AN ABSTRACT OF THE THESIS OF

Amy M. Guyer for the degree of Master of Science in Human Development and Family Studies presented on March 7, 2003. Title: Depression Risk: An Examination of Rural Low Income Mothers.

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Leslie N. Richards

This study used a multi-method approach to explore factors associated with high and low depression in a sample of rural mothers living in poverty. From a sample of 117 women with very high or very low CES-D depression scores, 40 cases were randomly selected for in-depth qualitative analysis. Qualitative comments about a variety of issues were explored including health, mental health, childcare, transportation, community, social support, and family of origin experiences. Quantitative data were then used in response to themes that emerged from the literature and the qualitative findings. All 117 eligible participants were used for quantitative analysis to increase power.

Analysis of the qualitative data revealed several critical differences between the two groups. Low risk participants mentioned fewer health issues and less severe health problems as compared to their high risk counterparts. Mental health issues were reported more in the high risk group, with this group being more likely to have multiple family members experiencing symptoms. All participants reported receiving social support, however, the low risk group
reported positive social support experiences, while the high risk group reported ambivalent relationships with the people who provided them with social support. Reported family of origin experiences were quite different between the two groups, with the low risk group reporting more positive past and current relationships.

Quantitatively, several interesting results were revealed, many confirming the qualitative findings. Mothers showing higher levels of depression reported significantly more health problems for themselves, their partners, and their children. Additionally, participant’s work status, income, perceived adequacy of income, childhood welfare use, and presence of partner were significantly related to depression. Low risk respondents were more likely to be working, perceive their income as adequate, and have a partner. They were also less likely to have received welfare as a child and had higher incomes.

The findings offer important implications for future research and policy. Risk for depression seems to be related to a variety of factors, indicating that something should be done to minimize an individual’s likelihood toward experiencing depression. This study ultimately provided a clearer picture of the existence of depressive symptoms among women with children living in rural poverty.
Depression Risk: An Examination of Rural Low Income Mothers

by
Amy M. Guyer

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Amy M. Guyer, Author
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CHAPTER ONE

INTRODUCTION

In the summer of 1996 Congress passed, and President Clinton signed, the “Personal Responsibility and Work Opportunity Reconciliation Act” (PRWORA) otherwise known as welfare reform (P.L. 104-193). This act radically changed the welfare system, thus ending an era of federally guaranteed cash assistance to low income families with dependent children. The federal government instead gave the responsibility to the states in the form of block grants. Due to welfare reform, Assistance to Families with Dependent Children (AFDC) was replaced by Temporary Assistance to Needy Families (TANF). While AFDC guaranteed cash assistance to needy children whose parents were unable to provide for them, welfare reform abolished entitlement benefits and services. The federal government mandated stringent work requirements, and created a five-year lifetime limit on the receipt of federal cash assistance. This lifetime limit can be cut even more if a state so wishes (Seccombe, 1999). Despite good intentions, flaws in the reform have made economic self sufficiency difficult for many low income families, with poverty remaining a concern more than six years later.

With the exception of a modest decline in 2000, the number of women and children living below the poverty line in the United States has been
increasing since the 1970's, with 34% of female headed households currently living in poverty (Dalaker, 2000). Women in poverty experience multiple barriers to employment and economic self sufficiency. For poor women living in rural areas the problem not only relates to lack of income, but also access to services (Zedlewski, 1998; Weber & Duncan, 1996). Many of these barriers can be so overwhelming that feelings of hopelessness and frustration emerge. Thus, not only are women in rural poverty disadvantaged due to lack of income, but they face multiple barriers that are unique to their location. Rural women are often unfairly disadvantaged in that services they need may be inaccessible, nonexistent, or of poor quality in the remote areas in which they live.

With public assistance changing and an emphasis being placed on all able bodied individuals going to work, economic self sufficiency has become imperative. The PRWORA emphasizes the importance of the transition from welfare to work (Seccombe, 1999). Rural poor are not immune from this legislation and are expected to participate in the mandated job search and work requirements. For many, juggling childcare, transportation, and overcoming other barriers is often stressful and time consuming. In rural areas, these resources are limited, but the requirements mandated by the government still hold (Richards, Merrill, Corson, Sano, Graham, & Weber, 2001; Weber &
Duncan, 1996). Poverty and the issues surrounding it often create more complex problems such as depression.

Many studies have revealed a variety of risk factors in regard to depression. Depression is one of the most significant mental health risks for women, especially younger women of childbearing and childrearing age (Glied & Kofman, 1995). Women are often socialized differently, which may contribute to the development of depression (Nolen-Hoeksema, 1990). Furthermore, single women are more likely to experience poverty (Seccombe, 1999), which is also linked to depression (Belle, 1982; Simonds, 2001). Thus, determining which factors contribute to an individual’s likelihood toward depression becomes difficult. Ultimately it is not surprising that women are overall significantly more likely to experience depression than men, due to their increased likelihood of experiencing many associated risk factors.

This research examined the links between rural poverty and depression in a sample of low income women with young children. The preexisting data set for the Cooperative Extension Regional Research Project, NC-223 includes a total of 448 families from 15 states from all regions of the United States. All 448 women were eligible for food stamps and had young children at the time of entry into the study. Interviews with women in the sample most at risk for clinical depression as measured by the CES-D depression measure (Radloff, 1977) were compared to women who were at lower risk for depression.
Variables examined for both groups were health, mental health, childcare, transportation, community, social support, and family of origin. It was thought that differences would be seen between the groups in regard to these factors. By the end of this study I have gained an understanding of what factors were associated with high or low levels of depression in a sample of low income rural women.

For the purposes of this study, the ecological approach (Bronfenbrenner, 1979) was used to provide a theoretical lens through which to view the data. This approach allowed an understanding of the many levels of influence in an individual's life. For the topic of women in rural poverty and their likelihood toward depression, it is possible for us to see the variety of factors that contribute to both well being and feelings of stress in their daily lives. This theory is appropriate for this topic in that a variety of factors on different levels can influence a person's life. In the case of families in poverty the factors are complex and occur on a variety of levels.

There are four levels that make up the circle of an individual's ecology. The first and innermost circle is known as the microsystem. A microsystem setting is an environment such as a home, classroom, or workplace that is the context for the developing person. Examples of microsystem influences are a mother's interactions with friends or family members at home or in the neighborhood. The mesosystem, the second circle out, describes the linkages
between two or more settings and the interrelations that occur. Common interconnections are between the mother’s home and work or work and school.

Next, the exosystem relates to settings that do not directly involve the person in question. The events that occur in that setting, however, have an effect on the person regardless of the lack of direct involvement. For example, the community a woman lives in can certainly have an impact on her family regardless of their involvement. Finally, the macrosystem includes the larger cultural and economical contexts. Examples of influences at the macrosystem level include broader cultural values (such as rugged individualism), economic conditions (boom or recession), public policies (PRWORA), and expectations about roles (women as caregivers). The mother in this example may find that the recession has made it difficult for her to find and keep a job. If she receives welfare she may experience the stigma surrounding it. These things in turn influence many things at microsystem level (Bronfenbrenner, 1979).

It is obvious that not all poor women are depressed and not all people with depression are poor. Thus it is difficult to prove that depression is caused by poverty alone. It is possible, however, to examine some of the factors involved in the lives of women in poverty by using an ecological framework. By examining a variety of factors in the lives of poor women we may be able to understand why some women are more susceptible than others to depression. The perspective of the individual will be used for this research project,
However, it is important to view all levels of the system since they all have an effect on each other as well as the person. Thus, the specific question that will be addressed during this research is:

- Of low income women living in rural areas, what differences exist between those who score at low risk and those who score at high risk for depression? Do health, mental health, childcare, transportation, community, social support, and family of origin experiences differ between the two groups?
CHAPTER TWO

REVIEW OF THE LITERATURE

The review of the literature begins with a description of the ecological approach and how it relates to rural poverty and depression. Next, an examination of rural poverty in the United States will reveal how poverty has become so problematic and what it looks like today. Looking at the subject of women in poverty paints the picture of who is most likely to be poor and the unique barriers faced by the poor. Health, mental health, childcare, transportation, social support, community, and family of origin experiences will each be examined to better understand aspects common in the lives of the participants. Finally, the review will look at depression in general, ultimately connecting it to women in poverty specifically. This study not only intends to illuminate the individual stories of poverty and mental health among rural women, but also seeks to explore the factors that possibly contribute to or minimize a woman's potential risk of depression.

The Ecology of Poverty

The ecological approach (Bronfenbrenner, 1979) best illuminates the lives of women living in poverty and their likelihood of depression. This theory allows an understanding of the context of a situation from different levels. Rural poverty, for example, is typically more pervasive and longer lasting than urban poverty (Duncan, 1992). Thus, poverty experienced by those
in rural areas is much different than that of their urban counterparts. Many women in rural areas also experience a wide variety of barriers such as lack of access to quality affordable childcare, transportation, and health care (Edin & Lein, 1997; Richards et al., 2001; Seccombe, James, & Battle-Walters, 1998). Further, social support and relationships with family of origin differ among individuals and are important factors when using the ecological approach. For clarification Figures 1-4 illustrates the ecological model with the relevant variables incorporated.
A microsystem setting is an environment such as a home, classroom, or workplace that is the context for the developing person.
A mesosystem describes the linkages between two or more settings and the interrelations that occur.

Figure 2. Mesosystem Model.

Mesosystem

- Family/School Communication
- Communication with extended family
- Home and work interface issues
The exosystem relates to settings that do not directly involve the developing person. The events that occur in that setting, however, have an effect on the person regardless of the lack of direct involvement.

Figure 3. Exosystem Model.
Figure 4. Macrosystem Model.

The macrosystem includes the larger cultural and economical contexts. It sets the overall backdrop for the developing person.
Rural Poverty

To many Americans, rural areas represent a quiet place that is best suited for raising children without the worries common in urban areas. This small town ideal represents a community in which everyone knows their neighbor, with stresses of the city far away. The assumption that rural areas are simply smaller versions of their urban counterparts is, however, quite inaccurate. Rural areas are different, with their own unique economies and resources. Thus, it is not surprising that not only do many rural residents experience poverty, but they also experience lower access to services and assistance (Findeis, Henry, Hirschl, Lewis, Ortega-Sanchez, Peine, & Zimmerman, 2001).

Census data reveal that poverty in rural areas is extremely high, with 13.4% (6.8 million) of individuals in non-metropolitan areas living in poverty compared to 10.8% (24 million) of individuals dwelling inside metropolitan areas (Dalaker, 2000). Although it appears that a greater number of people in the inner city are poor, it should be noted that the percentage indicates that living in a non-metropolitan area increases one’s likelihood of living in poverty. Individuals in rural areas are also more likely to live in poverty for greater stretches of time (Duncan, 1992; Findeis, et al., 2001). Lichter & McLaughlin (1995) concluded that poverty is high in rural areas especially among minorities, children, older adults, and the less educated. Rural areas are
especially economically vulnerable if they rely on only a few industries (Lichter & McLaughlin, 1995).

Similar to the entire nation, rural areas experienced an industrial transformation in the 1900's that changed the entire economy (Albrecht & Albrecht, 2000). Over the past century the number of farms and manufacturing jobs has decreased while the number of low wage service sector jobs has increased in rural parts of the country (Fletcher, Flora, Gaddis, Winter, & Litt, 2000). The increased number of low wage jobs available has highly contributed to the number of rural poor (Gorham & Harrison, 1996).

Albrecht & Albrecht (2000) found that agricultural employment, which primarily affects rural areas, is positively related to poverty. Further, service sector employment directly affects poverty, while also reducing male employment overall (Albrecht & Albrecht, 2000). In rural areas four out of ten workers earned incomes below the poverty line, with the percentage of low earners constantly increasing every year (Gorham & Harrison, 1990).

It is unlikely; however, that unemployment is the only crucial factor among those living in rural poverty. Many other barriers exist for those who live in rural areas such as employment opportunities for women, especially single mothers who are the sole wage earner for their families. Lichter & McLaughlin (1995) found that non-metropolitan areas fell further behind metropolitan areas in a variety of economic indicators including poverty and
real income. This is especially true for rural women, with a growing disparity appearing between women in non-metropolitan areas and their urban counterparts in regard to employment opportunities. Rural female-headed households are more likely than any other family to experience poverty (Duncan, 1992; Lichter & McLaughlin, 1995). Job growth strategies alone are not always beneficial to rural single mothers; rather, emphasis on quality and affordable childcare, increased wages, health benefits, and transportation is essential (Lichter & McLaughlin, 1995).

