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# THE WAGES OF PRECARIOUS WORK: AN ETHNOGRAPHY OF UPSTATE SOUTH CAROLINA’S RESERVE ARMY OF THE LABORING

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# THE WAGES OF PRECARIOUS WORK: AN ETHNOGRAPHY OF UPSTATE SOUTH CAROLINA'S RESERVE ARMY OF THE LABORING

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DISSERTATION

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Arts and Sciences
at the University of Kentucky

By

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Lexington, Kentucky

Director: Dr. Mary Anglin, Associate Professor of Anthropology

Lexington, Kentucky

2019

# ABSTRACT OF DISSERTATION

# THE WAGES OF PRECARIOUS WORK: AN ETHNOGRAPHY OF UPSTATE SOUTH CAROLINA'S RESERVE ARMY OF THE LABORING

The proliferation of precarious work represents a sea change in the opportunity structure of the new economies of the American South. As the role of the State has shifted from guarantor of rights and services to anxious custodian of economic liberalization, Americans have been enjoined to shoulder ever-larger shares of the responsibilities and risks associated with wage labor. As a result, the working poor have been left to weather the vicissitudes of the unfettered market with the increasingly paltry social membership guaranteed through waged employment. Among the risks now frequently assumed by individuals, are the responsibilities of health.

In the absence of this social support, the working poor increasingly rely on the rationed healthcare of the safety-net. It is in this setting that the indigent and uninsured must seek care for the social suffering that results from precarity—the experiential condition of sustained economic and existential uncertainty. This dissertation examines how uninsured working poor residents of Spartanburg, South Carolina endure and embody precarious labor arrangements with the safety net care they are relegated to.

KEYWORDS: The Working Poor, Precarious Labor, Safety Net Health Care, U.S. South

Henry Erikson Bundy

November 27, 2019

DATE

# THE WAGES OF PRECARIOUS WORK: AN ETHNOGRAPHY OF UPSTATE SOUTH CAROLINA'S RESERVE ARMY OF THE LABORING

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## Introduction

Much of the research on the health effects of precarious work—the insecure, often poorly paid jobs that lack standard employment protections—is conducted in countries with free or universal healthcare (Ando 2018; Cavinet et al. 2016; Julià et al. 2017), where work may be onerous, dangerous, or poorly remunerated, but where unstable or contingent labor arrangements do not preclude vulnerable employees from access to healthcare. In the United States, by contrast, working poor Americans are often unable to afford health insurance and must instead rely on the rationed aid of safety net institutions for medical care (Becker 2004; Garfield et al. 2019).

This dissertation focuses on a group of uninsured working poor men and women living in Spartanburg County, South Carolina. The county is in the Upstate, the westernmost part of the state, about as far as you can be from the sea while still in South Carolina. Most of the people I write about here live in Spartanburg, the county seat, a former mill town with a population of around 37,000.

This ethnography explores how the precarity associated with low wage work is experienced and inflected in South Carolina, a state that forewent Medicaid expansion and left many working poor residents unable to afford plans on the health insurance exchanges and ineligible for health care through federal or state programs. By exploring the lives of working poor Upstate residents, the following ethnographic study sheds light on an aspect of precarious employment—the health consequences of uninsured work and the subsequent reliance on safety net[1] care among the working poor—that has gone almost entirely unexplored.

I spent a year and half, between 2016 through 2018, interviewing uninsured working poor residents in Spartanburg County. I met most of my interviewees at the local free clinic, where they were known as "clients", and where they went when they were unable to afford care anywhere else. Many of these clients were part of what I have come to call the "Reserve Army of the Laboring" for the county. The term comes from Marx's (1992) concept of the *reserve army of labor*, which refers to a disposable population surplus to the requirements of capital accumulation. In South Carolina, the uninsured and ailing working poor comprise one of these surplus populations; a pool of expendable labor-power maintained and managed through safety net care organizations, precarious labor arrangements, and disability courts. This dissertation explores the consequences of precarious work in an effort to understand how insecure low-wage labor shapes the lives and determines the health of uninsured working poor clients in the American South.

## Precarious Work and the Reserve Army of the Laboring

> *It was hard to tell if the man slumped in his wheelchair at the entrance of the cavernous superstore was waving a welcome or appealing mutely for help. I wasn't sure if he had been hired as a greeter, or had been dressed in a red shirt and abandoned, left, disheveled and disavowed, to become a ward of Wal-Mart. He held his soiled wrist brace above his head and looked through me as I walked*

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[1] Safety net institutions provide underserved populations free or subsidized care (Willging et al. 2008).

*in.*

*Greeters are often seen as goodwill positions, acts of corporate semi-charity that employ individuals with disabilities for the lightest of light duty: saying "hi". But, as it turns out, Wal-Mart greeters are actually there to deter "loss prevention," that is, shoplifting.*

*-Fieldnotes from the summer of 2017*

The proliferation of precarious work represents a sea change in the opportunity structure of the new economies of the American South. As the role of the State has shifted from guarantor of citizen rights and services to anxious custodian of economic liberalization (Harvey 2017; Kingfisher and Maskovsky 2008; Smith 2011), Americans have been enjoined to shoulder ever-larger shares of the responsibilities and risks associated with wage labor (Kalleberg 2011; Rose 1996; Standing 2011). As a result, the working poor have often been left to weather the vicissitudes of the unfettered market with the increasingly paltry social membership guaranteed through waged employment. Among the risks now frequently assumed by individuals are the responsibilities of health.

This shift has been accompanied by an erosion of social support for the poor. The welfare provisions that once sought to insulate vulnerable populations from the unforgiving consequences considered inherent in capitalist reproduction have since the late 1970s increasingly been supplanted by a commitment to economic liberalization in which the State provides its citizenry only the most basic assurances of security and wellbeing (Harvey 2005; Lorey 2015; Smith 2011). A growth in precarious employment arrangements characterized by low pay, instability, and an absence of non-wage benefits has followed (Lewchuk 2017; Quinlan and Mayhew 1999).

Increasingly saddled with the responsibility of managing the embodied inequities of neoliberal capitalism, members of the uninsured Reserve Army of the Laboring have been doomed to low-wage work by their poor health and subsequent lack of access to healthcare. The members of this ailing reserve army are not a lumpenproletariat—a disparate, unaligned class defined by their position outside the relations of production (Han 2018; Marx 1992)—but a vital, yet dispossessed, engine of the economy of South Carolina.

The Laboring "labor" in both senses of the word, in that they have "difficulty doing something despite working hard" and that they are "expending great physical or mental effort at something taxing or compulsory." (*A note on the terminology used in this dissertation: For brevity's sake I will be referring to the ailing, uninsured individuals of Spartanburg County's reserve army of labor as "the Laboring." In using this collective noun I do not mean to dehumanize the individuals that make up this population, nor do I want to reduce the lives of the people I met to their working bodies. Instead, the term is an effort to underscore an institutionalized class asymmetry that consumes the health and determines the life-chances of working poor county residents. If these residents were considered simply as individuals of common socio-economic status, or their lives were explored as the consequences of living at intersecting axes of oppression alone, the larger structural inequality that results in and from a lack of access to health insurance, would remain hidden.*) They are an enfeebled subset of the reserve army of labor, an immiserated workforce trapped in cycles of poverty and illness, unable to escape their health conditions for lack of regular access to care, and kept indigent by precarious labor arrangements, poor health, and resultant medical expenses.

Once welders, construction workers, and assembly line technicians, now frail and unwell and unable to afford care, the Laboring are forced to accept the most provisional of jobs, their poor health relegating them to the permanently probationary low-wage employment glossed by social scientists as “precarious work.” This work is defined by unstable labor arrangements, jobs without medical benefits or other forms of non-wage compensation, and a denial of civil and economic rights, rendering precariously-employed workers supplicants that must be judged deserving to receive aid from the State (Standing 2011).

Workers in these poorly-paid, no-benefit jobs have higher rates of injury (Giraudo et al. 2016; Koranyi et al. 2018). Studies show that they absorb more radiation (Thébaud-Mony 1999) and are stuck more often with needles (Aiken et al. 1997). Precarious work is also a proven vector of poor psychological health. Epidemiological studies have repeatedly found an association between mental illness and low-paying unstable work (Benach et al. 2014; Butterworth et al. 2011; Vives et al. 2013; Zabkiewicz 2009).

The Laboring are working poor individuals that have been marginalized by, and abandoned to, the naked forces of capitalist reproduction. It is my hope that the critical medical anthropology perspective employed in this dissertation can serve as a corrective to reductive conceptions of economic vulnerability by examining how social class and economic disenfranchisement  determine and result from distributions of disease and health care access (Lock 2001: 479; Rivkin-Fish 2011; Singer 1995).

A relational approach is warranted here, an approach that recognizes that "poverty is not simply the byproduct of one's attributes or historical outcomes but is also actively produced through unequal relationships between the financially secure and insecure" (Desmond and Western 2018: 310). This is why I have chosen to forego the more conventional metric of socioeconomic status in favor of social class, and to examine working poor members of the Reserve Army of the Laboring not as a population located along a gradation of economic capital, but as a class characterized by their distinct position in relation to the means of production.

For in the case of the Laboring, it is more instructive to understand social class as an asymmetrical relationship, rather than one socioeconomic variable among many; while social classes, in Marxist terms (1992), are defined by their relation to the means of production, the distinction between the strata of socioeconomic statuses are more gradual and ambiguous, relying on variables such as prestige, education, and income. Using socioeconomic status as a synonym of class obscures the impediments to class mobility—the poor health associated with laboring poverty, for example—and can imply an easy and fluid movement between class strata that does not necessarily exist (Wohlfarth 1997). Here, exploring the lives of the Laboring in terms of social class can shed light on the determinants of health particular to this Southern surplus population.

## The Surplus Population that is The Reserve Army of the Laboring

Surplus populations like the Laboring are not the inevitable consequence of

Malthusian overpopulation, but rather a result of the intentional displacement of labor inherent in capitalism (Li 2010; Smith 2011). In the United States, the bodies and work of the employed poor have become increasingly superfluous, spurred by a diminishment in the social membership once gained through employment (Ferguson 2013), and propelled by the reduction of labor as a factor of production (Wright 2006; Yates 2011).

The composition of a reserve army is historically and economically contingent[2], a population maintained in an effort to aid maximal capital accumulation (Marx 1992). As a result, "extra-economic interventions" are necessary to keep surplus populations viable for when their labor is again required (Smith 2011: 15). The welfare state, for example, ostensibly seeks to insulate particular populations from the volatility often present in system of capitalist wage labor. Yet increasingly, working poor Americans fall outside State efforts to offset injurious capitalist relations (cf. Smith 2011).

In the Upstate of South Carolina, the conditions of the members of the Reserve Army of the Laboring are perpetuated by a vicious cycle of low-wage work and inadequate healthcare. The conditional aid of the Upstate's safety net—care rationed in an effort to promote self-sufficiency and dissuade overreliance among recipients—allows uninsured and impoverished individuals to continue working, often with pain or while sick, in the precarious jobs that render them unable to escape the poverty that relegates them to safety net care.

