 0-10), perhaps because they are healthier, or perhaps because their health problems have not been diagnosed because they are more likely to lack health insurance. Indeed, whereas 29% of mothers were without health insurance, 59% of the partners lacked coverage. The most common health problems reported for partners were: back problems (30%), tobacco use (30%), allergies (27%), eye or vision problems (27%), frequent colds/flu/sinus (21%), and joint problems (21%).

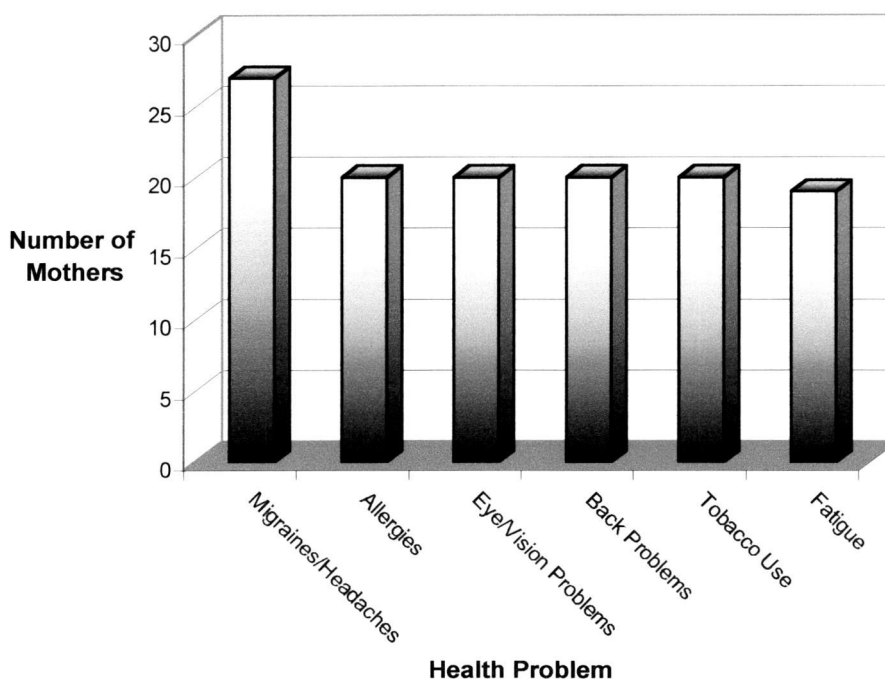


Figure 2. Most Common Health Problems for Mothers

There are many ways that these and other health problems can interfere with daily life, making it more complicated and less fulfilling. Poor health can hinder

attempts to find and keep employment and to gain education in order to become more employable. Health problems can also drain limited family resources.

Health problems may also interfere with a family's functioning as a unit therefore making their attempts at self-sufficiency even more difficult. Just confronting the everyday stresses of trying to make ends meet can be burdensome enough to significantly affect healthy family interactions. When problems with health are added, a rewarding family life becomes even more challenging.

As participants' words provide the most accurate, concrete, and rich illustration and description of their lives, excerpts from their interviews will be used on the following pages to demonstrate how adult health problems interfere with their lives in the ways mentioned above.

Seeking and Keeping Work. Though 60% of participants and 86% of partners were working at the time of the interview, disabling health conditions, both acute and chronic, may affect the ability to work and keep jobs. In fact, several participants stated straightforwardly that this was the reason either they or their partner were not working. For instance, Jordan, when asked what her husband does for work, replied frankly, "My husband at the moment isn't doing anything. He's disabled, or temporarily disabled." Natalie, 25, the mother of a six-year-old son was able to elaborate more regarding her circumstances. She was diagnosed with degenerative condition in her early twenties. Though she makes an effort to work, she believes the stress of her job and a full workday make her condition worse. She said,

Well, the reason why I'm working twenty hours a week is one, I was working thirty-two, and then all of my benefits (from the state) were cut down. So I dropped down to twenty. Another reason is I have multiple sclerosis, and I get really tired if I'm working too long and it's just too much for me to sit there and get cramps in my neck. So that's not good for me to sit in there all the time...Since I found out I had MS (multiple sclerosis), I haven't worked full-time.

Chronic health and mental health conditions have also affected the work history and capabilities of Molly, making it difficult to keep work. When asked to recall her previous jobs, Molly had to pause for a moment to try and recall the information, explaining:

I just recently, last year I had a memory loss so that's why I have to really think...[It's] due to an epileptic seizure...I was born with them, but the doctor [thought I was] through my seizures. So I haven't been on any medication until recently, and I didn't have a clear loss seizure, but [I] space out like. But for some reason, I have no recollection of the whole month of September.

She continued, discussing her work history:

...the job before that was I worked at a doctor's office...I was a receptionist. The only thing I did for a receptionist was make appointments. So I was an appointment scheduler, but receptionist too...I worked 32 hours a week. I can't tell you exactly...Started that in March of 1999 and I finished that in June of 1999. And that was due to, at the time I didn't know what was happening with my epilepsy and I was having brief memory losses and couldn't remember what day it was a lot of the times and so that really affected my job. So it was like a mutual separation...And then as I got older, I didn't keep a lot of jobs as I got from 18 to 24 maybe because I became an alcoholic. I was drinking a lot. Actually everyday I was drinking a lot. I held jobs, but not for a long time.

When the interviewer implied that perhaps Molly was self-medicating her seizure disorder through the use of alcohol, Molly was very forthright in her response:

I just became an alcoholic because I was seeing a guy that was an alcoholic, and I was young, and I just kind of fell into it. And it happened. Unfortunately now it's a disease I deal with everyday. But I'm recovering so it's working out for me. And yes, my alcoholism affects my life everyday because I have to deal with it every single day. Like I said, I'm not using [at this time], but it's a struggle every single day because I have got to make at least one meeting a day because if I don't, I know I'll pick up.

The interviewer then commented to Molly that keeping up such a schedule of meetings could certainly affect her employment situation, she agreed, saying “Yes, it has in the past.”

Alexandra also spoke about how her mental and social well-being affected her ability to work. She commented, “See, I would just like to stay home. I would like to work, but not go—I have a social disorder. I don't mind. Sometimes it's not bad, but sometimes it is bad...”

Indeed, Alexandra is not alone. Although only 23% of mothers reported that they suffer from depression or anxiety, 51% scored at risk for clinical depression on the CES-D measure. Interestingly, though, only a small number of participants were very dissatisfied (4.3%) or dissatisfied (5.8%) with their lives. The majority (41%), however, had mixed feelings about their life satisfaction, with 29% satisfied, and 20% very satisfied.

Obtaining Education. Though it is often the case that mothers without a high school diploma had their education interrupted because of a pregnancy, making such an assumption does not tell the entire story. Alyssa is such a mother. She was fortunate to get her high school diploma as an adult, yet her educational trek was



made more difficult due to the circumstances of her health. Alyssa quit high school when she

...was in the 11th grade...I graduated until [my daughter] was five months. She, 'til she was five months, I graduated... 'Cause I went to school afterwards...I was pregnant, I got pregnant in my senior year. And I didn't finish the senior year...Because of the pregnancy.

Her pregnancy was not the entire reason she quit high school, though. She went on "...And I had to take insulin, and they wouldn't, they couldn't keep me in the high school." After having her daughter, Alyssa "...went to adult school. 'Cause I couldn't go full time to a school. They wanted me to go to full time 'cause I only needed ten credits." At the time of her interview, Alyssa had completed her basic education and some specialized secretarial and real estate training.

Lauren also did not finish high school, presumably because she, too, was pregnant as she indicated that she only had some high school education when she became pregnant with her first child. When asked to clarify this point, however, she responded, "...I quit high school because I was in a car accident and I was in the hospital."

The case of Paige, 28, is a little more striking and solemn. When asked why she left school before finishing, she prompted the interviewer with, "Do you really want to hear the true story?" When she received an affirmative response, she continued,

Okay. It all started in eighth grade. It started with me missing a lot of time from school. The principal started getting after me, which in a way I can understand now, but what he did was so wrong. He would actually come into the lunch cafeteria and he would pull me, well, he wouldn't pull me, he'd say, 'Paige, come here for a minute.' And in front of everybody say, 'Do you want to turn out to be like your

mother?’ Well, my mother served in the military. You know, and she worked hard. And, I mean, he—he just had me. At that time I did have a problem with depression. Okay? And it was because I had been molested when I was a child. Okay. Even though I didn’t know that at the time, I didn’t know that I had depression. It just kept up, kept up. He called me into his office, ‘Please sign out of school,’ you know. And, so my sister was a witness to it...And it just got down to the point where I—I broke. I broke, and I walked out of school and I never went back.

Though it is difficult to know all of the circumstances regarding why Paige left school, her account indicates that she was suffering from emotional and mental health troubles, apparently prompted by environmental influences that affected her performance at school. Under different circumstances, perhaps she could have received help with her depression and been able to continue with her schooling. As it stands, though, she currently has a high school education or equivalent.

Despite the fact that the majority of mothers fall into the educational levels of specialized technical or vocational training, high school diploma or GED, or some high school or less, 22 mothers (30%) have completed some college or are college or university graduates. Of these mothers, four have no health problems, 14 have between one and five health problems, and another four have between six and 13 health problems. Those with the highest education have few health problems, ranging from zero to two. Of these three mothers, one is married and has three children with whom she stays home, working part time as a home-based marketing representative. Her husband also works, but their total family income is near 200% of the federal poverty guidelines for a family of five. The other two mothers with a college education are divorced, raising their children alone. One mother is looking

for a job; the other has a job, but her income, too, places her just slightly above 200% of the federal poverty guidelines.

For the remainder of the mothers who have attended at least some college, health problems are usually chronic and include conditions such as asthma, allergies, diabetes, depression, headaches/migraines, back problems, and fatigue. One of these mothers is Molly, the mother with the seizure disorder and previous alcohol problems; another is Natalie, the mother with multiple sclerosis, both disorders that present with a certain level of severity.

### Child Health Problems

The health of children may also limit and interfere with a family's attempts to become economically self-sufficient. Adults, of course, are not the only ones who suffer the consequences of health problems. Children do too. Multiple missed days of school because of health concerns can significantly interfere with the learning process and make it difficult for children to remain attentive and stay current with their classes, perhaps contributing to a lifelong deficit or delay in terms of education.

Child Health and Parent's Work. As mentioned previously, children's health can also inhibit and limit the work capabilities and opportunities of parents. Children in the sample had an average of less than two health problems (range 0-13), however, mothers reported 29 children had serious illnesses or accidents within the last year. Table 3 shows the frequency of health problems in children.

Table 3. Frequency of Health Problems in Children

<b>Number of Health Problems</b>	<b>Number of Children</b>	<b>%</b>
0	38	27
1	37	26
2	28	20
3	18	13
4	6	4
5	4	3
6	3	2
7	1	1
9	3	2
10	1	1
13	1	1

The most common health problems for children included ear infections (27%), allergies (23%), frequent colds/flu/sinus (18%), asthma (14%), conjunctivitis (14%), head lice (10%), and behavior problems (10%). Figure 3 provides an illustration of the most common health problems for children.

