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Robert Lejeune
Herbert H. Lehman College

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REPORTED ILL-HEALTH AND LIFE CYCLE AMONG WELFARE MOTHERS* (1971)

Robert Lejeune
Herbert H. Lehman College

A person's presentation of self, as Goffman uses that phrase, depends in part on the expectations of others, and also, no doubt, on the power which these others have over the person. Thus it happens very frequently that persons, particularly of low status or stigmatized positions, are called upon, as a conscious or unconscious technique of survival, to present to others negative features of the self; to resort to what Goffman has called "negative idealization." (Goffman 1959; 39-41; 1963). These considerations have direct bearing on the role of welfare recipients in American society. Welfare clients, if they are to continue to receive assistance, must present themselves to public officials in ways which reflect the welfare system's biases concerning the reasons for their "dependency."[1] This paper focuses on some of the social factors which increase the likelihood that one particular bureaucratically acceptable "reason for dependency"--poor health--assumes an important role in the legitimation of continued welfare assistance to mothers with dependent children.

Self-reported states of health are not easily interpreted. Empirically they represent a complex interaction among physiological, psychological, and social factors. (Kadushin, 1964, 1967; Zola, 1966; Crandell and Dohrendwend, 1967). Clearly, the "objective" physiological condition of one's body plays a major part in one's self-reported illness. But illness is also a form of behavior in which the individual is legitimately exempt from what are considered normal role obligations by others in the social system. Two decades ago, Parsons, following the psychoanalytic model, noted that people who are ill sometimes become unconsciously motivated to retain the "privileges and exemptions of the sick role." (Parsons, 1951). In a subsequent examination of the problem, Parsons hypothesized that the high level of achievement demanded of individuals in American society might accentuate the unconscious desire to use ill health as a means of exempting oneself from role obligations. (Parsons, 1958). Thus, the Parsonian hypothesis points to the likely influence of social expectations on the level of reported ill-health in a population. The particular social expectations under consideration in this paper, and their likely impact on illness behavior, are those contained in the rules which currently govern the administration of public assistance in America.

The welfare laws and the bureaucracies which implement them articulate a set of formal standards of eligibility for assistance which at

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[1]Beck (1967) examines the implicit value judgments which travel with the concept of welfare dependency.

best rely on an inadequate accounting of the reasons why people need such assistance (Steiner, 1966). To be eligible, a family or individual must demonstrate economic need and the inability to meet this need through socially prescribed channels which in most instances require employment. In turn, for the categories of assistance which provide some federal matching funds, exemption from employment is based on the presentation by the welfare applicant of one of the following attributes: physical or mental disability, dependent children under eighteen years of age to care for, old age (65 and over), or blindness. While such criteria do not in themselves represent an explanation for dependency, they are consonant with explanations which attribute dependency to the individual's presumed physical or moral failure rather than to the failure of institutions, communities, or the society.[2] Thus, there is a category of assistance for those who are physically disabled but no category of assistance for those whom technology has rendered unemployable. There is a category of aid to families with dependent children but no category of assistance for those whose employment is limited as a result of racial discrimination. Even if we limit the discussion to individual attributes likely to be correlated with the need for assistance, without considering the social factors which influence the presence or absence of these attributes, it is clear that the welfare system is very selective as to which of the poverty-related variables are considered relevant for eligibility. Thus, a forty-year-old man who cannot read and write and has a heart condition becomes a welfare client "because of" his state of health rather than "because of" his lack of education.

THE HYPOTHESIS

There are obvious economic pressures on welfare clients to define themselves in terms which are acceptable to the welfare officials. Consequently, it can be expected that when they are asked to explain their need for public assistance they will give reasons which can be coded into the categories of eligibility devised by the welfare system. This should be the case if the questioner is a stranger who announces herself to be a survey interviewer--but who unavoidably resembles a welfare worker to all but the most trustful welfare client.

It is here hypothesized that one consequence of the welfare eligibility laws is to make certain personal characteristics more salient in the welfare client's presentation of self. One such characteristic is poor health. More specifically, it is hypothesized that welfare mothers who are currently receiving assistance for the care of dependent children will be more likely to report poor health as a reason for their dependency as they approach the stage in their life cycle when the care of dependent children is no longer an acceptable reason for receiving

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[2]This is of course most evident with respect to the category of Aid to Dependent Children (Steiner, 1966: 6-8). However, old age in American society, where youth represents the most prestigeful part of the life cycle, may also be viewed as a form of "failure." For a discussion of illness as "failure" see: Lorber (1967: 306).

assistance. Most of these women will still be in their forties and fifties and consequently ineligible for old age assistance. Some, perhaps most, will seek employment. But realistically the employment prospect of many--with little education and limited job skills--is not optimistic.