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[2] As Magdoff and Magdoff (2004: 23) note the composition of U.S. reserve armies of labor has continually shifted, from Irish immigrants and Chinese laborers in the 1850s to Italian and other European workers at the turn of the twentieth century to African-Americans coming North after the world wars to undocumented Latinx workers in the modern era.

The safety net clients I interviewed were all in their 40s and 50s. Many had never been insured and had managed for decades without regularly seeing a doctor, but now the slow ruination of their bodies, the consequence of hard working conditions, poverty, and healthcare deferred, had become impossible to ignore. Mr. L., a construction worker (see Appendix A for biographical sketches of interviewees), was uninsured and was forced to continue working with a bad back after he ruptured a disc lifting heavy equipment from the bed of his truck. In lieu of the treatment he couldn't afford, he took twenty aspirin a day, against the advice of his doctor, and to little effect. In unbearable pain any time he was either standing up or lying down, he slept, upright and fitfully, in a recliner.

It was common for clients to have recently been to the emergency room. Most went after their chronic conditions, long untreated for a lack of resources, became intolerable. They then rode out their spells of hypoglycemia or hypertension or pancreatitis in the hospital for a night or two and were sent home, their conditions temporarily stabilized, but with no real prospect of recovery.

These conditions, left untreated, often worsened. Mr. W., a cabinet installer, developed foot drop from nerve damage he could not afford to see to. A doctor told Mr. Wa. he needed to stop working, or risk his leg being amputated. Ms. Gi. now had a mass on her neck, and was now unable to stand for very long or hold things well, two conditions that were causing her to struggle with the curriculum at the beauty school.

As their prospects dwindled, the health conditions of the Laboring came to consume their lives. Unable to dig themselves out of poverty with poorly-paid work, condemned to remain sick or ailing, ineligible for disability, and without health insurance, the only way these women and men had to sustain themselves was by low-paying unskilled precarious labor. But, as interviewees told me, it was often the conditions they labored in that had worn them down in the first place: The toxic fumes that poisoned you, the floating particulate that could suffocate you slowly, the duress from the unrelenting pace of assembly work that crippled your hands. But if you didn't come in to work, you wouldn't get paid, they said. And you'd be fired if you couldn't keep up. And you'd be let go if your days at the doctor were considered excessive or your recovery time was felt to be extravagant, they told me.

Then there was the unpaid work done after the shifts were over, the uncompensated moil of care that fell disproportionately to women, though some laboring men drove elderly parents to doctor's appointments, and cooked, and kept house too. Much of this work was done while exhausted, or in pain, chores and obligations finished hurriedly, for even though their shift had just ended, it might not be long before clients were called back in.

Members of this debilitated labor force are easily fired for cause, as their untreated conditions render them susceptible to mistakes, absences, and lapses in productivity. Ms. M., who suffered hand spasms due to a neurological condition, was let go after she had started dropping expensive components on the assembly line. Ms. J. had fallen one night while mopping, and kept trying to come back to work, but now had trouble standing and feared she would soon be fired. Ms. W., down the street, had never been able to hear all that well—you could tell from her speech—and had lost her last two jobs when, unable to understand instructions, she'd been written up for insubordination.

But often it was unnecessary to fire the Laboring, for they were likely going to fall out of the labor pool on their own. Mr. Wa. had been a roofer and a landscaper for decades, until he got sick. Now he took evermore-precarious work, work that paid little and offered no protections from illness or misfortune. Recently he had had to walk off a job after a persistent sore in his leg, the result of untreated blood clots, left him unable to climb a ladder. Mr. O., who drove a truck delivering furniture, had had to quit too. After he lost his father, the poorly-treated depression he had lived with nearly all his life became unmanageable, and he stopped coming in.

### The Growth of Precarious Work and Subsequent Exploitation of the Laboring

The term "reserve army" is not meant to imply that the poorly-paid positions of the Laboring are surplus to capitalism. To the contrary, these jobs sustain many U.S. industries and enterprises (Newman 1999; Shipler 2004). Instead, it is the individuals laboring in these immiserating arrangements that are increasingly disposable (Kalleberg 2011). Economically vulnerable and physically infirm, desperate and therefore tractable, the Laboring are often susceptible to exploitative work arrangements. The men and women I interviewed often worked hours for which they were not paid, stayed quiet when breaks were cut, and, for a lack of options, tolerated irregular shifts and being sent home early or kept late.

Champions of the free market portray such circumstances as aberrations, though capitalism is increasingly reliant on precarious labor (Calvão 2016; Harvey 2017; Stuesse

2016). Precarity as a system of regulation has introduced new forms of lucrative exploitation while neoliberal governance has provided evermore-meager assurances of security and stability, all while strategically producing uncertainty to facilitate economic exploitation. Instability, commonplace and calculated, has become a mode of governance (Butler 2015; Lorey 2015).

Since the 1970s, low wage work has come to be continuously more precarious, a result of technological advances, market deregulation, and the weakening of unions. In the ensuing four decades, employers have increasingly relied on flexible work arrangements such as outsourcing and subcontracting to decrease labor costs, frustrate collective bargaining, and relieve companies of any responsibility to provide non-wage benefits to their employees (Kalleberg 2011; Weil 2014).

For many of the working poor—individuals with jobs confining them to the lowest rung of economic attainment— the precarity associated with low-wage employment will very likely be a lifelong burden, rather than a passing hardship (Ehrenreich 2001, Kalleberg 2011, Newman 1999). Job stability has eroded as career advancement has stagnated, stalling inter-generational mobility (Shipler 2004) and for many toiling in low-wage jobs, opportunities for advancement have all but vanished (Kalleberg 2011).

Precarity has become a deliberate and distinguishing feature of modern life. The strategic induction of instability has come to be a form of regulation distinct to late modernity, in which flexibility and insecurity are fostered in an effort to render populations tractable (Butler 2015; Lorey 2015), and in which, as Butler notes, “certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death" (Butler 2009: 11).

The Laboring are an invisible population, absent from welfare rolls, living lives of unrecognized and sustained hardship, and often managing to get by only through pyrrhic acts of fortitude. Exploring the lives of this working poor population can advance our understandings of how exploitation and class function in the 21st century, revealing how the enduring associations between social class and health are embodied in the new economies of the American South. An examination of the lives of the uninsured working poor as a reserve army can also reveal the tension between the promised inclusion and stability long associated with work in the United States and the modern reality in which economic and social enfranchisement are not guaranteed. Furthermore, it can reveal what being part of a surplus population does to your health. Finally, examining the lives of uninsured Spartanburg County residents as part of a reserve army can show how structural inequalities are produced and refracted through disparities in insurance status.

This ailing workforce, sustained by South Carolina's safety net healthcare, quietly props up Spartanburg County's economy[3]. Once laborers, now the laboring: mechanics with bad hearts, suicidal gas station attendees, motel room attendants delirious with pain. Kept powerless by their poor health, the members of this reserve army belie the notion that in the United States gainful employment is necessarily a signal of, or path to,

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[3] The Spartanburg County healthcare safety net is comprised of the city's free clinic, a few privately funded health organizations, several faith-based charity initiatives, and a federally qualified health center.

mainstream integration.

For, as I wrote in my fieldnotes one day,

> *The wages of precarious work are hypertension and arthritis. They are strokes and seizures. They are bad backs. They're being unable to walk 100 feet without resting. They are fits, and nerves, and your sugar being too high. They are walking canes. They are suicidal ideation and uncontrollable rage. The reserve army is ostensibly on perpetual light duty. But no work is light when you can barely stand. And a night shift at the gas station can be interminable, when you want to die.*
>
> *-Fieldnotes from the fall of 2017*

## METHODS

Anthropology is, in its essence, a reporting back from elsewhere. In this case, from the "undiscovered countries" (Woolf 2002: 32) revealed by illness, in an effort to return with emic understandings and articulations of precarious life. The anthropologist Ruth Behar once described anthropology to her aunt as a "most…necessary form of witnessing" (1996: 5). I've always liked this idea. But a witness is a weird position to be put in. The following section details the methodology of my witnessing and explores some of the strangeness of being a self-appointed advocate for working poor Upstate residents, a vulnerable observer laboring, unsolicited, at what few of his interviewees would recognize as work.

## Recruitment

Through participant-observation and semi-structured interviews I have attempted to understand the lives of working poor safety net clients as they sought to persevere through the uncertainties of flexible, unstable, employment while managing their health with the conditional aid of the safety net.

With this in mind, I recruited interviewees using purposive sampling, a non-probability sampling strategy commonly employed to enlist reluctant or difficult-to-reach populations (Bernard 2006). This qualitative strategy required interviewees to be representative of the particular research population and knowledgeable in the cultural domain studied—in this case that meant knowing what it was like to work precarious jobs and rely on safety net institutions like the county's free clinic for healthcare. The first interviewees were recruited through flyers, informal conversations, and safety net staff referrals. The rest were found through snowball sampling—the recruitment of potential respondents through acquaintances and the acquaintances of acquaintances.

Some interviewees said they responded because they needed the money badly, others seemed more in need of someone to talk to, to have someone hear what they were going through. Their stories of close calls, perseverance through injury and illness, and attempts on their own life were reminders that the people that responded to my flyer were the survivors. They'd just been lucky, they told me. Others around them had died young or badly. Yet many interviewees were very ill, some gravely so. Ms. R.'s heart would likely give out soon. Mr. M., suffering from untreated pancreatitis, spent much of our time together bent over, clutching his stomach. Mr. H. met me at the downtown library for our first two interviews. For the third, I drove out to a hospice on the state line.

Ms. W. was also certain she would die before long. “If the lord wants me to go home, it’s up to him,” she told me nearly every time we met. Such vatic pronouncements were common among interviewees, sick men and women, none yet in their 60s, but of which many were expecting soon to die. The way they talked about their foreshortened lives always shook me. It meant that some of them would have technically entered middle age sometime shortly after high school.

### Interviewing

I had hung flyers with my phone number at the free clinic, and at a local non-profit dedicated to providing aid to low-income uninsured residents, and on the bulletin board of a faith-based charity. Interested respondents would call and I’d explain the process and vet them: to be eligible to participate in the study you had to be a Spartanburg County resident, over 18 and uninsured. You also had to have used the county’s safety net health care services at least once within the past year.

My research flyers mentioned compensation and I would tell the respondents that called that they would receive twenty dollars for participating in an interview. This amount was settled on after consulting various safety net staff; it was generally agreed that twenty dollars would make interviews worthwhile for potential interviewees, while not being a coercive amount of money, i.e. an amount that safety net clients could not pass up, even if they would not otherwise wish to be interviewed.

Only three or four callers did not decide to participate, and only a couple made appointments for interviews that they did not keep. I met about a third of the respondents in their homes, in browning condos or neat trailers, in quiet split-levels and Housing Authority apartments. The rest chose to meet in the the study rooms of the local libraries, usually at the main library downtown, but occasionally in smaller satellite branches around the county. Interviews were never conducted at safety net clinics, a precaution taken to prevent respondents from assuming that their receiving of care at the clinic was in any way contingent on consenting to an interview.