It is important to remember, however, that nearly half of the children are not yet five, which means some health problems (ear infections, conjunctivitis) may be overrepresented, while other health problems, including behavior problems and learning disabilities may not yet be apparent.

Jade talked about the jobs that she held in the past. The one she particularly enjoyed was a cashier's position at a grocery store. When asked what, in particular,

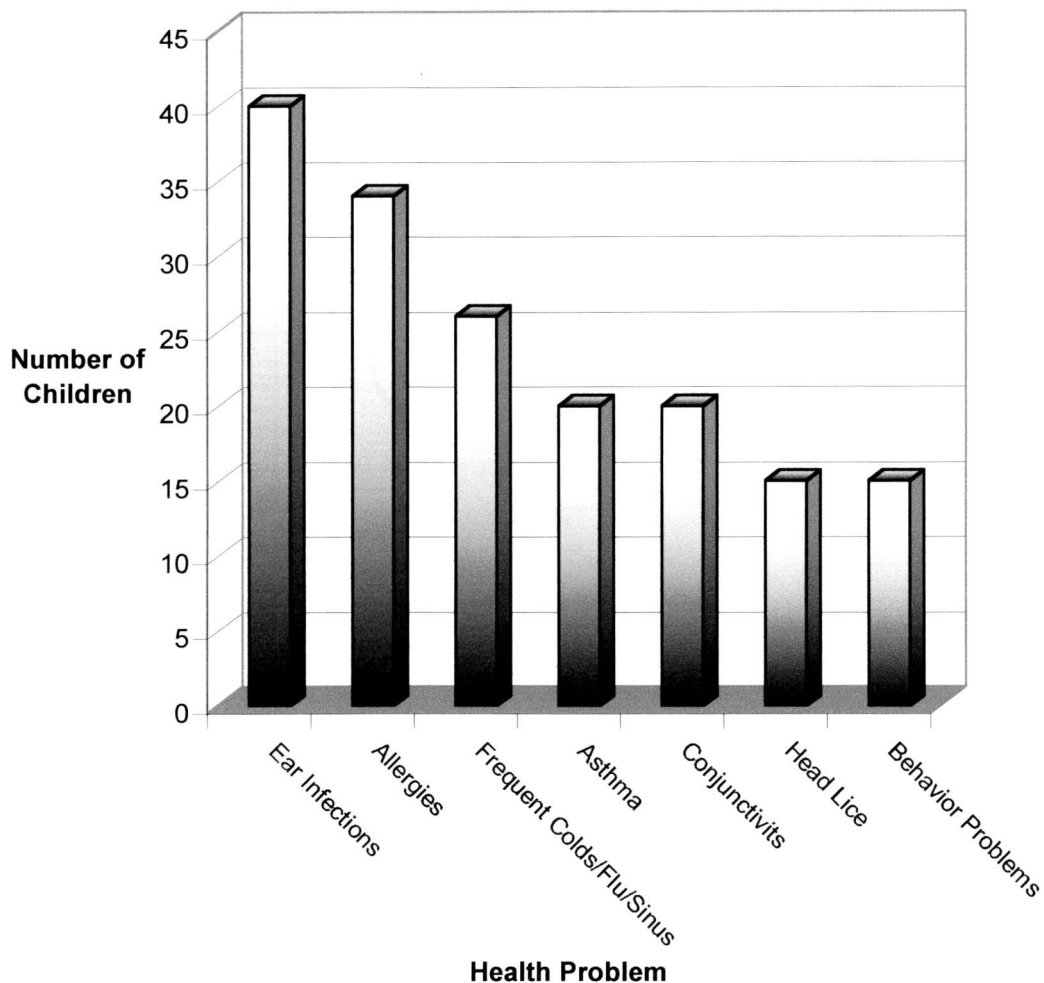


Figure 3. Most Common Health Problems for Children

she liked about that job, she replied, “I just liked working with the people. I’m kind of like a people person. I love to be around people. I love to talk to them and—.”

Though it seems apparent that Jade would have stayed at that position, she left because of problems with her daughter’s health. “[Then], it started being a hassle

with [my daughter],” she said. “I had found where she was constantly getting ear infections, and I had to keep taking the time off from work, and it just got to be kind of a hassle.”

Chronic health problems also plague the young son of Erin, which in turn consume the majority of her energy and focus. Currently, Erin is receiving benefits from Supplemental Security Insurance (SSI) and TANF. Though she has worked in the past, she is not currently, due first to circumstances with her pregnancy, and now because of her young son’s medical problems. She spoke about her situation:

I was working one day, and I was having sharp pains in my stomach and I couldn't sit up or nothing and I tried to go to work. I couldn't do it so I went and asked if I could leave. They were like, 'No, if you leave, we are going to fire you. If you walk out'. They said I had to have a doctor's note right then and there or if I walked out, I would get fired. It was like excuse me. It's like I don't go out that often...I was standing on my feet for three, maybe 2:00 or 3:00 in the afternoon until closing which was maybe 9:00 or 10:00. It depends. I was having trouble with my pregnancy anyways and they were always giving me grief about it...I left in November because my son tried to come early. So I went on bed rest and I was supposed to be back working [by a specific date]. I went in and I said I'm not coming back.

Erin’s son, Jeff, ended up not being born premature through the efforts of her medical care team, though she did go into premature labor once more after the initial scare. He does suffer significant health problems, though, and is unable to gain weight, weighing only 10 pounds at seven months of age. According to Erin, his doctor’s have not yet been able to determine the cause of his problems, nor provide a remedy. Jeff’s health problems so consume Erin that she has not even considered what opportunities may now be open to her and what she may want to do in the

future. When asked to consider what she thinks would be the ideal job for supporting herself and Jeff, her response was:

Ideal job? I don't know. I never really thought of it. I got too much stuff to do to go work anyways. I go to [the University Hospital] every single week. . .My son has a weight problem. He doesn't gain weight. He loses and gains and loses and gains. He's seven months and weighs only ten pounds. So I have to go to [University Hospital] every week. . .He's been in the hospital twice already. Between that and hav[ing] to do go to the doctor and constantly hav[ing] to call them, I have no time for work.

The interviewer then clarified, "So because of your son's medical problems, you are not looking for a job, and you really haven't considered what your ideal job would be?" Erin answered, "No, I can't because of the fact that I have to take care of him constantly. He ends up throwing up, and I have to keep an eye on him."

Morgan also has a child with serious health problems that have recently required much of her time and attention. In contrast to Erin, however, Morgan's daughter's problems ended up being acute, and she recovered from them, though Morgan did miss work for a significant amount of time. And in contrast, Morgan has employers who were supportive and helpful. She gave the following account:

My daughter was in the hospital for Christmas. She was back in the hospital in January. She had surgery. And actually she just got out of the hospital about two weeks ago (the interview was conducted in the middle of April). So actually I have been off all that time. [My employer] didn't take away any of my pay. Which he could have, but he didn't. It was during the process that we were moving from Mississippi. So the Medicaid had run out, and I had to go and reapply here, but I hadn't yet. So I took her to [the hospital]. She was there for like 14 days. So when they discharged her, I still didn't have the medication. So I had all this medicine, about like \$300 worth of prescriptions, and I didn't have insurance or Medicaid to pay for it. So, but because they didn't deduct from my salary, I was able to buy

the medicine. Of course Medicaid is going to reimburse me, but they did not take anything away from me. I mean I was out a long time...And she's actually just getting back in school.

The last comment made by Morgan tells of another problem poor health can create in these vulnerable families, namely, getting an adequate education. Poor health can make both immediate and long-term attempts at acquiring sometimes even a basic education difficult. Both adults, in regard to gaining new skills that make them more employable, and children, in regard to having their basic education uninterrupted, can suffer the consequences of poor health. The following accounts indicate how health concerns can create just such a problem for children.

Child Health and Education. As with seeking and keeping employment, the health concerns of children can also affect the educational decisions and opportunities of their parents. Amber's situation is particularly complicated, starting with a difficult pregnancy and continuing with a child who is critically ill. At the time of the interview, Amber was attending a family literacy program, working on completing her GED. Her intent was to begin training to become a nurse when she completed the GED. She told this story about her pregnancy, her attempt to complete her high school education in a state in which she was formerly living, the birth of her son, and the complications with his health:

And I was having morning sickness with him so they kicked me out because I had turned 18 in April and I missed more than three unexcused absences. I stayed there until I had him, and I stayed there for a while. He started having problems. He was in the hospital a lot. We constantly got air-flighted to [the hospital]. He's had a respirator down in with the feeding tube with things on him. He's had to be paralyzed for like a week so he couldn't pull the tube out. I mean he's



gone through a lot of health problems and medical problems. You know being in the hospitals and everything. It seems like every other week we were in there for a couple of days because of his breathing or just different things.

Not too long before the interview took place, Amber made a move from a southern state to a northeastern one. The interviewer asked her how her son likes it where she is now as opposed to in the south. Amber answered:

His breathing has gotten better. We still have to give him his breathing treatments, which is why his breathing machine is over there. It's not as bad. In Texas I was giving him four to five treatments a day. Here I give him maybe one or two every couple of days or something. It's not really bad. I haven't had to give one in a week so right now we're pushing it.

She was then asked if she ever has to miss school because of her son. She said,

Yeah, because he gets sick and stuff like that. Then we got ambulated to the [University Hospital]...They ambulated me there because he couldn't breathe or anything. I had given him plenty of breathing treatments that morning. I think I had taken him to that lake down there...I took him there for a school event, and let him go into the water. Big mistake. Next day he couldn't breathe or anything. I ran into [his doctor's] office. [His doctor] said get out of here and go straight to the hospital. He is my regular doctor since we moved up here. So we went straight to the hospital. The hospital gave him a couple of breathing treatments, didn't do nothing. They sent us straight to [University Hospital]...I wasn't panicking but yet I was because I'm used to it and I'm used to him doing this on me. But I never let it go. I always take him. So they ambulated me to [University Hospital]. [They] gave him some steroids and some other breathing treatments and some stuff like that and put an IV in his arm. Once he was stable enough, which was later on that night, they thought he was able enough to go home, so they sent us home. And I had to take a taxi, [which] the hospital paid for....

Amber was asked to summarize how the health problems of her son affect her everyday life. The following interchange took place between her and the interviewer:

Amber: ...I have to give him breathing treatments in the morning and you don't know when he's going to go into it. You constantly have to carry that thing around.

I: That whole machine?

Amber: That whole machine.

I: It's about the size of a lunch box, maybe a little bigger than that. (They are speaking about a nebulizer, a machine that forces medication into air passages through a fine mist, enabling easier breathing).

Amber: You've got the medicine you've got to carry around. You have to remember to give him one in the morning, one at night. You have to watch out because if he does have a problem breathing, you have to watch his chest. It's just—

I: So you have to be always on guard.

Amber: Yeah, and I have got to be there because at his day care, I can't even leave the building.

I: Because you have to be the one to administer?

Amber: I have to be there because in case something happens, they won't do it. I have to be around there twenty-four, seven because not a lot of people will take the time to learn that to do it for him. He, most of the time, has to be with me.

