"Health Related Behaviour and Perceived Health in Unemployed People"

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This project explores the relationships between perceptions of unemployment, reported health behaviour and subjective health status for a period of up to one year following job loss.

Factors influencing health related behaviours are investigated and the implications of the results for health promotion are discussed.

The initial intention was to select men with family commitments who were about to be made redundant in order to control for variables such as age and marital status. However major problems were encountered in obtaining a sample. Eventually 18 people including four women were recruited. Possible reasons for the low response rate, which should be considered carefully in the planning of future studies, are discussed.

Participants were interviewed as soon after becoming unemployed as possible. Thereafter interview times were standardised. Fourteen people were interviewed 24 weeks after job loss, 10 were interviewed 38 weeks after job loss and three were interviewed 52 weeks after job loss. Where possible participants were interviewed after regaining employment.

Three methods of collecting data were employed. In depth recorded interviews which were stuctured using a questionnaire; The Nottingham Health Profile (N.H.P.) was used to measure subjective health status; and a diary was kept by respondents in which health related behaviours were recorded for one week following each interview.

From the results it was apparent that the manifest function of employment was important for most of the sample. However employment also fulfilled latent functions such as providing social contact, a means of filling time and purposeful activity. For most people who remained unemployed problems associated with unemployment appeared to intensify around six months after job loss. Thereafter situations

improved when employment was regained or with attendance at college. For those who remained unemployed there was some evidence of adaptation to some of the changes brought about by job loss over time.

A variety of changes in health behaviours, occurred with changes in employment status. The extent to which diet was affected depended upon financial resources. In most cases cigarettes and alcohol consumption declined with unemployment but in a few cases these behaviours increased and appeared to be ways of coping. Changes in exercise depended upon how active previous jobs had been and upon interests in active pursuits prior to job loss.

There was little evidence of changes in perceived health since stopping work at the first interview. Thereafter perceived health improved with re-employment or attendance at college. The factor which appeared to be most strongly related to changes in perceived health was change in employment status. In general when respondents perceived their situations to improve perceived health also improved. While N.H.P. scores worsened when respondents perceived their situations to deteriorate, health ratings were not always consistent, perhaps suggesting that other factors influenced perceived health. There was no obvious relationship between respondents' perceptions of their situation and health related behaviours suggesting that health behaviours were influenced by other factors. In only a few cases, positive changes in health behaviours appeared to contribute towards improved perceived health.

One of the most important findings of this study is the diverse range of experiences which were disclosed. It is clear that there are a large number of important factors which mediate the effects of unemployment. The most important ones identified in this study were gender, age, marital status/household composition, employment history, length of unemployment, financial resources, personal characteristics and interests prior to job loss.

In almost all cases, however, unemployment was a distressing experience but there is a complex interaction of many factors which

influence how people cope with, respond to, or adapt to unemployment.

Since only 18 people were interviewed this severely limits the extent to which the results can be generalised. However the fact that such a variety of experiences was found in such a small sample leads one to question other studies in which data are aggregated. The advantage of studying such a small number of people lies in the ability to collect detailed qualitative information which contributes to our understanding of this complex social phenomenon.

In the majority of cases changes in health behaviours were due to changes in situational factors or financial status. This result tends to support the adaptational model of health in which behaviours are viewed as adaptive responses to changes in physical, social and economic circumstances.

The main conclusion of this study is that unemployment is detrimental to the psychological well-being of many individuals because of changes which may accompany job loss. This, it is proposed, is more important than the negative changes in health behaviours which may occur. Only when changes in physical, social and economic situations brought about by job loss are ameliorated or individuals are provided with resources which allow them to cope with such changes will they be in a position to adopt healthy lifestyles. Recommendations to change lifestyles are irrelevant for people in disadvantaged circumstances and improbable due to pre-existing problems. Furthermore global health promotion strategies which treat unemployed people as a homogeneous group are inappropriate.

I, Sheena M MacArthur, declare that this summary has been composed by myself. All of this thesis is original. Apart from instances which are noted in the text and unless so stated I have not availed myself of the work of others.

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INTRODUCTION

There are currently about three million unemployed people in the U.K. and the relationship between unemployment and health has received increased attention over the last few years. However, the topic is not a new one. Attempts have been made since the 1930s to investigate the hypothesis that unemployment affects health.

A causal relationship between unemployment and ill-health has not yet been established. A major reason for this is that research on this subject is full of methodological problems which has made it difficult to provide conclusive evidence that unemployment gives rise to ill-health rather than the other way around. In addition, despite claims that unemployment benefits are sufficient to sustain adequate living standards, unemployment for many people is closely linked with poverty. This makes it hard to distinguish between the effects of poverty, its sequelae and the effects of unemployment per se.

Nevertheless it is known that unemployed people experience a disproportionate amount of morbidity and mortality. If unemployment affects health, it is necessary to examine the possible mechanisms which could be involved. One commonly held view is that job loss causes loss of status, loss of a sense of purpose in life and lowered income which gives rise to poor psychological well being. For this reason many studies have measured affective responses to unemployment and psychological status. It has also been postulated that psychological and physical ill-health are linked through stress but only a few studies have assessed the physical health of unemployed people.

Although health related behaviours such as diet, smoking and lack of exercise are implicated in the aetiology of many illnesses currently found in the U.K., very few studies have examined the health behaviour of unemployed people as it might impinge on health status. Furthermore, although several cross sectional studies have proposed that people go through different phases in responses to unemployment, studies of this nature can only collect data at specific points in

time. Longitudinal studies which prospectively examine changes in health status are rare.

The thesis on which this project is based is that job loss may be accompanied by changes in the physical, social and economic environment of individuals and that associated changes in perceived health and health behaviours may result as part of the process of trying to cope with or adapt to these changes.

UNEMPLOYMENT AND HEALTH - A REVIEW OF THE LITERATURE

Since the 1930's researchers in various countries have studied the relationship between unemployment and health. Most reviews of the literature have classified studies according to different approaches and methodologies.

For example :-

1. Macro studies which examine the relationship between national economic indicators and aggregate morbidity and mortality rates; and Micro studies which examine the effects of unemployment on the health of individuals and families [1-2].

2. Studies which examine the relationship between unemployment and physical health and those which examine its relationship to mental health [3-4].

3. Quantitative studies and Qualitative studies [5].

4. A two by two classification based on method and conceptual base :-

   Aggregate studies - cross sectional and longitudinal

   Individual studies - cross sectional and longitudinal [6].

Other reviews, however, have been more general in nature [7-8]. In addition Jahoda and Rush [9] reviewed the literature using Merton's paradigm for functional analysis. This paradigm consists of 11 basic issues, which properly researched and clarified, make a social phenomenon understandable.

The following review is based on a taxonomy which incorporates aspects from the above classifications and which is similar to that adopted by the Lancet [10].

1. Macro-economic time series and aggregate studies.

2. Micro studies a) Cross sectional
   b) Longitudinal

3. Case studies.

MACRO-ECONOMIC TIME SERIES AND AGGREGATE STUDIES

Macro-economic time-series studies examine the relationship between the economic status of geographically defined units and the health status of their populations. The best known and most controversial work has been carried out by Brenner in various countries [11-14].

In these retrospective studies he analyses archival data and attempts to relate macro-economic indicators of long term economic growth and short term economic instabilities to aggregate indices of morbidity and mortality over a period of time.

In Brenner's 1977 study three indices (unemployment rates, per capita income and inflation rates) were selected as measures of economic distress which might explain how economic factors could feasibly influence pathological phenomena [12]. Economic indicators were examined in relation to indices for mental health, general health and criminal aggression for the period 1930-74. The main hypothesis was that pathological reactions would occur within zero to five years of increased unemployment, increased inflation and decreases in per capita income. The choice of lag times for the health indicators was based on Brenner's previous studies despite the fact that the results of these had not been independently replicated. The choice of a maximum five year lag was based on economic research findings which estimated that the span of the business cycle along with unemployment rate fluctuations is approximately three to five years.

It was proposed that an increase in inflation and unemployment and a decrease in income would lower the socio-economic status of sub-groups in the population which, in turn, would lead to poorer nutrition, an increase in social psychological stress and a reduced ability to pay for medical care. These factors would then have a deleterious effect on health. This model, while plausible, was only weakly supported by the data.

The most consistent findings were the relationships between unemployment rates and cardiovascular and cirrhosis of the liver

mortality rates; suicide and homicide rates; imprisonment and hospital admission rates. These results applied to the U.S. as a whole to different age, sex and racial sub groups and to three test States.

The relationship between inflation rates and the indicators tended to be inconsistent, as was that for per capita income. Brenner claims to have found similarities in the data for the United States, England, Wales and Sweden.

In a second stage analysis two non-economic factors which were thought to influence trends in specific diseases were incorporated into the equations. Brenner suggested that by adding these variables the relationships between the economic variables and indicators could be more clearly understood. While, as suggested, total food energy intake may relate in some way to Cardio-vascular disease mortality it cannot be considered a sensitive measure of obesity or of the consumption of certain foods. In addition, indicators of other possible risk factors in Cardio-vascular disease, such as smoking, were not considered.

Although Brenner stated that other important factors which could affect how individuals respond to economic traumas (eg family structure, previous health status) had not been incorporated into the model, the choice of only two non-economic factors appears to have been an attempt to correct a major weakness in the model. Brenner did comment that since analysis was based on correlation and regression no causal relationship could be inferred.

In a later study Brenner applied the same model (slightly modified) to data for England and Wales 1936-76 [13]. He concluded from the results that the decline in mortality rates could be accounted for by long term economic growth, improved nutrition, sanitation and education up until infectious diseases became less important causes of death. Medical technology had contributed to an improved life span and a reduction in mortality rates. He suggested that socio-economic differentials could be largely explained by economic instabilities and

high unemployment rates, in addition to implying loss of income and social status, but were an indirect measure of income loss and work stress for those employed in firms experiencing economic difficulty. Rapid economic growth, Brenner suggested, is particularly harmful for certain sub-groups especially those who have suffered in recessions and in industries where new technologies are being introduced.

Brenner's theory that unemployment is positively associated with mortality has received some support. However, other variables such as income, education level and consumption patterns are also strongly correlated with unemployment, and the unemployed may have a disproportionate experience of ill health prior to job loss. It is therefore possible, that if these factors were incorporated into Brenner's calculations, no significant associations would be found between unemployment per se and ill health.

Secondly, it has been argued that better indicators of economic change and government welfare expenditure could have been chosen and that variables such as diet and medical development could have had significant influences on health. The exclusion of these from calculations may have produced a serious bias in the results [15].

Thirdly, the reliability of the data has been questioned since there were apparent inconsistences e.g. while mortality data related to England and Wales, economic data related to the whole of the U.K. and unemployment rates for the interwar years were calculated using the insured working population only rather than the total working population [15].

Finally, the validity of the results has been assessed in a number of ways. The calculations were replicated using more reliable data and then applied to different periods of time to establish if the choice of time series affected the results. No significant relationship between unemployment and mortality could be found using a longer period or for a post war period. In addition the Chow test was applied and the model failed to accurately predict mortality rates in the 1970's. The lag structure was also shown to have been arbitary [15].

In a more recent study Brenner [14] attempted to overcome some of the weaknesses of previous studies. The "simple" economic change model was extended by incorporating additional indicators i.e. beneficial factors (provision and utilisation of health services) and adverse factors (cigarette and alcohol cumsumption) which he suggested are associated with economic growth. He also included "random shocks" which he suggested could have a deleterious effect on health without seriously disturbing the economy e.g. climate irregularities and oil prices.

It is difficult to find any consistent justification for the selection of indicators from one of Brenner's studies to the next, since while in the 1977 study total food energy intake was included and smoking behaviour was omitted, in this recent study the latter was included and the former omitted.

The main conclusions were that while economic growth and stability and health service availability have been the major beneficial influences on post war mortality rates in Britain, high unemployment rates, heavy cigarette and alcohol consumption and unusually cold weather (particularly in Scotland) have been the main detrimental influences.

Brenner went on to examine total mortality rates for several industrialised countries in relation to the simple economic change model. The results showed that while the model was applicable in West Germany, France, Italy and Spain using data since World War II, it was only applicable in Canada, U.S., England and Wales and Sweden if the analysis was started before World War II. He suggested that there was a relationship between epidemiological risk factors and economic growth and that different countries have had different post war economic experiences.

In general Brenner's work is suspect due to weaknesses in the theoretical model proposed, inconsistent selection of variables and the unjustified choice of lag time. It could therefore be suggested that the association found between unemployment and mortality in Brenner's studies could be the result of several other unidentified

associations.

Bunn [16] examined the association between I.H.D. mortality and the business cycle in Australia before, during and after the Depression and proposed that extreme economic down-turns could be associated with mortality from diseases with a stress component, high mortality rates and a chronic irreversible development.

The results suggested that increases in I.H.D. mortality followed rises in unemployment rates in each period with a lag range of zero to five years. However since insufficient information was provided (e.g. on curve fitting) it is difficult to comment upon whether or not the techniques of analysis used were appropriate for this type of data.

Eyer, in his analysis of U.S. data for the period 1870-1975, calculated that total mortality rates rose with prosperity and fell during recessions [17]. Only two out of the 24 peaks in mortality rates identified coincided with peaks in unemployment rates, with half of the mortality peaks occurring during periods of low unemployment. Unlike Brenner, Eyer did not consider long term economic growth or the long term decline in mortality rates. The conflicting interpretations made by Brenner and Eyer may be due to the fact that Eyer did not include a time lag in his analysis. His justification for this was based on the work of Kasl and Cobb who found that changes in factors which could affect mortality often preceded unemployment.

Spruit [18] in a review of macro-studies suggested that the greatest weakness in Brenner's model was that there was no theoretical or epidemiological basis for the choice of lag times. On the other hand he suggested that Eyer's analysis was weak due to his assumption that mortality follows immediately. Regardless of these points both models must be viewed as suspect because they assume that economic change causes stress which in turn precipitates ill-health without providing any clear evidence. In addition they do not take account of the possibility that individuals may respond differently to being

unemployed. Some people may be adversely affected by unemployment but others may benefit by losing jobs which were affecting their health. Thus when data are aggregated the differential effects may cancel each other out.

Catalano and Dooley [19] attempted to overcome some of the weaknesses of other macro-economic studies in their Kansas study which examined the relationship between the psychological well being of the population and the status of its supporting economy over a period of 18 months. Economic indicators for an economically rather than a politically defined unit were used and the time unit of analysis was one month. Self reported depressed mood and frequency of stressful life events were measured by survey rather than using archival data. The results showed that unemployment rates were strongly related to both mood and life events but inflation was not. Although this study did attempt to establish if stress followed economic change the question of whether this then caused ill-health remained unanswered.

Platt and Kreitman [20] examined trends in parasuicide and unemployment among men in Edinburgh 1968-1982. The main result was that the annual unemployment rate and the annual incidence of parasuicide were positively and highly significantly correlated. In addition the relationship for 1970-72 and 1980-82 across city districts was found to be significant even when controlling for social class. For the period 1970-72 a further analysis was carried out controlling for health, morbidity, housing, income and education. None of these affected the significance of the correlations except for poverty and the authors concluded :

"Thus unemployment appears to be associated with parasuicide only in so far as it relates to poverty or to some other variable closely connected with poverty" (page 1030).

When the incidence of parasuicide in unemployed men and employed men was compared the relative risk for the former group was found to be

high in each year. There was also found to be a higher relative risk for the long term unemployed. Possible sources of bias were discussed which would have the effect of underestimating the relationship.

Although the authors concluded that there is a strong association between parasuicide and unemployment trends this study, because of its aggregate approach, fails to establish that unemployment is a major cause of the problem.

The O.P.C.S. longitudinal survey on unemployment and mortality monitored the death rates of a one percent sample of men drawn from the 1971 Census of England and Wales [21]. Of these quarter million men, 161,699 were aged 15-64 and of these 5,861 were seeking work during the week prior to the Census. Throughout the analysis Standardised Mortality Rates (S.M.R.) were used.

The S.M.R. for the whole sample increased from 129 in the 1971-75 period to 144 in the 1976-81 period. While the S.M.R.s for those unemployed at the 1971 Census were higher in each age group, especially the younger ones, the confidence intervals were large and some contained 100, suggesting the results were not statistically significant. The effects of socio-economic distribution differentials were examined since a significant gradient in unemployment was found from Classes I & II to Class V (2% to 8.6%). For the whole sample the S.M.R. increased from 73 for Class I to 120 for Class V. The S.M.R.s for unemployed men were higher within each social class except for a group who could not be adequately classified. When age and class were standardised the overall S.M.R. for unemployed men was lowered suggesting that some of the excess mortality could be explained by class distribution. After controlling for social class the increase in S.M.R. from 1971-75 to 1976-81 disappeared suggesting that the increase was in fact due to social class distribution differences in these periods. Although social class appeared to explain some of the raised mortality in the unemployed group a 20% excess over the general population still remained.

It was found that there was an excess mortality in the unemployed from malignant neoplasms and, when social class was controlled, a clear excess was still observed. The S.M.R. for accidents, poisoning and violence was 202 and controlling for social class this dropped to 149. When suicides were taken separately the S.M.R. was 241 and when controlled for social class differentials this fell to 169. S.M.R.s for circulatory and respiratory diseases were standardised for social class but the differences were not statistically significant.

In a further analysis the data were examined to establish if regional differences in unemployment and mortality were contributing to the excess mortality among the unemployed [22]. For each region S.M.R.s were calculated from rates in a standard population comprising all men in the study sample living in that region. The men seeking work in the North, West and Central regions had significantly higher mortality compared with the standard populations (141 and 143 respectively).

Mortality from suicide was found to be very high amongst unemployed men in the North & West region and there was a significantly higher mortality rate from accidents, poisonings, and violence in the South East region. Mortality from lung cancer was found to be significantly in excess in the North & West region and although rates were raised in the other two regions they were not significant.

It was concluded that the results did not explain the excess mortality among unemployed men but rather were an indication of greater mortality in areas in which unemployment duration was longer and unemployment rates were higher.

Although the results suggest that the unemployed suffered excess mortality in general, the number of deaths were very small and therefore trends were difficult to detect. In interpreting the results consideration must also be given to the fact that most of the diseases examined may take many years to develop. This makes it difficult to establish if unemployment was responsible for the observed deaths. In addition there was no way of telling if those who were unemployed at the 1971 Census continued to be unemployed until 1981 or if a

selection effect was operating.

It was suggested that unemployment could affect the health of other members of the family through increased stress or income changes and therefore mortality rates for the wives of the unemployed men were examined [21]. The S.M.R. for all married women aged 15-59 in the period 1971-81 was 116 but since the confidence interval contained 100 the excess was not significant. When cause - specific data were analysed no clear excess pattern could be found except for I.H.D. where the S.M.R. was 157 and in most cases the confidence intervals were very large. Controlling for social class and housing tenure did not appear to affect the S.M.R.

Analysis was carried out on mortality data for all women in households containing a man who was aged 15-64, seeking work and who was not their husband [22]. When data were compared with those for a standard population the overall S.M.R.s and those for specific causes of death were found to be in excess, although not statistically significant.

However, the authors concluded that since the results were in the same direction and of similar magnitude to those for the men and their spouses this tended to support the thesis that raised mortality in the three groups was unlikely to be solely attributable to pre-existing ill-health.

Although approximately six thousand men were included in the study the small number of deaths which occurred made testing of the relationship between unemployment and mortality difficult and it was impossible to rule out selection bias.

Mortality in the period 1981-3 among 14,675 men seeking work and 6,889 women married to men seeking work at the 1981 Census was examined to investigate if similar results would be found [23]. As in the 1971-3 period, men who were seeking work, were retired or were sick each had S.M.R.s above 100 and those employed had a S.M.R. below 100. However the ratio for each group was lower in the 1981-3 period. This the authors suggested could be explained by the increase in the proportion

of men who were not employed.

In the 1981-3 period there were significant excesses in mortality due to lung cancer, circulatory diseases, accidents, poisonings and violence among the men seeking work which corresponds to the pattern in the period 1974-81. Although in 1971-3 similar excesses were found they were lower and, apart from lung cancer, not statistically significant.

Although the overall S.M.R. and the S.M.R.s for some causes of death for women were raised none were statistically significant. While in 1971-81 an excess mortality was found no excess was found in the period 1971-3. Due to the small numbers of deaths during the period 1981-3 it is difficult to draw conclusions from the results.

While the main results in the period 1981-3 appear to point in the same direction the authors suggest that a longer period of follow up is required before the 1980's result can stand alone.

Combined data from the 1981 and 1982 General Household Survey were analysed to examine the relation between social class, state of employment and ill-health [24]. The sample consisted of around 28,000 men and women, aged between 20-59 and was divided into seven groups on the basis of present or last occupation. Women were classified by their own occupation and by their husband's occupation if married. Two measures of ill-health were employed; limiting longstanding illness and subjective health status over the previous 12 months.

For men and women a linear gradient between chronic ill-health and occupational class was found with less reported ill-health in the higher occupational groups. Standardising for different age profiles in occupation groups, the higher professional men were 34% less likely and the unskilled men 55% more likely to report limiting illness than the average for all men. When classifying women according to their own occupation or their husband's, if married, a similar gradient was evident. When all women were classified according to their own

occupation a weaker class gradient was found which was not entirely linear.

Unemployed people reported more ill-health than employed people. Using age standardised ratios employed men were 20% less likely and the unemployed 40% more likely to report ill-health than the average. Part-time employed women were the least likely to report chronic illness and the unemployed 16% more likely to report ill-health. The highest prevalence however, was found in housewives who were 25% more likely to report ill-health.

The main conclusions from this analysis were that differentials in health between the employed and the unemployed were greater than the class differences in health among the employed. Secondly that the class differentials in health were greater in the unemployed group than the employed group. The author concluded that class affects the unemployed more than it does the employed.

In relation to the study of the effect of unemployment on health, macro-economic time-series and aggregate approaches in general would appear to have the following weaknesses.

1. Aggregate data e.g. morbidity, mortality and unemployment rates may be biased due to changes in definition and classification over time or to differences between countries.

2. Most studies use rather extreme indices of ill-health and have no measure of the prevalence of less serious but important health problems since morbidity data of this nature are not routinely available [6].

3. In macro-economic studies the decision to omit lag times or the selection of particular lag times has a crucial effect on the results and therefore their interpretation.

4. Most macro-economic studies (except that of Catalano and Dooley [19]) use State or National economic indicators which do not necessarily describe the experiences of an economically defined community but rather a politically defined unit [6].

5. It is impossible to separate the effects of unemployment from the effects of poverty and deprivation since unemployment, mortality and morbidity rates are strongly associated with poverty.

   Liem & Liem [25] suggest that the effects upon health could be due to social selection, social causation or an interaction between them.

6. None of the studies identify causal mechanisms and the models adopted are unsuited to inferences about causality [2].

7. The results from aggregate analysis cannot be applied to the individual [25]. In order to establish a causal relationship a precise theoretical model of how unemployment is related to ill-health aetiologically would be required which would allow the testing of hypotheses. At present none of the macro-economic or aggregate studies have satisfied this requirement and it is unlikely that in the future this will change because of their intrinsic nature. However studies of this type should be considered valuable prerequisites to more detailed, less global, research.

Indeed these studies have raised some issues which should be considered carefully in the planning of future micro-studies. Firstly, reductions in income which may be experienced by many people when they become unemployed may contribute to feelings of stress and may affect household consumption patterns. Secondly, although many of the studies have shown that unemployed people suffer disproportionate morbidity and mortality they have recognised the possible effect of self selection and the importance of health status prior to unemployment.

Finally, of specific importance to health promotion, some studies have recognised that behavioural factors which may be affected by changes in income such as diet, smoking and alcohol consumption may be important in the aetiology of major diseases. While aggregate studies are unable to link individual health related behaviour to health status these factors must be considered important for future micro-studies.

MICRO-STUDIES - CROSS SECTIONAL

As stated in the last chapter aggregate studies cannot show conclusively that there is a causal relationship between unemployment and health. Furthermore, aggregated morbidity and mortality data do not allow identification of the particular individuals who are experiencing ill-health. Therefore it is necessary to consider other studies which may be able to provide information as to whether and how unemployment and health status are related. Cross sectional studies examine populations at a single point in time and attempt to compare the personal characteristics of the sample with different levels of health status. Since the unemployed are not a homogeneous group the state of being unemployed cannot be viewed as a uniform experience [26]. Consequently most studies of this nature have examined possible mediating factors in responses to unemployment in an attempt to identify those individuals who are most at risk of experiencing deterioration in health and thus to provide explanatory models of the underlying processes.

Age, Social Class and Length of Unemployment

One of the first cross sectional studies to be carried out in Britain was that undertaken by the Pilgrim Trust in 1936 [27]. A random sample of 880 long term unemployed people was drawn from the unemployment registers in six towns in England and Wales. It was found that in areas of high unemployment it was easier for people to accept unemployment since they could meet others in the same situation and it was easier to explain their unemployment. It was also easier for older men to accept unemployment in high unemployment areas than in more prosperous areas. Due to low wages and the system of benefit payments, it was easier for single men to accept unemployment than for married men who had no children or one child. However, in families with more than one child it became progressively more likely that unemployment would be accepted and many married women gave up work because they would be no better off or worse off financially. Those who had been low paid unskilled workers found it easier to accept

unemployment because they previously had erratic incomes and those who had experienced poor working conditions e.g. seamen and miners, were reluctant to return to the same occupation. Despite this they felt isolated since work had provided social contact. Semi-skilled and skilled workers who previously had pride in their work experienced feelings of uselessness and isolation.

There was some evidence of undernourishment in adults and of other types of material and social deprivation. However, since three out of every 10 households were found to be below the poverty level and over half of these considerably below it, it was difficult, as the authors recognised, to distinguish between the effects of unemployment and those of poverty. Also because of differences in wage levels and benefit payments, it is difficult to evaluate the relevance of these results to current situations.

A more recent study [28], carried out in Sheffield, aimed to identify some moderating factors in the psychological impact of unemployment. The sample consisted of 92 men who were registered at an Unemployment Benefit Office; were aged between 19 and 63 years; had been unemployed for between less than one month and over two years; and who had previously been employed in a range of occupations. Fourteen men who had become unemployed due to ill-health were excluded from the sample.

The 12-item version of the General Health Questionnaire (G.H.Q.), [29] which is a self administered screening test designed to detect non-psychotic psychiatric disorder, was used to assess the proportion of men who might be suffering from psychiatric ill-health. A Present Life Satisfaction (P.L.S.) scale was used as a measure of subjective well being.

The results showed that it was the 35-44 age group who had the poorest mean G.H.Q. and P.L.S. scores and not the 45-54 age group as predicted, although the differences were not statistically significant. Significant differences were found, however, between the

mean health scores of different occupational status groups, with the unskilled and semi-skilled men showing the worst mental health. When the data (from a previous study) for an employed group were analysed no such differences could be found between occupational status groups. The author concluded that this showed a clear unemployment effect but the possibility that sample selection affected the results cannot be ruled out. G.H.Q. scores were found to be positively correlated with length of unemployment and P.L.S. scores negatively correlated, but since detailed data were omitted it is not clear if the relationships were strictly linear. An individual's ability to occupy his time meaningfully was found to be the best single predictor of mental health and was found to be positively correlated with occupational status and length of unemployment. The author suggested that while this may provide some explanation for the differential effect of occupational status it did not provide evidence of a causal link. This study does show that individuals may experience unemployment differentially.

The importance of situational factors interacting with psychological effects of unemployment was examined in a study of 78 young people aged 16-19 years [30]. It was found that there were no differences in the psychological health status (as measured by the 12-item G.H.Q.) of males and females. People who had been unemployed for four to nine weeks experienced more negative psychological effects than those unemployed for either shorter or longer periods of time.

Variations in work commitment could not explain the differences found between groups unemployed for different lengths of time. When background information was analysed all three groups were found to be well matched in relation to such factors as educational attainment and socio-economic background. One significant difference found for the group who had been unemployed for four to nine weeks was their anxiety about gaining a place on the Youth Opportunity Scheme. This group also reported more frequently that they had poor relationships with families and other people. The authors suggested that this was more likely to be a symptom of psychological distress and loss of self

esteem rather than its cause since several respondents who had low scores did not report such poor relationships. The authors came to similar conclusions to those of Hepworth [28] in respect of the importance of situational factors as modifiers of the psychological responses to unemployment. Since the study examined one very specific age group in a very specific situation it is not possible to apply these results to other groups of unemployed people.

A series of studies examining possible mediating factors between unemployment and health have been carried out by the Social and Applied Psychology Unit in Sheffield using cross-sectional and longitudinal designs (the latter will be dealt with in the next chapter). Jackson and Warr [31-32] examined the possible moderating role of length of unemployment and age in the effects of unemployment on psychological health.

A sample of 954 men was drawn from Unemployment Benefit Office registers throughout the U.K. and consisted of those who had previously held semi-skilled and unskilled manual jobs for at least three months. Since length of unemployment and age tend to be intercorrelated the respondents were divided equally into 10 age groups ranging from 16-64 years and into six levels of length of unemployment ranging from less than one month to more than 12 months. Three measures of health were used; the 30-item G.H.Q.; a single item measure of general health; and reports of illness experience in the last month. Employment commitment, self reported job seeking behaviour and financial stress were also measured.

In the sample as a whole, the health of those unemployed for less then six months was significantly better than those unemployed for longer than six months. While the G.H.Q. scores for the 16-19 year olds and 60-64 year old age groups were found to be significantly better than those for other age groups no significant differences in general health and sickness experience could be found. Psychological health scores were unrelated to length of unemployment for the youngest and oldest groups but were significant for the intermediate age groups.

Psychological ill health was found to be significantly associated with greater financial stress and with higher employment commitment. When financial stress and length of unemployment were examined to establish if they were intercorrelated no significant relationship was found suggesting that they were independent predictors of psychological ill health.

Although the results appear to suggest that age and duration of unemployment have mediating roles in the effects of unemployment on health it is not possible to predict that each individual will respond in the same way. As the authors stated the main limitation of this study lay in its cross-sectional design. This study has been criticised on a number of counts [10]. Firstly, although the G.H.Q. has been used in many studies of this type its applicability is questionable since it was initially designed to detect affective disorder among patients seeking help from general practitioners. The authors have also been criticised for using complex statistical methods in an attempt to remedy basic study design weaknesses. It was difficult to identify the true prevalence of ill health in the sample or how this related to the proposed mediating factors.

In a more recent analysis of the data two different hypotheses regarding the importance of local unemployment rates were examined [33]. Firstly, it was proposed that high unemployment rates would be associated with poverty which would adversely affect the psychological health of unemployed men. Conversely communities with high unemployment rates would develop resilience which to some extent would protect unemployed people.

The mean G.H.Q. scores for men living in areas of high unemployment, moderate unemployment and lower unemployment were compared. Even when personal factors which are known to be associated with mental health during unemployment (age, length of unemployment, family composition and salience of paid employment) were included in a covariant analysis significant differences in mean scores were found. While all mean scores were substantially above those found in samples of employed people the mean score for the area of high unemployment was

significantly better than the other areas.

The authors concluded that while the material deprivation which exists in areas of high unemployment is associated with a higher prevalence of poor physical health and premature death there was some suggestion that community support may to some extent protect unemployed men psychologically.

Data for the general U.K. population, suggest that there is a higher prevalence of psychological ill-health in the working classes as compared to the middle classes [34]. Payne et al [35] set out to establish if the same class differences existed among unemployed people. They predicted that there would be greater psychological ill-health among the working class unemployed and that social class would modify the effects of unemployment. The sample of 399 men was drawn from Unemployment Benefit Office registers throughout the U.K., controlled by age, race, length of unemployment and marital status and divided into two groups on the basis of social class defined in terms of the occupational level of the last job. Middle class was defined as occupational levels A, B and C1 while working class was defined as level D. (This classification originates from the Institute of Practitioners in Advertising). Retrospective changes in health and well being were measured using the 12-item G.H.Q. and a seven-item anxiety and depression scale. In addition the prevalence of strain and changes in subjective health status were recorded. The respondents' perceptions of the concomitants of the state of unemployment, including problems, opportunities, threats and social support were also assessed.

The results showed no significant changes in the general health of the sample since becoming unemployed and no significant differences between the working class and middle class groups. However, when the mean scores for psychological health status for the unemployed sample were compared with scores from a study of employed men they were found to be significantly different. The working class group was found to have reported more financial problems and financial worries than the

middle class groups. They were also more likely to report having problems with filling in their time which was thought to be due to the fact that the middle class group perceived the free time as an opportunity to take up new activities or to prepare for changing their careers.

The authors concluded that unemployment caused the social class differentials in health, found in the general population, to disappear. The fact that the men interviewed had been unemployed only for between six and 11 months could have influenced the results since longer periods of time could increase financial problems. In addition it is not surprising that the working class group was more likely to report financial problems since only 45% of them had escaped unemployment in the five years prior to the study compared with 71% of the middle class group.

The preceeding studies attempted to identify characteristics of unemployed people which might explain differences in health status. While the Pilgrim Trust found that social class, family composition, marital status, age and local unemployment rates acted as mediating factors in the psychological health status of unemployed men only some of these factors have been studied more recently.

Although the differences between G.H.Q. scores for age groups were not found to be statistically significant in Hepworth's study, the results from Jackson and Warr's study appear to strengthen the thesis that middle aged men experience poorer psychological health than older or younger men when unemployed. The mediating role of social class is less clear, since while Hepworth found that working class men had the worst G.H.Q scores, Payne et al. found no social class differences in G.H.Q. scores.

Three of the studies found that G.H.Q. scores were related to length of unemployment but in slightly different ways. Hepworth found that G.H.Q. scores were positively correlated to length of unemployment for all age groups but Jackson and Warr found this to be the case only

for the middle aged group. While Breakwell found that those who had been unemployed for the longest time did not have the poorest G.H.Q. scores, this was due to very specific circumstances. Both Hepworth and Payne et al. found that working class men were more likely to report difficulties with filling in their time and Hepworth found this to be a strong independent indicator of psychological health. While there is some consistency in the results of these studies, the inconsistencies (although perhaps due in part to the different measures employed) may indicate that particular situational factors contribute towards the differential effects of unemployment.

Occupational Status

Most comparative cross sectional studies have measured the health of full-time employed people and that of unemployed people. One study which differed in this respect, compared the mental health of five groups of people of varying occupational status; full-time employed, part-time employed, full-time students, retired people and unemployed people [36]. The study used the Langer-22 index as a method of measuring mental health instead of the G.H.Q. since the latter was thought to be a less sensitive index of psychological disturbance.

The sample of 196 people consisted of approximately equal numbers of males and females who ranged in age from 16-69 years and who all lived in Central London. The results revealed no sex or age differences in the mean Langer scores but significant differences were found between occupational status groups. The full-time employed had the best mean score while the unemployed had the poorest. Next to the full-time employed, the retired group, followed by students, had the best scores while the part-time employed had scores only slightly better than the unemployed. The results also showed significant differences between the scores for the full-time employed and other groups; the unemployed and all other groups except the part-time employed; and no significant differences between retired people and students. The standard deviation of the mean score for the part-time group was relatively large compared with the others suggesting that the health of this

group of individuals varied considerably for unknown reasons.

The study had a number of limitations some of which were discussed by the author. Firstly employment status was based on self description and therefore some people who were actually unemployed may have stated that they were part-time employed or students to avoid stigma. Secondly the sample was relatively small and since the respondents were volunteers and were paid for the interview it is unlikely that they were representative of the general population. Finally variables which could be important were omitted e.g. length of unemployment, social class, type of work and previous health status. Although the unemployed people in this study were found to have the poorest mental health it is impossible to distinguish between cause and effect.

In another study carried out by the Social and Applied Psychology Unit in Sheffield the perceived health status of men who had been made redundant or laid off by two engineering companies in South Yorkshire, was examined [37]. A sample of 20 men who had been made redundant was drawn from Factory A and a sample of 39 men who were being laid off for seven weeks on a rotating basis was drawn from Factory B. The men were interviewed five weeks after stopping work and two methods of measuring perceived health status were used - the 30-item G.H.Q. and The Nottingham Health Profile [38]. The Nottingham Health Profile (N.H.P.) is a general measure of perceived health which consists of statements covering six areas of distress; emotional reactions, pain, energy, social isolation, physical mobility and sleep.

Both samples of men were semi-skilled workers but those from Factory A were significantly older and had longer service than those from Factory B. The mean loss of income for Sample A was greater than that for Sample B but the former group had received redundancy payments.

The results for the N.H.P. showed that Sample A had worse perceived health than Sample B for all sections in the profile. In addition, when the mean scores were compared with norms for a matched sample of employed men derived from previous studies, Sample B were found to

have similar scores for all sections except pain and physical mobility where their scores were better. Since probability levels were not given it is difficult to judge whether the perceived health of Sample A was significantly poorer than Sample B and the comparison group. Sample A scores were found to be poorer on the G.H.Q. than those of Sample B. The mean scores for both samples were compared with norms for unemployed men obtained from previous studies. It was found that the mean scores for both samples were better than those of the matched comparison groups with the difference for Sample B being significant.

Differences in perceived health status found between Samples A and B were explained in terms of information gathered during interviews. Since Sample B were unemployed only temporarily and for a fixed length of time they were able to plan ahead and had some idea of what the future held. Many reported that they had planned their finances ahead to allow for the lay-off period and used their time to take holidays or to complete household tasks such as decorating. A greater number of Sample A reported being inactive and bored and the authors suggested that their poorer perceived health was due to uncertainty about the future. While there was a high refusal rate in Sample A it was suggested that this was due to anxiety implying that the scores for this group were understated.

However a number of points need to be considered when interpreting the results. Samples A and B were relatively small in relation to comparison groups and therefore may not have been representative. Only one significance level was quoted. It is possible that Sample B might experience more difficulties with finances and occupying time in subsequent lay off periods. The authors intend to investigate this. Since Sample A were older and had longer service it is possible that they may have had higher work commitment which could have contributed to poorer perceived health.

The perceived health status of unemployed men and re-employed men were compared in a study designed to investigate the effects of long term unemployment on health [39]. The sample was drawn from a larger

sample of unemployed men surveyed in a previous study discussed earlier [31]. The sample was divided according to social class and interviewed one year after the first interview. Three measures of perceived health status were employed; the 12-item G.H.Q., anxiety and depression subscales [40] and the N.H.P.

Eight out of the nine mean scores for the men who had become re-employed were significantly different from those of the unemployed sample with the latter group having more health problems. However, the former group contained a higher proportion of middle class men. No significant differences in scores could be found between the middle and working class men who were unemployed except for the working class group reporting more emotional problems. Although this result supports the findings of Payne et al. it is not perhaps surprising as this sample was drawn from Payne's original sample. When the scores for the re-employed sample were examined, no differences could be found between the classes. It should be noted however, that, since the working class sample was half the size of the middle class group, biases could have occurred.

Comparisons were also made between mean scores for the N.H.P. and norms for employed populations obtained from previous studies. The results suggested that the health status of those who had been unemployed for one and a half to two years was poorer than that of those who had regained employment or than norms for general working populations.

The fact that the N.H.P. has been extensively tested for validity and reliability strengthens the authors' conclusions that unemployment had a detrimental effect on the health of this sample. Unfortunately the N.H.P. was not used in the first interview of this sample so changes in perceived health status could not be measured.

The foregoing three studies compared the psychological health of people who were experiencing different types of employment and unemployment. Since different techniques were employed to measure

psychological health it is difficult to compare the results. However the findings perhaps help to illuminate some of the underlying mechanisms in the relationship between unemployment and health. While self-selection may have affected the results there appears to be some suggestion that uncertainty about the future and inability to plan for the future may be associated with poorer psychological health.

Unemployment and Physical Health

One study attempted to compare the physical health of employed and unemployed men (British Regional Heart Survey 1978-1980). Although designed to explain geographical variations in Cardio-vascular disease by evaluating environmental, socio-economic and personal risk factors, the data collected allowed this special analysis to be made [41]. A large sample of men aged 40-59 was drawn from the age-sex registers of General Practices in 24 towns throughout the U.K. Data collected by questionnaire allowed comparisons of age, social class, smoking and drinking habits, use of tranquillisers and the prevalence of several physical diseases. Information on reported illness episodes was supplemented by clinical measurements of blood pressure and respiration. The unemployed were divided into two groups according to whether the ostensible cause of the unemployment was ill-health or not.

Of the 7673 men in the study population, 408 were unemployed of which 258 were unemployed due to illness. The proportion of unemployed men who said they were ill increased as duration of unemployment increased. The mean age of the employed group was significantly lower than the unemployed group and there was a pronounced gradient in unemployment from Social Class I to Class V for both groups of unemployed with Class V having the largest number unemployed.

When data for illness (diagnosed from screening information) were analysed and rates standardised for age, social class, town of residence and smoking status, a significantly higher prevalence of bronchitis, obstructive lung disease and ischaemic heart disease

(I.H.D.) was found in the unemployed group as a whole, with the highest rates in the group who were unemployed because of illness. However the only significant difference between those not unemployed because of illness and the employed group was for I.H.D. Although there were more current smokers and heavy drinkers among the unemployed men, when standardised for age, social class and town of residence, a significant difference only in smoking behaviour could be found.

In this sample there appeared to be higher rates of diseases in those unemployed compared with the employed but this did not correlate with the rates for recalled diagnosis of illness. The authors concluded that this suggested that self reported measures of health or measures of health care utilisation may underestimate the actual prevalence of physical illness and that in future studies they should be used with care as indirect measures of health status.

They also recommended that investigations of the causal relationship between unemployment and health must take account of age, social class, area of residence, working history and pre-existing health status in addition to behaviour which may affect health. The strongest features of this study were that the sample was drawn randomly and the design allowed comparison with a control group. However due to the cross-sectional nature of the study no account could be taken of individual occupational circumstances and it was not possible to distinguish between ill health causing unemployment and unemployment causing ill health.

Reported Changes in Behaviour and Time Use

A few studies have examined the reported changes in behaviour and time use by people who have become unemployed. One such study surveyed a representative sample of the unemployed population in Great Britain to establish how people coped with unemployment [42]. The sample of 1043 people were asked to agree or disagree with statements relating to possible problems associated with unemployment. One of the major

problems identified was that of household budgeting, with 85% of the sample stating that they had cut back spending on everything. Concern with this problem increased with length of unemployment.

Worry about whether a job would ever be found was highly correlated with length of unemployment and positively correlated with social class, the A,B, and C1 groups being least concerned.

The lowest level of agreement was found with the statement that "being out of work is not so bad because of the benefit system". There was some correlation with length of unemployment and the critical point appeared to be around six months. Approximately three in four people missed the company of others at work, with older people being more concerned about this problem. Sixty nine percent agreed that it was boring having nothing to do. This appeared to be more of a problem for men than for women and was positively correlated with length of unemployment but was less disturbing for higher social classes. Nearly one half of the sample blamed the high level of unemployment on the world economic crisis and about one quarter blamed the present Government or Margaret Thatcher.

People aged 45 and over reported spending more time gardening and walking than other age groups and the 25-34 age group played more sport. The higher class groups and those over 45 years were less likely to report having done nothing. Approximately sixty eight percent stated that they had not developed new interests or hobbies since becoming unemployed and nearly half of the sample said that there were things they would like to do but could not, mainly because of lack of money.

About two thirds of the sample had reduced the amount spent on food a little or a lot. The percentage of people who had reduced spending a lot increased with length of unemployment. One third stated that they spent less on meat, one third spent less on alcohol, one quarter had cut out snacks and sweets and one in five people were eating cheaper cuts of meat and cutting down cigarette consumption. Almost one half of those unemployed for two years or more ate less meat and 40% had

cut out alcohol.

Thus financial constraints experienced by many people in this sample appeared to have affected health-related behaviour via household spending patterns particularly in relation to food consumption but also in relation to alcohol and cigarette consumption.

One case control study [43] carried out in the Brighton area was based on Jahoda's latent consequences of employment theory [44]. The main hypothesis was that unemployed people who had greater access in their lives to five categories of experience would be less psychologically affected by unemployment than others. These were referred to as Access to Categories of Experience (A.C.E.) measures (Boredom, Social Contacts, Collective Purposes, Time Structure and Status).

A sample of 300 unemployed men aged 21 and over and 100 employed men were interviewed. Two hundred of the men who had been unemployed for six months or more were asked to keep a time-budget diary for two consecutive weekdays.

Psychological well being was measured using the 12-item G.H.Q. and a life satisfaction scale. General health status was measured using a Satisfaction with state of health scale, specific symptoms of ill health and questions taken from the General Household Survey.

The few associations found between A.C.E measures and social characteristics which were statistically significant accounted for no more than four percent of the variance in A.C.E. measures.

When A.C.E. measures were analysed in relation to reported participation in activities highly significant associations were found :- Boredom was negatively associated with participation in most activities; Social contact and Status were strongly positively associated with participation in sports and other close contact activities; Time structure was positively associated with family based activities and domestic work; and Collective purpose was positively

associated with family involvement and engagement in voluntary or community activities.