I ended up conducting formal interviews with 46 uninsured safety net clients.

## The Interview Process

At the beginning of each interview I would introduce myself and explain the process: The interview would last about an hour, and would be recorded. All identifying information—names, employers, etc.—would be redacted in the resulting transcription. Though I tried to explain on the phone that these interviews would be open-ended discussions rather than quantitative surveys, respondents did not always know what to expect, and many brought their I.D.s and other records with them.

During the interviews I asked clients about their employment history. Then I asked about the health conditions that had brought them to the free clinic. I asked about pain. About medications and about depression. How long had they been uninsured? What kind of work did they do? I asked whether they were better off financially than their parents had been at their age, a question that tended to elicit such deep sadness in some, that I didn't always ask everybody (See Appendix B for a list of interview questions).

Almost every client I interviewed had suffered some form of depression during their lifetime, and many were deeply, actively, depressed. Mr. M. had suicidal thoughts at night. Mr. P., a line cook, told me quietly one day that he had tried to kill himself the week before. Mr. Bl. too, had recently tried to take his own life, only to be foiled, in his reckoning, by his truck's catalytic converter. So a few months into my fieldwork I took a Mental Health First Aid class, but never ended up using what I learned.

Many of the topics we discussed were sensitive, so I tried to be careful about how I broached them. I always told interviewees that if there were any questions that made them uncomfortable, just to let me know and I would move on, an option that, to my surprise, was never once exercised, though discussions would regularly turn to such delicate subjects as domestic violence, intimate medical procedures, and childhood sexual abuse.

Eventually, I invited five of these client-interviewees to participate in follow-up interviews. I didn't keep up with the number of times we met, but I saw two of these key informants every month for more than a year. The others I met with sporadically. These follow-ups ranged from rather formal interviews conducted at the library, to just catching up on the porch. I recorded most of these conversations, though not all of them proved insightful.

In these follow-up interviews I tried to find out who clients relied on. Who did they look to for support? What community resources did they use? Were there informal strategies they employed when they were short on medication, without transportation, or lacked access to reliable childcare? I wanted to know what compromises or contradictions, if any, these actions represented, and how these strategies varied from what interviewees considered to be optimal alternatives.

All the while I was also conducting interviews with local hospital administrators, free clinic nurses, charity directors, church volunteers, and detention center and Housing Authority employees. These interviews were important for understanding and contextualizing clients' strategies and resources. For care providers were often privy to institutional dynamics and decision-making invisible to their charges and would, I assumed, therefore be able to provide another vantage point from which to examine the safety net.

Care providers were asked about their experiences providing medical treatment in a setting of rationed aid; about the effects of unstable employment and a lack of insurance on their patients' health; and about the strategies and resources clients used to manage their physical and emotional well-being in lieu of regular access to healthcare. I took notes during all of these interviews, but rarely recorded them. Several interviewees were very forthcoming. The rest, usually individuals in positions of high authority, or representatives of larger organizations that didn't entirely know what to make of my request for an interview, were pleasant, but guarded.

I had decided that I wouldn't compensate non-client interviewees, though in some cases, I learned too late, I probably should have. It just didn't seem to make sense to pay doctors and administrators twenty dollars for interviews, and I wasn't ever really sure if I should compensate nurses and social workers for their time. Then, a few months in, I discovered that some of the staff I interviewed at these organizations, usually administrative assistants, front desk workers, or low-level staff, were themselves precariously employed, worked jobs without benefits, and could have used the money.[4] But by that time I had already conducted several unpaid interviews and I had to let the policy stand. Paying some of the staff and not others, or trying to go back and compensate past interviewees for their time, I worried, would make a mess of things.

### Participant-Observation

Anthropological insights are generally hard-won, knowledge gained through tedium and repetition, ethnography being more often a matter of endurance than epiphany. I found that the deep rapport necessary for meaningful participant-observation required long hours and most of my time conducting observations was spent driving around with community case workers, sitting in food pantries, shadowing the street-level bureaucrats of various safety-net organizations, and waiting in the waiting rooms of the city's main free clinic.

This observational work was done to try to understand how poor clients attempted to become responsible citizen-patients with, or in spite of, the conditional care of the safety net. I was also looking to explore the unintended consequences that resulted from the strategies clients implemented in lieu of regular medical care. I had been reading Lauren Berlant's *Cruel Optimism* (2011) and wanted to know if clients'

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[4] I do not know the exact proportion of front line staff that were precariously employed, for it was a particularly sensitive topic. I do however know that it was not uncommon for some of these safety net employees to make only slightly more than the clients they checked in. I know this because they told me.

attempts and aspirations were contradictory, i.e. if their strategies ultimately frustrated their ability to achieve mental and physical wellbeing and financial stability, or if, instead, they provided enduring resources with which to navigate and mitigate the persistent injuries of class associated with precarious work.

These questions were informed by my own experiences with unstable, low wage employment in the Upstate. Years earlier I had worked in one of the last textile mills in a neighboring county, hired to walk among the spinning frames mopping up the wax solution that spilled from the collection trays and sweeping up the piles of lint and yarn that accumulated under the machines over the course of a shift. The work was monotonous and physically taxing and my days were spent stirring particulate into the air with my broom and watching the workers on the floor.

During my fieldwork I had another job, as a factotum of sorts, that was irregular, poorly compensated, and dangerous. I was protected by my relative youth, my reasonably good health, and by my education, from much of the precarity my interviewees suffered, but not all of it; my job provided no benefits and I worked on high, pitched roofs, from which a fall couldn't be anything less than life-altering, in trailers that were mostly mold, and with poisons and chemicals. Furthermore, my health insurance had lapsed. So while I did not always directly experience the precarious work of my interviewees in person, I wasn't entirely unfamiliar with the vicissitudes of labor-related uncertainty. Consequently, research questions often came to me at work and when I had a private moment I wrote them down in a little notebook I kept.

## Transcription

Once completed, interviews were transcribed. Transcribing turned out to be more an act of judgment and interpretation than reproduction (cf. Buchholtz 2000). A few words into my first transcription and I was already struggling with how to render the demotic speech of client-interviewees into text.

I attempted to transcribe the non-standard English of these Southern working-class interlocutors in a way that was neither offensive in its representation, nor suggestive of inferiority by its excision. But this was harder than simply transcribing what I heard. In one of the following chapters, for example, there is this sentence about visiting Ms. W.: “I never saw her partner, laid up in the apartment, ‘He dying,’ she said.”

I’ve wondered about those two words quite a bit. Should I have changed them to “He’s dying”? Because, “He dying,” doesn’t represent how Ms. W. always talked. As interviewees became increasingly comfortable during interviews, they often began to use a more informal and intimate language, and I had met with Ms. W. nearly a dozen times at this point.

I worry that, devoid of this larger context, and stripped of the circumstances they were spoken in, the language interviewees used could be misconstrued, and could be taken as an alibi for their misfortunes, a way to dismiss their immiserating circumstances as self-inflicted, a result of a poor education or a culture of poverty.

That said, I don’t want to overstate the level of education interviewees had. I always had to puzzle out the texts Ms. W. sent me. In them, some words were actually meant as their homonyms, while others were spelled phonetically. Sometimes it took a while to realize that what you were looking at was actually two sentences, just that the first had ended and the second had begun without the notice of a period or a capital letter. But then other interviewees, maybe half a dozen, had been to college, at least for a little while.

### Data Analysis

After transcribing the interviews, I compiled, coded, and analyzed them using ATLAS.ti. The qualitative data analysis program was good for looking for themes, analytic categories, and examples. While sorting interview data I used an inductive process known as grounded theory analysis, an approach in which analytical categories and hypotheses emerge during the coding and sorting of the data, not before (Bernard 2006; Glaser and Strauss 2017).

One of the driving questions that emerged during this phase was how precariously employed working poor clients negotiated and endured modern obligations of mandated self-reliance and the privatization of health-related risk. I also explored the transcripts for how working poor Spartanburg County residents understood and navigated the discrepancy between the promise of economic and social inclusion through employment and the lived reality of precarious labor arrangements. How did clients experience, make sense of, and attempt to survive the instability in their lives? I wanted to understand what sacrifices they considered noble, what compromises were deemed intolerable, and what, when faced with indefinite financial and existential insecurity, really mattered to them. Finally, I tried to understand how clients thought of their strategies of endurance. For with the normalization of precarious work arrangements, conceptions of responsibility and citizenship were being reimagined and reconfigured (Ferguson 2013; Meehan and Stauss 2015; Smith 2011; Steusse 2016).

## On Ethnographic Dilemmas and Occasionally Losing the Plot

Ethnographic fieldwork sometimes felt like a never-ending string of ethical decisions, fraught with consequence, to be made alone and with little preparation. Many of these difficult choices revolved around matters of representation.

For example, I've used pseudonyms throughout this dissertation, though I don't know if that was the right decision. (*With the exception of Mr. R. and Ms. R., none of the interviewees are immediately related, as far as I know. Ms. W. and Mr. W., for example, probably don't know each other, they just happen to share the initial letter of their last name.*) I know Ms. G. wanted her employer, a chicken plant with a poor reputation, to be named and called to account. But I couldn't be sure she wouldn't face some kind of retribution, for I didn't know where, once published, clients' lives and names would end up. I feared that interviewees might be doxed—that is, that they might have their private information made public as a form of reprisal—or have their stories used against them by employers or in court. And while some interviewees said they were open books, they didn't know what parts of their interviews and what parts of their lives would make it into this dissertation, and not everything I have included here is flattering.

It's true that among the people I interviewed there was some penitentiary time, a dishonorable discharge, a few histories of addiction, and some ongoing careers of drug use and alcoholism. But interviewees also took care of their aging parents, worked night shifts, and many had suffered stoically for years. Several were pious churchgoers. They worried about their children in the military. They paid their taxes. Some had deferred care and slept in their cars rather than apply for disability. Some went weeks without a day off from work.

I don't want to imply here that care should be reserved for the righteous, and I am not including the paragraph above as a qualification. Instead I mean it as a response to the many things I heard about working poor safety net clients during my time in the field. For, the working poor—once they seek assistance—are regularly maligned as ignorant, improvident, and unprincipled, and their hard circumstances are often reimagined as reckonings. For having too many children, too early. For staying with their abusive partners. For spending the little money they made, when it came in, quickly and exuberantly. For smoking and continuing to drink.

This was always in the back of my mind when I was writing about the people I met. I debated whether or not to include interviewees' drunk driving convictions, their histories of anger issues, or their status as felons in this dissertation. Ms. C., for example, had spent five years in a federal prison. At job interviews she would always ask, "Are you sensitive to hiring ex-felons?", and while companies regularly assured her that she would be considered for open positions, the only employers that ever called her back were the ones offering unskilled, low-wage work. Dogged by her criminal record, she had been laboring in these poorly-compensated jobs ever since she had gotten out several years ago, and was having a hard time affording healthcare and supporting herself, despite a solid work history that went back decades.