Obviously, the activities Amber becomes involved with are very limited, as she is worried not just about the health of her young son, but also about his life. Trying to find a place of work that would honor her need to be constantly on call to respond to her son's medical emergencies would be a difficult, if not impossible task, which essentially puts her life on hold—at least for now.

Not only can the health of children affect their parents work and educational opportunities, it can also interfere with and limit children's own education, as indicated by some of the mothers who recalled how their own education was stifled

when they were younger. Unfortunately, this reality is not specific to only one generation. Several of the children of parents interviewed also had substantial health problems, resulting in excessive absences or interference with the learning process. Though mothers reported that the average number of missed school days for children in the past year was four, nine children missed ten days or more, with two children missing 40 days. Common conditions that prevented children from attending school were asthma, allergies, and frequent upper respiratory infections (colds/flu/sinus). Table 4 summarizes the number of school days missed by children.

A couple of mothers were able to be more specific about how exactly their children's health problems affect their everyday life. After filling out the health surveys, Molly was asked if the health problems she noted ever affected the family's everyday life. She elaborated,

Just my daughter's, because she has to wear the glasses everyday and we got to make sure her eyes are not, well I think it's her left eye, turns in. Usually the glasses corrects that, but on [occasion] it doesn't. But we do have to—Well I do have to constantly contact with her ophthalmologist...But that does affect her everyday life. Her ability to see well. And she does get headaches from it too, from the built up pressure behind her eyes, which causes the pressure on her optic nerve.

Table 4. Number of School Days Missed by Children

Number of Days Missed School	Number of Children	%
0-5	93	86
6-10	10	9
11-15	3	3
15+	2	2

Grace, a mother with 3 children, mentioned that the health problems of one of her children affect his attendance at school. When talking about the health history of her children, which was riddled with accidents, acute illnesses, and chronic respiratory infections, she noted, “My oldest one, he miss school a lot. Because of his asthma. If he get a cold, you gotta catch it or it'll turn to asthma. So he miss school a lot. He [also] has allergies. The oldest is allergic.”

### Health Insurance Coverage

Health insurance data are available for 141 of the 148 children in our sample. Of these, 132, or 94% have health insurance coverage, and 121, or 88% have dental insurance. Adults in the families fare less well: 17 mothers (24%) and 14 partners (59%) currently have no health insurance, and 40% of mothers and 60% of partners are without dental insurance. Of the mothers who were working in this sample of 73, only 16 received private health insurance benefits provided through their jobs. Thirty-five of the mothers received health insurance only from Medicaid or a state health plan. Of the 28 partners who were employed, only eleven were receiving private health care coverage. Seven other partners were covered by Medicaid or a state health plan. Children in this sample were more often covered by special health coverage programs, leaving adults the most vulnerable. Indeed, access to health insurance for children of the working poor has improved substantially with the

Children's Health Insurance Program (CHIP) implemented by the Clinton administration.

Universal health insurance coverage has long been of concern in this country (Marmor & Barer, 1997). The government typically provides access to health insurance for extremely poor families, that is, those on public assistance. Middle class families frequently are the beneficiaries of health insurance provided by employers, often at no cost to the worker. Workers who have low-wage jobs, however, may fall between the cracks and find themselves either without access to health insurance benefits, or unable to purchase benefits that may be available. Moreover, uncovered and out of pocket expenses may be so great that family finances are severely affected. Elizabeth was asked if there had been anytime in the past year when her family had had a hard time making ends meet. Her initial response was, "No." Then the interviewer recalled the \$45.00 co-payments that her family must pay when they see a health care provider that Elizabeth spoke about earlier in the interview. Elizabeth responded:

Yeah. That's why we don't go...I mean unless, it's, you know, an emergency, if, you know. I mean like I was, just, I went a couple months ago. And that's just because I had a sinus infection...And I just, it would not go away. I mean I had it for like two weeks, and my husband goes, just go to the doctor. And I'm like, but that's \$45!

The interviewer then clarified, "So it really does—that insurance really affects whether or not you go to the doctor." Elizabeth continued:

Yes. Yes it does. Yes. I mean I was sitting there trying to take vitamin Cs and trying to get rid of whatever I have before I, I mean that's, \$45 for me is just a lot... My sister goes, "Just tell [your boss]

to give you whatever premium he's paying, and you go find your own insurance...I think the lady in the office too. She goes, 'You have a \$45 copay?' And I said, 'Yeah.' She goes, 'I thought my \$25 was a lot.' And I said, 'Yeah.'

Kelsey is among those who do not have any health care coverage. When asked if she or her husband get any benefits from her job, she replied,

No. We, that's what caused me to go and get medical when I had my first baby was because we couldn't afford at that time we were paying almost \$400 a month just for medical. And we just couldn't afford that so someone suggested that I see if I could get the, you know, qualify for the kids...And that's how it is. My husband and I are not on the medical because we don't qualify. I only qualify when I'm pregnant.

When asked to clarify if they had any other kind of medical coverage, her response was, "No. No we don't."

Likewise, Kaylee finds the price of insurance premiums much too costly.

Speaking about her job, she confirmed that once she has been there for a set amount of time she would be eligible for health insurance coverage. Whether or not she gets it, though, will depend on "...if you want to pay what they want, too, I mean, if it's outrageous, I ain't getting it. 'Cause I depend on every penny I get."

Although insurance is available to both Jackie and her partner, they must pay for the premium, which is "...way too high... We don't even mess with insurance... We don't even go to the doctor's. Nope." Her young son, fortunately, is still covered by Medicaid.

Similarly, Taylor's children are covered by a special program called Healthy Families, but she spoke about the cost and inconvenience of health care coverage for

them before they were accepted into the Healthy Families program, "...I only got, their insurance like in March...So, it was, it was kind of inconvenient for the medical insurance [before] Healthy Families. 'Cause it did get kinda expensive."

The interviewer interjected, "Yeah, I know under those circumstances, then you, you have to think, okay, well is this bad enough to take 'em to the doctor."

"Or, when you decide to take them, for their ears, the medication," continued Taylor,

Yeah, and then my employer would provide them insurance, but I would be paying like \$72 a pay period... Which, if I took one of them to the doctor, it would be less than that... When they do get sick... So out of the \$52 in the year, it was—It adds up. With Healthy Families, I didn't have to go through the system. I did it all by mail, and, we fell in the rank where, my husband and I were full time employed. And we made this much money, so we, we qualified, the, the lady on the phone that called me when I, she submitted my application, she was really nice. And she let me know what was out there and, you know, 'cause, I mean, my sister in law that has five kids introduced me to Healthy Families. So it was really a difference... I'm paying \$14 a month. But, versus \$72 a pay period. For all my kids, I mean with \$72 I could pay for three months. Or even more than that. And then I just have \$5 copays. And then, like emergency. I mean, like with [my daughter] being sick yesterday, it would have cost me an easy— 'cause they gave her penicillin shots—I'd say over a \$100 visit. And with [my son] being sick this morning. I'm now going to go to the pharmacy, because his prescriptions, and it's only \$5.

### Welfare Reform

Another factor to consider is how welfare reform will affect the health of families, not just how health limits the ability of the participants in this study to become self-sufficient. There is concern that as families are no longer eligible for welfare benefits, including medical coverage, they will find themselves in low-paying

jobs with no medical coverage, paying out of pocket for oftentimes expensive medical procedures and appointments. As it is, a few families in this sample have already found themselves affected by limits placed on their medical coverage. When Jasmine was asked if she felt like the new welfare reform laws have had any effect on her or her family, she responded in the affirmative. The impact came for Jasmine when her family was cut off from Medicaid when she initially started working, at which point, she said, the changes "...affected me a lot."

Though it is unclear exactly how the changes affected Jasmine, it can be presumed that medical expenses that had before been covered by a source of insurance no longer were. For Erica, however, difficulties will result when certain procedures get dropped from coverage from her health plan. Though Erica is covered by a state health plan, she has some minor health problems that are not covered, that are a nuisance, and interfere with her comfort. It is unclear whether or not the procedure that remedies her condition was covered by her plan before but as funds become more limited, more and more procedures get dropped from coverage. Erica explained her situation:

...I have like four cysts on my head that um, they won't take off because [the State Health Plan] won't pay for it. And they are pretty big. You know, they're, they bother me...But um, and they want to charge me like \$450 to have them taken off. I can't afford \$450, you know?

Interestingly, the majority of those interviewed believe that the changes in welfare are a good thing, forcing those that are "able-bodied" to find work and stop using the system. This observation is consistent with the findings of Seccombe



(1999). Indeed, both Emma and Kathy, respectively, expressed this idea when they were asked their opinion on the changes in welfare regulations. Emma said,

I think it's a good change...Because, you have, I mean not always, but you have people that, that do take advantage of the system. Even though, I mean, disabled people, they shouldn't have to find a job, but people who are capable, and don't have disabilities, and can work should. I mean, there's no reason not to right now.

And Kathy expressed,

Well it's, well, it's nice because then they could really help the people that really, really need it, not just give 'em to anybody. Maybe young and healthy, I mean, you can work.

The words of Emma and Kathy help illustrate the points made above. First, believing all who are on welfare, even if they look able-bodied and capable, are physically or emotionally able to work, is a faulty assumption. Thinking that the same people do not want to work is also erroneous. What is important to remember is that there are multiple challenges and barriers to finding and keeping work, particularly for low-income rural families who are quite vulnerable. As mentioned in the introduction, childcare, transportation, and the availability of appropriate jobs that pay a living wage are chief challenges. As described in this section, health is also a substantial hindrance to economic self-sufficiency for these families. Determining the exact impact health has on the self-sufficiency of low-income rural families of concern in this research (or families situated within any demographic group) is a difficult endeavor. The families quoted above related very telling stories, yet not all families included in this sample are accounted for in the quotes. Yet, if health

problems are simply quantified, then the meaning of those health problems in the lives of families is lost. Moreover, not everyone within the same or even different socioeconomic strata copes with health problems in the same way. Other factors, such as social support, access to health care, and personal coping strategies must also be considered.

When just looking at the health information reported by these families in a systematic way, only four families report no health problems among their members. Some families report a health problem for only one member, but that problem might be something like asthma or diabetes, both of which can be life threatening if not managed properly. In other families, there may be more health problems, but they could be categorized as mild to moderate in their severity and might include conditions such as allergies; frequent colds, flu, or sinus problems; or ear infections. It is difficult to come to any general conclusions, then, regarding exactly how these families are affected by health problems. What is important to understand is that low-income families already have limited resources, thus their daily coping is limited. When one or more health problems are added, coping becomes even more difficult, and another layer to the challenge health presents to self-sufficiency is added.

### Chapter Summary

It would be a difficult task to exhaustively answer the question, how does health affect the ability of low-income rural families to obtain and maintain economic self-sufficiency? This research that looked at health, well-being, and self-sufficiency

in rural, low-income families, uncovered several themes that serve as at least a partial answer to this question. First, adult health can interfere with attempts to find and keep employment, because adults are either not well enough to sustain the physical and mental effort these attempts require, or because once they are employed, they may have to miss work due to a health condition. In addition, adult health can hinder attempts to obtain more skills and education that could possibly make them more employable.