Women in Poverty

The 1960's and 1970's witnessed dramatic increases in both the number of divorces and amount of nonmarital childbearing. Over the years, the result of these social changes has made women and their children increasingly susceptible to poverty (Garfinkel & McLanahan, 1986). Diana Pearce (1978) first called attention to the economic barriers women face when she coined the phrase “feminization of poverty”. Pearce (1978) found that almost two-thirds of the poor over age 16 were women. Despite the fact that more women had entered the labor force during these years, an overall decline in economic status of women from 1950 to the mid-1970s had occurred. This trend has not changed, even though the total number of female-headed families jumped from 3 million in 1970 to 10 million in 2000 (Dalaker, 2000). The 2000 Census shows that single parent families headed by women are far more
likely to experience poverty than those headed by men (34 percent as compared to 16 percent respectively). When race and female headed families are examined it becomes clear that women belonging to minority groups are even more susceptible to poverty with 39% of African American, 37% of Hispanic, and 22% of White female headed households living below the poverty line in 2000 (Dalaker, 2000). These facts exemplify how gender and poverty are located at the macrosystem level on the ecological model. In order to understand women and poverty better, we must explore factors at specific levels of the ecological model.

In addition to the fact that there are more single mothers than ever before, single mothers often experience poverty due to the multiple barriers they face. Some of these barriers are: physical and mental health concerns, lack of affordable quality childcare, unreliable transportation, lack of social support, community issues and family of origin experiences (Edin & Lein, 1997, Richards, et al., 1999; Seccombe et al., 1998.). This is not an exhaustive list of barriers experienced by rural poor women, but they frequently emerge in previous research. These factors will be explored in greater detail in the following section to provide a more complete understanding of the importance of each.
Health

Having health issues in a rural setting may cause a great deal of financial strain and stress on families with limited resources. Health issues range from lack of available services, lack of insurance coverage, and lack of providers who accept Medicaid. In a study of 14 women from in a pilot study of rural low income families Richards et al. (1999) found that, on average, participants each reported five health problems for themselves, six for their male partners, and three for their children. Health problems of adults included cancer, allergies, high blood pressure, smoking, digestive problems, and diabetes. Common health conditions for the children included allergies, asthma, ADHS, ear infections, and chronic colds, flus, and sinus problems. These numbers were especially alarming considering that the average age of study participants was 29 years.

In another study, among 47 women receiving cash assistance, one-third reported health problems such as back pain, asthma, and depression (Seccombe et al., 1998). The children in the study also experienced a high incidence of ailments such as asthma or lead paint poisoning. Thus, it becomes clear that low income families need medical care available in their communities (Seccombe et al., 1998).

Many rural areas, however, lack sufficient resources in regard to health care. Findeis et al. (2001) found that health care is limited in rural areas, with
fewer adults and children having health insurance than in other areas. In another study, Fletcher et al. (2000) found that many low income families in rural areas had to travel as far as 75 miles one way to receive routine medical and dental procedures, with entire counties not accepting Medicaid. Of those that do accept Medicaid, services may only be available on certain days, further limiting access to individuals in rural areas (Fletcher et al., 2000).

Mental health

Similar to health care issues, mental health is often a common concern for those living in rural poverty. A study of 500 uninsured, low income patients in Colorado found that they were twice as likely to have psychiatric disorders as compared to the general population (Mauksch, Tucker, Katon, Russo, Cameron, Walker, & Spitzer, 2001). Additionally, the patients exhibited lower levels of functioning, increased disability days, and increased overall physician’s visits.

A particularly large barrier particularly for low income rural residents is the high cost of medications and treatment. Of rural residents who have insurance, many do not have comprehensive coverage as compared to their urban counterparts. Thus, treatment such as psychotherapy is often not affordable for to rural residents (Budetti, Duchon, Schoen, & Shikles, 1999).

Access to inpatient care for the severely mentally ill is also low in rural areas. Hospitals are often the only place for a person to receive general care,
and many facilities are located a great distance away from rural communities. Drug and alcohol rehabilitation services are also limited in rural areas, which cause many individuals to be released having had little treatment (NIMH, 2000).

Childcare

Perhaps one of the largest barriers for families, particularly those with limited resources, is the availability and overall cost of childcare. For families in rural areas, access to regulated childcare is minimal (Findeis et al., 2001). Childcare centers with trained professionals are a rarity in most rural areas, forcing individuals to use informal settings instead. Many low income families rely on relatives and friends for childcare either because formal childcare does not exist or the cost is high (Findeis et al., 2001; Richards et al., 2001).

In addition to the lack of formal childcare in rural areas, the cost is often a significant barrier to many low income families as well. Formal childcare is often so expensive that many families are unable to afford it and are forced to choose affordability instead of quality. Seccombe et al. (1998) found that women were concerned about their child’s safety in low cost settings, but the cost of quality childcare made employment near impossible.

Additionally, childcare facilities rarely accept infants nor are they typically open during the second or third shift (Fletcher et al., 2000). This presents a dilemma for mothers who work in the service sector, which is
typical of many low income families (Findeis et al., 2001). Distance is also an issue Emlen (1991) found that rural families travel longer distances than their urban counterparts to receive childcare. With few transportation choices for rural low income families, it becomes apparent that barriers can become compounded.

**Transportation**

One common difficulty in rural areas is access and availability of transportation. Rucker (1994) found that 40% of rural residents live in areas with no form of public transportation and another 28% live in areas with low access. According to the Federal Highway Administration (1995) nearly 80% of rural counties have no city bus system compared to 2% of metropolitan counties.

Since public transportation is often a rarity, access to personal transportation becomes necessary. Many rural residents drive greater distances than their urban counterparts in order to get to work, the store, and to drop children off at childcare (Weber & Duncan, 1996). Personal transportation in the form of a vehicle can be extremely expensive, while walking or riding a bicycle can be time consuming (Weber & Duncan, 1996). In rural areas, if public transportation is available, it is only for a short amount of time (Richards et al., 1999). Many individuals at the bottom of the pay scale work outside of the regular shift, making the use of any existing public
transportation impossible. Ultimately, the ownership of a reliable vehicle is truly essential in rural areas.

The cost of owning a personal vehicle can however be extremely expensive. Car payments and insurance premiums are a financial burden for many low income families. This, coupled with the occasional cost of maintenance and the high price of gasoline, can be a strain on any budget. Seccombe et al. (1998) discovered that the women in their study who did have cars, many were constantly repairing them. Several women associated the constant cost of car repairs with actually keeping them poor.

Social Support

Social support can be difficult to measure, but is typically related to the number of friends or relatives with whom someone is involved, as well as membership in any groups in the community (Unger & Powell, 1980). In many rural areas social networks are smaller and more integrated compared to urban locations (Findeis, et al., 2001). Social support is often considered a buffer to negative life events, ultimately leading to higher levels of overall well being (Belle, 1982). In her renowned account of 43 Boston area low income families, Belle (1982) found that low income women with a great deal of social networks reported more emergency child care options as well as the existence of a confidant in which they could share their feelings.
Although in many ways social support can be beneficial, it can also come at a price. Reciprocity is often expected, which can result in a great deal of stress if unfulfilled (Belle, 1982; Belle, 1994). Belle (1982) also found that social support was not always beneficial, but instead caused stress among low income women. From this, she emphasized the importance of viewing social support from both positive and negative standpoints. For many low income women, the individuals who provide social support are often in similar economic situations and therefore have little to share. Thus, feelings of resentment and anger were common among Belle’s participants.

Family of origin

Looking at family of origin experiences from the exosystem level allows us to understand the whole individual. Examining family of origin experiences including family violence and abuse is important information because these experiences can ultimately shape how a person develops. Rosenberg and Fenley (1991) found that violence in one’s family of origin is predictive of violence in one’s family of procreation. Thus, knowing about abuse that occurred in an individual’s past is important when studying them in the present. Experiences with family of origin have also been shown to shape a variety of characteristics within a person such as motivation, achievement strategies, and coping styles (NIMH, 2000).
Since some types of depression have been biologically linked (NIMH, 2000), this too can give insight into the lives of participants in the study. Poor contact with parents and an emotionally “cold upbringing” (lacking in nurturing and attention to needs) have been found to be risk factors in experiencing depression (DepNet, 2002). Adults who are currently depressed are approximately ten times more likely to recall a “cold” upbringing than their healthy counterparts. It should be noted that the same individuals report their upbringing in the same way once they are healthy as well. Thus, the claim that persons who are depressed recall things differently may not always be accurate.

Depression

Throughout history, depression has been recorded as a mental health problem. Because depression affects such a wide array of individuals it has been described as “the common cold of mental illness” (Lickey & Gordon, 1991). Women, for many reasons, are more susceptible to depression than men (Formanek & Gurian, 1987; Nolen-Hoeksema, 1990; Stoppard, 2000). It has been estimated that 26% of American women and 12% of American men are depressed in any given year, with the disparity found across ethnic groups including African Americans, Latinos, and Caucasians (Sprock & Yoder, 1997). Minority women, however, are often found to be at higher risk for depression due to higher rates of poverty and other factors such as
discrimination (McGrath, Keita, Strickland, & Russo, 1990). The gender gap between women and men could be as much as 3 to 1 respectively, but has more commonly been reported as a 2 to 1 difference (Stoppard, 2000). The large disparity in numbers often brings up the question; why are there more women than men diagnosed with depression? Although there are a variety of factors that contribute to these numbers, it is beneficial to examine this disparity.

It has been proposed that men deal with depression differently, thus the large disparity is nonexistent. One theory common in research is the claim that men are less willing to share their feelings with mental health professionals than women (Nolen-Hoeksema, 1990). Despite the fact that women do tend to visit mental health professionals more often than men, research supports the theory that an actual disparity still exists (Simonds, 2001). King and Buchwald (1982) found men to be equally willing to share their feelings with an interviewer, while both sexes were not comfortable sharing the same information with the public. Two years later this study was replicated by Bryson and Pilon (1984) with the same results.

A more likely reason for the large disparity of depression seen between men and women is explained by substance abuse, with men being twice as likely to be diagnosed as alcoholics. Research has also shown that depression and alcoholism are genetically linked to women and men respectively. Also,
many men that are diagnosed as alcoholics are often considered depressed (Petty & Nasrallah, 1981). Thus depression becomes even more complex.

Many factors are thought to contribute to the large number of women who experience depression. Some explanations are biologically based while others are explained environmentally and socially. Although it is difficult to determine the ultimate “cause” of depression, many factors have been identified as links.

**Biological factors.** Biology has been the main explanation for the existence of depression for years. Mood changes and reproductive health events in women have been noted for years, with the gender gap being most prominent during female reproductive years. Key times for depression in women include premenstrual, pre and postpartum, and premenopausal. Also, differences in thyroid function, serotonin levels, and estrogen may also contribute to women experiencing depression more than men (NIMH, 2000).

Many researchers report that gender differences in depression exist between men and women across different cultures, emphasizing the role of biology (Nolen-Hoeksema, 1990). A great deal of research has been done in this area, with recent reports regarding biology as a predisposition or vulnerability to depression, but not being the only indicator. Further, it is believed that individuals biologically predisposed to depression are likely to
experience it only when triggered by environmental or social factors (NIMH, 2000).

*Genetics.* Family history of depression makes an individual more likely to experience it themselves (NIMH, 2000). Of persons with depression, the chances of their children also experiencing depression is 25% greater, with female relatives being more susceptible.

Since individuals who develop depression do not always have a family history of it and those who do have a family history of depression do not always experience it, the question turns next to what other factors are possible contributors. Researchers have spent a great deal of time attempting to answer this question, ultimately turning to psychosocial explanations such as environmental, social, and interpersonal factors as triggers (Bromberger, 1999).