So in the end I included details about trouble with the law, substance abuse, and conflict with employers, when the life-histories of clients would be incoherent without them, as in Ms. C.'s case. Otherwise I have omitted them.

I wondered too about how I should represent the county's safety net. Part of this dissertation examines the compromises of safety net care, though it has always felt a little unseemly to criticize the selfless labor done at these institutions. The county's organizations are staffed by individuals doing difficult and important work in taxing circumstances, work that will largely go unrecognized, and many client-interviewees said they didn't know where they'd be if not for this help. However, it is precisely these safety net clinics' statuses as charitable organizations that hides their complicity in the hyper-exploitation of the uninsured working poor. For the county's Reserve Army of the Laboring is sustained by its safety net healthcare, as the conditional aid of this care allows working poor individuals to continue in their poorly paid jobs, often while sick and in pain. But more than anything, I do not wish to impugn the reputation of Spartanburg's safety net institutions or their staff in this dissertation—and I should mention that they were always kind to me and were often more than accommodating—but it is important to illustrate how this conditional care subsidizes and allows a system of precarious employment to continue.

Another issue of representation concerns the county itself. Many residents of Spartanburg County may not recognize their home in this dissertation. For there are people that make a good living working decent jobs here. They attend well-appointed churches that have meeting rooms, industrial kitchens, and summer schools. They go out on the lake on the weekends. Their kids play travel ball. For them my depiction of the county may seem sensationalistic, a dour rendering of a resurgent area. Spartanburg has seven colleges, after all, and a coffee packing facility is scheduled to open soon and is projected to create 500 new jobs for the county.

But one of the results of the new Southern economy is a polarization of lived experience and life-chances. Consequently, the lives of the working poor rarely intersect, either geographically or socially, with those of the middle or upper class anymore (Kalleberg 2011). And what I have found is that the county's new prosperity is not all-encompassing, nor is it equally distributed, and in fact comes at the expense of those working the low-wage jobs that provide neither stability or security.

Anthropologists must draw a circle around what will constitute the field in their ethnography and decide what will become their objects of analysis. This dissertation examines the lives of those working poor county residents that must rely on rationed care to survive their precarious employment. It explores how irregular hours, an absence of health benefits, and unlivable wages are survived and how this low-wage work is subsidized by the county's food pantries, churches, and family members on fixed incomes. But not everyone in the county lives in these dire circumstances. I know.

Finally, there was the ever-present issue of how to represent myself. Telling someone who asked, that you're an anthropologist was usually unhelpful, and sometimes felt aggressive. So I quickly began to omit the word "anthropology" from my introductions. I eventually settled on some variation of: "I am a graduate student from the University of Kentucky and am studying the lives of uninsured Spartanburg residents in order to understand how they manage their health and other responsibilities."

Still, I was never entirely sure if people understood who I was. And I often found it hard to justify, without the aid of the nested presuppositions that constitute anthropology[5], just what exactly I was doing in the county. I would be carefully trying to explain why I was here, a strange stranger, in the living room of an interviewee, asking them delicate questions, and begin to wonder myself. I would get the unsettling sensation that once I had gotten up, said my goodbyes, and had driven away, a neighbor would come over to ask who that boy was, and the owner of the house would find that they were unable to explain my presence.

After these interviews I usually went home and slept.

## **FIELDSITE**

*It was just past noon, and looking out through the window I could tell it was hot. Beyond the hermetic air-conditioned atmosphere of the car it appeared as if the earth's gravity had increased. The men that lived at the Mission[6], and had walked these city blocks all spring, were now slumped, on the steps of churches, in the shade of signs, and under the eves of the mini-mart. Up the road two women had dropped their gear in the middle of the sidewalk and collapsed under the cover of a tree.*

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[5] Fieldwork served as a constant reminder that the doxic presumptions of anthropology—that the ordinary lives people live are of scientific interest, that an emic perspective is important, that deep hanging can be a form of data gathering, that the study of culture is worthwhile, etc.—are not always shared by interviewees.

[6] The Mission is the largest homeless shelter in Spartanburg. It is run by a local faith-based non-profit.

*This is a city of cars. For blocks there's no evidence of the inhabitants other than the rows of trucks and sedans left ticking in front of businesses. In this neighborhood, the remnants of car lots and the glass shells of abandoned fast food restaurants suggest, not a vibrant past, but simply a past.*

*Anyone that can avoid walking the long intermittent sidewalks along the highways does. You see those that can't, crossing the empty surfeits of asphalted space, bewildering cars stopped at intersections, and jogging across busy streets. They walk over fragrant hills of mulch, along ditches, and up onto tracts of grass where it's unclear if you'd be trespassing or not. If you're walking in this part of the city, it means you don't own a car.*

*I never knew it as a mill town. By the time I arrived many of the textile mills had closed, sat empty, and burned. But for much of the twentieth century the city had been a hub for the textile industry of the Southern Piedmont.*

*-Fieldnotes from the summer of 2016*

## History

In the late 19th century, the textile industry began to abandon New England for the South. By 1926, Spartanburg County had thirty mills, most of them controlled by Northern interests (Waldrep 2000). As the need for labor grew in the Upstate, company agents were deployed throughout Appalachia to find willing workers. Many came from Western North Carolina, others from Tennessee and Virginia.

The Roosevelt administration established a Cotton Textile Code in 1933, which mandated a forty-hour workweek and instituted a minimum wage for mill workers: 12

dollars a week for Southern workers, 13 dollars a week for their Northern counterparts (Taylor 2016). In response mill owners initiated a “stretch-out” system[7], raising productivity quotas in an effort to get their charges to maintain production outputs with fewer hours. “Minute men,” stopwatch-wielding enforcers of efficiency, were hired to guard against lapses in productivity. Individuals unable to handle the increased workload were summarily fired. Once instituted, these periods of frantic effort were sustained indefinitely, under various pretenses (Waldrep 2000).

Accusations of unending and illegal stretch-outs were not always taken seriously in the 1930s, and were dismissed by management as the natural consequence of mechanical innovation. Those complaining of ill-treatment were regarded as naïve by managers, and considered blind to the economic realities that purportedly necessitated the increased pace of production. The newly instituted Cotton Textile Labor Relations Board heard workers’ complaints and arbitrated conflicts between mill laborers and management, but their conclusions were not legally binding, and their judgments were therefore toothless. As a result, the minimum wage imposed by the Cotton Textile Code effectively became the new wage standard, and the accelerated pace of the stretch-out was codified as policy (Hayes and Hayes 2001).

Mill life was hard. Upstate textile mill villages suffered high rates of alcoholism,

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[7] Stretch-outs were first introduced by mill owners in an effort to maintain profits during the post-World War I recession. A stretch-out was a novel approach to productivity that aimed to reduce operating costs, particularly labor costs, while increasing a mill’s output (Flamming 1992; Hall et al. 1987). This was done by standardizing breaks, extending shifts without commensurate increases in pay, and introducing a system of time management that quantified everything, from how long it took employees to eat lunch to how much time they spent in the bathrooms (Taylor 2016).

domestic violence, and pellagra (Beardsley 1987; Hall et al. 1987). Furthermore, the Upstate mills paid some of the lowest wages in the South. Pay for African Americans, who, barred from production work, labored instead in and around the mills as janitors and boiler fireman, was particularly low, as these jobs did not fall under the wage provisions of the Cotton Textile Code (Beardsley 1987). Pushed beyond endurance, unionized workers eventually organized a general strike in 1934, frustrated with the ineffectual Textile Relations Board and the mill managers' general disregard for worker protections.

The strikers were evicted from their company houses and blacklisted and machine gun nests appeared at several of the mills. Protesting workers were famously killed at Honea Path by company deputies. The General Strike was eventually broken and the United Textile Workers of America went bankrupt. Other strikes followed and failed, and the Southern Piedmont became known as an anti-union stronghold (Waldrep 2000).

### The Decline of the Upstate's Textile Industry

After World War II, manufacturing and textile jobs increased in the South and per capita income rose in absolute terms, though Southern wages still fell short relative to the rest of the United States. But by the early 1970s jobs in textile and apparel manufacturing (two distinct, but related industries) had begun to decline all over the American South, a downturn that would became precipitous by the 1990s.

The end of the twentieth century saw a decrease in manufacturing as companies began offshoring work and as proponents of trade liberalization successfully lobbied against import controls on foreign textiles and apparel. Between 1997 and 2001 alone, the Carolinas lost 200,000 jobs (Minchin 2012). Pressure from overseas manufacturers continued to increase as textile imports grew and the industry declined rapidly after the North American Free Trade Agreement was signed in 1993 (Giermanski and Lodge 2002). In 2001 alone, eight Spartanburg County mills closed. Then in 2005, the Multifibre Agreement[8] was allowed to expire, further accelerating losses among the remaining U.S. textile jobs.

In South Carolina, textile mills and apparel plants were often small enterprises, scattered throughout the rural piedmont, and their closings gutted the small communities that grew up around them. Within a generation, two million textile and apparel jobs had disappeared (Minchin 2012).

### Work after the Mills

Throughout the twentieth century, Southern states had attracted industry by advertising low taxes, anti-union policies, and the modest wages that were tolerated by their residents (Zieger 2012). South Carolina continues to advertise the Upstate's desperate native workforce in an effort to court foreign manufacturers (Kingsolver 2016).

The new jobs displaced workers found rarely paid as well as their former textile work. *(This is not to suggest that textile jobs were ever all that lucrative, particularly during the industry's decline over the last few decades. But client-interviewees told me*

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[8] The agreement limited the amount of textiles that developing nations, who were considered to have a competitive advantage as they were not hampered by restrictive labor laws, could export to developed countries (Wohn 2001).

*that you could live on a textile mill wage, like their parents had. A recent Bureau of Labor Statistics (2017) study of occupational employment and wage estimates in South Carolina found that the median hourly wage for the few textile bleaching and dyeing operators still around was $13.60. For machine setters it was $13.47. Cutting machine tenders made $12.36 on average. Most interviewees estimated that they earned around $10 an hour now, which came out to about $20,000 dollars a year if you worked full time, which due to their health conditions many ailing interviewees couldn't.)* Textile jobs had usually provided non-wage benefits such as healthcare as well, which the new service jobs often did not. Racial minorities fared particularly hard during this reversal of fortune. Black men were disproportionately displaced and had lower reemployment rates—a difference of 30 percent—than their white counterparts. (Minchin 2012).

The mill I had worked at, nearly a decade ago now, was about 20 miles away, just on the other side of the North Carolina line. There the women on the floor had labored in a deafening, dusty environment, while the men worked with dyes and pushed heavy bins loaded with yarn in the hot basement below. It was obvious that the years of pushing bins, hunching over frames, and standing through long shifts had taken a toll on their bodies. Limps had accumulated and everyone seemed to stay in a state of perpetual weariness; every movement was carefully calculated as workers attempted to expend energy as efficiently as possible.

Most of these uninsured employees could not afford to see a doctor and therefore lived in a state of precarity that rendered every illness and injury a potential disaster: a debilitating toothache, the onset of arthritis, or a bout of depression could all be catastrophic as these conditions were made exponentially more devastating by financial insecurity and a lack of access to healthcare.

