Child TRENDS
RESEARCH BRIEF

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Symptoms of Depression Among Welfare Recipients: A Concern for Two Generations

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December 2001

Feeling hopeless, lonely, inadequate, fearful. Being unable to shake off "the blues." Having difficulty concentrating, getting motivated to make decisions, and sleeping. These are typical symptoms of depression. Research indicates that such symptoms are more prevalent among low-income single mothers than in the general population. This finding has important implications for welfare reform. With the dramatic drop in caseloads since the passage of the 1996 welfare law, attention has turned to those still on the rolls – and the barriers that have prevented them from leaving. Is depression a barrier to employment for welfare recipients who have not made the transition into the work force? And how do a mother's symptoms of depression affect children in households receiving welfare?

The evidence presented in this Research Brief suggests that welfare recipients who are depressed may have more difficulty getting and keeping a job and that the children of mothers with symptoms of depression are likely to have more problems.[1] We also present recent findings showing that when welfare recipients participate in a welfare-to-work program, these symptoms can be affected, sometimes negatively.

This brief is one of a series being prepared by researchers at Child Trends to help inform the public debate surrounding the 2002 reauthorization of the Temporary Assistance for Needy Families (TANF) block grant, the centerpiece of the 1996 welfare law.

SHINING A LIGHT ON THE PROBLEM

We looked at the levels of depressive symptoms among samples of welfare recipients studied in five experimental evaluations of welfare-to-work programs established before the enactment of the 1996 welfare law: the Job Opportunities and Basic Skills Training (JOBS) Program, New Chance, the Teenage Parent Demonstration, Florida's Family Transition Program, and the Canadian Self-Sufficiency Project.[2] Almost all of these recipients were women with children, as is true for the majority of welfare recipients.

While the studies differ somewhat in the populations examined and the exact time frame covered, they were all studies of current or recent welfare recipients. As such, they may help to provide insights into depressive symptoms among the larger population of individuals who have recently left or are currently part of the welfare system.

In these studies, a self-administered survey was used to determine the presence of symptoms of depression.[3] Respondents were presented with a series of statements such as "I felt depressed," "I felt lonely," "I thought my life had been a failure," and were asked to indicate how often the statements matched their feelings during the past week. A clinical diagnosis of depression cannot be made on the basis of how someone responds on this kind of survey, of course; such diagnosis requires an individual evaluation by a mental health professional. Nevertheless, survey measures can be useful for identifying those who may be

at risk for clinical depression. Given this distinction, we use the term "depressive symptoms," rather than "depression," throughout this brief.

The prevalence: In surveys of the general population, about 20 percent of respondents are reported to have symptoms suggestive of clinical depression.[4] Previous non-experimental studies have reported higher rates of depressive symptoms in low-income populations, especially among mothers with young children, than in populations with higher incomes.[5,6] In the five experimental studies that we reviewed, among welfare recipients who were not enrolled in a welfare-to-work program (the control group), the percentages that could be considered at risk of clinical depression were much higher than in the general population. Across all the research samples, the percentages of individuals currently or recently receiving public assistance who were considered to have many symptoms of depression ranged from 30 percent (in the Riverside JOBS Program) to 45 percent (in the Newark Teenage Parent Demonstration).

The findings in a nutshell: The relatively high rates of depressive symptoms among these pre-1996 samples of welfare recipients suggest that the risk of depression may well be a problem for large numbers of individuals who are currently receiving welfare.

A POSSIBLE BARRIER TO EMPLOYMENT

Perhaps because of its prevalence, depression is often discussed as one possible barrier to employment among individuals who are on public assistance.[7] People who are depressed may find it difficult to get and keep a job. Yet until recently, research on how depression affects the employability of welfare recipients has been limited, and the studies that do exist report differing results, as seen below:

- In a study of welfare recipients that used a refined screening tool to identify major depression, respondents were asked whether they were employed at the time of the survey. In this case, after controlling for other factors that may have kept these individuals from working (such as lack of child care or difficulty with transportation), depression *was* found to be a barrier to employment.[8] Thus, this study suggests that current depression can be a barrier to current employment status.
- Three studies that used a short survey to measure the prevalence of depressive symptoms, rather than diagnostic criteria for major depression, did *not*, however, find an association between having symptoms of depression and being employed.[9]
- Other studies *did* find such an association when using the same survey measure of depressive symptoms, but the association was driven by mothers who experienced both high levels of depressive symptoms and other problems that stymied their efforts to work, such as low literacy or limited work experience.[10]

