

Impending Job Loss and Behavioral Health

Author(s): Ronald J. Mancoske, Patricia Guillory, Gilda Eubanks and Shantell Francis

Source: *Race, Gender & Class*, 2018, Vol. 25, No. 1-2, Race, Gender & Class Conference 2017 (2018), pp. 166-189

Published by: Jean Ait Belkhir, *Race, Gender & Class Journal*

Stable URL: <https://www.jstor.org/stable/10.2307/26649540>

REFERENCES

Linked references are available on JSTOR for this article:

https://www.jstor.org/stable/10.2307/26649540?seq=1&cid=pdf-reference#references_tab_contents

You may need to log in to JSTOR to access the linked references.

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <https://about.jstor.org/terms>



Jean Ait Belkhir, Race, Gender & Class Journal is collaborating with JSTOR to digitize, preserve and extend access to *Race, Gender & Class*

JSTOR

IMPENDING JOB LOSS AND BEHAVIORAL HEALTH: DOWNWARD SOCIAL MOBILITY*

Ronald J. Mancoske and **Patricia Guillory**

School of Social Work
Southern University at New Orleans

Gilda Eubanks

Delgado Community College

Shantell Francis

Cadence of Arcadania

Abstract: This study reports on a survey of workers facing threats to class standing with job loss by the closing of a shipyard. The literature reports unemployment impacts health and mental health. This study explores the threat of job loss due to the phasing out of employment on worker's behavioral health. Change related to threatened social class standing with job loss is not suggested by differences in family changes (e.g., cohesion or adaptiveness) but the threat of job loss increases worry and fear. Social class is internally tied to income and earnings, but it also shaped by ideology, historicity, and economic dynamics shaping health and mental health outcomes. Downward social mobility creates devaluation and fear among those threatened by declining social mobility. Employment related support policies suggest how to help communities respond to the social determinants of behavioral health problems of those experiencing impending job loss.

Keywords: job loss; unemployment; social mobility; health determinants; mental health risk

Ronald J. Mancoske is (retiree) Millie M. Charles Professor of Human Rights and Social Work at Southern University at New Orleans and Interim Dean. His teaching responsibilities are primarily in mental health, program evaluation, and diversity. He directed the Post-Master's Certificate Program in Child Trauma (2006-2010). Has served with the Orleans Parish Juvenile Court Alliance. Prior evaluation experiences have been with the Louisiana Department of Social Services on welfare reform and the Louisiana Office of Behavioral Health's system of care services. Grant reviews, program evaluations, research and publications have been primarily in the area of HIV/AIDS, substance abuse and mental health.

Address: Southern University at New Orleans, School of Social Work, 6400 Press

Drive, New Orleans, LA 70126. Ph: (504) 286-5376, Email: RMancosk@suno.edu

Patricia Guillory is Associate Professor in the School of Social Work at Southern University at New Orleans. Her teaching responsibilities are primarily in mental health and direct (micro) practice. She has provided program evaluation, clinical consultation and supervision, and training in the greater New Orleans area to multiple community mental health programs. Her teaching and training expertise is primarily in the areas of adult mental health and substance use and treatment.

Address: Southern University at New Orleans, School of Social Work, 6400 Press Drive, New Orleans, LA 70126. Ph: (504) 286-5053.

Email: paguillory@yahoo.com

Gilda Eubanks is the Single-Stop Director at Delgado Community College. She received her MSW from Southern University at New Orleans and is working on her DSW from Tulane University. Her research interests include mental health services for higher education students on its impact on persistence, retention and graduation.

Address: Delgado Community College, 615 City Park Avenue, New Orleans, LA 70119. Ph: (504) 671-6563, Email: gbebanks@gmail.com

Shantell Francis is a Support Coordinator for Cadence of Acadiana. During her 12 years as a social worker, she has worked for child protection, non-profits, and has worked mostly with children and also the elderly. She holds a MSW from Southern University at New Orleans.

Address: Cadence of Arcadia, 2435 W. Congress Street, Lafayette, LA 70501. Ph: (337) 577-2325, Email: Shantellf0128@gmail.com

Corresponding Author: Ronald J. Mancoske.

*The authors would like to thank Nick Unger of the Strategic Campaign Center of the AFL-CIO for his support for this study.

Unemployment can be viewed on the continuum of fully employed, underemployed, threatened with job loss, unemployed, to having given up on seeking employment. This study explores the threat of downward mobility with job loss and its impact on the behavioral health of middle-income families threatened by job loss at a manufacturing plant closing at the Avondale Shipyards in Louisiana (hereafter referred to as Avondale). Avondale manufacturing jobs provided a means to middle-class membership. Nine out of ten new jobs created are now going to those with a college degree (Goldstein, 2018) with scant jobs going to skilled trades. The loss of higher paying manufacturing jobs (such as at Avondale) threatens not only the loss of income but the social class benefits associated with the jobs, including health and mental health. The decline in manufacturing jobs associated with union membership in America correlates almost perfectly with the exponential rise in income inequality (Kaufman, 2018).

The downward mobility impact of job loss includes a variety of behavioral health consequences on individuals, families and communities. There appears to be a growing animus for these spiraling downward reflected in safety-net related policies, programs, and social support services being disregarded and disparaged. As overall income inequality has grown in the past four decades, families from middle income neighborhoods have dropped from 65% to 44% of neighborhoods nationally (Reardon & Bischoff, 2011). This report examines the cascading effect of downward mobility in the threat of job loss on behavioral health. It examines family adaptiveness and the behavioral health of those families experiencing impending job loss due to the closure of the Avondale Shipyards.

Avondale (opened in 1933) had played an important role in the Louisiana Gulf Coast for over seventy years prior to its closing in 2015. The shipyard was vital to the community's economic, cultural, social, and political life. Avondale phased out local shipbuilding resulting in over 5,000 skilled trade workers losing their jobs. The Congressional Research Service (2012) estimates for every job lost in military base closures, 2 to 3 related jobs are lost in the closure communities. According to Louisiana Secretary of Economic Development (Conveners, 2011), the shipyard added an additional 7,000 related support jobs in the region. Avondale shipbuilding had been the largest local private employer in Southeast Louisiana contributing billions of dollars to the local economy. We are in a period of absolute decline in social mobility. The share of children with higher (adjusted for inflation) incomes than their parents has declined from ninety percent in 1940 to fifty percent in 1984 (Chetty, Grusky, Hell, et al., 2017). The loss of the employment had a sizeable impact on the families and communities where the shipyard was located.

This article explores the shaping of social determinants of health via the lenses of social class status and the threat of downward social mobility. In the Avondale study, the threat of job loss is integral with the threat of downward social mobility, and the rise in inequality that has tangible health consequences. The rise and fall of social class standing rides on a belief system that social mobility is predicated on "deservedness" qualities, with upward mobility is shrinking. There is a huge price paid in terms of health inequalities due to growing class inequalities (Kawachi, Daniel, & Dean, 2005). The greater the social inequality, the more negative impact that inequality has on health outcomes (Wilkinson, 2002).