*Psychosocial factors.* Many psychosocial factors may also contribute to an individual’s likelihood of developing depression (Bromberger, 1999). Personal attributes such as low self-esteem, a sense of having little control over life events, and excessive worrying are considered potential risk factors toward depression (NIMH, 2000). Women may also be more likely than men to experience the stress of multiple work and family obligations. Women may also experience sex discrimination in the community and in the workplace (Nolen-Hoeksema, 1990).
Physical, sexual, and emotional abuse may also contribute to a person’s likelihood of experiencing depression (McGrath, 1990). The rate of sexual and physical abuse among women is extremely high. Therefore, depressive symptoms are possibly post-traumatic stress associated with abuse experienced in the past (McGrath, 1990). In addition, a great deal of research has been devoted to examining other factors that may contribute to depression. Significant loss, difficult relationships, low levels of social support, and poverty has all been linked to depression (NIMH, 2000).

In closing, it is clear that determining the etiology of depression is a daunting task that goes beyond the possibilities of almost any research study. However, it is clear that biology alone is an insufficient explanation. Rather, depression can be triggered by a variety of factors such as significant loss, lack of control over life events, and experiencing poverty. We can now examine how poverty and depression are connected for women living in rural America.

**Bridging Poverty and Depression**

Since stress has been thought to activate depression in many individuals, it is not surprising that poverty is considered a common trigger. Andrew Solomon (2001) poignantly states, “checking depression among the indigent is like checking for emphysema among coal miners” (p. 347). Economic problems and lower socioeconomic status have been linked to high levels of depressive symptoms in many research studies (Belle, 1982;
Makosky, 1982; Moore, 2001; Simonds, 2001). At the time of his study, Solomon (2001) reported that while 13.7% of Americans live below the poverty line, 42% of the heads of households receiving Aid to Families with Dependent Children (AFDC) met the criteria for clinical depression. Since approximately one-third of single parent families (85% of whom are female headed) are poor (Seccombe, 2000), it becomes clear that this is a problematic issue for women in particular.

Kaplan, Roberts, Camacho, and Coyne (1987) conducted a nine year longitudinal study assessing depressive symptoms in the community. Inadequate income, job loss, and general money problems were associated with an elevated risk of depressive symptoms. One explanation for this association was that inadequate income over time created a great deal of personal uncertainty, isolation, and frequent experiences of negative life events (Kaplan et al., 1987).

Ahluwalie, McGroder, Zaslow, and Hair (2001) examined five experimental evaluations of welfare-to-work programs that were designed in response to the 1996 Welfare Reform. A self administered survey was used to determine if participants expressed depressive symptoms. They found these individuals scored much higher than the general population on a depression index. Of individuals that were currently receiving public assistance 30% to 45% had symptoms of depression, compared to 20% of the general population.
Many research studies have examined the issue of stigma and how it affects individuals in poverty who receive government assistance. In one study, Popkin (1990) interviewed 149 Aid to Families with Dependent Children (AFDC) recipients about self-efficacy. Two-thirds of the respondents felt that receiving assistance had negatively affected their families (Popkin, 1990). Both parents and children experienced feelings of depression and shame (Popkin, 1990). In a similar study Seccombe, James, and Battle Walters (1998) found that among 47 women who received cash assistance, most were aware of the stigma associated with welfare. The women realized that others viewed them as lazy and suspicious, but justified their situations by describing personal barriers.

Similarly, three focus groups of AFDC recipients revealed that all participants wanted to get off of assistance because it felt degrading (Davis & Hagen, 1996). Many of the women expressed concerns for their children having to use free lunch tickets, which was an experience they compared to the humiliation of using food stamps. Furthermore, Seccombe et al. (1998) found that the women in their study were able to differentiate themselves from other AFDC recipients. They viewed other women as lazy and unmotivated, while explaining their own situations as out of their control.

Women living in rural areas face many barriers to employment and economic self-sufficiency, while also finding access to services far from
superior. These barriers range in degree of difficulty, but include health,
mental health, childcare, transportation, social support, and family of origin.

This purpose of this study is to understand the lives of women living in rural
poverty and uncover what factors are related to depression among the
participants.
CHAPTER THREE

METHODS

Study Design

After significant changes in welfare policies, 448 women with children were interviewed to better understand how they are managing living in rural poverty over time. Researchers from universities with Agricultural Experimental Stations (AES) formed the NC-223 regional research project. In the first year of data collection, 15 states participated including: California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, Ohio, Oregon, Virginia, and Wyoming. In 1998, the multi-state group met to create the procedures and protocols for the project. One year later, pilot data were collected and aspects of the procedures and methods were refined. This study used a sub-sample (117 for quantitative and 40 for qualitative) from Wave I data collected in 2000/2001 for the NC-223 project.

Rural families living in poverty are not one-dimensional, thus qualitative and quantitative data were collected. This method of triangulation allows more depth in understanding the experiences of rural families living in poverty. Quantitative data and qualitative data complement each other and permit a more intense portrayal of poverty in rural areas.
Community Selection

The recruitment of the original participants was based on rural-urban continuum county codes developed by Butler and Beale (1994). Counties are classified on a continuum of zero to nine, based on 1993 definitions of metropolitan and nonmetropolitan counties. A score of nine indicates that the county is completely rural or has fewer than 2,500 urban population and is not adjacent to a metropolitan area. For the purposes of the NC-223 project, participants were recruited from counties that scored a six or a seven, an urban population of 2,500 to 19,999 that is adjacent to a metropolitan area or an urban population of 2,500 to 19,999 that is not adjacent to a metropolitan area, respectively. The most rural counties were not selected in order to assure a sufficient sample, while also ensuring that those studied had some access to services. Due to the multiple barriers many rural families face and the increasing number of rural poor, it is imperative that their voices be heard.

Sample Recruitment

Project members of NC-223 first met and agreed that each state wishing to participate must recruit at least 30 participants. Due to the expenses associated with data collection, however, the amount was later adjusted with a minimum of 20 participants required for participation. It was determined that this set minimum is a desirable, yet manageable, number for a long term
qualitative study without compromising the quantitative aspects of the research.

Qualifications were established in regard to participant recruitment. Because some of the interview questions concerned childcare arrangements which mothers were more likely to make than fathers, women eligible for food stamps and who had at least one child under the age of 12 at the time of recruitment were targeted. Women who received benefits from Women, Infants, and Children (WIC) or with incomes up to 200% of the federal poverty line also qualified for the study. Families were recruited through such organizations as Head Start, Adult and Family Services, and job training programs. In addition, the school system and word of mouth were also common forms of recruitment.

NC-223 Participants

Of the 448 persons recruited to participate, ethnicity is broken down as follows: 96 (21.4%) Hispanic/Latino, 40 (8.9%) African American, 286 (63.8%) Non-Hispanic White, 14 (3.1%) Multi-racial, 5 (1.1%) American Indian, and 1 (.2%) Asian. The number of children among participants ranged from 1 to 10, with a mean of 2.3. The total number of family members living in the home ranged from 2 to 11 persons, with a mean of 4.4. Mean education level among participants was high school degree or equivalent. Depression scores ranged from 0 to 53, with the mean 17.4 (SD=11.4). The Center for
Epidemiologic Studies Depression Scale (CES-D) was used to assess levels of depressive symptomology and is described in detail later in this chapter. Higher scores indicate an increased likelihood of experiencing depression.

**Study Participants**

Originally, 448 women with children participated in this study. The sample for this study was created through several steps. The traditional cut off for risk of depression on the CES-D is 16, many researchers have used alternative cut off points for their studies (Husaini, Neff, Harrington, Hughes, & Stone, 1980; Sears, Danda, & Evans, 1999). Since the lowest scores may be due to missing responses, SPSS was used to determine the respondents with missing cases. Cohen and Cohen (1983) suggest no more than 10% of the items making up a constructed variable should be missing. Using this guideline, each case was allowed only two missing items on the CES-D depression scale, thus 5.6% of the cases were dropped leaving 423 cases total.

Next, a means substitution was performed for the cases with two or fewer missing items. Frequencies were conducted in order to determine the number of individuals who scored below and above the designated cutoffs on the CES-D. It was found that 15% (n = 58) of respondents scored 6.25 and below, while 15% (n = 59) scored 30 and over, with the combined pool of eligible participants equaling 117 total. Individuals were randomly selected by counting every eighth case until 40 participants were gathered. All 117
individuals were not used for the qualitative analysis due to time constraints. However, for the purpose of quantitative analysis all 117 individuals were used in order to assure a strong sample and to increase power.

Demographics

Of the 40 participants selected for the qualitative aspect of the study 6 (15%) were Hispanic/Latino, 4 (10%) were African American, 25 (62.5%) were Non-Hispanic/White, 4 (10%) were Multi-racial, and 1 (2.5%) was American Indian. Number of children among selected participants ranged from 1 to 5, with a mean of 2.3 children. Total number of family members ranged from 2 to 9, with a mean of 4.6 family members. Education level ranged from some high school to a graduate degree. The average education among the sub sample is between a high school/GED and a specialized technical, business, or vocational training. Finally, the depression scores on the low end ranged from 0 to 6 with a mean of 3.5 among participants. The depression scores on the high end ranged from 30 to 53, with a mean of 38 among the sub-sample. Demographic information comparing the overall sample (n=448) and the sub-sample (n=40) is summarized in Table 1.
Table 1. Demographic Characteristics of Overall Sample and Sub-sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall Sample</th>
<th>Sub-sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 448</td>
<td>n = 40</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>96 (21.6%)</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>African American</td>
<td>40 (8.9%)</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>286 (63.8%)</td>
<td>25 (62.5%)</td>
</tr>
<tr>
<td>Multi-Ethnic</td>
<td>14 (3.1%)</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>American Indian</td>
<td>5 (1.1%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Number of Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>1-10</td>
<td>1-5</td>
</tr>
<tr>
<td>Mean</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Total Number of Family Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2-11</td>
<td>2-9</td>
</tr>
<tr>
<td>Mean</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th Grade or less</td>
<td>0</td>
<td>51 (11.4%)</td>
</tr>
<tr>
<td>Some high school</td>
<td></td>
<td>98 (21.9%)</td>
</tr>
<tr>
<td>High school/GED</td>
<td>120 (26.8%)</td>
<td>12 (30%)</td>
</tr>
<tr>
<td>Specialized technical, business, vocational</td>
<td>58 (12.9%)</td>
<td>8 (20%)</td>
</tr>
<tr>
<td>Some college, including Associate’s Degree</td>
<td>104 (23.2%)</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>College or university graduate</td>
<td>12 (2.7%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>3 (.7%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>119 (26.6%)</td>
<td>12 (30%)</td>
</tr>
<tr>
<td>Married</td>
<td>204 (45.5%)</td>
<td>17 (42.5%)</td>
</tr>
<tr>
<td>Living with Partner</td>
<td>57 (12.7%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>68 (15.2%)</td>
<td>8 (20%)</td>
</tr>
<tr>
<td>Depression Scores—Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>N/A</td>
<td>0-6</td>
</tr>
<tr>
<td>Mean</td>
<td>N/A</td>
<td>3.5</td>
</tr>
<tr>
<td>Depression Scores—High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>N/A</td>
<td>30-53</td>
</tr>
<tr>
<td>Mean</td>
<td>N/A</td>
<td>38</td>
</tr>
</tbody>
</table>
Procedure

All 15 states collected data on common variables and state specific issues. Participants will be revisited each year for three years in order to maintain the longitudinal data set. Each year certain aspects of the interview content will change to avoid redundancy. The data from Year 1/Wave 1 are included in this analysis since it is the first year of complete data. The project has completed its second wave of coding and data entry and analysis and its third wave of data collection.

Ethics and Compensation

Participants were assured confidentiality and given the right to refuse or terminate participation. Each research team had approval from their university's own Institutional Review Board. Participants signed an informed consent form providing information on confidentiality, the right to terminate participation, and contact information. A copy of the Oregon Informed Consent is located in Appendix B. Any written materials were provided in both English and Spanish. Participants were also able to choose the language (English or Spanish) in which they preferred the interview to be conducted.

Interview Procedure

The interviews were conducted at a location of the participants choosing (e.g. home or community facility). Many of the questions were open-ended to allow interviewees the freedom to express themselves as much
or as little as they felt comfortable. Survey measures were incorporated into
the format of the interview to obtain information about a variety of
demographic characteristics and other outcome measures.

In recognition of the time and effort involved in being in a research
study, participants received compensation that varied by state. For example, in
Oregon, families were given books or school supplies for their children and a
gift certificate to a local store. To protect the identities of each participant,
pseudonyms were used and all identifying details were changed.