The women that worked the floor were, with few exceptions, African-Americans and Latinas. Management was exclusively white. Upper management exclusively male. This was not unusual, these mills and their communities had long histories of segregation. During the strikes of the 1930s black mill workers were allowed to join union organizing, but only as separate, segregated locals, a strategic concession white organizers reluctantly made to ensure that workers of color were not employed as strike breakers (Waldrep 2000). It wouldn't be until the Civil Rights era that job prospects improved for black mill employees in the South (Frederikson 1982).

> *Many of the safety net clients I've ended up interviewing had worked in the mills in the 1980s and 1990s, and had parents, aunts and uncles, and siblings and neighbors that had too. The work, as they remember it, had provided a steady, if not always easy, living for their families. Now they cleaned factories at night, gutted chickens, or sat on assembly lines, a vestigial workforce reliant on free clinics and food banks[9]. Many had moved to Spartanburg from surrounding counties looking for opportunity and work, but in the intervening years had never shed the hardships they had sought to abandon.*

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[9] Throughout this dissertation I assert that many interviewees are wary of assistance and reluctant to take charity. But nearly all relied, or had relied at some point, on the county's church-run food banks. The donated food they received allowed them to continue to work the jobs they couldn't otherwise afford to keep. These food banks all had their own systems of means testing, and once you had received donated food, you weren't allowed back for a period of time, sometimes up to six months.

*Clients came to the free clinics for job-related conditions: arthritis from years of repetitive movements, herniated discs from lifting or falling, a seizure, likely from years of breathing toxic glue while sealing carpet. These occupational injuries were often accompanied by other health conditions. Diabetes and high blood pressure were common, and a little over three quarters of interviewees had prescriptions to ease their psychological suffering—though only about half of these clients could afford to fill them.*

*In the city you are marooned without a car. And few residents attempt little without one—though traffic was occasionally confounded by the irregular underpowered moped being willed down the highway. The city has a bus system*[10]*, but it doesn't run after six p.m., a remnant, I was told, of a time when African-American domestic workers left the white neighborhoods of their employers and traveled home across the city after supper. In this part of the city, where I spent the most of my time, the long sidewalks that line the avenues are rarely peopled. Pedestrians are so rare here that when you find yourself walking along and discover another person behind you walking in the same direction, you're suspicious.*

*A third floor vantage, of which there are few here, will allow you to see for blocks upon blocks. But the view is deceptive. It's check-cashing counters that now operate in the shells of the restaurants and you'll find quick stops in the old*

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[10] SPARTA, the Spartanburg Area Regional Transit Agency, runs 8 routes throughout the city from 6:00 a.m. to 6:00 p.m. on weekdays and from 10:00 a.m to 6:00 p.m. on Saturdays. Busses do not run on Sundays, nor does service extend much beyond Spartanburg proper.

*laundries. All divided by wide expectant parking lots that stretch the streets interminably.*

*One of the city's main mills had run not too far from here, and once it closed, the surrounding communities had slowly been left to deteriorate. The local grammar school and company store have closed. As a consequence, many houses have been abandoned, left vacant to fall into disrepair. A corner store serves as the de facto grocery and pharmacy. It has some packaged food, but most of the groceries are meant to relieve pain or adjust mental states: cold silos of high-gravity beer, ultra-caffeinated sodas, CBD gummies, aspirin, and rows and rows and rows of energy shots.*

*In this neighborhood the specter of homelessness is always present. Two men sit with packs either joking or arguing under a busy overpass. Another man, shirtless from the heat, leads a bike burdened with plastic bags down the highway. The food pantry dumpster and donation bins have had locks put on them after being pried open night after night.*

*The summer will be hard on people, with their kids being out of school, I'm told. The food pantry gets busier in June. "You have a lot of grandparents raising children," the reverend who runs the place tells me, "and there's a lot of drug use, too."*

*-Fieldnotes from the spring of 2017*

## Spartanburg as a Site of Precarious Labor

Several factors make Spartanburg a particularly apt site for a study examining the effects of unstable, low-paying employment on the health and wellbeing of the uninsured working poor (see Appendix C for demographic data). In response to rapid deindustrialization and increasing manufacturing competition from abroad, South Carolina championed market-driven solutions—the establishment of foreign trade zones, the suppression of labor unions, the courting of foreign manufacturers, etc.—to address the state's social problems (cf. Kingsolver 2010; 2016). Consequently, initiatives such as living wage ordinances have been rejected as fiscally irresponsible and damaging to the state's pro-business climate (Kingsolver 2010; Wilkinson 2016).

South Carolina is also one of 25 states with right-to-work legislation discouraging labor organization and maintaining low wage structures, and one of 19 states where the lowest earners make the federal minimum wage of $7.25 an hour, or $2.13 for tipped employees. In his 2018 State of the State address, Governor Henry McMaster (2018) urged South Carolina to keep pace with a global economic transition in which "workers who previously carried tool boxes now carry tablets." But in Spartanburg just as many carry trays.

Finally, Spartanburg is a particular fitting site for an examination of the health consequences of uninsured work because South Carolina opted out of Medicaid expansion, which would have expanded coverage to individuals under the age of 65 with incomes up to 138% of the poverty rate. Opting out of the expansion produced a coverage gap for individuals unable to afford plans on the health exchange and ineligible for Medicaid in South Carolina (see Appendix D for the state’s leading causes of mortality). Furthermore, the county fares worse than other peer counties in the state in terms of health indicators (Brady 2016). A recent Gallup-Healthways (2017) study examining health and well-being ranked the city 182nd out of the 186 major U.S. metropolitan areas polled.

## Conclusion

In the following chapters I will examine how a decades-long shift in the terms of contract labor has produced a particular type of vulnerability peculiar to the emergent class that is the Laboring (Chapter 2). I will then explore how the consequent inequity is rendered unremarkable through a rhetoric of bad faith that dismisses the dispossession of the Laboring as the result of ill-fated mischance or self-inflicted misfortune (Chapter 3). In later chapters I examine the roll of the safety net in managing and perpetuating precarious labor arrangements (Chapter 4), the psychic toll of being a member of the reserve army (Chapter 5), and how the desperation of working clients produces a disciplined and exploited low-wage workforce (Chapter 6).

I spent nearly two years in Spartanburg County doing fieldwork. The old mills are being turned into lofts and a ten-story hotel has been erected downtown. The restaurant on its rooftop boasts of its “small plates” (language that would almost certainly still doom a business ten floors below) and the governor recently used the “inland port” of Greer, a town located partially within the county, as an example of success in his State of the State address (McMaster 2018).

But not everyone is benefitting from this prosperity. Many still labor in dead-end jobs, unable to escape their poor health and their economic miseries. For these uninsured working poor residents it’s not the uncertainty of precarious work that is worrisome, but the near-inevitability of imminent ruin.

## Chapter 2. The Wages of Precarious Work: Embodying and Cementing Inequity in the Upstate

*"I don't got insurance, but I got this pain," Mr. M. said.*
*"Been working all my life," Ms. J. sighed.*
*"I take Ibuprofen constantly," Mr. B. remarked.*
*"They help, but not that good," Ms. W. reported.*
*"If something happened to me, nobody would know." Ms. H. said.*

—*Collected Fieldnotes*

### Introduction

The poorly-paid employment of the Laboring sustains South Carolina's economy. The state has the second-highest percentage of hourly workers earning at or below the federal minimum wage in the nation, only Louisiana has more (Bureau of Labor Statistics 2019). The human cost of this low-wage work is revealed in the slow ruin of the bodies of Spartanburg's reserve army, a result of the poverty that attends precarious employment arrangements and the consequent lack of access to healthcare.

The work of the Laboring is literally sickening, marking and mutilating the bodies of this uninsured population with the "lived effects of neoliberalization" (Muehlebach 2013: 299); repetitive machine labor is inscribed in their cartilage and muscle and ever-present uncertainty is scored into their nerves. Ms. O. had worked for years in the cold of the county's chicken farm. **"**You know, you are just all day, clipping, clipping, clipping," she said. Workers on the lines in poultry plants can repeat the same movement up to 60,000 times per shift (Stuesse 2018), and now she had trouble just holding her coffee cup.

These are literal "injuries of class" (cf. Adair 2001; Sennett and Cobb 1973): pain, disease, and disfigurement, not always occupational injuries exactly, but ailments and afflictions that result from, and endure because of, an inability to afford care, a corollary of the low wages inherent in precarious labor arrangements.

This chapter examines how the inequities inherent in precarious work are embodied and cemented among the Laboring—how the insults of poverty accrete, and how the vulnerabilities of uninsured life compound. Below I explore how the vulnerabilities and class asymmetries particular to insecure low-wage employment induce pain, presenteeism, and shadow work—bounded forms of precarity particular to the class of uninsured, working poor Americans that make up Spartanburg's ailing reserve army.

## Precarious Labor Arrangements, Embodied

The stylish clothes Ms. F. wore to our interview contrasted with the deep bruises and dark rashes on her arms. Contact dermatitis, a safety net doctor had told her. Long untreated, it had rendered the back of her hands discolored and scaly. "No doctor really addressed what the actual cause of the rash was, "she said, "they would give me medication and then I would start breaking out more and it spread from my hands, to my arms, to my legs, to my stomach and I'm left with all these marks." Most of her teeth were gone too; of her top teeth, only the front two remained. With her elegant outfit she wore an incongruous pair of tennis shoes, a necessary concession as she had started having difficulty walking.

Missing or dying teeth, visible bandages and knee braces, limps, canes, and slow careful walks, and sores and scars, were all common markers of infirmity gone unaddressed among the Laboring, working poor women and men once able-bodied[11], now maimed and crippled by years of hard work, a lack of regular health care, and attendant strategies of endurance.

Many interviewees had been betrayed by their hands first. Their fingers would begin to lock or swell, then stiffen and gnarl, and then, sometimes, close into claws. Ms. T. had trouble holding anything, the result of years of working in the cold of a meat packing plant. Ms. Gi.'s fingers would swell up to the point where she couldn't see through them. Ms. N.'s pain was audible, you could hear her hands creak and pop when she tried to open them. When I asked her about it, she said "I have arthritis, when I hold stuff, I drop stuff, it's hurting and my hand get cramped and it hurt. I would get some of that medicine, but I can't afford it because I don't have no insurance, so I'm trying to do the best I can, and with the grace of God I'll be okay and get this medication for it. It hurts a lot."

Bad backs were common too. Nearly half (22) of all interviewees were struggling with back-related issues. Many stories of chronic misery began with a cracked vertebra or bulging disc. Ms. P. had been in pain since she slipped and fell in an industrial kitchen in 1984. Mr. Bl. was increasingly having trouble bending over. "They keep lowering the ground on me," he laughed, and it was making his job at the gas station hard. Mr. E., a custodian, had been in pain for more than half a decade, was doing better after a charitable organization paid for his back surgery, but he remembered little of the two years leading up to the operation. The pain, he said, had left the period a blur. "I actually

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[11] "Able-bodied" in the sense used by David Harvey (2000: 106) who has noted that sickness, under capitalism, is often defined as the inability to work.

have to sit down and look at records and things just to determine what I was doing two years ago," he told me.