Making sense of the findings: This set of findings suggests that *major* depression may act as a barrier to employment for welfare recipients, but that *symptoms* of depression may not. A number of factors could be responsible for these results. It could be that when using a less refined survey measure, the level or type of depressive symptoms that act as a barrier is missed. Or it could be that just having symptoms of depression, rather than clinical depression, may not in itself act as a barrier to employment, but that when these symptoms are combined with other risk factors, they may. It is also possible that depressive symptoms may not hurt individuals' abilities to *get* a job, but that they may hurt their abilities to *keep* a job. For example, research has shown that depressed workers take more sick days.[11] This may make them prime candidates for dismissal. On the other hand, depressive symptoms may actually be lifted once individuals are working because holding a job may improve their opinions about their own abilities and their future prospects. In the case of major depression, this may not hold true. Future research on the effects of depression and depressive symptoms on both employment status and employment stability may be able to clarify the results from these studies.

A RISK FACTOR FOR CHILDREN

We now turn to how children are faring in households receiving welfare when their mothers have symptoms of depression.

The relation to child outcomes. Research has consistently documented that children of mothers who are depressed are at greater risk for poor outcomes in a variety of areas than children of mothers who are not. This holds for families across all income levels. Children of depressed mothers have been reported to show more behavior,[12, 13] and academic problems,[14] and to have a greater likelihood of health problems than children whose mothers are not depressed,[15] especially when depression is sustained over time.[16]

Results from a sample of current and recent welfare recipients, taken from a study of parenting behavior among welfare recipients, mirror these findings as they pertain to children's behavioral and cognitive outcomes.[17] Mothers in the sample were asked how their children were faring at two points in their lives: when they were 5- to 7-years-old; and then, when they were between 8 and 10.

- Children of mothers with more symptoms of depression exhibited significantly more behavior problems at ages 5 to 7 than did children of mothers with fewer symptoms of depression. Specifically, the children of mothers with more depressive symptoms showed both more "externalizing" behavior problems (such as bullying and acting disobedient) and more "internalizing" behavior problems (such as acting sad or showing low self-esteem).[18]
- When the children of mothers with more symptoms of depression were a little older (8 to 10), they again exhibited more internalizing behavior problems, as well as more "hyperactive" behaviors (such as disrupting others and acting without thinking).
- At this older age, these children also scored lower on a math achievement test than children of mothers with fewer depressive symptoms.[19]

In combination with other barriers. Additional evidence from this and other studies suggests that children of mothers who have symptoms of depression may be at even greater risk for poor outcomes when their mothers also have other problems. For example, the combination of maternal depressive symptoms and low maternal literacy predicted poorer behavioral outcomes (but not poorer cognitive outcomes) in 5- and 7-year-olds.[20] When these children were between 8 and 10, the combination of maternal depressive symptoms and low maternal literacy resulted in poorer cognitive outcomes (but not poorer behavioral outcomes). That is, when the children were younger, they were more likely to have behavior problems if their mothers had both symptoms of depression and low literacy; at the older age, they were more likely to show poor academic performance. Study authors suggest that, among children of mothers with both risk factors, the behavioral problems soon after school entry may have interfered with children's learning, translating into longer-term academic problems.[21] Evidence from this study also suggests that higher maternal literacy appears to buffer the relationship between maternal depressive symptoms and unfavorable child outcomes. In other words, depressive symptoms were associated with more problems in children when mothers also had low levels of literacy, though not when mothers had higher levels of literacy.[22] Similarly, another study found that work experience appears to buffer the effects of maternal depressive symptoms on children.[23]

The connection to parenting. Research suggests that parenting may be a pathway through which depression undermines children's development. Thus, mothers with depressive symptoms, or with diagnoses of clinical depression, may be less responsive to their children, more irritable, more harsh and coercive in disciplining, and less effective in teaching their children.[24] Several studies, including those focusing on mothers currently or recently receiving welfare, show that parenting behavior differs according to level of depressive symptoms or diagnosis of depression.[25] Through their parenting, mothers with high levels of

depressive symptoms may put their children at higher risk for emotional and behavioral difficulties themselves.