Job Loss/Downward Mobility's Impacts

Unemployment and Family Dynamics

Schliebner and Peregoy (1994) report that unemployment affects the individual directly experiencing the unemployment and also family systems. Strom (2003) summarized studies showing various adversities that occur among families impacted by unemployment such as a propensity for divorce, greater challenges to the overall well-being of children, and role shifts for men, i.e., more participation in domestic labor in the home. Unemployment is associated with the propensity for

divorce and presents an overall challenge to the well-being of children. Brand (2015) summarizes the research on the impact of job loss to include such things as subsequent unemployment, long-term earnings loss, lower job quality, declines in health/mental health, family disruption, and lower children's attainment and wellbeing.

Wauchope (1985) reports that parents play an instrumental role in mediating how children perceive parental unemployment. Parents with no history of joblessness react to paternal unemployment by increasing maternal employment, reorganizing the responsibility of labor, and developing roles that protect children's lifestyles. Children perceive parental job loss as causing increased marital conflict and reducing positive parental interactions. Parents who had previously dealt with unemployment repeatedly respond with strategies that decrease negative changes within the family interactions between father and child. Wauchope's findings (1985) contribute to the understanding of how families learn to manage stresses as a result of economic downturns.

Unemployment generates financial strain that impacts family roles in various ways. Women's roles as primary caregivers vary in family constellations and impact family adaptation or cohesion. Artazcoz, Benach, Borrell, and Cortez (2004) summarize studies on unemployment and report that children are directly affected by parent's experiencing unemployment. Roles of wives were found to change as a result of the husband losing employment. Men with fewer assets have a harder time dealing with the effects of job loss which result in greater negative impacts on the family.

Mattingly and Smith (2010) investigated the impact of the breadwinner of the family losing her or his job and found that more women entered the work force and increased hours worked per week if males became unemployed. Women already in the work force increased work hours (interviews of 8,825 households). Women who newly entered the work force did so for income to support families. Women not previously employed outside the home responded to unemployment within a year of the job loss by entering the work force with some becoming sole breadwinner.

Children of unemployed parents experience psychosocial problems related to parental job loss. According to Schliebner and Peregoy (1994), parental unemployment has a negative impact on children including substance abuse, physical illnesses, domestic violence, and increased suicide rates. Children may experience disruption in feelings of security and in their personal relationships due to their fears of the unknown and due to shifts in family dynamics. Adolescents may encounter problems foreseeing their own futures and experience decline in academic performance. Isaacs (2013) also reports unemployment negatively impacting child development, including poor school performance. Stevens and Schaller (2011) report parental job loss increases by nearly fifteen percent of a child being held back in school.

Unemployment and Behavioral/Health.

When people lose their jobs, or are underemployed, their mental health suffers (Norris, 2016). Underemployment is connected to depression, lowered self-esteem, anxiety, anger and substance use. This has historically been associated with men (Creed & Moore, 2006). Women are less likely than men to view men as “less masculine” with job loss (Michniewicz, Vandello, & Bosson, 2014). Clark and Heath (2014) outline the psychological impact of economic decline as does Bambra (2011) by the impact of unemployment and underemployment on behavioral health. Dooley, Fielding and Levi (1986) found unemployment and under-employment both increase risk taking behaviors and, with job loss, access to care diminishes.

Communities decline when work disappears (Wilson, 1996) with the deleterious impact of concentrated poverty on health and mental health. Wilson reports that employment supports asset accumulation to meet basic life needs. Employment provides more than just an individual’s physical needs. It also provides satisfaction for individuals to express their creative sides, promotes self-esteem, and provides avenues for self-realization and achievement. Downward mobility seen in unemployment has been found to increase feelings of anxiety and depression, lower self-esteem, and pose adverse physical health consequences (Linn, Sandifer, & Stein, 1985). Underemployed workers’ express problems with boredom, loneliness, anger, and less life satisfaction (Feldman & Turnley, 1995).

There is a connection between mental hospital admissions and employment rates (Keefe, 1984), and this theory is supported in the meta-analysis of findings of the increased use of mental health services by the unemployed (Jin, Shah, & Svoboda, 1997). Behavioral and emotional problems associated with stress and stress induced diseases increases unemployment (Keefe, 1984). The stress of job loss contributes to the health and mental health problems including mood, substance use and anxiety related problems (Eliason & Storrie, 2010). Keefe (1984) examined physiological, psychological, and interpersonal factors impacted by job loss. The physiological stress response, including the response to unemployment, had long term negative effects on loss of self-esteem, loss of personal identity, worry and uncertainty about the future, loss of sense of purpose, and depression experiences. The absence of social support directly contributes to depression which is itself a stress and is related to job loss. It is likely that illness creates risk of job loss as well as conversely, the threat of job loss creates mental and physical distress. Access to health services diminishes with job loss. Grief reactions, feelings of guilt, feelings of losing self-identity, and anger are emotions reported by clinicians who work with unemployed individuals seeking assistance from social service agencies (Keefe, 1984). Unemployment is estimated to fuel a fifth of suicides worldwide (Nordt, 2015). Using population level data, Nordt suggested community-level preventive interventions focus on those at risk for unemployment and those unemployed.

Having a job with a secure middle-class standing improves multiple avenues of a person’s life. Snow (2009) stated that work not only provides income but it also creates a network of individuals with whom people can connect and relate. People may have access to sports teams and social clubs through their job. The shame and stigma of losing a job limits support networks and can be psychologically damaging. There is a positive relationship between suicide rates

and economic downturns (Dooley, Fielding, & Levi, 1996). This has been studied since the classic Durkheim *Le Suicide* study (1897) that identified the impact of economic recession on suicide and other mental health related social variables. Dooley, Fielding and Levi's (1996) meta-analysis of the literature on health and unemployment found a relationship between poor health and both unemployment and underemployment. Their meta-analysis indicates mental health, while less than for health, is negatively impacted by unemployment and underemployment.

In a meta-analysis examining the impact of unemployment on mental health, Karsten and Klaus (2009) conclude from an analysis of 237 cross-sectional and 87 longitudinal studies that unemployment impairs mental health. They found significant differences in levels of distress, depression, anxiety, psychosomatic problems, subjective well-being and self-esteem. These longitudinal studies report that unemployment is more than related to impairment, but *causes* impairment.

Global economic downturns are thought to have an impact on mental health (Davalos, 2011). Using macro-economic analyses and linking data with health, quality of life, and substance use measures, Davalos reports on the relationship between economic recession and poor mental health. The theoretical models which explain this empirically support the link between unemployment, economic recession and poor health outcomes that have differing levels of explanatory power (Janlert & Hammarstrom, 2009). The relationship is explained by such theories as economic deprivation, stress, social controls, and social supports. Janlert and Hammarstrom note that there is consensus on the negative impact, though less certainty on its etiology. Job loss results in financial problems which in turn impacts health.