Analysis of the time budget diaries showed that on average unemployed men spent two thirds of their time at home and about one half of their time alone although this varied according to marital status. Slightly more of their leisure time was spent at home than outside of the home. These results were compared with results from a B.B.C. study of employed men and differences in time use could be discerned. However there were a number of major differences between the studies which could have influenced the results.

The unemployed men tended to report more symptoms of ill health and lower well-being than the employed control sample. Although there was a high correlation found between G.H.Q. scores and the A.C.E. measures, only about a quarter of the variation in well being scores could be accounted for by the A.C.E. measures. When considering mediating factors which might explain the rest of the variation only work involvement was found to have any significance. The fact that the unemployed men who scored highest in the A.C.E. measures reported poorer well being than the employed group led the author to conclude that even access to alternatives to employment did not fulfill the psychological function of formal employment. It is possible, however that other consequences of job loss, not included in the study, might have explained some of the remaining variance in well being.

While access to categories of experience appeared to be greater for the employed man, as the author stated it is difficult to identify whether this is due to employment per se or to socialisation which may train people to look for opportunities through formal employment.

Obviously only a longitudinal study of men becoming unemployed, could provide firm evidence that unemployment affects health by reducing the range of access to experiences.

A study of changes in reported behaviour asked subjects to state how 37 behaviours (grouped under seven headings) had changed, if at all, since job loss [45]. Analysis of the baseline data indicated that the working class men were more likely to report smoking; and less likely to report book reading, doing physical exercise, having hobbies, having a drink at home, spending time with friends or being involved in church and voluntary work than were the middle class men.

For the sample as a whole increases were found in all forms of domestic work, domestic pastimes, other pastimes, (except smoking for middle class men) book reading, exercise, gardening, hobbies, social contacts and charity after unemployment. No increases were found in attending classes, courses, church and political meetings or in watching and taking part in sports. Decreases were found in entertainment involving money and attendance at union meetings.

For the middle class group, increased time spent on domestic and other pastimes was found to be significantly associated with financial and health problems and with more negative changes in health since job loss. In addition it was found that the greater the reduction in entertainment involving money the lower was psychological well being. While in the working class group similar associations were found the correlations tended to be lower, although the differences between groups were not often significant.

While there appeared to be a reduction in drinking alcohol for the sample as a whole, reported consumption was not recorded. Working class men seemed to be smoking more but again actual consumption was not measured. The authors suggested that the social class differences in behaviour change were an indication that the classes responded differentially to income reduction in ways which were in agreement with their interests, habits and social norms before job loss. They also concluded that it was difficult to identify causal associations between behaviour and health status since lower health status might cause changes in behaviour or changes in reports of behaviour. To elucidate this a longitudional study would be required.

A study of 150 men aged 25-45 was carried out in Belfast with the aim of investigating how unemployed men spent their time [46]. Respondents were obtained through a Social Security Office and asked to keep a time diary for a specified day of the week. They were then interviewed the day after the diary was filled in and psychological health was measured using the 12-item G.H.Q.

On average the largest proportion of time was spent on passive leisure pursuits e.g. T.V. followed by personal care activities and domestic chores. Only one percent stated that there had been no change in their life since becoming unemployed. Having less money, boredom, alienation, ill effects on the family and curtailment of social activities were the most commonly reported negative changes. While three people reported that their health was poorer, three stated that it was better than when they were employed. Moreover a small number of men stated that they had more time for interests since becoming unemployed.

When asked specifically about the effect of unemployment on their physical health 61% felt that it had had little effect and nine percent felt that their health had improved. The latter group tended to be those who had stopped work for health reasons. In relation to G.H.Q. scores 64% could be described as having a tendency to minor psychiatric disorders and the mean score was found to be high compared with that for employed men found in a previous Belfast study.

Four main groups of men were identified based on cluster analysis of their activities. These groups were subsequently labelled Active interests, Social, Domestic and Passive interests. When the socio-demographic characteristics of these groups of men were examined, differences in activity patterns were found to be associated with age, marital status, family size and length of unemployment.

Although these four studies, which attempted to establish changes in certain behaviours since job loss, used different measures and surveyed different groups some similarities in results can be

identified. Firstly income reduction affected household budgeting which led to changes in consumption patterns. In some cases this resulted in changes in diet and alcohol consumption. While in one study some people reported a reduction in smoking another suggested that working class men were smoking more. Three of the studies indicated that activities outside of the home involving money were curtailed and most studies identified boredom as being a problem for many people. In addition, those studies which measured psychological health found that decreased activity outside of the home was associated with poorer psychological well being.

Summary of Cross Sectional Studies

In summarising the significant results of the cross sectional studies consideration must be given to the similarities and differences in study designs.

Nine of the 12 studies surveyed only men while the remaining three surveyed both men and women. Ten surveyed a wide age range while two surveyed narrower age ranges. Nine used some form of the G.H.Q to measure health status. The major differences lie in the variables examined. Three studies examined age and length of unemployment, three examined social class differences, three examined different types of employment and unemployment and four investigated retrospective changes in behaviour and time use. Two studies found that men in intermediate age groups had poorer health status than either younger or older unemployed men and this may be due to salience of work and to family life cycle stage. Although duration of unemployment was not found to be significantly associated with health status for the youngest and oldest age groups, those in the intermediate age groups who had been unemployed for the longest period had the poorest health status.

While one study found that working class men had poorer psychological health than middle class men another study found no such differences. In the studies which compared the health of unemployed people with

other groups the former were found to have poorer psychological health than full-time employed, part-time employed, temporarily laid off, re-employed people and old age pensioners.

When the associations found between poor psychological health and other variables are examined some of the underlying mechanisms are illuminated. Most of the studies found that poor psychological well being was associated with problems of filling time, boredom and curtailment of activities. Reduction in income, it appeared, not only resulted in financial stress for many but removed the freedom to choose how incomes were spent. Moreover, reduced incomes restricted social contact and the ability to engage in activities which might occupy time meaningfully. In general the results support the proposition that unemployed people cannot be viewed as a homogeneous group.

LONGITUDINAL STUDIES

Longitudinal prospective studies, which assess the experiences and the health of individuals over time, appear to be the most likely to provide evidence for a causal relationship between unemployment and changes in health status. However, because they tend to be expensive and time-consuming few have been carried out.

One of the best known studies, in America, followed a sample of male blue-collar workers for a period of up to two years [47-50]. A model was proposed which linked an individual's objective environment (defined by e.g. social status, employment status and patterns of affiliation) to the subjective environment (defined by subjective public esteem, perceived economic state and sense of security) and to physiological, behavioural and affective responses, which would in turn influence the psychological and physical health of the individual. It was postulated that enduring characteristics of the person (e.g. coping styles, flexibility, ego strength and social support) would act as mediating factors.

Two samples of men aged 35-60, who were all married and had worked for at least three years were drawn from factories which were about to close in South East Michigan. Factory A was situated in an urban area while Factory B was set in a rural situation. Data were collected by public health nurses using formal interview questions, self administered questionnaires, card sorts and physiological measurements. The first interview was carried out approximately six weeks before the plant closure (anticipation stage) and the second visit six weeks after the plant closure (when men were either unemployed or in probationary employment). Thereafter data collection was repeated approximately every three months as long as the individual's employment status did not change, or as soon as was possible if it did change and terminated as soon as the new job situation was stabilised. The last visit made to any member of the sample was two years after the plant closed. Control groups of men in secure employment were surveyed to determine seasonal fluctuations in measurements and to establish baseline data. There were no

significant differences between the cases and controls with respect to socio-demographic characteristics and psychological measures at the onset of the study. The refusal rate was approximately the same for cases and controls and the final total numbers surveyed were 100 cases and 76 controls.

The cumulative employment experience of both groups was found to be about the same, with on average, approximately 15 weeks of unemployment having been experienced during the two years. However the sample from Factory A had experienced only seven weeks of unemployment in the first year compared with 12 weeks for the sample from Factory B, and in the second year the situation was reversed.

When information from Health Diaries of the control sample was analysed it was found that there were seasonal fluctuations and differences between rural and urban samples with the latter cases having more days with health complaints, disability days and medical consultations. When the results were checked against records from several companies and the Health Survey, fluctuations matched reasonably well and there were no significant trends over time. Values for the cases were adjusted for seasonal changes, rural-urban differences and case-control differences in past illness.

Analysis of the effect of objective employment experience on the number of days when complaints were recorded showed that the reduction in scores from visit one to visit two was about the same for men who were unemployed and those who had become re-employed. The authors suggested that this reflected reaction to change per se whether it be unemployment or re-employment. However at visit three the unemployed men had higher mean levels of complaints than those who had become re-employed. One and a half to two years after the plant closed those who remained unemployed had very high scores but since these men had high scores throughout it suggested that ill health was preventing re-employment. Overall there was a statistically significant correlation between average levels of complaints throughout all visits and rating of the severity of job loss experience. Men who scored low on the ego scale also rated the experience of job loss more severely.

The number of job changes experienced was found to be positively related to Days Complaints but only for the urban cases.

The scores for the Days Disability showed that differences between visits were very small and there was no relationship between scores and employment experience. In sample A the younger men had higher mean scores in phase one but lower scores in phase five than other cases, suggesting that anticipation of job loss was more stressful for them, but that they recovered better than older men.

The number of days on which respondents used drugs remained fairly constant throughout the study period and since mean scores were found to be correlated with personal characteristic measures e.g. ego strength, the authors suggested that any differences in this index were due to individual drug taking habits.

Norepinephrine excretion levels were significantly higher for cases than for control levels before closure but 24 months after closure there was no difference. Those men who had four or more job changes had higher levels during the first year suggesting that there was a relationship with changes in employment status. The authors proposed that the differences in levels could be explained by three independent variables - life stresses, psychological defenses and caffeine intake. Serum creatinine levels for all cases increased significantly from visits two to three and decreased from visits three to four but were higher on average for rural cases. Also men with low defence scores had lower levels on all visits. The cases' uric acid levels were high for visit one especially for those with little perceived social support and there appeared to be some relationship between levels and employment experience since levels fell dramatically when men became re-employed. While the mean changes in serum cholesterol levels for cases decreased from the first two visits to the last two visits no such change was found amongst controls. Higher levels were found in men who remained unemployed throughout and who had little perceived social support.

An excess of coronary heart disease, dyspepsia, joint swelling, hypertension and alopecia was found in the study sample. Since some of these conditions take some years to develop it is difficult to establish if change of employment status was the direct cause or if it exacerbated pre-existing conditions.

Although the results of this study are complex and difficult to interpret there is some suggestion that individuals suffer deterioration in health prior to unemployment and this continues until they have settled in re-employment. The physiological measurements suggest that they may also be at increased risk of illness. However the use of the Health Diary as a measure of health status raises a number of points which could have affected the results. The act of recording in itself could have sensitised respondents and this together with the effect of repeated responses could have biased the results. Furthermore the duplication data collected at interviews was not found to be sensitive to employment experience and perceived stress while the Health Diary data was, leading one to question the validity of these results. Since other studies have found that some people adopt the "sick role" in order to explain their unemployment to others, it is possible that those who continued to be unemployed reported more ill-health. Although the physiological measurements taken may give some indication of increased risk of illness there may have been other explanatory variables omitted e.g. diet which could have accounted for some of the differences.

The major limitations of this study, apart from the techniques used, were that the sample was small and restricted to married middle aged men which prevents extrapolation to other population groups. In addition few men remained unemployed for the whole two years so the effects of long term unemployment cannot be assessed. Despite these limitations the study has advantages over others since data were collected prior to plant closure, over a period of two years and matched controls were used. Indeed it provides the strongest evidence so far that unemployment affects health and that psychological and physical health may be related through stress.

The effect of employment status change on self attitudes was examined using a sub-sample from the U.S.A. National Panel Survey [51]. During 1968-72 approximately five thousand people who were employed in the first survey but unemployed at the second were selected and controls chosen from those who were employed at both surveys. Self attitude was assessed by asking respondents whether they were more often satisfied or dissatisfied with themselves. The results showed that those who became unemployed were significantly more dissatisfied with themselves than those in employment. Social role performance changes were related to self attitudes for those who were unemployed except for mothers suggesting that the existence of an alternative role modified the effects. It was also found that individuals had lower satisfaction if they lived in areas of low unemployment. The author concluded that unemployment adversely affects self attitude, if role performance changes are negative, if an alternative role is unavailable and if the cause of unemployment cannot be attributed externally. The results however should be viewed with caution since very insensitive measures of self attitude and of unemployment were used.

The D.H.S.S. Cohort Study [52] surveyed a sample of 2,300 men who were registered as unemployed in the autumn of 1978. Interviews were conducted approximately one month, four months and 12 months after registration and information was collected on disabilities or health problems, the use of health services, subjective judgements of changes in health since registration, and the number of weeks spent out of work due to ill-health in the year before and the year after registration.

In the year prior to registration 12% had spent some time out of work due to ill-health which was a higher proportion than for the year after registration. In both periods the proportion of men who had spent time out of work because of sickness increased with age (except for those over sixty) and was higher for married men with more than four children.

Those men who had been continuously unemployed were more likely to have had poor health records than the unemployed as a whole and there was no evidence to suggest that health deteriorated because of unemployment. On the contrary health appeared to improve, but the authors felt that this could be due to the fact that financial losses could be incurred if men changed from being registered unemployed to being sick. The proportion of men reporting disabilities or health problems did not appear to change over the three interviews. At the second interview the majority of men reported that their health was about the same as when they registered and by the third interview more men reported improvements in health. This latter result could suggest that some men's health improved by not being employed or it might be explained by the fact that the second interview took place in the Winter and the third in the Autumn.

A significantly higher percentage of the men than that recorded in the General Household Survey for the same age group had visited their G.P. in the two weeks prior to the third interview. Since the cohort sample had a larger proportion of younger men this result was unexpectedly high although socio-economic differentials could explain some of it. This measurement cannot be viewed as a sensitive indicator of health status however since it may have been easier for the unemployed to have found time to visit their doctors.

In general it was concluded that most of the men in the sample who remained unemployed were relatively healthy and their health did not seem to deteriorate during the year; those who had disability before becoming unemployed were more likely to remain unemployed for a long time; although the proportion of men sick at each interview appeared to remain fairly constant this was due to some individuals reporting improvements in health and others reporting deterioration; there appeared to be little decline in health from the second to third interviews for the whole sample or for those who had been unemployed throughout; and there was no difference in use of health services between the long term and short term unemployed although the sample as a whole used them more than the general population.

A study of young people in Leeds [53-55] has provided both cross sectional and longitudinal data on the effects of unemployment on the risk of minor psychiatric disorder. Two cohorts were drawn from a population of sixteen year olds who were leaving school.

The cross sectional results [53] showed that there were significant differences in G.H.Q. scores across employment status groups (unemployed but not wanting work were excluded) with the unemployed having the poorest scores. Sex differentials were less clear since, although females scored higher throughout, only three significant differences were found in all interview scores. Asians were found to score consistently higher and whites lower in three of the interviews. There appeared to be no differences in G.H.Q. scores according to educational qualifications.

Regression analysis was carried out to establish the strength of the relationship between employment status and G.H.Q. scores controlling for sex, ethnic and educational differentials. The proportion of variance accounted for by these variables ranged from 10% to 23% with the main contributors being employment status and sex variables. However when all other variables were controlled there still appeared to be a strong relationship between employment status and G.H.Q. scores i.e. unemployment was associated with poorer G.H.Q. scores.

Data for cohort B were used for the longitudinal analysis since they had been interviewed before leaving school (B1) and employment status was classified as the status at the second interview which took place nine months after leaving school (B2).

The unemployed showed significant increases in G.H.Q. scores for B1 to B2. Those employed at B2 however showed significant decreases in G.H.Q. scores from B1 to B2. Consequently there was a significant difference in the G.H.Q. scores of the unemployed at B2 compared with the employed. Also when G.H.Q. scores from B1 and B3 (24 months after leaving school) were compared the unemployed showed significant increases and the employed significant decreases in scores. When analysis of variance was carried out the best predictor of G.H.Q.

scores was found to be employment status.

The cross sectional results appeared to support the hypothesis that unemployment was associated with increased risk of psychiatric disorder. However it was not possible to establish if it was the same people who were scoring high or low since some people changed employment status between interviews and some were lost before the final interview. The longitudinal results appear to support the proposal that unemployment affects mental health rather than the other way round since there were no differences in G.H.Q. scores before the samples left school. Also it was found that the scores for the sample as a whole were higher before leaving school as compared with after suggesting that they were all anxious about finding a job. Attrition of the sample occurred but there was no evidence that the characteristics of the sample changed.

Large changes in G.H.Q. scores were found with changes in employment status. Those who changed from being unemployed to being employed had improved G.H.Q. scores while those who experienced the reverse situation had poorer scores. Those who did not experience changes in employment status had very similar scores between interviews but the unemployed mean scores were poorer than those of the employed. It was also found that there were larger increases in psychological distress for those who had high work commitment when they became unemployed and larger reductions when they became employed.

The results provide some evidence that the mental health status of this sample of young people, as measured by the G.H.Q., deteriorated when unemployment was experienced and that this deterioration was more severe for ethnic minorities and for those with high work commitment.

The effect of mass unemployment on community mental health was studied in Youngstown U.S.A. with the purpose of providing information for planning public policies [56]. The study was designed to examine how workers and their families reacted to job loss, the responses of formal agencies and the implications for mental health care.

Samples of married steel workers and managers were selected and interviewed one year and two years after plant closures were announced. Control groups who had secure jobs were also selected and interviewed. One year after the plant closures the steelworkers were more likely to be unemployed than were the managers. The results from the first interview showed that men who were unemployed evinced more stress than others but the differences were only significant for four indices i.e. they consumed more alcohol, had more family problems, they felt more victimised and they were more anxious. However by the time of the second interview all significant differences had disappeared. This would suggest that the increased stress was due to the initial effects of job loss or that men adapted to their situation.

At the first interview the managers had lower scores than the steelworkers on depression and mobility. The results from the second interview also suggested that the managers were better at coping with the initial stress of job loss and over a longer time.

In general the results showed that none of the subgroups appeared to be severely affected one or two years after the plant closure and that the incidence of pathology was about that expected for the general population. The authors concluded that these results could be explained by several factors. Firstly that 95% of the sample found new jobs or retired. Secondly that in U.S.A. those workers would be among the highest paid and may have had substantial financial resources. In addition the steelworkers had received benefits from Unions and the Government. Since the community of Youngstown has highly integrated family and social networks it was likely that strong social support mediated the effects of unemployment. Finally it was possible that the use of alcohol and self administered drugs may have helped to cope with mild depression.

The only longitudinal study on the effects of unemployment on the health of families to be carried out by a British general practitioner took place in Calne [57]. The medical records of 129 employees of a

meat processing factory and their families were examined for a period of six years prior to redundancy and two years after redundancy. In addition records of 99 similar people in stable employment and their families were examined for the same period in order to act as controls.

The number of medical consultations, episodes of illness, referrals to hospital and attendance at out patient clinics were counted and subsequently two periods for comparison were identified. The first period was the four years when jobs were secure and the second the four years when jobs were either insecure or had been lost.

Statistically significant increases in the number of consultations from the first period to the last period were found for all cases and their families but not for controls. While there were no significant differences in consultation rates between cases and controls during the first four year period, significantly more consultations were found for the cases in the second period compared with controls. Although not statistically significant there was a 10.6% increase in illness espisodes for case families from period one to two while there was a 9.3% decrease for control families.

There was no significant increase in out patient attendance for control families but a significant increase was found for case families from the first to second period.

The authors concluded that the results showed that the threat of redundancy and unemployment had a detrimental effect on the health of the men, women and their families.

Further analysis was carried out to examine the influence of age and previous morbidity on the results [58]. The subjects were divided into two age groups; for men < 40 and 41 - 60 and for women < 35 and 36 - 55 at the time of redundancy. They were also divided into two groups on the basis of consultation behaviour in the first four years of the study. Those who consulted more often than the mean rate for their age/sex were classified as High consulters and those who

consulted less often as Low consulters.

Significant increases were found in the number of consultations and attendances at out-patient clinics for the men aged 41 - 60 but not for those aged < 40 years. Significant increases in the number of consultations and referrals were found for the women aged 36 - 55 years but not for those aged < 35 years. No significant changes were found for the controls.

There was a significant increase in consultations, illness episodes, referrals and attendances at out-patient clinics for the Low consulters. A significant decrease in illness episodes however was found for the High consulters.

When age and consultation behaviour were combined it was found that for the older Low consulters there was a significant increase in all measures from the first to the second period. Therefore it appeared that the younger people or those who consulted their doctor less frequently were not affected so much as the others. The authors concluded that the younger people may have been better able to adapt to the threat of redundancy and job loss. They also suggested that the latent functions of work may have been more important to the Low consulters and therefore they suffered more distress when threatened with job loss and when made redundant.

The records of 20 employees who had previously been excluded from the study because they were close to retirement were examined together with 13 spouses [59]. For the 10 male employees there was a significant increase in consultations and illness episodes from the first to the second period. However no significant changes were found for the women or for any of the spouses.

The authors concluded that the men were less able to adapt to threatened redundancy or job loss than the women since work for them was their main social role.

Since other studies have found differences in the effects of unemployment according to local employment rates it is possible that subjects were more affected than others in areas of high unemployment might have been. Secondly the population in this area was relatively stable and close knit. Some studies have reported greater perceived social support in close knit communities and have found that this moderated some of the effects of unemployment. While this suggests that subjects might have been less affected than those in a less stable community this contradicts the last point somewhat. Finally the employees themselves had been a stable semi- or unskilled working population and many had worked in the factory for several years. This means that it is difficult to extrapolate the results to other types of working population. This study however provides the strongest evidence so far that the threat of redundancy and the event itself affects the health of people and their families.

A six month study was carried out in Yorkshire to examine the psychosocial dynamics of redundancy and unemployment [60]. Out of a total of 2200 people being made redundant from one company only 58 volunteers were recruited (3.1% response rate). Subsequently 10 people were excluded because of language difficulties. The remaining 31 women and 17 men were interviewed every four weeks for six months. A matched employed control group was interviewed on two occasions, once during the first four weeks and once in the last four weeks of the study.

A homeostatic model of stress was presented which proposed that people whose self esteem was threatened by job loss would experience a period of disturbed homeostasis during which attempts to return to a state of tension-free equilibrium would be made.

Significant differences were found between the unemployed and the employed on measures of symptomatology, hostility and on selected indicators of self-concept and quality of interpersonal relations but not on indicators of satisfaction with family relationships. In each case the unemployed displayed more distress. While the differences

between female and male scores were not significant unemployment was experienced differently with the women coping better. No significant changes in any of the measures for the sample as a whole were found over the six months. It was concluded that redundancy was a threatening and disturbing experience. While financial benefits had removed extreme physical hardship it had failed to counteract the widespread feelings of boredom, isolation, powerlessness and hopelessness.

Summary of Longitudinal Studies

The results from longitudinal studies replicate some of the results found in cross-sectional studies and provide additional information about the association between unemployment and health, the mechanisms involved and the moderating factors.

In summarising the results consideration must be given to differences and similarities in the methodologies adopted - the samples surveyed varied in terms of gender, age ranges, social class and nationality; each study used different indicators to measure health; three studies measured health before unemployment; four studies covered a period of up to two years after people became unemployed; and all studies except one had control groups. While the major differences between studies make it difficult to compare results, it could be argued, that if similar results are found this strengthens the validity of the conclusions. From the results of those studies which measured health before people became unemployed there is some suggestion that health is not only affected by job loss itself but by anticipation of redundancy or uncertainty about future employment. This may be due to increased strain which could lead to deterioration in psychological and/or physical health directly or through coping behaviours.

Two studies found that changes in employment status affected health. While Kasl & Cobb found that the health of those who became re-employed was detrimentally affected until they settled into new jobs, Banks et al. found that psychological health improved when

people became re-employed and declined when employed people became unemployed. The differences in these findings may be due to the different age groups studied and may be an indication of differences in ability to adapt to change. Indeed Kasl & Cobb found that although younger men were affected more in the anticipation stage their health improved again during unemployment. Two studies found raised levels of health service utilisation. While unemployed people may have more time to make use of services the fact that all family members in one study increased their use suggests that an alternative explanation is required. It was suggested that this result may have been an indication of more ill health per se or that the health problems were psychosomatic and therefore more difficult to diagnose.

While most studies found that unemployed people had poorer health than employed controls, two found no serious changes in the health of people who became unemployed. One of these suggested that financial resources could have ameliorated the effects of unemployment.

Only one study took physiological measurements and although it was suggested that physical health could be affected by job loss little information about behavioural factors which might have affected these measurements was collected. While there was an indication that some unemployed people may have been consuming alcohol in order to cope with depression, few studies have collected information on the health related behaviour of unemployed people. Indeed little is known about whether changes in health related behaviour such as smoking, consumption of alcohol and food, or exercise occur during unemployment and if they do whether they are results of income loss, ways of coping with unemployment, or due to situational factors.

CASE STUDIES

Investigations based on a case study design involve recording very detailed information on comparatively small numbers of individuals or families. The data collected from such studies tend to be qualitative rather than quantitative.

One of the first studies on reactions to unemployment was carried out in 1931 in the Austrian Village of Marienthal [61]. The village of 478 households had grown up around the flax mill and the majority of adults worked in the mill until it was closed in 1930 due to the Depression. After this only 22 heads of families were still in full-time work.

The purpose of the study was to bridge the gap between offical statistics and literary accounts of unemployment and the main thesis was that prolonged unemployment led to a state of apathy in which victims no longer utilised even the few opportunities left to them. Data were collected from aggregate records and case histories and the main variables examined were attitudes to and the effects of unemployment.

The attitudes of familes were analysed and classified into four groups i.e. Unbroken; Resigned; Broken and in despair; and Broken and apathetic. The overall impression that the community gave to the researchers, however, was that of resignation. The authors suggested that the small percentage of "Unbroken" families they found could in part be explained by the fact that younger and more energetic families had possibly emigrated before the study commenced.

Unemployment relief was paid for a period of 20-30 weeks, followed by emergency assistance for 22-52 weeks after which time all payments ceased. Consequently one of the main effects of unemployment was that of severely reduced incomes which subsquently affected the diet and material well being of the families. Less than half of the families had three meals a day and often these meals consisted of only soup or bread and a drink. Generally diets were high in carbohydrate with

vegetables and meat being rare commodities.

In the past the adults' state of physical health had not been particularly good because of heavy factory work in an environment which caused health problems. Consequently their physical health on the whole improved after closure. This however was not the case for children under 14 and many of their health problems were attributed to poor diets.

Since the factory was the social centre of the village, involvment in social activities decreased dramatically after closure, but this could also be partly explained by reduced incomes. However one of the most striking changes was in the decreased political activity which could not be related to income changes.

Time lost all its meaning for the men and the major part of their day was spent doing nothing. The meaning of time for women was however different. Whereas they previously had worked in the factory, looked after the children and the house, they now managed to fill their whole day with household activities.

The authors suggested that the four categories of attitudes identified were probably stages in the process of psychological deterioration which ran in parallel with dwindling economic resources and the wear and tear on personal belongings. They proposed that the time it took to reach the "Broken" stage depended on financial status before unemployment and the ability of the family to adapt. However since the study was cross sectional rather than prospective this thesis could not be tested. Although now largely of historical interest, some aspects of this study have been confirmed by more recent investigations.

One of the earliest studies in Britain examined the effect of Unemployment Insurance payments on the willingness and ability of workers in Greenwich to support themselves [62]. The research worker lived in the community during the study and this allowed him to gather

detailed information on the consequences and adjustments involved in unemployment, through observations and informal interviews.

He found that unemployment payments alleviated some of the effects of unemployment, by allowing a reasonable diet to be provided, by preventing rent arrears, by obviating the necessity to sell furnishings and to some extent by allowing people to keep up with social contacts for longer. However he found that the psychological effects of unemployment such as loss of status and self respect were not relieved.

The willingness and ability of men to support themselves was found to be related to a number of factors, most important of which was occupational status, since this influenced the scale of wages, skills and, therefore, the opportunities available to men to change their situation.

The findings allow some distinction to be made between the effect of low income and job loss. While the unemployment benefits prevented some of the worst effects of poverty which might have accompanied unemployment it is clear that work also fulfilled psychological needs.

A more recent study carried out in London and Merseyside explored in detail the nature of the social and psychological impact of unemployment [63]. The sample was drawn from Department of Employment registers and consisted of equal numbers of people from different stages in life who had been unemployed for varying lengths of time.

In the final sample of 148 people Hill identified five categories of people for whom job loss meant different things. Firstly there were school leavers who had never worked, then there were those for whom unemployment followed a major change in another part of their lives, e.g. immigrants and widows. Thirdly there were those whose occupations involved erratic employment e.g. building workers for whom the experience of temporary unemployment was familiar. Next there

were people who had no chosen occupation who had held a series of casual unskilled jobs and for whom work might have little meaning beyond the pragmatic. Finally there were professional and trades people for whom unemployment was traumatic.

Hill, in common with other writers, identified phases or stages in responses to unemployment. For some the initial response which lasted from a few weeks up to two months was shock, especially for those who had worked for a long period of time, but, more frequently, the response was one of denial. The intermediate phase lasted some months and this was when people started to accept unemployment. In this phase, when savings were exhausted, household chores finished and job applications had been unsuccessful, problems with filling in time became apparent and leisure took on a different quality. In this stage people developed an apathy which was psychologically debilitating. The final stage, which occurred when people had been unemployed for about nine months to one year, was that of settling down to unemployment. Most people by this time had adjusted to the changes in standard of living and life style, for some depression lifted and although some continued to look for a job they did so without hope.

Hill also discovered a number of effects on relationships with families and friends. Many people felt socially isolated since work had been their main place of contact and reduced incomes curtailed their social lifes. Men with families felt ashamed and some resented changes in role performance although for many, wives were the main source of social support. Generally when fathers were unemployed it tended to create tensions within the family.

The overall conclusion of the study was that for most of the sample work was not only an economic necessity, but also a psychological one. Hill also suggested that the phases in responses to unemployment were dependent on the extent to which an occupational identity had been established. He proposed that unemployed people require psychological support which is work orientated in order to prevent them from

becoming reconciled to unemployment. He made a number of suggestions which he proposed would channel discontent into constructive activities, which would shorten periods of unemployment and which would enable people to adjust more quickly to work when it was found.

Although this study used a retrospective and case history design which rules out causal inferences it does provide valuable information on variables which should be considered in larger prospective studies e.g. employment history, previous type of occupation and length of unemployment.

One of the best known case studies of recent years is a pilot study, funded by the D.H.S.S., of 22 married men living in different regions of England and Wales who were interviewed six months and one year after registration of unemployment [64,65]. The aim of the study was to describe the process of unemployment in families and to identify a pattern of responses to prolonged unemployment.

The main finding was that the health of the whole family could be affected by the father being unemployed. Some husbands and wives showed clinical features of moderate to severe depression and people who had previously experienced psychosomatic disorders had recurrences of illnesses. Disabled people who had managed to adjust to their conditions when working suffered serious and rapid exacerbation of their physical handicaps. In fact adopting the sick-role appeared, for some, to be an unconscious way of explaining their unemployment when they felt under pressure from families or society. While children under 12 became attention seeking and displayed behavioural problems most children over 12 began to take on adult responsibilities. In a small number of cases subjective and objective assessments of health improved, for example, if the men had disliked their job or where women took over as breadwinners.

The phases in responses to unemployment were similar to those found by Hill [63] although the number of phases experienced and their duration varied from individual to individual. Generally it was concluded that

most men experienced severe distress due to loss of identity, loss of family role, loss of wage earning capacity, reduction in social activities, inability to control their lives and inability to fill in time. It was also concluded that responses were dependent on a number of factors, e.g. the salience of work to the individual, his perceptions of society's attitude to his joblessness, his chances of regaining employment, the strength of family and marital relationships, the degree of financial stress and the power of the sick role in the family. It was also proposed that families responded to unemployment by trying to minimise disruption to patterns of daily living. For some families the changes served to reinforce existing patterns of behaviour and in others the changes meant major role changes had to occur.

The prospective data from this study allowed changes to be assessed and the findings add to our knowledge of the possible mechanisms and moderating factors involved in the effects of unemployment on health.

Detailed descriptions of the experiences of unemployment have been made in two different areas of England [66] using work histories of 13 unemployed men in their prime years, most of whom had family commitments, and a smaller number of teenagers.

It was found that household budgeting tended to put emphasis on one basic essential at the expense of another. For some families the first essential was heating since they lived in damp houses and were at home most of the day. Many families were short of food and what food there was tended to be repetitious and unappetising. Many parents did not apply for free school meals because it would have made their children different from others. Often mothers were described as looking undernourished since they tended to go without food for their children. Some men experienced lack of appetite while others went without food so that their children had more, or in order to afford a drink with their friends.

Where relationships with relatives had previously been tense, disapproval of unemployment was more direct and relationships were further strained. Whether the husband's presence at home was regarded as an opportunity to develop a new relationship depended upon the previous pattern of marriage and the strength of the former relationship.

For the men in the South East of England who had formerly been more mobile workers the shortage of money led to social isolation and wives sometimes felt under pressure if they had more social contacts than their husbands. The less mobile workers in the North East of England tended to spend more time with their friends than their families no doubt due to the high unemployment rates in the area and the fact that local attitudes were more sympathetic towards unemployment. The social lives of these families centred around the working men's clubs where there were activities for all of the family.

For those men who had never been unemployed before, the initial reaction was of short-lived elation and confidence in finding a new job. This was followed by feelings of boredom and growing anxiety over finding work. As time went on requirements for work began to slip in terms of the type of job, wage, locality and prospects men were willing to accept. After about six months of unemployment their confidence was shaken and the urgency to find work had passed its peak.

A slightly different type of study examined 100 unemployed white collar workers who had been very committed to their jobs [67]. The distinctive feature of this study was that it was designed to assess the effectiveness of counselling in unemployment.

The general images tended to be conflicting; while on the one hand there were those of hate, despair, threat, fear, insecurity, shame, bitterness and loss; on the other hand there were those of hope, release and elation.

The major factor which appeared to be important in moderating the effects of unemployment was how threatening the impact was in its significance to the individual and how well they ultimately coped with such a threat. Although the author suggested that those who had failed to cope adequately had the highest levels of stress and stress related diseases, details of how these were measured were not given. Those who felt rejection, failure or loss experienced the situation to be threatening i.e. they had feelings of insecurity and felt their identities and self worth threatened.

The results suggested that the psychological health of this sample could not only be affected by the experience of unemployment but also could be affected if new jobs were stressful or unsatisfying. It was concluded that long term unemployment brought about changes in attitudes with deepening cynicism and fatalism rather than progressive worsening of stress. In addition it was suggested that while counselling was helpful to some, for others the sense of hopelessness and helplessness was too chronic to be relieved in a small number of sessions.

A study of 20 unemployed managerial and professional men who were attending a Manpower Services Commission course was carried out to investigate, at an individual level, the psychological impact of unemployment [68]. The sample ranged in age from 31-57 and had been unemployed for between two months and two years or more.

The most frequently reported initial feeling about becoming unemployed was that of shock. In contrast with previous studies, feelings of shame, loss of status and self respect were less frequently mentioned. Eleven of the sample felt that there were some positive aspects of unemployment but for the majority this was qualified by the feelings of fear and uncertainty due to the depressed state of the job market. The effect on families was varied, with evidence of support in many cases but evidence of strain in others. Generally the quality of marital relationships was an extension of what it had been before job loss.

The majority of men stressed the importance of keeping active but many commented on how difficult it was to be self directed. Most of the sample were not in immediate financial difficulty although they did have financial worries related to maintaining living standards in the future.

The findings although based on a small sample were compared with those of previous studies. The author concluded that the men were passing through similar phases in responses to unemployment found in other studies but at a slower pace. There was an indication that most men were aware of the possible consequences of unemployment in relation to apathy and depression. Therefore none of the sample, regardless of length of unemployment, had accepted unemployment or had become pessimistic because they were making a determined fight against the negative effects.

Another case study carried out in an inner city area in North West England by a health visitor found that for men the worst aspects of unemployment were boredom, reduction in income, loss of social contact, feeling unhealthy or tired, insomnia and depression [69]. For their wives men sitting around all day was the most commonly reported problem and more wives mentioned loss of social contact than did men.

The majority of couples reported deterioration in their relationship accompanied by reduced communication. In addition more than half of the parents reported deterioration in their relationships with children. Seven out of the 20 families had experienced reductions in income, 14 were in debt and, of these, eight had incurred debts for the first time. Since most of the debts were for fuel bills and rent arrears these were deducted at source so little money was left for food and clothing.

All families who had experienced a reduction in income reported increases in the consumption of bread and potatoes and 14 reported increases in the use of convenience foods. The majority said they no

longer ate fresh fruit, vegetables, fish, meat or cheese and reported increased consumption of biscuits and crisps. The factors which appeared to influence changes in diet were the women's mental state, their ability to manage, previous dietary habits and the prices and availability of food in the local shops. These results indicate that, for the majority of the families, decisions about how to spend their incomes were severely restricted.

Seven of the men had started, recommenced or increased smoking since becoming unemployed for reasons of boredom and insomnia. Of the six men who had reduced smoking five had been advised to by their General Practitioner for health reasons. A large number of women had started or increased smoking and none had reduced smoking. Thirteen men had reduced their alcohol consumption because of reductions in social contact. Two men had increased their alcohol consumption in order to sleep at night and two women had drinking problems.

Generally there was an increased demand on the National Health Services by all members of the family. Sixteen men had visited a General Practitioner with new health problems, none of whom had had a record of ill-health before becoming unemployed. Half of the women reported problems with sleep or depression and 51 new health problems were reported in 29 children.

Seven families felt that they were coping very well or quite well with unemployment, 10 were just about coping and three felt they were not coping very well. The main factors which appeared to influence the ability to cope with unemployment were help from extended families and not having debts.

This study, although retrospective in nature, provides valuable information not only on the social and financial problems some unemployed people experience but also on their health related behaviour.

General practitioners' observations of the effects of unemployment on their clients have been reported in a series of articles in the British Medical Journal [70].

While observations varied somewhat with geographical location some similarities could be highlighted. The majority of doctors were concerned about young people many of whom displayed behavioural problems because of boredom. Alcohol and drug abuse was evident. There was some evidence that the cigarette and alcohol consumption of unemployed men had not decreased and in some instances it was thought to have increased.

The most consistent observation was that many wives of unemployed men showed symptoms of anxiety and depression resulting from financial problems and in some practices there was evidence of increased wife abuse.

There was some suggestion that high local unemployment rates had an effect on the consultation behaviour of those people in employment. In Liverpool requests for sick lines reduced considerably suggesting that people were frightened of losing their jobs and in another practice people who were ill would not stay off work in case they lost their jobs.

Since some people are employed in stressful, unchallenging, unsatisfying jobs with poor working conditions, even though unemployment results in loss of income there may be compensatory gains. Unemployment and employment can have negative or positive characteristics [71]. A study of 11 people who were coping well with unemployment described this group as being pro-active defined as displaying selected goal behaviour [72]. An agency hypothesis was proposed in which people are viewed as active social agents as opposed to being passive and dependent and in which employment is not seen as being a necessity for psychological well-being.

All subjects were found to be able to perceive, create and exploit opportunities in unemployment in order to bring about changes in valued directions. They also distinguished quite clearly between purposeful activity and employment and this enabled them to find opportunities to work even if there was no payment for it.

Although many of the subjects experienced financial and material deprivation most preferred productive and meaningful unemployment to non-productive and meaningless employment. In fact most of the consequences imposed by employment were resented by the subjects.

The authors concluded that while Jahoda's latent consequences hypothesis [44] could explain some of the psychological effects of unemployment their agency hypothesis could explain all of the empirical evidence. This study has been criticised for not treating the 11 case histories individually and for the way in which the data were aggregated [7].

Moreover all of the subjects had been either very successful academically or were in skilled and professional careers prior to unemployment and could be described generally as upwardly mobile. They are thus far from typical of the unemployed population.

Summary

A number of the findings in this chapter reflect those from cross-sectional and longitudinal studies. Although few were prospective, several studies identified similar phases in the responses to unemployment. The number and duration of phases experienced appeared to be related to employment history, occupational identity, financial stress and the ability to adapt. These findings have implications for the design of future prospective studies.

Work appeared to fulfill psychological needs as well as economic ones and this seemed to be related to the salience of work for the individual, ability to fill time meaningfully and to perceived social

support.

In some cases the health of the whole family was affected. In others, the health of individuals improved if previous jobs had been stressful or unsatisfying or if work conditions had been detrimental to health. There was also some evidence to suggest that diets could be affected by low income but this depended to some extent upon budgeting skills and budget priorities. The effects of unemployment on relationships appeared to depend upon the nature and strength of former relationships.

Even those studies which were prospective in nature cannot demonstrate a causal association between unemployment and ill health because of small sample sizes and the nature of the data collected. Furthermore, as Jahoda and Rush [9] state there is a danger in extreme disaggregation of data which prevents even limited generalisations from being made. However the findings of case studies help to illuminate some of the more complex aspects of unemployment and explain why its effects can be varied. For most people paid employment, in a work orientated society, is not only a financial necessity but a psychological one. Therefore job loss may bring about changes in two major facets of life. However it is only when the implications of the loss of manifest and latent functions of employment are considered that it becomes clear just how many aspects of an individual's life and their family's life may be affected. It appears that the differential effects of unemployment may be due to the individual's and family's ability to adapt to changes brought about by job loss. Since many of the alternative ways in which people might be able to fulfill the psychological functions of employment require money the two facets become interrelated. The ability to adapt may therefore be enhanced if there is access to financial resources or if the individual is pro-active in nature but may be inhibited if the reverse is true. Thus a whole range of factors are likely to influence the ability to adapt to and cope with unemployment. It is easier then to understand why unemployment may affect people differently.

Thus the major advantage of the case study design is that very detailed qualitative information is collected which is often missing from studies based on more "scientific" methodologies. Indeed it could be argued that in an area of research which is dealing with people and their experiences (i.e. a social phenomenon) much useful information is lost by reducing it to numerical data. The major value of these studies is to highlight the complexity of individual reactions and feelings and to provide a more holistic view of unemployment and its sequelae than do epidemiological studies.

Concepts of Health

It is necessary, in any study which examines health status and health related behaviour to review associated concepts and models. The traditional medical view is that health is the absence of disease. While psychological disorders are acknowledged, the primary emphasis is on biological and physiological disturbances which have defined symptoms and which are treated in specific ways [73]. This negative model of health is based on the supposition that diseases can be measured objectively and that if symptoms cannot be discerned then the individual is probably healthy. However, it does not account for the fact that people may feel ill without displaying symptoms or for the converse situation. Thus illness is distinct from disease since it involves subjective evaluation on the part of the individual. The subjective element is important in influencing whether people consider themselves to be healthy or ill and will determine to some extent their subsequent behaviour e.g. whether or not they adopt a sick role.

A more positive view of health is illustrated in the World Health Organisation definition "Health is a state of complete physical, mental and social well being and not just the absence of disease or infirmity" [74]. While this definition has been criticised for being utopian its underlying contention is that there are different components in health. However it does not indicate how health is achieved or illness prevented.

Ecological and adaptational concepts of health emphasise the relationship between the individual and the physical, social and economic environment. Dubos suggested that health corresponds to the situation in which an individual successfully adapts to environmental stimuli [75].

Kelman has proposed two concepts of health - experiential and functional [76]. In functional terms health is viewed as a state of optimum capacity which enables an individual to perform effectively the roles and tasks which society demands. In experiential terms health is the capacity for self development and discovery and for overcoming alienating social circumstances. He suggests that in capitalist societies, where production controls the pattern and dynamics of social organisation, functional health will be more important than experiential. Furthermore, he predicts that in societies where individuals have more control over their social circumstances, ideas and practices reflecting experiential health will be less alienating.

It has been argued that "health is not an empirical fact or an objective phenomenon. The concept of health is a human construct that we invent in accordance with our cultural values and social norms"[77].

Stott and Pill [78] found that there were three main categories of concepts of health held by a sample of working class women; absence of illness, functional capacity and a positive condition of physical and mental well being. About half of the sample gave external factors, outwith the control of the individual, as being the main reasons for illness. The rest mentioned the potential of lifestyle choices for causing illness and they tended to view health as being a balance between the individual and the environment.

In a three generational study of working class women in Aberdeen health was also viewed in functional terms as the absence of illness which seriously disrupts practical and necessary activities [79].

A study carried out by Herzlich in France found that while health was viewed as something internal to the person, illness was viewed as external [80]. Therefore people were not thought to be responsible for illness but were responsible for losing their health. Health comprised three distinct dimensions, the absence of illness, a reserve of health and a more positive dimension of equilibrium in which full realisation of the individual's reserve of health was maintained.