Second, child health can also interfere with adult's work efforts. When children are ill, parents often do not have any other choice than to attend to their children's well-being, often necessitating being absent from or leaving work. If children's health problems are chronic or severe, parents may make the choice to not be employed or to not look for work, as they believe it is more important to attend to their children. Likewise, education can be hindered by children's health in the same ways. In addition, children's health can interfere with their own education by contributing to missed days of school and difficulties with learning. If substantial deficits in learning occur, they can be difficult for children to compensate for, perhaps contributing to life long educational deficits and once again interfering with the capacity to work and maintain economic self-sufficiency.

Moreover, either the lack of health care insurance, or the costs of uncovered procedures or conditions, makes it difficult for some families to obtain or maintain self-sufficiency as their family finances are impacted. Or, they simply do not have their illnesses and injuries treated. Finally, welfare reform policies, particularly those

that lead to cuts in services and programs, influence the health, and thus the self-sufficiency of these vulnerable families.

## CHAPTER 5

### DISCUSSION AND CONCLUSION

It is clear that some of the participants in this sample have numerous health problems that interfere with their lives in several ways, particularly with their attempts to become economically self-sufficient. Despite numerous health problems of varying severity, many among this sample do not have health insurance, or the insurance they do have is inadequate, often resulting in costly out of pocket expenditures. These shortfalls make it even more difficult for them to obtain self-sufficiency. In addition, certain welfare reform policies, particularly service cuts, can make it more difficult to obtain health care in order to avoid further health problems.

Moreover, the data revealed that there are several ways in which health problems can interfere with attempts by low-income, vulnerable families to become self-sufficient. The poor health of adults can interfere with job seeking activities, as well as make it difficult, at times, even to keep a job. Poor health can also hinder attempts to obtain more education; education that can improve employability. The health of children in low-income families may also hinder the ability of parents to find and keep work, as well as interfere with the educational pursuits of both the children and the parents, particularly when the health concerns are of a serious nature and require much time and attention.

As with any research, though, there are limitations in the design of this study and generalizability of findings. These limitations will be identified in the following section. In addition, there are two important questions that remain. One is: What causes the health problems? In accordance with the emphasis on personal responsibility that the welfare reform act of 1996 promotes, the tendency is to hold these vulnerable families responsible for their own plight. In the ensuing discussion, however, several other ideas will be presented that provide a different way of looking at health problems in vulnerable populations.

The second question left to address is: What is the solution? More specifically: What are the implications for policy and action? Though poverty is a complex problem not inviting one easy solution, there are certain ways of thinking and acting that promote a sense of understanding and care for those who experience difficulties resulting from a lack of physical and human resources on a daily basis. These ways of thinking and acting will be covered at the close of this thesis.

### Limitations

This research provides a preliminary look at how health can affect attempts to become self-sufficient in a rural low-income population using a subsample from the Rural Families Project. Though it is not anticipated that the ways in which health interferes with attempts at economic self-sufficiency will be significantly different from what is reported here, when all data are assessed, the case can be made stronger and more substantive, with perhaps additional themes presenting.

Moreover, findings from previous research (Richards et al., 2000; Seccombe, 1999) support the findings presented here.

It might also be argued that individuals and families with health problems are oversampled in this analysis. In a robust economy with record low unemployment rates, those who are continuing to receive welfare funds may be unable to find and keep work because they, or their children, have health problems. The primary point of this research was to illustrate just this phenomenon.

Another potential weakness is that the health of family members is determined by subjective reports of participants; no objective health assessments were made by medical personnel to determine actual health status. Health surveys used for the Rural Families Speak Project, however, were designed to capture health problems that would be more likely to present in vulnerable populations. The goal was to gain an understanding of how these families perceive health as affecting and possibly limiting their daily activities, particularly activities focused on attaining self-sufficiency. Furthermore, it is probably more likely that a participant might underreport, rather than overreport health problems of family members. When filling out a health survey for each family member, the tendency would likely be to forget about a health concern rather than report a nonexistent one.

Staunch proponents of quantitative investigation will question the validity of this analysis because there is no hypothesis testing included within the design. The point of qualitative research, however, is to provide first-hand accounts of the life experiences and perceptions of individuals from their unique perspective that build

theory and “elucidate” meaning, not test theory or quantify experiences (Gilgun, 1992, p. 31). An attempt to bring out both the subjective and objective “meaning” of health in the lives of low-income, rural families in the context of welfare reform has been made here.

### What Causes Health Problems?

This first question cannot be answered with one concise and simple statement. Of course, genetics and heredity are factors that must be considered but are beyond the scope of this research. Another is personal behavior and choices. Popular public health promotion and education theories and programming practices often look only at individual explanations for health and health behavior change (Glanz, Lewis, & Rimer, 1997), insinuating that those who are exhibiting poor health and potentially harmful health habits are solely responsible for their condition. What are often overlooked are broader influences that fit into a more ecological framework. It is here where the ecological perspective that guides this research is most important, as it is not just the influence of one factor—personal behavior—that affects health and therefore the working lives and financial self-sufficiency of low-income families. Summarized below are certain factors that must be taken into account when considering the lives and experiences of low-income vulnerable individuals and the women of concern for this research.

Krieger (1999) described how socioeconomic position, in many cases through discrimination, can affect health through several pathways. She divided them into



five clusters, including inadequate access to, availability of, and receipt of health care; socially inflicted trauma (verbal, mental, physical) from a variety of sources (personal relationships, workplace interactions); exposure to toxic substances and hazardous conditions, also in different microsystem settings; targeted marketing of health damaging substances and products (legal and illicit drugs, junk foods); and economic and social deprivation in multiple different microsystem settings (e.g., home, work, neighborhood). These pathways can also be placed within the ecological framework used to guide this research, illustrating more succinctly the multiple different levels of influence that must be considered when examining the lives and experiences of individuals and families.

For instance, inadequate access to, availability of, and receipt of health care could predominately be considered an exosystem factor. Initially, the lack of quality health care and its accessibility is a community concern; however, the lack may be driven by macrolevel policies and economics, and the effects of this lack are then realized in individuals and families. In turn, if individuals experience poor health as a result, there will be certain consequences for the community, and possibly the health care system, showing that all systems are interconnected and bi-directional. Figure 4 provides a pictorial illustration of where each health conduit is located in the ecological framework. It is important to keep in mind, though, that each conduit may necessarily cross systems.

All five of the above mentioned conduits through which social position can affect health, except the targeting of health damaging substances, a factor that was

not addressed in the interviews, were at least briefly mentioned by the participants in this sample. As already described in the results section of this paper, participants' health was affected by lack of access to and availability of health care and will not be covered again. In regard to socially inflicted trauma, very few respondents in this sample mentioned abusive personal relationships, though several talked about their treatment by public social service, nonprofit, and private agency employees, a particularly important occurrence emphasized here because of the context in which this research is framed—welfare reform and personal responsibility. Although many participants conveyed that social service and nonprofit agencies had been helpful to them, and employees of those agencies treated them respectfully, many others mentioned feelings of shame and humiliation just because they were receiving welfare services and/or for having been treated poorly by social service agency employees or the general public.

To more fully illustrate these concepts and the experiences of low-income rural women, I once again use participant quotes. Destiny, for example, spoke about the mixed experiences she has had from agencies and those in the public sector:

I like my AFDC worker and I think she treats me pretty well. We have had some stupid disagreements, but I think on that level [it] goes fine. [I'm] trying to think of anyone else that I go to. I don't really, anywhere that I go, I don't put that face on. I don't think I've ever been discriminated against for being [poor]. You know the grocery store is a pain in the butt. I'll tell you that because I hate using the food stamps at the grocery store, and you definitely get some looks from that—that you do receive food stamps. In terms of agencies, no, I think that everybody has treated me pretty fairly.

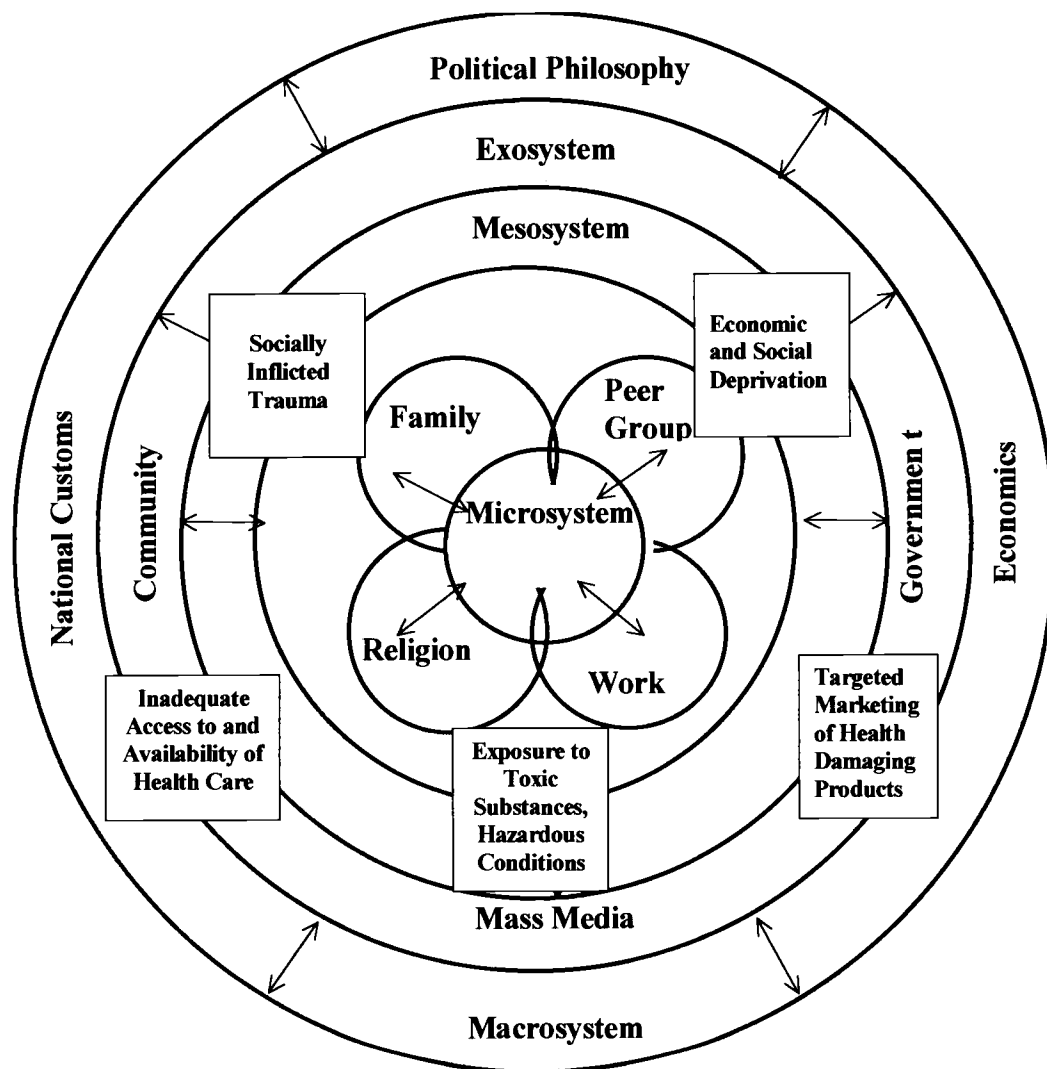


Figure 4. Health Conduits Within an Ecological Framework

Poor treatment and the sense of being judged and looked upon in shame can evoke overwhelming stress, further contributing to the vulnerability and tenuous

well-being of this population (Belle, 1982; Krieger, 1999). The following two narratives are good illustrations of such a scenario. In this first account, Alyssa spoke not about how she was treated by agencies from which she had solicited assistance, but about how she had observed other people being treated.