Most of the men I interviewed were still trying to do manual labor: "slinging boxes" at a warehouse, or construction, or landscaping. The work was hard for these men, who often spent their shifts bending over and picking things up: rolls of sod, building materials, debris. The gendered jobs laboring women were confined to were no less strenuous, particularly if you were sick: standing all day, cutting hair, stripping beds and cleaning rooms, working long hours in kitchens and warehouses[12].

Interviewees tried to ignore the pain of their blood clots during their shifts, and came in to work with vertiginous blood pressure or dangerously high sugar. Some continued to lift with ruptured discs, others stood for hours on poor hips. Most had been to the free clinic, but often the doctors there could offer little other than referrals to physical therapists and the suggestion to kind of take it easy. The physical therapy seemed to help some interviewees like Mr. W. for a while, but would eventually reveal its limits. "My doctor kept sending me to physical therapy," he said, "And so I did the therapy and did the therapy with a box, electrical stuff, everything, and finally my physical therapist said, "You're not getting any better. You need to have your doctor do an MRI." But it was a moot suggestion, as Mr. W. had come the therapy only because he could afford nothing else.

The emergency room was the only place that could offer real relief, several

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[12] Women are overrepresented in this type of gendered and racialized labor, providing care and service on an industrial scale (Vosko 2000): cleaning hotel rooms, cooking and serving food, and looking after the elderly and the infirm.

interviewees told me. There it was likely that you would at least get care. “The E.R. now has become a doctor’s office for the uninsured,” Mr. H. said. But after a while the E.R. would just refer uninsured patients back to the free clinic.

The health conditions of the Laboring were not only the result of long hours in rough working conditions, they were also the embodiment of decades lived without health insurance. Working poor clients labor in ill-health in part *because* they have to rely on safety net care. The free clinic, with its limited resources, could often only help interviewees manage their symptoms, while their underlying conditions went unaddressed. As a consequence, interviewees like Ms. W., who was suffering from unmanaged asthma and diabetes, remained in poverty:

> “My health, see, drags me down. Because I have to take care of myself. It's hard trying to deal with your health when you're trying to work. If you're sick, you're sick. You got to take care of yourself. But sometimes I can't help it, I can't work. I just can't do the job like I used to do. I just physically can't do it no more. I mean, I try my best, what more can I do?”

In most cases this meant that interviewees had no choice but to simply suffer their conditions. They were uninsured, unable to access meaningful care, and could not afford to take time off.

Consequently, Laboring workers became mired in cycles of poorly-paid work, ill-health, and poverty, which in turn created an evermore vulnerable reserve army of labor as interviewees took increasingly desperate work. In early interviews Mr. Wa. seemed to be managing his deep vein thrombosis, and had even been offered a small house to stay in, a house with “furniture in every room,” he told me. He would work off the rent by doing repairs and keeping thieves and squatters away. But then his leg got worse. The open sore on his shin wouldn’t heal and it was getting to where he couldn’t walk. Eventually he had to turn the offer of the house down. “Can’t walk, can’t work,” he said. The last time I saw him he was trying to mow lawns and was staying at the Mission.

## The Pain of Precarious Work

Many interviewees lived with near-constant pain. Mr. M.’s pancreatitis was often so severe he couldn’t eat. Mr. Wa.’s distress had made him start buying two packs of Ibuprofen at the convenience store in the morning before work to dull his discomfort. He would return on his lunch break for more. Eventually he began buying pills in 200, and then 500 count bottles. At 10 to 15 pills a day, the expense would eventually become too much, he knew. But the pain made it difficult for him to sleep. He’d been living with it for 14 years and was depressed. Mr. I. couldn’t sleep at night either, his injured hand would throb, he said, “like a toothache.” The free clinic doctors wouldn’t prescribe pain medications and Mr. I. couldn’t afford to see a doctor that would, so, when desperate, he bought a few pain pills from someone he knew.

The pain isolated interviewees. Ms. Ma. would occasionally talk on the phone with friends, but no longer felt up to going out anywhere anymore. Ms. W.’s world had been reduced to the courtyard sidewalk outside her building, where she walked in circles at night if it was cool enough and her legs weren’t bothering her too much. Mr. L.’s pain regularly kept him out of work. Now he no longer could afford a car and was stranded in an apartment complex deteriorating on the edge of town. “It’s when I get alone that I kind of get depressed,” he said.

The pain kept many interviewees from sleeping, so they tried to take something to sleep, or drank, I was told[13]. There was a local community health center that would dispense pain medications, but you had to be able to afford them, and most interviewees couldn't. Because the free clinic wouldn't prescribe Mr. M. anything for pain he had to wait until his pancreatitis flared up and became unbearable before he could go to the emergency room and get something to ease his suffering. The free clinic, an institution that was supposed to act as a safety net for people in his position, was no help. "So I mean, if y'all know all that," he said addressing an imaginary clinic staff in his living room,

> Help me out. You know? Y'all give me a little bit of medical treatment, for…all last week. For a whole week, but then y'all tell me to go for a follow-up and y'all sending me to places that ain't accepting new patients. [The free clinic] ain't got the equipment and going to a regular doctor's office, you got to have some kind of insurance.

Migraines were also common among the laboring interviewees. These headaches often seemed to be the result of untreated dental problems, as interviewees' chronic tooth pain would regularly blossom into a concentrated, all-consuming agony. A meta-analysis of U.S. government studies in the Journal *Headache* found that self-reported migraines and severe headaches were more "common and burdensome" for unemployed and disabled individuals, and among part-time employees, and people with

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[13] Many large quantitative studies have found pain to be more prevalent among adults living in poverty (Dahlhamer et al. 2016; Macfarlane et al. 2009; May et al. 2018). However, as one paper noted, due to the methodologies employed by such studies, it is often impossible to determine a "definite direction of association between poverty and pain" (May et al. 2018: 130).

family income less than $35,000 per year, “populations likely [to] have reduced access to health care and treatment for their headaches” (Burch et al. 2018: 503).

Prone to migraines myself, I was lucky that I was free to, if necessary, quickly wrap up interviews or excuse myself from participant-observation and if I could drive, drive home. Otherwise I would sit in my car with my eyes covered, waiting for pills to kick in, nauseated and fragile, but also deeply grateful for my relative lack of responsibilities. Ms. B., by contrast, was a room attendant at a nearby hotel, and suffered strong migraines two or three times a week. With no insurance, she had to rely on Excedrins and Aleves. “It’s very hard, living this life I’m living,” she said.

## The Vulnerabilities of Laboring Life

Poverty-related policies often conflate low-wage workers with jobless welfare recipients (Newman 1999). And while the working poor share many of the struggles of the unemployed poor—among them inadequate housing, ill-health, and a lack of access to regular medical and child care (Ehrenreich 2001; McAllister 1998; Shipler 2004)—other hardships are particular to the growing ranks of indigent workers attempting to live on precariously low wages without government assistance.

The working poor are often one misfortune, even a relatively minor mishap, away from insolvency. Interviewees’ stories suggested that financial ruin could come in many forms: job loss, car trouble, a work-related accident, an unexpected repair, evictions, lay-offs, rent increases, trouble with the law, etc. Then work could overwhelm some months and dissipate during others, leaving interviewees overburdened or broke. To make matters worse, illness and injuries could flare up and need immediate attention, taking up large, unexpected, portions of paychecks, sometimes leaving laboring individuals bankrupt.

Mr. C., for example, had lived in the same blockhouse for 25 years, paying the rent by installing cabinets. Then, a few years ago, he had slipped a disc while at work. Unable to pay for surgery, he attempted to get help from a free clinic in a neighboring county. They sent him to physical therapy, which did not help his condition. Eventually he had to quit his job and look for work he could do sitting down. Desperate for employment, he entered a vocational rehabilitation program offered by the county and after completing the program several months later was referred to a temp agency. The agency found him a job, he said:

> Over there at the warehouse. I slung boxes. It hurt like crazy. But they had, I couldn't figure out, they had sit-down jobs over there. And I couldn't figure out, if I'm going through this program, and I get an evaluation from these people that's doing the physical therapy, and they tell me I can't do no bending, lifting, had a whole list of stuff, said I couldn't do, I mean how come they couldn't find me a sit-down job before I left there, somewhere?

He didn't last long at the warehouse, and his back kept him from getting steady work. But without a paycheck he was unable to do anything about his slipped disc. Eventually he was evicted from his home. Like Mr. Wa., Mr. C. now lived at the Mission[14].

Mr. C. is typical of the Reserve Army of the Laboring in that he can barely work. As a result, the Laboring represent a labor force to be replaced rather than revived or sustained: a disposable workforce to be exploited while forever relegated to entry-level

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[14] This was a familiar story among the men at the Mission. Bentley et al. (2019) found that insecure employment was associated with a fivefold increase in experiences of housing affordability stress, which, the authors argue, has a significant detrimental impact on the health of precariously employed persons.

jobs. You aren't meant to retire from the gas station or the chicken plant, clients told me. Consequently, the individuals I interviewed lived at the edge of destitution, unaided, and with the threat of homelessness always looming. Ms. R. and her partner slept in their truck in a friend's driveway. Mr. K. got sick and had to leave the hotel he was staying at and move into the Mission. Ms. Gi. had had to start her beauty school education while residing at a shelter.

Living on the precipice of insolvency wore you down, Mr. D. said. His arthritis and his bad knees were making his construction job almost impossible. He knew he would have to give up his job eventually, but hadn't been able to find anything else. Anxiety now kept him up at night and his depression was getting worse. "I can't even sleep," he said, "I sleep a couple of hours, wake up the next day I'm so drowsy. May as well have, after about two or three days sleeping like that, you just, you know. That's very depressing. You asked me about that word earlier. That's very depressing."

To make matters worse, the safety net was often of little help. For many Laboring clients the free clinic could provide no care other than pharmaceuticals. There interviewees received prescriptions for Neurontin. Metformin. Meloxicam. Indomethacin. Lexapro. Cyclobenzaprine. Buspirone. Clonidine. Fluoxetime. Naproxen. Trazodone. Citalopram. Coumadin. Duloxetine. Xanax. Prednisone. Prozac and other Selective Serotonin Reuptake Inhibitors. Statins. Anxiolytics. Muscle relaxants. Central Nervous System agents. Antibiotics. Heart pills. Blood pressure drugs. Depression meds. Prescriptions to take in lieu of narcotics. Something to help you sleep. Something to aid your breathing. Things that were a godsend. "Stuff that make you feel like a zombie," (Ms. O.). A smoking cessation aid that could make you want to kill yourself, according to Ms. C.