In a study of elderly Aberdonians health and illness emerged as separate entities and thus bad health could exist in the absence of disease just as disease could exist without compromising good health [81]. While two dimensions of health, the absence of disease and health as a strength, were found to be similar to those in the French study, the third 'functional fitness' varied from the concept of equilibrium. It was suggested that this could have been due to cultural differences. However Herzlich's findings have been replicated in a more recent Scottish study [82].

It is apparent that while elements of the traditional medical concept of health form part of lay concepts, health is also expressed in experiential terms. It is also clear that lay people hold relatively complex ideas about health and while many feel that health is the responsibility of the individual, illness is not.

Health Behaviour

Health related behaviour has been defined as "a group of behaviours namely health behaviour, illness behaviour, sick role behaviour, chronic illness behaviour and at risk behaviour" [83]. Clearly ideas of what constitutes health behaviour will be related to concepts of health. Two main approaches are employed by researchers when investigating health behaviour i.e. behaviour is researcher defined (usually medically approved) or behaviour is respondent defined.

Most of the national survey data collected in this country on health behaviour is researcher defined and includes behaviours which are thought by professionals to influence health. This approach emphasises behaviours which are thought to increase the risk of certain diseases, e.g. alcohol and cigarette consumption. In relation to concepts of health it is based upon the medical/epidemiological model.

"Good health habits" have been identified as 7-8 hours sleep, regular meals, eating breakfast, regular moderate exercise, moderate alcohol consumption, not smoking and maintaining proper body weight [84]. Although these practices have been shown to be associated with "good" health status there is no proof of a causal association. Furthermore people may engage in these practices for reasons other than for maintaining, promoting or protecting health.

Preventative health behaviour is a term used often in research literature especially in America and would appear to imply some behaviour deliberately performed for the purpose of protecting health or preventing ill health. Langlie [85] defines it as "any medically recommended actions voluntarily undertaken by a person who believes himself to be healthy that tends to prevent disease or disability and/or detect disease in an asymptomatic stage". However indicators chosen included driving and pedestrian behaviour and seat belt use which in some way are related to health but may not be perceived in such a way by lay people. Many researchers include utilisation of health services in health behaviour e.g. Pratt [86], but clearly access and ability to pay for services will influence utilisation.

Few studies have been carried out using respondent defined health behaviour. In one study by Harris and Guten health protective behaviour was defined as "any behaviour performed by a person regardless of his or her perceived or actual health status in order to protect, promote or maintain his or her health whether or not such behaviour is objectively effective toward that end" [87]. In this study the most commonly reported self defined health protective behaviours related to nutrition, sleep, relaxation and exercise as

well as contact with the health services, hygiene and use of medicines. In a study of changes in behaviour which respondents thought had affected their health, the most common changes reported were related to diet, exercise, smoking, drinking and work. Of those people who thought that their health had improved, over half reported that the changes were made for health reasons [88].

However, an alternative perspective has been presented by Cameron and Jones who argue that these behaviours are not autonomous choices of individuals unaffected by external factors [89]. They have proposed that "drugs of solace" are used to relieve pain or suffering brought about by society. Furthermore they suggest that "drugs of solace" are self administered remedies and that the medical profession ignores the underlying diseases and treats the unwanted side effects of the remedies. The real diseases, they argue, such as loneliness, anxiety and depression are caused by lack of harmony between the individual and his environment which may be due to such things as poverty, unemployment or bad housing.

Differentials in Health Status And Health Behaviour

In 1980 the Black Report drew attention to the inequalities in health between social classes in Britain [90]. An updated review of the evidence indicates that while overall mortality rates are declining they are decreasing more rapidly for higher social classes with the exception of babies under one year where the gap has narrowed [34]. The findings indicate that lower social classes are still experiencing higher mortality rates at every stage of life and that the causes of death cover a wide range of diseases. Data from the General Household Survey also show class gradients in reported chronic and acute sickness with the gradient for long standing illness being the steepest. While males experience higher mortality than women at all ages women report higher levels of chronic and acute sickness. Regional data show that mortality rates increase from the South and South East of the country to the North and North West for men and married women. However there is evidence from smaller studies that

health status varies within regions and that the gap between classes is widest in the North of the country.

Cross sectional data, from a variety of sources, are available on differentials for selected health related behaviours.

Gender Differentials

Gender differentials in health status and health related behaviour have been reported in a number of studies. In a review of changes in the gender ratios of different disorders it was suggested that biological factors alone could not fully explain the phenomenon [91].

In a large British survey it was found that women were more likely than men to consult their doctor, report more symptoms, take more prescribed and self prescribed medicines, take medicine if they had symptoms and to report emotional symptoms [92]. It was proposed that some of these results could be explained by differences in perceptions of health, attitudes to and relationships with doctors and access to doctors and medicines.

Waldron proposed that differences in behaviour have a major influence on gender differentials in morbidity and mortality rates in a number of ways: firstly men tend to be more likely to engage in risk taking behaviours; secondly that preventive behaviours differ between genders; and finally that women tend to visit doctors more frequently [93]. Although the last point could partly be explained by biological factors it was suggested that all of these behaviours are influenced by cultural factors.

In relation to other forms of health related behaviour little additional data have been collected on gender differentials except in

National surveys. The most recent figures showed that the prevalence of cigarette smoking for men was 36% and for women 32% (G.H.S. 1984) [94]. The lower prevalence among women was evident in all age groups except in the 50-59 age group where the prevalence was the same as for men. Women's average weekly cigarette consumption was also lower than for men in all age groups. This general pattern of lower prevalence and lower consumption was also apparent in each socio-economic group.

The General Household Survey classifies informants into different categories of drinkers using a Quantity/Frequency Index. Since there are a number of problems with this approach the results must be viewed with some caution. The most recent figures indicate that there are fewer women classified as moderate or heavy drinkers than are men. This general pattern is also found amongst all age groups and in each socio-economic group.

In a Scottish study a representative sample of 2453 people aged 17.5 and over was drawn from the Electoral Register [95]. It was found that 74% of men and 46% of women were regular drinkers (at least once a week) but male regular drinkers consumed on average 20.5 units compared with 4.8 units for women. While there was no appreciable difference in the proportion of male regular drinkers amongst social classes, 74% of Class 1 women were regular drinkers compared with 28% of Class 5. The average weekly consumption for both genders was found to be highest in the lowest social group. While men were more strongly motivated to drink for enjoyment or psychological effects than women, when men and women who drank equivalent amounts were compared, women were consistently more likely to drink for psychological reasons.

In general it would appear that men are more likely to engage in the risk behaviours of smoking and drinking than women but the reasons for such behaviours may be different.

Another survey includes data on participation in sports, games and physical activities (Social Trends 1983) [96]. It is difficult to compare the genders since slightly different activities were listed for each. However for the sample as a whole fewer women had participated in outdoor activities and active indoor activities in the four weeks prior to the interview than men. With a few exceptions this pattern tended to be consistent in each socio-economic group. While it would appear that men take part in more physical activities women may get more exercise during the course of daily activities.

Socio-Economic and Employment Status Differentials

Data on socio-economic differentials in cigarette smoking indicate a clear class gradient for men with the highest percentage of smokers being found in the unskilled manual group (G.H.S. 1984) [94]. A similar, though not so clear, pattern is found for women. However the data on average weekly cigarette consumption does not show a class gradient with the professional, intermediate non manual and semi-skilled manual male groups consuming 108 cigarettes and the employers and managers and skilled manual male groups consuming 121 cigarettes. For females the professional group consumes 78 cigarettes on average per week compared with the skilled manual group who consumes 101 cigarettes on average per week. Data also reveals that 36% of men and 34% of women who are in work are smokers compared with 61% of men and 48% of women who are unemployed.

The G.H.S. data indicate that for males there is a class gradient for those classified as heavy drinkers with the highest percentage being found in the unskilled manual groups (G.H.S. 1984) [94]. For women the pattern is not so clear for although there appears to be fewer moderate and heavy drinkers in the higher social groups more are classified as frequent light drinkers.

As far as economic activity is concerned a higher percentage of unemployed men have been classed as heavy drinkers compared with

employed or economically inactive men in all age groups. For women this is also the case for age groups 18-24 and 24-55. However these figures do not mean that unemployment causes heavy drinking since it could be the case that heavier drinkers are more likely to be unemployed and unskilled manual people are more likely to be unemployed than higher social class groups.

In a review of studies on the effects of unemployment on drinking behaviour it has been suggested that two hypotheses could explain why unemployment might affect drinking behaviour [97]. Firstly the stress hypothesis which predicts that alcohol will be used as self medication and secondly the leisure hypothesis which predicts that lack of time structure and an increase in free time will put some people at risk of drinking more. None of the studies carried out so far have tested these hypotheses. Furthermore as has been discussed in previous chapters the effects of unemployment are moderated by a number of psychological, demographic and situational variables.

The only study which has collected prospective data was carried out in Edinburgh to compare the drinking behaviour of men working in the brewing and distilling industry with that of men working in a "low risk" occupation [98]. Thus the study was not primarily designed to examine the effect of unemployment on drinking behaviour and the number of men unemployed at the second interview (one year later) were very small i.e. eight who had been employed as alcohol producers and six controls. Unfortunately consumption data were aggregated and no indication of range or variability was given.

The unemployed men who had worked as alcohol producers had reduced average consumption by 40.3% compared with a 31.2% increase for the employed. However six out of the eight were still said to be heavy drinkers. The six unemployed controls had increased average consumption by 92.8%. However of these men one was drinking the same, two had slightly reduced consumption and three had increased consumption. Two years later the average consumption of eight men who

had been employed as alcohol producers had increased very slightly and for the seventeen unemployed controls average consumption had increased by 54.5%.

The results appeared to indicate that drinking behaviour may change with job loss but the way in which it changes varies from individual to individual.

Data on sports, games and physical activities indicate that people in different social classes tend to take part in different types of activities (Social Trends 1983) [96]. However there appears to be a higher percentage of professional people who reported taking part in physical activities in the four weeks prior to the interview compared with lower social class groups. Furthermore, in general the higher social class groups were more likely to have taken part in at least one activity in the four weeks compared with lower social class groups. However the differences may be due to the fact that lower social class occupations may be more physically active and therefore these people may prefer more passive leisure pursuits.

The major source of information on food consumption comes from the National Food Survey [99]. There are a number of limitations to this survey which must be considered in the interpretation of data. Those of most importance to this discussion are firstly that only food brought into the household is recorded and total household food is divided to give consumption per head. Due to sampling methods and the difficulty of recording, low income households are less likely to be included in the sample and are under represented.

When consumption figures for Income Group A (£270 and over) are compared with Income Group D & E2 (£82 and under) for households containing only adults it is found that the low income groups consume more processed meat products, processed cheese, processed fish products, margarine, lard, total fats, sugar, preserves, processed vegetables, white bread, total bread, cakes, biscuits and total

cereals than Income Group A. They consume less cheese, fresh fish, poultry, butter, fresh vegetables, total vegetables, fresh fruit, total fruit and wholemeal bread. However it should be remembered that this does not relate to total consumption although low income groups on average consume 10% of their food outside of the home compared with 16% for the higher income groups.

In a review of the relationship between low income, food intake and nutrition it has been suggested that children, young adults and women are amongst those most at risk [100] and that Supplementary Benefit (S.B.) payments are not sufficient to allow nutritionally adequate diets to be purchased. Although there is no set figure within S.B. for food, the figures quoted by the D.H.S.S. for the normal dietary costs which should be deducted from the costs of special diets, are in the author's view, inadequate to meet the D.H.S.S. Recommended Daily Amounts. Sample diets were constructed and costed and it was found that a diet following N.A.C.N.E. recommendations [101] costs 35% more than the average consumption of an U.K. household.

Little direct information on the diets of unemployed people is available. One exploratory study carried out in Scotland [102], was designed in a similar way to a previous study in the North of England [103] and the results were very alike. The sample consisted of 587 individuals with net personal incomes of less than £100 per week including 126 unemployed people.

Sixty One percent of the unemployed cut food expenditure when short of money compared with 55% of the employed. Alcohol and cigarette expenditure was cut by 18% of the unemployed compared with 12% of the employed but the smoking status of the sample was unknown. Of the total sample 13% did not usually have enough money for food to last all week compared with 21% of the unemployed. The unemployed or their

families were also more likely than others to have gone without a proper meal because of shortage of money. Seventy eight percent of the unemployed said there was a food which they would eat more of if they could afford it compared with 66% of the total sample. The most frequently mentioned food in this respect was meat with only a small number of people mentioning fruit. In the sample as a whole 40% had changed the type of food they ate in the previous two years but the unemployed were less likely to have changed for health reasons and more likely to have changed for financial reasons than the employed. A large number of the total sample appeared to be aware of the relationship between food and health.

When money was short the most frequently consumed foods were eggs, pies, bread, beans and chips. The unemployed group and those on Government Schemes were the people who ate white bread more frequently and wholemeal bread less frequently than others. Futhermore the unemployed were more likely to eat processed meat and chicken more frequently than unprocessed. There were marked differences in the frequency of fresh or frozen fruit and vegetable consumption between employment status groups with the unemployed eating it less frequently. About half of the sample had chipped, roast or fried potatoes daily or several times a week and there was little difference in this respect between employed and unemployed people. The unemployed group were the most likely to consume alcohol infrequently but men consumed alcohol more frequently than women. There was however no indication of the quantities consumed.

The authors concluded that while it seemed that some health messages had been assimilated, some groups were still either unaware of or unable to implement nutritional changes. An unpublished local study was cited in which a week's meals, based on healthy foods, for a family of four was costed. In February 1987 using prices from local supermarkets the total minimum cost was £45. However the cost per head would be increased if food was bought in smaller shops or for those living alone. It was suggested therefore that some people would be unable to make changes to their diet and there was some evidence

that structural and economic issues needed to be addressed.

Summary of Differentials in Health Behaviour

Thus on the basis of the information available it appears that men are more likely to engage in the risk behaviours of smoking and heavy drinking than are women but they are more likely to take part in active pursuits. People in lower socio-economic classes are more likely to smoke, be heavy drinkers and are less likely to take part in physical exercise. The food consumption patterns of lower income groups suggest that their diets may not be in line with recent nutritional recommendations.

The data on unemployed people is sketchy and incomplete. What information there is appears to mirror that for lower socio-economic groups. Since people in lower social classes are more likely to be unemployed it is possible that social class explains the differences rather than unemployment per se. However, it is also possible that low income could be associated with the health behaviours discussed. Clearly some people such as Mrs Edwina Currie believe that the poorer health status of low income people is due to ignorance. Recently she has been reported as having suggested that the poor, through health education have to learn to take control of their own lives and prevent unnecessary deaths [104]. However others have proposed that behavioural factors cannot fully explain the wide range of health problems from which the lower social classes suffer and that social and material factors are more important [34].

Models of Health Related Behaviour

Attempts to explain differences in the propensity to carry out health-related activities have been based on a variety on models. The Health Belief Model (H.B.M.), influenced by Lewin's field theory, assumes that the subjective rather than the objective environment determines behaviour i.e. the perceived benefit of action is weighed against the perceived psychological, physical, financial and other

costs of barriers to taking action [105]. One additional element added to the model by Becker et al. [106] was motivation which, it is proposed, affects the individual's perception of the environment. Critics of the model suggest it is limited, since behavioural outcomes are viewed as either right or wrong, since it fails to take account of risk taking behaviour and since it assumes that health related behaviour is performed purely for health reasons. Empirical evidence to support the H.B.M. is inconclusive [83] and even its author views it as only partially developed.

The social network model, an extension of the H.B.M., proposes that social groups differ both in terms of their norms of preventative health behaviour and the pressure they exert on their members to conform to these norms [86]. The model suggests that active preventative health behaviour is more likely if individuals perceive they have some control over their health status; if perceived benefits of preventative action are high and/or costs are low; and if individuals belong to a social network characterised by high socio-economic status and frequent interaction with non-kin.

Seeman et al. examined the relationships between health behaviour and personal autonomy and found that a sense of low control was associated with less self initiated preventative care; less optimism concerning the efficacy of early treatment; poorer self reported health status; more illness episodes; and greater dependency on the G.P. [107].

Another study found that socio-economic status (probably as a proxy for education and income) could only explain about half of the variance in preventative health behaviour and that social participation had an independent effect on behaviour [108]. Pratt found that families were more likely to engage in preventative health behaviour if the members had varied and regular interaction with each other and others in the community; if members had a high degree of autonomy and if the family actively engaged in creative problem

solving. These characteristics were found to have no relationship to socio-economic status [86].

While in some studies there is a suggestion that socio-economic status is related to preventative health behaviour others have found this not to be the case. However two consistent findings have been that social participation and perceived personal autonomy were positively associated with preventive health practices. The reasons for these findings, however, are not clear.

In the U.K. few studies have been carried out which are relevant to health behaviour in general. In one small study the relationship between socio-economic status , health related knowledge and health related habits was examined [109]. The results showed that middle class men had a higher mean knowledge score than working class men but this could have been due to levels of education rather than socio-economic status per se. The mean habit scores were similar for both groups of men but while there was found to be a relationship between knowledge scores and habit scores in the middle class group none was found in the working class group. The results point to the conclusion that knowledge does not necessarily determine behaviour and that perhaps situational factors could be important.

Pill and Stott in a study of working class mothers found that at least half of their sample held fatalistic views about illness and these women were likely to be less well educated and less likely to be owner occupiers [78]. The authors hypothesised that those individuals who do not accept responsibility for their health will be more resistant to changes recommended by health professionals. Also they proposed that for a large sector of society, which is restricted by socio-economic circumstances, recommendations to change lifestyles will be either impractical or irrelevant, irrespective of whether people wish to change behaviour.

These proposals have been supported by the findings of a small study which investigated self initiated changes in health related behaviour [82]. Little evidence was found that changes were made for health reasons but rather were more related to situational factors. An interactionist theory was proposed which predicts that attempts to change behaviour through health education will be unsuccessful where health behaviours are adaptive responses to everyday circumstances. Furthermore it was suggested that for disadvantaged groups in society behavioural change for health reasons will be improbable due to the strain imposed by pre-existing everyday problems.

The decision making process is obviously complex and none of the models or studies have been able to fully explain how people make decisions regarding their health or how these are translated into behaviour. This is partly due to the fact that concepts of health and health related behaviour as discussed previously do not have universally accepted parameters and partly that insufficient studies using the same concepts or measures have been carried out to give reliable and comparable data. Furthermore there is an absence of a theoretical framework which would allow links to be made and systematically tested.

Since there have been few studies carried out which record respondent defined health behaviour it is difficult to say how lay people's ideas about what constitutes health behaviour correspond to those of researchers. Due to recent media coverage of issues such as nutrition, alcohol consumption, smoking and exercise it is not unreasonable to suggest that lay people are probably more aware of the behaviours which professionals believe influence health. However this is not to say that the public will either agree or subsequently change behaviour. Furthermore, as discussed previously, many lay people do not consider disease prevention to be their responsiblity since disease is believed to be due to external factors outwith their control.

Adaptational Models of Behaviour

As has been discussed in previous chapters, one possible explanation for the apparent differential effects of unemployment is the extent to which individuals are able to cope with or adapt to unemployment. Adaptational models due to their conceptual basis are process orientated and therefore may be useful in trying to explain behavioural responses to unemployment.

"From a social psychological point of view adaptation must be considered in terms of the relationship between external, physical and social demands on the person and his responses to deal with these" [110].

Although adaptation and coping are often used synonomously it has been suggested that they are indeed different and that adaptation is the master concept [111]. White considers all behaviour to be an attempt at adaptation and that mastery, defence and coping are all strategies of adaptation used in different circumstances i.e. they are employed in order to avoid conflict, resolve conflict or accept conflict.

Mechanic [110] believes that for successful adaptation, at the individual level, a person must have three characteristics: the capabilities and skills to deal with social and environmental demands; motivation to meet the demands; and the ability to maintain a state of psychological equilibrium. At the social level successful personal adaptation is mainly determined by the extent of fit between the social structure and environmental demands. That is successful adaptation requires a combination of personal capacities and structural opportunities. Other writers have supported this idea that adaptive behaviour functions through the social system [112].

A few authors have put forward adaptational models in attempts to explain differences in health related behaviour and health status. Dubos [75] suggests that health outcomes are determined by the nature of the adaptational responses made to a situation rather than by the nature of the situation itself. The model developed by the Institute

of Social Research, University of Michigan [113] proposes that the type of response made will be influenced by individual cognition and perception. It has been suggested that individuals can cope with stressors by taking direct action to change themselves or the environment. If either of these are impossible then the only other solutions are to change self perception or the environment [114,115].

Hart proposed that stress is the physiological link in the social process of disease and that an individual's cognition and perception of a stressful situation produces physiological changes which may damage the immunity system and therefore will lead to increased susceptibility to disease [115]. However, it has been postulated that only when stress interacts with existing potential endogenic and exogenic pathogens will pathological consequences occur. Antonovsky, for example, believes that the ability to manage tension will determine whether stress is experienced and that successful tension management is influenced by a range of resistance resources [116]. Central to his model of "Salutogenesis" is the concept of a sense of coherence, the development of which is determined by the extent to which our lives provide us with resources to resist stress. He believes that capitalist and totalitarian societies do not facilitate the development and maintenance of a strong sense of coherence and do not provide resistance resources. Presumably the more disadvantaged in such societies will have the fewest such resources.

Askham [117] proposed that behaviour is an adaptation to a particular situation which is reinforced by two sets of values, norms and beliefs. The first set may be common to many people arising from their general situation and through the process of socialisation. The second set will differ in that they will be responses or adaptations to particular situations. She suggested that behaviour should be seen as being guided by a continual process of adaptation to mutually reinforcing, causally connected situations, which will help produce and reinforce a set of values, beliefs, norms and behaviour patterns - i.e. behaviour is guided by the stimulus and response to a particular situation.

In her study of fertility and deprivation she hypothesised that the greater the impact of situational factors, the greater would the need be for adaptation in terms of norms and behaviour patterns. She found that cultural factors could not provide an adequate explanation of behaviour and suggested that situational factors were the crux of the matter.

Blaxter also believed that the environment in which a person lives is very important in influencing behaviour [79,118]. In her deprivation studies she found that the health related behaviour of two generations of women was not necessarily related to attitudes or beliefs but possibly could be explained by the disadvantaged environments in which the sample lived.

This view of health as a property of the social environment and of individual's relationships with it is supported by other writers [115, 119]. Hart proposed that the higher morbidity and mortality rates found in lower socio-economic groups can be explained by the fact that not only do these groups experience stressful life events but that they experience long term difficulties. In addition they suffer from material and cultural deprivation which impedes their ability to cope.

Job loss for the majority of people brings about changes in their physical, social and economic environment. The nature of adaptational responses made to cope with such changes will be influenced by whether the individual perceives the changes to be positive or negative. As has been discussed in previous chapters, job loss for most people is experienced as a stressful process. The ability to adapt to the situation depends upon access to a variety of resources which can be used to mediate the impact of the negative changes. Furthermore the type of responses made will be influenced not only by previous experiences of unemployment but by the nature of previous coping measures in adverse situations.

In relation to the effect of unemployment on health related behaviour different outcomes can be expected. Firstly, if income is not

affected dramatically diet may remain unchanged or individuals may eat more to cope with boredom. However food intake may be reduced as a result of stress or the quality of diet affected if income is reduced. Alcohol and cigarette consumption may decrease because of income reduction or may increase as ways of coping with boredom or stress. Finally physical activity may be reduced if previous occupations were active or may increase as a way of occupying time or as a result of not being able to afford transport. These health behaviours may contribute directly towards an individual's health status or indirectly through an individual's perception of health status.

Since health related behaviours may contribute towards poorer health status in unemployed people it is necessary to consider the potential of health education/promotion in ameliorating this.

Health Education and Health Promotion

Since concepts and models of health vary so widely it is not surprising that it has been difficult to establish a consensus view of the aims and objectives of Health Education or the methods which should be employed.

Four theoretical models of Health Education, based on different assumptions and bearing different characteristics, have been identified by Thomson [120].

The first, the traditional medical model is based on the assumption that people will change their behaviour if supplied with knowledge by professionals. This emphasis on individual behaviour is illustrated in "Prevention and Health : Everybody's Business" [121] in which individual behaviour is considered to be more aetiologically significant than socio-environmental variables.

Ethical issues obviously arise in attempting to define the aims and methods of health education. While some writers believe that people

should be persuaded to change their behaviour and that government should take legal action to prohibit certain behaviours, other authors emphasise individual freedom of choice e.g. " the major goal of health education is to encourage and help people to make voluntary and informed decisions about factors which affect their health and the health of their families and the community" [122].

This emphasis on voluntary action underlies the broader educational model which seeks to promote individual growth and development, to assist individuals to identify their own capacties and to achieve or maintain autonomy [120]. It is based on the assumption that changes in values and attitudes are required in addition to changes in knowledge in order to change behaviour. However there is little empirical evidence to support the view that knowledge, attitudes and behaviour are directly related [123].

A recent development in the educational model is that of self-improvment which places emphasis on developing self image and belief in personal autonomy [124]. The aim is to facilitate informed choice by developing a sense of control in individuals.

The political model incorporates a range of legislative, fiscal and political strategies which aim, to a greater or lesser extent, to coerce people into changing their behaviour [120]. While some policies could facilitate the voluntary adoption of healthy lifestyles and government policy clearly has a role in the promotion of health, the use of legislative measures to force behaviour change raises major ethical issues.

Proponents of the foregoing models fail to seek out the real causes of ill health. Many sociologists consider the origins of ill health in the UK to lie in the social structure which economically and politically favours the free market economy, private enterprise and the pursuit of profit at the expense of other values.

The community development model takes account of the importance of socio-economic structures in patterns of ill health [120]. It is based on the assumption that poor and deprived people will tend to be passive and lack the power to change the environment which may be affecting their health. The role of health education then is to promote collective action to improve the health of the whole community but requires parallel improvments in education, socio-economic conditons and health services to be effective. Health professionals are viewed as facilitators, resource persons and agents who assist the community to identify their own needs and objectives and to participate in decision making affecting the community.

More recently the term "health promotion" has begun to appear in literature and the media and it has been suggested that this may reflect a growing concern to emphasise activities which promote positive health in addition to those which aim to prevent illness [125]. However there has been considerable confusion and debate about whether health promotion and health education are in fact different entities or whether health promotion encompasses health education.

Several attempts have been made to define health promotion e.g. "the process of enabling people to increase control over and to improve their health" [126].

This definition would appear to be too vague to be of practical use. A more commonly used definition is "any combination of health education and related organisational, political and economic intervention designed to facilitate behavioural and environmental adaptations that will improve or protect health " [127]. It has been suggested that this definition is too broad and that it could be regarded as being the same as "public health" [128].

A revised version has been formulated which restricts it specifically to intervention that leads to changes in behaviour viz "Any combination of health education and related organisational, economic, and environmental supports for individual, group and community

behaviour conducive to health" [129]. Both definitions therefore imply that health education is just one component of health promotion.

A more detailed model of health promotion had been proposed in which it is viewed as comprising "three overlapping spheres of activity - health education, prevention and health protection" [130]. In this model, health education is defined as "Communication activity aimed at enhancing well being and preventing or diminishing ill health in individuals and groups through favourably influencing the knowledge, beliefs, attitudes and behaviour of those with power and the community at large." This means not only influencing policy makers and health professionals but helping those without real power to acquire it.

Prevention in this model is defined as "reducing risk of occurrences of disease processes, illness, injury, disability, handicap or some other unwanted event or state" and includes procedures such as immunisation and screening. Health protection is viewed as a descendent of traditional public health activities and is defined as "legal or fiscal controls, other regulations or policies or voluntary codes of practice aimed at the prevention of ill health or the positive enhancement of well being." This includes decisions by local, national and international government or other influential bodies which will positively promote health. Four other domains are identified in which the three activities overlap.

While this model is rather complex it supports the ecological and adaptational concepts of health since it implies that not only do people need knowledge and skills, but a supportive environment which supplies social, physical and economic conditions conducive to health. It is also clear that the responsibility for health promotion lies as much with regional and national organisations as with communities and individuals. Furthermore many of the requirements for positive health promotion would appear to lie in government policy rather than in individual behaviour.

From previous studies it can be concluded that unemployment detrimentally affects the psychological well being of many people. It

is also possible that job loss results in changes in health behaviours which could be injurious to health. Consequently the nature of different approaches to health education and health promotion for unemployed people must be examined.

The traditional medical approach would concentrate upon the dissemination of information on the health risks of cigarette smoking, excess alcohol consumption, inactivity and of consuming diets which are high in sugar, salt and saturated fat and low in fibre. People might also be warned about the possible effects of unemployment on psychological health.

The educational approach would aim to encourage informed decision making in relation to health behaviour through the exploration of values and attitudes towards lifestyle patterns. Health professionals would work with unemployed people to promote individual self-esteem and the ability to make autonomous choices.

Interpretations of the political model could range from conservative to radical. Therefore activities could extend from taxes on alcohol, cigarettes and certain foodstuffs to changes in the social structure which would be beneficial to unemployed people.

In the community development strategy people in areas of high unemployment would be assisted to identify their own needs and goals. Local political action would be encouraged to tackle such issues as housing, recreational facilities, public transport and food availablity and costs. Simultaneous improvements in education, social conditions , economic status and health services would also be required.

Implementing the model of health promotion discussed previously would mean tackling the problem of unemployment and health on a wider front. While aspects of the last three approaches might be incorporated responsibility for action would fall more upon local and national government. This strategy could be viewed as treating the cause rather than the symptoms since activities would be directed at either

creating employment or providing alternative means of fulfilling the manifest and latent functions of employment.

Health promotion in deprived communities poses some very particular problems. It has been suggested that for health education activities directed at changing behaviour to be effective in areas of multiple deprivation, they should be linked to other efforts to effect social change [131]. Changes in health related behaviour are unlikely to occur in the absence of changes in other areas of peoples lives. Cornwell has suggested that health campaigns might be more effective if they were addressed to people in specific sets of social circumstances rather than the public as a whole [132]. The importance of involving lay people in the planning of health education activities and the use of trained people in the communication process has also been emphasised [133].

Most areas of multiple deprivation within Strathclyde [134] correspond to those areas with the highest unemployment rates [135]. Although this is not surprising since one indicator of multiple deprivation is unemployment these areas also tend to be ones which lack amenities, have overcrowding, have high percentages of single parent families and an above average number of large families [134]. It is therefore likely that people living in such areas who become unemployed may not only experience difficulties in adapting to the situation, resulting in health problems, but that they may also experience environmental stressors which are inimical to health.

METHODOLOGY

INITIAL AIMS

The adaptational model of health proposes that people continually attempt to adapt to changes in their physical, social and economic environment. The nature of the adaptational responses made to cope with such changes will be influenced by whether an individual perceives the changes to be positive or negative. Perceptions of the situation will be mediated by a number of factors e.g. demographic characteristics, perceived social support, and previous experience.

Adaptation may take the form of physiological, affective or behavioural responses. The ability to adapt is influenced by personal characteristics developed through past experiences and opportunities. However, situational factors may act as barriers or facilitators to adaptation. The nature of responses made will take the form of behaviours which attempt to change the physical, social or economic environment and may result in positive or negative changes in health status. Finally changes in health status may influence an individual's perception of the situation and the nature of future responses or the ability to make further adaptations.

Aims

1. To examine the effects of unemployment on subjective health status and reported health related behaviour.

2. To explore the relationships between perceptions of unemployment, health related behaviour and subjective health status.

3. To explore factors influencing health related behaviour.

4. To identify the implications of the findings for health promotion.

INITIAL DESIGN

A number of factors have been found to mediate the effects of unemployment for example, age, social class, marital status, previous employment history and financial status. While few studies have included women it was considered that gender might also be important. These factors therefore influenced the choice of the survey population.

Some studies had identified phases in responses to unemployment and differential effects according to length of unemployment, these findings, therefore, influenced the choice of interview times and study period.

Few studies have proposed theoretical models which could fully explain the variety of results. Therefore a model was constructed from which hypotheses were drawn for testing.

Survey Population

Initially it was intended to select a sample which would allow as many variables as possible to be controlled. Men were selected in preference to women since a larger percentage of the male labour force in Strathclyde is registered unemployed (22% compared with 11.7% of women at September 1987) [135]. Furthermore men would be more likely to see their main social role as that of breadwinner. Originally men with family commitments were chosen in order to control for marital status and to limit the age range.

Study Design

A longitudinal prospective design was planned in order that changes over time could be observed, with three interviews to be carried out over a period of one year. While it would have been desirable to extend the study period this was not possible due to time and financial resources available. Since responses to unemployment, have been found to be related to length of unemployment, men who were newly unemployed were chosen for the study.

Hypotheses

a) Those men who perceive the changes brought about by unemployment to be negative will display negative changes in subjective health status.

b) Those men who display negative changes in subjective health status will display negative changes in health related behaviour.

Sample Selection

Consideration had to be given to how the sample was to be drawn. The best way of contacting newly unemployed men is to gain access to a company about to make redundancies. A large engineering company in Glasgow announced large scale redundancies and the Union respresentative and Personnel Officer were contacted. While both were willing to co-operate in the study it was discovered that, at that time, only voluntary redundancies were being made and that the Union was fighting the others planned for one year hence.

The Area Organiser for the Unemployed Workers Centres (U.E.W.C.) in Glasgow was contacted and he offered to make introductions to club organisers. However it was decided not to pursue this since individuals attending the clubs were either young men who had never been employed, or the long term unemployed.

Discussions were held with a member of staff at Glasgow University who arranged an introduction to The Redundancy Improvement Scheme (R.I.S.K.). R.I.S.K., organised and run through Strathclyde Region's Education Department, offers a service to companies who have declared redundancies. In co-operation with Management and Trade Unions, pre-redundancy seminars are held which aim to help people to look, as constructively as possible, at the changes which are being forced upon them by redundancy. Invited speakers from e.g. D.H.S.S. Offices, Community Education Departments, Job Centres and Banks give information and advice.

A proposal was submitted to the Management Committee of R.I.S.K. on 3/6/85 and permission was given to contact people at future seminars (Appendix 1). It was decided that a personal appearance at seminars would be more desirable than issuing letters since it would be more likely to elicit affirmative responses.

Pilot Study

Three R.I.S.K. seminars were attended at a light engineering company in West Renfrewshire which was closing down, making 81 people redundant. Of these 42 were men but their marital status was unknown. A short talk was given explaining the aims of the project and asking for volunteers. It was explained that the results of the study, it was hoped, would be of benefit to other people experiencing unemployment. In addition, 35 explanatory letters were issued with Freepost envelopes to be returned stating suitable interview times. Only three replies were received (response rate 8.5%).

In view of the sensitivity of the situation great care had been taken with the content of the talk in order to avoid causing distress. It was felt that this, therefore, had not been a major contributory factor to the low response rate. However, the timing of the talk may have been partly responsible since it came at the end of the four hour seminar in which a great deal of information had been given. It had also ended just before lunch.

Since no other R.I.S.K. seminars were planned at that time other ways of contacting unemployed men had to be sought. For the purposes of testing the questionnaire, it was decided to contact any unemployed men regardless of length of unemployment. A local Job Centre was contacted to obtain permission to approach their clients. Permission was denied. Subsequently the Area Manager for Job Centres granted permission for attendance at a Job Club in one of the Centres. Job Clubs offer information, advice and facilities for job search and applications to people who have been unemployed for longer than six months. All five eligible men present agreed to be interviewed. At the same time an Unemployed Workers Centre was visited and an additional two men were recruited which together with the three men

previously recruited gave a total of ten participants. Since few difficulties were experienced with the questionnaire it was decided to discontinue recruitment for the pilot study. The profile of respondents in the pilot study is given in Table 1.

Table 1 Age and Previous Occupation of Pilot Study

No	Age	Previous Occupation	Place of Interview
1	32	Machine Setter	Home
2	60	Chief Inspector Engineer	Home
3	49	Machine Setter	Home
4	20	Various Manual	U.E.W.C.
5	43	Slater	U.E.W.C.
6	42	Production Worker	Job Club
7	50	Engineer	Job Club
8	28	Labourer	Job Club
9	22	Assistant Manager Public House	Job Club
10	43	Welder	Job Club

Main Study

Nine R.I.S.K. seminars were attended between the 6th and 23rd May, 1987 at a large electronics company (X) who were making 359 people

redundant including 259 men.

The seminars lasted for a whole day and the research project presentation was scheduled for just before lunch. It was felt that this would allow people to discuss the project over lunch if they wished to know more about it. Groups of approximately twenty-thirty people attended each seminar, the aims of the project were explained and 110 explanatory letters were issued. It became apparent that the response was slow and a follow up letter was planned. However, on discussing the matter with the Human Resources Officer it was agreed that he would talk to Union representatives first. The Union representatives reported that some people were too anxious about redundancy to talk about it and that others, especially older men, did not want to discuss their lives with anyone. While sending a follow up letter might have increased the response slightly it was felt that this would have been pressurising people. Eventually a total of five replies was received of whom one subsequently gained employment and was not interviewed (Response rate 1.93%). Another R.I.S.K. seminar was attended on 6th June 1986 at a warehouse in Glasgow where 75 people were made redundant. However, they were paid off on the day prior to the seminar and only three people (one male) attended. No volunteers were recruited. Since no further seminars were planned for the near future other ways of contacting newly unemployed men had to be sought.

The Industrial Missions Organiser for the Church of Scotland was contacted for names of other companies who were planning redundancies (Appendix 2). Seven companies were contacted but only one reply was received which stated that no redundancies were planned.

In late June 1986 it was discovered that the Manpower Services Commission had paid off some people from a Community Programme at two centres in Renfrewshire. The names and addresses of 38 people were received and letters were sent explaining the aims of the project and asking for volunteers. In view of recruitment difficulties and the time schedule of the project it was decided that both males and females regardless of marital status would be interviewed.

If replies were not received within two weeks people were contacted again by telephone if possible or, if not, by letter. Details of responses at each stage are presented in Table 2.

Table 2 Recruitment Responses, June 1986

Method of Contact	Number Contacted	Affirmative Responses	Number Interviewed	Reasons for not keeping appointment
1st letter	38	8	6	2 obtained employment
2nd letter	14	5	4	1 obtained employment
Telephone	16	1	1	-
Total Number Interviewed			11	

Reasons for negative responses were elicited at the time of the second contact. Details are presented in Table 3.

Table 3 Reasons for Non-Participation, June 1986

Method of Contact	Number of Negative Responses	Reasons for Negative Responses
Letter	2	Letters returned to sender
	2	Not interested in taking part
Telephone	5	Numbers unobtainable
	4	Obtained employment
	5	Not interested in taking part
	1	Moved house

Of the 38 people, 14 agreed to be interviewed (Response rate 36.8%) and 11 were subsequently interviewed (Response rate 28.9%).

Concurrently, attempts to recruit additional people continued. On 31/7/86 an advertisement was placed in a local newspaper which is distributed free of charge, asking for volunteers (Appendix 3).

Payment for the interviews could not be offered, but in common with letters sent to the Community Programme workers, travelling expenses were offered if volunteers preferred to be interviewed at The Queen's College, Glasgow instead of at home. No replies to the advertisement were received.

R.I.S.K. was contacted again to ascertain if future seminars were planned. However, the Management Committee decided that, while they wished to continue their support for the project, due to the low response rates previously obtained, attendance at future seminars would not be desirable.

In January 1987, it was discovered that more people were being paid off from the Community Programme in Renfrewshire and the names and addresses of 43 people were obtained.

Details of the responses are presented in Table 4.

Table 4 Recruitment Responses, January 1987

Method of Contact	Number Contacted	Affirmative Responses	Number Interviewed	Reasons for not keeping appointment
Letter	21	2	2	-
Telephone	22	3	1	2 obtained employment
Total Number Interviewed			3	

Details of reasons for negative responses are presented in Table 5.

Table 5 Reasons for Non-Participation, January 1987

Method of contact	Number of Negative Responses	Reasons for Negative Responses
Telephone	8	Numbers unobtainable
	5	Obtained Employment
	6	Not interested in taking part

Of the 43 people, five agreed to be interviewed (Response rate 11.6%) and three were subsequently interviewed (Response rate 6.9%). Since time was becoming short it was decided to discontinue recruitment and to adopt a case study design. This approach would provide detailed qualitative data which would increase our understanding of the individual impact of unemployment, an aim which is more difficult to achieve in aggregate studies. Consequently while the questionnaire was retained it was supplemented by in depth interviews and the number of interviews per person was increased from three to four.

RESPONSE RATE

Before discussing possible reasons for the low response rates experienced in this study, it is useful to examine response rates in previous studies and to identify any problems in sampling discussed by other researchers. Studies which used aggregate archival data and the 1930s studies are not included. Details of other studies are presented in Table 6.

RESPONSE RATES IN PREVIOUS STUDIES

TABLE NO 6

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATIRITION	DISCUSSION OF RESPONSES OR PROBLEMS
Hepworth [28]	Cross Sectional	Approached outside Benefit Office	92 men (14 excluded - = 78)	Aged 19-63. Unemployed <1 month - >2 years	No precise figures Refusal rate <50%	None
Breakwell et al [30]	Cross Sectional	Random Sample from Careers Office Register	36 men 36 women	Aged 16-19. Unemployed <3 weeks - 16 weeks	None given	None
Jackson & Warr [31]	Cross Sectional Retro-spective	Sampling frame. Approached in vicinity of Benefit Office by Survey Research Co.	954 men	Aged 16-64. Unemployed <1 month - > 12 months working class	Not possible to calculate	None
Payne et al [35] & McKenna & Paynes [39]	Cross Sectional Retro-Spective Longitud-inal	Approached in vicinity of Benefit Office by Survey Research Co.	399 men	Aged 25-39. Unemployed 6-11 months. 203 middle class, 196 working class	Not possible to calculate	None
Furnham [36]	Cross Sectional	Advertised . Paid for Interview	106 men 90 women	40 unemployed. 41 part time employed. 49 full time employed. 13 retired. 53 students.	Not possible to calculate	None

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATTRITION	DISCUSSION OF RESPONSES OR PROBLEMS
McKenna & Fryer [37]	Cross Sectional	2 factories - 1 closing, 1 rotating lay offs. Closure factory personal contact. Lay off factory letter from Trade Union.	Closure - 20 men Lay off - 41 men	Closure mean age 48.5 Lay off mean age 42.7 Semi-skilled	Closure factory 50%. Lay off - no response rate given - 2 dropped out	Closure factory impression given was that men were too distressed. Many said they were too depressed.
Cook et al [41]	Cross Sectional	Age/sex registers of G.P.s	7673 men (408 unemployed)	Aged 40-59	None given (55 excluded)	None
Economist Intelligence Unit [42]	Cross Sectional Retro-spective	Representative sample of unemployed population in U.K. Unemployed registers	1043	Aged 16-65	None	None
Miles [43]	Cross Sectional Case/ Control	Cases mostly approached leaving Benefit Office. First 150 randomly selected. Subsequently those unemployed >6 months. Controls door to door.	300 cases. 100 control men	Aged >21 Brighton area	None High refusal rate in controls	None Cases paid £1 for interview and £9 for keeping diary for 2 days.
Trew & Kirkpatrick [46]	Cross Sectional	Approached in Benefit Office.	150 men	Aged 24-45 Unemployed <1 month to >5 years	None given	None - Largest % of respondents unemployed 2 - 5 years

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATTRITION	DISCUSSION OF RESPONSES OR PROBLEMS
Kasl & Cobb [47]	Longitudinal Prospective Case/ Control	Factory closures Union backing	100 cases 76 controls	Aged 35-60 Blue collar workers. Married. Service 3 year or more. Half urban half rural. Michigan	79% cases 76% controls Interview 1 94 (91) 2 93 (91) 3 92 (90) 4 82 (79) 5 80 (77) Attrition unclear Numbers unemployed by interview 4 & 5 = 8	Responses were higher than expected
Cohn [51]	Longitudinal Retrospective Case/ Control	US National Survey sub-sample	Approximately 5000	American	Not possible to calculate since selection was retrospective	None
Ramsden & Smee [52]	Longitudinal Prospective	D.H.S.S. Registered Unemployed claiming benefit	2300 men	Representative of registered unemployed in the UK	Interview 1 72% 2 55% 3 47%	None

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATTRITION	DISCUSSION OF RESPONSES OR PROBLEMS
Warr et al [54]	Longitudinal Prospective	2 cohorts leaving 12 schools in Leeds. Addresses obtained	Cohort A = 648 Cohort B = 1096	16 year olds. Equal male/ female.	Cohort A Interview 1 75% 2 84% 3 76% Cohort B Interview 1 almost 100% 2 76% 3 64%	Reasons Unobtainable Refusals 4% Non-response high for Asian females
Stokes [60]	Longitudinal Prospective Case/ Control	Factory Closure Management and Union support Leaflets distributed.	Cases 58 (41 female 17 male) Controls 48 (10 excluded)	Manual, semi-skilled, skilled. Yorkshire.	Cases 3.1% Controls 1.6% in one factory. 4.2% in other. Attrition not given.	Of 11 case companies approached only one supported. Of 55 control companies approached only 2 supported. No concrete evidence to explain response rates. Suggestion apathy and resignation. Alienation from all official & quasi official bodies.