She started off by saying that she was generally treated “all right,” yet then qualified her answer upon further thought:

...but sometimes they do put you down, like, you know, what are you doing there. ‘Cause there’s people that take advantage, so they automatically think that you gonna take advantage of the programs...I think that they kinda, protocol, like people, they kinda say, oh yeah, this person's gonna take advantage, or no, this person. Sometimes they're more rude to one person than the other, depending on the way you look...‘Cause I've seen, I've gone myself, and then, while you're waiting, like at one point, about five years, four years ago I received medical, and I went and, when I was applying for it, there was this other lady that was applying for it too, and she, she like, well of course, she wasn't like, all nicely dressed, but they did tend to like, not want to help her. Like, if she didn't understand, they told her, ‘If you don't understand, well don't fill it out, or try to get somebody, but we're, we're not supposed to help you.’ They told her that here at the, at the welfare place.

Molly’s experience is a little more distressing. She told of a time when she applied for fuel assistance that she felt like she was “...talked to like an idiot because you can’t pay your bills or something.” Moreover, Molly has been in the situation where she reached out to an agency to get some assistance with parenting during a time of crisis. The end result of this interaction was that she felt snubbed because she was told that her problems were not of a magnitude that required assistance in comparison to the other calls for help this agency was receiving at the time. She related the following story:

I called Parent's Anonymous one time because—It wasn't because I wanted to beat my child or anything. I was just stressed out—How to deal with this because [my daughter] was screaming all the time about not getting away. And I was in a state where I couldn't just deal with it all the time because I was newly a single parent. I never got a break at that point, and I wasn't used to dealing with not having a break. And I was just at the point of crying because I didn't know what to do anymore. But this time, she was just lying in her bed screaming, 'I hate you, I hate you.' So I was at the point of crying. And I called Parent's Anonymous and they told me, 'Well, things will get better.' And they said that 'We have a lot of lines and it doesn't seem like you are in that much of a crisis.' And I said, 'Well, thanks a lot for nothing,' and hung up. And so I've never tended to call back again.

Though it is difficult to assess how such incidents might directly impact the health of these mothers, the exposure to undue stress in an already overly stressful existence surely has a negative influence. Olivia, the biological mother to three children and the foster mother to two children, on the other hand, has had experiences with agencies that most certainly could have directly influenced the health of her children, or, as she conveyed, even harmed them. At one point several years prior, Olivia was receiving Medicaid coverage for one of her biological daughters. She expressed her dislike for being on Medicaid, relating the following story:

I didn't like being on Medicaid. I felt—when [my daughter] was little, I had to get Medicaid...And there was times that she was sick, and I would say—here it was Monday, can you bring her Thursday? And she had a high fever. So sometimes I would call and say, first they ask you... 'What's your method of payment?' And I'd say, you know, 'Medicaid.' 'Okay, well can you come in three days?' And one time I said cash, and she said, 'We have an appointment...today at such and such.' And then I give her the name, she's like, 'Well don't you get Medicaid?' And I'm like, 'Yes, but I want to pay cash, because I

want her to see today.’ You know, ‘Well we can’t take your cash if you have Medicaid.’

Olivia’s biological children are now covered by private insurance, but the two foster children, both girls, are covered by Medicaid. She continued, speaking about her current experiences with getting and receiving medical care for the children, and how the experiences are so different in terms of whether or not the children are covered by public or private health insurance:

And with the girls (the foster children), when I take them to the doctor—they do see them, but I am there for four to five hours, at the medical clinic. And they’re really good, you know, the doctor’s really good, but it’s just a wait. Whereas, when I take my kids, I’m out of there in like 30 minutes ‘cause it’s a private insurance.

Olivia takes the children to different clinics, based on who will accept Medicaid coverage versus private pay, though, as her above words express, the difference between the two clinics is tremendous.

Others talked about how workplace exposures and practices have impinged on and even damaged their health. Occupational hazards can affect those in every economic stratum, though those in the vocational and service sector jobs appear to suffer disproportionately (Gaboury, 1998; Zwerling & Sprince, 1996). The male partner of Shelby, who was present at her interview, was asked if he had any problems at work, anything that made it harder. His response was, “My back, I guess.”

When asked to explain, Shelby took over, “...I say I’m telling him he pulled a muscle...He is always sore...Picking the asparagus fast, it starts to hurt.”

Though Sophia did not specifically mention that the health of her immediate family affected their daily living, she did speak about her mother, who was living in Sophia's household, and had health problems she acquired while on the job a couple of years prior. The interviewer prompted Sophia to speak about what she mentioned earlier in the interview about her mother needing surgery. "Oh...that is a long story," Sophia said,

Two years ago come this July [my mom] was at work for [a builder of manufactured homes] was walking on top of the roof of one of the trailers and had fell through a skylight. Um, simply because of [their] negligence. Um, in that two years she has been through a shoulder surgery, three times she has been through neck surgery, she went through a temporary implant surgery a week ago and now she is going back to get the permanent one put in. It has just been a long, long road.

Asked how all of these things affect her everyday life, Sophia replied, "Oh, they affect it very much. Mom can't do her normal stuff that she used to do anymore..."

What Natalie, the mother with multiple sclerosis, experienced was a little less dramatic but still influential on her health and well-being. Her answer to what kind of problems she faced at work was,

I say sore wrists. I'm typing on a computer all day so my hands and wrists cramp up. Eye problems from looking at a computer screen all the time.

Ironically, she finished the thought with, "But other than that, I don't think there are really any problems," as if sore wrists and eye problems were just something to be tolerated and accepted, not realizing that both problems can be permanently debilitating and/or require medical procedures to remedy, as was the case for Erica.

While recounting her work history, Erica talked about the job at which she had worked the longest—at a meat smoker. She spoke about being treated badly at this job because she filed a claim for suffering a repetitive stress injury. She explained this story to the interviewer:

I: And how long did you work there?

Erica: About 5 years.

I: Okay, and you had this job how long ago?

Erica: '89 to '90 something.

I: About '93 or '94?

Erica: Yeah.

I: And that's the one you left because you got hurt.

Erica: Yeah. Carpal tunnel in my wrist and it moved up to my arms.

I: Okay, like a repetitive stress?

Erica: Yeah. Cause I was tying pepperoni and so I constantly moved the same arm, in the same direction.

I: Did you like anything about it in particular or that was the job that you were kind of frustrated with the way they treated you?

Erica: I liked it, but I was frustrated with the way they treated me because um—I just didn't like to be treated like that because I filed a workman's comp claim and that's when everybody was just starting to file claims you know, and so everybody was, I don't know I got called some names.

I: Did they treat you okay until you filed those claims, or?

Erica: Yeah. So I think that's why I got a little extra money. I mean they settled out of court. I remember getting like \$20,000 from them you know?

Erica then admitted that she squandered the money she received from that settlement on drugs, which brings us to the last way in which health can be affected by socioeconomic position—targeted marketing of health damaging substances and products. Though data from the participants in this study do not directly support the contention that health damaging products are marketed directly to those in the lower



socioeconomic strata, research does (Hastings & MacFayden, 2000; MacKay, 2000; Saloojee & Dagli, 2000).

Erica's confession, however, does bring us back to the idea of a social milieu, as discussed by Pincus (1994) and Adler (1993), and its influence on health and health behaviors. In a nutshell, those situated within certain socioeconomic and social strata tend to associate with others like them. The habits and actions of one are likely to be reflected in others, particularly since some of those practices are likely to have been what has drawn the individuals together to begin with. For those who are situated in lower and more vulnerable socioeconomic positions, behavior is often driven by daily exposures. These exposures, such as the use of licit or illicit drugs or the maintenance of a diet lacking in nutritional quality, might result from choice, necessity, or even coercion. Oftentimes there is great guilt that comes from such behaviors. Though Erica's interview indicated that she has stopped using drugs, her confession that she had spent the money she received from the settlement on drugs was made hesitatingly, perhaps reflecting a sense of shame. She also hesitated elsewhere in the interview when speaking about her former drug habit. To get a better sense of these feelings of shame, observe the following interchange that took place between Destiny and the interviewer, when Destiny was asked what she would do if she were to get \$20 the following day:

Destiny: Well, I'm going to get \$25 today so I'll tell you what I'll do with it. I need \$10 for gas. I need \$5 for cigarettes, and I'm going to put the other \$10 towards the \$50. I saved \$50. I'm going to put that \$10 towards—I'm going to pay off some of my credit cards, \$60 on my credit cards.

I: How much do you smoke? How much do you pay for cigarettes?

Destiny: This is the worst. This is why I'm broke all the time. Four dollars a pack and I probably smoke a pack every other day. The habit is probably \$12 or more a week.

I: Have you considered stopping?

Destiny: I did when I was pregnant. I stopped for nine months. The whole time I was pregnant didn't pick up a cigarette. Then I just started again. I have been smoking since I was 12 going on 13. It's been almost ten years for me now. I don't know. It's going to be a huge struggle. My parents pressure me, a lot of people pressure me. I would love to stop.

I: You were saying something about smoking. Your parents have been pressuring you into going to a—

Destiny: Yeah, a doctor, everybody. I'm only 24. I've been smoking for ten years. It's scary.

I: Has it occurred to you when you stretch your money that if you never smoked or you smoked less, you might be saving \$10 or \$12 a week, which would be \$40 or \$50 a month.

Destiny: Absolutely.

I: Which is addictive.

Destiny: I'm absolutely addicted. I almost think—You know my friend...smokes too and she says to me, 'This is my money for not abusing my son.' Because that's the way you—like now I'm shaking because I need it. It's bad. It's really bad. I would save a tremendous amount of money. I had so much money for that nine months. I saved, I saved. I had all this money.

A clarification is needed here to assure the reader that I am not entirely denying the role of personal responsibility in regard to health and health behaviors, even in this vulnerable population. What I am trying to present, however, is the reality that it is harder to be healthy and make choices that support and sustain health when both social supports and economic resources are inadequate and limited. In essence, there are many more factors than meet the eye, not just individual, microlevel ones, but also larger macrolevel influences and policies that make it more difficult for low-income populations to make healthy choices and receive the assistance they need.

The last pathway, economic and social deprivation, needs little mention as the focus of this research is on low-income families who are sometimes isolated because of their residential location. It is a given that low-income families experience economic deprivation; nevertheless, Grace presented an interesting perspective when she spoke about the effects growing up in poverty had on her continuing health. Speaking about her childhood and being raised in a single-parent family in which her father left when she was quite young, she said,

...Long as I can remember, we had a lot of problems with money. My momma used to stay in old houses. As a young child, it would keep you depressed the way people live, the way the family live. And that's how I was. That's how I got the ulcer when I was 10 years old. My doctor was wondering how come you're so young? What you worried about? Why you got a ulcer? It just hard for a child to grow up without they daddy, especially if they love they daddy so much. And that's how I was.