Ruhm (2003) reports that during economic recessions, mortality tends to increase and health tends to decline. Ruhm suggests that we not view this data in purely macro-level economic terms (aggregated data) but look also at its impact in specific populations and circumstances to get a truer and more nuanced picture. Strully (2009) examined data from the United States Panel Study of Income Dynamics (PSID) to investigate the effects of job loss on health. Job disruptions were measured with four dichotomous variables, using questions about why respondents left their last job: (1) no-fault job loss, (2) fired/laid off, (3) voluntary job separation, and (4) miscellaneous job separation. Health was measured with self-report variables including self-rating health, whether a doctor had ever told them they have certain health conditions, and the chronic nature of health problems. The results indicate that poor health is positively associated with job loss/separation categories. Losing a job because of site closure increases the likelihood of developing new health conditions by 83%, and for those losing a job because of site closures increase the odds of reporting fair/poor health by approximately 54% (Strully, 2009). For those fired or laid off, the likelihood increased reporting fair/poor health by 80% and having been fired/laid off increased the odds of a new health condition by 43%.

In a meta-analysis examining the impact of unemployment on health, Jin, Shah and Svoboda (1997) concludes that the evidence strongly supports the common perception that unemployment has an adverse impact on health. It is associated with greater risk of morbidity (physical and mental). Their analysis reveals

evidence that also supports the relationship between unemployment and suicide, motor vehicle accidents, and alcohol consumption while reducing access to health and mental health services. The Robert Wood Johnson Foundation (2013) summarizes research indicating 54% more unemployed compared with employed workers report poor health, and are 83% more likely to report developing stress related health conditions such as strokes, heart attacks, heart disease, and arthritis. In summary, downward mobility seen in job loss and unemployment is associated with a variety of negative health effects.

The unemployed report more visits to their physicians, more medication use, and more sick days (Murphy & Athanasou, 1999). The consequences of unemployment to physical and mental health increase burdens of care on families, communities and society. Murphy and Athanasou also found that employed people had lower levels of health disorders than those who were unemployed. Their analysis found consistent reports of the negative impact of unemployment. Injury-related health expenses are related to the type of employment workers have. In states where there is less union-membership, there are higher rates of worker injury and mortality. In the construction trades, there is a forty percent increase in fatalities in right to work states (Zullo, 2011). This “health outcome” is related to unionization spending on drug testing, training in new technologies, and other sponsored training programs—a balancing social determinants with health outcomes.

Job loss results in financial problems which impacts health. Strully (2009) reports that job loss may have an indirect impact on health risks by making it more difficult to secure replacement jobs impacting job “churning”, which in turn produces associated health and mental health risks. The historical linking of health coverage access to employer-based insurance is linked with social inequality (Shaefer & Sammons, 2009). This access linked to employer-based systems of health coverage and employment generates emotional and behavioral health implications that impact health outcomes.

Impending Job Loss and Behavioral Health

There is a less substantive amount of research that examines the impact of the “threat of job loss” as a social determinant of health outcomes. The threat of job loss negatively impacts health and mental health. Those threatened by the possibility of job loss are at greater behavioral health risk. The threat of job loss not only affects individuals but it also has effects on marital and family life. Unemployed married men experienced greater risks of poor mental health associated with being unemployed than do unmarried men (Artazcoz, Benach, Borrell, & Cortes, 2004). This finding contrasts with the general reported better health of married men than those who are single. The high risk of poor mental health suggests that in addition to stigmatization, economic issues related to family responsibilities impact mental health. Marital status can be a source of financial strain for unemployed men in lower social class categories, especially when they are considered the breadwinners. The cascading effect of downward mobility as

seen in threatened job loss creates behavioral health risks that in turn impact job stability.

Cuyper, Elst, Witte & Handaja (2009) studied how workers handled potential job insecurity and associated strain. They define job security as the relationship between the threat of unemployment and situational uncertainty and strain. Job insecurity is defined as the worker informed of possible unemployment and situational uncertainty meant workers were actually laid off. They surveyed 129 workers and concluded that workers who were informed of the threat of unemployment began to worry about job insecurity. The job insecurity strain relates to situational uncertainty. Tefft (2011) reports “filing for unemployment insurance compensation” increases mental health problems such as depression and anxiety. The threat of job loss threatens the loss of income, self-esteem, motivations, and vocational opportunities which in turn impacts emotional problems (Baker, Procter, & Gibbons, 2009).

Zivin, Paczkowski, and Galea (2010) summarized studies on the impact of economic recessions creating unemployment and employment risks showing that they are detrimental to health. They conclude from the studies they reviewed that there is a consistently reported relationship between economic recessions and health and mental health outcomes (suicides, help-seeking behaviors, care access, mood disorders, and distress). The impact of recession is more detrimental to those more at risk such as those experiencing poverty, unemployment, and less education.

Workers who face the threat of job loss demonstrate emotional problems as they restructure their lives. They express feelings of guilt, betrayal, resentment and fear of the organization. Linn, Sandifer and Stein (1985) studied unemployment, psychological and physical functioning in a longitudinal approach where 300 men were assessed every six months over a period of three years. The interviews measured symptoms including somatization, depression, interpersonal sensitivity, and anxiety due to the threat of job loss. More stress from unemployment increase risks of somatization, depression and anxiety. A 2010 Gallop Poll reported by the Robert Wood Johnson Foundation (2013) found unemployed Americans were far more likely than employed Americans to be diagnosed with depression and feelings of sadness and worry. The literature shows a pattern of risk to behavioral health posed by unemployment and the threat of job loss caused by broad economic and structural forces impacting interpersonal wellbeing.

The intersectionality of social inequality and race shape downward social mobility experiences. The threat of downward class standing of the workers has economic, intrapersonal, and social impacts. For example, in the mid-1930's, less than one percent of African American males were union members and by the mid-1970's, forty percent were union members (Kaufman, 2018). As unionization rates collapse, so do salaries decline, inequality increases, and the social determinants of health outcomes deteriorate. The job loss threat imperils social class status reflected in economic and the related health threats filters through a diversity of experiences.

The threat of job loss is a threat to class standing. Middle class standing is often defined in economic terms, but it also is entwined with other social variables. Due to racism and discrimination, the middle class in the past decades was seen as

an implicit proxy for race (predominantly white). However, since 2017, the majority of American children under 10 are black and/or brown. The middle class, in economic terms, is becoming more diverse. Policies that promote (or degrade) health opportunities are often implied even if without using racial terms. Policies that help the middle class, promote equality, and improve health outcomes could be a unifying force in a divided social context (Reeves and Busette, 2018).

The purpose of this study is to describe data reported by a small convenience sample of Avondale workers and to examine relationships between the threat of job loss, family adaptation, and behavioral health.