Measures

*CES-D Scale.* Each participant’s mental health was measured with the
Center for Epidemiologic Studies Depression (CES-D) Scale. The CES-D
depression scale measure consists of 20 statements rated on a four point likert
scale and was developed for population surveys at the National Institute of
Mental Health to assess various levels of depressive symptomology (Radloff,
1977). To make the measure “user friendly” we re-titled it “Feelings About
How Things are Going.” The respondents were asked to rate how frequently
depressive symptoms were experienced over the past week. Major
components that are represented are feelings of guilt, worthlessness,
helplessness, and despair. Example questions are: “I felt that everything I did
was an effort” and “I had trouble keeping my mind on what I was doing.”
Choices available to respondents were: 1) rarely or none of the time, 2) a little
of the time, 3) a moderate amount of the time, or 4) most or all of the time. A copy of the CES-D ("Feelings About How Things are Going") can be found in Appendix B. It should be noted that scores above 16 indicate that an individual is susceptible to experiencing depression, but should not be considered a clinical diagnosis (Radloff, 1977).

Health Surveys. Data were collected for both adults and children about their health issues. For the adult health survey mothers were asked to report on both their own health problems and those of their partner (if applicable). Child health surveys were completed for each child in the family. Both surveys have a checklist of illnesses and conditions that range from allergies and fatigue to heart problems and depression. A space on the list is provided for the respondent to mention other health concerns not on the list. Both surveys also ask information regarding medical and dental insurance, number of times each family member has visited a doctor or dentist in the past year, and the number of days of work or school missed due to an injury or illness. The health surveys can be seen in Appendix C.

Parenting Ladder. The Oregon State University Family Policy Program, for statewide evaluation of the Healthy Start Program, constructed the "Parenting Ladder". The measure is divided into two sections, one a self-assessment of parenting confidence and the other self-perceived level of parenting support. For example, one item on the parenting confidence half
asks parents, “where would you place yourself on the parenting ladder in terms of the ability to cope with the stress in your life?” An example of the self-perceived level of parenting support section asks parents; “parenting is often smoother when others are there to help, here would you put yourself on the parenting ladder in terms of other parents for you to talk to?” Parents rate themselves on a six-point scale, which appears as a ladder, for each item ranging from low (0) to medium (3) or high (6). One item on the ladder (the amount of stress in your life right now) is reverse coded. Cronbach’s alpha for this scale is .85. A copy of the “parenting ladder” is in Appendix D.

**Other Questions.** Participants were asked about a variety of issues during Wave I data collection. Topics included household composition, employment status, source of income, work history, knowledge and perception of welfare, community, housing, transportation, childcare, family of origin, well being, levels of education and training, life skills, parenting, and social support networks. The triangulation approach was used in that similar subject qualitative and quantitative questions were asked of each respondent. For example, in addition to the CES-D (“Feelings About How Things Are Going”) measure, other questions pertaining to family well being were covered. Questions such as, “tell me about a typical day?” and “overall, how would you say things are going for your family right now?” were asked of each respondent. A complete copy of the interview protocol is in Appendix E.
Coding Procedure

All 15 states were responsible for collecting and transcribing the data for analysis. The coding was done based on grounded theory principles in that thematic content throughout the interview were considered regardless of where the topics occurred (Glaser & Straus, 1967). Each state sent transcribed data to Oregon State University, the central coding point. Under the direction of Dr. Leslie Richards, a coding scheme was created which consisted of 18 general codes. Codes relevant to this study are health, mental health, childcare, transportation, community, social support, and family of origin. A copy of the coding scheme can be found in Appendix F. Inter-rater reliabilities for Wave 1, calculated on approximately 5% of the interviews ranged from .75 to .93, with an average of .86. Finally, WinMax, a computer-assisted qualitative analysis program, was used to assist with data management, transfer, and analysis.

Because of the demonstrated link between ethnicity and depression (Brown, Schulberg, & Madonia, 1996) I examined the ethnic distribution of participants in the high and low depression categories. Although the numbers are too small for statistical comparison, it appears that, ethnicity and depression scores are unrelated in this small sample of 40. Table 2, shows a summary of depression scores among each ethnic group represented in this study.
Table 2: Ethnicity and Depression Score Comparison

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>≤6.25 (percent)</th>
<th>≥30 (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>3 (7.5)</td>
<td>3 (7.5)</td>
</tr>
<tr>
<td>African American</td>
<td>2 (5)</td>
<td>2 (5)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>13 (32.5)</td>
<td>12 (30)</td>
</tr>
<tr>
<td>Multi Ethnic</td>
<td>2 (5)</td>
<td>2 (5)</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>1 (2.5)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20 (50)</strong></td>
<td><strong>20 (50)</strong></td>
</tr>
</tbody>
</table>

Data Analysis

Qualitative Analysis

Coded segments relating to health, mental health, childcare, transportation, community, social support, and family of origin were examined and further sub-coded. Sub-coding occurred as suggested by Lofland and Lofland (1995) and Berg (1995). Key words were used to identify themes within each category and allowed the data to be labeled, separated, and organized. Based upon themes that emerged from reading the coded segments from each category multiple times, a more sophisticated coding strategy was developed. This ultimately ensured that the sub-coding was done in a regular and systematic manner. After sub-codes were created, each segment was coded appropriately. A list of the sub-codes is seen in Appendix G. Coded segments were not separated into the low risk and high risk groups until after the coding was completed. For clarification purposes, the original interviews
were referred to in several cases. To explain, in some cases the coded segments were out of context and needed explanation which the transcript provided.

Quantitative Analyses

Quantitative data analyses were conducted in two ways: similar to past findings in the literature and the results of the qualitative research indicated. First, health profiles were compiled for each participant. The profile indicated types and number of health problems among the participants and their families. It also shows the last time that they visited the doctor and if they have health insurance. Independent Sample T-test comparisons compared variables in the total high and low groups (n = 117) with respect to number of health problems, number of children, number of family members, education level, marital status, number of times participants visited the doctor in the last year, participants work status, childhood mobility, parental welfare use, food insecurity, perceived adequacy of income, and total monthly income. T-tests conducted in response to the qualitative results included: amount of support, overall satisfaction of life, number of health conditions for participants, number of health conditions for partners, and total number of health conditions for all children in the household. Green, Salkind, and Akey (2000) recommended using t-tests instead of ANOVA's because it allows the researcher to define a grouping variable using a cut point. In this study, all of the low risk
individuals comprised group 1 while the high risk group members comprised group 2. Also, using a dichotomized variable is beneficial when the groups that are defined by the cut-off point have a meaning beyond just the score (Green, Salkind, & Akey, 2000). A prime example of this is using scores from the CES-D to indicate participant likelihood toward depression. For increased power all 117 eligible participants were used in the quantitative data analysis rather than only the 40 randomly selected for the qualitative portion of the study.

Themes in Qualitative Data

In presenting the data, I have used the exact quotes of participants, without correcting for word choice or grammar. On occasion, I have edited certain quotes for readability by reducing the number of “false starts”, or, sentences that begin but are not finished. Clarifying information was also added when necessary by the use of parentheses. All names of the participants, partners, and children have been changed in order to ensure confidentiality. Assigned pseudonyms will be maintained throughout the paper for consistency. Other identifiable characteristics such as names of towns, institutions, and business have been altered or omitted. The quotes used were chosen to be most representative for as many voices as possible and to best illustrate the theme under discussion.
CHAPTER 4

RESULTS

The results of the qualitative data are both interesting and revealing. No differences were observed among the participant’s reports of child care, transportation, and community. Childcare and transportation were barriers for both groups in regard to accessibility, affordability, and quality. Most respondents had childcare and transportation arrangements, but found at times they were difficult to maintain. Community was described as either positive or negative by mothers who had low and high depression scores. Many respondents in both groups reported feeling unsafe in their community, while others stated the quiet solitude of rural living was beneficial.

Although similarities may be informative, the differences are the focus of this study and are equally as telling. Large differences were noted between the low risk and high risk groups in regard to reports of mental health and health conditions among themselves and their immediate family. Differences were observed between the low risk and high risk groups with regard to their family of origin experiences, both past and present. Perhaps the largest differences, however, were revealed when participants from either group spoke of the social support they received from family members and friends and what that meant for their current relationships with these people. To clarify, none of the individuals in the low risk group reported ambivalence with family
members or the expectation of repaying their debts. The high risk group, however, commonly spoke of having ambivalent relationships with those who provided frequent social support, having no friends to rely on or have fun with, and feeling that they were a burden to their families in general. For consistency, each section will begin with the low risk group assessment and will then discuss the high risk group.

Mental Health

Large differences were seen between the frequency and severity of mental health issues discussed by those in the low risk group compared to the high risk group. Only three individuals out of twenty in the low risk group reported anything in regard to mental health. Furthermore, of those three, one was a brief statement on an undiagnosed condition and another was about the mental health of the respondents' brother. This is not surprising, given that depression is a mental health issue. In contrast, most individuals in the high risk group reported mental health issues within their immediate family, with the majority being personally affected. In fact, 14 women in the high risk group reported personally experiencing mental health issues, with 8 taking medication for their ailments. In addition, five women said their children also have mental health problems.
Low Risk—Mental Health.

As mentioned above, only three individuals spoke of mental health issues as a part of their lives. Jolie described the years she spent worrying about her brother who was addicted to drugs for many years. She said, “I would try to carry the burden of my brother. And now he’s, he’s been gone a year, so it’s, it’s like, wow. It’s different.” Jolie is also the primary caregiver for her father who has had severe alcoholism for the majority of his life. He stopped drinking only because he had to have stomach surgery. She described the stress her family experienced during the surgery her father underwent by stating, “Cause I almost, I mean it was stressful on me, and my job, and my kids to see him like that. To where my brother wouldn’t even go see him cause he was so scared for him.”

Another respondent in the low risk group, Kellan, spoke of her three children who she described as having “level 1” behavioral problems. Although the behavioral problems were quite severe, Kellan spoke of having a Personal Care Attendant (PCA) who visited three times a week. The PCA assisted with daily activities and encouraged the children to do homework. She described the benefits of this by stating, “Yes, I just love it. A tremendous help. Cause I just was drowning before she came. You know, I’d be working all day, I come home pretty much exhausted. And then I’d have to start my second job.” This
indicates that although her family experienced issues with mental health, they also received a great deal of assistance.

High Risk—Mental Health.

The majority of high risk individuals spoke of mental health issues involving themselves or their immediate family. In most cases, multiple mental health problems existed for each family including the respondent, her children and her partner. Eleven respondents discussed being on antidepressants or having a clinical diagnosis such as depression or other mental illnesses. Three were on disability as a result. Other respondents reported anxiety or anger issues within their immediate family. It should also be noted that many respondents also spoke of substance abuse issues among their immediate family, which we considered to be a mental health issue.

Isabel, a mother who had substance abuse issues in her past, reported a great deal of mental health problems within her family. She and her son both struggle daily, with work being impossible for her. She describes her situation eloquently:

I think the depression and the whole host of problems that come with depression just affects our quality of life. You know, the ability to function on a daily basis, um, for me and for my fourteen year old son. Um, you know, it’s heartbreaking to watch him suffering through some of the stuff I suffer through. And as much as I’ve tried to protect him from my problems, you know, they’re all tied together.
Keely describes her depression as severe enough that getting out of bed is often difficult. When asked if she would like to get a job she states, “Yeah, I would like to have a job. And a lot of it’s my depression that keeps me in bed and not getting up and going out there. And I have no self-esteem any more.”

Another respondent, Joan spoke of how her depression affected her day to day life and ability to interact with her children. She shared,

I’m not able to have my daughters all the time. They stay quite a bit at my brother’s house. Because of the kids fighting and arguing which causes a lot of stress. They are trying to figure out the right kind of medicine for me. It makes you feel groggy and want to sleep a lot. It affects me keeping up with the house and keeping the bills straight, trying to keep up with the house.

Finally Keri, diagnosed as bipolar with psychotic features, described how her illness scared her due to past attempts at suicide. When asked to describe a typical day, Keri responded,

This is going to be hard on me because typical days, I don’t have typical days. I suffer from mental illness. I have times where I could go to bed at eight o’clock at night and sleep ‘til twelve the next day. Then I have, like the night before last I didn’t go to bed until one o’clock in the morning and I was up until two thirty trying to go to sleep. Lying in bed.