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATTRITION	DISCUSSION OF RESPONSES OR PROBLEMS
Hill [63]	Case Study Cross Sectional	Department Employment Registers. Country wide. Letters sent.	118 men 30 women	Prescribed - Sex Ratio 1 women : 3 men Aged <19-54 London Merseyside Unemployed 1 -52 weeks	22% Range between offices 9%-33%	Misunderstanding research purpose. Relationship with Department of Employment. State of mind-disincentive to be interviewed.
Fagin [64]	Case Study Longitud-inal Prospective Pilot	Unemployed Registers in selected towns. Letters sent by DHSS.	22 men	Prescribed - married with dependent children. Unemployed 6 months - 1 year.	45.5% (40 excluded) Attrition refusal Interview 3 = 19	None
Marsden [66]	Case Study Cross Sectional	SE England Trade and Claimants Union. NE England personal contacts and networks.	Unclear 13 men and smaller number of teenagers.	Prescribed - mainly men in prime of their working lives with families. Some women and teenagers.	80%	None
Fineman [67]	Case Study Longitud-inal Prospective	Counselling sessions at Government sponsored career development programme	100	Aged 20-60+ Well educated.	None	None
Swinburne [68]	Case Study Cross Sectional	M.S.C. Course for unemployed managers	20 men	Prescribed - age 31-57 Unemployed 2 months - >24 months	None	None
McLellan [69]	Case Study Cross Sectional	Names given by Health visitor	20 men	Prescribed - men with children. Unemployed >6 months - <3 years Social Class IV or V	Volunteers Not possible to calculate	None

AUTHOR(S)	STUDY DESIGN	METHOD OF SELECTING SAMPLE	NUMBERS INTERVIEWED	CHARACTERISTICS OF SAMPLE	RESPONSE RATES/ ATTRITION	DISCUSSION OF RESPONSES OR PROBLEMS
Fryer & Payne [72]	Case Study Cross Sectional	Contacted through community worker	11	Prescribed - "Pro-active" 9 males 2 females. Aged 25-53. Mostly well educated	Not possible to calculate	Difficult to obtain even 11 people

Since the MRC/ESRC Social and Applied Psychology Unit at the University of Sheffield has carried out many research projects involving unemployed people it was contacted for information on response rates. Details are included in Table 6. However Dr Paul Jackson also provided some examples of response rates in post graduate projects in his department (Appendix 4). One project obtained a 38% response to a postal questionnaire of men and women who had left a Community Programme in the prior six months. Another project obtained no positive responses from 500 leaflets distributed in a depressed area of South Yorkshire.

In a total of 22 studies reviewed six did not quote response rates and in six response rates could not be calculated due to the sampling selection methods employed.

Of the nine studies quoting response rates four did not discuss reasons for refusals. Three of these studies contacted samples either outside Benefit Offices or through the D.H.S.S. and obtained response rates between 45.5% and 72%. The other study obtained a better response (80%) and this may have been because contact was made through Trade Unions and personal networks. Of the five studies which did discuss response rates none had obtained reasons for refusals and in most cases the characteristics of non-responders were unknown. The three studies which obtained between 50% and almost 100% response rates included two closure studies and one on school leavers. Kasl and Cobb commented that their response rate was higher than expected and thought that it might have been due to Union support for the study. No reasons for refusals were given. While Warr et al. found only a four percent refusal this may have been due to the very specific nature of their sample i.e. school leavers may have felt more compulsion to take part. McKenna & Fryer made personal contact with their sample and although no concrete evidence was obtained the general impression they received was that non-responders were too distressed or depressed about their redundancy to take part. The two studies which obtained lower response rates consisted of one cross sectional study and one closure study. Stokes obtained a 3.1% response rate despite having Union support and suggested two possible explanations. Firstly

non-responders felt alienated from official or quasi-official bodies and secondly they experienced apathy and resignation which prevented them from taking part. Similar explanations were offered by Hill who obtained a 22% response.

It is surprising and somewhat alarming that so many of these studies have not quoted response rates or have used sampling methods which do not allow reasons for refusals or characteristics of non responders to be identified.

In those cases which did discuss response rates, it is difficult to generalise about reasons for refusals, due to the absence of detailed evidence, however a number of factors are highlighted. Firstly, closure studies pose particular problems in relation to obtaining volunteers but only three of these studies were designed in this way. It is possible that people who have been unemployed for some time would be more willing to take part than people who are about to be made redundant. In addition, the method used to obtain samples is likely to be of importance in influencing responses. While Union backing may have contributed to better response rates in some cases it did not appear to have helped in Stoke's study. Both Hill and Stokes suggested that being associated with an official body may have contributed towards poorer responses. However, in other studies where samples were contacted through Benefit Offices, response rates were better, but these studies were cross sectional.

Since so few authors have discussed possible problems of recruiting unemployed volunteers there is little evidence on which to base explanations for the low responses in this study. This is an issue which should be closely considered in future studies with unemployed people. However, it is still important that possible reasons for the low response in this study are discussed.

Timing of Explanatory Study

The low response rate in the pilot study was thought to be partly due to the timing of the explanatory talk and therefore full consideration was given to this in relation to the talks at Company X within the constraints laid down by R.I.S.K. While the time of the talk remained just before lunch, the seminar lasted the whole day and was more leisurely with longer breaks. In addition the author was present over lunchtime to allow for further discussion of the research aims. However, due to the nature of the information being given by other speakers it is possible that people were too worried to be motivated to take part. The feedback from Union representatives would appear to confirm this.

Incentives

Although it was explained that it was hoped that the research findings would be of practical use and might benefit other unemployed people there was little real incentive for people to take part. The better response from the first group of people leaving the Community Programme was thought to be due to the fact that most of these people had been employed as door to door interviewers. The lower response from the second group was thought to be due to the exceptionally bad weather prevailing at that time. Many telephones were out of order and road conditions may have acted as a disincentive to travel.

Place of Interview

Initially only home interviews were offered for two main reasons. Firstly Company X had made it clear that first interviews could not take place in the factory. Secondly most of the employees lived in the area surrounding the factory and since this was a considerable distance from College it was felt that people would not be prepared to travel. It is possible that some people did not wish to have an intrusion on the privacy of their home.

However of the 14 people subsequently offered a choice of interview venue six wished to be interviewed at College and eight at home. A number of explanations for this can be suggested. Some people's family circumstances did not allow them to visit College for interview. The financial circumstances of others prevented them from outlaying travelling expenses even though these were reimbursed. Most of those interviewed at College treated the visit as an outing which broke the monotony of every day routine. Nevertheless in many cases the timing of the interview had to be carefully planned to coincide with benefit payment.

Gender

The few researchers who have addressed the subject of gender in research activities have tended to concentrate upon the effects on the research process rather than upon response rates. Easterday et al reported that female researchers have experienced difficulty in gaining access to male dominated settings [136]. It has also been suggested that female researchers who talk to men about their feelings and family details in their own homes are contravening both the domestic/familial privacy and the marital privacy [137]. Cornwell found that it was easier to interview women than men because men did not know how to talk to her and had little idea of what to say on personal matters [132]. However, in some cases being a female researcher has been found to be of advantage when interviewing males [138]. This, it has been found, depends largely upon the approach adopted by the researcher and a balance between being too feminine and too professionally aggressive is necessary. In preparation for the talk at Company X careful consideration was given to such matters as style of dress and style of delivery in an attempt to control such effects. However it is possible that some of the men in Company X did not wish to be interviewed by a female and especially not at home if their wives were present.

There was, however, little difference between the response rates of males and females leaving the Community Programme (Affirmative responses 35.7% female and 37.5% male). Furthermore of those offered a

choice of interview situation five males were interviewed at home and five at College. The fact that all but one man were single, divorced or separated must be considered important.

Authority/Class

Stokes suggested that his survey population may have been alienated from official or quasi-official bodies and therefore would have been disinclined to take part [60]. Although at Company X people were contacted through R.I.S.K. and there was Union support for the project, Human Resources Personel were also involved. Considerable bitterness towards Management existed because of the redundancies and it is possible that some people may have identified the author with the Management.

It has been suggested that the "expert" is the modern face of authority. Cornwell found that being middle class, with further education, together with being female, in an area of London where it was unusual for anyone to have experienced further education, caused difficulties in gaining access [132]. Little new research on the influence of class, race, age, gender and authority has been carried out since the 1960s [139].

Anxiety

With the exception of Kasl and Cobb there is some suggestion from previous closure studies that those about to be made redundant may be too distressed and concerned about other problems to want to take part in research projects.

In the case of this study the feedback from Union representatives in Company X tended to confirm this proposition. When faced with the uncertainties of unemployment it is unlikely that people would choose to put themselves in a situation with unknown outcomes. Although in relation to those people already unemployed, Hill suggested that their state of mind would provide "strong motives for not wishing to expose themselves to an interview" [63].

Another study found that some unemployed people were anxious about being selected for interview [140].

"Do you remember when we read it in the Evening News about this survey, and he read it, so many families were going to be chosen. And we said, oh I hope they don't pick us, we don't want them snooping around into what we're doing .... And then when you called I thought just my luck, we've been picked. We were quite apprehensive weren't we?" (page 28)

The personal costs to unemployed people when taking part in research interviews have been fully discussed by Fryer [141]. These costs are not only material but psychological and raise major ethical issues for reseachers. While perhaps of secondary importance research involving direct contact with unemployed people also brings personal costs to the researcher [142].

In conclusion it is likely that several different factors contributed towards the low response obtained in this study and that the factors were different in the case of Company X when compared with the Community Programme.

Studies based on case history design whilst not generating quantitative data do have certain advantages particularly in relation to a research topic such as this. Detailed qualitative information can be collected on individual experiences which provides a greater understanding of the complex interrelationships between unemployment and health and casts light on the variability of responses to unemployment. In the introduction to the well known 1930s review the authors state:

"When we try to formulate more exactly the psychological effects of unemployment we lose the full poignant and emotional feeling that this word brings to people." (page 358) [143]

Revised Aims

In view of the foregoing discussion the aims were revised as follows:

1. To explore the relationships between perceptions of unemployment, reported health behaviour and subjective health status for a period of up to one year following job loss.

2. To explore factors influencing health related behaviour.

3. In the light of results to identify implications for health promotion.

Interview Schedule

Participants were interviewed as soon after becoming unemployed as possible. For a variety of reasons the timing of the first interview ranged from four days to 12 weeks after job loss. Thereafter interview times were standardised as outlined in Table 7. Where possible people were interviewed after gaining re-employment.

Table 7 Timing of Interviews

Interview Number	Number of Weeks Unemployed	Range
2	24 Weeks	24-32 weeks
3	38 Weeks	38-43 weeks
4	52 weeks	52 weeks

Details of the numbers of people interviewed at each stage are presented in Table 8.

Table 8 Number of Respondents at Each Interview

	Interview 1	Interview 2	Interview 3	Interview 4
Numbers Interviewed	18	14	10	3
Reasons not Interviewed	1 employed	2 employed 1 unobtainable 1 moved	1 employed 1 unobtainable 1 disabled 1 pregnant	5 employed 1 moved 1 College full-time

Participants were interviewed alone whenever possible. However it was not always possible to achieve this, particularly when there was only one public room and other family members were around. Since some of the first interviews were carried out while recruitment was still continuing and a large number of participants was still anticipated these interviews were not recorded. Subsequent interviews were recorded, transcribed and the tapes wiped thereafter.

Data Collection

Five groups of data were collected.

1. Perceptions of unemployment.
2. Factors which mediate perceptions of unemployment.
3. Reported health related behaviour.
4. Subjective health status.
5. Perceived factors influencing health related behaviour.

Three methods of collecting data were employed.

a. In depth interviews which were structured using a questionnaire. After the first interview the questionnaire was abbreviated

(copies of Questionnaire one and two are presented in Appendices 5 and 6). In many cases questions were open ended to allow for individual responses. Where responses were pre-defined, cards with responses in large print were shown to respondents.

b. The Nottingham Health Profile (Appendix 7) [38].

c. A diary recording food and drink intake, cigarette/tobacco consumption and exercise for a period of one week following each interview. This was returned in a Freepost envelope (Appendix 8).

1. PERCEPTIONS OF UNEMPLOYMENT

Firstly it was established whether respondents did or did not miss working or being at work and the reasons for responses given. Secondly a scale of problems based on possible changes which might accompany job loss and unemployment was constructed. Some of the statements were adapted from those constructed by Payne et al [35] and were broadly based upon the manifest and latent functions of paid employment [44]. With the exception of the first interview, respondents were asked to explain any changes in responses from the previous interview.

2. FACTORS WHICH MEDIATE PERCEPTIONS OF UNEMPLOYMENT

Questions were included to identify factors which other studies had found mediated perceptions of job loss and unemployment i.e. demographic characteristics, employment history, perceived social support, changes in financial circumstances.

3. REPORTED HEALTH RELATED BEHAVIOUR

Health related behaviour is defined in terms of diet, exercise, alcohol consumption, smoking behaviour, medicine use and doctor consultations. These were chosen since they were the most commonly reported behaviours in the few studies which have examined lay definitions of health behaviour. In addition the

first four behaviours are cited in the aetiology of major causes of morbidity and mortality in the United Kingdom. Retrospective reported changes in health behaviours were recorded at each interview together with reasons for changes.

a. Diet

Total consumption of food and non alcoholic drink was recorded in the diary for a period of one week following each interview. An example of how to complete the diary was given and explained. While diaries of this nature are not accurate enough to assess the nutritional adequacy of diets, they are satisfactory for the purposes of identifying trends in consumption.

b. Exercise

Frequency of participation in vigorous and other types of exercise were recorded. Questions were adapted from the Scottish Health Survey [144]. In addition, exercise was recorded in the diary.

c. Alcohol Consumption

Weekly reported consumption measured in units was recorded at each interview and consumption recorded in the diary. Questions were adapted from the Scottish Health Survey [144].

d. Smoking Behaviour

Reported smoking behaviour was measured by the number of cigarettes and cigars or the amount of tobacco smoked, on average, each day and consumption was also recorded in the diary. Questions were adapted from the Scottish Health Survey [144].

e. Medicine Use/Doctor Consultations

Frequency of reported use of prescribed and non-prescribed medicines was recorded at each interview. Questions were adapted from the Scottish Health Survey [144]. The number of times respondents had visited a doctor since the previous interview and the reasons for visits were recorded.

4. SUBJECTIVE HEALTH STATUS

At the first interview respondents were asked to rate their health while employed on a five point scale from Very Poor to Very Good. This allowed comparisons to be made with The Nottingham Health Profile (N.H.P.). Ratings on the scale were used to assess perceived health. At subsequent interviews respondents were asked if their health had changed in anyway, and if so in what way, since the previous interview.

At each interview the N.H.P. was completed. It is a general measure of perceived health which consists of 38 statements covering six areas of health; emotional reactions, pain, energy, social isolation, physical mobility and sleep. However the authors prefer it to be viewed as a measure of distress and discomfort. It has been widely tested for validity and reliability [38]. In addition it has one major advantage. "Allowing individuals to evaluate their own health status solves to some extent the problem posed by different professional definitions of health and illness and reduces the balance between lay and professional objectives" [145]. The N.H.P. was administered at the beginning or at the end of the interview although the timing was kept the same for individual respondents at each interview. This method was adopted in an attempt to prevent biases in responses given during interviews. Since the sample size was small N.H.P. scores could not be aggregated. Therefore individual scores for each section were compared with age/sex population means which have been established from previous studies and were scrutinised for changes over time. Each section of the profile has a possible maximum

score of 100 (Appendix 9).

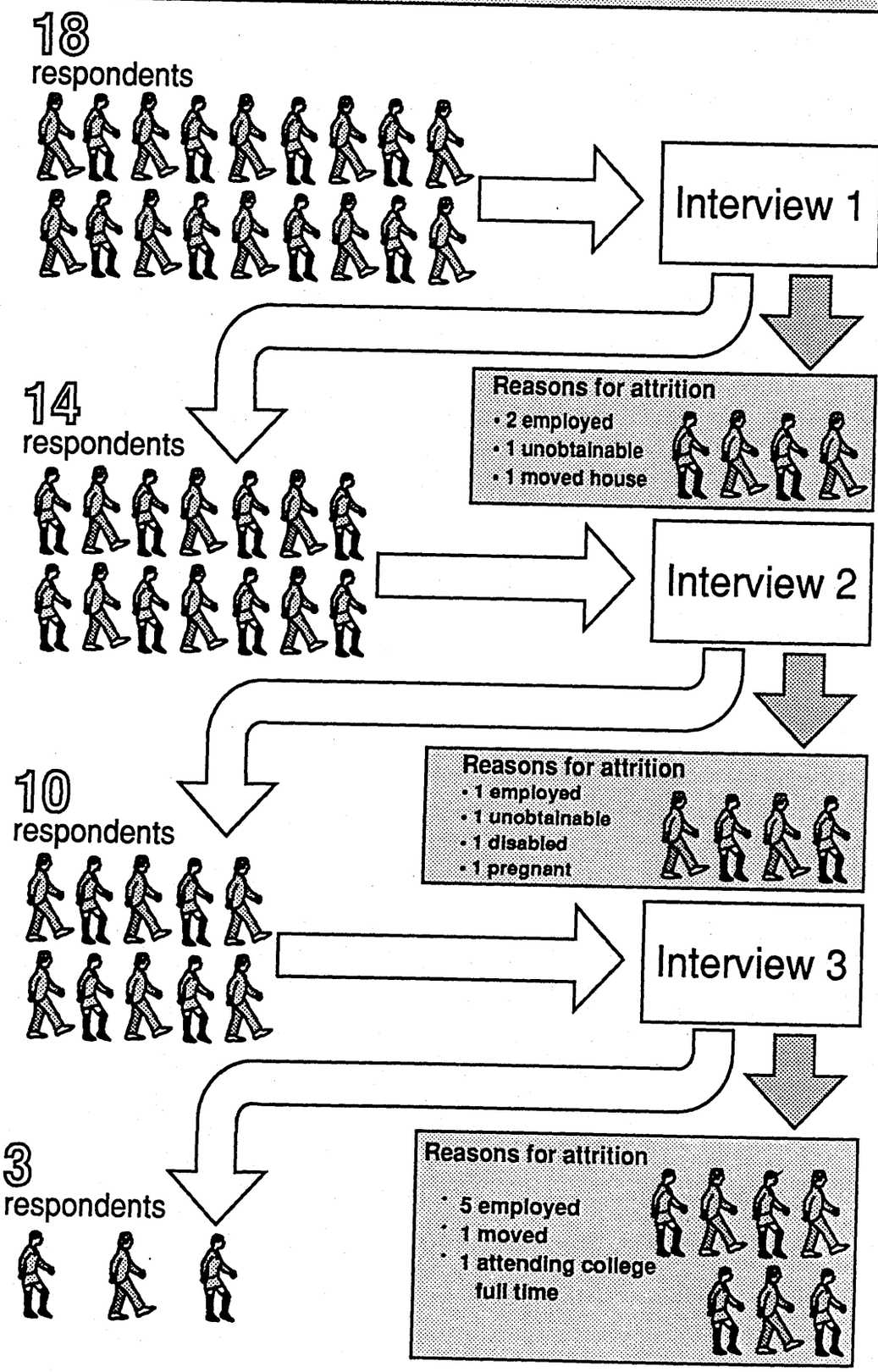
5. PERCEIVED FACTORS INFLUENCING HEALTH RELATED BEHAVIOUR

Questions relating to household budgeting were included at each interview in an attempt to identify factors which might influence health behaviour. In addition questions were included to establish whether or not respondents felt motivated to change their health behaviours and the perceived barriers or facilitators to changing behaviour.

RESULTS

A total of 18 people were interviewed for the first time, four days to 12 weeks after job loss. Fourteen people were interviewed a second time, 24-32 weeks after job loss. Of those lost between the first and second interviews, two people had regained employment and two could not be contacted. Ten people were interviewed a third time, 38-43 weeks after job loss. Of those lost between the second and third interviews, one person had regained employment, one had become disabled, one had become pregnant and one person had moved to London. Three people were interviewed 52 weeks after job loss. Of those lost between the third and fourth interview, five people had regained employment, one had moved residence and one was attending college full time. For details of attrition see Figure 1. A profile of resondents is presented in Appendix 10 and individual case studies are presented in Appendix 11.

Figure 1 **Number of respondents at each interview and reasons for attrition**



PERCEPTIONS OF UNEMPLOYMENT

Salience of Employment

At the first interview only one person did not miss working or being at work and this was because he engaged in voluntary work and could now spend more time on it. The most frequently reported reasons for missing work were reduced incomes, social contact and activity. Six people mentioned reduced income first. Of these, two had working spouses, three were living with their parents and one had been made redundant. Apart from the latter case all had been unemployed before. Six people mentioned missing social contact the most. Of these, three were female, two lived alone and one was a married man. Three people mentioned missing most the activity that work provided. Of these, one man lived alone and two lived with their parents. All had been unemployed before.

Those who remained unemployed continued to miss work unless they started attending college. However, in a few cases there was some evidence of adaptation over time. Most of the females and those men living alone either mentioned missing social contact or activity most of all, perhaps suggesting that while unemployed they had little contact or activity outside of the home.

Income Changes

At the first interview three people had three quarters of the income they had when working. Of these, two had working spouses and one had a working flat mate. Twelve people had one half of the income they had when working. The remaining two people had one quarter of the income they had when working. One was receiving supplementary benefit and the other was separated from her husband who did not contribute to the household income.

Although for the majority incomes had halved, actual incomes varied considerably. In addition the men who had been made redundant did not include the redundancy money in their incomes.

Types Of Problems Associated With Unemployment

At the first interview 11 people had financial problems. Of those who did not have financial problems, three had received redundancy money, two had working spouses and one was subsidised by his parents. It is apparent that those who did have problems endured long term difficulties either because they had been unemployed for extended periods before or because they had experienced erratic employment in the past.

Thirteen people were worried about not regaining employment. Of those not worried, one person engaged in voluntary work, one married female was not seeking employment, one person had never been unemployed before and one person lived with his parents. Therefore the majority of people were concerned about getting the offer of a suitable job.

Twelve people were worried about the future. Of those not worried one man was fifty-nine years old and had a working wife, one person had strong religious beliefs, two people lived alone and one person lived with his parents. Since all had experienced erratic employment in the past it is possible that they had become accustomed to uncertain futures. However it is also possible that some had personal characteristics which meant that they did not worry about the future.

Six people had problems with boredom. All had mentioned missing the social contact or activity that work had provided and all of them had been unemployed several times or for long periods before. Of those not bored most had previous interests to which they could now allocate more time or had households to look after.

The people who had the least number of problems were the men who had been made redundant, two people with working spouses and the man who did not miss work. The rest had similar numbers of problems except for the separated female who had the biggest number of problems. In the case of the latter some of the problems were not associated with unemployment but with marital difficulties and her husband's unemployment.

Therefore it would appear that in the initial stages of unemployment those people who had relatively secure financial backgrounds experienced fewer problems than the others.

Changes in Perceptions over time

Changes from Interview One to Interview Two

Five people were experiencing the same problems as before but for two of them continuing to look for work had become more difficult and for two others keeping in contact with friends was more difficult than before.

Four people were experiencing more problems than before. Of these three now had problems with boredom, two had more financial problems, two had difficulty in keeping in contact with friends and two were anxious about the future.

For three people some problems had improved and some had got worse. Two of these had started attending college part time and while boredom was no longer a problem, they experienced more financial difficulties and were now worried about the future. Increased financial problems had also made it more difficult to keep in touch with friends. The remaining case now had problems with boredom and with keeping in touch with friends but had adapted to financial difficultes and to uncertainty about the future.

Two people were experiencing fewer problems than before. One had regained employment. The remaining case's estranged husband had regained employment and consequently financial difficulties had eased and their relationship had improved. She had also adapted to boredom.

Therefore at the time of the second interview, the majority of people were experiencing more problems or problems had worsened. The most common problems related to financial difficulties and boredom. Keeping in contact with friends was also a problem for many, mainly because of their financial situation.

Changes from Interview Two to Interview Three

Three people were experiencing the same problems as at the second interview. However, for one person looking for work was more difficult although he had adapted to not seeing his friends. For another person boredom was worse.

Seven people were experiencing fewer problems than at the second interview. Of these, four were now working, one was now attending college and one had been offered a job when he finished college. While the remaining case's husband was back at work again and therefore financial problems had eased she was now seeking work and found this difficult.

Therefore regaining employment or attending college appeared to remove some of the previous problems experienced.

Changes from Interview Three to Interview Four

One man had adapted to unemployment but continuing to look for work was more difficult. He was also more anxious about the future.

For the two females financial problems were worse since one had stopped receiving benefit and the other was now receiving supplementary benefit. Both were anxious about regaining employment. All three lived in an area of high unemployment and had little prospect of gaining employment locally.

Perceptions of Unemployment and Perceived Social Support

Five people had no perceived social support. Of these one person had the most problems of the whole sample, one had below average number of problems and three had about the average number of problems. Therefore there appears to be no obvious relationship between perceptions of unemployment and perceived social support in this sample.

CHANGES IN HEALTH RELATED BEHAVIOURS

DIET

Interview One

Nine people had not made changes to their diet since stopping work. Of these, four people had been made redundant and one person had an employed husband. Due to these factors, changes in expenditure on food had not been necessary. Since two people lived with their parents changes in expenditure were made only on personal items. The remaining two cases had experienced unemployment either several times or for long periods. While no reported changes had been made, food consumption was basic and monotonous.

In quantitative terms four people were eating less than when working. Two were missing breakfast since they were getting up later, one person had lost his appetite and one person was eating less for financial reasons. Three people were eating more than when working. For two people this was due to boredom and for one it was due to being at home more.

In qualitative terms one woman was using fewer convenience foods because she had more time to spend on shopping and cooking. One man living with his parents was eating more convenience foods and snacks because he could not be bothered cooking. Two people were eating poorer quality food for financial reasons.

At the time of the first interview it was apparent that few people had made major dietary changes and only two had made changes for financial reasons. This is not surprising since one would not expect people to make changes in such a short time. The majority of households spent between £10 - £15 per head on food each week. However two of the households with redundant workers spent in excess of this and the separated woman and one man living alone spent less than £10 per head.

Interview Two

Of the 14 people interviewed, eight reported no changes in diet since the previous interview. Two people lived with their parents and one person had not made any changes since stopping work. Three men reported no changes but less money was being spent on food. All three had been made redundant and by this stage economies on food expenditure were being made even although one had regained employment.

Three people were eating more food or better quality food than before. One separated woman was now receiving money from her husband who had regained employment and two men living with their parents were trying to eat better quality food for health reasons.

Three people were eating less than before. Two had gained weight and were now trying to lose it by reducing food consumption. One man living alone was eating less and poorer quality food for financial reasons.

The two men living alone were the ones who had had to make changes for financial reasons, one at the first interview and one by the second interview. Those with redundancy money, working spouses or who lived with their parents, although perhaps still experiencing financial difficulties, clearly did not have to make such major changes.

Interview Three

Of the 10 people interviewed, only one person did not report changes in diet.

Five people were eating more or better quality food than before. Two of them had regained employment. One woman who previously had been trying to lose weight had been unsuccessful and therefore had returned to her previous consumption pattern. One man living with his parents was now eating breakfast and fresh vegetables for health reasons. One man living alone who previously had cut food consumption for financial reasons was now eating more because he was spending less on fuel.

Four people were eating less than before. Of these one was eating less because he was now working. The remaining three men were all trying to lose weight. One had gained weight while unemployed but was now employed again. One had gained weight since stopping smoking and the final case had been advised to lose weight by his doctor.

Interview Four

Of the three people interviewed one did not report changes. However since this woman was still unemployed and no longer receiving benefit she thought that economies in food expenditure would now have to be made. The other woman had gained weight since becoming unemployed and was now trying to lose it. The man who was still unemployed was still trying to lose weight.

Motivation to Change Diet

Nine people had never considered changing their diets. Of these, five people liked what they were eating and one was very conservative about food. One person felt healthy enough and saw no need to change.

Of the nine people who had thought of changing their diets four people had actually implemented the changes for health reasons or because of physical disorders. Of the remaining five, two people were prevented from changing for financial reasons, one had no willpower, one person did not like vegetables and one man's wife liked to eat a lot of meat.

Of those people who mentioned some food which they thought they should eat for health, but did not for some reason, six mentioned wholemeal bread. Three people did not eat it because they did not like the taste, two people could not afford it and the remaining case did not think he had to worry about his health because he was young. Three people mentioned fresh fruit or vegetables. Of these one could not afford them and two people did not like them. Two people thought that meat was good for health but they could not afford it. One person thought that he should eat tripe for health but did not know how to cook it and one person thought that she should eat high fibre

breakfast cereals but did not like their taste.

Ten people mentioned food they would like to eat more of but could not afford. Of these, six people mentioned meat or better quality meat, two mentioned fresh fruit and vegetables, one mentioned foreign dishes and the remaining person would have liked to have been able to eat out.

Factors Influencing Changes in Diet

A large number of changes in diet were due to situational factors i.e. stopping work and starting work. However there were still a number of changes, particularly in terms of quality, which were due to financial factors. Some changes were health related. However most of these were reducing food consumption in order to lose weight gained since stopping work. In only two cases were changes consciously made in an attempt to improve health.

In two cases changes in diet were related to changes in smoking behaviour. One person stopped smoking, subsequently gained weight and thereafter reduced food consumption. One person reduced food consumption in order to lose weight and consequently increased smoking. Fourteen people mentioned that food was one of the three priorities in the household budget. The four who did not mention food were the men who lived with their parents. Five people said that they cut expenditure on food when short of money. Of these three were women and the other two lived alone.

EXERCISE

Interview One

Five people did not report changes in the amount of exercise they were getting. Two had inactive jobs previously and now were taking little exercise. Two had active jobs previously and now walked regularly to save bus fares.

Five people were taking more exercise than when working because they had more time to spend on previous active interests.

Eight people were getting less exercise than when working. Of these four had active jobs previously and now took very little exercise of any kind. One man had not felt like exercising since the redundancies had been announced and two men had not felt like doing much since stopping work. The remaining case had been able to take part in Territorial Army activities while working but could no longer afford to attend.

Interview Two

Of the 14 people interviewed four did not report changes since the previous interview. Of these, three took very little exercise and were all still unemployed. The remaining case was still taking more exercise than when working to make sure that he slept at night.

Four people were taking more exercise than before. Of these, two were now attending college part-time and were walking long distances to save bus fares. One man had gained weight and was taking more exercise to lose it. The remaining case had been promoted in the Territorial Army and was now exercising more to regain fitness.

Six people were taking less exercise then before. Of these, one had regained employment and therefore did not have time to spend on previous interests. One man had partially lost his eyesight and did not have enough confidence to go out on his own. One woman was even less active than before since she was pregnant and hardly ever left the house. One man was prevented from engaging in his outdoor interests because of the weather. The remaining two men were still unemployed and appeared to be less active than before for psychological reasons.

Interview Three

Of the 10 people interviewed three did not report changes. Two men were now working and while they were taking less exercise their jobs were physically demanding. The remaining case still took little exercise apart from housework.

Four people were getting more exercise than before. One had regained employment which involved a lot of walking. One man, still unemployed, was taking more exercise because he felt better psychologically. The two remaining cases were also still unemployed and appeared to be taking more exercise for health reasons.

Three people were taking less exercise than before. One was now working and did not have time and another had broken her ankle. The remaining case was now attending college and was taking less exercise because he could not be bothered and could now afford bus fares.

Interview Four

Of the three people interviewed one did not report changes. One woman was attending keep fit classes in an attempt to lose weight. The other woman was now walking more to fill in time.

Motivation to Change

Five people had never thought that they should take more exercise. Of these three felt fit as they were, one had an active job and the other said he was too lazy.

Ten people had thought that they should take more exercise and five of them intended to do so. Of the remaining five people, three were not motivated, one was prevented for financial reasons and the other did not have access to a sports centre.

Three people were very active and therefore were not asked about motivation to increase exercise.

Factors Influencing Changes in Exercise

In the majority of cases changes in exercise were due to situational factors. In a few cases changes appeared to be related to changes in psychological well being. In two cases exercise levels were increased in the hope of losing weight and in only two cases were exercise levels increased consciously to improve health.

ALCOHOL CONSUMPTION

Interview One

Eight people reported no change in alcohol consumption since stopping work. Of these one never drank alcohol, four drank it only occasionally, two were light drinkers and one was a moderate drinker, using the criteria reported in the Royal College of Psychiatrist's Report [146]. Ten people reported drinking less than when working. Of these two rarely drank alcohol but were doing so less often for financial reasons. Three people who were classed as light drinkers had also reduced consumption for financial reasons. The remaining five people were classed as moderate drinkers. Of these, three single males who were living with their parents, had reduced consumption for financial reasons. The remaining two cases had reduced consumption because they were not going out as often. No-one reported drinking more alcohol since stopping work.

Interview Two

Of the 14 people interviewed nine reported no changes in alcohol consumption. Five of these never or rarely drank alcohol and all were still unemployed. Two light drinkers and one moderate drinker were also still unemployed. One man now employed was still classed as a moderate drinker.

Three people reported drinking less alcohol than before for financial reasons. Of these, two were single males living with their parents

who had previously been classed as moderate drinkers and were now light drinkers. The other case lived alone and was still classed as a light drinker.

One person reported drinking more but was still classed as a moderate drinker. This man did not feel that his wife was supportive and in addition he had partially lost his eyesight. The increase in alcohol consumption may have been a coping mechanism.

While one male living alone did not report an increase in alcohol consumption he was now classed as a moderate drinker instead of a light drinker from the consumption recorded in the diary. During the interview he admitted to sometimes getting drunk to break the monotony.

Interview Three

Of the 10 people interviewed, seven reported no changes in consumption. Of these four never or rarely drank alcohol and were still unemployed. The remaining three people were now working or attending college.

One man previously classed as a light drinker had reduced his consumption even more for financial reasons.

Two men had increased their consumption because they were working and could now afford to drink more alcohol. One of these increased his consumption drastically and was now classed as a moderate drinker instead of a light drinker.

Interview Four

All three of the people interviewed reported no changes in consumption and never or rarely drank alcohol.

Motivation to Reduce Alcohol Consumption

Only those six people classed as moderate drinkers at the first interview were asked about motivation to reduce consumption. Four people had never thought of reducing consumption either because they did not consider that they drank too much or because they enjoyed it. Two people had thought of reducing consumption but had not done so because they enjoyed drinking.

Factors Influencing Changes in Alcohol Consumption

In almost all cases changes in alcohol consumption were related to changes in income. However in two cases increases in consumption may have been ways of coping. Only one person mentioned that alcohol was one of the three priorities in his budget and he lived with his parents. Eight people reduced expenditure on alcohol when short of money.

SMOKING BEHAVIOUR

Interview One

Of the 18 people interviewed 10 were smokers, two were ex-smokers and six had never smoked. Three of the women were smokers and one was a non-smoker.

Four people were smoking the same number of cigarettes as when they were working. Of these, two men lived with their parents, one had received redundancy money and one man lived alone.

Two people were smoking more than when working. Of these one female was smoking more because of "nerves" and one male was smoking more because it had not been allowed in his former workplace.

Four people were smoking less than when working. Of these, three were doing so for financial reasons and the other because he was "fed up"

with smoking.

Interview Two

Of the 14 people interviewed seven were smokers and one was an ex-smoker. Three people were smoking less than before. One man had regained employment and smoking was not allowed at work. One man living with his parents was smoking even less than before for financial reasons and another man was smoking less because his stomach complaint had worsened. One man has stopped smoking since the previous interview and while he could not explain this it may have been due to increased financial difficulties.

Four people were smoking more than before. One woman was doing so because of boredom and because her estranged husband was now giving her money. One man was doing so because he was on a reducing diet and another because he was staying up late at night to make sure that he slept. One female was smoking more but the reason for this was unclear.

Interview Three

Of the 10 people interviewed four were smokers. One woman was smoking the same amount as before. One man who had increased smoking between the first two interviews had reduced again because he was now working and it was not allowed at work. One man had reduced smoking even more than before for health reasons. One man had increased smoking because he was now working and had more money. The man who had stopped smoking between the first two interviews had not recommenced.

Interview Four

Of the three people interviewed only one was a smoker and she had increased smoking even more than before because of "nerves". The man who had stopped smoking previously had not recommenced.

Motivation To Stop Smoking

Only two people had never thought of stopping smoking. One of these did not believe what she heard about the effects on health. It is interesting that the other case was the man who subsequently stopped smoking. However at the first interview he was only smoking three to six cigarettes per day.

Eight people had considered stopping smoking and at the time of the first interview two were trying to stop. Of the others, three said they had not got the willpower to stop, one was prevented from stopping because of boredom, one did not think about the effects on health and the remaining case enjoyed smoking which she said was her only pleasure.

Factors Influencing Changes in Smoking Behaviour

In the majority of cases changes in smoking behaviour were related to changes in income. In other cases changes were due to situational factors. In two cases increases in smoking appeared to be ways of coping and it is interesting to note that both were females. In only one case was reducing smoking a conscious decision to improve health. In two cases changes in smoking behaviour were related to changes in food consumption. For one man stopping smoking led to an increase in weight which he subsequently tried to reduce. In the other case going on a reducing diet led to an increase in smoking.

Only one person, a man living with his parents, mentioned that cigarettes were one of the three most important priorities in his budget. Six people reduced expenditure on cigarettes when they were short of money.

MEDICINE USE/MEDICAL CONSULTATIONS

Interview One

In general little change in the frequency of medical consultations could be identified over the study period due to the low rates recorded. At the first interview six people were taking prescribed medication but had been taking the medication while working.

Interview Two

One male who previously was taking medication for Diabetes and Angina had partially lost his eyesight because of the Diabetes and consequently was having medical consultations more frequently. One woman was pregnant and was taking medication because she had failed to gain weight during the first five months of pregnancy. She had been prescribed medication inbetween interviews for depression but medication had been stopped when the pregnancy was confirmed. One male was taking medication more frequently since his stomach complaint had worsened, another male was now receiving medication for bronchitis and one female was taking medication for a bladder complaint. One male had developed knee trouble but had not consulted a doctor because he thought the complaint might be psychosomatic.

Interview Three

Two people were taking the same medication as at the previous interview. One male was taking his medication less frequently since his stomach complaint had improved. The male who had developed the knee trouble had regained employment and his complaint had improved. One male was taking medication for depression and had suffered from several colds and an ear infection since the previous interview. One female had been prescribed medication for depression between interviews and had broken her ankle twice. Her epileptic condition previously had been under control but she had experienced one fit after breaking her ankle for the first time.

Interview Four

Of the three people interviewed one woman was now taking less medication since her bladder complaint had improved. The other two were not taking prescribed medication.

SUBJECTIVE HEALTH STATUS

Details of the Nottingham Health Profile (N.H.P.) scores are given in Appendix 12. Sometimes respondent's ratings of their health on the five point scale did not correspond with reported changes in health or with changes in N.H.P. scores. This may have been due to individual concepts of health or to the possibility that changes in perceived health were not great enough to cause a change in rating.

N.B. The higher the score, the greater the distress experienced.

Changes in Subjective Health Status since Stopping Work

Fourteen people did not feel that their health had changed since stopping work. Two people perceived their health to be better than when working. In one case the reason for this is unclear since he missed work and had a score for Emotional Reactions which was higher than the population mean. However this person suffered from Angina and Diabetes and it is therefore possible that he felt better physically because he was not working. Although the other man missed the activity that work provided he had not enjoyed the type of work he had been doing. However his score for Emotional Reactions was also higher than the population mean.

Two people perceived their health to be worse than when working. One woman missed work for the company and she had very high scores for Energy, Emotional Reactions, Sleep and Social Isolation. Although the other case had only worked for a few months since leaving school he also missed work because of the company. This young man had scores for Emotional Reactions and Sleep which were higher than the

population means.

Therefore at this time there appeared to be little change in perceived health for the majority of the sample.

Types of Changes Over Time

Of those 14 people interviewed more than once there was only one who did not report changes in perceived health over time. This man was 56 years old and there was some suggestion that he was perhaps more resigned to unemployment, treating it like early retirement.

There was only one person who perceived his health to be better at the first interview and thereafter did not report changes. While at the second, third and fourth interviews he achieved zero scores on all sections of the N.H.P. information given during interviews suggested that he was reluctant to give affirmative responses but was indeed experiencing emotional problems.

Five people reported no changes in perceived health at the first interview followed by deterioration in perceived health and then improvements in perceived health. Of these, three people reported improvements in perceived health when they regained employment. Of the others, one person had started college by the second interview and while three N.H.P. scores improved by this interview one score increased. Although attending college contributed in some ways towards better perceived health, damp housing conditions were said to be responsible for poorer physical health and it is possible that this was the main reason for the poorer health rating. Deterioration in psychological health was reported between the second and third interviews and while perceived health was better by the third interview he only rated it as Fair. The remaining case who experienced deterioration in health by the third interview and improvements by the final interview achieved consistently high scores throughout. This female was mentally handicapped and this might explain the high scoring.

Three people reported no changes in perceived health subsequent to unemployment at the first interview and thereafter perceived it to improve. In two of these cases improvements appeared to be related to changes in health behaviours. While the N.H.P. scores for one case did improve with improved perceived health, two scores for the other case actually increased with better perceived health. The reasons for this are unclear. The remaining case's perceived health improved with part time attendance at college and with changes in health behaviours.

One woman reported no changes in perceived health at the first three interviews but worse perceived health at the final interview. The N.H.P. scores for Emotional Reactions were consistent with this. This married woman had no intention of seeking re-employment until the Unemployment Benefit stopped. At the final interview with no employment in sight she was becoming increasingly worried about the future financial situation.

Two people perceived their health to be worse at the first interview than when working and thereafter it improved. Of these, one woman achieved high N.H.P. scores at both interviews and while the score for Emotional Reactions had increased, by the second interview she felt better because her estranged husband had regained employment and their relationship had improved. The other case was still unemployed at the second interview but improvements in perceived health appeared to be due to changes in health behaviours.

Only one person perceived his health to be better at the first interview than when working and worse at the second. However this was the man who partially lost his eyesight and this appeared to be contributing towards worsened perceived health.

There appeared to be no relationships between perceived health and employment history, perceived social support, redundancy, gender, marital status or household composition.

RELATIONSHIP BETWEEN CHANGES IN PERCEPTIONS OF UNEMPLOYMENT AND CHANGES IN PERCEIVED HEALTH

Interview One

There were no apparent relationships between changes in perceived health since stopping work and the number or types of problems being experienced.

Changes from Interview One to Interview Two

Of the 14 people interviewed, five, all still unemployed, had the same problems as before. Of these, two perceived their health to be the same (one had worse N.H.P. scores) two perceived their health to be better (both had improved N.H.P. scores) and one perceived his health to be worse (he had increased N.H.P. scores).

Four people, all still unemployed, had more problems than before. Of these, two perceived their health to be worse (one had increased N.H.P. scores), one perceived her health to be the same (but had increased N.H.P. scores) and the remaining case perceived his health to be better, (some N.H.P. section scores improved but one increased).

Three people had fewer problems than before. Two of these perceived their health to be better (one had worse N.H.P. scores) and one perceived his health to be the same (but N.H.P. scores had improved). For two people some problems had improved and some had got worse. While one of these perceived his health to be better, two N.H.P. section scores had increased. The remaining case perceived his health to be worse and while one N.H.P. section score had improved one section score had increased.

Changes from Interview Two to Interview Three

Seven people had fewer problems than before. Of these five perceived their health to be better than before. (All had the same or better N.H.P. scores). Two people perceived their health to be the same and had the same N.H.P. scores.

Three people had the same problems as before. One perceived his health to be the same and had the same N.H.P. scores as before. One perceived his health to be better and had lower N.H.P. scores but perceived health had been worse inbetween interviews. The remaining case perceived her health to be worse but had lower N.H.P. scores. However perceived health had been worse inbetween interviews.

Changes from Interview Three to Interview Four

All three people had more problems than before. One perceived his health to be the same and had the same N.H.P. scores, one perceived her health to be better but had worse N.H.P. scores and one perceived her health to be worse and had worse N.H.P. scores.

Generally when perceptions of circumstances associated with unemployment improved either people perceived their health to be better or the same and this was fairly consistent with N.H.P. scores. When perceptions were worse most N.H.P. scores increased but this was not consistent with perceived health. When perceptions were unchanged perceived health and N.H.P. scores were varied.