Questions Asked of the Avondale Workers

- What are the characteristics of the Avondale workers that responded to our survey (e.g., age, race, gender, relationship status)?
- What are some health access risks reported by the workers (e.g., health coverage, last checkup)?
- What are some behavioral health risks reported by the workers (e.g., mood, worry and fear, supports, problems, child with problems)?
- What are the family adaptation levels reported by the families (e.g., Family Adaptation Scale: Social relations, leisure time, communication between family members; or others such as level of supports, problems experienced, and problems of children)?
- Is there a relationship between Avondale workers' reported family adaptation and reported demographics, their health access, and their behavioral health risks?

Methodology

This study describes a sample of shipyard workers ($n = 43$) with threatened job loss with work being phased out and examines the relationships between the threat of job loss, family adaptiveness, and behavioral health risks. The data was collected from Avondale workers with a self-administered questionnaire. The surveys used a non-random method to collect the data and depended on the available subjects. Surveys were completed based on the availability of the workers leaving work or left in designated places for employees to complete at their discretion or convenience and return in sealed boxes where no names were required to support maximum privacy of the respondents. This convenience sampling approach only represents those people participating in the surveys and cannot be generalized to other workers beyond these respondents (Rubin & Babbie, 2017).

Measurement

The research team used items drawn from the Behavioral Risk Factor

Surveillance System (BRFSS) and the Family Adaptive Scale.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System is designed by the Centers for Disease Control and Prevention (CDC) and is the world's largest, telephone health survey system, tracking health conditions and risk factors in the U.S. yearly since 1984 (CDC, 2011). The BRFSS tracks health conditions and risk behaviors and is designed to measure depression, anxiety, and potential stress associated physical health effects. There have been nearly twenty separate studies that have examined issues related to the reliability and validity of the BRFSS (CDC, 2011). The BRFSS reports more than two hundred reliability and validity studies of measures on the BRFSS. It is a cross sectional surveillance survey used in 54 reporting areas (states, territories, major metropolitan areas) sponsored by the Centers for Disease Control and Prevention to assess behavioral health risks. The BRFSS questionnaires, data and reports are available for public use. The BRFSS is used as the basis for comparing data gathered from this study and from the BRFSS surveys of local parish (county) adults. This study reports on data from a sample of Avondale shipyard workers comparing findings with local parish (county) data on behavioral risks for exploratory study purposes.

Family Adaptive Scale (FAS)

The FAS is a standardized instrument that consists of ten semantic differential items scored from 1 to 7 and questions are answered "completely satisfied" to "completely dissatisfied" (Antonovsky & Sourani, 1988). The authors report the instrument has a reported high reliability of .921. It asks respondents questions about family adaptiveness and family cohesion. Antonovsky and Sourani (1988) used the FAS to determine if the threat of unemployment affects the family. The Family Adaptive Scale was defined as a fit between family members, the family unit, and the community. Stress is not seen as an automatic negative on family well-being but based on the family's generalized resilience. The FAS measures how families adapt when faced with the threat of job loss. Kickbusch (1996) reports on the properties of the scale designed to identify the pathways to good health mediated by family adaptiveness and cohesion—which shaped health outcomes. Antonovsky and Sourani (1988) measured the outcomes as exhibited on health risk behaviors rather than on the stressors (stress, coping styles, upbringing, financial assets, social supports) contributing to health and mental health because these can be mediated by family life qualities.

Potential Bias/Limitations

The study has many limitations and is intended to explore the relationships between the "threat of unemployment" and with family adaptation and behavioral health risks. The sample size is small ($n = 43$) which influences findings and limits

analysis of the data. The sample plan does not represent the population but describes only those people surveyed. The study was approved by the university for protection of subjects. The literature describes the behavioral health impact of unemployment/underemployment, and this exploratory study examines the behavioral health impact of the “threat of job loss”.

Findings

Questions in this study were asked to help identify characteristics of the sample as well as to examine relationships between job loss threat and behavioral health risks. Question #1: Who are the Avondale workers that responded to the survey? We asked general questions of the respondents to get information on their demographic characteristics and information on access to care. We asked about their age, race/ethnicity, gender, relationship status, whether or not they had health coverage, when they had not seen a doctor because of the cost, and how long since their last medical checkup. The Avondale worker respondent’s data are reported next to broader BRFSS survey data collected in Orleans Parish (County) for comparison purposes only (noted as “Orleans” on Table 1). (See Table 1).

The Avondale workers responding to our survey ($n = 43$) were in some ways like the respondents in Orleans Parish responding to the Centers for Disease Control and Prevention (2011) surveillance surveys ($n = 1,021$) but in other ways they were different. This important limitation requires caution in making comparisons. The purpose of providing the data from both is to provide context to the data, and not to emphasize comparisons.

The Avondale respondents were similar in age (50.0 years) compared with the Orleans sample (55.9 years). The Avondale workers were 36.8% White and 50.0% African American. The Orleans Parish survey respondents were 27.3% White and 64/6% African American. The Avondale respondents were primarily male (92.1%, 7.9% female) and the Orleans Parish BRFSS survey respondents had considerably fewer males (35.4%, 64.4% females). The Avondale respondents were married (66.7%), divorced/separated (22.1%), or never married (11.1%) compared with the Orleans Parish survey respondents who fewer were married (52.0%), fewer divorced/separated (14.7%), and slightly more never married (15.4%).

The Avondale respondents reported higher rates of having health coverage (97.5%) compared with the Orleans Parish respondents (87.2%) though the coverage through employment differs from the Orleans Parish sample that have larger numbers of people receiving coverage from public programs. The Avondale respondents also reported the average number of months since last seeing a doctor as greater in the number of months (7.1 months) compared with the Orleans Parish respondents (1.5 months on average).

Question #2: What are the health-related profiles of the Avondale respondents compared with the Orleans Parish surveillance survey respondents? For these health-related profiles, the respondents were asked to generally rate their own self-reported general health related characteristics. Respondents were asked about their

Table 1: *Demographic Profile of Respondents and Care Access*

Characteristics	freq	%	freq	%
	Avondale (n = 43)		Orleans (n = 1,021)	
Average Age (mean/st. dev.)	50.0	10.8	55.9	16.9%
Race/Ethnicity				
White-Euro-American	14	36.8%	3	27.3%
Black-African American	19	50.0%	660	64.6%
Latino/Hispanic	3	7.9%	109	6.9%
Other	2	5.3%	228	1.2%
Gender				
Male	35	92.1%	361	35.4%
Female	3	7.9%	660	64.4%
Marital Status				
Married	24	66.7%	531	52.0%
Divorced/separated	8	22.1%	150	14.7%
Never Married/other	4	11.1%	159	15.6%
Have health coverage	39	97.5%	890	87.2%
Average # Months since last checkup	7.3 (sd = 9.6)		1.5 (sd = 1.0)	

*(missing data not reported in percentages)