Health

Both low risk and high risk groups reported having difficulty paying for medical expenses such as insurance premiums or co-payments for doctor’s visits. Furthermore, both groups spoke of the lack of local access to medical and dental services. The differences seen between the low risk and high risk
groups in regard to health conditions, however, were profound. Although the individuals in the low risk group reported health problems, it was commonly among family of origin rather than in their immediate families or consisted of fewer and less severe conditions. High risk respondents spoke in more detail of their own serious health issues or of their immediate family and often reported multiple or more severe conditions. To illustrate, the average number of health conditions per family among the low risk group was 9, while the high risk group’s average was 16 per family. Of the low risk group 6 reported that one member of their family had experienced a major health issue in the last year, while 13 in the high risk group reported such.

Low Risk—Health.

Individuals in the low risk group reported that the cost and access to health care were their largest barriers in this area. The health problems they did report were often among family of origin rather than in their immediate families. Furthermore, the low risk respondents reported fewer conditions overall and their health conditions were typically less severe. To clarify, if an immediate family member had a health issue, it was a relatively common ailment. Also, it was unusual for a respondent in the low risk group to identify multiple conditions that would be considered severe in total.
Cost and Access Issues. Cost of health care is often an issue for individuals. Belle, spoke about a time when she couldn’t go to the doctor due to the expense. She states,

My kids, I know, they’re covered, health insurance wise. But mainly it’s hard for me and my husband. Because there are times when I am not able to go to the doctor just because we couldn’t afford it. I think that’s the hardest part, not having us covered because I worry that what if something happens to me or to my husband. If we go to the doctor we could end up with some outrageous bill. That would put us much more behind.

Magdalena explains the confusion of different insurance programs.

She explains the different plans her family members are on by stating,

I get Blue Cross for myself and my spouse. But my children are on a program for Healthy Families. And compared to the Blue Cross, you pay 30 dollars a visit and your doctor’s office is like 40 dollars. So when I started on Healthy Families it [referring to copay] was eliminated

When asked what the worst thing about living in her community, Harriet states,

Being a little bit isolated from ah, some of the benefits of the bigger city. Like, with my daughter’s surgery, we had to drive clear to [nearest large city] and stay there while she had her surgery. Just not having instant access to specialists and that kind of thing.”

Health Issues among Family. Many respondents spoke of their family of origin when asked about the health of their family. One such respondent, Nellie, said that her immediate family had not experienced many health problems in the past year. She then turned to talk about her parents by saying,
"My dad was disabled most of the time I was growing up, so both of my parents were usually at home. My mom later on developed diabetes and lost her eyesight. Not totally. She could see like shadows and things."

Raven, whose children are on Medicaid, had what she described were basic health problems ranging from strep throat to the common cold. She shared one traumatic event for her youngest daughter by saying, "It's highly serious to her, she has like a wart on her arm and she can't be beautiful in the first grade. So we've had to go twice to get that removed." When asked if she had medical debt she joked about it by stating, "Well, I paid off two kids, so I guess I would say yes. Actually I had to pay in advance... The bills are paid off. The kids are mine. I got their birth certificates, I guess that's the title, isn't it?"

Belle spoke mostly of her parents' health and the general family medical history. When asked if any of the people in her household had health problems, she responded,

Not that I can think of. Just, I think, one of the hard ones is dental. Because that's one of those things where I know it's very important to get that checked up on. And I'm one of those people that wants to make sure everybody else gets taken care of before me. I think that's probably the hardest, because it's important.

Access to services was a commonly discussed subject among low risk individuals. Eve, spoke of the frustration she felt in regard to access to health services in her small rural community. She described one particular situation
by saying, “and the medical care, his pediatrician is in Pleasantville and with
gas prices you have to run to...because I have him a pediatrician because he
has asthma. And it’s hard when you have to run up there, but we pretty much
have his asthma under control, I hope.”

High Risk—Health

Similar to the low risk group, the high risk group spoke of the high cost
and the lack of access to medical care in their rural communities. Unlike the
other group, however, the high risk group was much more likely to experience
severe medical problems within their immediate family. They were also much
more likely than the other group to experience multiple health problems of a
serious nature.

Cost and Access Issues. Many respondents spoke of the expense and
general lack of access to medical care that they experienced. Keri, spoke of
the issue of many doctors not accepting the medical state plan in her
community. This has forced her to travel great distances to receive routine
health care. Not only is this time consuming, but it is also very expensive.
She explains:

So I’m gonna have to be travelin’ to Garden Valley and with one
income the price of gas, the way it is right now, I mean you almost
need a bank loan to get gas. You know, I’m gonna have to travel to
Pleasantville to take my kids to the dentist and then there’s no
guarantee that the dentist is going to be able to see all four of them.
Maxine’s entire family has serious health problems including her son who was born prematurely and has an ongoing heart problem. Her daughter has chronic asthma, which requires constant medical attention as well. To add to the overall seriousness of her family’s health is the lack of access to services. She expands, “The only thing is, both of them [referring to her children], they won’t treat them here for her asthma, it’s chronic. We’ve got to go to the University Clinic an hour away. And with him and his heart murmur and his tubes, they won’t treat him here either.” To make matters worse, she does not have reliable transportation and must rely on friends or the community Medical Van to take her and her children to the doctor. She describes the situation:

At first I was getting people to take me, but then it got where they wouldn’t take me anymore. So I heard about the Medivan and they’ve taken me over there. Usually somebody else with appointments goes with you and you have to wait for hours after they’re out you’ve got to walk the floors of the clinic to keep them quiet. You’ve got to make sure you bring enough stuff to last you all day, cause you may be there all day, even if your appointment is only one hour.

Multiple Conditions Among Family. Beyond the high cost and frustration involved in having constant health care issues, are the multiple health issues themselves. Many individuals spoke of personally experiencing serious health conditions as well as among other family members or their family members. Paige, who is 28, experienced a variety of anger issues as an adolescent. She reported breaking her mother’s wrist and throwing a cutting
board at her mother’s partner. Her family has a variety of health conditions ranging in severity. Her son has seizures due to high fevers he had as a baby and her daughter has severe allergies that make it difficult for her to breathe. Paige was most troubled by her diagnosis of multiple sclerosis, but found that smoking marijuana was helpful to ease the pain she was experiencing. When asked more about her diagnosis of multiple sclerosis she bluntly states,

Yeah it has to do with your bones. Supposedly I’m supposed to be in a wheel chair, but whenever that happens, you won’t be seeing me around here because I will kill myself. There ain’t no way in hell I’m going to be walking around in a wheelchair. No, because when that happens, I’m gone.

*Inability to Work.* Severe health issues often meant that respondents were unable to work. Depending on the diagnosis, some respondents received disability benefits, while others could not. Joan, who was diagnosed with major depression, described her work issues by saying,

I’m on family medical leave act right now. I’ve been off work for about three months. I was working full-time at a hospital here in town. I got sick and I’ve been off work since July 1st. I went back part-time for a few weeks and got sick again. Then I had to be in the hospital again and I’m still recovering. Right now it’s tough.

Due to rheumatoid arthritis, Flora, who is 45, had hip replacement surgery and experienced problems in the months following. Her hip dislocated and additional surgery was needed. To make matters worse, she will need her other hip replaced in the near future. During her recovery Flora filled in as a hostess instead of her usual waitressing position, thus her income has suffered
since tips are much lower for a hostess. Her overall frustration was apparent when she responded to how things were going for her currently, “Um, kind of stressful, because of my health. I need some surgery done, and I’m just so tired, drained, you know, just not feeling like a healthy mom.” Flora then added, “God, I wish I didn’t have to have two hips, you know, two hip replacements, but I do. You know, I didn’t do anything, rheumatoid arthritis took over.”

Family of Origin

Family of origin was also an area in which differences were seen in regard to both past and current relationships. Although some individuals in the low risk group spoke of negative experiences as children, they were not as extreme and were most likely coupled with a positive current relationship with family of origin. To expand, seven individuals in the low risk group reported positive past relationships, nine reported neutral (considered average day-to-day experiences), and four described negative past relationships. Furthermore, 17 out of 20 women from this group reported that their current relationships were positive. In many ways the numbers in this group show a high level of positive relationships throughout their lives or reconciliation after childhood.

High risk individuals, however, were more likely to report severely negative experiences growing up as well as negative or ambivalent present relationships with family of origin. Among high risk participants, 15 reported
negative past experiences, 4 reporting neutral, and 1 positive. As for current relationships, 14 reported negative, 3 neutral, and 3 positive.

**Low Risk—Family of Origin**

The low risk group was not immune to negative or neutral family of origin experiences as they were growing up. In fact several individuals reported some amount of negative family of origin experiences in their past, but it was typically not as severe or was coupled with positive current relationships. Many more low risk respondents, however, reported both positive past and current relationships with family of origin than their high risk counterparts.

*Reconciliation with Family of Origin.* Some respondents in the low risk group recalled that their parents worked a great deal and were rarely at home to take care of them. Concettina, who had 12 siblings, spoke of how her mother would leave the children at home alone while she went to work. Although she said there was no law against this in Mexico, she doubted it would be legal in the United States. She explains, “She didn’t have a partner, she would work days and nights. She tried her best to feed us. Sometimes she would leave us alone. Here in America you can get in trouble.” Her current relationship, however, proves to be strong and positive. When asked about her contact with her family, most of whom are still in Mexico, she says, “Well, about three times, personally, but by phone I go get in touch daily.”
Perhaps the best example of reconciliation was from Magdalena whose father left when she was only four years old. At the age of 18 her father came back into her life and is currently living with her family. Although her father left her family when she was young, her mother remarried. She reported having a good childhood and a stepfather who was an important part of her life. She joked about a conversation she had with her own son, which clearly illustrates the theme of reconciliation. Magdalena explains, "Yeah I enjoy the fact that I can talk to my kids and, being able to be there for them. And now it's funny, because they say, 'Well, why do you take care of Grandpa? He left you.' And I say, well, see that's what we learn from."

In regard to the current relationship Lupe has with her mother in Puerto Rico, she states, "Yeah, I talk to my mom almost every other day. A couple times a week."

*Relationships Both Past & Present.* Of the respondents in the low risk group that reported positive past and present family of origin experiences, Raven best illustrates feelings of a carefree childhood. When asked what she remembers about growing up, she illustrates:

I guess what I remember is mom would shove us out the door at 8 o'clock in the morning and tell you not to come back until lunch. We basically had the run of the town. Everybody in town knew everybody's kids, everybody was safe. All the kids played together. Nobody ever worried about what happened to the kids or where the kids were. Somebody always knew. There was the parent phone chain. If one got lost, they just called somebody else and everybody knew
where they were or whatever. It’s not like it is today. You can’t just turn the kids loose today. Even if you could, somebody would tell on you and you’d get reported.

The respondent also spoke of her current relationships with family of origin as being positive. When asked how much contact she had with her family now, Raven said, “All the time. My mom lives right there in the brick house behind me. So every day.”

Monique also had a positive past and present relationship with her family of origin. When asked what she remembered about her childhood she responds, “Just going to school and playing with my friends and growing up with my brothers and doing things with mom and dad and vacations. Stuff like that.” Monique is the closest to her two brothers and mother. Her father travels a great deal for work yet she manages to speak with him weekly and the rest of her family daily. When asked what her relationship is like now with her family she states, “Good. Really close.”

High Risk—Family of Origin.

Similar to the low risk group, the high risk group reported negative past experiences with their family of origin. The difference, however, was seen in the severity and frequency with which it was reported. The high risk group was much more likely to report negative past experiences as a whole. Furthermore, the high risk group was also more likely to report negative
current relationships with family of origin in conjunction with negative past experiences.

*Lack of Reconciliation with Family of Origin.* The high risk respondents did not speak of reconciliation among family of origin. In fact, for many individuals who reported negative family of origin experiences as a child, little reconciliation had since occurred. One extreme case was the story of 32-year-old Keri. She recalled being abused physically, sexually, and emotionally by her alcoholic father, while her mother did nothing to save her. When asked what her relationship is like with her family currently, she said bluntly, “None. Don’t want to.” She even reported not being in contact with her brothers who she said helped her through the rough years growing up.