RELATIONSHIPS BETWEEN CHANGES IN PERCEPTIONS OF UNEMPLOYMENT AND CHANGES IN HEALTH RELATED BEHAVIOUR

Regarding positive changes in health related behaviours, in four instances these occurred when perceptions of circumstances associated with unemployment were better, in one instance when perceptions were worse and in one instance when perceptions were the same as before.

Regarding negative changes, in five instances these occurred when perceptions of circumstances associated with unemployment were worse and in six instances when perceptions were better.

DISCUSSION

The first aim of this study was concerned with examining perceptions of unemployment, health related behaviours and subjective health status following job loss.

PERCEPTIONS OF UNEMPLOYMENT

It is apparent from the results that the manifest function of employment was important for the majority of this sample. This concurs with the results of previous studies which found that income reduction was one of the most negative aspects of job loss [46,69]. However it is also clear that work fulfilled latent functions such as providing social contact, a means of filling time and purposeful activity, a result which has also been found before [42,46,69].

Previous studies, although few were longitudinal, have suggested that people go through phases in responses to unemployment [61, 63, 64, 66]. It appeared that for most people problems with such things as finance, boredom and lack of social contact intensified around six months after stopping work. Thereafter situations improved when employment was regained or with part or full time attendance at college. One study, although cross-sectional, also found that six months of unemployment appeared to be the critical point as far as financial problems were concerned [42] and Hill identified an "Intermediate phase" when problems with finance and boredom worsened [63].

For those remaining unemployed there was some evidence of adaptation to some of the changes brought about by job loss by the third or fourth interview. This corresponds with Hill's "Final phase" which occurred around nine months to one year after job loss [63]. However since few people remained unemployed for the whole year it is difficult to generalise from their experiences.

HEALTH RELATED BEHAVIOUR

Diet

A variety of changes occurred during the study period mainly for situational or financial reasons. Those people who gained weight tended to be those not so financially affected by job loss. Unlike previous studies [42,103,104] in which approximately one third to three fifths of the samples cut food expenditure when short of money only five of this sample did.

Those who were worst hit financially tended to have monotonous, poor quality diets with food consumption patterns similar to those found in previous studies [102,103]. In these cases many items in the budget were static leaving food expenditure one of the few flexible items, a fact identified by McLellan [69].

The most common food which could not be afforded was meat with few people mentioning fruit or vegetables which concurs with previous studies [42,102]. However, in general, fresh fruit and vegetable consumption was infrequent amongst this sample. Nevertheless there appeared to be some awareness of health issues in relation to diet in some of the respondents. The most common reasons for not eating particular foods which were thought to be good for health were dislike of the food or cost.

Exercise

Changes in exercise patterns appeared to be mainly related to situational factors. Those who had previous interests in active pursuits tended to increase these activities when unemployed. Despite having more free time those who did not have previous active interests did not tend to take the opportunity to engage in exercise. In some cases this appeared to be due to apathy but in others because activities which might be of interest involved spending money.

Alcohol Consumption

Winton proposed two hypotheses to explain the effects of unemployment on drinking behaviour i.e. leisure versus stress [98]. In this study most changes were related to changes in financial status. In almost all cases alcohol consumption was reduced while unemployed, a result which is consonant with previous studies, [42,45,69,102]. In two cases alcohol consumption appeared to increase with length of unemployment and in these instances consuming alcohol may have been a way of coping. In previous studies there has been a suggestion that a few individuals increased consumption to cope with mild depression [56] or insomnia [69].

Smoking Behaviour

Half of the men, and three quarters of the women in this sample smoked. This compares with 61% of unemployed men and 48% of unemployed women from National samples [94]. Changes in smoking behaviour were mainly related to changes in financial status or situational factors with most people reducing consumption while unemployed. Three fifths of the smokers cut expenditure on cigarettes when short of money a result which agrees with one previous study [42]. However, in other studies some people had increased cigarette consumption in order to cope with boredom or insomnia [45,69]. Two men appeared to increase their consumption for these reasons. The three women smoked very heavily and it appeared that they did so because of "nerves". The two who were interviewed more than once increased their cigarette consumption and this may have been a way of coping with their situation. This result is similar to that of Graham [147], who found that smoking provided a way of coping with the increasing demands made by the family and a way of temporary escape for women.

Medicine Use/Doctor Consultations

There appeared to be little evidence of changes in medical consultation rates during the study period. Three people were prescribed medication for depression at some point in the study

period. However unemployment appeared to be only one of several factors which contributed towards their depression. During interviews, however, several people made statements which indicated that they might be depressed by unemployment although they did not seek medical assistance. This is not surprising since the majority of the sample were male and men have been found to be less likely to report emotional problems [92].

SUBJECTIVE HEALTH STATUS

At the first interview there appeared to be little change in perceived health since stopping work for the majority of the sample which agrees with the findings of Trew and Kirkpatrick [46]. Previous studies have reported that a small number of unemployed people perceived their health to be better than when working [46,64] and this was found to be true in the case of two individuals in this study. Perceived health improved in the majority of cases when they regained employment a result which has been found before [39,53,54]. Perceived health also appeared to improve for those men who started attending college part or fulltime. This concurs with Furnham's study in which students had better psychological health than unemployed people [36]. The factor which appeared to be most strongly associated with changes in perceived health was change in employment status.

The first aim of this study was also concerned with examining relationships between perceptions of unemployment, subjective health status and health related behaviour.

RELATIONSHIP BETWEEN PERCEPTIONS OF UNEMPLOYMENT AND SUBJECTIVE HEALTH STATUS

Apart from financial difficulties one of the most common problems associated with unemployment for many of this sample was boredom. Previous studies have found this to be strongly associated with poor psychological well being [28,31,37]. The results of this study tended to support this. In general it appeared that positive changes in

perceptions of circumstances were associated with positive changes in perceived health. However while N.H.P. scores worsened with negative changes in perceptions of unemployment, health ratings were not always consistent, perhaps suggesting that other factors influenced perceived health.

RELATIONSHIP BETWEEN PERCEPTIONS OF UNEMPLOYMENT AND HEALTH RELATED BEHAVIOUR

There was no obvious relationship between perceptions of unemployment and health related behaviour in the sample as a whole, suggesting that health behaviours were individual and influenced by other factors. However in a few cases, particularly in relation to smoking and drinking, negative changes in perceptions of circumstances associated with unemployment appeared to be related to increased consumption.

RELATIONSHIP BETWEEN SUBJECTIVE HEALTH STATUS AND HEALTH RELATED BEHAVIOUR

In a few cases only, positive changes in health related behaviours appeared to contribute towards improved perceived health.

MEDIATING FACTORS

One of the most important findings of this study is the diverse range of experiences which have been disclosed. It is clear that there are a large number of important factors which mediate the effects of unemployment. While some of the previous studies have taken a few variables into account others have not been considered in the study designs. The most important variables identified in this study are gender, age, social class, marital status/household composition, employment history, length of unemployment, financial resources, personal characteristics and interests prior to job loss.

Few studies have been carried out which include both men and women. It is likely that married women view paid employment in a different

way from married men. Of the three married women in this study two had no problems with boredom and it was clear in these cases that their roles as wife and mother expanded to replace some of the functions of paid employment. This result, that women in general and mothers in particular have less problems with boredom and usually cope better with unemployment than men has been reported before [42,51,60,61]. While the women missed the social contact and extra money, the fact that they had working husbands meant that the reduction in income did not cause too many problems. The remaining married woman was separated and was without support from her husband. In this case job loss intensified everyday problems of survival and she spent less time looking after the house than when working. The single female, although sharing accommodation, viewed paid employment in a similar way to the men. All of the women had experienced long periods of unemployment previously.

Age has been identified in previous studies as an important variable since it is related to attitudes towards work and tends to be correlated with employment history. The age range in this sample was from 18 years to 59 years. The younger people were more likely to have experienced erratic employment and few had ever been employed in permanent jobs. The older people, apart from the females, were more likely to have been employed for a long time in the same job. There was some evidence that the two men over 50 were resigned to unemployment since it could be treated as early retirement. It might be assumed that those people who were made redundant would have experienced more distress initially than those who had been on a fixed term contract. However this did not appear to have been the case in this sample. Although two of the redundant men were fairly pessimistic at the first interview about regaining employment, because of their age, all three redundant men gave the general impression that they would indeed eventually find another job. These results reflect those of Marsden who reported that the initial reaction of those who had never been unemployed before was short lived elation and confidence in finding a new job [66]. However the fact that they volunteered for the study while so many others did not may indicate that they were different in some respects from other redundant men.

Those who had experienced erratic employment had less well developed work identities and many viewed the future as a series of one year M.S.C. contracts with spells of unemployment in between.

Social class in this study was based on previous occupation. The sample consisted of people who had been employed in unskilled, semi-skilled and skilled manual occupations.

In relation to marital status and household composition, seven people were married, one was divorced, two were separated but only three people lived alone. The women have been discussed previously. Apart from one man the married men had strong support from their wives. There was some evidence also that their wives relieved them of some problems of financial management. Those single men who lived with their families were subsidised to some extent and they also had fewer problems to cope with. The men living alone, especially the two younger ones, had many problems to cope with.

The importance of personal characteristics is difficult to measure quantitatively but in qualitative terms individual characteristics may influence perceptions and how people cope with adverse situations. One person in this sample stood out as being particularly different from the others. He could be described as an example of the pro-active unemployed studied by Fryer and Payne [72]. He resented some of the consequences imposed by employment and was able to perceive and create opportunities to engage in purposeful activity while unemployed. Mainly because of this, unemployment posed few problems for him.

Length of unemployment is one factor which has been examined in previous studies. However many of these have been cross sectional in nature and such studies fail to capture the dynamic nature of responses and adaptions to unemployment. This study has identified changes in perceptions and health behaviours over time related to changes in employment status. The period in which most changes appeared to take place, for those remaining unemployed, was between the first and second interviews i.e. from three months to eight months after job loss.

Since the study period was limited to one year and few people were interviewed four times it is difficult to predict what if any further changes would have occurred over a longer time scale.

It is apparent in this study that access to financial resources was important in influencing the extent to which people coped with unemployment and was important in influencing health behaviour. Firstly, it determined the extent to which previous expenditure patterns were affected. For those with redundancy payments or with working spouses few changes in expenditure patterns were made initially and standards of living were maintained for some time. However the longer they remained unemployed the more they began to worry about what would happen in the future. This is a similar finding to that of Swinburne in a study of unemployed managers [68]. The men who lived alone were the hardest hit financially. For them, decisions regarding how to spend their income were severely restricted and emphasis on one basic essential was at the expense of another. Secondly, money provided means by which some people could procure alternative means of fulfilling some of the latent functions of employment. Those people who had interests outside of work prior to job loss tended to find useful ways to fill their time and had few problems with boredom.

In almost all cases unemployment was a distressing experience and there was some evidence that subjective health status improved with re-employment or attendance at college.

It is clear from the results of this study that there is a complex interaction of many factors which influence how people cope with, respond to, or adapt to unemployment. The complicated nature of the situation is best illuminated by qualitative information which aggregate studies are unable to collect. In addition such studies, unless longitudinal in nature, cannot highlight the dynamics of the interactions

LIMITATIONS

Major problems were experienced in obtaining a sample for this study. A variety of factors were considered in the planning stages and several actions were taken throughout in order to maximise numbers. Possible reasons for the low response rate have been proposed in the methodology chapter and these should be carefully considered in the planning of future studies. Since only 18 people were interviewed this severely limits the extent to which the results can be generalised. However the fact that such a variety of experiences was found in such a small sample leads one to question other studies in which data are aggregated. The advantage of studying such a small number of people lies in the ability to collect detailed qualitative information which contributes to our understanding of this complex social phenomenon.

Attrition occurred during the study with only three people being interviewed one year after becoming unemployed. Six people were lost due, either to the inability to contact them, or because they no longer wished to be interviewed. Therefore patterns of changes in health behaviours and subjective health status over the longer time scale are not too clear.

In relation to the reliability of data collected there are a number of points. Firstly reported health behaviour rather than overt behaviour was recorded and this method relies upon respondents giving accurate information. Since cigarette smoking and excessive alcohol consumption are likely to be viewed as negative behaviours it is probable that reported consumption will be an underestimate of actual consumption. Furthermore since exercise is likely to be considered a positive behaviour it is probable that reported exercise will be an over-estimate of actual behaviour. In relation to food consumption the use of a diary means less reliance upon memory which should result in more accuracy. However one still cannot rely absolutely on the accuracy of recordings. In addition some people did not return diaries and it was necessary to accept reported changes in food consumption in these cases.

The act of recording food consumption in itself may have affected actual behaviour. As far as other health behaviours are concerned asking questions about them during interviews may also have affected reported behaviour.

In the case of people interviewed more than once questions were repeated at each interview and this could have sensitised respondents to the particular topics. However interviews were conducted several months apart and many respondents mentioned that they could not remember how they had responded in previous interviews.

Finally four people were interviewed in the presence of other family members. This may have affected their responses to some of the more personal questions.

FACTORS INFLUENCING HEALTH RELATED BEHAVIOUR AND IMPLICATIONS FOR HEALTH PROMOTION

The second aim of this study was concerned with examining factors which influenced health related behaviour.

The Health Belief Model [105] discussed previously assumes that health behaviours are performed purely for health reasons. The results of this study indicate that in only a very few cases were changes in health behaviours made specifically for health reasons. There was some indication of motivation to change behaviour but also evidence that a number of factors acted as barriers to change. In the majority of cases changes in health behaviours were due to changes in situational factors such as physical environment or availability of time and financial status, a result previously reported by Hunt and MacLeod [82]. This finding tends to support the adaptational model of health behaviour in which health behaviours are viewed as adaptive responses to changes in social, physical and economic cirmcumstances [75].

The final aim of the study was concerned with identifying, from the results, the implications for health promotion.

The results indicate that unemployment was accompanied by changes in health behaviours although the types of changes tended to vary from individual to individual.

It is also apparent that most people's psychological well being was detrimentally affected by unemployment. In view of this it is necessary to examine which health promotion strategy would be most appropriate when considering unemployed people.

The traditional approach to health education assumes that people engage in harmful health behaviours because they lack knowledge. While some of the sample displayed awareness of the relationships between health behaviour and health status others did not. However in a situation where changes to many aspects of everyday life are being forced upon individuals because of job loss, it is improbable that people would freely decide to make other changes. This is particularly unlikely if they enjoy what they are doing and have little else in their lives which they do enjoy. As others have suggested [78] recommendations to change lifestyle are irrelevant for people in disadvantaged circumstances irrespective of motivation and changes are improbable due to pre-existing problems [82]. Furthermore this approach cannot really tackle the psychological sequelae of job loss. Even those people in this sample who were aware of the possible effects felt powerless to do much about it.

The educational approach to health education which seeks to promote individual self esteem and the ability to make autonomous choices, it could be argued, might be more appropriate. Psychological well-being might be improved through raising self esteem. However autonomous choices may not always be possible for unemployed people especially if the choices have financial implications.

The conservative political approach to health education could enable unemployed people to adopt healthier lifestyles if, for example, subsidies were made on some foodstuffs. However although taxes on alcohol and cigarettes would probably result in reduced consumption this approach raises major ethical issues. Furthermore, this strategy

would not tackle the psychological effects of unemployment.

The radical political strategy which aims to change the social structure of society would very probably be beneficial to unemployed people. However major changes would be required and in the current climate this is unlikely to be a realistic strategy.

The community development approach which is based on collective action to improve the health of whole communities might be appropriate in areas of high unemployment. However, for unemployed individuals living in other areas the ability to act collectively might be more difficult. The major limiting factor of this approach is that it requires parallel improvements in education, socio-economic conditions and health services to be effective. While current government policies encourage self help with less reliance on the state they do little to improve living conditions or health care provisions for large numbers of people in this country.

The Health Promotion strategy focuses on achieving equity in health by providing equal opportunities and resources which enable everyone to achieve their fullest health potential. Unemployed people are one of the disadvantaged groups in our society and would undoubtedly benefit if this strategy was implemented. A charter for action to achieve the W.H.O.'s global target of "Health For All By The Year 2000" has been presented [148]. Activities would involve building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting Health Services. In terms of unemployment this would mean creating social, physical and economic conditions which were conducive to making the healthier choice the easier choice. In real terms this would mean either creating healthy employment or alternative ways of fulfilling the manifest and latent functions of employment.

The main conclusion of this study is that unemployment is detrimental to the psychological well being of many individuals because of the changes which may accompany job loss. This, it is proposed, is more important than the negative changes in health behaviours which may

occur. Only when the changes in physical, social and economic situations brought about by job loss are ameliorated or all individuals are provided with resources which allow them to cope with such changes will they be in a position to adopt healthy lifestyles. The results show the wide variety of ways in which unemployment is experienced and the disparate effects on health behaviours. For this reason global strategies which treat unemployed people as a homogeneous group are inappropriate.

APPENDIX 1

University of Strathclyde

Director: Peter F. Nelson BSc FPS

Continuing Education Centre

McCance Building, Richmond Street, Glasgow G1 1XQ
Tel: 041-552 4400 Ext. 2132/2239/2246

LAH/FW

3 June 1985

Mrs S. MacArthur,
The Queen's College,
1 Park Drive,
Glasgow
G3 6LP

Dear Mrs MacArthur,

Research project on unemployment and health

As promised, your proposed research project was discussed at the RISK advisory group meeting held last week. As I thought, the committee would not agree to give out names and addresses of those who have attended recent RISK seminars as this information is confidential to the project.

The advisory group is, however, keen to co-operate with you and it was suggested that at future RISK seminars, written details of your project could be given out and volunteers asked for. Perhaps a pre-paid envelope could also be issued for use by those who did not want to commit themselves at the seminar.

Please contact either myself or the RISK Project Officer Mr Charlie Radcliffe if you wish to discuss this proposal further. I can be contacted either via the Continuing Education Centre or at my home (638.1431); Mr Radcliffe's phone number is 227.2838. At present there is only 1 RISK seminar planned in June although more may be run over the summer.

With best wishes for your research.

Yours sincerely,

Lesley A. Hart

cc Mr C. Radcliffe

APPENDIX 2

APPENDIX 3

▼SITS.VACANT

RECENTLY UNEMPLOYED?

Willing to give an hour of your time for a worthwhile research project?
We aim to collect information about some of the problems newly unemployed people may have in their daily lives, and we would like to interview you.

Tel: 041-334 8141 (day)

or write to

S. Macarthur,
The Queens College, 1 Park Drive,
Glasgow

All expenses refunded

APPENDIX 4

MRC
Medical Research Council

ESRC
ECONOMIC AND SOCIAL RESEARCH COUNCIL

MRC/ESRC Social and Applied Psychology Unit
Department of Psychology
University of Sheffield
Sheffield S10 2TN

telephone 0742 756600

PRJ/JS.

21st January, 1987.

Ms. Sheana MacArthur,
Department of Management Studies,
The Queen's College,
1 Park Drive,
Glasgow,
G3 6LP.

Dear Ms. MacArthur,

I apologise for not replying to your letter sooner: Christmas, new term and bad weather have made life rather hectic. I enclose a couple of papers giving details of follow-up response rates on some of our projects. I sympathise with your problem since it has happened here too with some of our postgraduate projects.

A recent M.Sc. project I supervised obtained a 38% response to a postal questionnaire of men and women who had left Community Programme in the prior six months. Similar rates have been found with managerial samples. Another project tried to elicit support for a Replan programme of adult education classes in a depressed area of South Yorkshire. Over 500 leaflets were distributed to homes and not one positive response was obtained!

I hope these examples give you some encouragement in your own work.

Best wishes.

Yours sincerely,

Paul Jackson

Dr. Paul Jackson

APPENDIX 5

1. Could you please tell me how long you have been unemployed this time? (Round days to weeks)

2. (a) Have you been unemployed before?

(Yes 1 No 2)

(b) (If yes) how many times have you been unemployed before?

3. Could you please tell me if any of these people are unemployed at present?

Someone in your immediate family
Other relatives
Close friends

(Yes 1 No 2)

4. Could you tell me how long you worked in your last job. (In years. Count <12 months as 1. Round months up)

5. (a) Now can you tell me please do you miss working or being at work?

(Yes 1 No 2)

(b) (If yes) what do you miss <u>most</u> about work?
(Allow two responses and rank No order *)

(c) (If no) why is that?

---

6. Could you tell me who or what you feel is <u>mainly</u> responsible for your present unemployment?
(No prompting)

Self	1
Management	2
Trade Unions	3
The Government	4
The Economy	5
Private Industry	6
The Common Market	7
Other	8

I am interested in finding out what people think about their diets therefore I would now like to ask you some questions about food.

7. (a) Since becoming unemployed/the redundancies were announced/ have you made any changes at all in the type or quantity of food you eat?

(If no go to Q8) (Yes 1 No 2)

(b) (If yes) could you tell me what changes you have made?
(Allow two responses. No ranking)

(c) and could you tell me what made you change?

---

8. (a) If there any kind of food you would like to eat more of but you cannot afford to buy it?

(If no go to Q9) (Yes 1 No 2)

(b) (If yes) what is it?
(Allow two responses. No ranking)

---

9. (a) Have you ever thought of changing the type of food you eat?

(If no go to f) (Yes 1 No 2)
(Have changed 3)

(b) (If yes) what changes have you /thought of making/made?
(Allow two responses. No ranking)

(c) and could you tell me why you have /thought of making/made these changes?
(Allow two responses. No ranking)

(d) and could you tell me what has prevented you from making these changes?
(Allow two responses. No ranking)

(e) Can you think of anything which would make it easier for you to change your diet?
(Allow two responses. No ranking)

(f) Could you tell me why you have never thought of changing the type of food you eat?

---

10. (a) Is there any type of food you think you <u>should</u> eat because it is good for your health but don't?

(If no go to Q11) (Yes 1 No 2)

(b) (If yes) can you tell me what it is?

(c) and could you tell me why you don't eat it?

---

11. (a) Are you on a special diet of any kind?

(Yes 1 No 2)

(b) (If yes) what is the reason for being on a special diet?

Now I would like to ask you some questions about exercise.

12. At present how often do you take part in vigorous exercise such as swimming, cycling, running, squash or football?

(Display Card 1)

Never	1
Less than once a month	2
1-2 times a month	3
3-4 times a month	4
2-3 times a week	5
Almost every day	6

13. At present how often do you take part in other forms of exercise such as taking long walks, gardening or golf?

Never	1
Less than once a month	2
1-2 times a month	3
3-4 times a month	4
2-3 times a week	5
Almost every day	6

14. Since becoming unemployed/the redundancies were announced/ would you say that you had been exercising:

(Display Card 2)

More than you used to	1
Less than you used to	2
Just about the same as you used to	3

15. (a) Have you ever thought that you should take more exercise?

(Yes 1 No 2)

(b) (If yes) do you intend to do something about it?

(Yes 1 No 2)

(c) (If no) can you tell me why not?

(d) Can you think of anything that would make it easier for you to exercise more?
(Allow two responses. No ranking)

Now I would like to ask you some questions about your health.

16. Before you became unemployed/the redundancies were announced would you say that your health on the whole was usually :

(Display card 3)

Very good	1
Good	2
Fair	3
Poor	4
Very poor	5

17. Ar present are you taking any of the following medicines or pills?

(Display card 4)

	Every day or almost	At least 1/week	Less often 1/week	Never rarely
Tranq/Sleeping pills	3	2	1	0
Other prescribed	3	2	1	0
Not prescribed	3	2	1	0

18. Since becoming unemployed/the redundancies were announced would you say that you had been taking medicines or pills :

(Display card 2)

More than you used to	1
Less than you used to	2
Just about the same as you used to	3

19. (a) In the last four months how many times have you seen a doctor/nurse?

(b) Could you tell me the reason for seeing your doctor/nurse. Was it because of :

Illness	1
Injury	2
Other	3

20. Since becoming unemployed/the redundancies were announced would you say that you had been seeing your doctor/nurse :

(Display card 2)

More than you used to	1
Less than you used to	2
Just about the same as you used to	3

Now I would like to ask you some questions about drinking.

21. (a) Do you ever drink alcohol of any kind?

Yes most days	1
No	2
Yes every week	3
Yes < every week	4
yes rarely	5

(b) (If yes) how much of the following drinks do you consume on average in a week?

(Display card 5)

Beer/lager/Stout/Cider	Pints	----------
Spirits/Liquers	measures	----------
Port/Sherry/Martini	glasses	----------
Wine	glasses	----------
Total number of units		----------

22. Since you became unemployed/the redundancies were announced would you say that you had been drinking alcohol :

(Display card 2)

More than you used to	1
Less than you used to	2
Just about the same as you used to	3

23. (a) Have you ever thought of reducing the amount of alochol you drink?

(Yes 1 No 2)

(b) (If yes) do you intend to do something about it?

(Yes 1 No 2)

(c) (If no) can you tell me why not?

(d) Can you think of anything which would make it easier for you to cut down on drinking?
(Allow two responses. No ranking)

(Only ask question 23 to moderate and heavy drinkers i.e.

Men		Women	
1-10	units light	1-5	units light
11-50	units moderate	6-35	units moderate
>50	units heavy	>35	units heavy

Now I would like to ask you some questions about smoking.

24. (a) Do you smoke at present?

(Yes 1 No 2)

(b) (If no) have you ever smoked?

(Yes 1 No 2)

(c) Could you please tell me how many cigarettes you smoke per day?

(d) How many cigars do you smoke per day?

(e) How much pipe tobacco do you smoke per day? (in oz)

25. (a) Since becoming unemployed/the redundancies were announced has your smoking behaviour changed in any way? (Ask everyone)

(Yes 1 No 2)

(b) Can you tell me in what way it is changed?

(c) And can you tell me why it has changed?

---

26. (a) Have you ever thought of giving up smoking? (Ask current smokers)

(Yes 1 No 2)

(b) (If yes) can you tell me what has prevented you from stopping smoking?

(c) Can you think of anything which would make it easier for you to stop smoking?

Now I would like to ask you some questions about your household/your budget.

27. Could you tell me how much your household has/you have to spend now compared with when you were working.

(Display card 6)

More than before	1
Same as before	2
About three quarters	3
About half	4
About a quarter	5
Less than a quarter	6

28. Could you tell me which three items you give most priority to in your household/your budget at present? Here are some examples. (Rank most important first)

(Display card 7)

Rent/Mortgage/Rates	1
Fuel	2
Food	3
Clothes	4
Cigarettes	5
Alcohol	6
Cinema, football match and other outings	7
Holidays	8
Household furnishings	9
Other	10

29. Could you tell me which three itmes you give least priority to in your household/your budget at present? (Rank least important first).

(Display card 7)

Rent/Mortgage/Rates	1
Fuel	2
Food	3
Clothes	4
Cigarettes	5
Alcohol	6
Cinema, football match and other outings	7
Holidays	8
Household furnishings	9
Other	10

30. At present when you are short of money are you cutting back on:

Rent/Mortgage/Rates	
Fuel	
Food	
Clothes	
Cigarettes	
Alochol	
Cinema, football match and other outings	
Holidays	
Household furnishings	
Other	

(Yes 1 No 2)

31. Can you tell me please how much money on average your household spends on food per week?

(Display card 8)

£10 - 19	1
20 - 29	2
30 - 39	3
40 - 49	4
50 - 59	5
59 +	6

Now I would like to ask you some questions about problems you might be experiencing at present.

32. Could you please tell me if any of the following are a problems for you at present?

(Display card 9)

(a) Managing on the money you have. (Yes 1 No 2)

(b) Not being able to do the things you like to do because you are short of money. (Yes 1 No 2)

(c) Being financially supported by others. (Yes 1 No 2)

(d) Not knowing what is going to happen to you in the future. (Yes 1 No 2)

(e) Keeping yourself from being bored. (Yes 1 No 2)

(f) Finding useful ways to spend your time. (Yes 1 No 2)

(g) Not getting the offer of a suitable job. (Yes 1 No 2)

(h) Keeping looking for a job. (Yes 1 No 2)

(i) Living up to what other people expect of you. (Yes 1 No 2)

(j) keeping up with former social contacts. (Yes 1 No 2)

(k) Getting on with your wife/husband/ cohabittee/parents. (Yes 1 No 2)

(l) Your children's behaviour. (Yes 1 No 2)

(m) Dealing with people at the tax/social security offices or Job Centre. (Yes 1 No 2)

(n) Are there any other things which you feel are a problem at present because of your unemployment? (Yes 1 No 2)

(If yes) can you tell me what they are?
(No ranking)

---

33. (a) Could you please tell me if you feel that people have been helping and supporting you since the redundancies were announced/you have become unemployed?

(Explain - not just financial) (Yes 1 No 2)

(b) (If yes) who do you feel has been giving you the most help and support?

(c) In what way do you feel they have been helping and supporting you?

Now finally I have to ask you a few personal questions.

34. Could you please tell me what age you were on your last birthday?

35. Could you please tell me are you :

(Display card 10)

Single	1
Married	2
Separated/Divorced	3
Widowed	4
Other	5

36. What was you usual occupation before you became unemployed?

---

37. Can you tell me how many adults aged 16 and over live in your household (including self)?

38. How many children aged fifteen or less live in your household?

39. (a) How old were you when you finished school education?

(b) Did you undertake an apprenticeship?

full time further education?
part time education?
other types of training?

(Yes 1 No 2)

40. Could you please tell me into which group your total weekly household income falls? (Including benefits, rent allowance etc).

(Display card 11)

£ 50 - 69
70 - 89
90 - 109
110 - 129
130 - 149
150 - 169
170 - 189
190 +

41. Are you receiving supplementary benefit?

(Yes 1 No 2)

42. Sex Female 1 Male 2

43. Health profile

Before 1
After 2

44. Interview Number.

APPENDIX 6

1. a. Are you in paid employment at present?

(Yes 1 No 2)

b. (If yes) How long have you been working this time?
(In weeks. Round up days) Go to Q5.

2. a. (If no go to Q3) Since we last talked have you been in paid employment at all?

(Yes 1 No 2)

b. (If yes) How long were you in paid employment?
(In weeks. Round up days)

3. Could you please tell me if any of these people are unemployed at present?

Someone in your immediate family
Other relatives
Close friends

(Yes 1 No 2)

4. (a) Now can you tell me please do you miss working or being at work?

(Yes 1 No 2)

Now I would like to ask you some questions about food.

5. (a) Since the last time we talked have you made any changes at all in the type or quantity of food you eat?

(If no go to Q6) (Yes 1 No 2)

(b) (If yes) could you tell me what changes you have made? (Allow two responses. No ranking)

(c) and could you tell me what made you change? (Allow two responses. No ranking)

---

6. Could you tell me what are the main difficulties you have in providing the kind of food you would like to.

---

7. (a) If there any kind of food you would like to eat more of but you cannot afford to buy it?

(If no go to Q8) (Yes 1 No 2)

(b) (If yes) what if it?
(Allow two responses. No ranking)

---

8. (a) Are you on a special diet of any kind?

(Yes 1 No 2)

(b) (If yes) what is the reason for being on a special diet?

Now I would like to ask you some questions about exercise.

9. Since we last talked have there been any changes in relation to how often you take part in vigorous exercise such as swimming, cycling, running, squash or football?

(Display Card 1)	Never	1
(Refer to last interview)	Less than once a month	2
	1-2 times a month	3
	3-4 times a month	4
	2-3 times a week	5
	Almost every day	6

10. How about taking part in other forms of exercise such as taking long walks, gardening or golf?

(Refer to last interview)

Never	1
Less than once a month	2
1-2 times a month	3
3-4 times a month	4
2-3 times a week	5
Almost every day	6

11. a. Since we last talked has your general activity pattern changed in any other way?

(Yes 1 No 2)

b. (If yes) Could you tell me in what way it has changed?

Now I would like to ask you some questions about your health.

12. At present are you taking any of the following medicines or pills?

	Every day or almost	At least 1/week	Less often 1/week	Never rarely
Tranq/Sleeping pills	3	2	1	0
Other prescribed	3	2	1	0
Not prescribed	3	2	1	0

13. (a) Since the last time we talked how many times have you seen a doctor?

(b) Could you tell me the reason for seeing your doctor. Was it because of :

Illness	1
Injury	2
Other	3

14. (a) Could you tell me it you feel your health has changed in any way since we last talked?

(Yes 1 No 2)

(b) (If yes) In what way do you feel it has changed?

Now I would like to ask you some questions about drinking.

15. (a) The last time we talked you said that you had a drink _____. Do you still take a drink _____?

(Yes 1 No 2)

(b) (If no) How often do you now take a drink?

Most days	1
Never	2
Every week	3
< Every week	4
Rarely	5

16. How much of the following drinks do you consume on average in a week?

(Display card 5)

Beer/lager/Stout/Cider	$\frac{1}{2}$ Pints	----------
Sprits/Liquers	measures	----------
Port/Sherry/Martini	glasses	----------
Wine	glasses	----------
Total number of units		----------

Now I would like to ask you some questions about smoking. (Refer to last interview)

17. (a) Do you still smoke?

(Yes 1 No 2)

(b) (If non smoker at last interview)
Have you started smoking since we last talked?

(Yes 1 No 2)

(c) Could you please tell me how many cigarettes you smoke per day?

(d) How many cigars do you smoke per day?

(e) How much pipe tobacco do you smoke per day? (in oz)

18. (a) Since we last talked has your smoking behaviour changed in anyway? (Ask everyone)

(Yes 1 No 2)

(b) (If yes) Can you tell me in what way it has changed?

(c) And can you tell me why it has changed?

Now I would like to ask you some questions about your household budget.

19. Could you tell me how much your household/you has to spend now compared with when you were working.

(Display card 6)

More than before	1
Same as before	2
About three quarters	3
About half	4
About a quarter	5
Less than a quarter	6

20. Could you tell me which three items you give most priority to in your household/your budget at present? Here are some examples. (Rank most important first)

(Display card 7)	Rent/Mortgage/Rates	1
	Fuel	2
	Food	3
	Clothes	4
	Cigarettes	5
	Alcohol	6
	Cinema, football match and other outings	7
	Holidays	8
	Household furnishings	9
	Other	10

21. Could you tell me which three items you give least priority to in your household /your budget at present? (Rank least important first).

(Display card 7)	Rent/Mortgage/Rates	1
	Fuel	2
	Food	3
	Clothes	4
	Cigarettes	5
	Alcohol	6
	Cinema, football match and other outings	7
	Holidays	8
	Household furnishings	9
	Other	10

22. At present when you are short of money are you cutting back on ?:

Rent/Mortgage/Rates	
Fuel	
Food	
Clothes	
Cigarettes	
Alochol	
Cinema, football match and other outings	
Holidays	
Household furnishings	
Other	

(Yes 1 No 2)

23. Can you tell me please how much money on average your household spends on food per week?

(Display card 8)

£10 - 19	1
20 - 29	2
30 - 39	3
40 - 49	4
50 - 59	5
59 +	6

24. Could you tell me what you feel are the main difficulties in household budgeting at present?

Now I would like to ask you some questions about problems you might be experiencing at present. (Do not ask employed c,g,h,n).

25. Could you please tell me if any of the following are a problem for you at present?

(Display card 9)

(a) Managing on the money you have. (Yes 1 No 2)

(b) Not being able to do the things you like to do because you are short of money. (Yes 1 No 2)

(c) Being financially supported by others. (Yes 1 No 2)

(d) Not knowing what is going to happen to you in the future. (Yes 1 No 2)

(e) Keeping yourself from being bored. (Yes 1 No 2)

(f) Finding useful ways to spend your time. (Yes 1 No 2)

(g) Not getting the offer of a suitable job. (Yes 1 No 2)

(h) Keeping looking for a job. (Yes 1 No 2)

(i) Living up to what other people expect of you. (Yes 1 No 2)

(j) keeping up with former social contacts. (Yes 1 No 2)

(k) Getting on with your wife/husband/ cohabittee/parents. (Yes 1 No 2)

(l) Your children's behaviour. (Yes 1 No 2)

(m) Dealing with people at the tax/social security offices or Job Centre. (Yes 1 No 2)

(n) Are there any other things which you feel are a problem at present because of your unemployment? (Yes 1 No 2)

(If yes) can you tell me that they are?
(No ranking)

---

26. (a) Now the last time we talked you said that

---

was a problem for you. This time you say it is not a problem. Can you perhaps explain that for me?

(b) And the last time we talked you said that

---

was not a problem for you but this time you say it is a problem. Could you perhaps explain that for me?

---

27. (a) Could you please tell me if you feel that people have been helping and supporting you since the last time we talked?

(Explain - not just financial) (Yes 1 No 2)

(b) (If yes) Who do you feel has been giving you the most help and support?

(c) In what way do you feel they have been helping and supporting you?

Now finally I have to ask you a few personal questions.

28. Could you please tell me are you still:
(Refer to last interview)
(Display card 10)

Single	1
Married	2
Separated/Divorced	3
Widowed	4
Other	5

29. Can you tell me how many adults aged 16+ and over live in your household (including self)?

30. How many children age 15 or less live in your household?

31. Could you please tell me into which group your total weekly household income falls? (Including benefits, rent allowance etc).

(Display card 11)

£ 50 - 69
70 - 89
90 - 109
110 - 129
130 - 149
150 - 169
170 - 189
190 +

32. Are you receiving supplementary benefit?

(Do not ask employed) (Yes 1 No 2)

33. Health profile

Before 1
After 2

34. Interview Number.

APPENDIX 7

HEALTH PROFILE

BEFORE YOU START

Please be sure to read the instructions

1. Study No. ☐☐☐☐

PLEASE DO NOT WRITE IN THIS MARGIN

LISTED BELOW ARE SOME PROBLEMS PEOPLE MAY HAVE IN THEIR DAILY LIFE.
LOOK DOWN THE LIST AND PUT A TICK IN THE BOX ☑ UNDER YES FOR ANY PROBLEM YOU HAVE AT THE MOMENT.
TICK THE BOX UNDER NO FOR ANY PROBLEM YOU DO NOT HAVE.

PLEASE ANSWER EVERY QUESTION. IF YOU ARE NOT SURE WHETHER TO SAY YES OR NO, TICK WHICHEVER ANSWER YOU THINK IS MORE TRUE AT THE MOMENT.

	YES	NO
I'm tired all the time	☐	☐
I have pain at night	☐	☐
Things are getting me down	☐	☐

	YES	NO
I have unbearable pain	☐	☐
I take tablets to help me sleep	☐	☐
I've forgotten what it's like to enjoy myself	☐	☐

	YES	NO
I'm feeling on edge	☐	☐
I find it painful to change position	☐	☐
I feel lonely	☐	☐

	YES	NO
I can only walk about indoors	☐	☐
I find it hard to bend	☐	☐
Everything is an effort	☐	☐

PLEASE DO NOT WRITE IN THIS MARGIN

	YES	NO
I'm waking up in the early hours of the morning	☐	☐
I'm unable to walk at all	☐	☐
I'm finding it hard to make contact with people	☐	☐

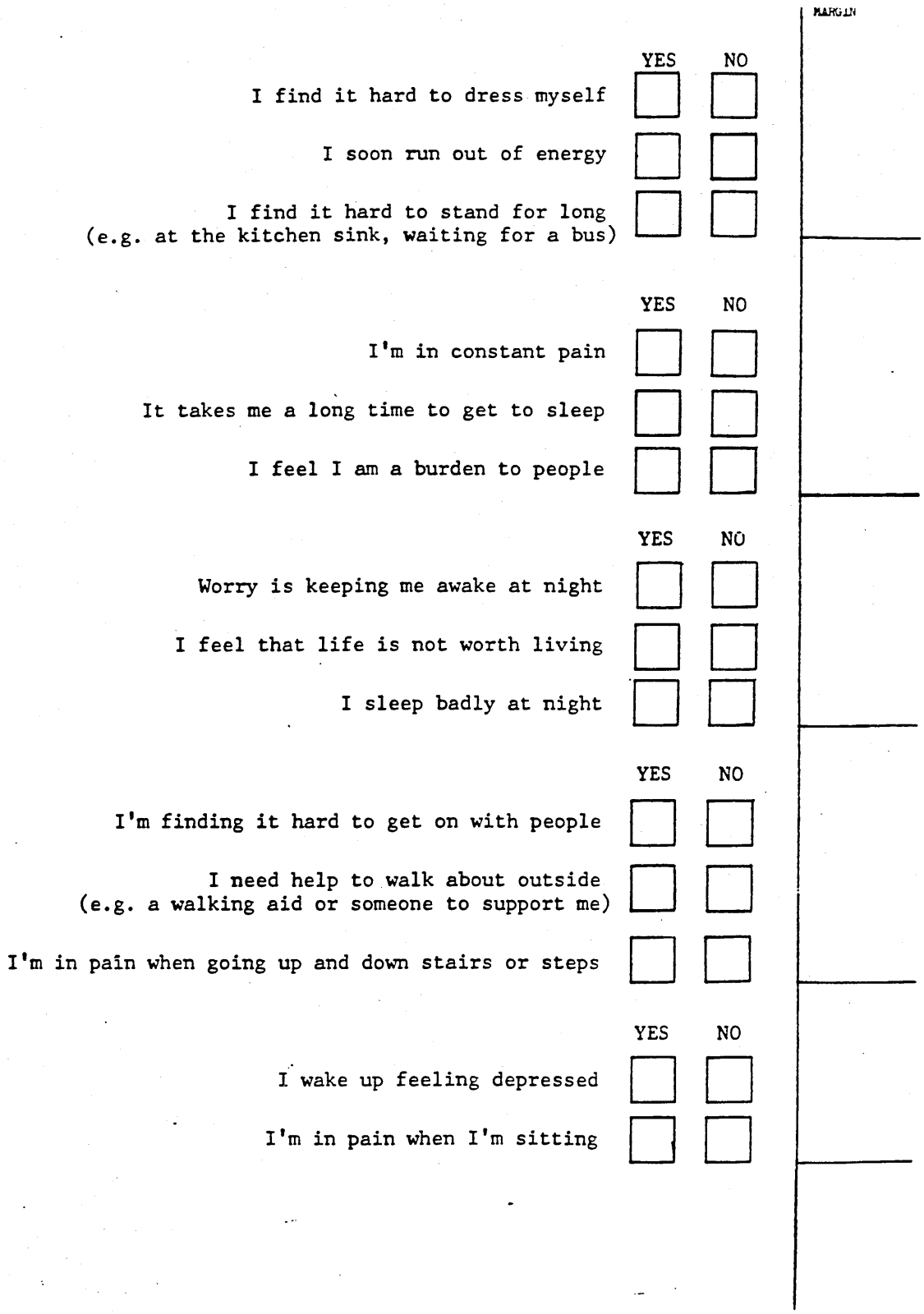
	YES	NO
The days seem to drag	☐	☐
I have trouble getting up and down stairs or steps	☐	☐
I find it hard to reach for things	☐	☐

REMEMBER IF YOU ARE NOT SURE WHETHER TO ANSWER YES OR NO TO A PROBLEM, TICK WHICHEVER ANSWER YOU THINK IS MORE TRUE AT THE MOMENT.

	YES	NO
I'm in pain when I walk	☐	☐
I lose my temper easily these days	☐	☐
I feel there is nobody I am close to	☐	☐

	YES	NO
I lie awake for most of the night	☐	☐
I feel as if I'm losing control	☐	☐
I'm in pain when I'm standing	☐	☐

Please turn over


MARGIN
YES
NO
I find it hard to dress myself
I soon run out of energy
I find it hard to stand for long
(e.g. at the kitchen sink, waiting for a bus)
YES
NO
I'm in constant pain
It takes me a long time to get to sleep
I feel I am a burden to people
YES
NO
Worry is keeping me awake at night
I feel that life is not worth living
I sleep badly at night
YES
NO
I'm finding it hard to get on with people
I need help to walk about outside
(e.g. a walking aid or someone to support me)
I'm in pain when going up and down stairs or steps
YES
NO
I wake up feeling depressed
I'm in pain when I'm sitting

Please do not write in this margin

HOW WOULD YOU DESCRIBE YOUR HEALTH AT PRESENT?

	YES
Very Good	☐
Good	☐
Fair	☐
Poor	☐
Very Poor	☐

NOW PLEASE GO BACK TO PAGE 1 AND MAKE SURE YOU HAVE ANSWERED YES OR NO TO EVERY QUESTION ON EACH PAGE.

THANK YOU FOR YOUR HELP

I would be grateful if you would keep this diary of all the food and drink you consume on each day of the next week from Monday to Sunday. Here is an example of how to fill in the diary.

Monday

Time	Food and Drink
Morning	White toast with margarine and jam Cup of coffee with sugar and milk
Mid Morning	Cup of coffee with sugar and milk 1 Digestive biscuit
Mid Day	1 Cheese roll Cup of tea with sugar and milk
Afternoon	Glass of lemonade
Evening/ Tea time	Tinned soup Fried fish with chips, tinned peas White bread with margarine Tea with sugar and milk
During Evening	Cup of coffee with sugar and milk Packet of crisps

Day

Time	Food and Drink
Morning	
Mid Morning	
Mid Day	
Afternoon	
Evening/ Tea Time	
During Evening	

HOW MANY ALCOHOLIC DRINKS DID YOU CONSUME TODAY?