These drugs weren't simply taken; they were cached, rationed, cut in quarters, and mixed. When Ms. R. was running out of her blood pressure medication and had to make it last she would take half the prescribed dose. Ms. H., who did piecework from her house, relied on expired medicines. "It probably isn't a good idea," she noted. Because she couldn't get anything from the free clinic, Ms. M. took the pain medications of others in an effort to continue to work. "I found my mother had a hip injury years ago and she does get Lortab. I do not like to take medicine, but I'll break one in half sometimes if I have to and take it. I just have to work around it."[15]

Interviewees laboring in poorly-paid, low-skill positions were easily dismissed or fired, as low-wage employers have adapted to insecure work and have developed systems of frictionless labor turnover (Jaffee and Bensman 2016); if the Laboring are let go from a job, a replacement can often assume their fired counterpart's responsibilities after an evening of shadowing. As a result, the familiar opportunity structure once associated with millwork and other blue-collar labor in the Upstate has largely disappeared, supplanted by a proliferation of jobs that are forever probationary. This is by design: contingent, temporary workforces allow managers and owners to save on labor costs (Van Arsedale 2016).

Consequently, presenteeism, working while ill or injured, is common among precariously-employed interviewees. Laboring clients continued to work despite

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[15] Often clients appeared to be simultaneously over-medicated and under-medicated. That is, taking a multitude of prescription drugs, but still in pain.

degenerative disc disease, high blood pressure, neuropathy, hip problems, COPD, sleep apnea, migraines, bloodclots, diabetes, fluid on the heart, enlarged hearts, dangerously low heart rates, bone spurs, carpal tunnel, numbness, “terrific, terrific, pain” (Ms. K.), congestive heart failure, shoulder arthritis, back spasms, trigger lock, cirrhosis of the liver, bulging discs, gout, and cancer.

Because clients could get kicked off the line for calling in, they tried not to miss any days. Once released from the hospital, Mr. Ma. went straight back to work; with no paid sick leave available to him, calling in due to his heart condition would mean risking his livelihood. “You know, you need to stop working, period, on a 40 hour job,” Mr. Ma.’s doctor had told him, “do your little…make your little hustle or something, but sit down.” But Mr. Ma. had a girlfriend to support and rent to pay and loathed the idea of not having his own money.

Because there were no sick days for these precariously employed interviewees, the threat of prolonged illness was particularly ominous as it meant a direct loss of income. Ms. M. had lost her last job due to her uncontrolled diabetes. The long hours on the assembly line did not give her time to manage her blood sugar. “They kept sending me home when my sugar dropped, and then they kept sending me home when my sugar gets high. And then I had to go back and forth to the doctor and that's how I lost my job.” Caught between ill-health and immediate financial ruin, interviewees like Ms. M. were forced to sacrifice their bodies.

While it was often traumatic accidents and serious injury that consigned working poor interviewees to the Reserve Army of the Laboring in the first place, it was the insidious short-term compromises they had to continually make just to get by that really eroded their health. These continuous compromises aggravated clients' conditions and could make their jobs dangerous. Mr. Ca. had COPD, and could not make it to his mailbox, which I estimated to be about 200 feet from his trailer, without stopping to rest on his way there and on his way back. He had begun suffering seizures too, and was afraid to continue working construction for fear that he'd be struck while on a roof or would fall ill underneath a house and go undiscovered. "I've worked construction," he told me,

> And that's what I've always done. You know flooring for the most part. I did electrical and plumbing, roofing, yard maintenance too. I mean, how am I supposed to get on top of a roof and have a seizure and fall off, or get up underneath somebody's house and crawl all the way up underneath somebody's house and do plumbing and start having a seizure and somebody can't get to me, you know? So I don't know what they want me to do.

Ms. L.'s condition was making her work hazardous too. She was taking half a dozen medications to cope with her pain and depression and shouldn't have been working her shift around dangerous machinery or, she admitted, even really be driving to work anymore. But she couldn't afford to stop. Mr. La., who lived nearby, couldn't either. He had recently had hip surgery and, at the urging of the plant, started coming in again, though he knew he was not ready to work and was endangering his health. All he could do, he said, was pray he wouldn't rack up enough "occurrences"[16] to get fired. But he was getting close. "A person like me and my situation with all this going on, I just had to work [the days he was sick]. You know, you take a day, and that's an occurrence. After a few occurrences they fire you," he said.

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[16] Calling in, being late, or failing to clock out would all result in an occurrence.

The resultant poor health of the Laboring, the consequence of this presenteeism and an absence of regular healthcare, produced a burdensome amount of shadow work for impoverished clients. Here I am not referring to the common unremunerated chores necessary to exist in a wage economy (cf. Illich 1980), or to the unpaid labor we now regularly provide for free when we pump our own gas or scan groceries in the self-checkout aisle (cf. Lambert 2011)—although the Laboring do this work like everyone else. Here the term “shadow work” will refer to the hidden and extraneous labor that accompanies and is particular to those toiling in precarious labor arrangements; work made necessary or more difficult by the ailing conditions of sick clients.

## The Shadow Work of Precarity

The shadow work of laboring life takes many forms. Finding and staying employed could be a job all in itself. For example, many interviewees had to fund their own training to make themselves employable, as employers have increasingly abdicated the risk and responsibility of preparing workers for work (Kalleberg 2011; Quinlan and Mayhew 1999).

Mr. G., for example, had to pay for his own security guard course. To make matters worse, the training was conducted an hour and a half away in Charlotte, forcing him to keep a motel room there for several nights. He eventually was sent to work at a trucking company, only to realize that his job entailed entering shipping and receiving data into a computer. He wasn’t good with computers, so the job didn’t work out and the security company never called again.

The shadow work of health was similarly labor-intensive. Ms. B. had to be at the

Mission at 4:30 in the morning on a Saturday to get in line for the dentist. There she would have her aching tooth pulled for free.[17] Without a car, and on a bad leg, she walked in the dark, across a part of town that she probably shouldn't have walked through that early.

Health-related shadow work also included the tedious, uncompensated drudgery of applying and repeatedly proving oneself qualified for means-tested care. Several interviewees noted that this had almost become their full-time job; filling out paperwork, getting I.D.s, and providing proof of employment, residence, and income, could all take up entire days.[18]

Mr. M., for example, couldn't get into the medical park for a doctor's appointment because he didn't have an I.D. He had lost his old one and the DMV wouldn't issue a replacement without a proof of address. His rent office was inexplicably closed for the week, so Mr. M. brought letters from his lawyer and even a prescription pill bottle with his address on it, but to no avail. When I talked to him, he had been going to the DMV for days now, catching rides with anyone that would take him. With no I.D. he would get no medicine. " You gotta wait for hours," he sighed, "You got to have all kinds of I.D.s and proof of this, proof of that. I went to the DMV ever since 8:30

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[17] Unable to afford mainstream dental care, poor clients often have no other option but to have their teeth pulled, for at these free pop-up clinics tooth extraction is usually the only service available. As a result, visibly missing teeth were common among interviewees.

[18] To qualify for care at the free clinic, for example, prospective clients had to present a current picture I.D., a social security card, proof of income for the past four weeks for all of the individuals in the client's household, a list of all the medications the client took, including doses, food stamp documentation, if applicable, and any disability, SSI, or Social Security award letters or denial statements.

this morning. I been there two days in a row. I just been here with paperwork yesterday. You gotta wait for hours, man."

Health-related shadow work was for many clients a daily part of their laboring life. This shadow work abounds in my fieldnotes, where I documented Gi.'s attempt to escape the cycle of precarious employment by going to school.

> *Ms. Gi.'s days started in pain. "Every morning when I wake up I can hardly walk," she said. She began taking medications as soon as she got up, "I take Neurontin. I take Flexeril. I take Buspar, because I got bad nerves. I take Cymbalta, because I got depression." She had also recently been on Celexa, Effexor, and Xanax. And the other night at the E.R. she had been given something for her blood pressure.*
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> *Ms. Gi. rode the bus every morning to the beauty school she was attending. The trip took about two hours. "I have to ride two different buses," she said, "One coming at the top of the hour and the other one coming at the bottom of the hour. So, whether it is morning or afternoon, I still have to spend 30 minutes at the bus station."*
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> *Most students would attend school from 9 to 3, but Ms. Gi., who was on warning for having missed so much school over the last few months due to her poor health, would regularly have to stay until 7:30 to make up her hours. "I've missed so much school over the last few months," she explained, "because, you know, I have to go to the doctor. And the clinic. And I see a different doctor every time I go. Or the hospital."*

*Ms. Gi. was in her 50s, and had degenerative disc disease, neuropathy, and arthritis of the hands. During her days cutting hair, her extremities would regularly go numb, and she would sometimes find her arm and one side of her face paralyzed. "You have to constantly be doing combing, and drying hair, she said, "I mean, we never lay our comb down, and we hold two or three things in our hands at a time. And that swells my hands and makes them to where I can't open or close them."*

*"I can't go to the doctor, Ms. Gi. said, "I gotta a lot of things wrong with me and I can't go to the doctor." (Here I believe Ms. Gi. was referring to a non-safety net doctor.) As a result, she often had to rely on the emergency room for care. A few weeks ago, for example, she had been knocked unconscious after she had fallen off the high steps of her friends' trailer during a dizzy spell. Once revived and with no one to call, she went home, but ended up in the emergency room the next night. "Because when I woke up I couldn't turn my head," she said, "yeah, everything was swollen and I couldn't turn my head any way. I was in so much pain I was crying."*

*Ms. Gi. chose cosmetology because there would always be work, "people always need cosmetologists," she told me. Until recently she had been working as a fry cook at a fast food restaurant, but had had to quit because her arms kept going numb, and I wondered how she'd manage, cutting hair all day.*

*If she had to stay late at school to make up hours, Ms. Gi. would have to call a friend to come pick her up; the bus didn't run in the evening. Such* *arrangements were common among interviewees. Clients often relied on friends or family or acquaintances to make it to work or to the doctor. (But rarely were these rides free. Mr. Ca. would buy his neighbor a pack of chicken every time he got a ride to the grocery store. Ms. W. paid her sister gas-money when she needed to get to the free clinic. A ride with a coworker out to the plant would sometimes costs Mr. J. 15 dollars. Ms. Gi. did not elaborate on the arrangement she had with her friend.)*

*Once she got home, Ms. Gi. took a bath in Epsom salt. "Because my whole body hurts so bad," she said,*

> *I mean I'm trying so hard to do this. I've been in school for almost a year. And, yeah, I'm older. I go to school with 20-year-olds and they are younger and their minds are sharper than mine. And it's really (crying)…it's really, really, hard. Yeah. You know, I can't get more help. You know, life didn't stop just because I decided I want to go to school and try to make something of my life and don't have to depend on a man to do it for me.*

*-Interview notes from 2017*

In addition to their own health-related shadow work, many of the Laboring cared for people besides themselves too. They cared for their aging parents, or for adult children that had disabilities that kept them from living alone. These responsibilities were often a further burden on the delicate health of interviewees, for the unpaid care they provided was time-consuming, physically taxing, and often emotionally draining. Ms. M., for example, took care of her sick mother as much as her own poor health allowed. She wrestled her wheelchair into the car and drove her to doctors' appointments. (*I realize it may appear as if I am making contradictory, or at least* *confusing claims about whether interviewees had cars or not. In interviews with clients I always asked if they did. But the answer was often complicated. It depended on what you meant by "having" a car. Owning a car didn't mean you necessarily had transportation. Some interviewees had cars, but couldn't afford insurance. Others had cars that wouldn't run and they didn't have the money to fix them. Still others interviewees might have access to a car, but weren't allowed to drive, for one reason or another, an expired license or a DUI, for example. The car mentioned here is Ms. M.'s mother's car. Ms. M. didn't have a car of her own.)* She fixed her sandwiches. At night, finally home, she would spend long hours on the phone talking to the lonely woman. Her son helped with any heavy lifting and she was teaching him some basic housekeeping chores, but he was having a hard time getting a hang of them, and she worried about what would happen to him when she was gone.