IMPACTS OF WELFARE-TO-WORK PROGRAMS

The purpose of welfare-to-work programs, as their name signifies, is to help move individuals from welfare dependency to economic self-sufficiency. Addressing the issue of depressive symptoms or clinical depression among welfare recipients was not an explicit goal of most of the programs cited in this brief. Yet because depression may impede employment, as well as compromise the well-being of children, it seems appropriate to consider what impact these programs had on symptoms of maternal depression.

We looked at the results of seven experimental studies that evaluated programs designed to decrease welfare dependency or improve economic well-being in low-income families. The programs include the five mentioned earlier in this brief in connection with our discussion of the prevalence of depressive symptoms among welfare recipients (the Job Opportunities and Basic Skills Training (JOBS) Program, New Chance, the Teenage Parent Demonstration, Florida's Family Transition Program, and the Canadian Self-Sufficiency Project), as well as the Minnesota Family Investment Program and New Hope.[26]

On adults. Even though it was not anticipated that enrolling in a welfare-to-work program would have an effect on symptoms of depression, the studies show that it can. Across 20 samples analyzed in the seven evaluation studies, one-third showed impacts of the programs on symptoms of depression. And within this group, the majority of programs had an unfavorable impact on these symptoms; that is, they increased these symptoms. Specifically, five unfavorable and two favorable impacts were found.[27]

The reasons behind this pattern are unclear, as the programs showing negative impacts on depressive symptoms varied in the populations they served, their structure, and whether participation was mandatory or voluntary.[28] Even without knowing what exact factors in these diverse programs were responsible for the apparent results, however, it still may be a concern that there were impacts and that the majority of these were unfavorable.

On children. Evidence from two programs that showed increases in depressive symptoms among participants (Grand Rapids' Labor Force Attachment Program and New Chance) suggests that the increase in these symptoms among mothers in the programs may have been related to negative impacts on their children. Mothers in the Grand Rapids' Labor Force Attachment Program (which is under the umbrella of the JOBS Program) reported experiencing more depressive symptoms and feeling less warmth toward their children, compared with a control group of mothers who were not in the program. In turn, children of mothers in the program exhibited more behavior problems, such as bullying or being disobedient, than children in the control group.[29] Analyses suggest that the increase in maternal depressive symptoms and decrease in warm parenting that occurred when women enrolled in the program may have contributed to the increase in children's behavior problems.[30] Results from the New Chance program raise this possibility as well.[31]

SUMMARY

The descriptive findings from experimental studies of welfare-to-work programs show that depressive symptoms are relatively common among populations currently or recently receiving welfare. Non-experimental findings presented here suggest that major depression – or even the presence of symptoms of depression – may act as a barrier to employment for some welfare recipients. Research also suggests that in addition to potential implications for employment, depressive symptoms are associated with unfavorable outcomes for children. Moreover, some evaluations of programs designed to decrease welfare dependency that were initiated before the passage of the 1996 welfare reform law have found that programs produced changes in symptoms of depression and that a majority of the impacts were in an unfavorable direction – a consequence that was clearly unintended.

IMPLICATIONS FOR RESEARCH AND POLICY

In the current context of welfare reform, with its strong emphasis on employment, it may be important to consider the negative impacts on symptoms of depression among some welfare recipients in pre-1996 welfare-to-work programs. How these individuals fared after enrolling in a welfare-to-work program may foreshadow how other welfare recipients may fare when they enter (or try to enter) the work force.[32]

Further research is needed to examine how and why some welfare-to-work programs caused an increase in depressive symptoms, as well as how other programs caused a decrease in these symptoms. In addition, research is needed to develop effective strategies to deal with the problem that maternal depression may pose for families on welfare, both as a potential barrier to employment and as a potential threat to the development of children. Some policies and programs are being implemented already to address these issues.[33] However, the upcoming reauthorization of the Temporary Assistance for Needy Families (TANF) block grant may be an opportune time for policy makers and social service providers to take a fresh look at this problem. This discussion should include not only a focus on employment, but also a focus on children.