PLEASE STATE _____

HOW MANY CIGARETTES DID YOU SMOKE TODAY?

PLEASE STATE _____

HOW MUCH EXERCISE DID YOU TAKE TODAY?

PLEASE STATE _____

WEIGHTED SCORES FOR 'YES' RESPONSES ON PART I

STATEMENT	WEIGHT	CODE
I'm tired all the time	39.20	EN1
I have pain at night	12.91	P1
Things are getting me down	10.47	EM1
I have unbearable pain	19.74	P2
I take tablets to help me sleep	22.37	SL1
I've forgotten what it's like to enjoy myself	9.31	EM2
I'm feeling on edge	7.22	EM3
I find it painful to change position	9.99	P3
I feel lonely	22.01	SO1
I can only walk about indoors	11.54	PM1
I find it hard to bend	10.57	PM2
Everything is an effort	36.80	EN2
I'm waking up in the early hours of the morning	12.57	SL2
I'm unable to walk at all	21.30	PM3
I'm finding it hard to make contact with people	19.36	SO2
The days seem to drag	7.08	EM4
I have trouble getting up or down stairs or steps	10.79	PM4
I find it hard to reach for things	9.30	PM5
I'm in pain when I walk	11.22	P4
I lose my temper easily these days	9.76	EM5
I feel there is nobody I am close to	20.13	SO3
I lie awake for most of the night	27.26	SL3
I feel as if I'm losing control	13.99	EM6
I'm in pain when I'm standing	8.96	P5

STATEMENT	WEIGHT	CODE
I find it hard to dress myself	12.61	PM6
I soon run out of energy	24.00	EN3
I find it hard to stand for long	11.20	PM7
I'm in constant pain	20.86	P6
It takes me a long time to get to sleep	16.10	SL4
I feel I am a burden to people	22.53	SO4
Worry is keeping me awake at night	13.95	EM7
I feel that life is not worth living	16.21	EM8
I sleep badly at night	21.70	SL5
I'm finding it hard to get on with people	15.97	SO5
I need help to walk about outside	12.69	PM8
I'm in pain when going up or down stairs or steps	5.83	P7
I wake up feeling depressed	12.01	EM9
I'm in pain when I'm sitting	10.49	P8

PROFILE OF RESPONDENTS

Case Study Nos	Nos of Inter-Views	Gender	Age	Marital Status	Household composition	Length of Unemployment	Previous Spells of Unemployment	Previous Occupation	Service in Last Occupation	Redund-ancy	Inter-View Situation
1	1	Male	44	Married	3 Adults 1 child	0 weeks	2	Mechanical Inspector	11 years	Yes	Home
2	1	Male	40	Divorced	1 Adult	At least 10 weeks	1	Senior Process Operator	1 year	No	College
3	1	Male	38	Single	3 Adults	23 weeks	3	Various Unskilled	1 year	No	College
4	1	Female	28	Married	2 Adults 1 Child	At least 26 weeks	1	Various Unskilled	1 year	No	Home
5	2	Male	46	Married	2 Adults 1 Child	18 weeks	0	Electronic Product Technician	22 years	Yes	Home
6	2	Male	59	Married	2 Adults	At least 24 weeks	1	Various Clerical	1 year	No	Home
7	2	Female	25	Separ-ated	1 Adult 2 Children	At least 28 weeks	1	Railway Guard	6 months	No	Home
8	2	Male	18	Single	4 Adults	At least 38 weeks	1	None	6 months	No	Home
9	3	Male	20	Single	4 Adults 1 Child	32 weeks	2	Y.T.S. Community Programme	1 year	No	College

Case Study Nos	Nos of Inter-views	Gender	Age	Marital Status	Household Composition	Length of Unemployment	Previous Spells of Unemployment	Previous Occupation	Service in Last Occupation	Redund-ancy	Inter-view Situation
10	3	Male	56	Married	2 Adults	34 weeks	0	Electronic Product Technician	13 years	Yes	Home
11	3	Male	36	Married	2 Adults 1 Child	34 weeks	1	Product Operator	13 years	Yes	Home
12	3	Male	22	Single	4 Adults	37 weeks	6	Various Unskilled	1 year	No	Home
13	3	Male	28	Single	1 Adult	40 weeks	2	Brick Layer	1 year	No	Home
14	3	Male	24	Single	3 Adults	At least 42 weeks	1	Cabinet Maker	1 year	No	College
15	3	Male	22	Single	1 Adult	1 year	3	Y.O.P. Community Programme	5 months	No	Home
16	4	Male	37	Separ-ated	3 Adults	At least 1 year	1	Caulker	1 year	No	College
17	4	Female	47	Married	3 Adults 1 Child	At least 1 year	1	Shop Assistant	6 months	No	Home
18	4	Female	49	Single	2 Adults	At least 1 year	1	Various Secretarial	7 months	No	College

CASE STUDY NO. ONE (MR B)

NUMBER OF INTERVIEWS: One
SUBJECT: Male
AGE: 44
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Two Adults / Two Children
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Mechanical Inspector
LAST EMPLOYMENT: Company X
SERVICE IN LAST EMPLOYMENT: 11 years
REDUNDANCY PAYMENT: Yes
ATTRIBUTION OF UNEMPLOYMENT: Corporate Management
DURATION OF PRESENT UNEMPLOYMENT: Zero Weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No (Wife not employed)
Other Relatives : Yes
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT : Two

Interview One

PERCEPTIONS OF UNEMPLOYMENT

Interviewed four days after being made redundant. Had immediately obtained other employment. Household income £170.00 - £180.00 per week slightly less than previously. No financial problems because of redundancy payment. No other problems.

PERCEIVED SOCIAL SUPPORT

Wife had been very supportive throughout. Had helped to keep his spirits up. "In the day time you've got your mates to keep you going, but at night you need somebody else. My wife has even phoned me at work to tell me if any letters have arrived about job applications".

HEALTH RELATED BEHAVIOUR

Diet

No changes made in type or quantity of food eaten. Some awareness of health issues. Had been trying to eat more vegetarian dishes. Using oil instead of solid cooking fat. Started growing bean sprouts for Vitamin C content. Would have liked to have been able to afford more fresh fruit and vegatables. Five meals eaten on weekdays, three meals plus one snack at weekends. Large amount of bread, half white and half brown, consumed. Some indications of health awareness e.g. occasional use of artificial sweetner and low fat milk. But frequent use of honey in tea and sandwiches. Relatively varied diet over the week with some fruit and vegetables. However fried fish and chips twice and processed meat e.g. pies four times in the week.

Exercise

No vigorous exercise. Main activities gardening and walking. Less active since the redundancies had been announced because he had not felt like doing very much. Did not feel need for more exercise because occupation fairly active. Diary no exercise recorded.

Alcohol Consumption

Drank alcohol once a week. Two pints beer plus one whisky per week. Three units recorded in diary. No change in drinking behaviour since the redundancies had been announced.

Smoking Behaviour

Ex-smoker.

Medicine Use/Doctor Consultations

No prescribed or non prescribed medicines. No medical consultations in previous four months.

HOUSEHOLD BUDGETING

On average £40 - £49 spent on food per week. Priorities - food, rent and clothes - least important alcohol and holidays. But financially secure and rarely had to reduce expenditure on anything.

SUBJECTIVE HEALTH STATUS

No change in perceived health since redundancies announced and rated it as "Very good".

N.H.P. score : SLEEP - 12.57 (General Pop. Mean - 11.9)

SUMMARY

Mr B felt that he had been very lucky getting another job so quickly and although the period after the redundancies had been announced had been filled with uncertainties he did not think there would be any lasting effects on himself or his family.

CASE STUDY NO. TWO (MR C)

NUMBER OF INTERVIEWS: One
SUBJECT: Male
AGE: 40
MARITAL STATUS: Divorced
HOUSEHOLD COMPOSITION: One Adult
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Senior Process Operator
LAST EMPLOYMENT: M.S.C. Community Programme (part time)
SERVICE IN LAST EMPLOYMENT: One year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: The Government
DURATION OF PRESENT UNEMPLOYMENT: At least 10 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: One

Interview One (Unemployed 10 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Prior to community programme had been made redundant. Felt this to have been main cause of his divorce. Missed the activity of working and the money. Income £36 per week (plus rent allowance) - about one quarter of earnings as process operator and about half of earnings on Community Programme. Having problems managing. Prevented from doing many things because money was short. Worried about getting another job. Very concerned about the future.

PERCEIVED SOCIAL SUPPORT

Little except from sister and nephew, who had been looking out for employment for him.

HEALTH RELATED BEHAVIOUR

Diet

Reported missing meals because felt less active and got up later in the morning. Diary indicated both breakfast and lunch eaten every day. Little variety - sausages or pies daily, fried food five times. Potatoes, chips, peas and beans main vegatables. Fresh vegetables and fruit once only. White bread and rolls. Sugar in tea. Would like steak but could not afford it. Thought he should eat tripe for health but did not know how to cook it. Had never considered changing the type of food he ate " I like curries, chips, chilli. I like what I eat."

Exercise

Exercise pattern had not changed since stopping work. Bowls and walked long distances several times a week. Not motivated to take more exercise. "I'm too lazy". Thought the only thing that would make it easier would be "Getting a pay at the end of it."

Alcohol Consumption

Drank alcohol three or four times every week. On average twelve pints of beer (29 units) per week. Diary sixteen pints beer (32 units). No change in drinking behaviour but thought he should reduce consumption. Had tried but found it difficult because he enjoyed drinking and thought the only way it could be done was "Close the pubs! That's the only way."

Smoking Behaviour

Twenty cigarettes per day. No change since stopping work. Had given up smoking for a period of two years before but felt he had no willpower now to do so.

Medicine Use/Doctor Consultations

No medication. No medical consultations.

HOUSEHOLD BUDGETING

£10 - £19 spent on food per week. Rent deducted at source. Priorities, fuel and food, the least important being alcohol, social outings and holidays. When money short expenditure on alcohol and cigarettes reduced.

SUBJECTIVE HEALTH STATUS

Health percieved as "very good". No change since stopping work.

N.H.P. : Zero scores on all sections.

SUMMARY

Worried about the future. Little evidence that health affected by unemployment. Previous unemployment may have influenced this. Food consumption was unvaried but this was probably not due to shortage of money. Alcohol and cigarette consumption had remained the same as when working. Despite some financial strain these were seen as two of the few remaining pleasures in life.

An attempt to contact Mr C was made fourteen weeks later but the letter was "returned to sender."

CASE STUDY NO. THREE (Mr Q)

NUMBER OF INTERVIEWS: One
SUBJECT: Male
AGE: 38
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: Three Adults
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Various Unskilled
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One Year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Partly self partly Government
DURATION OF PRESENT UNEMPLOYMENT: 23 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : Yes
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: Three

Interview One (Unemployed seven weeks)

PERCEPTIONS OF UNEMPLOYMENT

Previously had left employment to do voluntary work abroad and did not miss work. "If I could afford not to work I wouldn't because I can fill in my time doing different things.... Why should I spend my time working for somebody else and get peanuts at the end of the week and they're making million's profit? I can go and help someone and get self satisfaction. I enjoy that."

Personal income £30 (about half of previous earnings). Total household income about £150 per week. Had problems managing. Two student sisters paying his share of mortgage. This did not cause him concern. Not worried about future. "Nobody can tell what's going to happen tomorrow ....The Lord will provide." No problems finding useful ways

of filling time. "The problem is trying to find enough time to do things. When I was working full time I don't know how I managed to do all the things." Constantly seeking work. Visited different Job Centres several times every week. Problem was finding job with reasonable pay to make it worthwhile.

PERCEIVED SOCIAL SUPPORT

Sisters very supportive since he had stopped work. However incensed that D.H.S.S. expected student sisters to support him financially, since if they threw him out, a council house would have to be provided and furnished.

HEALTH RELATED BEHAVIOUR

Diet

Reported eating more because at home more. Suffered from colitis. Had to take care over fibre content of diet. Apart from that felt diet was fairly varied. Three meals and three snacks eaten most days. Variety of fresh and processed meats plus eggs, cheese, pizza. Potatoes everday (twice as chips). Small amounts of fresh or tinned vegetables four times. White bread and rolls with butter or magarine. Felt that varied diet was important for health. Could not think of any food he would like to eat more of but could not afford.

Exercise

More exercise than when working because more time. Cycling most days, walking long distances several times a week.

Alochol Consumption

Drank alcohol only occasionally depending upon social activity. Estimated consumption averaged out over year at 1 pint beer per week. Drinking less than when working because of expense.

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

Pills everyday for colitis but condition no worse than when working. Consulted doctor six times in previous four months for this condition.

Household Budgeting

£30 - £39 spent on food per week. Priorities mortgage, food and household furnishings, the least important being alcohol and social outings. When money was short expenditure not reduced on food but on clothes. This proved problematic when going for interviews since Mr Q felt he had to be smartly dressed.

Subjective Health Status

Health perceived as "Very Good." No change since stopping work.

N.H.P. scores : Zero on all sections.

Summary

Apparent that unemployment posed few problems for this subject. Main function of employment was to provide money. Mr Q could be considered an example of the "Proactive" unemployed described by Fryer and Payne [73].

A second interview arranged but subject did not keep appointment. He had regained employment.

CASE STUDY NO. FOUR (MRS M)

NUMBER OF INTERVIEWS: One
SUBJECT: Female
AGE: 28
MARITAL STATUS: Married - second time
HOUSEHOLD COMPOSITION: Two adults/one child
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: None
PREVIOUS OCCUPATION: Various unskilled
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One Year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: The Government
DURATION OF PRESENT UNEMPLOYMENT: At least 26 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : Yes
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: One (eight years after birth of son)

Interview One (Unemployed 12 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed extra income provided by employment. Also missed company and had found job interesting. Husband working. Total weekly income about £100 (about half of income when she was working). Having problems managing on this amount. Worried about not finding suitable job and about the future. No problems filling the day. Had housework and son to deliver and collect from school. Some marital problems with new husband but did not appear to be related to her unemployment.

PERCEIVED SOCIAL SUPPORT

Apart from husband no-one else supportive since she had stopped work. " Since I got married and he's working, and we've got a car everybody thinks we've got loads of cash. I think if I'd been on my own, you know, with the boy, things would've been much worse."

HEALTH RELATED BEHAVIOUR

Diet

Since not working making more fresh meals rather than convenience products because more time. Had thought she should make even more products herself. "It's better for your health. At least you know what's in the things then." Expense of buying special ingredients prevented this. Thought she should eat brown bread and breakfast cereals for health but did not like taste. Would have liked more good quality meat instead of processed meats but could not afford. Had an ulcer but did not keep to special diet unless in extreme pain. Diary indicated food intake quite low. No proper meal until evening. During day lemonade, biscuits and crisps. Processed meats e.g. sausages three times, chips five times, fried fish once. Fresh fruit and vegatables infrequent. Peas three times, cauliflower once, fresh fruit once.

Exercise

Walked long distances almost everyday. No change since stopping work. Had never felt need to take more exercise "I've always been one for walking and I'm not overweight so I don't think I have to".

Alcohol Consumption

Drank alcohol less often than every week because of expense. No alcohol recorded in diary. No change in drinking behaviour since stopping work.

Smoking Behaviour

Forty cigarettes per day. More than when working. Reported reason - "Nerves, you know I don't have trouble filling in the day so it must be nerves". Had considered stopping but no will power. Could not think of anything that would make it easier.

Medicine Use/Doctor Consultation

Taking sleeping pills several times a week. Problem had not worsened since stopping work. Had consulted doctor three times in previous four months because of illness.

HOUSEHOLD BUDGETING

£30 - £39 spent on food per week. Priorities, rent, fuel and food and least important alcohol, holidays and social outings. When money was short expenditure on food, clothes, alcohol and social outings reduced.

SUBJECTIVE HEALTH STATUS

Health perceived as "Good". No change since stopping work.

N.H.P. Scores : Zero scores for four sections;

Emotional Reactions : 30.93 (General Pop. Mean 14.7)

Sleep 60.17 (General Pop. Mean 9.7)

SUMMARY

Some evidence of financial strain. Some of reported dietary changes should have brought about improvements but diary indicated little variety. Also some valuable nutrients might have been deficient. Increase in smoking cause for concern. Apparent that Mrs M had emotional and sleep problems but not possible to say this due to

unemployment.

Second interview arranged three months later but on calling subject was out. Further letter sent but no reply received.

CASE STUDY NO. FIVE (MR D)

NUMBER OF INTERVIEWS: Two
SUBJECT: Male
AGE: 46
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Two adults/one child
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Electronic product technician
LAST EMPLOYMENT: Company X
SERVICE IN LAST EMPLOYMENT: 22 years
REDUNDANCY PAYMENT: Yes
ATTRIBUTION OF UNEMPLOYMENT: Corporate Management
DURATION OF PRESENT UNEMPLOYMENT: 18 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate family : no (wife not employed)
Other relatives : no
Close friends : yes

PREVIOUS SPELLS OF UNEMPLOYMENT: None

Intervew One (Unemployed two weeks)

PERCEPTIONS OF UNEMPLOYMENT

Mr D missed working. Felt it was his duty to provide for family. Also missed mental activity provided by work. No financial problems because of large redundancy payment. Worried about the future particularly because of his age.

PERCEIVED SOCIAL SUPPORT

Wife and three daughters had kept his morale up since the redundancies announced.

HEALTH RELATED BEHAVIOUR

Diet

No change since stopping work. Three meals each day. Variety of food eaten. Mixture of fresh and processed meats. Fish twice. Fried food six times. No fresh fruit. Fresh vegetables five times and potatoes six times. Had never considered changing diet because quite happy with it. No food he thought he should eat for health. No food which could not be afforded.

Exercise

No vigorous exercise. Walked a good deal, played bowls two or three times a week. Felt he was taking more exercise than when working but thought he should take even more. Intended to do something about it.

Alcohol Consumption

Drank alcohol several times a week. Consumed five pints beer and three whiskys (13 units) per week. Diary 12 pints beer and eight whiskys (28 units) recorded. Had never thought of reducing consumption because did not feel he drank too much. Thought he had been drinking less since redundancies announced.

Smoking Behaviour

Twenty cigarettes per day. Fewer than before because he was fed up with smoking. While working smoked cigars but had stopped because of expense. Was considering stopping all together. Could not think of anything which would make it easier.

Medicine Use/Doctor Consultations

No medication. One consultation in previous four months because of injury.

HOUSEHOLD BUDGETING

£50 - £59 spent on food per week. Priorities rent, fuel, food, least important alcohol, cigarettes and social outings. No shortage of money in past but did not know how things would work out in the future.

SUBJECTIVE HEALTH STATUS

Health perceived as "Very Good". No change since stopping work.

N.H.P. Scores : Zero scores on all sections.

SUMMARY

Little evidence of changes in health behaviour or expenditure patterns. Pessimistic about regaining employment. Worried about future. No evidence that health affected by redundancy.

Interview Two (Unemployed eighteen weeks re-employed six weeks)

PERCEPTIONS OF UNEMPLOYMENT

Employed as library caretaker. Household income about half of previous earnings but no financial problems. Situation helped because rent reduced in line with earnings. No longer worried about future. "There's no many people in this day and age, especially at forty six can turn and say - well that's me till I'm sixty five." Serious consideration had been given to leaving area to look for work. "Because I don't agree with Norman Tebbit but I believe in ma own dignity and I wud have tae work and feed ma own family."

PERCEIVED SOCIAL SUPPORT

No change.

HEALTH RELATED BEHAVIOUR

Diet

Did not feel diet had changed but less money now spent on food. This could not be confirmed since diary not returned.

Exercise

Less than previously because bowling season finished. Also at weekend felt he had done his work so tended to take it easy. Could no longer attend choir practices because of working hours. Had been a member for years and enjoyed comradeship. This activity sadly missed.

Alcohol Consumption

Still drinking several times a week but drinking at home because of working hours. Now drinking five pints beer and half bottle whisky (22 units) per week.

Smoking Behaviour

Less than 20 cigarettes per day because smoking only allowed at tea breaks.

Medicine Use/Doctor Consultations

No medication. One consultation since previous interview because of illness.

HOUSEHOLD BUDGETING

No change but £10 less spent on food per week.

SUBJECTIVE HEALTH STATUS

Health perceived as "Very Good". Felt that it had improved since starting work. "I felt myself going into a shell, you know, that just wasnae for me - the type of person I am. I was always involved wi people and groups and various things. So I was getting a bit scared and I must admit that because I didnae know what was ahead for me." Had started feeling this way about two months after redundancy. "All the holidays were over - the euphoria - bags of cash!" Could only think about future. "I think I was heading for depression - God forbid it - but I was really worried and I didnae know where tae turn. I knew I had tae keep looking ahead - but what was there?"

N.H.P. Scores : zero scores on all sections.

SUMMARY

Little evidence of financial problems possibly due to redundancy payment. While Mr D did not feel diet had changed, less money being spent on food. Perhaps indication that wife was economising without making drastic changes. Changes in other health behaviours due to changes in situational factors. Had obviously found unemployment a stressful experience. Appears he went through some phases described in previous studies.

CASE STUDY NO. SIX (MR W)

NUMBER OF INTERVIEWS: Two
SUBJECT: Male
AGE: 59
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Two adults
AGE COMPLETED SCHOOL: 14
OTHER EDUCATION: Full-time Further Education Course
PREVIOUS EMPLOYMENT: Various - Clerical
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Margaret Thatcher
DURATION OF PRESENT UNEMPLOYMENT: At least 24 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate family : No
Other relatives : No
Close friends : Yes

PREVIOUS SPELLS OF UNEMPLOYMENT: One (two months)

Interview One (Unemployed six weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed money and companionship provided by work. Receiving sickness benefit. Total household income £150 - £169 per week (about three quarters of income when working). Being financially supported by wife (worked full-time) was a problem as was living up to other's expectations. Not worried about future but worried about not finding suitable job.

PERCEIVED SOCIAL SUPPORT

No perceived support since stopping work. People too busy with own lives. Did not feel wife had been supportive. "My wife doesn't appreciate that I've been the breadwinner for thirty odd years and now it's her turn."

HEALTH RELATED BEHAVIOUR

Diet

Reported eating more since stopping work because of boredom. Since developing Diabetes had changed diet to include more dietary fibre. No food he thought he should eat for health. No food which could not be afforded. Unfortunately diary not completed.

Exercise

Very little exercise of any kind. Less than when working. Thought he should take more. Considering buying exercise bike.

Alcohol

Consumed two and a half pints of beer and ten whiskys per week (fifteen units). Had thought of reducing consumption but enjoyed drinking. Thought it was part of life. Drinking less than when working because did not go out so often.

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

Tablets everyday for Diabetes and Angina. Visited doctor for regular checkups.

HOUSEHOLD BUDGETING

Amount spent on food unknown. Priorities mortgage, food and clothes, the least important being social outings, household furnishings and alcohol. Household never really short of money.

SUBJECTIVE HEALTH STATUS

Perceived health when working "fair". Thought it had improved now "good".

N.H.P. Scores : zero scores on all sections except

Emotional Reactions 17.69 (General Pop. Mean 7.7)

SUMMARY

Relatively financially secure because wife working. Although not worried about future, pessimistic about regaining employment because of age. Little evidence of changes in health behaviour since stopping work except eating more and exercising less. Perceived health had improved but responses to N.H.P. indicated that things were getting him down and that he was feeling on edge.

Interview Two (Unemployed 24 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Had partially lost eyesight overnight about two months before interview due to diabetes. Doctors thought improvement unlikely. No longer worried about wife supporting him financially. "We've been married 35 years and I've been working all that time so she should work a few years for me ... It did worry me when I became unemployed at first but not now." Still not worried about future. "It can't get any worse. There's nothing you can do about it. No point in worrying about it. I know one thing, it's very unlikely unless this improves

that I'll ever get a job again." Did not feel bored but because of poor eyesight had problems finding useful things to do.

Some evidence of resignation to unemployment. "You've just got to accept something you can't do anything about."

PERCEIVED SOCIAL SUPPORT

Still no perceived support. "Nothing much anyone can do. My wife helps as much as she can. It's frustrating for her as well."

HEALTH RELATED BEHAVIOUR

Diet

No reported changes. Diary not completed.

Exercise

Even less active because no confidence to go out on his own.

Alcohol Consumption

Now drinking at home. Some evidence that consumption had increased. Now drinking two cans beer every night and half bottle whisky per week (22 units).

Smoking Behaviour

Still non-smoker.

Medicine Use/Doctor Consultations

Medication unchanged. Visiting doctor more frequently.

HOUSEHOLD BUDGETING

No change. Standard of living same but less money saved.

SUBJECTIVE HEALTH STATUS

Perceived health had deteriorated now "fair". "I haven't accepted losing my eyesight. I used to think I was very positive. But I feel I haven't started fighting back. I'm hoping for a miracle. Get on with it! But I haven't reached that situation yet. Maybe when I do I'll get up and get out and cross the road and get on with it. But it's difficult to get your confidence back." Due to the circumstances the N.H.P. completed by author. This may have influenced responses.

N.H.P. Scores : Zero scores on only four sections now.

Emotional Reactions 17.69 (general pop. mean 7.7) - Same

Social isolation 22.53 (general pop. mean 3.4) - Increase

SUMMARY

Apparent that loss of eyesight had caused many of changes identified and exaccerbated some of problems associated with unemployment. Some evidence that alcohol consumption had increased. May have been way of trying to cope. Unemployment had been accepted but loss of eyesight had not. This possibly contributed towards poorer perceived health.

CASE STUDY NO. SEVEN (MRS V)

NUMBER OF INTERVIEWS: Two
SUBJECT: Female
AGE: 25
MARITAL STATUS: Separated
HOUSEHOLD COMPOSITION: One adult/two children
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Guard Training, Open University Certificate
PREVIOUS OCCUPATION: Railway Guard
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: Six months
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Self (only one 'O' Grade)
DURATION OF PRESENT UNEMPLOYMENT: At least 28 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate family : Yes
Other relatives : Yes
Close friends : No (none)
PREVIOUS SPELLS OF UNEMPLOYMENT: One (several years)

Interview One (unemployed 11 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed working for company and money. Weekly income £50 - £69 (about quarter of earnings). Large reduction also due to husband leaving her. No contribution from him. Financial problems, worried about future and getting another job, bored, problems with personal relationships.

PERCEIVED SOCIAL SUPPORT

No perceived support. Reason for leaving community programme early because of marital problems. These caused by her father and brother moving in when parents separated. Husband also unemployed.

HEALTH RELATED BEHAVIOUR

Diet

Qualitiative and quantitative changes in diet since stopping work because short of money. Less food purchased. Less fresh meat, vegetables and fruit could be afforded. Varied meal pattern. One day, two meals and one snack. Three days only one meal and one snack. Two days only meal in evening. High consumption of tea. Mixture of fresh and processed meats. Fried food once. Vegetable consumption restricted to potatoes everyday, twice as chips, tinned vegetables three times, fresh twice. One piece fresh fruit. Very little bread. Would have bought more fresh meat, fruit and vegetables if they could be afforded. Thought she should eat salads and wholemeal bread for health but too expensive. Family's diet had changed in last year because son's bowel trouble due to complete absence of dietary fibre.

Exercise

No exercise reported. Much less than when working. Thought she should take more. "I can't be bothered. I'm tired all the time. I even send the wains for the messages cause I'm too embarassed tae go wi nae money."

Alcohol Consumption

Only drank every six weeks or so because of expense. Then would consume about eight vodkas. Quarter bottle vodka recorded in diary on one evening. Celebration for husband gaining employment.

Smoking Behaviour

Twenty roll up cigarettes per day but smoked up to 40 if she had money. Smoking less than when working because of expense. Had never considered stopping. " I like it. I don't believe all that garbage you see on telly."

Medicine Use/Doctor Consultations

History of overdoses. Therefore tried when possible not to take pills. Had been taking sleeping pills prior to interview. Had now stopped. Since then no medical consultations.

HOUSEHOLD BUDGETING

£10 - £19 spent on food per week. Priorities food and fuel, the least important being social outings, alcohol and holidays. When money short expenditure on food and cigarettes reduced. Money for food often short. "If I say tae ma mother I don't have money for food - she says - what dae you want me tae do about it? I'm short!"

SUBJECTIVE HEALTH STATUS

Perceived health when working "very good". Now "good".

N.H.P. Scores : Zero scores for Pain and Physical Mobility

Energy 63.2 (general pop. mean 20)

Emotional Reactions 46.54 (general pop. mean 14.7)

Sleep 77.63 (general pop. mean 9.7)

Social Isolation 57.34 (general pop. mean 6.9)

SUMMARY

Unemployment very problematic but impression was that whole life was problematic. No perceived social support and little social contact. Employment had provided some contact and this clearly was missed. Shortage of money a big problem causing material deprivation and affecting quality of diet. Perceived health "good " but obvious problems in this area. However from information given possible that N.H.P. scores would have been high while working.

Interview Two (Unemployed 28 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Husband employed and now contributing. Household income increased to £70 - £89 per week. Making sure money lasted all week still a problem but not quite so difficult. Between interviews Family Allowance stopped because mother-in-law told Housing Department that they were living together. Mrs V said untrue but now six months pregnant. Had not applied for extra allowances for baby because process an intrusion of privacy. Relationship with husband now improved but still worried about future. "Another wain! And he might not come and live here if he's going tae be worse off financially." Boredom no longer a problem. "Eventually you don't even feel bored. Everyday's the same. Last time I was bored tae tears. Not now." Had intended to apply for Social Work course. "But then I fell pregnant so I can't now. I was heartbroken."

PERCEIVED SOCIAL SUPPORT

Still no perceived support. Rest of family had own problems. Did not support each other.

HEALTH RELATED BEHAVIOUR

Diet

Pregnant therefore eating more. Extra money meant better quality meat could be bought but still little fresh fruit or vegetables. Diary not returned. Changes could not be confirmed.

Exercise

None. Generally less active.

Alcohol Consumption

No change but husband drinking more because he was working.

Smoking Behaviour

Increased to 40 cigarettes per day because more money and had nothing else to do all day.

Medicine Use/Doctor Consultations

Between interviews taking tranquillisers but these stopped when pregnancy discovered. Had not gained weight in first five months so prescribed tonic and iron tablets for anaemia.

HOUSEHOLD BUDGETING

Food expenditure increased to £30 per week. Budgeting priorities same. When money was short now expenditure on fuel and cigarettes reduced.

SUBJECTIVE HEALTH STATUS

Experienced problems associated with pregnancy but feeling better since husband started work. Not so many arguements and not so much worry about money. Perceived health still "good".

N.H.P. Scores : Scores for Energy, Sleep and Social Isolation same.

Emotional Reactions increased from 46.54 to 50.2. (General pop. mean 14.7)

SUMMARY

Increased income resulted in improvements in diet but despite pregnancy an increase in smoking. N.H.P. scores remained high perhaps suggesting little relationship between perceived health and

improved income. Evidence of intention to improve her situation by obtaining qualifications but hopes dashed. Now resigned. Difficult in this case to separate problems associated with unemployment from those associated with marital difficulties and material and social deprivation.

CASE STUDY NO. EIGHT (MR J)

NUMBER OF INTERVIEWS: Two
SUBJECT: Male
AGE: 18
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: Four adults
AGE COMPLETED SCHOOL: 17
OTHER EDUCATION: Uncompleted part-time
PREVIOUS OCCUPATION: None
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: Six months
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Self (only three 'O' Grades)
DURATION OF PRESENT UNEMPLOYMENT: At least 38 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate family : No
Other relatives : No
Close friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: One

Interview One (Unemployed 14 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Supplementary Benefit £23.80 per week (about half of earnings). Difficulty managing on this amount. Other problems - being financially supported by parents, getting a job, keeping looking for a job, other's expectations and worried about future. Parents worked, he looked after house so no difficultly filling time.

PERCEIVED SOCIAL SUPPORT

Parents very supportive. Tried to cheer him up when he was down.

HEALTH RELATED BEHAVIOUR

Diet

Reported no boredom but reported eating more because bored. Three meals and two snacks each day. More processed meats eg hamburgers, than fresh. Potatoes most days, three times as chips. Peas four times. Fresh fruit and vegetables only once each. Had never thought of changing diet because he liked it. But thought he should eat breakfast cereals and fruit for health.

Exercise

No vigorous exercise. Walked dog several times a day. Less exercise than when working. Thought he should take more and intended to do something. If he had more money would be easier.

Alcohol

Drank every weekend. Five pints beer, three vodkas (13 units) per week. Ten units in diary. Had never thought of reducing consumption. Did not think he drank too much. Drinking less now because of expense.

Smoking

Ten cigarettes per day. No change since unemployed. Ten each day in diary except weekends when more smoked. Had thought of giving up but prevented by boredom. If he had something to look forward to or something to do would be easier.

Medicine Use/Doctor Consultations

No medication. One consultation due to illness in previous four months.

HOUSEHOLD BUDGETING

Priorities in personal budget social outings and clothes. Least important being holidays. £10 contributed to household but parents subsidised him frequently. When money short did not go out socially.

SUBJECTIVE HEALTH STATUS

Perceived health when working "very good". Now "fair".

N.H.P. Scores : Zero scores on all sections except Emotional Reactions - 17.55 (general pop. mean 11.6)
Sleep - 3.7 (general pop. mean 8.4)

SUMMARY

Reported no problems with boredom but reason for eating more and continuing smoking was boredom. Also affirmative response to N.H.P. item "The days seem to drag". Less exercise and alcohol. Since parents worked financial problems restricted to personal budget. Had only worked for six months since leaving school but missed working for extra income and company.

Interview Two (Unemployed 32 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working. Other problems remained. Keeping looking for work was getting Mr J down.

PERCEIVED SOCIAL SUPPORT

Unchanged.

HEALTH RELATED BEHAVIOUR

Diet

Had started reducing diet about two months after first interview. Had lost one and a half stones. At Christmas had eaten normally but now back on diet. Reason for diet - "Well apart from people calling me fat all the time I found I couldn't get into shirts and trousers ... and my friend is on a diet so that helps too." Diary showed food consumption reduced considerably. Also types of food eaten changed. More fresh fruit and vegetables. No fried food. Slimming soups or yoghurt instead of snacks. Crisp bread replaced biscuits.

Exercise

Had started taking more exercise. Visiting gym and swimming two or three times per week to lose weight.

Alcohol Consumption

Unchanged.

Smoking Behaviour

Now smoking 15 cigarettes per day because eating less (15 recorded in diary except weekends 20-25).

Medicine Use/Doctor Consultations

No medication. Zero consultations.

HOUSEHOLD BUDGET

Unchanged.

SUBJECTIVE HEALTH STATUS

Health improved. Now perceived as "good". "I feel more fit now, I don't feel so flabby and tired, I feel more lively."

N.H.P. Scores : Zero on all sections.

SUMMARY

Changes in diet and exercise resulting in weight loss contributed to improved perceived health. However reduction in food intake caused increase in smoking. Some suggestions that positive changes made for other than health reasons. Despite improved perceived health unemployment still perceived problematic. Contacted 35 weeks after becoming unemployed for third interview but going to London to seek employment.

CASE STUDY NO. NINE (MR P)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 20
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: Four Adults/One Child
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: None
PREVIOUS OCCUPATION: Y.T.S.
LAST EMPLOYMENT: M.S.C. Community Programme (Part-time)
SERVICE IN LAST EMPLOYMENT: One year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Capitalist System
DURATION OF PRESENT UNEMPLOYMENT: 32 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : Yes
Other Relatives : Yes
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: Two

Interview One (Unemployed six weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed work for extra money but also structured day. "When I'm not working I sleep late and get lazy." Personal income £30 (half of earnings). Problems managing on this amount. Worried about not getting a job. Keeping looking for employment a problem. Difficulties getting on with family.

PERCEIVED SOCIAL SUPPORT

No perceived support.

HEALTH RELATED BEHAVIOUR

Diet

Now missed breakfast when he slept later. Processed meats eg sausages recorded nine times. Fried foods six times. High consumption of white bread. At least one bottle soft drinks (sometimes more) consumed daily. Potatoes everyday, twice as chips, tinned vegetables five times, fresh vegetables twice. Had never thought of changing diet. Enjoyed what he ate. Thought little wrong with it. Thought should eat wholemeal bread for health but did not. "I'm young and I don't need to worry about my health. May be when I'm older I might think about it."

Exercise

No vigorous exercise. Walked long distances two or three times a week. Less exercise than when working. Thought he should take more. "I'm lazy when I'm not working. I don't feel like doing anything."

Alcohol Consumption

Drank once or twice every week. Ten pints beer (twenty units) seven pints in diary (fourteen units). Less than when working because of expense. Never thought of reducing consumption. "I enjoy it. It gets you out. It's something to do."

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

No medication. One medical consultation for injury in previous four months.

HOUSEHOLD BUDGETING

Contributed £10 to household. Priorities in personal budget alcohol. When money was short reduced expenditure on clothes, alcohol and social outings.

SUBJECTIVE HEALTH STATUS

Perceived health as "very good". No change since stopping work.

N.H.P. Scores : Zero on all sections.

SUMMARY

Worried about regaining employment because no "proper" job since leaving school. Structuring the day was difficult but no problems with boredom. Exercise decreased due to situational factors. Alcohol consumption reduced due to lack of money. No evidence of health problems.

Interview Two (Unemployed 25 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed work. Same problems as before but now being financially supported by others was a problem. Boredom also problem, worst in evenings. Difficulty keeping in contact with friends.

PERCEIVED SOCIAL SUPPORT

Felt mother more supportive recently.

HEALTH RELATED BEHAVIOUR

Diet

No changes except now eating fresh fish. Despite two diaries being issued none returned.

Exercise

Unchanged but felt less active than before. Watching great deal of television.

Alcohol Consumption

Drinking less often because short of money. About eight pints beer every two weeks.

Smoking Behaviour

Unchanged.

Medicine Use/Doctor Consultations

No medication. No consultations.

HOUSEHOLD BUDGETING

Priorities same but expenditure on alcohol and newspapers reduced.

SUBJECTIVE HEALTH STATUS

Felt health had deteriorated. Now perceived as "good". Felt less physically fit. "I used to find that when I walked to sign on I was all right. But recently I've felt very tired. The last time I felt dizzy and sick by the time I got there and was sweating a lot."

N.H.P. Scores : Zero on all sections.

SUMMARY

More problems with finance and boredom but more perceived support. Decreased alcohol consumption. While N.H.P. scores zero some suggestion that perceived health had deteriorated.

Interview Three (Unemployed 32 weeks. Employed six weeks)

PERCEPTIONS OF UNEMPLOYMENT

Employed on another Community Programme. Quite enjoying it because had been "sick of no money." Income doubled but still had problems managing. "It's still hard to enjoy yourself." Contract for one year but still worried about future. "I'll get paid off in a year and be back on the Buroo."

PERCEIVED SOCIAL SUPPORT

Problems getting on with mother. Felt no-one supportive.

HEALTH RELATED BEHAVIOUR

Diet

Eating more because working. Substantial breakfast and lunch. Diary not returned again.

Exercise

Since job involved door to door interviewing more exercise than before.

Alcohol Consumption

Drinking several times every week. Twenty-two pints beer per week (44 units).

Smoking Behaviour

Unchanged.

Medicine Use/Doctor Consultations

No medication. No consultations.

HOUSEHOLD BUDGETING

Contributing £20 per week to household. Priorities unchanged but more clothes and some records could be afforded. While working no money saved.

SUBJECTIVE HEALTH STATUS

Felt health improved since starting work but still perceived as "good". "I feel more active. I feel better - maybe it's psychological. I don't feel fit yet but better."

N.H.P. Scores : Zero scores on all sections.

SUMMARY

Evidence suggests work provided time structure and money which allowed him to drink more alcohol. Increase in exercise due to situational factors. Some evidence that perceived health improved. However obtaining employment for one year not enough to remove uncertainties about future.

CASE STUDY NO. TEN (MR H)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 56
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Two adults
AGE COMPLETED SCHOOL: 14
OTHER EDUCATION: Coal Mine Training
PREVIOUS OCCUPATION: Electronic Product Technician
LAST EMPLOYMENT: Company X
SERVICE IN LAST EMPLOYMENT: 13 years
REDUNDANCY PAYMENT: Yes
ATTRIBUTION OF UNEMPLOYMENT: Corporate Management
DURATION OF PRESENT UNEMPLOYMENT: 34 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate family : No (wife not employed)
Other Relatives : Yes
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: None

Interview One (Unemployed two weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed work for money and company. Unemployment benefit not yet received. Thought it would be about three quarters of earnings. No financial problems due to redundancy payment. Worried about future and about regaining employment because of age.

PERCEIVED SOCIAL SUPPORT

Wife and daughters very supportive. "They say don't worry everything will work out."

HEALTH RELATED BEHAVIOUR

Diet

No changes since redundancies announced. Three meals including cooked breakfast plus supper each day. Mixture of fresh and processed meats. Fish twice. Fried meals four times. Glass of milk each day. Potatoes everyday, three times as chips. Vegetables mostly fresh, four times. Fruit juice everyday but fresh fruit only once. Had never thought of changing diet because quite conservative. No food which could not be afforded. No food thought he should eat for health.

Exercise

Enjoyed walking long distances, fishing and gardening almost everyday. More active than when working since more time.

Alcohol Consumption

Drank two or three times per week. Six cans lager (nine units). Consumption same as when working.

Smoking Behaviour

Ex-smoker.

Medicine Use/Doctor Consultations

Back broken 20 years ago so pain killers everyday. One consultation in previous four months.

HOUSEHOLD BUDGETING

£40 spent on food per week. Priorities rent, fuel and food, least important being social outings. Had never really been short of money in past.

SUBJECTIVE HEALTH STATUS

Perceived health as "very good". No change since redundancies announced.

N.H.P. Scores : Zero scores on three sections

Pain - 33.3 (general pop. mean 2.9)

Sleep - 22.38 (general pop. mean 11.7)

Physical Mobility - 11.2 (general pop. mean 3.7)

SUMMARY

No evidence of changes in expenditure patterns. Increase in exercise because more time. Few problems because of redundancy but pessimistic about regaining employment due to age. No change in perceived health. Responses to N.H.P. because of back trouble.

Interview Two (Unemployed 26 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working. Still worried about future and getting another job. "I don't have much chance of getting one. I still look but at my age what's the hope?" Household income £70 - £89 (about half of earnings). But few financial worries. Keeping in contact with friends now a problem because could not afford to go out so much..

PERCEIVED SOCIAL SUPPORT

Wife and daughters still supportive, "They don't ask me why I don't have a job."

HEALTH RELATED BEHAVIOUR

Diet

No changes reported but diary indicated some. Less eaten at breakfast. Sometimes porridge instead of bacon and eggs. No fruit juice and no glasses of milk. Fewer vegetables and no fresh fruit.

Exercise

Prevented from walking so much because of weather. Was sleeping more during day.

Alcohol Consumption

Unchanged.

Smoking Behaviour

Unchanged.

Medicine Use/Doctor Consultations

Medication unchanged. One consultation.

HOUSEHOLD BUDGETING

Priorities same. Food expenditure unchanged. Only problem paying large bills. Money had to be withdrawn from bank. In future would not be able to afford so many visits to daughter in England.

SUBJECTIVE HEALTH STATUS

Health still perceived as "very good".

N.H.P. Scores : Pain - 12.91 (general pop. mean 2.9) decrease

Sleep - 22.37 (general pop. mean 11.7) same

Physical Mobility - Zero (general pop. mean 3.7) - decrease

SUMMARY

No evidence of changes in expenditure pattern. Previous standard of living maintained by use of savings. Decrease in exercise seasonal. Some changes in food consumption might be seasonal. While N.H.P. scores improved, comments made suggest that back problem no different. Responses different because did not want his condition to be considered a disability.

Interview Three (Unemployed 34 weeks. Employed seven weeks)

PERCEPTIONS OF UNEMPOYMENT

Working in British Rail Booking Office. Income same as when unemployed but would increase after initial training period. No longer worried about future. Before regaining employment had become apprehensive about visits to Job Centre because seemed to be no hope.

PERCEIVED SOCIAL SUPPORT

Unchanged.

HEALTH RELATED BEHAVIOUR

Diet

Eating less because not at home so much. Only changes in diary - more fresh vegetables, tea and toast instead of cooked breakfast. Other changes identified previously appear to have been permanant not seasonal.

Exercise

Could no longer take walks everyday but continued whenever possible.

Alochol Consumption

Unchanged but going out more often.

Medicine Use/Doctor Consultations

Medication unchanged. One consultation.