THE DATA AND THE SAMPLE

Data from a 1966 survey of New York City welfare mothers are used to test the above hypothesis. The primary aim of that study was an examination of the determinants of medical utilization by welfare families.[3] To that end, a systematic stratified sample of 2179 welfare mothers was interviewed in the summer of 1966 by the staff of the National Opinion Research Center. It is important to note that the sample did not include any respondents classified as receiving aid to the disabled, aged, or blind. The respondents ranged in age from 18 to 64. All were either mothers or female guardians of dependent children. In 39% of the cases there was a male head of household, but he either was not employed or his income was insufficient to support the family.

Most of the structured interview was used to collect information on attitudes and behavior presumed to be associated with the utilization of medical services. The data were not collected with the above hypothesis in mind, but the hypothesis was formulated prior to the analysis of the data.

FINDINGS

Before testing the hypothesis it is necessary to examine the extent to which welfare dependency is viewed as a fairly permanent state at each stage of the life cycle. Clients who define themselves as only temporarily on welfare, until the children are older, would be under no particular pressure to present themselves as in poor health.

The mothers' reported preference for working or staying at home and their estimates of the likelihood they would be employed in the future are used as two separate indicators of the acceptance of the welfare status as more or less permanent.[4] Age is used as an indicator of stage of life cycle. Not unexpectedly, as can be seen in Table 1, younger clients are most likely to feel they will work or work again in the future--when the children are older. However, welfare mothers whose children <u>are</u> now older tend not to be as optimistic about future employment. Nor are they as likely to say that they would prefer to work rather than stay at home. Employment expectation which seems to be a more reality-linked indicator than employment preference declines more rapidly with age. Thus, while 63% of the mothers over 40 would prefer to work rather than stay at home only 39% expect that they will ever work in the future.

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[3]For a more detailed description of the sample and some of the findings of this study see: Lejeune (1968).

[4]The two questions were: "Would you rather work for pay or stay at home?" and "Do you think you will ever (again) work for pay?"

TABLE 1. PERCENT WHO WOULD PREFER TO WORK AND PERCENT WHO EXPECT TO WORK, BY AGE

	Age			
	Under 30	30-39	40 and over	Total
Percent who would rather work than stay at home:	72% (793)	70% (845)	63% (537)	69% (2175)
Percent who expect to work (again):	77% (792)	70% (847)	39% (535)	65% (2174)

Following the question concerning the preference for working or staying at home, each respondent was asked in an open-ended question the reason for her choice. For the minority of welfare mothers (31%) who, irrespective of age, expressed a preference for staying home rather than working, the reasons given provide an indication of the frame of reference used by welfare mothers to legitimate welfare assistance of a more permanent nature. As may be noted in Table 2, the two major reasons mentioned, the care of children (77%) and poor health (19%) correspond to the two major criteria of eligibility for assistance for persons under sixty-five years of age. Other assumed "reasons" for dependency which have become incorporated into models and programs aimed at reducing dependency, such as lack of economic incentive, lack of work skills, or no day care facilities, appear very infrequently or not at all in the responses of welfare mothers.

TABLE 2. REASONS GIVEN FOR PREFERRING TO STAY HOME RATHER THAN WORK

Reasons	%	N
Child care	77	(516)
Poor health	19	(130)
Management of household	10	(69)
Work would not be economically rewarding	8	(53)
Lack of work skills	4	(28)
Care of sick relatives	1	(7)
Husband would object	1	(8)
Other reasons	2	(13)
	122%	(670)

As expected, stage of life cycle is related to the type of reasons given for preferring not to work. (See Table 3). With increasing age, child care declines and poor health becomes a more important reason. Thus, 9% of the mothers under 30 gave poor health as a reason for preferring not to work, compared to 42% in the 40-and-over group.

TABLE 3. TWO MAJOR REASONS GIVEN FOR PREFERRING TO STAY AT HOME RATHER THAN WORKING, BY AGE

	Age			
Reasons	Under 30	30-39	40 and over	Total
Child care	85%	86%	56%	77%
Poor health	9%	11%	42%	19%
Number of cases	(220)	(253)	(197)	(670)

The most obvious interpretation for this shift is, of course, that there are more persons with poorer health in the 40-and-over group. There is some evidence which suggests that this is only a partial explanation--that social factors are probably as strongly, if not more strongly, associated with reports of poor health than with a greater prevalence of disease conditions in the older group of mothers. In Table 4, the relation between age and giving poor health as a reason for preferring not to work is shown, with the number of reported illnesses in the past year held constant. Of particular interest is the fact that the association between age and giving poor health as a reason for preferring not to work is maintained even among respondents who earlier in the interview had reported that they had not been sick in the past year. Thus, even though the number of reported illnesses in the past year may itself have been affected by subjective considerations, older respondents who by their own account had not been sick in the past year were nonetheless more likely than younger respondents to give poor health as a reason for preferring not to work.