*Relationships Both Past & Present.* Possibly the most striking was the story of Sandra who openly shared her experiences as a child. When asked what it was like for her growing up, she said, “I lived with my mom and dad, I was the oldest, I have two sisters and a brother. My mom and dad were really strict, a lot of yelling and bad words. My mom would call me ugly names like ‘big mouthed’.” Although Sandra has daily contact with her family currently, it was clear that this was not always positive. Referring to how much contact she has with her family she stated, “I go there about every day. I help, run errands for my brother and sister who are still at home. I just can’t get away from them.”
Zola described her childhood as “rocky” and attributed it to her father’s alcoholism. When asked how often her family moved she said, “My father finding new jobs and, with him being an alcoholic he lost a number of jobs due to that. So we were constantly moving.” She later described her past relationship with her father, “Um, it always seemed like my dad couldn’t stand the ground I walked on. You know, it was just like I was there for a reason to get beat on constantly. That’s how my father was.” Zola’s parents passed away years ago, but her current relationship with her siblings is also quite informative. She spoke of the reason that she did not talk to her siblings much, by explaining,

Not very, not very often. Usually it’s to start rumors. You know, that’s how they are. So, it’s more like, you stay away, so you haven’t got to get blamed for anything. So, no, I don’t really talk to them unless there is a death in the family or something they think I should know about. They will call me out of the blue, but otherwise they don’t.

Another respondent, Keely, spoke of her parents being unreliable when she was a child. She jumped from her mom’s, dad’s, and grandparent’s houses throughout her childhood. She expands on one such incident when she was living with her father, “But my dad winded up getting remarried and my, I went and lived with them. My step mom didn’t like me so she kicked me out, so I wound up living with my grandparents.” Her current relationships with both her father and grandparents were equally tumultuous. She described her current contact with her father by saying, “And my dad and I only talk on
holidays. He’s a good guy and I love him to death, but he’s that, you know, do everything yourself. You’ve got to make it on your own.” She further painted a picture of her current interactions with her grandparents, “But my grandparents, I mean, my grandpa has his problems too and I’ve actually started avoiding my grandparents when I know bad stuff’s going on with them. Cause I don’t want to hear it.”

Social Support

The largest disparity between the low and high risk groups pertained to the social support they received and what that meant for relationships with those individuals. Respondents in the low risk group often reported having a great amount of social support, and the social support came without strings attached. Two respondents actually stated this fact, while others did not refute it with their recollections of social support in general. Only one woman from the low risk group spoke of feeling obligated to repay others for the support they gave her. The high risk group, in contrast, frequently stated that they had ambivalent relationships with the individuals that provided social support, reported having no friends, or felt that their constant need for social support was burdensome. To exemplify, nine women from the high risk group reported that their parents made things difficult for them. Only two respondents did not report a difficult experience with their primary sources of social support in
some manner. Furthermore, six women in this group said that they had no friends or were unable to see their friends.

Low Risk—Social Support.

Individuals in the low risk group often reported that they had a great amount of emotional and instrumental social support from their family and friends. Not only was the social support they received beneficial, but it also came without the animosity that many of the high risk group members experienced.

Emotional Support. Cordelia spoke of her father being her backbone in many ways. When asked about the person most important in her life, she responded, “My dad.” She continued, “He is my entrepreneur…He’ll go out of his way to help me do whatever I need to do.”

Joelle, speaks of her mother as a vital part in her life in regard not only to instrumental support, but also emotional support. She explains,

My mom is very, very important to me. Well, we are on the internet practically every day. Either I go to the library up here and send her email and she looks forward to coming home and reading them just as much as I look forward to going up there and reading one from her. It’s refreshing.

Instrumental Support. Instrumental support was also common among the low risk group. In addition to the vast amounts of social support the respondents spoke of, it was rare that feelings of animosity were discussed. Harriet’s family had a great deal of social support from their church family
since her husband was currently serving as the minister. One prime example she shared,

Then we’ve got other people in the church, one family who ah, loved to help us take care of our cars and has written on his calendar when they are due for oil changes and he comes and picks them up and takes them and goes and changes their oil and cleans them top to bottom every three thousand miles.

Another respondent, Nellie speaks of the burden-free social support she receives from her friends and partner’s family. She illustrates,

We have, well the people we bought the house from, we’re friends, and his parents live in an apartment downstairs. An um, they have two vehicles, so. Since we’ve been here if we’re in dire straights they’ve been more than willing to let us borrow one.

Belle also spoke of her father-in-law helping her family in a variety of ways. She shares,

Don’s father has helped us out a lot. There’s been instances where we couldn’t afford diapers or food, and he’s sent down and helped us out. Or when we were looking for a car, he helped us out. Not necessarily money wise, but helped us out as far as finding a good deal. He helps us out a lot with finances, figuring things out. How to deal with hard situations as far as business money goes.

High Risk—Social Support.

Similar to the low risk group, social support was reported by all of the participants. The difference, however was seen in the “price” the individuals had to pay for the support they received. The high risk group frequently stated that they had ambivalent relationships with the individuals that provided social support. Many individuals relied a great deal on family and friends for
transportation, child care, and financial support. When asked about their relationships with these people, they also reported a great amount of ambivalence and other negative feelings. Somewhat related was the constant feeling of being a burden to those on whom they relied. For example, some women spoke of only asking for favors if it was absolutely necessary because they felt as if they were bothering their family and friends. Six of the women reported having no friends. This often was due to living in a new location or not having time to go out with the friends, thus leaving them feeling isolated.

"I Wish We Got Along." Ambivalent relationships were quite common among the high risk group. Rashida, who relies on her mom for child care and housing, is honest about the relationship she has with her mother. When asked what the one thing she would change, Rashida answered shortly, “I hope my momma treat me better. Sometimes I have a hard time with her.”

Maxine describes a more severe situation with her siblings, who lent her money. She describes:

We borrowed $100 off of my sister. And I wasn’t able to pay it back so she don’t talk to us no more. And I’ve tried to make her understand that whenever I get money it goes for diapers or to pay the electric bill or things like that. I tell her, one of these days I will get a job and pay ya. Not long ago my brother came down and just offered me $50 which we took it but we shouldn’t have, but we needed it. Now, him and my husband aren’t talking.

Paige, whose mother provides frequent financial assistance is a prime example of the strings often attached to social support. She expands on asking
her mother for help by stating, “She does once in a while. I like to do things on my own because then no one can say, ‘I’m doing this, I’m doing that.’ When she feels like it and feels like you need it, she will help.”

“I Feel Like a Burden To Others.” Although being a burden to others was not a large theme across participants, it was mentioned and inferred in enough interviews to warrant some discussion. When discussing her transportation, Vanessa shares that she feels like a burden to her family. When asked how she usually gets around she states, “I usually don’t. I have to beg and plead and...rely on others and that’s really tough.”

Joan discussed the constant issue of child care as a single mother. When asked if she found time for outside activities she articulated, “Well, you have to find a sitter and pay a sitter. You don’t want to ask your family all the time, so you are just kind of stuck at home.”

“I Feel Like I Have No Friends.” Several respondents reported that they did not have friends to rely on for social support or that they did not have friends at all. The lack of having friends was attributed to moving to a new area, thus not knowing anyone or simply not having the time to see people they once considered friends.

Rosemary recently moved to a new location several months before the interview and ultimately found social support distant. Her grandmother lives nearby and provides child care and transportation, however she indicated that
something was still missing. When asked if she goes out with friends, she states frankly, “I don’t have any up here.” Lauren, whose social support is somewhat lacking, shares similar feelings. She states, “No. No. I don’t have none [friends] no more.”

Vanessa, a young mother, reminisces a time when she was free to do a variety of activities. When asked what she would do if she had time she said, “Well, before I had a child, I use to love going bike riding, going dancing, going swimming, and walking.” When asked if she goes out with friends she replied, “Hardly ever at all. I never have time to do anything.”

Summary

Several themes emerged in the qualitative comparison of both the low risk and high risk depression groups. These themes include the vast difference in the manner that the low risk group spoke about their mental health and health issues compared to their high risk counterparts. Differences were also noted between the groups’ past and current relationships with their families of origin. The data revealed that the low risk group had more positive social support experiences than the high risk group, with the latter group being more likely to report ambivalent relationships with individuals who provided social support. Due to results of the greatly revealing qualitative data, further examination of the quantitative data was warranted. Ultimately, the quantitative data analysis completed the picture of the women in this study.
Quantitative Results

After examining the qualitative data, several themes arose for which quantitative analysis was possible. For this part of the study, all 117 (the total of the low risk and high risk groups) participants were used for analyses. Independent-samples $t$ tests were conducted to compare the low risk and high risk groups. A number of variables were chosen for analyses because the literature and previous research suggests they are linked to depression. These include participant's age, presence of a partner, number of children, participant's education level, participant's work status, childhood mobility, parental welfare use, food insecurity, adequacy of income, and monthly income.

Table 3 provides the results of these analyses. Many of the variables were statistically significant. First, participant's work status was significant, $t$ (115) = 2.587, $p = .011$. The high risk group was significantly less likely to be currently employed. This coincided with the literature in that being unemployed was a risk factor for depression (McGrath et al., 1990). Childhood mobility, was significant $t$ (109) = -2.343, $p = .021$. The high risk group being more likely to report frequent mobility as a child. Parental welfare use was significantly more common among the high risk group, $t$ (106) = -3.421, $p = .001$. The high risk group was significantly more likely to report
being food insecure than the low risk group, \( t(109) = -4.258, p = .000 \).

Perceived adequacy of income was significant, \( t(114) = 3.912, p = .000 \). The high risk group is less likely to consider their income enough to live on than their low risk counterparts. Somewhat related, monthly income was significant \( t(115) = 2.366, p = .020 \), indicating the high risk group is more likely to have a higher monthly income. The literature repeatedly shows that economic issues and lower socioeconomic status have been linked to high levels of depressive symptoms (Belle, 1982; Makosky, 1982; Moore, 2001; Simonds, 2001).

Third, the presence of a partner was marginally significant, \( t(115) = 1.768, p = .080 \).

Table 3. Summary of Quantitative Findings.

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<td>Childhood mobility</td>
<td>2.912</td>
<td>5.482</td>
<td>109</td>
<td>-2.343</td>
</tr>
<tr>
<td>Parental welfare use</td>
<td>.315</td>
<td>.629</td>
<td>106</td>
<td>-3.421</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>1.379</td>
<td>1.755</td>
<td>109</td>
<td>-4.258</td>
</tr>
<tr>
<td>Perceived Adequacy of income</td>
<td>2.814</td>
<td>2.105</td>
<td>114</td>
<td>3.912</td>
</tr>
<tr>
<td>Monthly income</td>
<td>1534</td>
<td>1108</td>
<td>115</td>
<td>2.366</td>
</tr>
<tr>
<td>Amount of Support/Collapsed Variable</td>
<td>23.47</td>
<td>15.02</td>
<td>107</td>
<td>7.468</td>
</tr>
<tr>
<td>Overall satisfaction with life</td>
<td>4.153</td>
<td>2.895</td>
<td>100</td>
<td>7.268</td>
</tr>
<tr>
<td>Participant: Number of health conditions</td>
<td>3.597</td>
<td>7.63</td>
<td>109</td>
<td>-5.042</td>
</tr>
<tr>
<td>Partner: Number of health conditions</td>
<td>1.8</td>
<td>3.61</td>
<td>56</td>
<td>-2.28</td>
</tr>
<tr>
<td>All children: Number of health conditions</td>
<td>4.29</td>
<td>5.47</td>
<td>115</td>
<td>-1.013</td>
</tr>
</tbody>
</table>
The high risk group was less likely to have a partner. The literature, shows conflicting viewpoints in this area, with McGrath et al. (1990) reporting that married women were more likely to experience depression and more recently Simonds (2001) stating that single women are more prone to depression than married women. The variables that were not significantly different were participant's age, number of children, and participant's education level. It should be noted that age, number of children, and education level have all been found to be major factors in a person's likelihood toward depression despite their lack of significance in this study (Glied & Kofman, 1995; McGrath et al., 1990). In this study age may have been compressed because families with young children were chosen for participation. Further, because poverty is associated with low education there may be less variability in this sample than in others.