HOUSEHOLD BUDGETING

Budgeting not yet settled. Slightly less money spent on food. Not buying luxury foods and keeping less in store cupboard. Since Christmas had reduced expenditure, now used to situation.

SUBJECTIVE HEALTH STATUS

Perceived health still "good".

N.H.P. Scores : Same as interview two.

SUMMARY

No evidence of changes in perceived health over time. Changes in exercise due to availability of time. Changes in diet, while not

drastic, may have been for financial reasons. Little suggestion that unemployment proved problematic partly because of financial security and partly because of age. While worried about future possible that he was relatively resigned to situation, treating it as early retirement.

CASE STUDY NO. ELEVEN (MR M)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 36
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Two adults/one child
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Product operator
LAST EMPLOYMENT: Company X
SERVICE IN LAST EMPLOYMENT: 13 years
REDUNDANCY PAYMENT: Yes (£5,500)
ATTRIBUTION OF UNEMPLOYMENT: Corporate Management and Government
DURATION OF PRESENT UNEMPLOYMENT: 36 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No (Wife not employed)
Other relatives : Yes
Close friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: One (very short)

Interview One (Unemployed four weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed work because of contact with people but also gave some purpose in life. Worried about future, regaining employment and others expectations of him. Not yet receiving unemployment benefit (thought it would be half of earnings). Due to redundancy payment no financial problems.

PERCEIVED SOCIAL SUPPORT

Wife very supportive since redundancies announced. "She hasn't applied pressure on me to look for a job. She's treated me the same as when I was employed."

HEALTH RELATED BEHAVIOUR

Diet

No changes since redundancies announced. Had thought of eating more vegetarian food because healthier. Prevented from doing so. "My wife really loves meat. You know all her family does and so it would be difficult for her to make special meals just for me." No other food he should eat for health. No food which could not be afforded. Three meals and two snacks most days. Wide variety of food. Mixture of fresh and processed meats. Fresh vegetables almost everyday. No fresh fruit. Two fried meals and chips three times. White bread and rolls. Large amount of full fat milk.

Exercise

No vigorous exercise but gardening almost every day. More exercise than when working but thought should take even more. Intended to do so.

Alcohol Consumption

Drank alcohol only on special occasions. None recorded in diary.

Smoking Behaviour

Twenty cigarettes per day. No change since redundancies announced. Had thought of stopping but not motivated. "I can afford to smoke so I do so. I don't think about the effects on my health. If I didn't have money for cigarettes I wouldn't smoke."

Medicine Use/Doctor Consultations

No medication. No consultations in previous four months.

HOUSEHOLD BUDGETING

£30 - £39 spent on food per week. Priorities mortgage, food, holidays. He explained " When we got married, I said, look love whatever happens I promise I'll take you home to Ireland every year on holiday. So you see holidays are very important to us." Least important alcohol and social outings. Had never really been short of money before.

SUBJECTIVE HEALTH STATUS

Perceived health as "very good". No change since redundancies announced.

N.H.P. Scores : Zero on all sections.

SUMMARY

Although worried about future relatively optimistic about finding employment. Little evidence that redundancy had caused major changes in expenditure patterns or health behaviours. Was looking forward to holiday following week.

Interview Two (Unemployed six months)

PERCEPTIONS OF UNEMPLOYMENT

Still missed being at work. "I don't miss working. I miss the activity, meeting people etcetera. Money is not everything but its a great bloody help to keep you going." Same problems as before but beginning to think he would not be offered work locally because of

former union activities. Redundancies received great publicity. Another union colleague suspected a job offer had been withdrawn because she was union representative. Difficulties now with boredom and filling time. "I'm running out of things to do and I'm having to think about it. When I go to my bed I'm saying now - what can I get up to tomorrow?" Keeping looking for work now a problem. "I've run out of places to write to. I've written to them all and I haven't seriously looked for a job since I came back from holiday in July - August." Had not been socialising . "I don't really want to meet people and talk about old times in the factory and talk about unemployment in general."

PERCEIVED SOCIAL SUPPORT

Wife still supportive. Father also supportive. "In the six months I've been unemployed he's never once said how are you getting on looking for a job? Have you got a job? Asking silly questions like that. He's never mentioned it once and I find that absolutly fabulous." Unlike father-in-law who kept sending job adverts "He's a marvellous guy but tact and diplomacy he's none!" Their political views did not agree. "He's very much Conservative and I'm not at all and he probably feels that because I'm Labour minded, that as with most of the press, if you vote Labour you're idle, good for nothing, left wing, go to sleep on the nightshift, never worked a day in your life type of person."

HEALTH RELATED BEHAVIOUR

Diet

No reported changes but diary indicated some. Meal patterns same but breakfast cereal replaced toast and brown bread replaced white. Other changes eg home made soups and jam could be seasonal.

Exercise

Hard manual work everyday. "On the odd occasion, like today, when I don't do something manual, I find I can't eat so much and it's harder to get to sleep at night." But now having to watch expenditure on D.I.Y. and worried about running out of things to do. "I dread the morning I wake up and I say to Mrs M - well what do you think I should do today? - and she says - well there's nothing very much really - and I'm still unemployed and the money has run out. I'm not looking forward to that at all. And now the winter's coming in I'm getting rather perturbed about what I'm going to get up to."

Alcohol Consumption

Unchanged. Zero recorded.

Smoking Behaviour

Now 25 cigarettes per day. Smoking more at night because going to bed later. "Because I don't have to get up so early in the morning and to make sure that when I do go to bed that I'm able to sleep."

Medicine Use/Doctor Consultations

No medication. No consultations.

HOUSEHOLD BUDGETING

Household income £73 (half of earnings). Priorities unchanged but mortgage interest paid by D.H.S.S. Spending £10 less per week on food. Previously food bought from small local shops, now purchased from supermarket in nearest town every fortnight. "So she's being more spend thrift. Still getting the same stuff but if she can get it cheaper she'll get it." Milk now bought daily instead of delivered in attempt to economise. Redundancy money used to maintain previous standard of living. "We're not living strictly on the Giro yet so there's no pressure on us at the moment to put money away for bills.

We just fall back on the bank account whenever a bill comes in. I'll start panicking when all the money is gone. We'll have to work out something when that happens." (Wife) A lot of money had been spent on decorating, the garden and holiday but now having to be more careful. "This time of year - Christmas - if it wasn't for the money in the bank Christmas would be cancelled this year." Benefits not thought to be sufficient. "I'm not saying it's an impossibility. We're fortunate, I've only been unemployed six months out of twenty years. Someone who has been unemployed for four or five years might have more problems." Mrs M now considering working since it might be easier for her to find work locally.

SUBJECTIVE HEALTH STATUS

Health now perceived as "good". Felt it had changed. "I don't know whether it's in the mind, I feel the cartilages in both knees are away and I wonder whether it's a mental thing or it's a physical thing. I don't really know." Previously knees given some trouble but to lesser extent. Doctor not consulted because he thought problem might be psychological. Marked changes in N.H.P. scores previously all zero.

N.H.P. Scores : Emotional Reactions 9.76 (general pop. mean 10.3) increased

Social Isolation 41.37 (general pop. mean 2.7) increased

Physical Mobility 10.49 (general pop mean 1.2) increased

SUMMARY

More problems than before. More anxiety about future. Changes in health behaviours, some positive, some negative, due to situational factors. Previous standard of living maintained by using redundancy money. Perceived health had worsened. Some suggestion that psychosomatic condition had developed.

Interview Three (Unemployed 36 weeks. Employed eight weeks)

PERCEPTIONS OF UNEMPLOYMENT

Employed by local factory. Just returned from six weeks training course in West Germany. After six months trial period job would be fairly secure. When asked if enjoying being back at work "Half and half. I've got mixed emotions. I think to myself - here we go again, how long is it going to last this time?" Only problem now keeping in contact with friends because working shifts. Household income now £90 - £109. Would increase further after trial period. No financial problems. Some redundancy money left.

PERCEIVED SOCIAL SUPPORT

Wife and father still supportive. Six weeks in Germany difficult. "It was a big strain being away from Mrs M, not just in bed, I mean, but not having someone close to talk to. And living in the hotel all the time ... It was a strain the whole six weeks, you had to play the game, watching what you did and said all the time."

HEALTH RELATED BEHAVIOUR

Diet

Since starting work eating less (except in Germany). Gained 7-10lbs when unemployed but had now lost it. Week recored in diary atypical. Three birthdays in family, one day holiday and relations staying. On more normal days less food being consumed, butter substituted margarine, less brown bread, more salads, now drank fruit juice.

Exercise

Now little time for gardening but just as physically active as when unemployed. "The work is physically very hard. You're working all the time, climbing up furnaces, standing all the time. So it's a lot more demanding than the last job."

Alcohol Consumption

Unchanged but reported drinking a lot in Germany. Due to special occasions ten units alcohol recorded in diary.

Smoking Behaviour

Now no more than 20 cigarettes per day. "We're not allowed to smoke at work except in the canteen because there are highly flammable materials about, so I only smoke about three during the day. But I'm probably smoking more at home - but certainly not as much as when I wasn't working."

Medicine Use/Doctor Consultations

In hosptial for weekend with Quincy but had signed himself out because did not want to be off sick so soon after starting work.

HOUSEHOLD BUDGETING

Priorities unchanged. Ability to manage on reduced income not yet known. £40 was again spent on food per week.

SUBJECTIVE HEALTH STATUS

Perceived health as "very good" once more. Felt it had improved since starting work. Problem with knees improved. "It may be psychological, you know, not having time to think about them or it might be just moving around all the time. But they're much better now."

N.H.P. Scores : Zero on all sections Decreased.

SUMMARY

Changes in health behaviour noted and behaviour had returned to nearer that recorded in first interview. Improvement in perceived health.

Suggestion that Mr M experienced psychological effects during unemployment. Financial strains minimised by redundancy payment.

CASE STUDY NO. TWELVE (MR F)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 22
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: Four Adults
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Y.O.P.S.
PREVIOUS OCCUPATION: Various Unskilled
LAST EMPLOYMENT: M.S.C. Communtity Programme (Part-time)
SERVICE IN LAST EMPLOYMENT: One Year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: No-one
DURATION OF PRESENT UNEMPLOYMENT: 37 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: Six

Interview One (Unemployed seven weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed work "Basically it's finding things to do. The boredom is the worst and the money of course." Supplementary Benefit £23.75 (about three eights of earnings). Had problems managing on this amount. Not bothered by friends helping out financially now and again. "When I was working I bought them drinks, now the situation is reversed." Worried about future and about regaining employment. Problems getting on with father. "He's never been unemployed. He doesn't understand."

PERCEIVED SOCIAL SUPPORT

Girlfriend supportive. "She tries to cheer me up. Although I don't get down much because it's a waste of time getting depressed."

HEALTH RELATED BEHAVIOUR

Diet

Eating less than when working. Eating more junk food and snacks instead of proper meals. "Cause I can't be bothered cooking I don't feel like making the effort and I'm not hungry because I'm not doing much all day." Diary indicated no substantial meal till evening. Snacks ten times. Unprocessed meat four times. Processed meat e.g. hamburgers nine times. Vegetables consisted of potatoes four times, chips three times, baked beans four times, fresh vegetables twice. No fresh fruit. Sandwiches thirteen times. Would like to each out more but could not afford. Never thought of changing diet. "I'm not into health foods. There's nothing like a big plate of greasy chips!" Should eat wholemeal bread and cut sugar for health but did not like taste.

Exercise

No vigorous exercise. Walked long distances two - three times a week. Exercise much less than when working. Never thought should take more "I feel quite fit as I am."

Alcohol Consumption

Went out for drink once a month. On such occasion consumed two pints beer. None recorded in diary. Drinking a lot less than when working. "We went out on Thursday and Friday nights and had a right bevy." Could not afford now.

Smoking Behaviour

Five roll ups a day. Between two and 20 recorded in diary. Smoking much less than when working because of expense. Used to smoke thirty ordinary cigarettes a day. "Anyway it's bettter for health to cut down because I'm not so active." Was trying to stop at present.

Medicine Use/Doctor Consultations

Medication now and again for skin rash. No medical consultations in previous four months.

HOUSEHOLD BUDGETING

Spent about £40 on food per week. Personal budgeting priorities £10 to mother and £5 for H.P. stereo per week, £5 per month clothes account. Least important alcohol and social outings. When money short cut expenditure on cigarettes, alcohol and social outings. Also if could not afford bus fares walked instead.

SUBJECTIVE HEALTH STATUS

Perceived health as "fair". No change since stopping work.

N.H.P. Scores : Zero scores on three sections.

Energy : 24.0 (general pop. mean 10.1)

Emotional Reactions : 7.08 (general pop. mean 11.6)

Sleep : 77.63 (general pop. mean 8.4)

SUMMARY

Boredom and financial difficulties appeared to be biggest problems associated with unemployment. Dietary changes not for financial reasons but appeared to be for psychological reasons. High frequency

of snacks and food relatively unvaried. Less exercise due to situational factors. Alcohol and cigarette consumption reduced for financial reasons. While two N.H.P. scores considerably higher than population means no evidence of changes in perceived health since stopping work.

Interview Two (Unemployed 24 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed work. "I definately miss the money but I'm getting used to it now." Not worried about future now. "You get used to it." All other problems noted previously remained but now keeping in touch with friends was a problem because of lack of money. "When you come off work it's a bit of a shock. Your whole lifestyle changes. You get bored and fed up."

PERCEIVED SOCIAL SUPPORT

No girlfriend now, but mother supportive. "Yes she kicks me out of bed."

HEALTH RELATED BEHAVIOUR

Diet

Reported cutting junk foods and trying to eat healthier foods. Had got appetite back. Although diary indicated now eating lunch more often and snacks less often, pizzas recorded four times (total seven pizzas). Tea less frequently. Slightly less processed meats. Fresh vegetables increased to four times. No fresh fruit. Would like to cook foreign dishes but could not afford special ingredients.

Exercise

No real change but getting out more because weather better.

Alcohol Consumption

No reported change. Three pints recorded in diary.

Smoking Behaviour

Reported smoking less 10 - 12 cigarettes per day. Although last time reported five roll ups per day diary indicated between two and 20. Diary this time three days zero and four days ten roll ups. Explained that between interviews had increased smoking but now reduced because short of money.

Medicine Use/Doctor Consultations

No medication. One medical consultation for knee check up which had been injured a year previously.

HOUSEHOLD BUDGET

No change but money did not last for two weeks. "It's impossible! Basically the money you get is not enough. They only expect you to survive!"

SUBJECTIVE HEALTH STATUS

Still perceived health as "fair" but felt healthier because he had reduced junk food.

N.H.P. Scores : Energy : (General pop.mean 10.1) Decreased from 24.0

Emotional Reactions : 16.84 (general pop. mean 11.6) increased from 7.08

Sleep : Zero (general pop. mean 8.4)decreased from 77.63

Social Isolation : 61.48 (general pop. mean 5.5) increased from 0

Summary

Some evidence of adaptation to reduced income and the future. Although reported changes in diet, diary indicated food relatively unvaried. No other changes in health behaviours except smoking reduction due to shortage of money. Although felt healthier changes in N.H.P. scores. While scores for Energy and Sleep had decreased to zero, scores for emotional reactions and social isolation increased considerably. May be indication that perception of health related more to physical rather that psychological health.

Interview Three (Unemployed 37 weeks - Employed five weeks)

PERCEPTIONS OF UNEMPLOYEMENT

Had regained permanent employment with reasonable prospects. Income £95 per week (four times benefit). No problems this time except other's expectations of him at work.

PERCEIVED SOCIAL SUPPORT

Mother still supportive but father more supportive since he had regained employment.

HEALTH RELATED BEHAVIOUR

Diet

Reported eating more in general because working. However eating more convenience foods again since employed in frozen food shop. During the day meals consisted of food from freezer cooked in the microwave. Diary indicated dramatic increase in total food consumption and erratic meal patterns. Large increase in bread consumption with 65 slices of bread or rolls being recorded. Consumption of processed meats and chips also increased. Six cans of lemonade recorded this time together with seven chocolate bars and fifteen cakes or biscuits.

Exercise

Not taking dogs for walk so often because working. However worked long hours and job involved a lot of walking and lifting so more active than before.

Alcohol Consumption

Now going for a drink once a week instead of once a month. On such occasions drank two - three pints beer. Six pints beer recorded in diary (12 units).

Smoking Behaviour

Smoking more now. Reported 20 normal cigarettes per day since he could now afford to buy them. Between 10 and 16 cigarettes recorded in diary each day.

Medicine Use/Doctor Consultations

No medication and zero medical consultations.

HOUSEHOLD BUDGETING

Priorities unchanged but contributing much more to household. Reduced expenditure on cigarettes and alcohol when short of money.

SUBJECTIVE HEALTH STATUS

Feeling better since starting work but tired because of long working hours.

Perceived health as "very good" (fair last time)

N.H.P. Scores : Zero scores on all sections.

Emotional Reactions : decreased

Social Isolation : decreased

SUMMARY

Regaining employment had removed all problems previously experienced. Changes in diet due to situational factors. Increases in alcohol and cigarette consumption due to financial reasons. Obvious improvement in perceived health.

CASE STUDY NO THIRTEEN (MR R)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 28
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: One Adult
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Bricklayer
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One Year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: Margaret Thatcher
DURATION OF PRESENT UNEMPLOYMENT: 40 Weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: Two

Interview One (Unemployed Six Weeks)

PERCEPTIONS OF UNEMPLOYMENT

Missed work mainly for social contact. "It got me out of bed. And just getting out and meeting folk" Income £30 per week (about half of earnings). Managing on this amount difficult. Not worried about future but worried about regaining employment. Keeping looking for work was frustrating. "I'm going tae paint a big sign and go doon one night and put Job Centre closed, Joke Centre opened!" Boredom a problem. "It is really. You see Eastenders, old Arthur, I don't want tae get into his state." Finding useful ways to fill time also a problem. "There's nothing in this scheme to do."

PERCEIVED SOCIAL SUPPORT

No-one supportive. "I don't really like people helping me."

HEALTH RELATED BEHAVIOUR

Diet

Eating less meat and more baked beans, eggs and soup since stopping work for financial reasons. Only substantial meal in evening. Breakfast and lunch very light. Little variety in food. Eggs eight times, fish twice, meat twice and cheese three times. Fried food ten times. Soup for lunch five times. No vegetables except potatoes seven times, six times as chips. Thought meat good for health but too expensive. "I give my sister money and she gets mince and things like that in Asda because its too dear here. There's no supermarkets and tae go doon the toon costs another pound on top of the cost of food." Had thought of changing diet to include more variety but could not afford.

Exercise

No vigorous exercise. Walked long distances two or three times a week. Less than when working. Thought should take more. Used to run long distances with Territorial Army but could not afford to go much now because they went drinking on Saturday nights.

Alcohol

Only went drinking once a fortnight. Would drink eight pints beer a fortnight (16 units), four pints recorded in diary. Drinking less than when working because of expense.

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

No medication. No medical consultations in previous four months.

HOUSEHOLD BUDGETING

Spent £12 on food which lasted one and a half weeks. Had to borrow from sister until benefit paid. Priorities rent, fuel and food. The least important being social outings and holidays. When short of money reduced expenditure on food and alcohol. "I can't cut fuel. I've got tae keep the fire on all the time cause this house is so damp."

SUBJECTIVE HEALTH STATUS

Perceived health as "very good". No change since stopping work..

N.H.P. Scores : Zero scores on three sections

Energy : 36.8 (general pop. mean 8.6)

Emotional Reactions : 17.55 (general pop. mean 10.3)

Sleep : 16.10 (general pop. mean 8.6)

SUMMARY

Missed work mainly for social contact but apparent financial difficulties. Not worried about future but pessimistic about regaining employment. Quality of diet affected by reduced income. Diet monotonous and unbalanced. Exercise reduced for situational and financial reasons. Alcohol reduced for financial reasons. Little evidence that perceived health had changed but three N.H.P. scores above population means.

Interview Two (Unemployed 24 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed work. "It's starting tae get tae me noo! I've even started tackling the garden. Just tae break the boredom." Increase of £2 per fortnight although small made it easier to manage financially. Apart from that the same problems as before. Increased anxiety about regaining employment. "I'll need tae get something even if it's cleaning the streets, anything tae get oot. I'm bored oot of my brains!". Keeping in touch with friends was a problem. "I try my hardest tae keep in touch wi the ones I've been working wi. It's kindae hard cause a lot of them are unemployed and your money's all at different times."

PERCEIVED SOCIAL SUPPORT

No perceived support.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes. However from diary change identified in meal patterns. Most days only two meals. Still little variety. Consumption of eggs, fried foods and chips still very frequent. This time salad twice.

Exercise

Now going to Territorial Army most weekends. Had run 60 miles over three weekends. "It was pure physical hell! I thought I was fit until then." Because of this now running two - three times a week.

Alcohol Consumption

No reported changes. About eight to 10 pints beer a fortnight. "Sometimes I just go out and go beserk and get drunk but that's only once a fortnight. In diary 21 pints (42 units) recorded.

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

No medication. No medical consultations since previous interview.

HOUSEHOLD BUDGETING

Priorities unchanged. "I can always starve but I can't do without heat and light. With the gas and electricity they can throw me oot but with grub they cannae."

SUBJECTIVE HEALTH STATUS

Still perceived health as "very good" but felt it had improved. "I feel healthier than I did the last time because I'm running. I've even lost a bit of my belly."

N.H.P. Scores : Energy : zero (general pop. mean 8.6) decreased

Emotional Reactions : 26.05 (general pop. mean 10.3) increased

Sleep : zero (general pop. mean 8.6) decreased

SUMMARY

Increased problems with boredom and worry about regaining employment. Diet little change. Some suggestion that increased exercise contributing towards better perceived health. Some suggestion of

increased alcohol consumption. Previous diary four pints, this diary twenty one pints. While perceived health was better and N.H.P. scores for Energy and Sleep decreased to zero, scores for Emotional Reactions increased from 17.55 to 26.05. Therefore some suggestion that while physical health had improved psychological health had worsened.

INTERVIEW THREE (Unemployed 40 weeks full time college two weeks)

PERCEPTIONS OF UNEMPLOYMENT

Not missing work so much now since attending college. "I'm meeting people and learning something as well. I had tae do something cause I was bored out of my brains."

Receiving grant of £52 per week. Although more than benefit had to pay more rent and had college expenses. Managing on income slightly easier but not much more money than before. Boredom no longer a problem. Still looking for work because found college work difficult and did not think he would pass exams. Keeping in contact with friends easier because of eased financial situation.

PERCEIVED SOCIAL SUPPORT

Felt his sister was taking more interest in him since starting college.

HEALTH RELATED BEHAVIOUR

Diet

Doctor had recommended that he lost weight. Reported eating less and grilling food instead of frying. No breakfast most days. One main meal plus one snack most days. Even less variety than before. Total food consumption consisted of toast five times, cheese roll four times, fried fish three times, hamburgers three times and chips five times. As before no other fruit or vegetables recorded.

Exercise

Less than before. Had given up running. "I couldnae be bothered and now I'm at college I don't have the same time." Also walking less because could now afford bus fares.

Alcohol Consumption

Reported drinking the same as before about six to eight pints a week. Six pints of beer recorded in diary. Explained that high intake recorded previously was a week when he went "beserk".

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

Zero medication. One medical consultation since previous time because of pulled muscle.

HOUSEHOLD BUDGETING

Although income increased spending less on food because on a reducing diet. Budget priorities unchanged. Reduced expenditure on food and alcohol when money was short.

SUBJECTIVE HEALTH STATUS

Felt better since he had lost some weight. Perceived health as "very good'.

N.H.P. Scores : Zero scores on all sections except

Emotional Reactions 7.08 (general pop. mean 10.3) decreased.

SUMMARY

Attending college had solved the problems with boredom. However found the course difficult and was still anxious about regaining employment. Financial difficulties had eased. Although reported being on a reducing diet, food consumption monotonous and high in fat. Taking less exercise due to lack of motivation and for financial reasons. Subjective health status appeared to have improved possibly due to attendance at college.

CASE STUDY NO. FOURTEEN (MR S)

NUMBER OF INTERVIEWS: Three
SUBJECT:Male
AGE: 24
MARITAL STATUS: Single (Engaged)
HOUSEHOLD COMPOSITION: Three adults
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Cabinet Maker
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: No-one
DURATION OF PRESENT UNEMPLOYMENT: At least 42 weeks
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No (mother not employed
Other Relatives : Yes
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: One

Interview One (Unemployed seven weeks)

PERCEPTIONS OF EMPLOYMENT

Missed work because of money but also activity outside home. Personal income about quarter of earnings but total household income £110 - £129. Had problems managing on his income. This prevented him from keeping in contact with friends. Worried about future and about regaining employment. Keeping looking for work was a problem. Involved in voluntary work so no problems with occupying time or with boredom.

PERCEIVED SOCIAL SUPPORT

Fiancée very supportive. She had encouraged him to apply for College courses.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes since stopping work. Food intake appeared relatively meagre. Most days only meal consumed in evening. Unprocessed meat most days. Fried food three times. Only vegetables were potatoes four times, as chips once and as crisps three times. No food which could not be afforded. Thought he should eat vegetables for health. Had thought of becoming vegetarian but did not like vegetables.

Exercise

Only exercise a walk once a week. No change since stopping work. Thought he should take more. Would be easier if Sports Centre nearer.

Alcohol Consumption

Drank once or twice every week. Total consumption six pints beer (12 units). Had never thought of reducing consumption because did not consider it harmful but drinking less now because of expense. Seven pints beer recorded in diary (14 units).

Smoking Behaviour

Fifteen cigarettes per day. Smoking more now because last employment in non-smoking office. Between 15 and 18 cigarettes recorded each day. Had thought of stopping but no willpower.

Medicine Use/Doctor Consultations

Prescribed medication for stomach complaint several times a week. No medical consultations in previous four months.

HOUSEHOLD BUDGETING

£40 spent on food per week. Priorities rent, food and cigarettes. Least important social outings, alcohol and records. Although problems managing personal income, not reducing expenditure on anything except alcohol because had saved while working.

SUBJECTIVE HEALTH STATUS

Perceived health as "good". No change since stopping work.

N.H.P. Scores : Zero scores on all sections except

Sleep : 37.8 (general pop. mean 8.4)

SUMMARY

Main problems worrying about future and regaining employment. Drinking less because of reduced income and smoking more because of situational changes. No evidence that perceived health had changed but was experiencing sleeping difficulties.

Interview Two (Unemployed 27 weeks. Part-time course 13 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Had started two year Social Work course but since too late to apply for grant attending part time. No longer missed work because at College but more problems managing on income. This due to buying a flat. Intended to marry in six months time. Fiancee paying mortgage bothered him but this would not be a problem when receiving grant.

Still worried about future. "There's no guarantee that I'll get a job at the end of the course." Due to increased financial strain having difficultly keeping in contact with friends.

PERCEIVED SOCIAL SUPPORT

Still supported by fiancée.

HEALTH RELATED BEHAVIOUR

Diet

Now eating fresh fruit and drinking Ribena because thought he needed more vitamins. Unfortunately diary not returned so changes could not be confirmed.

Exercise

Walking part of way to College so now getting more exercise. Generally more active.

Alochol Consumption

Now only drinking once a fortnight because of expense. On such occasions consumed about three pints beer (six units).

Smoking Behaviour

Reduced cigarettes to 10 per day because stomach condition was worse.

Medicine Use/Doctor Consultations

Medication for stomach several times a week. One medical consultation since previous interview because of this condition.

HOUSEHOLD BUDGETING

Household income increased to £111 - £129 because brother earning more. Same amount spent on food. Cigarettes no longer priority. When money short social outings reduced.

SUBJECTIVE HEALTH STATUS

Perceived health as "good". Did not feel it had changed.

N.H.P. Scores : Zero scores on all sections - decreased.

SUMMARY

Part-time study had replaced some of functions of work but still worried about future. Financial strain due to purchasing flat had caused decrease in alcohol consumption. Changes in diet for health reasons. Changes in exercise due to situational factors. Previously changes in smoking behaviour due to situational factors but this time for health reasons. While no reported change in perceived health improvement in N.H.P. score observed.

Interview Three (Unemployed 42 weeks. Part-time study 16 weeks. Full-time study 12 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Had managed to switch to full-time one year course. Happier about this because getting married. Now receiving grant but income the same. Managing still a problem. No longer worried about future or about fiancee paying mortgage because had been offered job on completing course.

PERCEIVED SOCIAL SUPPORT

Still supported by fiancee.

HEALTH RELATED BEHAVIOUR

Diet

Now eating lots of vegetables and trying to eat breakfast. Motivation to change had come from involvement in health week at placement. Once again changes could not be confirmed since diary not returned.

Exercise

Now jogging. Generally more active.

Alcohol Consumption

Consumption more erratic. "I didn't have a drink for about six weeks then I was out every night for a week."

Smoking Behaviour

Trying to cut down for health reasons. Now smoking about thirty cigarettes and 1 oz tobacco per week.

Medicine Use/Doctor Consultations

Medication for stomach condition now stopped. No medical consultations since previous interview.

HOUSEHOLD BUDGETING

No change.

SUBJECTIVE HEALTH STATUS

Health still perceived as "good" but felt it had improved. "I feel fitter because of the running and going off my stomach pills. I'm kept busy all the time."

N.H.P.Scores : Zero scores on all sections - Same.

SUMMARY

Many of problems associated with unemployment had been removed by full time study and because of job offer received. Changes in health behaviour due to a variety of health, financial and situational factors. Some evidence that these changes were associated with improvements in perceived health.

Contacted one year after becoming unemployed but letter was "returned to sender".

CASE STUDY NO. FIFTEEN (MR E)

NUMBER OF INTERVIEWS: Three
SUBJECT: Male
AGE: 22
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: One Adult
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Y.O.P.S.
PREVIOUS OCCUPATION: None
LAST EMPLOYMENT: M.S.C. Community Programme (Part-time)
SERVICE IN LAST EMPLOYMENT: Five months
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: The Government
DURATION OF PRESENT UNEMPLOYMENT: One Year
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: Three

Interview One (Unemployed six weeks)

PERCEPTIONS OF UNEMPLOYMENT

Although never worked permanently missed work for company. Income £35 (about half of earnings). Problems managing on this amount. Not worried about future but anxious about regaining employment. Boredom a big problem. Transition from unemployment to employment and back to unemployment proved difficult in terms of sorting out rent allowances and arrears.

PERCEIVED SOCIAL SUPPORT

No one supportive since stopping work.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes since stopping work. Three meals plus one or two small snacks each day. More processed than fresh meat. Vegetable consumption limited to potatoes four times and tinned beans and peas. No fresh fruit or vegetables. Would have bought more better quality meat, milk and had more substantial breakfasts if they could be afforded. Had never thought of changing diet but thought it would be better if more money available. Thought should eat wholemeal bread and steak for health but could not afford.

Exercise

No vigorous exercise. Walked almost every day. No change since stopping work. Had never thought of taking more exercise "I don't need it. I feel healthy enough except that I'm underweight. I could do with eating more."

Alcohol Consumption

Could only afford to drink about once a fortnight. On such occasions consumed about three whiskys (three units). Drinking less since stopping work because of expense. One whisky recorded in diary.

Smoking Behaviour

Non-smoker.

Medicine Use/Doctor Consultations

Vitamin pills everyday. Asprin for migraines. Two medical consultations in previous four months because of illness.

HOUSEHOLD BUDGETING

£10 spent of food per week. Priorities fuel, hire purchase and food, least important being holidays, furnishings and social outings. When money short expenditure on food, alcohol and furnishings reduced.

SUBJECTIVE HEALTH STATUS

Perceived health as "fair". No change since stopping work.

N.H.P. Scores : Energy 63.2 (general pop. mean 10.1)

Pain 9.99 (general pop. mean 0.7)

Emotional Reactions 28.29 (general pop. mean 11.6)

Sleep 21.7 (general pop. mean 8.4)

SUMMARY

Apart from lack of social contact and boredom major problem lack of money. While working a few extras could be afforded but now only basic necessities purchased. No evidence that diet changed but it was relatively basic. Obviously underweight. Perceived health not particularly good but no evidence of deterioration since stopping work.

Interview Two (Unemployed 27 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Had started attending college part-time in attempt to get 'O' grades so not missing work so much. "When you're unemployed you're stuck in the home all day, you become a vegetable like person. Everyday's the same. Now I'm going out and talking and you're learning something as well so your mind's not stagnant." Managing fiancially still a

problem. "I'm surviving but that's about all. I have more problems in the winter because of heating bills." Still problems keeping in contact with friends. "I've had to say I couldn't meet them - make excuses rather than say I couldn't afford to go out!" Now worried about future. "Even though I'm going to college ... that doesn't mean I'm going to get a job at the end of it. I'd rather do away with myself than think I'll never get a job." Boredom no longer a problem because attending college and had work to do in the evenings.

PERCEIVED SOCIAL SUPPORT

No-one supportive since last time. "Everybody else has got problems. They don't want to know about yours."

HEALTH RELATED BEHAVIOUR

Diet

Had cut expenditure on food because of increased fuel bills. "I'm a good cook, I watch telly programmes, but I could never afford to buy things. If I didn't have that butchers in the High Street I wouldn't be able to buy meat at all. It's not very hygienic but it's much cheaper." Diary confirmed changes occurred. Meat, vegetables and biscuits recorded on fewer occasions. Increased frequency of fried food and chips. Now margarine sometimes instead of butter.

Exercise

Walking longer distances to college.

Alcohol Consumption

Drinking less often now because of increased fuel bills.

Smoking Behaviour

Unchanged.

Medicine Use/Doctor Consultations

Two medical consultations since previous time because of bronchitis.

HOUSEHOLD BUDGETING

Fuel bills most important priority. During winter expenditure on other items had to be reduced. "I couldn't afford to heat the bedroom everyday, that's beyond my budget. I only really heat this room, that's only because I get a higher heating allowance because of my bronchitis." Needed clothes and new shoes because attending college but would have to wait.

SUBJECTIVE HEALTH STATUS

Now perceived health as "poor". "It's deteriorated. Every year it does. I have bronchitis but living in such a damp house does affect my health. I had to get my walls removed, there was black fungus on them, but the walls are still wet. They said the mould was because I didn't heat the house properly. I had to take court action for them to fix it and now it's just coming back again."

N.H.P. Scores : - Pain - Zero (decreased)

Sleep - Zero (decreased)

Energy - 39.2 (general pop. mean 10.1) decreased

Emotional Reactions 38.41 (general pop. mean 21.6) increased

SUMMARY

Increased fuel bills caused all ready limited financial resources to be stretched further and resulted in changes in food and alcohol consumption. Health had deteriorated but it did every winter. Some N.H.P. scores improved but increased emotional problems. Attending

college had provided some social contact and activity but now worried about future.

Interview Three (Unemployed 39 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Did not miss work so badly because at college but missed extra money. Income to be increased by £1 from following month. All problems noted previously remained. Intending to apply for pre-entry course to University following session.

PERCEIVED SOCIAL SUPPORT

Still felt unsupported "Other people just say dry your eyes, other people have problems too, you know."

HEALTH RELATED BEHAVIOUR

Diet

Little change but perhaps eating slightly more because fuel expenditure reduced. Had gained a little weight but still very thin. Would have bought better quality food and more variety if could afford since diet monotonous. Diary indicated food consumption again similar to that recorded in first diary i.e. biscuit and butter consumption increased, chips consumption decreased. However vegetable consumption remained lower than that recorded initially.

Exercise

Continued to walk to college. Had started floor exercises.

Alochol Consumption

No change.

Medicine Use/Doctor Consultations

In prior two months had been prescribed medication for depression but did not take it everyday. "I don't like taking too many cause I might get hooked. I just started coming out of the depression last week. I was watching Eastenders and thought at least I've got more than Mary." Had also suffered from many colds and ear infection. Three medical consultations since previous interview.

HOUSEHOLD BUDGETING

Priorities unchanged. Had managed to buy some clothes and shoes with Provident Cheques. However budgeting still a problem. "I get really fed up with all the money going on the house. There's nothing left for me! And I don't have a choice about what to spend it on."

SUBJECTIVE HEALTH STATUS

Perceived health as "fair" once again but it had been worse in between interviews. Depression caused by state of the house. Mould had returned in bedroom. Had been told caused by insufficient heating. Had applied for another house. Told some people had to wait twenty years. "The thought of being in this house till I'm middle aged really depressed me."

N.H.P. Scores :- Zero scores on all sections except

Emotional Reactions - 29.7 (general pop. mean 11.6) decreased.

SUMMARY

Main problem associated with unemployment lack of money. Situation exacerbated by long term deprivation. No freedom of choice in expenditure. This was a source of frustration. Attendance at college had helped initial problems of boredom and lack of social contact.

Food and alcohol consumption affected by reduced income. Evidence that health deteriorated between interviews but this due to poor housing conditions and seasonal factors. However when health improved again still only rated as "fair". Difficult in this case to distinguish between those problems associated with unemployment and those related to social and material deprivation but some evidence to suggest unemployment intensified everyday problems of survival.

Contacted one year after becoming unemployed but since just about to start another Community Programme no longer wished to be interviewed.

CASE STUDY NO. SIXTEEN (MR A)

NUMBER OF INTERVIEWS: Four
SUBJECT: Male
AGE: 37
MARITAL STATUS: Separated
HOUSEHOLD COMPOSITION: Three adults
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: Apprenticeship
PREVIOUS OCCUPATION: Caulker (Shipyards)
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: One year
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: The Government
DURATION OF PRESENT EMPLOYMENT: At least one year
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : Yes
PREVIOUS SPELLS OF UNEMPLOYMENT: One

Interview One (Unemployed 10 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Had worked in shipyards since leaving school but when wife left him, had a nervous breakdown. Could not face work so accepted redundancy. On recovering had thought regaining employment would not be a problem. This not the case. Eventually accepted post on Community programme. Missed working because of activity. Income about half of earning in last employment and about quarter of earnings in Shipyards. Lived with parents. Total weekly household income £90 - £109. Managing on this amount not a problem but personal income not sufficient to do things he wanted. Parents subsidising him worried him. Worried about

future and about regaining employment because of high local unemployment.

PERCEIVED SOCIAL SUPPORT

No-one supportive except parents.

HEALTH RELATED BEHAVIOUR

Diet

No change since stopping work. Three meals and two snacks most days. Mixture of fresh and processed meats together with eggs. At least two glasses of milk everyday. Fried food four times. Vegetables four times. Potatoes as chips three times. No fresh fruit. No food which could not be afforded. Thought he should eat wholemeal bread for health but did not like it. Had never thought of changing diet. "I feel healthly enough so there's no need to change."

Exercise

No vigorous exercise but walked dog everyday. More exercise than when working.

Alcohol Consumption

Did not drink alcohol at any time. No change since stopping work.

Smoking Behaviour

Smoked three roll up cigarettes per day. Four to six recorded in diary. No change since stopping work. Had never thought of stopping.

Medicine Use/Doctor Consultations

No medication. No medical consultations in previous four months.

HOUSEHOLD BUDGETING

Priorities food, fuel and rent the least important being holidays and social outings. When he was short of money reduced expenditure on cigarettes and social outings. £30 - £39 spent on food per week.

SUBJECTIVE HEALTH STATUS

Health perceived as "Good" when working. Now perceived as "Very Good".

N.H.P. Scores :- Zero scores on all sections except

Emotional Reactions : 17.69 (general pop. mean 10.3)

SUMMARY

No major financial problems mainly because living with parents. Main problem worried about future and regaining employment. Exercise increased due to situational factors. Some evidence that perceived health had improved since stopping work.

Interview Two (Unemployed 32 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working. Would have taken any type of job available "but there's nothing left in this area now." since previous interview had given up part time chiropody course just a few months before final examinations. Previous redundancy money had paid for fees and equipment. Had been doing well on course but could not continue for financial reasons. "If I'd asked my parents for some money they'd have given me it. But I didn't feel I could ask them for more." Since stopping course was managing on income a little better but still a problem. Now keeping in contact with friends from course was a problem. Still worried about future and about regaining employment.

PERCEIVED SOCIAL SUPPORT

Parents still supportive.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes but commented "I'm eating much better than I would living alone." Diary not completed.

Exercise

Less active than before. "I've lost a bit of heart." Generally he had "slowed down a lot."

Alochol Consumption

Non drinker. No change.

Smoking Behaviour

Had stopped smoking seven weeks prior to interview but could not explain why.

Medicine Use/Doctor Consultations

No medication. Zero medical consultations since previous interview.

HOUSEHOLD BUDGETING

Priorities unchanged. Now when he was short of money reduced expenditure on clothes instead of cigarettes.

SUBJECTIVE HEALTH STATUS

Still perceived health as "very good". Did not feel it had changed.

N.H.P. Scores : - Zero scores on all sections.

SUMMARY

Still worried about future and about regaining employment. Stopping course had removed main source of social contact. Reason for stopping smoking unknown. Decreased exercise appeared to be due to poorer psychological well being. This however not confirmed by N.H.P. scores which had improved. During interview general impression given was increased dejection and pessimism about future.

Interview Three (Unemployed 47 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working but managed to keep busy doing odd jobs for friends. Household income due to increased benefit payments. This made it easier to manage financially. Had applied for about eighty jobs since stopping work but not often received replies. Did obtain interview for security guard but not financially worthwhile. "I wasn't really interested in money cause I didn't expect to get as much as in the shipyards but this job was eighty hours a week and after tax and travelling expenses you were coming out with about £45. I just wasn't interested in that!" Seeking employment and thinking about the future were depressing for him. However keeping in touch with friends no longer a problem "You just get used to it!"

PERCEIVED SOCIAL SUPPORT

Parents still supportive.

HEALTH RELATED BEHAVIOUR

Diet

Had been eating more since stopping smoking and since he had gained weight now on reducing diet. Although diary indicated that sugar consumption in drinks reduced and chips less frequent few other changes. Indeed frequency of lemonade consumption had increased.

Exercise

Now exercising more since had returned to karate classes, was jogging and doing floor exercise. Generally felt more active. Thought may be due to better weather.

Alcohol Consumption

Non drinker. No change.

Smoking Behaviour

Still ex-smoker.

HOUSEHOLD BUDGETING

No change.

SUBJECTIVE HEALTH STATUS

Still perceived as "very good".

N.H.P. Scores : Zero scores on all sections - same.

SUMMARY

Apparent that job seeking with continued lack of success and looking towards future were depressing. Some evidence of adapatation to loss

of social contact. Cessation of smoking had resulted in increased food consumption but this now being tackled for health reasons. Increased exercise may be due to seasonal factors. Suggestion that this was contributing towards improved perceived health.

Interview Four (Unemployed One Year)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working but "It gets easier - you get used to it." Taking massage course two days a week. Although no qualifications at end was something to do. Supplementary benefit would be about £4 less a week but hoping parents would be able to claim more to compensate. Had applied for nine jobs since previous interview. Only one reply which was negative. "Keeping looking for a job is a heart break." Visiting Job Centre also distressing. "You can stand and watch that job going on the board and when you go to the desk it's away. To me it's under the table!" Did not think he would apply for another Community Programme. "It's derogative! To the likes of people like me, a bit older, we have work experience and you go into a job like that and it's just irrelevant, what you're doing. It's just one big con!" Still worried about future and was pessimistic. "I'll be on the dole for the next five years if this crowd (Conservative Government) get in. If I can't make a move between now and the next year, I'll be on the dole for the next five years or maybe for life!" Process of claiming benefit was distressing. "Every two weeks I've got to psyche myself up three or four days before it. I've got to go down to this place and you know I've got nerves in my stomach actually thinking about it."

PERCEIVED SOCIAL SUPPORT

Parents still supportive.

HEALTH RELATED BEHAVIOUR

Diet

Had lost some weight but still trying to reduce food consumption. This not confirmed since diary not returned.

Exercise

Still going to karate, jogging and doing floor exercises.

Alochol Consumption

Non drinker.

Smoking Behaviour

Still ex-smoker.

Medicine Use/Doctor Consultations

No medication but reported sometimes feeling like getting tranquillisers. No medical consultation since previous interview.

HOUSEHOLD BUDGETING

No change but would be giving less to parents in future.

SUBJECTIVE HEALTH STATUS

Still perceived health as "very good".

N.H.P. Scores : - Zero scores on all sections - same.

However sometimes depressed. "There's days you get up and the sun's shining - you feel great - and if I've got something to do I'm happy. But if ever there's a day when it's raining and I've got nothing to do

I'm on a low."

SUMMARY

Unemployment distressing mainly because in area of high unemployment little prospect of regaining employment and at 37 he could see no future. Some evidence that part time course fulfilled some of the latent functions of employment and that problems increased when he left. Changes in exercise due to situational and seasonal factors. Increased food consumption result of stopping smoking. Some suggestion that when weight lost through reducing food consumption and increasing exercise this contributed towards improved perceived health. Changes in N.H.P. scores did not always concur with information given during interview. Impression of reluctance to admit to problems. Apart from fears about future some evidence of adaptation to unemployment, reduced income and loss of social contact. May have been affected more if lived alone.