Table 2: *Description of Health Profiles Reported by Respondents*

Health Characteristics	Avondale Workers (n = 43)		Orleans Residents (n = 1,021)	
	<i>x</i>	sd	<i>x</i>	sd
Rating of general health (1=excellent; 2=v.g.; 3= good; 4=fair; 5=poor)	2.6	0.9	2.4	1.1
Days past month physical health not good	2.9	4.5	12.5	11.5
Days past month physical/mental health not good	6.6	9.8	12.9	11.3
Days past month health/mental hlth. limited activity	3.3	7.2	12.3	11.0
Days past month not enough sleep	10.7	9.6	12.6	10.4
Days past month had at least one alcohol drink	5.4	7.8	2.0	1.7
Largest number of drinks at one day	2.5	3.8	2.8	2.5
Days past month felt sad, blue, depressed	8.4	9.9	7.4	8.7
Days past month felt worried, tense, anxious	11.2	11.4	5.3	16.5
Days past month felt very healthy and energetic	15.6	9.9	16.5	8.5
Days past month provided care too sick or disabled	7.5	10.4	1.7	2.9

general health, and a variety of questions about in the past 30 days such as how many days they experienced health related problems. These problems included numbers of days physical health was not good, days their mental health was not good, days their health or mental health problems limited their activities, days they did not have enough sleep, days they had at least one alcoholic drink including the largest number on average of drinks they had, days they felt sad, blue, or depressed, days they felt worried, tense or anxious, days they felt healthy and energetic, and days they provided caretaking to someone sick or disabled. The Avondale respondents reported considerably better mental health related outcomes than did those in the Orleans Parish surveys, but with some notable exceptions. (See Table 2)

The Avondale respondents rated their general health on average as good to very good with a mean score of 2.6 on a 1 (excellent) to 5 (poor) scale. This is very similar to how the Orleans Parish respondents also reported their general health (mean of 2.4). The Avondale respondents reported considerably less days in the past 30 days in which their physical health was not good (2.9 days) compared with the Orleans Parish respondents who reported 12.5 days. This was also so for their reporting average number of days when their mental health was not good (6.9) compared with the Orleans respondents average of 12.9 days. The Avondale respondents reported considerably fewer days when their physical or mental health problems limited their activities (3.5 days) compared with those in the Orleans area reporting 12.3 days. Both groups reported somewhat similar levels of problems with sleep (Avondale at 10.7 days and Orleans at 12.6 days).

The Avondale respondents reported more days when they had at least one drink a day (on average of 5.4 days per month) compared with the Orleans Parish respondents (2.0 days). The Avondale respondents reported similar largest average number of drinks at a time (2.5) compared with the Orleans Parish similarly reported average (2.4).

The Avondale respondents reported slightly more problems with depression (8.4 days reporting being sad, blue, depressed) compared with the Orleans Parish respondents (7.4 days). However, the Avondale respondents reported considerably more days (11.2) dealing with anxiety problems (worried, tense, anxious) compared with other Orleans Parish respondents (5.3 days in the past 30). They reported similar numbers of days in the past 30 feeling healthy and energetic (15.6) compared with the Orleans respondents (16.5). The Avondale workers reported considerably more days spent care giving for sick or disabled others (7.5) than did other Orleans respondents (1.7 days).

Question #3: Respondents were asked about some other mental health related psychosocial risks. They were asked about their perception of social supports they have, some common psychosocial problems, and problems their children are experiencing. There comparative data from the surveys on Avondale workers' social supports, but not for the other related problems. (See Table 3)

The Avondale respondents reported lower levels of social and emotional supports in their lives compared with the Orleans Parish respondents. The Avondale respondents reported always to usually having good social and emotional supports (41.0%) compared with the Orleans Parish respondents (73.5%). In

Table 3: *Other Mental Health Related Issues*

	Avondale Workers (n = 43)		Orleans Residents (n = 1,021)	
	freq	%	freq	%
How often receive social/emotional support				
Always	10	25.6%	465	48.7%
Usually	6	15.4%	237	24.8%
Sometimes	12	30.8%	114	11.9%
Rarely	7	17.9%	55	5.8%
Never	3	7.7%	61	6.4%
Have problems			NA	
Depressed, mentally ill, suicidal	8	21.6%		
Problem drinking, alcoholic	3	8.1%		
Served time in jail, prison	3	8.1%		
Child with problems			NA	
Expelled/suspended from school	3	7.0%		
Receiving failing grades	3	7.0%		

another way of viewing the reported information, Avondale respondents reported (25.6%) never or rarely having adequate social or emotional supports compared with the Orleans Parish respondents 12.2% reporting never or rarely.

We do not have comparable data from both groups on some of the other reported social problems. However, the Avondale respondents reported that 21.6% felt depressed, mentally ill or suicidal, 8.1% having a drinking problem, 8.1% having someone in the household serving time in jail/prison, and 3.1% reporting experiences with domestic violence. The Avondale respondents reported that 7.0% of their children were expelled/suspended from school and 7.0% were experiencing failing grades.

Question #4: What are the family satisfaction levels using the family adaptation scale as reported by the Avondale respondents? The family satisfaction scale measures different aspects of how satisfied respondents feel with things occurring in their family life. (This information is only available for the Avondale respondents).

The Avondale respondents reported overall high levels of satisfaction with dynamics of family life. Most reported high satisfaction on all dimensions. The lowest reported area was some reported difficulty of family members communicating with each other. (See Table 4).

Table 4: Family Satisfaction

Family Satisfaction Items*	Avondale Workers (n = 43)	
	x	sd
Belonging to family	6.5	1.5
Way children being raised	5.1	2.0
Family way of life	5.5	1.7
Expressing feelings for family	5.8	1.6
Closeness of family members	5.8	1.7
Spending of leisure time	5.2	1.8
Communicate with each other	4.8	1.8
How family fits into neighborhood	5.5	1.8
Social relations your family has	5.5	1.8
Way family relates to each other's wishes	5.2	1.9
Family is well adjusted	5.2	1.9
OVERALL SCORE	5.4	1.6

* (1=very not satisfied; 7 = completely satisfied)

Question #5: Is there a relationship in the Avondale responses between family satisfaction and health and mental health outcomes? This question is asking whether the average Avondale respondents who report greater levels of satisfaction with their family life (family adaptation) are reporting less health and mental health related problems. (See Table 5).

The Avondale respondents reported that their level of satisfaction with family life was not related to their health or mental health risks in general. There were reported differences in two areas. If the workers reported higher levels of satisfaction with their family life, they also indicated overall health as better.