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Child Trends gratefully acknowledges the John D. and Catherine T. MacArthur Foundation for support of its *Research Brief* series. We also thank officials of the U.S. Department of Health and Human Services, who granted Child Trends permission to use pre-release National Evaluation of Welfare-to-Work Strategies (NEWWS) Child Outcomes Study data to conduct many of the analyses reported in this brief.

Editor: Harriet J. Scarupa

Endnotes

[1]See also, discussion in Lennon, M. C., Blome, J., & English, K. (March 2001). *Depression and low-income women: Challenges for TANF and welfare-to-work policies and programs.* New York, NY: National Center for Children in Poverty; and in Rosman, E., McCarthy, J., & Woolverton, M. (2001). *Focusing on families in welfare reform reauthorization: Adults with mental health needs and children with special needs.* Washington, DC: National Technical Assistance Center for Children's Mental Health.

[2]For detailed information on the studies discussed, see the reports published for each study. Specifically, see McGroder, S.M., Zaslow, M.J., Moore, K.A., & LeMenestrel, S.M. (2000). *The National Evaluation of Welfare-to-Work Strategies: Impacts on young children and their families two years after enrollment: Findings from the Child Outcomes Study.* Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families and Office of the Assistant Secretary for Planning and Evaluation, and U.S. Department of Education. (NEWWS/COS); Quint, J., Bos, H., and Polit, D. (1997). *New Chance: Final report on a comprehensive program for young mothers in poverty and their children*. New York: Manpower Demonstration Research Corporation. (New Chance); Kisker, E., Rangarajan, A., & Boller, K. (1998). *Moving into adulthood: Were the impacts of mandatory programs for welfare-dependent teenage parents sustained after the programs ended?* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (TPD); Bloom, D., Kemple, J.J., Morris, P., Scrivener, S., Verma, N., Hendra, R., with Adams-Ciardullo, D., Seith, D., & Walter, J. (2000). *The Family Transition Program: Final report on Florida's initial time-limited welfare program.* New York: Manpower Demonstration Research Corporation. (FTP); Morris, P., & Michalopoulos, C. (2000). *The Self-Sufficiency Project at 36 months: Effects on children of a program that increased parental employment and income.* Ottawa, Ontario: Social Research and Demonstration Corporation. (SSP).

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[4]Comstock, G.W. & Helsing, K.J. (1976). Symptoms of depression in two communities. *Psychological Medicine, 6,* 551-563; Devins, G.M., & Orme, C.M. (1985). Center for epidemiological studies depression scale. In D.J. Keyser & R.C. Sweetland (Eds.), *Test Critiques* (pp. 144-160). Kansas City, MO: Test Corporation of America.

[5]Moore, K.A., Zaslow, M.J., Coiro, M.J., Miller, S.M., & Magenheim, E.B. (1995). *How well are they faring? AFDC families with preschool-aged children in Atlanta at the outset of the JOBS evaluation.* Washington, DC: U.S. Department of Health and Human Services; Quint, J.C., Polit, D.F., Bos, H., & Cave, G. (1994). *New Chance: Interim findings on a comprehensive program for disadvantaged young mothers and their children.* New York: Manpower Demonstration Research Corporation. For further discussion, see Coiro, M.J. (2001). Depressive symptoms among women receiving welfare. In M.C. Lennon (Ed.), *Welfare, work, and well-being* (pp.1-23). Bingham, NY: The Haworth Medical Press.

[6]Parental mental health more generally is also poorer among low-income parents and parents on welfare. See, for example, Vandivere, S., Moore, K.A., & Zaslow, M.J. (2000). *Children's family environment.* Snapshots of America's Families II: A View from the Nation and 13 States. Washington, D.C.: The Urban Institute.

[7]For reviews, see Olson, K., & Pavetti, L. (1996). *Personal and family challenges to the successful transition from welfare to work.* Washington, DC: The Urban Institute; Kalil, A., Corcoran, M., Danziger, S., Tolman, R., Seefeldt, K., Rosen, D., & Nam, Y. (1998). *Getting jobs, keeping jobs, and earning a living wage: Can welfare reform work?* Institute for Research on Poverty Discussion Paper, No. 1170-98. Madison, WI: University of Wisconsin-Madison.