Though children were not interviewed for this study, it is likely that their health, too, like Grace's, is affected by the difficulties they must confront on a daily basis.

Another way in which this pathway works is via the schedules many of these families must keep in order to be in compliance with welfare regulations, or in an attempt to maintain their limited existent self-sufficiency. Vanessa, who is a migrant worker, described to the interviewer a typical daily schedule:

I: Um, tell me about a typical day for you. What would you do on a typical day? Get, when would you get up and what would you do?

Vanessa: Oh, I'll get up at 4:30 in the morning or 5:30, make lunch and then cook breakfast.

I: Wow. So you take your, take the children to your niece's [house]?

Vanessa: Yes.

I: What time do you usually arrive at work?

Vanessa: Ah, 6:30.

I: 6:30?

Vanessa: Yes.

I: And then you work until what time?

Vanessa: From seven to sometimes the, when it was in asparagus, we would work until seven at night or eight.

I: Oh, that's a long day.

Vanessa: Yes.

### Implications for Policy

What is the solution or, more appropriately, what are the implications for policy? These questions are even more difficult to answer. To presume I could suggest a solution to such a large and complex problem would be audacious. Nevertheless, I can suggest an ethic from which to think and act when considering the plight of the vulnerable population on which this research was based, and when making new policies and revising old ones. That is an ethic of care.

An ethic of care, first described by Gilligan (1982) as a means of explaining the differences in moral reasoning between men and women, is now applied as an ethic from which both genders and the larger society can function. It promotes an empathetic look at the unique circumstances of individuals and families, and does not issue judgments based predominantly on rules and principles or rights and responsibilities. When personal or policy decisions include this relational element, black and white judgments are not so easily made. Carse (as cited in Tong, 1998), described a care ethic as one that

“asserts the importance of an active concern for the good of others and of community with them, of a capacity for sympathetic and imaginative projection into the position of others, and of situation-attuned responses to others’ needs.” (p. 134)

As Rumsey (1997) explained, this means that others must be understood in their concreteness, or distinctiveness and depth. Essentially, an ethic of care can be looked at as a means from which to reason that allows one to look phenomenologically and empathetically into the realities of others before making judgments about them or decisions that affect their world.

Some do not believe that an ethic of care is contrary or distinct from an ethic of justice (Kroeger-Mappes, 1994). They assert that both ethics are orientations or “stances from which to do theory” (Little, 1998, p. 190) and from which to act and practice. This approach, one that includes justice and care, provides the most comprehensive approach for accounting for the multidimensionality of human experience. For example, context as well as abstraction, individual rights and autonomy as well as responsibility and relationships, and actions as well as character are dichotomies that can be accommodated (Tong, 1998). This is a notion that fits the plight of rural low-income individuals with health concerns facing the inevitable consequences of welfare reform policies.

One criticism of an ethic of care is that it is not broad enough to be applicable to anything other than private relationships, since central to the ethic is the idea of being in relationship to others (Jecker & Reich, 1995; Little, 1998). This criticism assumes that we live in a world disconnected from each other. Yet, as suggested in a work by Tronto (1995), care is “. . . a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as

possible ’’ (1995, p. 141). This ideal does not exclude public or professional life in which we come in contact with and must consider those who are financially vulnerable.

Another concern with acting from an ethic of care is that it can be perceived as threatening. Macrosystem institutions may disregard or discourage acting from such an ethic as “[a] system that cares for and empowers others loses ultimate control over their decisions” (van der Wal, 1996, p. 42). Inherent in this concern is the supposition that an ethic of care cannot guide public policy decision making because it is not neutral nor based on principles (Groenhout, 1998; Jecker & Reich, 1995). This argument does not acknowledge that an ethic of care is not necessarily separate from justice, which *does* consider rules and regulations. Nor does this stance admit that, regardless of the theoretical position from which one argues, real people are behind the argument. Real people are not neutral. Moreover, those who are deciding public policy usually come to the policy arena with an agenda. An ethic of care listens to the voices of all those involved, thereby gathering more information from which to begin policy deliberation. In other words, an ethic of care begins where the people are, which was the intent of this research, as opposed to beginning with a set of disassociated principles and rules. Moreover, neutrality is not warranted, nor should it be esteemed, when at issue is the health and welfare of disadvantaged or oppressed groups.

One lingering question then is, how can an ethic of care be applied? In the context of this research, where health status is the factor limiting the self-sufficiency

attempts of individuals and families, an ethic of care can be applied in at least two important areas. One is by employers in the workplace; the other is in the development of new policy. The contrast between Erin's and Morgan's accounts provide a good example of how an ethic of care can be applied in the workplace. Recall that Erin was having health problems while pregnant, yet was required to be on her feet all day thus exacerbating her condition. When she expressed her discomfort to her employer, she was told that she would be fired if she did not come to work. Eventually, she lost her job. In turn, Morgan's child was hospitalized for an extensive duration requiring Morgan's absence from work. Yet her employer, a faith-based organization that presumably already operates from an ethic of care, did what they could to help Morgan, continuing to pay her wage throughout her absence and keeping her job available to her.

These examples show two extreme positions. An ethic of care may fit somewhere in between. Employers have the opportunity to make efforts to understand workers' stress, and to work with those stresses in an understanding and caring way, as opposed to exacerbating them. This does not mean that all employers who operate from a care ethic will do what Morgan's employers did for her. There is most certainly a continuum of care on which employers can find a reasonable place to operate so that both their needs and those of their employees are met as satisfactorily as possible.

As for policy, first listening to and gaining information about how health affects the lives of vulnerable families, as was done here, is an important first step. It is not

solely the responsibility of policy makers, however, to gather this information. Researchers who are collecting data and reaching conclusions have a responsibility to present these findings not only to their colleagues in an academic forum, but also to the public, to practitioners, and to policy makers. This means disseminating findings through popular press, perhaps employing the tenets of media advocacy in which the media is “strategically used to apply pressure for changes in policy” (Wallack, Dorfman, Jernigan, & Themba, 1993, p. xi), as well as academic journals. Such strategies require staying informed as a researcher as well as developing key relationships with media representatives. Initiating conversations and presenting findings with both local and federal policy makers is an appropriate second step. Unless we present the important findings of our research to those who are making the decisions regarding the lives of individuals and families, what we have learned will most likely stay locked in the realms of academia and be of little practical use. Hopefully, then, an ethic of care can be further put into practice.

As Kittay (1998) suggested, regardless of our social or economic position, and the ideal of personal responsibility, we are dependent on one another. Kittay termed this idea “nested dependencies” (para 39). Such thoughts lead to an answer to, what is the solution? To be exact, it is adopting an attitude of public responsibility, in which we allow and support this the concept of nested dependencies. I use the words of Cottle (1996), then, sum up:

This could be a historic moment for our society. We have the potential to change a system that encouraged dependence into one that emphasizes self-reliance. Neither liberals nor conservatives can



argue with this goal. To succeed, however, will require both heart and money. While it is immoral to support a system that keeps millions of families dependent on handouts, it would be equally wrong to demand that millions of poor parents go to work without our making every effort to ensure that the necessary jobs, training, and *support services* are available...The idea that every person who drops off the rolls has overcome poverty is absurd. . .While we're asking welfare recipients to change their views on personal responsibility, most of us could stand to re-examine our views on public responsibility (emphasis added). (para 40)

I emphasize support services because it is here where assistance with health care and the health problems of vulnerable families need to be addressed, and public responsibility needs to be enacted more proficiently. If we do not pay any heed to these concerns, and the potential damage we may be doing to these individuals, we may in fact create a population that is even less able-bodied, needing a greater amount of expensive resources to function and live, resulting from our insistence on personal responsibility at the neglect of public responsibility.

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## APPENDICES

## APPENDIX A

### Informed Consent

**Project Title:**    **The Rural Family Well-Being Project**

**Researcher:**       **Leslie Richards, Assistant Professor**

I am being asked to help with a research project exploring how families living in rural communities are managing with limited resources. I will participate in an in-depth interview and answer some survey questions. Families in many other states are participating in this study. The results of this research will help us to better understand how changes in the welfare system are affecting all limited-resource families in rural areas.

I understand:

- The information I give will be kept private and confidential. My name will never be used in any written materials produced by this project. The information I provide in the interview will be identified only by a number, and will be kept in a locked file.
- I do not have to participate in this project. If I decide that I do not want to answer some questions or that I wish to stop the interview, that is okay. I will receive a gift certificate even if I decide not to finish the interview.
- If I have questions about the research study, I can contact Leslie Richards, Oregon State University, Corvallis, OR 97331, (541) 737-1071. If I have questions about my rights as a research subject, I should contact the IRB Coordinator, OSU Research Office, (541) 737-8008.

**My signature below indicates that I understand the The Rural Family Well-Being Project and agree to participate in this study. I understand that I will receive a signed copy of this form.**

---

**Participant's Signature**

---

**Participant's Name**

---

**Participant's Address**

---

**Participant's Phone Number**



## APPENDIX B

## Interview Protocol

Interviewer: \_\_\_\_\_

ID:

Date: \_\_\_\_\_

## PARENT INTERVIEW PROTOCOL

## YEAR 1

Thank you for agreeing to participate in this important research on family life. As you probably know, we are part of a big study that is looking at how families living in rural parts of the country are managing on a limited income. We are talking to families living in small towns and rural areas all over the United States. Not all of the families we will talk to are currently receiving welfare. In fact, we will talk to some families who have never received cash assistance from the government, but nevertheless have trouble making ends meet each month. There are no “right” answers to any of our questions; we just want to hear what life is like for you and your family. Remember, this interview is voluntary. If you don’t want to answer a question, you don’t have to. All information you give us will be kept confidential. **(Do not proceed unless you have a completed informed consent document.)**

Let's begin by talking about who lives in your household. Besides you, who lives in your house?

## CURRENT HOUSEHOLD COMPOSITION

A. Mother's 1st Name	DOB	Marital Status*	Ethnicity**
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B. Partner's 1st Name                      DOB                      Ethnicity\*\*

Child (First Name)	Sex	DOB	Relation to A ***	Relation to B ***	Contact w/ bio parent (Y, N)	Receives child support (Y, N)
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5. \_\_\_\_\_
6. \_\_\_\_\_

<b>* Key to codes</b>	<b>**Key to Codes</b>	<b>*** Key to codes</b>
S = Single	W =Non-Hispanic White	A = Adopted
M = Married	H =Hispanic/Latino	SC = Stepchild
LWP = Living with partner	AA =African American	B = Biological child
D = Divorced	N =Native American	F = Foster child
SEP = Separated	A =Asian	NR = Not related
	M =Multi-racial	O = Other
	O =Other	

Do you have any children not currently living with you? (If yes) Who are they, and where are they living?