Table 5: *Family Satisfaction by Health Outcomes*

# days Health Outcomes	Higher Family Satisfaction (n = 22)		Lower Family Satisfaction (n = 10)		df	p*
	mean	sd	mean	sd		
Rating of general health	2.19	(0.98)	3.00	(0.47)		29.0.004*
Physical health not good	2.05	(4.33)	3.33	(4.15)		15.5.450
Mental health not good	4.19	(9.23)	15.33	(10.63)		13.4.017*
Limited sleep	7.45	(7.74)	15.30	(11.11)		13.1.064
Drinks alcohol	4.05	(6.83)	5.60	(9.80)		13.1.657
Depressed	5.76	(8.00)	12.80	(11.42)		12.8.121
Anxiety	9.90	(11.42)	12.40	(12.39)		16.8.600
Days felt energetic/healthy	18.00	(9.47)	9.56	(10.63)		13.7.059
Days providing care-giving	7.80	(9.48)	9.78	(14.02)		11.4.707
Problems with depression	0.16	(0.37)	0.44	(0.52)		12.0.169
Incarceration	0.10	(0.32)	0.11	(0.33)		15.0.965
Have problem drinking	0.10	(0.32)	0.11	(0.33)		15.0.965
Child expelled/suspended school	0.11	(0.31)	0.11	(0.33)		15.0.965
Child failing grades	0.05	(0.23)	0.11	(0.33)		11.7.643
Have social and emotional supports	2.18	(1.26)	3.10	(1.29)		17.1.077

Likewise, if the worker reported better family adaptation and coherence, they reported less days of having mental health problems. Both of these differences were statistically significant. Family adaptiveness and cohesion did not in general predict behavioral health outcomes.

DISCUSSION

In the myth of a “classless society”, inequality is based on myths such as those with lower standing deserve this fate due to personal qualities rather than social and economic dynamics. This deeply-held belief in “the land of opportunity” falsely assumes upward social mobility as characteristic—despite evidence of the shrinking opportunities for upward mobility. This reinforces unscientific assumptions about downward social mobility due to personal qualities such as genetics, gender, or racial and ethnic (Braverman, 2012) which influence the prisms in which we view disparities in health, mental health, and well-being. The findings of this study report differences that are best understood when viewed in light of class issues.

There were similarities and differences in the characteristics of the Avondale respondents and those from the Orleans Parish respondents. The numbers of White and Latino respondents were similar and the numbers of African American (Black) or multi-racial respondents were less among the Avondale workers than the local parish (county). Also, the Avondale respondents were primarily male and the Orleans area respondent primarily female. The Avondale respondent was more likely to be married than the Orleans Parish respondent. These indicate that some of the mental health access questions and mental health experiences of the respondents might be influenced by racial, gender and relationship status. This reminds us to view this data as descriptive of the experiences the Avondale respondents are reporting to us and not to generalize to the population.

The Avondale respondents reported primarily having access to health coverage (94.5%). The Orleans average having coverage (87.2%) included those having coverage from their employment as well as coverage by public means such as having Medicare and Medicaid coverage. However, 21.6% reported not having seen a doctor for health or mental health related problems because of the cost. This includes such things as co-payments and services not covered. The Avondale respondents reported greater numbers of months since last seeing the doctor compared with the average reported by the Orleans respondents. This may be related to the data that shows Avondale respondents reported less days when their health and mental health were not good compared with the Orleans respondents.

Both the Avondale and Orleans respondents rated their health as very good. When asked about the numbers of days that both their physical and their mental health were not good, the Avondale respondents reported considerably more days of good health and mental health. The number of days when respondents reported sleep problems and feeling depressed were similar. The Avondale respondent's higher average number of days in the past month having consumed alcohol was higher. The average number of days spent in care giving (sick or disabled family or relatives) was also higher for the Avondale respondents. This may be unusual

since in general women tend to report more care giving responsibilities. This difference might be related to the Avondale respondents through their employment have more resources to take on the responsibilities of care giving.

In one area of mental health, the reported number of days when respondents reported a greater number of days with problems with anxiety (feeling worried, tense or anxious) were considerably more for Avondale respondents than for the average number of days where anxiety was a problem for those in the Orleans area. In studies of the total population, men and women have similar levels of anxiety disorders (Satcher, 1999). The Avondale respondents do not appear to be reporting anxiety because of other health or mental health related differences nor because of differences in satisfaction with their family life which the average rating of their family life was very satisfied. However, the average Avondale respondent reported lower levels of receiving social and emotional support (44.5%) compared with the Orleans Parish respondent (73.5%). Greater levels of anxiety and less social supports existed among the worker respondents and family adaptiveness and cohesion was not a predictor of the groups due to the social determinants of the threat of job loss.

This issue of worry, fear and anxiety by the Avondale respondents might be accounted for by the stress these workers are feeling related to the threat of downward mobility in the threat of job loss due to the (then) impending closing of the shipyards and their perceptions of the inadequacy of the social and emotional support they are experiencing. There are a variety of reasons why declining social mobility is itself a worry. Krause and Sawhill (2018) identify various reasons for this worry: middle-class incomes are stagnant, employment wages are declining, children's prospects are declining, disparities between race and gender are widening, regions matter more than ever, a general sense of well-being is eroding, and families are becoming more fragile. The reasons for this anxiety expression are enshrined in a cascade of social determinants of health threats.

The literature cited shows a clear pattern of stress on workers threatened by "unemployment" which had a direct bearing on their emotional and behavioral as well as physical health. From this small survey of workers facing job loss, there appear to be adverse effects of threats to job loss on the anxiety levels of workers that are beyond what are explained by families adapting to the stressful environment. Worry and fear appear to be directly related to job loss threats and emotional and behavioral health challenges. This problem is magnified beyond the work force to the communities most directly impacted by the adverse threats of job losses to others in the communities impacted by the threats. This suggests that workers and their families as well as other families in the community impacted by the job loss threats need supports not only for the economic development needs of those workers, families and communities, but also the related behavioral health risks faced by the workers, families and communities. Health and health inequalities are an artifact of how communities respond to the challenges faced by the diverse communities impacted by the changes shadowing those facing job loss threats. The looming threat of the plant closure threatens jobs, family adaptations, and behavioral health. Though the problems are manifest on the individual level, the social determinants are at the etiological roots of the problems. As Norris

(2016) describes these “public issues”, unlike personal troubles, public issues cannot be solely solved by individual’s own actions. Broader community challenges confront these behavioral health issues. Social mobility perspectives in addressing social determinants of behavioral health offer directions to bridge gaps between community level determinants and worker level needs (Simmons, 2016).

Oxfam America (2013) surveyed lower income workers and the concerns of lower income workers expressed are certainly influencing the discussion of workers fearing falling out of the middle class into lower paying jobs. Though these workers express beliefs in the “work ethic”, they also believe that government has a responsibility that if they work hard, they and their families should not go hungry, fall into poverty, and suffer related deprivations. Low wages equate to low benefits and poor working conditions (impacting health and welfare). Respondents fear deleterious impacts on retirement potentials, borrowing, and health access. The workers believe laws are passed to benefit the wealthy (at their expense). They and their families fear being locked out of healthy nutrition, education opportunities, child care, and affordable health care. They face discrimination in the job sites (with intersectionality between class, race and gender) worries. The worker surveys by Oxfam America (2013) shed light in their own voices as to why the fall from middle class poses risk to health, mental health, and overall wellbeing.