The results of the qualitative data analysis also suggested additional variables that were tested to ascertain their relationships to depression in this sample. They include amount of support, overall satisfaction of life, number of health conditions for participants, number of health conditions for partners, and total number of health conditions for all children in the household (these variables can also be found in Table 3). Amount of support, was an averaged score from five questions on the parenting ladder regarding the following:
amount of stress, parents to talk with, others to relax with, someone to help in emergency, and satisfaction in the amount of support received. Answers ranged from 0 (low) to 6 (high) according to how they would place themselves on the ladder.

The result was significant $t(107) = 7.468, p = .003$ indicating that participants in the low risk group were more likely to report a greater amount of social support. Overall satisfaction of life was significant, $t(100) = 2.202, p = .03$, with the high risk group less likely to feel satisfied with life in general. The qualitative data revealed a large difference between how the two groups spoke of health conditions. Mothers showing higher levels of depression reported significantly more health problems for themselves ($t(109) = -5.042, p = .000$), their partners ($t(56) = -2.28, p = .007$), and their children ($t(110) = -2.42, p = .004$). Thus, it is clear that the number of health conditions among participants and their family members was associated with an increased likelihood of depressive symptoms.

Many women in the study spoke of the stress related to frequent moves as a child. Therefore, childhood mobility was examined and found to be significant, $t(109) = -2.343, p = .021$. The high risk group was significantly more likely to move as a child. Another variable mentioned repeatedly in the interviews was food security. The high risk group was significantly more likely to be food insecure, $t(109) = -4.258, p = .000$. 
Summary

Although primarily qualitative, the quantitative data greatly enhanced the study. Both the literature and the qualitative results provided suggestions for quantitative analysis. In most cases the quantitative data reinforced already existing themes in the literature and qualitative findings. Thus, a clearer picture was painted of the factors associated with depressive symptoms among women with children living in rural poverty.
CHAPTER 5

DISCUSSION

This study has examined in depth how forty women with children responded to living in rural poverty and its relationship to depression, while also examining the larger sample of 117 respondents on a variety of quantitative measures. All of the women had similar life situations including the presence of young children, living in a rural area, and having a low income. Yet some women were identified at high risk for depression while others were at low risk.

One of the primary motivations for this research was a desire to understand how depression is related to women living in rural poverty. Since depression and poverty are such complex issues, I was unable to prove causality. However, the research questions examined what differences exist between women who are at high risk and those who are at low risk for depression. Several themes emerged after examining each woman’s account of her experiences with health, mental health, childcare, transportation, community, social support, and family of origin. Quantitative analyses were then run to further validate the findings from the qualitative analysis.
Summary of Findings

Perhaps it is appropriate to come back full circle to the research question: Of low income women living in rural areas, what differences exist between those who score at low risk and those who score at high risk for depression? Do health, mental health, childcare, transportation, community, social support, or family of origin experiences differ between the two groups? Answers to this question were framed primarily qualitatively, with some quantitative analyses for validation.

*Health and Mental Health.* Health and mental health were subjects of great difference between the low and high risk groups. The differences qualitatively involved the participant’s accounts of their family’s mental health and health status. Not surprisingly, mental health differed greatly between the low risk and high risk group, with the latter reporting far more experiences with mental health problems and more serious conditions. To clarify, only three individuals in the low risk group reported a mental health condition, compared to 14 from the high risk group. Of the three individuals in the low risk group, only one spoke of a condition in her immediate family. Of the women in the high risk group that spoke of mental health issues, all reported a condition they personally were experiencing, with eight taking anti-depressants.
at the time of interview. In addition, five women reported that their children also had mental health concerns.

Health was also an area in which differences were seen between the two groups both qualitatively and quantitatively. Although the individuals in the low risk group reported health problems, it was commonly among family of origin rather than in their immediate families, or they reported fewer and less severe conditions. High risk respondents spoke in more detail of their own serious health issues or those of their immediate family, and often reported multiple or more severe conditions. The average number of health conditions per family among the low risk group was 9, while the high risk group’s average was 16 per family. Of the low risk group 6 reported that one member of their family had experienced a major health issue in the last year, while 13 in the high risk group reported such. Additionally, the quantitative analyses revealed that high risk respondents, their partners, and children were more likely to experience a greater number of health conditions than the low risk group

*Family of Origin.* Family of origin was also an area in which differences were seen in regard to both past and current relationships. The low risk group was much more likely to report both past and current positive relationships with their parents and siblings. To better illustrate, when speaking of past relationships seven individuals in the low risk group reported
positive relationships and an additional nine reported neutral. Referring to current relationships, 17 women in the low risk group reported positive experiences. On the other hand, high risk individuals were more likely to report severely negative experiences growing up as well as negative or ambivalent relationships with family of origin in the present. In fact, 15 individuals reported negative past experiences, 4 reported neutral, and 1 positive. As for current relationships, 14 reported negative relationships, 3 neutral, and 3 positive.

_Social Support._ The largest disparity between the low and high risk groups pertained to the social support they received from friends and family and what that meant for the relationships with these people. Respondents in the low risk group often reported not only that they had a great amount of social support, but also that the social support came without strings attached. The findings from the high risk group were quite the opposite. To simplify, nine different respondents reported that their parents made things harder for them. Six women claimed to either have no friends or be unable to go out with old friends. Only two women out of the group did not report a difficult relationship with their social support of some nature. Somewhat related, the quantitative data revealed that the low risk group was much more likely to report having more overall support from friends and family. The low risk group was also more likely to have the presence of a partner and to be
currently working, which could in turn translate into having access to more potential support. Participants in the high risk group were more likely to be highly mobile as children, thus possibly leaving them less anchored in a certain community. Although not directly related, this could have a large influence on the amount and type of social support that they receive.

**Theoretical Implications**

The ecological theory was appropriate for the study of women with children living in rural poverty and their likelihood toward depression. It provided a clearer picture of the levels of influence in the lives of these 40 women. Gender and poverty in an era of welfare reform clearly sets the macrosystem backdrop for the study itself. It is clear that mental health, health, family of origin, and social support play different yet important roles in the lives of the low risk and high risk groups. These four influences can be seen at different levels on the Ecological Framework.

Mental health, a microsystem factor, clearly had a large impact on the lives of the high risk group, while the low risk group was not impacted. Not only were the women themselves affected, but there may be serious implications for their children as well. There is extensive literature on the consequences for children having a mother who is depressed (Nolen-Hoeksema, 1990; Stoppard, 2000). This is a prime example of mesosystem, in that a child is indirectly affected their mother’s mental health status.
Health was a barrier for both groups in regard to the actual access to health care itself and the overall cost, exemplifying how the mesosystem level is linked to the microsystem level. The actual health issue itself is a microsystem influence, but for rural families, access to the health care they need is minimal. Therefore, health and access to health care are interrelated. The high risk group was more likely than the low risk group to experience severe medical problems and multiple conditions, which in turn made access to health care even more imperative. Additionally, transportation was also a barrier to the access of health care, making the issue even more complicated.

The influences of family of origin, typically an exosystem factor, was very different among the low risk and high risk groups. The low risk group reported some negative family of origin experiences in the past, but they were not as severe or they were coupled with a positive current relationship. Many others in the low risk group reported that they had positive experiences both past and present with their families of origin. The high risk group, however, typically reported negative past and current relationships with their families of origin. Thus, the exosystem influence of family of origin was great for both groups.

Social support, a mesosystem factor, showed perhaps the largest difference between the two groups. Low risk individuals reported a large amount of social support that came without strings attached. The high risk
group was the opposite, however, with ambivalent relationships being common. Many others reported not having friends to count on and feeling that their constant need was a burden to others. Both groups relied heavily on the social support they received at the microsystem level. Childcare, transportation, financial support, and emotional support were common needs among both groups. The high risk group, however, was much more likely to feel ambivalence toward the people who provided them with support. Thus, social support was vital for both groups, but the issues surrounding it were different.

Links Between Literature and Research Findings

Rural communities have their own unique qualities, but also experience low access to services such as health care (Findeis, et al., 2001). Clearly exemplified in both the literature and research findings, health care causes a financial strain on families in addition to the access issues surrounding health care in rural areas.

Also difficult in rural areas is access to child care and transportation. Although no differences were seen in regard to these two factors, both groups spoke of the issues surrounding affordable quality childcare and transportation. Many low income families rely on their relatives and friends for childcare (Findeis et al., 2001; Richards et al., 2001). This was exactly the case for most
of the respondents in the study. They either found childcare too costly or nonexistent, thus requiring them to find alternative types of childcare.

As mentioned in the literature, public transportation is a rarity in rural areas (Rucker, 1994). This was demonstrated multiple times among the respondents who either spoke of the lack of public transportation or limited hours of operation. Most respondents owned automobiles, but found that it was expensive to maintain them and purchase gasoline. The literature also shows that personal transportation is a burden for many families with limited incomes (Weber & Duncan, 1996; Seccombe et al., 1998).

Many researchers have found that social support is not always beneficial (Belle, 1982; Stack, 1974). In fact, Belle (1982) found that it was the cause of stress among the low income women in her study. This could not be more true in regard to this study, with the low and high risk groups experiencing social support in two very different ways. For the low risk group, social support was usually a positive experience. The high risk group, however, found social support tied with certain expectations and feelings of being a burden.

Although the literature on family of origin experiences is somewhat limited, one major link between the literature and the research findings should be noted. Emotionally cold upbringings as well as poor contact with one’s parents have been found to be risk factors for depression (DepNet, 2002). The
high risk group resembled this greatly in that they were much more likely to speak of negative family of origin experiences both in the past and present. The low risk group, although not immune to negative experiences as children, commonly reported that their current relationships were positive. Some members of this group spoke of positive past and current relationships with their parents and siblings.

Finally, the use of the CES-D proved to be extremely valid in this study. Only three individuals in the low risk group mentioned anything relating to mental health, while 14 women in the high risk group reported personally experiencing mental health issues, with 8 taking medication for their ailments. In addition, five women said their children also have mental health problems. From this it becomes clear that the measure used to assess depressive symptomology during larger data collection coincided with the personal stories of the 40 women in this study.

Limitations and Directions for Future Research

Common with any study are limitations and areas for improvement. First, is the amount that an individual researcher’s personal thoughts and feelings influence the results. To minimize this I coded the transcripts without identifying the low and high risk groups. In many ways I felt like I had experienced living in poverty vicariously through the forty women in this study.
Since this study was primarily qualitative, many will argue the validity of the analysis because a hypothesis was not identified a priori. However, qualitative research is designed to assess the meanings, interpretations, and subjective experiences of family members. Qualitative research is meant to look at interactions, dynamics, and contexts in order to build theory and meaning. This study has attempted to bring out both subjective and objective meanings relating to women living in poverty and depression.

Many studies similar in nature are emotionally draining on the researcher. My recommendation to future researchers in this area is to be prepared for emotional exhaustion evoked by reading the stories the participants may share. Even though I did not personally interview these women, it was still difficult to read many of the experiences they recalled. Finding an outlet to balance the extreme emotions elicited from a study can be helpful.

As is common with qualitative research, more questions come out of the research as time progresses. This can be positive in that it allows suggestions for future research. It would be interesting to research the same variables among women living in urban poverty to see if there were any similarities between rural and urban women in regard to how they conceptualize health, mental health, childcare, transportation, community, social support, and family of origin experiences.
Since my study revealed a vast difference between the social support the low risk and high risk groups received, future studies may expand in this area. Also, the quantitative results show that the high risk group was more likely to experience not being employed, moving as a child, and food insecurity. This opens up three very interesting areas for future research as well.

Implications for Policy

What are the implications for policy and how can this be achieved? These questions are difficult to answer. Although I can not solve the problems that come out of living in poverty, it is possible to suggest some practical tools for minimizing the barriers that affect both the poor and the affluent in our society. Barriers that have come up repeatedly in the literature as well as in this study include access to quality affordable childcare, health and mental health care, and transportation. These are barriers that affect many Americans and show no relief in the near future.