---



---

### OTHER HOUSEHOLD MEMBERS

Relationship to A	Length of Time in Household	Permanent or Temporary Arrangement
_____	_____	_____
_____	_____	_____
_____	_____	_____

Interviewer Notes:

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### *LIVING IN THE COMMUNITY*

1. Tell me about how this neighborhood/area is as a place to live. Does this neighborhood/area have everything that you and your family need? If not, what sorts of things are missing? (Probe if necessary: Do you have easy access to a grocery store; a mini-mart or convenience store; other household shopping; medical care; a gas station; church; school; child care; a library?)
2. Families may need to know how to find many different services available in the community. The services needed are different for each family. I have a list of resources that are often available in communities. I'd like to know about the kinds of community services you know about. Shall I read the list to you, or would you like to fill this out yourself? (*Administer: Knowledge of Community Resources Measure*)

**NOTE: IF THE INTERVIEWEE ASKS YOU TO READ THE MEASURE, ASSUME THAT ALL FURTHER SURVEY MEASURES SHOULD BE READ ALOUD.**

3. What's the best thing about living where you do? The worst?
4. Is your housing adequate for you and your family's needs? Why or why not? (Probe: size, quality, price, landlord.)
5. Have you moved in the past two years? If so, why? How does this place compare with where you lived before? (**If not addressed**) How has your family responded to these changes? How do you feel about this?

(**Optional, ask if not addressed in #5**) In the last two years was there ever a time when you and your family were homeless? For how long were you homeless? What did you do? How did you get housing again?

### **EMPLOYMENT/CURRENT WORK**

1. Let's talk about your employment situation. Are you currently working? (**If not employed, skip to Question #2**) What do you do? How much are you paid? When did you start working there? How many hours do you generally work each week? How many weeks do you work during the year? Have you ever had a raise? When? How much? (**List only current employment; space provided for up to three jobs**)

### Participant's Current Employment

	Wage/Salary	Date Started	Hours/week	Weeks/Year	Amount Raise
Job 1	_____	_____	_____	_____	_____
Job 2	_____	_____	_____	_____	_____
Job 3	_____	_____	_____	_____	_____

2. **(Ask only if not currently employed)** Are you looking for a job now? **(If yes)** How are you going about it? Have you ever worked for pay? **(If answer is no, ask the appropriate questions in this section, but skip work history section)**
3. What about your partner? What does your partner do? How much is your partner paid? When did your partner start working there? How many hours does your partner generally work each week? How many weeks does your partner work during the year? Has your partner ever had a raise? When? How much?

### Partner's Current Employment

	Wage/Salary	Date Started	Hours/week	Weeks/Year	Amount Raise
Job 1	_____	_____	_____	_____	_____
Job 2	_____	_____	_____	_____	_____
Job 3	_____	_____	_____	_____	_____

4. Is there anyone else in the household who has a job? **(If yes)** Tell me about that.
5. **(Ask if currently employed)** What problems, if any, do you currently face at work?
6. **(Ask if currently employed)** Do you get any benefits from your job(s)? How about your partner? What about health insurance...

<i>Benefit</i>	<b>Provided by Mother's Job(s)</b>		<b>Provided by Partner's Job(s)</b>	
Health insurance for self	Yes	No	Yes	No
Health insurance for children	Yes	No	Yes	No
Sick leave	Yes	No	Yes	No

Vacation pay	Yes	No	Yes	No
Overtime	Yes	No	Yes	No
Retirement plan	Yes	No	Yes	No

7. What would be your ideal job for supporting your family? What would help you to get that kind of job?
8. In the last several years welfare regulations have changed. There is now more of an emphasis on getting a job, and there are now time limits (**talk about specific state programs, if appropriate**). What do you think about these changes? Has your family been affected by them?

## WORK HISTORY

1. We also want to know about the kinds of work that people have done in the past. Tell me about your work history. How old were you when you got your first job?
2. About how many jobs do you think you've had since then? Have you been more likely to work full-time or part-time? Why?
3. What kinds of jobs have you had? What were some of the reasons you left these jobs?
4. Tell me about the job that you held the longest, not counting your current job. When did you have this job? What did you do? What did you like about it? Why did you leave?

## TRANSPORTATION AND CHILDCARE

1. What about transportation? How do you usually get around? (**If not addressed: Do you own a car or have one you can borrow? How do you and your partner get to and from work?**)
  - a. (**If the family has no car**) How do you get your groceries, take your children to the doctors, run errands?
  - b. (**If the family has a car**) How reliable is your car? When was the last time your car broke down? What happened?

2. What do you do when you really need transportation and it's not available to you?
3. When you are working (or participating in a job training program or the state's welfare-to-work activities) who takes care of your children? Tell me how you get them there, and about how long they stay every day. Is it different if you have to work evenings or weekends?
4. **(If appropriate)** What about your older children? What do they do after school? What about school holidays and summers?
5. How many childcare arrangements do you have each week/month? Overall, how much do you pay for childcare each month?
6. How do you like your childcare provider? Why do you feel this way? Have you ever changed providers? Why?
7. Is there ever a time when you need someone to take care of your children outside your time at work? Who does that? How does it go?
8. Tell me about a situation when you needed emergency childcare. What did you do? Have you ever had to miss work or a training program because of a childcare problem? How did your supervisor react?
9. What do you do for childcare if your child gets sick? What happens if your provider is sick?

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### Family of Origin Characteristics

1. Tell me a little bit about your background. What was your family like when you were growing up? Who was in your family? Where did you live? What do you remember about your childhood?
2. Did your parents work? What kind of work did they do?
3. How much education did your mother have? \_\_\_\_\_ Your father? \_\_\_\_\_

**1 = 8<sup>th</sup> grade or less**

**2 = some high school**

**3 = high school or GED**

**4 = specialized technical, business or vocational training after high school**

**5 = some college, including Associate's Degree**

**6 = college or university graduate**

**7= one or more years beyond college**

**8= graduate degree**

**9 = don't know**

4. Do you know if your family ever received welfare or other assistance? ☐ Yes  
☐ No ☐ Don't Know
  5. How often did your family move when you were a child? Why did you move?
  6. **(Optional)** How much contact do you have with your family now? Who are you in contact with? Where do they live? What is your relationship like now?
- 
- 

## **FAMILY WELL-BEING**

1. Tell me about a typical day (a working day, if appropriate). What time do you get up? When do your children get up? Then, what happens next? And then...?  
**(The goal here is to get through a typical weekday for the family.)**
2. What sorts of things do you do for fun with your family? How often do you get to do them?
3. Overall, how would you say things are going for your family right now? **(If not addressed)** How are things going for you personally? **(If appropriate)** How are things going between you and your partner?
4. Here is a checklist that asks about how things have been in the last week.  
**(Administer: *Feelings About How Things Are Going*)**
5. Parents need lots of skills to help their families get by. Everyone has certain skills and abilities, but it's usually not possible for someone to have every single skill needed. We'd like to know what sorts of skills you have. **(Administer: *Life Skills Assessment*)**
6. Family members often have health problems. Sometimes these problems don't have much of an impact on day-to-day life, while at other times they can be a big problem. We'd like to know about any health problems the members of your family might have. **(Administer: *Adult Health Survey*; Administer: *Child Health Survey*; use more than one if needed to get info about all children)**
7. Are you satisfied with the health care you receive? Why or why not?

8. Is there anything that makes it easier or harder for you and your family to stay healthy?
9. **(If there are other people living in the household)** Do any of the other people in your household have any health problems? **(If yes)** What kinds of health problems?
10. **(If applicable)** Do any of these health problems affect everyday life in your family? If so, how?
11. What things about your family make you proud and happy right now? What are the biggest challenges for your family as a whole?

## EDUCATION AND INCOME

1. What is your current educational level? \_\_\_\_\_ (use scale below)
  - 1= 8<sup>th</sup> grade or less
  - 2 = some high school
  - 3 = high school or GED
  - 4 = specialized technical, business or vocational training after high school
  - 5 = some college, including Associate's Degree
  - 6 = college or university graduate
  - 7 = one or more years beyond college
  - 8 = graduate degree
  - 9 = don't know
2. How much education did you have when you first became a parent? \_\_\_\_\_ (use scale)
3. **(If no high school diploma)** Why did you leave high school before finishing?
4. **(If appropriate)** What about your spouse/partner-how much education does he have? \_\_\_\_\_ (scale)
5. In the last few years have you had the opportunity to get further education or develop new job skills? What kind? How were you able to do this?
6. We'd like to know a bit about your family's sources of income. Remember, all of this information is completely confidential. From which of the following sources do you receive income?



Source of Income	Take Home Pay	Weekly	Bi-Weekly	Monthly
Wages and salaries (self)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wages and salaries (partner)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tips, commissions, overtime	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Disability	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Retirement/Pensions	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SSI (Supplemental Security Income)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TANF	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment Compensation	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Disability Compensation	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veterans' Benefits	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child or spousal support	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's wages	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Stamps	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular gifts from family/friends	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Housing is usually the largest expense for families. Tell me about how much you pay per month and what utilities, if any, are included. Is this a rental or do you own? What utilities do you pay each month? How much? What happens if you can't pay for utilities?

8. Families sometimes receive assistance from a variety of government or private programs. Do you receive assistance from any of the following? (**Try and record cash value if possible**)

- |   |  |
|---|--|
| <input type="checkbox"/> WIC                        | <input type="checkbox"/> Transportation Assistance   |
| <input type="checkbox"/> School Lunch Program       | <input type="checkbox"/> Educational Grants or Loans |
| <input type="checkbox"/> EIC (Earned Income Credit) | <input type="checkbox"/> Oregon Health Plan          |
| <input type="checkbox"/> Child Care Assistance      | <input type="checkbox"/> Other                       |
| <input type="checkbox"/> Housing Assistance         |  |
| <input type="checkbox"/> Energy/Fuel Assistance     |  |

9. Have you received any of these services in the past? Has the type or amount of help you have received changed over time?

10. Is there any other assistance you're getting now, such as help with healthcare, food, meals, clothing, holiday gifts, furniture, baby goods, day care, or school supplies?

Type of Help	Amount	Type of Help	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Compared to two years ago, would you say your family's economic situation has:

- 5 = Improved a lot**
- 4 = Improved a little**
- 3 = Remained the same**
- 2 = Gone down a little**
- 1 = Gone down a lot**

12. **(Optional)** To what extent do you think your income is enough for you to live on?

- 1 = Not at all adequate**
- 2 = Can meet necessities only**
- 3 = Can afford some of the things we want but not all we want**
- 4 = Can afford about everything we want**
- 5 = Can afford about everything we want and still save money**

13. In past year, has there been a time when you had a hard time making ends meet or paying for necessities? What did you have trouble paying for? Food? Clothing? Healthcare? Credit payments? Personal care or non-food items? **(If appropriate)** Diapers? What did you do?