CASE STUDY NO SEVENTEEN (MRS K)

NUMBER OF INTERVIEWS: Four
SUBJECT: Female
AGE: 47
MARITAL STATUS: Married
HOUSEHOLD COMPOSITION: Three Adults, one child
AGE COMPLETED SCHOOL: 15
OTHER EDUCATION: None
PREVIOUS OCCUPATION: Shop Assistant
LAST EMPLOYMENT: M.S.C. Community Programme (Part-Time)
SERVICE IN LAST EMPLOYMENT: Six months
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: No-one
DURATION OF PRESENT UNEMPLOYMENT: At least one year
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: One (Several years)

Interview One (unemployed 10 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Only missed work sometimes mainly for company. Household income £110 - £129 (about three quarters of when working). No problem managing on this amount. However replacement of household furnishings could not be afforded. Worried about future but no intention of looking for job until benefit stopped. Boredom not a problem because had house and family to look after.

PERCEIVED SOCIAL SUPPORT

Husband very supportive. He was helping around house since off work after accident.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes since stopping work. Three meals and two snacks every day. Although low fat spread and artificial sweetners used, puddings, biscuits, lemonade, crisps and sweets recorded several times. Mixture of fresh and processed meats together with cheese, eggs and fish. Vegetable consumption, potatoes twice, chips three times, and fresh vegetables four times. One piece of fresh fruit. No food which could not be afforded. Had thought of changing diet to lose weight because had knee trouble but had no willpower. Food consumption recorded appeared high for sedentary female. Thought she should eat high fibre breakfast cereals for health but did not like them.

Exercise

No exercise apart from housework. Less exercise than when working. Thought she should take more. Intended to do something about it.

Alcohol Consumption

Rarely drank alcohol.

Smoking Behaviour

Non Smoker.

Medicine Use/Doctor Consultations

No medication. One medical consultation in previous four months because of bladder trouble.

HOUSEHOLD BUDGETING

£40 - £49 spent on food per week. Priorities rent, food and fuel the least important being alochol and clothes. Money never really short.

SUBJECTIVE HEALTH STATUS

Perceived health as "fair". No change since stopping work.

N.H.P. Scores :- Zero scores on all sections except

Pain : 5.83 (general pop. mean 7.0)

Sleep : 12.57 (general pop. mean 15.2)

SUMMARY

Main function of work to provide little extra money (sometimes company). Since becoming unemployed role of wife and mother had expanded to fulfill other functions work may have provided. Only change in health behaviours was reduction in exercise due to situational factors. No evidence of changes in perceived health.

Interview Two (Unemployed 24 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed work for company. Son now unemployed and husband receiving sickness benefit so household income reduced to £95 per week. Problems managing on this amount. Still worried about future and worried about son. "I think he's getting really fed up. He's

desperate to get a job. You see plenty that just want to sit at home but he's not one of them."

PERCEIVED SOCIAL SUPPORT

Husband still supportive.

HEALTH RELATED BEHAVIOUR

Diet

Had tried to cut food consumption because gaining weight but had not been successful. Less tea, fewer biscuits and puddings but potatoes and chips more often. More fresh fruit.

Exercise

No change.

Alcohol Consumption

No change.

Smoking Behaviour

Non smoker.

Medicine Use/Doctor Consultations

No medication. One medical consultation for bladder complaint since previous interview.

HOUSEHOLD BUDGETING

Budgeting priorities unchanged but expenditure on food and clothes reduced. Additionaly no longer able to save.

SUBJECTIVE HEALTH STATUS

Perceived health as "good" now but did not feel it had changed.

N.H.P. Scores :- Pain : zero (general pop. mean 7.0) decreased

Sleep : 34.27 (general pop. mean 15.2) increased

SUMMARY

Increased financial problems not due to Mrs K's unemployment. No change in health behaviours except food consumption. Reasons for this may have been financial. No reported changes in perceived health but rating improved. Reasons for changes in N.H.P. scores unclear.

Interview Three (Unemployed 38 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Husband back at work but son still unemployed. Still only missed work sometimes but had started looking for work. Worried about not regaining employment when benefit stopped. Household income increased to £130 - £149 per week. Managing financially not so difficult but still could not afford to replace household furnishings.

PERCEIVED SOCIAL SUPPORT

Husband still supportive.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes but was thinking of joining slimming club. Butter and margarine instead of low fat spread. Consumption of puddings, sweets and biscuits increased again and now same as first interview.

Fresh fruit increased once more.

Exercise

No change.

Alcohol Consumption

No change.

Smoking Behaviour

Non smoker.

Medicine Use/Doctor Consultations

Medication every day for bladder complaint. Two medical consultations since previous interview for this problem.

HOUSEHOLD BUDGETING

No change.

SUBJECTIVE HEALTH STATUS

Still perceived health as "good".

N.H.P. Scores : Zero on all sections except

Sleep : 34.27 (general pop. mean 15.2) same.

SUMMARY

Little evidence of change except that now more worried about regaining employment. Reasons for changes in diet unclear but may have been due to increased income. Sleeping difficulties reported as being due to bladder complaint.

Interview Four (Unemployed One Year)

PERCEPTIONS OF UNEMPLOYMENT

Unemployment benefit stopped. Did not qualify for supplementary benefit so managing on reduced income was going to be a problem. Actively seeking employment but reported only 38 local jobs in Job Centre for whole of Greenock. "Now this crowd are in again there's no chance... She (Prime Minister) doesn't know what it's like. I've known what it's like to be sitting waiting for a Giro and you're watching for the postie coming ... and he goes by and you say Hells Bells! Until someone's experienced it they don't know how bad it is. It's worse for ones who havenae anyone to turn to."

Son now employed in temporary job. "I could see it was getting him doon. He would be sitting watching this video until all hours in the morning.... and then lie till dinner time. That caused manys a row with his dad. He wanted tae work but I could see he was getting really fed up."

PERCEIVED SOCIAL SUPPORT

Husband still supportive.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes. This confirmed by diary except that low fat spread once again instead of butter or margarine.

Exercise

Attending keep fit class in attempt to lose weight.

Alochol Consumption

No change.

Smoking Behaviour

Non smoker.

Medicine Use/Doctor Consultations

Medication stopped since bladder complaint improved. Two medical consultations since previous interview because of virus.

HOUSEHOLD BUDGETING

Budgeting priorities unchanged but changes would have to be made to expenditure unless Mrs K regained employment. "I don't think we're extravagent but I don't know - we'll just have tae cut doon on something. It'll probably need to be food cause you've got tae pay your rent and heating. Thought could also cut expenditure on newspapers and thinking about returing rented video player.

SUBJECTIVE HEALTH STATUS

Now perceived health as "fair".

N.H.P. Scores : Energy : 39.2 (general pop. mean 17) increased

Emotional Reactions : 17.69 (general pop. mean 13.1) increased

Sleep : 12.57 (general pop. mean 15.2) decreased

While previously sleeping difficulties due to bladder complaint reasons now different. "I'm no sleeping now thinking about this drop in wages. I think O God! I'm no sleeping so very well." The increased score for energy may have been due to illness caused by virus during three weeks before interview.

SUMMARY

Evidence that main problem associated with unemployment was reduced income. Initial decrease in exercise due to situational factors but subsequent increase for health reasons. Reasons for changes in diet unclear but may have been financial. Perceptions of health changed from "fair" to "good" returing to "fair". While some changes in N.H.P. socres probably due to physical complaint, some suggestion at last interview that worry over reduced income related to perceived health.

CASE STUDY NO. EIGHTEEN (MISS R)

NUMBER OF INTERVIEWS: Four
SUBJECT: Female
AGE: 49
MARITAL STATUS: Single
HOUSEHOLD COMPOSITION: Two adults
AGE COMPLETED SCHOOL: 16
OTHER EDUCATION: Part-time course
PREVIOUS OCCUPATION: Clerical
LAST EMPLOYMENT: M.S.C. Community Programme (part-time)
SERVICE IN LAST EMPLOYMENT: Seven months
REDUNDANCY PAYMENT: No
ATTRIBUTION OF UNEMPLOYMENT: No-one
DURATION OF PRESENT UNEMPLOYMENT: At least one year
SOCIAL CONTACTS UNEMPLOYED: Immediate Family : No
Other Relatives : No
Close Friends : No
PREVIOUS SPELLS OF UNEMPLOYMENT: One (Several years)

Interview One (Unemployed five weeks)

PERCEPTIONS OF UNEMPLOYMENT

Was mentally handicapped and had spent many years in hospital. Now lived in supported accommodation shared with handicapped man. Only worked for seven months but missed it for company and extra money. Personal income £38 (about three quarters of earnings). Flat mate worked so total weekly income £98. Managing financially, keeping in touch with friends and boredom were problems. Worried about future, regaining employment, other's expectations of her.

PERCEIVED SOCIAL SUPPORT

Social worker very supportive since stopping work.

HEALTH RELATED BEHAVIOUR

Diet

No reported changes since stopping work. Three meals plus one snack each day. Food relatively unvaried. Meat consumption limited to bacon and sausages. Fried food six times. Vegetable consumption very low. Restricted to chips five times and salad in rolls four times. Fresh fruit once. Would have bought more meat if it could be afforded because though it good for health. Had never considered changing diet.

Exercise

Limited to walking into town two or three times a week. No change since stopping work. Thought she should take more but not motivated.

Alcohol Consumption

Very rarely drank alcohol. No change since stopping work.

Smoking Behaviour

Twenty to 30 untipped cigarettes per day depending upon availability of money. Had thought of stopping but "I enjoy it. It's the only pleasure I've got."

Medicine Use/Dotor Consultations

Had been receiving medication for epilepsy but over previous months had been reduced and now stopped. Two medical consultations in previous four months for this reason.

HOUSEHOLD BUDGETING

£20 spent on food per week. Priorities food, fuel and rent the least important being social outings, holidays and household furnishings. When short of money reduced expenditure on clothes and cigarettes.

SUBJECTIVE HEALTH STATUS

Perceived as "good". No change since stopping work.

N.H.P. Scores : Zero scores for four sections

Sleep : 12.57 (general pop. mean 25.2)

Emotional Reactions 36.78 (general pop. mean 13.1)

SUMMARY

Experienced many problems associated with unemployment. No evidence that health behaviours had changed although food consumption fairly monotonous. No evidence of changes in perceived health.

Interview Two (Unemployed 24 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Still missed work but now attending college one afternoon and had voluntary job one morning. Slight increase in benefit but managing on money still a problem as was boredom. Other problems experienced before remained. Now increased problems keeping looking for work "I haven't looked for a week or two. You go in and look and these days there's just nothing. It's a wee bit disheartening."

PERCEIVED SOCIAL SUPPORT

Social worker giving increased support.

HEALTH RELATED BEHAVIOUR

Diet

Had been trying new recipes because bored with food they were eating. This not easy on £20 a week and a lot of time had to be spent shopping for best prices. Increased variety in food not apparent in diary. No vegetables apart from potatoes twice. Chips increased to eight times. Most days lunch, roll with chips or sausage. Unprocessed meat once only.

Exercise

No change.

Alcohol Consumption

No change.

Smoking Behaviour

Now 30 or more cigarettes a day. Increase since last time.

Medicine Use/Doctor Consultations

No medication. Several medical consultations since previous interview for check ups.

HOUSEHOLD BUDGETING

No change.

SUBJECTIVE HEALTH STATUS

Still perceived health as "Good". Did not feel it had changed.

N.H.P. Scores : Sleep : 12.75 (general pop. mean 15.2) same

Emotional Reactions : 62.3 (general pop. mean 13.1 increased

Energy : 60.8 (general pop. mean 17.0) increased

Social Isolation : 22.01 (general pop. mean 5.3) increased

SUMMARY

No change in problems experienced despite more active outside home. Smoking increased but reasons for this unclear. While perceived health remained same N.H.P. scores on three sections increased.

Affirmative responses to statements such as "I feel that life is not worth living " and "I wake up feeling depressed" not recorded previously suggest that health status poorer than before.

Interview Three (Unemployed 39 weeks)

PERCEPTIONS OF UNEMPLOYMENT

Since New Year had stopped shorthand course but now going to cookery class. Had to give up voluntary job because had broken ankle twice in two months. Same problems experienced as before but boredom worse because more confined to house.

PERCEIVED SOCIAL SUPPORT

Social Workers still suppportive. "If it wasn't for them I'd be in queer street."

HEALTH RELATED BEHAVIOUR

Diet

Still trying to introduce variety but still little evidence of this in diary. Fried food seven times and chips five times. No other vegetables or fruit.

Exercise

Due to broken ankle getting less exercise. Since stopping work had gained weight and this attributed to less activity.

Alcohol Consumption

No change.

Smoking Behaviour

Still 30 or more cigarettes a day.

Medicine Use/Doctor consultations

Had just finished taking pills for depression experienced in previous few months. Depression due to death of mother and to breaking ankle twice. After first break had epiletic fit but not receiving medication.

HOUSEHOLD BUDGETING

No change.

SUBJECTIVE HEALTH STATUS

Now perceived health as "fair" but felt it had been even worse between interviews.

N.H.P. Scores : Sleep : 12.57 (general pop. mean 15.2) same

Emotional Reactions : 48.07 (general pop. mean 13.1) decreased

Energy : 36.8 (general pop. mean 17.0) decreased

Social Isolation 22.01 (general pop. mean 5.3) same

Physical Mobility 11.2 (general pop. mean 4.1) increased

SUMMARY

No change in problems being experienced except increased boredom. No change in health behaviours except decreased exercise. Although some N.H.P. scores same as before and others decreased perceived health worse than before. This might be due to reduced physical mobility. Depression between interviews due to reasons other than unemployment. However possible that she could have coped better if not unemployed.

Interview Four (Unemployed One Year)

PERCEPTIONS OF UNEMPLOYMENT

Still missed working. "I can't accept the idea that there's nothing suitable for me." Back on Supplementary Benefit £5 less per week giving increased financial problems. All other problems noted before remained.

PERCEIVED SOCIAL SUPPORT

Social workers still supportive.

HEALTH RELATED BEHAVIOUR

Diet

Since stopping work had gained weight. So now trying to cut food intake. Grilling instead of frying. While this confirmed in diary in some instances fried food twice, chips three times and roast potatoes once. Also more bread and rolls than before. No other vegetables or fruit.

Exercise

Now walking more often "to kill some time."

Alcohol Consumption

No change.

Smoking Behaviour

Now smoking 30-40 cigarettes. Thought that increase due to nerves. "I'm smoking more at night. It's not so bad when I'm out doing something."

Medicine Use/Doctor Consultations

No medication. No medical consultations since previous interview except for plaster removal.

HOUSEHOLD BUDGETING

Unchanged but economies would have to be made now income reduced.

SUBJECTIVE HEALTH STATUS

Perceived health as "good" once again although reported to vary from day to day.

N.H.P. Scores : Sleep : 12.57 (general pop. mean 15.2) same

Emotional Reactions : 66.28 (general pop. mean 13.1) increased

Energy : 60.8 (general pop. mean 17.0) increased

Social Isolation : 42.4 (general pop. mean 5.3) increased

Physical Mobility : 0 (general pop. mean 4.1) decreased

SUMMARY

Despite only having worked for seven months unemployment proved very problematic. Diet was monotonous, the main limiting factor being lack of money but also could be due to lack of knowledge. Gained weight after stopping work due to situational factors. Smoking increased

over year and some suggestion that this due to combination of boredom and anxiety. Perceived health deteriorated then improved again. However N.H.P. scores inconsistant with health ratings since generally they increased, then decreased and subsequently increased again. Reason for inconsistency unclear.

APPENDIX 12

NOTTINGHAM HEALTH PROFILE SCORES

CASE NO	AGE/ GENDER	N.H.P. SECT.	AGE/ SEX POP. MEAN	INTER-VIEW 1	INTER-VIEW 2	INTER-VIEW 3	INTER-VIEW 4
1	44 MALE	EN.	10.1	0 -			
		P.	5.8	0 -			
		EM.	10.4	0 -			
		SL.	11.9	12.75 +			
		SO.	5.0	0 -			
		PM.	3.2	0 -			
2	40 MALE	EN.	10.1	0 -			
		P.	5.8	0 -			
		EM.	10.4	0 -			
		SL.	11.9	0 -			
		SO.	5.0	0 -			
		PM.	3.2	0 -			
3	38 MALE	EN.	5.0	0 -			
		P.	2.6	0 -			
		EM.	10.3	0 -			
		SL.	5.7	0 -			
		SO.	2.7	0 -			
		PM.	1.2	0 -			
4	28 FEMALE	EN.	20.0	0 -			
		P.	2.8	0 -			
		EM.	14.7	30.93 +			
		SL.	9.7	60.17 +			
		SO.	6.9	0 -			
		PM.	2.0	0 -			

KEY

EN - ENERGY
P - PAIN
EM - EMOTIONAL REACTIONS
SL - SLEEP
SO - SOCIAL ISOLATION
PM - PHYSICAL MOBILITY

CASE NO	AGE/ GENDER	N.H.P. SECT.	AGE/ SEX POP. MEAN	INTER- VIEW 1	INTER- VIEW 2	INTER- VIEW 3	INTER- VIEW 4
5	46 MALE	EN.	8.0	0 -	0 -		
		P.	3.0	0 -	0 -		
		EM.	7.7	0 -	0 -		
		SL.	8.4	0 -	0 -		
		SO.	1.6	0 -	0 -		
		PM.	1.1	0 -	0 -		
6	59 MALE	EN.	13.3	0 -	0 -		
		P.	2.9	0 -	0 -		
		EM.	7.7	17.69 +	17.69 +		
		SL.	11.7	0 -	0 -		
		SO.	3.4	0 -	22.53 +		
		PM.	3.7	0 -	0 -		
7	25 FEMALE	EN.	20.0	63.2 +	63.2 +		
		P.	2.8	0 -	0 -		
		EM.	14.7	46.54 +	50.02 +		
		SL.	9.7	77.63 +	77.63 +		
		SO.	6.9	57.34 +	57.34 +		
		PM.	2.0	0 -	0 -		
8	18 MALE	EN.	10.1	0 -	0 -		
		P.	0.7	0 -	0 -		
		EM.	11.6	17.55 +	0 -		
		SL.	8.4	37.80 +	0 -		
		SO.	5.5	0 -	0 -		
		PM.	1.5	0 -	0 -		

CASE NO	AGE/ GENDER	N.H.P. SECT.	AGE/ SEX POP. MEAN	INTER-VIEW 1	INTER-VIEW 2	INTER-VIEW 3	INTER-VIEW 4
9	20 MALE	EN.	10.1	0 -	0 -	0 -	
		P.	0.7	0 -	0 -	0 -	
		EM.	11.6	0 -	0 -	0 -	
		SL.	8.4	0 -	0 -	0 -	
		SO.	5.5	0 -	0 -	0 -	
		PM.	1.5	0 -	0 -	0 -	
10	56 MALE	EN.	13.3	0 -	0 -	0 -	
		P.	2.9	33.30 +	12.91 +	12.91 +	
		EM.	7.7	0 -	0 -	0 -	
		SL.	11.7	22.37 +	22.37 +	22.37 +	
		SO.	3.4	0 -	0 -	0 -	
		PM.	3.7	11.2 +	0 -	0 -	
11	36 MALE	EN.	5.0	0 -	0 -	0 -	
		P.	2.6	0 -	0 -	0 -	
		EM.	10.3	0 -	9.76 -	0 -	
		SL.	5.7	0 -	0 -	0 -	
		SO.	2.7	0 -	41.37 +	0 -	
		PM.	1.2	0 -	10.49 +	0 -	
12	22 MALE	EN.	10.1	24.0 +	0 -	0 -	
		P.	0.7	0 -	0 -	0 -	
		EM.	11.6	7.08 -	16.84 +	0 -	
		SL.	8.4	77.63 +	0 -	0 -	
		SO.	5.5	0 -	61.48 +	0 -	
		PM.	1.5	0 -	0 -	0 -	

CASE NO	AGE/ GENDER	N.H.P. SECT.	AGE/ SEX POP. MEAN	INTER-VIEW 1	INTER-VIEW 2	INTER-VIEW 3	INTER-VIEW 4
13	28 MALE	EN.	8.6	36.8 +	0 -	0 -	
		P.	1.6	0 -	0 -	0 -	
		EM.	10.3	17.55 +	26.05 +	7.08 -	
		SL.	8.6	16.10 +	0 -	0 -	
		SO.	5.6	0 -	0 -	0 -	
		PM.	1.6	0 -	0 -	0 -	
14	24 MALE	EN.	10.1	0 -	0 -	0 -	
		P.	0.7	0 -	0 -	0 -	
		EM.	11.6	0 -	0 -	0 -	
		SL.	8.4	37.8 +	0 -	0 -	
		SO.	5.5	0 -	0 -	0 -	
		PM.	1.5	0 -	0 -	0 -	
15	22 MALE	EN.	10.1	63.20 +	39.2 +	0 -	
		P.	0.7	9.99 +	0 -	0 -	
		EM.	11.6	28.29 +	38.41 +	29.70 +	
		SL.	8.4	21.70 +	0 -	0 -	
		SO.	5.5	0 -	0 -	0 -	
		PM.	1.5	0 -	0 -	0 -	
16	37 MALE	EN.	5.0	0 -	0 -	0 -	0 -
		P.	2.6	0 -	0 -	0 -	0 -
		EM.	10.3	17.69 +	0 -	0 -	0 -
		SL.	5.7	0 -	0 -	0 -	0 -
		SO.	2.7	0 -	0 -	0 -	0 -
		PM.	1.2	0 -	0 -	0 -	0 -

CASE NO	AGE/ GENDER	N.H.P. SECT.	AGE/ SEX POP. MEAN	INTER-VIEW 1	INTER-VIEW 2	INTER-VIEW 3	INTER-VIEW 4
17	47 FEMALE	EN.	17.0	0 -	0 -	0 -	39.2 +
		P.	7.0	5.83 -	0 -	0 -	0 -
		EM.	13.1	0 -	0 -	0 -	17.69 +
		SL.	15.2	12.57 -	34.27 +	34.27 +	12.57 -
		SO.	5.3	0 -	0 -	0 -	0 -
		PM.	4.1	0 -	0 -	0 -	0 -
18	49 FEMALE	EN.	17.0	0 -	60.80 +	36.8 +	60.80 +
		P.	7.0	0 -	0 -	0 -	0 -
		EM.	13.1	36.78 +	62.30 +	48.07 +	66.28 +
		SL.	15.2	12.57 -	12.57 -	12.57 -	12.57 -
		SO.	5.3	0 -	22.01 +	22.01 +	42.14 +
		PM.	4.1	0 -	0 -	11.20 +	0 -

REFERENCES

1. GREENWOOD, G. (1981) "Unemployment and its Effects on Health." Journal of the Institute of Health Education 19 (4) 105-109.

2. COLLEDGE, M. (1982) "Economic Cycles and Health." Social Science and Medicine. 16 (22) 1919-1927.

3. UNEMPLOYMENT AND HEALTH STUDY GROUP (1985) "Unemployment, Health and Social Policy." Nuffield Centre for Health Services Studies. University of Leeds.

4. MULLEN, K. (1985) "The Social Context of Unemployment and Health : A Review of the Literature." M.R.C. Occasional Paper No. 8.

5. WARR, P. (1982) "Psychological Aspects of Employment and Unemployment." Psychological Medicine. 12 7-11.

6. DOOLEY, D. and CATALANO, R. (1980) "Economic Change as a Cause of Behavioural Change." Psychological Bulletin. 87 450-468.

7. SMITH, R. (1985-1986) "Occupationless Health." British Medical Journal. 1985 291 1024-1027; 1985 291 1107-1111; 1985 291 1191-1195; 1985 291 1263-1266; 1985 291 1338-1341; 1985 291 1409-1412; 1985 291 1492-1495; 1985 291 1563-1566; 1985 291 1626-1629; 1985 291 1707-1710; 1986 292 263-365; 1986 292 320-323; 1986 292 470-472.

8. WARR, P. (1985) "Twelve Questions about Unemployment and Health." in Roberts, B. et al (eds) New Approaches to Economic Life. Manchester University Press. Manchester.

9. JAHODA, M. and RUSH, H. (1980) "Work, Employment and Unemployment." Science Policy Research Unit, University of Sussex. Occasional Paper Series No. 12.

10. Anonymous, (1984) 'Unemployment and Health." Lancet. 2 1018-1019.

11. BRENNER, M.H. (1973) "Mental Illness and the Economy." Harvard University Press. Cambridge. Massachusetts.

12. BRENNER, M.H. (1977) "Health Costs and Benefits of Economic Policy." International Journal of Health Services. 7 (4) 581-623.

13. BRENNER, M.H. (1979) "Mortality and the National Economy." Lancet. 2 568-573.

14. BRENNER, M.H. (1983) "Mortality and Economic Instability." International Journal of Health Services. 13 (4) 563-619.

15. GRAVELLE, H.S.E. et al (1981) "Mortality and Unemployment : A Critique of Brenner's Time Series Analysis." Lancet. 2 675-679.

16. BUNN, A.R. (1979) "Ischaemic Heart Disease, Mortality and the Business Cycle in Australia." American Journal of Public Health. 69 (8) 772-781.

17. EYER, J. (1977) "Prosperity as a Cause of Death." International Journal of Health Services." 7 (1) 125-150.

18. SPRUIT, I.P. (1982) "Unemployment and Health in Macro-Social Analysis." Social Science and Medicine. 16 1903-1917.

19. CATALANO, R. and DOOLEY, C.D. (1977) "Economic Predictors of Depressed Mood and Stressful Life Events in a Metropolitan Community." Journal of Health and Social Behaviour. 18 (3) 292-307.

20. PLATT, S. and KREITMAN, N. (1984) "Trends in Parasuicide and Unemployment among Men in Edinburgh 1968-1982." British Medical Journal. 289 1029-1032.

21. MOSER, K.A. et al (1984) "Unemployment and Mortality in the O.P.C.S. Longitudinal Study." Lancet. 2 1324-1329.

22. MOSER, K.A. et al (1986) "Unemployment and Mortality : Further Evidence from the O.P.C.S. Longitudinal Study 1971-1981." Lancet. 1 365-367.

23. MOSER, K.A. et al (1987) "Unemployment and Mortality : Comparison of the 1971 and 1981 Longitudinal Study Census Samples." British Medical Journal. 294 86-90.

24. ARBER, S. (1987) "Social Class, Non-employment and Chronic Illness : Continuing the Inequalities in Health Debate." British Medical Journal. 294 1069-1073.

25. LIEM, R and LIEM, J. (1978) "Social Class and Mental Illness Reconsidered." Journal of Health and Social Behaviour. 19 139-156.

26. DANIEL, W.W. (1974) "A National Survey of the Unemployed." Political and Economic Planning XL. Broadsheet No 546. London.

27. THE PILGRIM TRUST (1938/1983) "Men Without Work." Cambridge University Press.

28. HEPWORTH, S. (1980) "Moderating Factors in the Psychological Impact of Unemployment." Journal of Occupational Psychology. 53 139-146.

29. GOLDBERG, D.P. (1972) "The Detection of Psychiatric Illness by Questionnaire." Oxford University Press. London.

30. BREAKWELL, G.M. et al (1984) "Explaining Psychological Effects of Unemployment for Young People." British Journal of Guidance and Counselling. 12 (2) 132-140.

31. JACKSON, P.R. and WARR, P.B. (1984) "Unemployment and Psychological Illhealth : The Moderating Role of Duration and Age." Psychological Medicine. 14 605-614.

32. JACKSON, P.R. (1985) "Differential Vulnerability and Psychological Health in Unemployment." The Statistician. 34 83-91.

33. JACKSON, P.R. and WARR, P.B. (1987) "Mental Health of Unemployed Men in Different Parts of England and Wales." British Medical Journal. 295 525.

34. WHITEHEAD, M. (1987) "The Health Divide : Inequalities in Health in the 1980s. " Health Education Council. London.

35. PAYNE, R. et al (1984) "Social Class and Psychological Illhealth during Unemployment." Sociology of Health and Illness. 6 152-174.

36. FURNHAM, A. (1983) "Mental Health and Employment Status : A Preliminary Study." British Journal of Guidance and Counselling. 2 (1) 197-201.

37. McKENNA, S.P. and FRYER, D. (1984) "Perceived Health during Layoff and Early Unemployment." Occupational Health. May. 201-206.

38. HUNT, S.M. et al (1986) "Measuring Health Status." Croom Helm. London.

39. McKENNA, S.P. and PAYNE, R.L. (1984) "Measuring the Perceived Health of Unemployed and Re-employed Men." M.R.C./E.S.R.C. Social and Applied Psychology Unit. University of Sheffield.

40. GOLDBERG, D.P and HILLIER, V.F. (1979) "A Scaled Version of the General Health Questionnaire." Psychological Medicine. 9 139-145.

41. COOK, D.G. et al (1982) "Health of Unemployed Middle Aged Men in Great Britain." Lancet. 1 1290-1294.

42. THE ECONOMIST INTELLIGENCE UNIT (1982) "Coping with Unemployment : The Effects on the Unemployed Themselves." The Economist Intelligence Unit Ltd. London.

43. MILES, I. (1983) "Adaptation to Unemployment?" Science Policy Research Unit. Occasional Paper No. 20. University of Sussex.

44. JAHODA, M. and RUSH, H. (1982) "Employment and Unemployment : A Social Psychological Analysis." Cambridge University Press.

45. WARR, P. and PAYNE, R. (1983) "Social Class and Reported Changes in Behaviour After Job Loss." Journal of Applied Social Psychology. 13 (3) 206-222.

46. TREW, K. and KILPATRICK, R. (1984) "The Daily Life of the Unemployed : Social and Psychological Dimensions." Department of Psychology. Queen's University of Belfast.

47. Cobb, S. et al (1966) "The Health of People Changing Jobs." American Journal of Public Health. 56 1476-1481.

48. KASL, S. et al (1972) "Changes in Reported Illness and Illness Behaviour Related to Termination of Employment : A Preliminary Report." International Journal of Epidemiology. 1 (2) 111-118.

49. KASL, S. et al (1975) "The Experience of Losing a Job : Reported Changes in Health Symptoms and Illness Behaviour." Psychosomatic Medicine. 37 (2) 106-122.

50. COBB, S. and KASL, S.V. (1977) "Termination : The Consequences of Job Loss. : U.S. Department of Health, Education and Wellfare. Cincinatti, Ohio.

51. COHN, R.M. (1978) "The Effects of Employment Status on Change in Self Attitudes." Social Psychology. 41 81-93.

52. RAMSDEN, S. and SMEE, C (1981) "The Health of Unemployed Men." Employment Gazette. 89 397-401.

53. BANKS, M.H. and JACKSON, P.R. (1982) "Unemployment and Risk of Minor Psychiatric Disorder in Young People." Psychological Medicine. 12 789-798.

54. WARR, P. et al (1982) "Duration of Unemployment and Psychological Well Being in Young Men and Women." Current Psychological Research. 3 207-214.

55. JACKSON, P.R. et al (1983) "Unemployment and Psychological Distress in Young People : The Moderating Role of Employment Commitment." Journal of Applied Psychology. 68 525-535.

56. BUSS, T.F. et al (1983) "Mass Unemployment : Plant Closings and Community Mental Health." Sage Publications. London.

57. BEALE, N. and NETHERCOTT, S. (1985) "Job Loss and Family Morbidity. A Study of a Factory Closure." Journal of Royal College of General Practitioners. 35 510-514.

58. BEALE, N. and NETHERCOTT, S. (1986). "Job Loss and Health - The Influence of Age and Previous Morbidity." Journal of Royal College of General Practitioners. 36 261-4.

59. BEALE, N. and NETHERCOTT, S. (1986) "Job Loss and Morbidity in a Group of Employees Nearing Retirement." Journal of the Royal College of General Practitioners. 36 (287) 265-266.

60. STOKES, G.J. (1981) "The Psychological and Social Consequences of Economically Precipitated Stress." Unpublished Ph.D Thesis : Birmingham University.

61. JAHODA, M. et al (1933/1972) "Marienthal - The Sociography of an Unemployed Community." Tavistock Publications. London.

62. BAKKE, E.W. (1933) "The Unemployed Man." Nisbet. London.

63. HILL, J.M.M. (1977) "The Social and Psychological Impact of Unemployment - A Pilot Study." The Tavistock Institute of Human Relations. London.

64. FAGIN, L. (1981) "Unemployment and Health in Families - A Pilot Study." D.H.S.S. London.

65. FAGIN, L. and LITTLE, M. (1984) "The Forsaken Families." Penguin. Harmondsworth .

66. MARSDEN, D. (1982) "Workless." Croom Helm. London.

67. FINEMAN, S. (1983) "Counselling the Unemployed - Help and Helplessness." British Journal of Guidance and Counselling. 11 (1) 1-9.

68. SWINBURNE, P. (1981) "The Psychological Impact of Unemployment on Managers and Professional Staff." Journal of Occupational Psychology. 54 47-64.

69. McLELLAN, J. (1985) "The Effect of Unemployment on the Family." Health Visitor. 58 June 157-161.

70. JACOB, A., GOODMAN, M., MacKAY, J., HUSAIN, M.H., TANNER, C.P., HIGGS, R., WILSON, J. (1981) "Unemployment in My Practice." British Medical Journal. 282 1844, 282 2020, 282 2104, 283 26, 283 201, 283 532, 283 770.

71. WARR, P. (1983) "Work, Jobs and Unemployment." Bulletin of the British Psychological Society. 36 305-311.

72. FRYER, D.M. and PAYNE, R.L. (1983) "Pro-activity as a Route into Understanding Psychological Effects of Unemployment." Social Applied Psychology Unit. Memo 540. University of Sheffield.

73. ROBINSON, K. (1983) "What is Health?" in CLARKE, J. and HENDERSON, J (Eds) "Community Health." Churchill Livingstone. London.

74. WORLD HEALTH ORGANISATION, (1984) "The Constitution." The World Health Organisation. Geneva.

75. DUBOS, R. (1965) "Man Adapting." Yale University Press. London.

76. KELMAN, S. (1975) "The Social Nature of the Definition Problem in Health." International Journal of Health Services. 5 (4) 625-642.

77. BALOG, J.E. (1981) "The Concept of Health and the Role of Health Education." Journal of School Health. 51 (8) 461-464.

78. PILL, R. and STOTT, N. (1982) "Concepts of Illness Causation and Responsibility." Social Science and Medicine. 16 43-52.

79. BLAXTER, M and PATERSON, E. (1982) "Mothers and Daughters : A Three Generational Study of Health Attitudes and Behaviour." Heinneman Educational Press. London.

80. HERZLICH, C. (1973) "Health and Illness - A Social Psychological Analysis." Academic Press. London.

81. WILLIAMS, R.G.A. (1983) "Concepts of Health : An Analysis of Lay Logic." Sociology 17 185-205.

82. HUNT, S.M. and MacLEOD, M. (1987) "Health and Behavioural Change : Some Lay Perspectives." Community Medicine 9 (1) 68-76.

83. MIKHAIL, B. (1981) "The Health Belief Model : A Review and Critical Evaluation of the Model, Research and Practice." Advances in Nursing Science 4 (1) 65-82.

84. BELLOC, N.B. and BRESLOW, L. (1972) "Relationship of Physical Health Status and Health Practices." Preventive Medicine 1 409-421.

85. LANGLIE, J.K. (1977) "Social Networks, Health Beliefs and Preventive Health Behaviour." Journal of Health and Social Behaviour 8 244-260.

86. PRATT, L. (1976) "Family Structure and Effective Health Behaviour - The Energised Family." Houghton Mifflin Company. Boston.

87. HARRIS, D.M. and GUTEN, S. (1979) "Health Protective Behaviour - An Exploratory Study." Journal of Health and Social Behaviour. 20 March 17-29.

88. ANDERSON, R. (1983) "How Have People Changed Their Health Behaviour?" Health Education Journal 42 (3) 82-86.

89. CAMERON, D. and JONES, I.G. (1985) "An Epidemiological and Sociological Analysis of the Use of Alcohol, Tobacco and Other Drugs of Solace." Community Medicine 7 (1) 18-29. D.H.S.S.

90. D.H.S.S. (1980) "Inequalities in Health." Report of a Research Working Group Chaired by Sir Douglas Black, D.H.S.S. London.

91. MURPHY, H.B.M. (1978) "Historic Changes in the Sex Ratios for Different Disorders." Social Science and Medicine 12B 143-149.

92. DUNNEL, K. and CARTWRIGHT, A. (1972) "Medicine Takers, Prescribers and Horders." Routledge and Kegan Paul, London - Boston.

93. WALDRON, I. (1983) "Sex Differences in Illness Incidence, Prognosis and Mortality : Issues and Evidence." Social Science and Medicine 17 (16) 1107-1123.

94. O.P.C.S. (1986) "General Household Survey for 1984." H.M.S.O. London.

95. DIGHT, S.E. (1976) "Scottish Drinking Habits." H.M.S.O. London.

96. CENTRAL STATISTICAL OFFICE, (1986) "Social Trends" 1986 Edition 16 H.M.S.O. London.

97. WINTON, M. et al (1981) "Effects of Unemployment on Drinker's Behaviour : A Review of Relevant Evidence." Unpublished Mimeo. Ninewells Medical School Dundee.

98. PLANT, M.A. (1979) "Drinking Careers." Tavistock Publications. London.

99. M.A.F.F. (1986) "Household Food Consumption and Expenditure 1984" Annual Report of the National Food Survey Committee. H.M.S.O. London.

100. COLE-HAMILTON, I. (1986) "Tightening Belts." London Food Commission.

101. National Advisory Committee on Nutrition Education (1983) "Proposals for Nutritional Guidelines for Health Education." Health Education Council, London.

102. MILBURN, J. et al (1987) "Nae Bread." Health Education Department Argyle and Clyde Health Board.

103. LANG, T. et al (1984) "Jam Tomorrow." Food Policy Unit. Manchester Polytechnic.

104. CURRIE, E. (1987) Reported in The Guardian 3/7/87 Page 2.

105. ROSENSTOCK, I.M. (1974) "Historical Origins of the Health Belief Model" in Becker, M.H. (Ed.). "The Health Belief Model and Personal Health Behaviour." Charles B. Slack. New Jersey.

106. BECKER, M.H. et al (1974) "The Health Belief Model and Personal Health Behaviour." Health Education Monograph 2 326-473.

107. SEEMAN, M. et al (1983) "Health Behaviour and Personal Autonomy." Journal of Health and Social Behaviour. 2 144-160.

108. COBURN, D. and POPE, C.P. (1974) "Socio-Economic Status and Preventive Health Behaviour." Journal of Health and Social Behaviour . 15 67-78.

109. AUCKLAND, J. N. et al (1984) "The Influence of Socio-Economic Status on Health Related Knowledge and Habits of Middle Aged Males." Journal of The Royal Society of Health 104 (4) 130-134.

110. MECHANIC, D. (1974) "Social Structure and Personal Adaptation." in Coelho, G. et al (Eds) "Coping and Adaptation." Basic Books Inc. New York.

111. WHITE, R. (1974) "Strategies of Adaptation" : in Coelho, G et al (Eds) "Coping and Adaptation." Basic Books Inc. New York.

112. HAMBURG, D. et al (1974) "Coping and Adaptation : Steps Towards a Synthesis of Biological and Social Perspectives." in Coelho, G. et al (Eds) "Coping and Adaptation." Basic Books Inc. New York.

113. KATZ, D. and KAHN, R. L. (1978) "The Social Psychology of Organisations." 2nd Ed. John Wiley. New York.

114. LAZARUS, R. et al (1974) "The Psychology of Coping." in Coelho, G. et al (Eds) "Coping and Adaptation." Basic Books Inc. New York.

115. HART, N. (1985) "The Sociology of Health and Medicine." Causeway Press Ltd. Lancashire.

116. ANTONOVSKY, A. (1979) "Health, Stress and Coping." Jossey-Bass Publishers. London.

117. ASKHAM, J. (1975) "Fertility and Deprivation." Cambridge Press Books. London.

118. BLAXTER, M. (1981) "The Health of Children." Heinneman Educational Books. London.

119. BROWN, G. W. and HARRIS, T. (1978) "Social Origins of Depression." Tavistock Publications. London.

120. THOMPSON, I.E. (1983) "Theoretical Models of Health Education." in "Health Education Inservice Training Needs for District Nurses, Health Visitors and Midwives." Scottish Health Education Group. Edinburgh.

121. D.H.S.S. (1976) "Prevention and Health : Everybody's Business." H.M.S.O. London.

122. BILLINGTON, D.R. (1981) "A Critical Review of Health Education in Relation to Behavioural Sciences." in "Health and Behavioural Change." Scottish Home and Health Department Health Services Research Committee. Scottish Home and Health Department.

123. HUNT, S.M. (1974) "The Teaching and Practice of Social Psychology in Health Education." in "The Preparation of Health Personnel in Health Education." W.H.O. Regional Office of Europe.

124. KEMPA, R. and LAMBERT, C. (1986) "Certificate in Health Education Open Learning Project University of Keele." Health Education Council. London.

125. ANDERSON, R. (1984) "Health Promotion : An Overview." in "European Monographs in Health Education Research No. 6." Scottish Health Education Group. Edinburgh.

126. WORLD HEALTH ORGANISATION (1984) "Health Promotion. A Discussion Document on the Concept and Principles." W.H.O. Copenhagen.

127. UNITED STATES OFFICE OF HEALTH PROMOTION (1980) Quoted in "European Monographs in Health Education Research No. 6." Scottish Health Education Group. Edinburgh

128. FISHER, F.K. et al (1986) "Health Education and Health Promotion - An Australian Perspective." Health Education Journal 45 (2) 95-98.

129. GREEN, L.W. (1979) "Health Promotion Policy and the Placement of Responsibility for Personal Health Care." Family and Community Health 2 (3) 51-63.

130. TANNAHILL, A. (1985) "What is Health Promotion?" Health Education Journal 44 (4) 167-168.

131. SCOTTISH HEALTH EDUCATION CO-ORDINATING COMMITTEE (1984) "Health Education in Areas of Multiple Deprivation." Scottish Health Education Co-Ordinating Committee. Edinburgh.

132. CORNWELL, J. (1984) "Hard Earned Lives." Tavistock Publications. London.

133. ROSS, C.K. (1981) "Factors Influencing Successful Preventive Health Education." Health Education Quarterly. Fall. 8 (3) 187-208.

134. GREATER GLASGOW HEALTH BOARD INFORMATION SERVICES UNIT (1981) Census Report. Greater Glasgow Health Board.

135. STRATHCLYDE REGIONAL COUNCIL CHIEF EXECUTIVE'S DEPARTMENT (Dec 1987) Strathclyde Economic Trends.

136. EASTERDAY, L. et al (1977) "The Making of a Female Researcher - Role Problems in Fieldwork." Urban Life 6 (3) 333-348.

137. McKEE, L. and O'BRIEN, M. (1983) "Interviewing Men : Taking Gender Seriously" in Gamarnikow, E. et al (Eds) "The Public and the Private." Heinneman. London.

138. PLATT, J. (1976) "Realities of Social Research." Sussex University Press.

139. BYNNER, J. and STRIBLEY, K.M. (1979) "Social Research : Principles and Procedures." Longman in association with The Open University Press.

140. McKEE, L. and BELL, C. (1984) "His Unemployment : Her Problem. The Domestic and Marital Consequences of Male Unemployment." Paper presented to British Sociological Association Annual Conference 1984.

141. FRYER, D. (1986) "The Ethics of Psychological Research into Unemployment : Some Dilemmas." Occupational Psychology Newsletter. Special Issue on Values and Ethics in Occupational Psychology 23 20-26.

142. MacARTHUR, S.M. (1987) "Some Experiences of Research into Unemployment." The Occupational Psychologist. No 1. 38-39.

143. EISENBERG, P. and LAZARSFELD, P.F. (1938) "The Psychological Effects of Unemployment." Psychological Bulletin 35 358-391.

144. SCOTTISH HOME AND HEALTH DEPARTMENT. "The Scottish Health Survey." Common Services Agency. Edinburgh.

145. HUNT, S.M. and McEWAN, J. (1980) "The Development of a Subjective Health Indicator." Sociology of Health and Illness." 2 (3) 231-246.

146. ROYAL COLLEGE OF PSYCHIATRISTS (1979) "Report of Special Committee on Alcohol and Alcoholism." Tavistock Publications. London.

147. GRAHAM, H. (1976) "Smoking in Pregnancy : The Attitudes of Expectant Mothers." Social Science and Medicine. 10 403.

148. WORLD HEALTH ORGANISATION, HEALTH AND WELFARE CANADA & CANADIAN PUBLIC HEALTH ASSOCIATION (1986) "Ottowa Charter for Health Promotion." International Conference on Health Promotion. Ottowa 1986.