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[9]See Coiro, 2001; McGroder, S.M., Zaslow, M.J., Papillo, A.R. & Ahluwalia, S.K. (2001, April). *Do mandatory welfare-to-work programs eliminate selection into maternal employment?* Paper presented at the meetings of the Society for Research in Child Development, Minneapolis, MN; Zaslow, M.J., Hair, E.C., Dion, M.R., Ahluwalia, S.K. & Sargent, J. (2001). Maternal depressive symptoms and low literacy as potential barriers to employment in a sample of families receiving welfare: Are there two-generational implications? In M.C. Lennon (Ed.), *Women & Health, 32*(3), 211-251.

[10]Hair, E.C., McGroder, S.M., Zaslow, M.J., Ahluwalia, S.K., & Moore, K.A. (in press). How do maternal risk factors affect children in low-income families? Further evidence of two-generational implications. *Journal of Prevention and Intervention in the Community.* McGroder, S. M., Ahluwalia, S. K., Papillo, A. R., McGarvey, A. (2001, November). Barriers to employment in a welfare sample facing mandatory work requirements: A cluster-analytic approach. Paper presented at the annual meeting of the Association for Public Policy and Management in Washington, D.C.

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[12]For example, Gross, D., Conrad, B., Fogg, L., Willis, L., & Garvey, C. (1995). A longitudinal study of maternal depression and preschool children's mental health. *Nursing Research, 44,* (2), 96-101; Hammen, C., Adrian, C., Gordon, D., Burge, D., Jaenicke, C., & Hiroto, D. (1987). Children of depressed mothers: Maternal strain and symptom predictors of dysfunction. *Journal of Abnormal Psychology, 96*(3), 190-198; Harnish, J.D., Dodge, K.A., & Valente, E. (1995). Mother-child interaction quality as a partial mediator of the roles of maternal depressive symptomatology and socioeconomic status in the development of child behavior problems. *Child Development, 66,* 739-753; Lang, C., Field, T., Pickens, J., Martinez, A., Bendell, D., Yando, R., & Routh, D. (1996). Preschoolers of dysphoric mothers. *Journal of Child Psychology and Psychiatry, 37*(2), 221-224.

[13]See Downey, G., & Coyne, J.C. (1990). Children of depressed parents: An integrative review. *Psychological Review, 108,* 50-76.

[14]See, for example, Field, T. (1992). Infants of depressed mothers. *Development and Psychopathology, 4,* 49-66.

[15]For example, Angel, R. & Worobey, J.L. (1988). Single motherhood and children's health. *Journal of Health and Social Behavior, 29,* 38-52.

[16]See discussion in Coiro, M. J. (1998, January). *Maternal depressive symptoms as a risk factor for the development of children in poverty.* Dissertation Abstracts International: Section B: The Sciences and Engineering. Vol. 58 (7-B). (pp. 3943). U.S.: Univ. Microfilms International.

[17]The sample is from the JOBS Observational Study, which is a longitudinal study of parenting behavior among mothers receiving welfare who had a three- or four-year-old child at study entry. The JOBS Observational Study is a substudy of the Child Outcomes Study of the National Evaluation of Welfare-to-Work Strategies (NEWWS). For details on the Child Outcomes Study, see McGroder et al., 2000.

[18]Zaslow et al., 2001.

[19]Hair et al., in press. Although several health outcomes were examined at this timepoint, maternal depressive symptoms were not related to these measures of health in this sample.

[20]Zaslow et al., 2001.

[21]Hair et al., in press.

[222]Zaslow et al., 2001 and Hair et al., in press. Higher maternal literacy appeared to buffer the relationship between maternal depressive symptoms and the following child outcomes: increased internalizing behaviors, worsened reading and math achievement test scores, and lower engagement in school.

[23]McGroder et al., 2001.