The economic vitality of a community experiencing a business closure is challenged but how devastating the closure becomes as it is impacted by various structural considerations (local and regional job markets, educational infrastructure, and health care delivery access) and community engagement characteristics empowering communities to act together to address the impact of the closure on the communities. Workers anticipate their loss of job stability and financial security to influence their sense of standing in the community (Walley, 2013). How serious the economic challenges impacting overall employment and income levels varies by communities, Hooker, Knetter, and Sakakibara (1998). Though the economic and employment circumstances related to closures can be devastating, early planning and community engagement can mitigate the impact (Cowan, 2012). Unfortunately, while earning good wages, workers tended to support the local United Way for example, but when they needed more help, the United Way as well becomes stressed with declining revenues due to plant closures in a cycle challenging community impact. When families have greater behavioral health needs, community resources may be influenced more by macro structural indicators than by community need. Communities are impacted by the changing social contract where perceptions of the rewards of hard work are dislodged. The structural consequences of job loss are manifest at individual and familial levels, though solutions that focus on these levels do not get to the social determinants of behavioral health challenges. Unions have been a structural buffer as a broadly-based movement for worker’s protections. There is a decline in union membership—in 1953, 37.5% of workers belonged to unions, and in 2015, the number declined to 6.7% (Wright, 2016). Class includes more than just these economic structures. As Jedediah Purdy (2018:55) describes in reviewing the changes in the metaphors of class, “class is [also] contaminated water and children with chronic pain and fatigue—it is living downhill of the pond where fracking

fluids are stored". This indicates need for diverse community collaboration efforts to impact improved class-driven behavioral health status.

Social inequalities over the last fifty years have been increasing—in 2017 the richest ten percent of Americans owned seventy-seven percent of the nations wealth, the highest inequality since the “gilded age” (Cole, 2018). Cole reports that (p. 25) in 1979, CEO’s earned about thirty times what skilled trades employed earn, and by 2013, this was three hundred more. Incomes for working people during this growth period fell (adjusting for inflation). Stone (2018) reports that the bottom sixty percent of the workforce lost 4.4% of income, while the top one percent income increased by 5.7%. The threat of downward social mobility has extensive tentacles in people’s health, mental health, and well-being.

This research report calls to attention downward social mobility’s impact on behavioral health from the job site closures in partnership with community-based groups such as faith-based, organized labor, educational, business, neighborhood, political and health-related community participants. Policies to address the health impact of business closures with these partnerships can mitigate public health harm and empower communities to shape requisite community responses. Policies and social action to support a community development approach that supports the health and mental risk associated with major business closures and the ensuing job loss threats. Behavioral health determinants display a complex interaction between communities social and economic structures and individual and family biopsychosocial wellbeing (Soaks, Gutierrez, & Santiago, 2013).

This study demonstrates the need for multi-level social supports in plant closing processes to positively influence individual and family behavioral health outcomes threatened by downward social mobility in the “threats” to job loss. The perceived threat of job loss is more than financial loss, and includes loss of social standing and community support. Solutions to the social class downward mobility are ingrained in the solutions to class inequality. Gornick and Jantti (2013) provide examples of structural policy interventions to address these threats: reduce inequality (e.g., living wages, taxation of inheritance), invest in upgrading skills (educational policies as well as through unionization), expand wage subsidies (e.g., childcare, earned income tax credits), paid family and medical leave, child savings accounts at time of birth, boost unionization, establish wage boards, and close the respect gap. Persons experiencing social class decline may well experience this suffering not only socially (Gornick & Jantti, 2013) but interpersonally. This is occurring during a period when the current administration is further dismantling safety nets and access to health care. Advantages cluster in the upper classes, and disadvantages in the lower social classes ... with the risk of for those in the middle class of falling social mobility risking of their health and wellbeing. The evidence speaks to the need to broaden access to effective personal supports, broader social supports, and policies to change the course of the decline in social equality.

References

- Antonovsky, A. & Sourani, T. (1988). Family sense of coherence and family adaptation. *Journal of Marriage and the Family*, 50:79-92. Doi 10.2307/352429

- Artazcoz, L., Benach, J., Borrell, C., & Cortes, I. (2004). Unemployment and mental health: Understanding the interactions among gender, family roles, and social class. *American Journal of Public Health, 94*(1):82-88. Doi 10.2105/AJPH.94.1.82
- Bambra, C. (2011). *Work, worklessness, and the political economy of health*. NY: Oxford University Press.
- Brand, J.E. (2015). The far-reaching impact of job loss and unemployment. *Annual Review of Sociology, 41*:359-375. Doi 10.1146/annurev-soc-071913.043237
- Centers for Disease Control and Prevention. (2011). Behavioral risk factor surveillance system. Retrieved from the Centers for Disease Control and Prevention at www.cdc.gov/brfss
- Chetty, R., Grusky, D., Hell, M., Hendren, N., Manduca, R., & Narang, H. (2017). The fading American dream: Trends in absolute income mobility since 1940. *Science, 24*:398-406. Doi 10.1126/science.aa14617
- Clark, T. & Heath, A. (2014). *Hard times: The divisive toll of the economic slump*. New Haven, CT: Yale University Press.
- Coles, D. (2018). Taxing the poor. *The New York Review of Books, 65*(8):25-26.
- Congressional Research Service. (2012, February 7). Military base closures: Socioeconomic impacts. Available from www.crs.gov for download on May 30, 2012.
- Conveners, A.S. (2011). *Avondale Shipyard Research Project*. New Orleans: Avondale Shipyard Research Project.
- Cowan, T. (2012). Military base closures: Socioeconomic impacts. Available for download by the Congressional Research Services (RS22147) at www.crs.gov
- Creed, P.A. & Moore, K. (2006). Social support, social undermining, and coping in underemployed and unemployed persons. *Journal of Applied Social Psychology, 36*:321-339. Doi 10.1111/j.0021-9029.2006.004.x
- Cuyper, N., Elst, T., Witte, H., & Handaja, Y. (2009). Objective threat of unemployment and situational uncertainty during a restructuring: Associations with perceived job insecurity and strain. *Journal of Business and Psychology, 25*:75-85. Doi 10.1007/s10869.009.9128y
- Davalos, M.E. & French, M.T. (2011). This recession is wearing me out! Health related quality of life and economic downturns? *Journal of Mental Health Policy and Economics, 14*(2):61-72.
- Dooley, D., Fielding, J., & Levi, L. (1996). Health and unemployment. *Annual Review of Health, 17*:449-465. Doi 10.1146/annual.pu.17.050196.002313
- Eliason, M. & Storrie, D. (2010). Inpatient psychiatric hospitalization following involuntary job loss. *International Journal of Mental Health, 39*(2):32-55. Doi 10.2753/IMH0020-7411.3902032
- Feldman, D.C. & Turnley, W.H. (1995). Underemployment among recent business college graduates. *Journal of Organizational Behavior, 16*:691-706. Doi 10.1002/job.4030160708
- Goldstein, S. (2018). Nine out of ten new jobs are going to those with a college degree. Available on www.MarketWatch
- Gornick, J. & Jantti, M. (2013). *Income inequality: Economic disparities and the middle class in affluent societies*. Stanford, CA: Stanford University Press.
- Hooker, M.A., Knetter, M. M., & Sakakibara, M. (1998). Measuring the economic effects of Military base closures. Available from the National Bureau of Economic Research at www.nber.org/papers/w6941
- Isaacs, J. (2013, March). Unemployment from a child's perspective. Washington DC: Urban Institute. Available at www.firstfocus.net
- Janlert, U. & Hammarstrom, A. (2009). Which theory is best? Explanatory models of the relationship between unemployment and health. *BMC Public Health, 1*-9.