Item	Yes	No
Food	<input type="checkbox"/>	<input type="checkbox"/>
Clothing	<input type="checkbox"/>	<input type="checkbox"/>
Medical Care	<input type="checkbox"/>	<input type="checkbox"/>
Dental Care	<input type="checkbox"/>	<input type="checkbox"/>
Medicines	<input type="checkbox"/>	<input type="checkbox"/>
Credit Payments	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care Items	<input type="checkbox"/>	<input type="checkbox"/>
Diapers	<input type="checkbox"/>	<input type="checkbox"/>
School Fees or Expenses	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

14. Within the last year, have you ever had to borrow money from family or friends? **(If yes)** How much did you borrow? Why did you borrow it? Have you been able to pay it back? **(If no)** Did anything happen because you didn't pay it back? **(If yes)** How were you able to get the money to pay it back?
15. The past year, have you sold or pawned anything you owned?
16. If you got \$20 tomorrow, what would you do with it?
17. If you got \$200 tomorrow, what would you do with it?
18. If your child needed a new pair of shoes, how would you get them for him or her?
19. Have you ever gotten the Earned Income Credit in a lump sum? **(If yes)** What did you do with the money?
20. Think about your income and your bills and the things you need to buy. How do you decide which comes first?
21. If your child's birthday were 2 months from now, and he/she wanted a present that costs \$30. Would you buy it for him/her? How would you get the money?
22. Have you or members of your household ever gone hungry or been close to going hungry? Please describe the situation as fully as you can. What led to it? How did you deal with it?
23. What do you need most to prevent this situation from happening? **(Administer Food Security Module)**
24. When you've gone for help from an agency, how were you treated? **(Probe for specific agencies.)**

## *PARENTING*

1. Let's talk about being a parent. What do you enjoy most about being a parent? What are your strengths as a parent? What is the hardest part of being a parent?
2. **(If appropriate)** How does your partner help you with parenting?

**(Optional)** Here's another checklist that asks you to describe how you feel about yourself as a parent. *(Administer: Parent Ladder)* Why do you feel that way?

## SOCIAL SUPPORT

1. Who are the people who are most important to you and your family? By this, we mean friends or relatives who are important to you for one reason or another. **For each person ask:** Who is this person? Why are they important to you? **(If appropriate)** How did you meet them? How often are you in contact with them? Is there anyone else?
2. Is there anyone who makes things harder for your family? How so? Tell me about that.
3. Do you ever get to go out with your friends? Have you been able to find the time for any outside activities? What sorts of things do you do?

## SUMMARY

1. When you look back over the past few years, what do you think are the most important things that have happened to you and your family?
2. Looking ahead into the future, what are you most looking forward to in the coming year? What do you most worry about? What do you think things will be like for your family in three years?
3. Overall, how satisfied are you with your life right now? **(Use scale below)** Why do you feel that way?
  - 1 = very dissatisfied
  - 2 = dissatisfied
  - 3 = mixed feelings
  - 4 = satisfied
  - 5 = very satisfied
4. Is there anything else that you think we should know about how your family is doing right now? Is there anything we've missed?

ID: \_\_\_\_\_

Date: \_\_\_\_\_

**CONTACT INFORMATION: TO BE REMOVED AND KEPT IN STATE  
FILES**

As you know, we would like to visit with you again in a few months to see how your family is doing. To make it easier to contact you in case you move and forget to tell us, will you share the name and phone numbers of three people who will always know where you are? Please be sure to tell them that we may contact them.

**Name****Phone Number**


Thank you so much for your time.

**NOTES:**

## APPENDIX C

## Measures

**FEELINGS ABOUT HOW THINGS ARE GOING**

For each of the following statements, check the box that best describes HOW OFTEN YOU HAVE FELT THIS WAY DURING THE PAST WEEK.

	<b>Rarely or none of the time</b>	<b>A little of the time</b>	<b>A moderate amount of time</b>	<b>Most or all of the time</b>
1. I was bothered by things that don't usually bother me...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I did not feel like eating; my appetite was poor.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt that I could not shake the blues even with help from my family and friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I felt that I was just as good as other people.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I had trouble keeping my mind on what I was doing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I felt depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I felt that everything I did was an effort.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt hopeful about the future.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I thought my life had been a failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt fearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My sleep was restless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I was happy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I talked less than usual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I felt lonely.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People were unfriendly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I enjoyed life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I had crying spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I felt sad.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I felt that people disliked me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I could not "get going".....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ADULT HEALTH SURVEY**

Do you and/or your partner  
have medical insurance?

You Yes \_\_\_\_\_ No \_\_\_\_\_  
Partner Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what kind?

- ☐ Private/HMO  
☐ Medicaid  
☐ State Health Plan  
☐ Other (Explain)  
\_\_\_\_\_

Do you and/or your partner  
have any type of dental  
insurance?

You Yes \_\_\_\_\_ No \_\_\_\_\_  
Partner Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what kind?

- ☐ Private  
☐ Medicaid  
☐ Other (explain)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

About how many times in the  
past year have you been to a  
doctor or other health care  
provider?  
\_\_\_\_\_

Your partner? \_\_\_\_\_

If none, when was the last time  
you visited a doctor or health  
care provider?  
\_\_\_\_\_

Your partner? \_\_\_\_\_

About how many times in the  
past year have you visited a  
dentist? \_\_\_\_\_

Your partner? \_\_\_\_\_

If none, when was the last time  
you did visit a dentist?  
\_\_\_\_\_

Your partner? \_\_\_\_\_

Have you or your partner  
had any injuries or serious  
illnesses in the past year?

You Yes \_\_\_\_\_ No \_\_\_\_\_  
Partner Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

About how many times in  
the past year have you  
missed work or job training  
due to an illness/injury?  
\_\_\_\_\_

Your partner? \_\_\_\_\_

Have you been pregnant in  
the past three years  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes: How many times  
\_\_\_\_\_  
\_\_\_\_\_

Are you and your partner  
able to have more children?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If so, do you currently use  
birth control?  
Yes \_\_\_\_\_ No \_\_\_\_\_

In the past three years, have you or your partner experienced any of the following health problems?

	You	Partner		You	Partner
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder/Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Disability	<input type="checkbox"/>	<input type="checkbox"/>

Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anger Management	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Problem	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu/sinus	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emotional, physical, or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraines/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
_____	<input type="checkbox"/>	<input type="checkbox"/>			
_____	<input type="checkbox"/>	<input type="checkbox"/>			



First name of Child 1: \_\_\_\_\_ Child 2: \_\_\_\_\_ Child 3: \_\_\_\_\_

### CHILD HEALTH SURVEY

Does C1 have medical insurance? ☐ Yes ☐ No

If yes, what kind?

- ☐ Private/HMO  
☐ Medicaid  
☐ State Plan  
☐ Other (Explain): \_\_\_\_\_

C2: ☐ Yes ☐ No

If yes, what kind?

- ☐ Private/HMO  
☐ Medicaid  
☐ State Plan  
☐ Other (Explain): \_\_\_\_\_

C3: ☐ Yes ☐ No

If yes, what kind?

- ☐ Private/HMO  
☐ Medicaid  
☐ State Plan  
☐ Other (Explain): \_\_\_\_\_

About how many times in the past year has your child been to a doctor or other health care provider?

C1 \_\_\_\_\_ C2 \_\_\_\_\_ C3 \_\_\_\_\_

If none, when was the last time your child visited a doctor or health care provider?

C1 \_\_\_\_\_ C2 \_\_\_\_\_ C3 \_\_\_\_\_

Does C1 have any type of dental insurance? ☐ Yes ☐ No

If yes, what kind?

- ☐ Private  
☐ Medicaid  
☐ Other (Explain): \_\_\_\_\_

C2: ☐ Yes ☐ No

If yes, what kind?

- ☐ Private  
☐ Medicaid  
☐ Other (Explain): \_\_\_\_\_

C3: ☐ Yes ☐ No

If yes, what kind?

- ☐ Private  
☐ Medicaid  
☐ Other (Explain): \_\_\_\_\_

About how many times in the past year has your child visited a dentist?

C1 \_\_\_\_\_ C2 \_\_\_\_\_ C3 \_\_\_\_\_

If none, when was the last time your child did visit a dentist?

C1 \_\_\_\_\_ C2 \_\_\_\_\_ C3 \_\_\_\_\_

Has your child had any injuries or serious illnesses in the past year?

C1: ☐ Yes ☐ No

C2: ☐ Yes ☐ No

C3: ☐ Yes ☐ No

If yes, please explain

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

About how many times in the past year has your child missed school due to an illness/injury?

C1: \_\_\_\_\_

C2: \_\_\_\_\_

C3: \_\_\_\_\_

In the past three years, has your child experienced any of the following health problems?

	C1	C2	C3		C1	C2	C3
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Lice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis (pink eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder/Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds/flu/sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fetal Alcohol Effects/ Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Drug Effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## APPENDIX D

## Coding Scheme

**CODES FOR WAVE 1 CODING (NC-223)**

<b>CHILDCARE</b>	Any mention of childcare arrangements; childcare needs, who watches kids; cost of childcare; type of childcare arrangements; emergency childcare; childcare problems.
<b>FAMILY ISSUES</b>	Comments on relationships with family of procreation and partner or co-parent of child; challenges and positive aspects of family; important events; comments on parenting; what they enjoy, their perceived strengths; partner's parenting, if appropriate; family violence.
<b>FAMILY OF ORIGIN</b>	Comments on the history or current relationship with members of family of origin.
<b>HOUSING</b>	Any references to housing or basic utilities.
<b>WELL-BEING</b>	Comments on general well-being: how they are doing, or coping with day-to-day issues. Includes economic well-being, general psychological well-being, family well-being. Summary of daily life will usually go here; may be double-coded with other issues.
<b>MAKING ENDS MEET</b> (sub-code of well-being)	Anything that comments on how they pay bills or for necessities (not including food); how they manage to cover costs, or NOT cover costs. All economic issues, taxes, income, expenses, EITC, etc.
<b>FOOD SECURITY</b> (sub-code of well-being)	Any mention of hunger, insufficient or inadequate food; strategies to make food last to the end of the month; etc.
<b>CURRENT JOBS</b>	Any mention of their or their partner's current job, including work-family interface issues; job search activities; problems with current job.
<b>JOB HISTORY</b>	Any mention of their or their partner's past jobs or sources of working income (not quantitative).
<b>TRANSPORTATION</b>	Anything that has to do with transportation, family cars, or emergency transportation.
<b>WELFARE</b>	Respondent's current experiences with or perceptions of welfare; changes they've seen/experienced since reform.
<b>HEALTH</b>	References to health concerns of themselves or their family of procreation, or serious health issues in family of origin that influenced everyday living and functioning.
<b>MENTAL HEALTH</b>	References to mental health issues in respondent or their family; for instance, depression, anxiety, and deviant behavior in self or other family members. (Mental health issues that are not clearly defined are coded as well-being).

<b>SOCIAL SUPPORT: AGENCIES</b>	Comments on how agencies, landlords, community organizations, etc. provide assistance, includes lack of support; r experiences with agencies.
<b>SOCIAL SUPPORT: FRIENDS AND FAMILY</b>	Comments on how friends or family members provide assistance: social, emotional, material, with bills or childcare, including lack of support; who makes things hard; support interviewee offered to others.
<b>EDUCATION AND TRAINING</b>	Comments on job skills developed over the past few years, or education developed in the past few years.
<b>COMMUNITY</b>	Comments on what it is like to live in the community— apart from housing itself; comparison with other communities where they have lived; neighborhood issues.
<b>FUTURE</b>	Fantasy job, where family will be in the future, worries about the future.