[24]For example, see Dodge, K.A. (1990). Developmental psychopathology in children of depressed mothers. *Developmental Psychology, 26*(1), 3-6; Downey & Coyne, 1990; Gelfand, D.M., & Teti, D.M. (1990). The effects of depression on children. *Clinical Psychological Review, 10,* 329-353; Goodman, S.H., & Brumley, H.E. (1990). Schizophrenic and depressed mothers: Relational deficits in parenting. *Developmental Psychology, 26*(1), 31-39; Hall, L.A., Gurley, D.N., Sachs, B., & Kryscio, R.J. (1991). Psychosocial predictors of maternal depressive symptoms, parenting attitudes, and child behavior in single-parent families. *Nursing Research, 40*(4), 214-220; and McLoyd, V. C. (1990). The impact of economic hardship on black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61*(2), 311-346.

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[26]The Minnesota Family Investment Program and New Hope were not included previously because while mean levels of depressive symptoms were examined for these studies, the published reports did not include the specific measure of the percentages at risk for clinical depression. For greater detail on the studies presented, see the published reports. Specifically, see McGroder et al., 2000 (NEWWS/COS); Quint et al., 1997 (New Chance); Kisker et al., 1998 (Teenage Parent Demonstration); Bloom et al., 2000 (Family Transition Program); Morris & Michalopoulos, 2000 (Self-Sufficiency Project); Gennetian, L.A., & Miller, C. (2000). *Reforming welfare and rewarding work: Final report on the Minnesota Family Investment Program. Volume 2: Effects on children.* State of Minnesota: Department of Human Services. (MFIP); Bos, J.M., Huston, A.C., Granger, R.C., Duncan, G.J., Brock, T.W., & McLoyd, V.C. (1999). *New Hope for people with low incomes: Two-year results of a program to reduce poverty and reform welfare.* New York: Manpower Demonstration Research Corporation. (New Hope).

[27]Depressive symptoms were *increased* by the Grand Rapids' Labor Force Attachment JOBS Program, New Chance, the Teenage Parent Demonstration program in Chicago, the Incentives Only portion of the Minnesota Family Investment Program for recent applicants, and the Canadian Self-Sufficiency Project for parents of 6- to 11-year-olds. Depressive symptoms were *decreased* by the Teenage Parent Demonstration program in Newark and the Incentives Only portion of the Minnesota Family Investment Program for long-term recipients. For the presentation of these impacts and others across the experimental evaluations, see Zaslow, M.J., Brooks, J.L., Moore, K.A., Morris, P., Tout, K., & Redd, Z. (2001). *Impacts on children in experimental studies of welfare-to-work programs.* Report to the Edna McConnell Clark and David and Lucille Packard Foundations and Zaslow, M.J., Moore, K.A., Brooks, J.L., Morris, P., Tout, K., Redd, Z., & Emig, C. (in press). Experimental studies of welfare reform and children. *Future of Children.*

[28]Because of the many differences in these programs, descriptions of them are not presented here. For details on the programs, see the individual reports, as well as Zaslow, Brooks, Moore, Morris, Tout, & Redd, 2001 and Zaslow, Moore, Brooks, Morris, Tout, Redd, & Emig, 2001.

[29]McGroder et al., 2000.

[30]McGroder, S.M., Zaslow, M.J., Moore, K.A., Hair, E.C., & Ahluwalia, S.K. (2001). The role of parenting in shaping the impacts of welfare-to-work programs on children. In J.G. Borkowski, S. Landesman, & M. Bristol-Power (Eds.), *Parenting and the child's world: Influences on academic, intellectual, and social-emotional development* (pp. 283-310). Mahwah, NJ: Lawrence Erlbaum Associates; McGroder et al., 2000.

[31]Quint et al., 1997

[32]See also, discussion in Lennon, Blome, & English, March 2001.

[33]See Knitzer, J. (2000). *Promoting resilience: Helping young children and parents affected by substance abuse, domestic violence, and depression in the context of welfare reform.* New York: National Center for Children in Poverty; Cauthen, N.K. & Knitzer, J. (1999). *Beyond work: Strategies to promote the well-being of young children and families in the context of welfare reform.* New York: National Center for Children in Poverty; and Knitzer, J. & Cauthen, N.K. (1999). *Enhancing the well-being of young children and families in the context of welfare reform: Lessons from early childhood, TANF, and family support programs.* Washington, DC: U.S. Department of Health and Human Services.

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