- Jin, R.L., Shah, C.P., & Svoboda, T.J. (1997). The impact of unemployment on health: A review of the evidence. *Journal of Public Health Policy*, 18(3):275-301. Doi 10.2307/334331
- Karsten, P. & Klaus, M. (2009). Unemployment impairs mental health: A meta-analysis. *Journal of Vocational Behavior*, 74(3):264-282. Doi 10.1016/j.jvb.2009.01.001
- Kaufman, D. (2018). *The fall of Wisconsin: The conservative conquest of a progressive bastion and the future of American politics*. New York: W. W. Norton & Company.
- Kawachi, I., Daniels, N., & Robinson, D.E. (2005). Health disparities by race and class: Whyboth matter. *Health Affairs*, 24(2):343-352.
- Keefe, T. (1984). The stress of unemployment. *Social Work*, 29(3):264-268. Doi 10.1093/sw/29.3.264
- Kickbusch, I. (1996). Tribute to Aaron Antonovsky—what creates health? *Health Promotion International*, 11(1):5-6. Doi 10.1093/heapro/11.1.5
- Krause, E. & Sawhill, I.V. (2018, June 5). Seven reasons to worry about American middle class. Washington DC: Brookings Institution, in “Social Mobility Memos”.
- Linn, M. W., Sandifer, R., & Stein, S. (1985). Effects of unemployment on mental and physical health. *American Journal of Public Health*, 75(5):502-506. Doi 10.2105/AJPH.H.75.5.502
- Mattingly, M. (2010). Changes in wives’ employment when husbands stop working: A recession-prosperity comparison. *Family Relations*, 343-357. Doi 10.1111/j.1741-3729-2010-00607.x
- Michniewicz, K.S., Vandello, J.A., & Bosson, J.K. (2014). Men’s (mis)perceptions of the gender threatening consequences of unemployment. *Sex Roles*, 70:88-97. Doi 10.1007/s11199-013-0339-3
- Murphy, G.C. & Athanasou, J.A. (1999). The effect of unemployment on mental health. *The Journal of Occupational and Industrial Psychology*, 72(1):83-99. Doi 10.1348/096317999166518
- Nordt, C., Warmke, I, Selfritz, E., & Kawohl, W. (2015). Modeling suicide and unemployment. *The Lancet Psychiatry*, 2(3):239-245. Doi 10.1016/S2215-0366(14)00118-7
- Norris, D.R. (2016). *Job loss, identity, and mental health*. New Brunswick, NJ: Rutgers University Press.
- Oxfam America. (2013). *Hard work, hard lives*. See a discussion of the survey at www.OxfamAmerica.org
- Purdy, J. (2018). The remaking of class. *The New Republic*, July/August, 51-56.
- Reardon, S.F. & Bischoff, K. (2011). Growth of residential segregation of families by income: 1970–2009. Available from www.socialcapital.wordpress.com from the Russell Sage Foundation on November 16, 2011.
- Reeves, R.V. & Busette, C. (2018, February 27). The middle class is becoming race-plural, just like the rest of America. The Brookings Institution (Brookings Notes).
- Robert Wood Johnson Foundation. (2013). How does employment-or-unemployment-affect Health? Available at www.rwjf.org/healthpolicy
- Rubin, A. & Babbie, E. (2017). *Research methods for social work (ninth edition)*. Belmont, CA: Brooks/Cole.
- Ruhm, C.J. (2003). Good times make you sick. *Journal of Health Economics*, 22(4):637-658. Doi 10.1016/S067-6296(03)00041-9
- Satcher, D. (1999). *Mental health: A report of the Surgeon General*. Washington DC: USDHHS, CMHS.
- Schliebner, C.T. & Peregoy, J.J. (1994). Unemployment effects on the family and the child: Interventions for counselors. *Journal of Counseling & Development*, 72(4):368-72. Doi 10.1002/j.1556-6676.1994.tb00951.x

- Shaefer, H.L. & Sammons, E.D. (2009). The development of an unequal social safety net: A case study of the employer-based health insurance (non) system. *Journal of Sociology and Social Welfare*, 36(3):179-199. Doi 10.15640/jssw
- Simmons, L. (2016). Opportunities for community organizing in the realm of economic justice and low wage worker struggles. *Journal of Community Practice*, 24(2):166-181. doi 10:1080/10705422.2016.1165779
- Snow, T. (1987). Effects of unemployment on workers' health will prove a burden for nurses. *Nursing Standard (Royal College of Nursing)*, 23(21):3-12. Doi 10.1007/s12103-013-9199-1
- Soska, T.M., Gutierrez, L., & Santiago, M. (2013). The intersection of community practice and health practice. *Journal of Community Practice*, 21(1):1-8. Doi 10.1080/10705422.2013.780282
- Stevens, A.H. & Schaller, J. (2011). Short-run effects of parental job loss on children's academic achievement. *Economics of Education Review*, 30(2):289-299. Doi 10.3386/w15480
- Stone, C. (2012, March 1). Helping workers adjunct to permanent job losses. Washington DC: Center for Budget Policies and Priorities. Available on www.cbpp.org
- Strom, S. (2003). Unemployment and families: A review of research. *Social Service Review*, 77(3):399. Doi 10.1086/375791
- Strully, K.W. (2009). Job loss and health in the U.S. labor market. *Demographics*, 46(2):221-246. Doi 10.1353/dem.0.0050
- Tefft, N. (2011). Insights on unemployment and mental health. *Journal of Health Economics*, 30(2):258-264. Doi 10.1016/j.jnea/econ.2011.01.0006
- Walley, C.J. (2013). *Exit zero: Family and class in post-industrial Chicago*. Chicago, IL: University of Chicago Press.
- Wilkinson, R.G. (2002). *Unhealthy societies*. London: Routledge.
- Wilson, W.J. (1996). *When work disappears: The world of the new urban poor*. New York: Random House Publishers.
- Wauchope, B. (1995). Children experiencing unemployment stress: A comparison of families with stable and unstable employment histories. *Dissertation Abstracts International Section A: Humanities and Social Science* 56, 56.
- Wright, M.J. (2016). Editorial: The decline of American unions is a threat to public health. *American Journal of Public Health*, 106(6):6-7. Doi 10.2105/AJPH.2016.303217
- Zullo, R. (2011). Right to work laws and fatalities in construction. *Journal of Labor and Society*, 14(4):225-234.
- Zivin, K., Packowski, M., & Galea, S. (2011). Economic downturns and population health. *Psychological Medicine*, 43:1343-1344. Doi 10.1017/S003321171000173x