One prime example revealed in the excerpts from several women in the study pertained to the importance of respite relief for single mothers and families with severe health and mental health problems. Kellan, a single mother from the low risk group, explained the benefits of her Personal Care Assistant (PCA) by saying, “She kinda helps the boys, you know, get in the shower. She used to make them do their chores, and she helps them do their
homework, and keeps them under control.” When asked if this worked well for her she responded, “Yes, I just love it. A tremendous help. Cause I felt like I was drowning before she came.” Flora, a single mother with multiple health problems from the high risk group spoke of the stress she experiences and the need for respite relief. Flora stated,

Last week, I just needed a break from everything. You know, I think with my hip and the demands for my two little kids, two jobs. I needed a break. So my social worker suggested crisis, um, nursery. Which I never knew about, but I called ‘em up and it was a big-time process of trying to get through to them that I need help, that I am not abusing my kids, or they said that’s what it was for, mothers that are mentally stressed and physically not feeling well. And just wanted some good care for my children, because I wasn’t able to care for them. I just needed a break. There’s nothing there for me or anybody. Granted I have family, but sometimes I need more than an hour or two break. I mean, I need an overnight break. Just time for myself.

These two examples show clearly the need for respite relief for single mothers with health and mental health issues in their family. The Personal Care Assistant made a large difference in the life of the first mother, Kellan. Flora, however, felt that resources of this nature were scarce for her and others in similar situations. The difference between the two women’s lives is obvious. Thus making services such as respite relief imperative to both the lives of mothers and their children.

In closing, policy makers and researchers must work together to improve the lives of individuals and families. If policy makers are unaware of the needs of their people, it is the responsibility of researchers to share this
information. A wide variety of methods should be used to alert policy makers and others in regard to the findings of research. Academic journals, popular press, and advocacy are three ways this goal can be accomplished.
CHAPTER 6

CONCLUSIONS

What do these results mean? First, it should be noted that although a great deal was revealed in this study, no causality was determined between poverty and depression, nor was this the goal. The results, both qualitative and quantitative, do shed light on the topic of women living in rural poverty and the likelihood they will experience depression. All of the women in the study are subject to a variety of difficult life experiences. All live in rural areas, which are limited in resources. All are living in poverty, which is known to have serious implications. All have young children, many of whom are doing so as single parents. When these factors are combined, it becomes clear that the women in this study are at relatively high risk of experiencing depression, a serious mental health condition affecting 17 million Americans each year.

The results of this study should also be of particular interest to policy makers in the area of child development and well being. Maternal depression is consistently linked with less effective parenting and poor child outcomes (Oyserman, Mowbray, Allen-Meares, & Firminger, 2000). Children with depressed mothers are more likely to have health problems, behavioral problems, and academic problems, regardless of family income level (Ahluwalia, et al., 2001; Downey & Coyne, 1990; Jones, Forehand, Brody, & Armistead, 2002). With this being laid out, it is clear that depression is serious
and affects more than simply the individual personally experiencing the mental illness. Thus, knowledge about potential risk factors for depression can in turn shed light on policy regarding needed support for families.
REFERENCES


Butler, M. A., & Beale, C. L. (1994). Rural-urban continuum codes of metro and nonmetro counties, 1993. (Staff report No. 9425), Agriculture and
Rural Economy Division, Economic Research Service, Washington, DC: USDA.


APPENDICES
APPENDIX A

Center for Epidemiologic Studies Depression Scale

**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.

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

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 C

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) 

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 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?

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?

<table>
<thead>
<tr>
<th></th>
<th>You</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder/Obesity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/Anxiety</td>
<td></td>
<td></td>
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<tr>
<td>Reproductive Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Problem</td>
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<td>Allergies</td>
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</tr>
<tr>
<td>Alcohol Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent colds/flu/sinus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional, physical, or sexual abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraines/Headaches</td>
<td></td>
<td></td>
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<tr>
<td>Eye or vision problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

The Parenting Ladder

Where would you put yourself on the Parenting Ladder in terms of:

Your knowledge of how children grow and develop? ______
Your confidence that you know what is right for your child? ______
Your ability to create a safe home for your child? ______
Your success in teaching your child how to behave? ______
Your skill at finding fun activities that interest your child? ______
The amount of stress in your life right now? ______
Your ability to cope with the stress in your life? ______

Parenting is often smoother when others are there to help. Where would you put yourself on the Parenting Ladder in terms of:

Other parents for you to talk to? ______
Someone to help you in an emergency? ______
Someone to offer helpful advice or moral support? ______
Someone for you to relax with? ______

**Professional people to talk to when you have a question**
about your child? ______
Your overall satisfaction with the amount of support in your life? ______
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**

B. Partner’s 1st Name _____ DOB _____ Ethnicity**

<table>
<thead>
<tr>
<th>Child</th>
<th>Sex</th>
<th>DOB</th>
<th>Relation</th>
<th>Relation</th>
<th>Contact w/</th>
<th>Receives</th>
</tr>
</thead>
<tbody>
<tr>
<td>(First Name)</td>
<td>(Y, N)</td>
<td>(Y.N)</td>
<td>to A ***</td>
<td>to B ***</td>
<td>bio parent</td>
<td>support</td>
</tr>
</tbody>
</table>
Do you have any children not currently living with you? (If yes) Who are they, and where are they living?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Single</td>
</tr>
<tr>
<td>SS</td>
<td>Single</td>
</tr>
<tr>
<td>A</td>
<td>Adopted</td>
</tr>
<tr>
<td>M</td>
<td>Married</td>
</tr>
<tr>
<td>SC</td>
<td>Stepchild</td>
</tr>
<tr>
<td>LWP</td>
<td>Living with partner</td>
</tr>
<tr>
<td>B</td>
<td>Biological child</td>
</tr>
<tr>
<td>D</td>
<td>Divorced</td>
</tr>
<tr>
<td>F</td>
<td>Foster child</td>
</tr>
<tr>
<td>SEP</td>
<td>Separated</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
</tr>
<tr>
<td>W</td>
<td>Non-Hispanic White</td>
</tr>
<tr>
<td>H</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>AA</td>
<td>African American</td>
</tr>
<tr>
<td>N</td>
<td>Native American</td>
</tr>
<tr>
<td>A</td>
<td>Asian</td>
</tr>
<tr>
<td>NR</td>
<td>Not related</td>
</tr>
<tr>
<td>MM</td>
<td>Multi-racial</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
</tr>
</tbody>
</table>
Other Household Members

<table>
<thead>
<tr>
<th>Relationship to A</th>
<th>Length of Time in Household</th>
<th>Permanent or Temporary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Participant's Current Employment</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weeks/Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raise Job 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job 2</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job 3</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage/Salary</td>
<td>Started</td>
</tr>
<tr>
<td>Hours/week</td>
<td></td>
</tr>
</tbody>
</table>

Weeks/Year | 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...

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provided by Mother’s Job(s)</th>
<th>Provided by Partner’s Job(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance for self</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Health insurance for children</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Sick leave</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Vacation pay</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Overtime</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Retirement plan</td>
<td>Yes    No</td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

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?
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\textsuperscript{th} 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?

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**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 = 8th 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?

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

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)

- WIC
- School Lunch Program
- EIC (Earned Income Credit)
- Child Care Assistance
- Housing Assistance
- Energy/Fuel Assistance
- Transportation Assistance
- Educational Grants or Loans
- Oregon Health Plan
- Other

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?

<table>
<thead>
<tr>
<th>Type of Help</th>
<th>Amount</th>
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</table>

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?
<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Clothing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medical Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dental Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medicines</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Credit Payments</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Personal Care Items</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diapers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>School Fees or Expenses</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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 we've missed?
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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you so much for your time.
## APPENDIX F

**Coding Scheme**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDCARE</strong></td>
<td>Any mention of childcare arrangements; childcare needs, who watches kids; cost of childcare; type of childcare arrangements; emergency childcare; childcare problems.</td>
</tr>
<tr>
<td><strong>FAMILY ISSUES</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>FAMILY OF ORIGIN</strong></td>
<td>Comments on the history or current relationship with members of family of origin.</td>
</tr>
<tr>
<td><strong>HOUSING</strong></td>
<td>Any references to housing or basic utilities.</td>
</tr>
<tr>
<td><strong>WELL-BEING</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>MAKING ENDS MEET</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>FOOD SECURITY</strong></td>
<td>Any mention of hunger, insufficient or inadequate food; strategies to make food last to the end of the month; etc.</td>
</tr>
<tr>
<td><strong>CURRENT JOBS</strong></td>
<td>Any mention of their or their partner’s current job, including work-family interface issues; job search activities; problems with current job.</td>
</tr>
<tr>
<td><strong>JOB HISTORY</strong></td>
<td>Any mention of their or their partner’s past jobs or sources of working income (not quantitative).</td>
</tr>
<tr>
<td><strong>TRANSPORTATION</strong></td>
<td>Anything that has to do with transportation, family cars, or emergency transportation.</td>
</tr>
<tr>
<td><strong>WELFARE</strong></td>
<td>Respondent’s current experiences with or perceptions of welfare; changes they’ve seen/experienced since reform.</td>
</tr>
<tr>
<td><strong>HEALTH</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>SOCIAL SUPPORT:</strong></td>
<td>Comments on how agencies, landlords, community...</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AGENCIES</td>
<td>Organizations, etc. provide assistance, includes lack of support; r experiences with agencies.</td>
</tr>
<tr>
<td>SOCIAL SUPPORT:</td>
<td>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.</td>
</tr>
<tr>
<td>FRIENDS AND FAMILY</td>
<td></td>
</tr>
<tr>
<td>EDUCATION AND</td>
<td>Comments on job skills developed over the past few years, or education developed in the past few years.</td>
</tr>
<tr>
<td>TRAINING</td>
<td></td>
</tr>
<tr>
<td>COMMUNITY</td>
<td>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.</td>
</tr>
<tr>
<td>FUTURE</td>
<td>Fantasy job, where family will be in the future, worries about the future.</td>
</tr>
</tbody>
</table>
APPENDIX G

Sub-code Scheme

Childcare
Affordability: Anything having to do with the cost of childcare, subsidized childcare, bartering for services, etc.
Accessibility: Anything having to do with access or barriers to childcare such as strict hours of availability, difficulty in finding childcare, family and friends providing childcare, etc.
Quality: Anything pertaining to quality of childcare such as worries that child will not be cared for properly in certain childcare settings, not being comfortable with the childcare offered in a particular area.

Family of Origin
Past/Childhood
Positive/Neutral: General experiences of growing up, memories of family of origin.
Negative: Accounts of negative family of origin experiences such as Physical/sexual/emotional abuse, alcohol/drug use, and other negative Experiences.

Current Relationships
Good relationships: Explanations of current relationships that are positive in nature.
Poor with no contact: Statements relating to having no current contact with family of origin or poor experiences that have lead to no contact.
Poor with contact: Statements that relate to current relationships with family of origin being poor/negative in nature.

Social Support: Agencies
Positive experiences: Any accounts of positive experiences with agencies such as employment office, landlord, WIC office, etc.
Negative experiences: Any accounts of negative experiences with agencies such as employment office, landlord, WIC office, etc.

Social Support: Friends & Family
Instrumental Support:
Friends: Support given by friends that involve material goods, loans, transportation, childcare, etc.
Family: Support given by family that involves material goods, loans, transportation, childcare, etc.

Emotional Support
Friends: Emotional support given by friends such as advice, listening, spending time together.
Family: Emotional support given by friends such as advice, listening, spending time together.

Lack of support
Friends: General lack of support by friends.
Family: General lack of support by family.
Health & Mental Health

Mental Health Problems: Mental health issues such as; depression, anxiety, deviant behavior, which affects any member of the family.
Health Problems: Health concerns that affects any member of the family and may alter the way they live day to day.
Stress: The stress associated with health or mental health issues such as cost, access to services, and general stress.
Disability: Limitations due to health or mental health issues. May affect ability to work and perform other basic activities.

Transportation

Affordability: Anything having to do with the cost of transportation, upkeep, insurance, etc.
Accessibility: Anything having to do with access or barriers to transportation such as lack of public transportation or strict hours of availability, family and friends providing transportation, or having no access what so ever.
Quality: Anything pertaining to quality of transportation such as worries that car will break down.

Community

Safety: Anything pertaining to the overall safety of community including emotional safety.
Access to resources: Anything relating to resources in the community such as jobs, entertainment, stores, clinics, etc.
Social environment: The overall feeling of the community as a place to live. Feelings pertaining to the closeness of community positive or negative.