TABLE 4. PERCENT WHO GAVE POOR HEALTH AS REASON FOR PREFERRING NOT TO WORK, BY AGE AND NUMBER OF REPORTED ILLNESSES IN PAST YEAR

Number of reported illnesses in the past year	Age		
	Under 30	30-39	40 and over
None	1% (86)	3% (93)	24% (63)
1-2	4% (52)	9% (75)	37% (51)
3 or more	18% (80)	21% (84)	62% (76)

In addition, it should be noted that chronological age and the illness measure have both independent and interactive effects on mentioning poor health as a reason for preferring not to work. Thus, among women who are under 30, the number-of-illnesses variable accounts for a 17 percentage-point difference down the first column of Table 4. There is a similar difference (18 percentage points) in the 30-to-39 age group. However, in the group aged 40 and over, the difference is 38 percentage points. This seems to indicate that it is not only illness per se but, more importantly, illness in combination with aging which increases the likelihood that illness will become a basis for legitimating dependency.

Given the nature of the welfare eligibility rules, it was hypothesized that aging would increase the salience of illness as a reason for dependency, particularly as the care for dependent children declined as an acceptable reason for receiving assistance. As a final test of this hypothesis, it is necessary to examine the simultaneous effect of both the mother's age and that of her children on giving poor health as a reason for preferring not to work. In Table 5, age of youngest child is used as an indicator of the extent of child-rearing responsibilities. It turns out that even when mother's age is controlled, age of youngest child is associated in the expected direction with giving health as a reason for preferring not to work. The association is particularly strong for those over 40. Women who are over 40 and have no children under 11 years of age are almost three times more likely than any other category to give health reasons for preferring not to work. The decline of child-rearing functions, as one aspect of aging, leads to an increasing tendency to legitimate welfare dependency by evoking the sick role. The issue here is not whether or not older respondents are "sicker" than younger respondents. Even if we assume that they are, it is only among those whose children are growing up that this becomes salient as the reason for their welfare dependency.

TABLE 5. PERCENT WHO GAVE POOR HEALTH AS REASON FOR PREFERRING NOT TO WORK, BY OWN AGE AND AGE OF YOUNGEST CHILD

Age of youngest child	Respondent's age: Under 30	30-39	40 and over
0 to 5	8% (202)	9% (165)	15% (34)
6 to 10	13% (16)	14% (64)	27% (63)
11 or over	* (2)	21% (24)	63% (94)

Thus, it is evident that although illness plays only a small part in legitimating dependency in the total family welfare population, it becomes one of the primary bases of legitimating a claim to welfare support among women over 40 whose youngest child is, or is about to become, an adolescent. As these women reach the end of their child-rearing years, their opportunity for economic independence is highly limited. They are over 40, they lack a recent job history, and have limited skills in an industrial society.[5] If at the same time they are black or Puerto Rican (as most of them are), their realistic opportunities for independence are further restricted. Claiming the exemptions of the sick role appears to be one adaptation to this dilemma.

SUMMARY

In conclusion, I do not deny the importance or reality of disease conditions as one factor in the reports of ill health of welfare clients. Sociologists all too often, in their eagerness to explain by means of social factors, tend to neglect the biological and other non-social limits to human behavior. As Friedson notes: "Psychosomatic medicine notwithstanding, most illnesses, and certainly most impairments, are not motivated, they are the contingencies of inheritance, accidents of infection and trauma." (1965:81). That being said, it is also well documented that symptoms have different meaning, interpretation, and salience depending on the social context in which they occur. (Zborowski: 1958, Kadushin: 1964, 1967; Zola: 1966; Crandell and Dohrendwend: 1967).

[5]Less than one-third of the mothers over 40 have some education beyond the eighth grade.

The effects of social pressures generated in the interview situation yielded some evidence that the presentation of oneself as ill does not occur at random, but is clearly related to stage-of-life cycle. Here the boundary between "true" or "false" illness is not that clear. By choosing to make salient existing (and real) conditions, most individuals in American society could adopt the sick role more frequently if they wished. (Zola: 1966). But many individuals choose not to take notice of existing conditions--which may at times be serious--and thereby maintain a healthy presentation of self. For many welfare clients, there are few rewards for the maintenance of a healthy presentation of self, and some gains to be derived from adopting the sick role.

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