Finally, there was job-related shadow work. This could mean rolling silverware off the clock[19], perpetually being on call—not free, but not paid either—or simply working hours that went unacknowledged and for which interviewees were not compensated. Some of the Laboring regularly worked 60 hours a week, but were only paid for 40 or 48. Such illegal arrangements were endured out of desperation. Overtime

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[19] Restaurant jobs, particularly waiting tables, were notorious for the amount of obligatory side work they required. This might include bussing tables, vacuuming, refilling condiments and restocking coolers, taking out trash, cleaning bathrooms, cutting lemons, or "rolling silverware," i.e. pairing sets of knives and forks and wrapping them in napkins for the next shift. In an effort to save on payroll, managers assign this work to tipped employees (in South Carolina that means that these employees could be making as little as $2.13 an hour), who may not leave until these tasks have been completed.

pay could be a mixed blessing anyway, as a month with extra income could disqualify clients for some of the subsidized healthcare of the safety net for a time.

Ms. H. had been a pre-K teacher until dizzy spells and weakness, the result of uterine fibroids, forced her to quit. “I was able to get food stamps for a little while.” She said,

> But it's like, that was another thing, I think you had to make like... I made a little over the amount. And so, I'm not eligible for it. Because that's the other thing was my job, the pay fluctuates, it depends on the number of students I have. So sometimes, I'm like, well okay, this will be a good month. But then sometimes I look at the number of the enrollment and I'm just like, okay I'm just not going to eat this month (laughs). Eat twice a day instead of eat three times a day (laughs).

The last time I talked to Ms. H. she had gotten a new job doing piecework. This new job allowed her to work from home, but didn’t pay much.

Too much work, or too little work, or irregular work created inevitable shadow jobs for interviewees. When pay fluctuated the Laboring were often forced to enter predatory payday loan arrangements in which debts were accrued and, if they were not paid off quickly, compounded with impossible interest. More shadow work would follow: the managing and renegotiating of arrears—delinquent E.R. payments were common—the fraught process of borrowing money from family or acquaintances, the search for side work, the selling of assets, the moving to cheaper accommodations, and so forth.

Consequently, most of the Laboring sought to work at any cost, though for many being and staying employed was becoming increasingly expensive. It wasn’t uncommon, for example, for an interviewee to spend the first couple hours of their shift paying off the cab fare incurred on the way to work. This shadow work was tolerated for a lack of options. So interviewees continued to labor in conditions akin to a perpetual stretch out, in unsustainable economizing conditions subsidized by safety net care and the county's charitable organizations (cf. Dickinson 2016). As a result they developed chronic health conditions, which in turn cemented their vulnerability and immiseration.

**Cementing Inequalities**

Rates of employer-provided health insurance have decreased for all workers since the late 1970s, but individuals laboring in blue-collar and low-paying service jobs have been disproportionately effected during this shift, as the low wages of the working poor can effectively preclude this vulnerable population from accessing health care (Kalleberg 2011; Newman 1999).

As Horton and Barker (2010) have noted, such disparities in insurance coverage can result in entrenched health inequalities that in turn produce conspicuous and stigmatized forms of embodied inequity. Their work, examining the effects of early childhood caries (cavities) on the lives of Mexican-American farmworker children, suggests that the enduring consequences of underinsurance become cemented as "stigmatized biologies,"—the conspicuous and enduring biological consequences of inequality (Horton and Barker 2010: 199).

Ms. W. is one of the city's Laboring and her story illustrates just how complex a determinant of health precarious service labor is and how inequalities could become cemented:

> *She'd lived in Spartanburg County her entire life, but had never worked in the mills. Instead she had a job assembling auto parts and cleaned at the*

*hospital. But she was sick a lot with heart troubles and suffered from nerves. On top of that she's was partially deaf. She had been since birth.*

*I first met Ms. W. at her apartment, located in a housing project named after a hunter and plantation poet. She was dressed, like her neighbors, for leisure—shorts, flip flops, and a t-shirt—that never seemed to come. She told me how proud she was to be part of my research. She'd eventually frame my recruitment flyer, which saddened and embarrassed me.*

*Ms. W. had made ends meet with food stamps. But groceries were high and the six dollar a month reduction in SNAP benefits a few years ago had been hard on her, she said.*[20]

*Now Ms. W. frequented ministries and food pantries to eat. Here groceries were not sought, but come upon, as the stock was unpredictable and the items shelved incongruously: slim tubes of jerky next to sandwich bags of coffee creamer next to soap. Cardboard boxes full of assorted medicines: dented and suspicious.*

*Ms. W. tried to eat well. But most of her groceries had to be boiled back into food before being consumed. Eventually she got sick again. It was her blood pressure, then a series of infections, then trouble breathing. Ms. W. had been*

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[20] A six dollar a month reduction might not seem a particularly significant loss for a person working nearly full time. And throughout the rest of this dissertation there will be other mentions of margins so slim and severe that they may seem unbelievable to readers. So here I would just like to reiterate that the clients interviewed for this dissertation were not simply working poor, they were the uninsured, laboring, working poor, individuals that had been caught in spirals of bad health and evermore dismal employment, sometimes for decades. As a consequence, most interviewees were very, very poor.

> *uninsured all her life and had, like most of the Reserve Army of the Laboring, relied on the rationed aid of the city's safety net healthcare to get by. And like many, see got by through harmful acts of endurance that compromised her health.*
>
> *I never saw her partner, laid up in the back of the apartment. "He dying," she said. They had some furniture, and a TV and a microwave, so at first I didn't know how devastatingly poor she was. But I soon found out; with only her income to support her and her partner, a five-dollar box of diabetic test strips was regularly beyond her means.*
>
> *In the elevator of her building, a piece of paper announced that the weekly "Coffee Chat" for residents could no longer afford to offer free coffee. A coffee club would replace the meeting. The cost would be three dollars a month and would include the expenses for coffee, sugar, and creamer. The three dollars that had seemed like an insignificant expense on my way up to see Ms. W., felt like a reckless indulgence as I took the elevator back down.*
>
> *-Fieldnotes from visits with Ms. W., 2016-2018*

Interviewees' conditions were cemented by the continuous compounding of precarious work and poor health, which often led to irreparable medical conditions (Adair 2001; Horton and Barker 2010)—permanent losses of vision, irreversible damage to organs, and joints and vertebrae that would never be the same. Talking about one of his scars, Mr. Wa. said, "That scar will never leave me. That will be there for the rest of my life. The blood clots and scars in my legs, they'll be there the rest of my life."

Other types of cemented and stigmatized inequity were less readily apparent. Several interviewees, overwhelmingly but not exclusively women, mentioned episodes of sexual abuse, and many were survivors of domestic violence. This was not something I asked about, but it usually came up while discussing depression, as interviewees often attributed their poor mental and physical health to trauma that had gone unreckoned with for years, sometimes decades. “My first husband abused me,” Ms. Gi. said, “like regularly. So I think that’s where a lot of my body pain comes from. Comes from those beatings.” Of free clinic clients, a volunteering physician, Dr. Otis L. Baughman, a former dean and director of medical education at Spartanburg Medical Center told the local paper, “Often, they suffer from post-traumatic stress disorder, and their condition has been misdiagnosed and improperly treated for the majority of their lives” (Hughes 2019).

Violence too seemed to be prevalent in the lives of the safety net clients I spoke to.[21] A man’s brother had beaten him with a baseball bat, leaving him in a coma for a week. The brother, who lived in a trailer on the same lot, had lost a lung after he had been shot at a party. The brother of the woman sitting a few seats down had been shot in the stomach and was now unable to work. Another woman that came in a few minutes later told me she had a mental breakdown and had been hospitalized after her brother had been charged with murder.

Lasting pain from severe car wrecks, like physical and sexual abuse, were common among laboring interviewees too, the effects of which, unaddressed, could

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[21] The anecdotes in this paragraph are not from interviews, but from clients I happened to talk to, informally, at a safety net organization one day.

linger for decades. Ms. L. attributed her health problems to a series of accidents she had been in in her 30s. "My illnesses mostly came from a car wreck [and the pain in my] back and my leg come from a car wreck. The migraines too, I was beaten on top of the head," she explained. Ms. B. had been in a bad wreck in 1996 in which she severely injured her leg. It was tender to the touch even now. "The older I get, the more it hurts now," she said. Mr. P. had been in a car accident too, years ago, and now could no longer walk more than 100 feet at a time, according to a note a doctor had written for him. He had a pin in his leg and got around on a donated cane.[22]

These embodied effects of poverty were both a result and cause of poor health. The consequences of precarious work were cemented through exploitive labor arrangements and rationed medical aid. For the Laboring, unable to escape their ill-health due to paltry wages and a lack of insurance, opportunities for meaningful advancement were almost non-existent; chances at upward mobility had largely evaporated and good jobs were vanishing as employers increasingly used part time work as a cost-saving employment strategy (Hall et al. 2018; Kalleberg and Vallas 2017;).

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[22] I want to be careful here. I am not suggesting that car wrecks or sexual abuse are more common among members of the Reserve Army of the Laboring. My point is that working poor clients, because they lack regular access to healthcare, appear to suffer disproportionately from these traumatic events. As for violence, I don't know if the Laboring are exposed to violent crime more often than non-Laboring individuals. I suspect they are though, as their poor wages often confine their housing options to more dangerous parts of the city (The following studies seem to support this hypothesis: Graif and Matthews 2017; Hernández 2016; Rosen 2017). Ms. J., for example, lived on a notorious block. A police cruiser was always parked up the hill from her house, presumably watching the sales of crack cocaine and heroin that went on at the end of the street. One of the first things Ms. J. told me was that she kept a pistol in her house for protection. Ironically, the gun she bought to keep herself safe was the same one she regularly contemplated ending her own life with.

The outsourcing and subcontracting of work was also used to decrease labor costs, and to absolve companies of any responsibility for providing benefits, living wages, and training for employees that worked *for* the company, but not in their name (Jaffee and Bensman 2016; Weil 2014).

Ms. J.'s story illustrates how easy it is in these circumstances, after decades of work, to become an unwilling "deserter," to use Virginia Woolf's phrase of "the army of the upright" (2002: 37)—once among righteous working poor, now sick and ailing and in need of help.

> *Ms. J. cleaned at a plant at night for an independent contractor. Over the course of the workday, particulate from the manufacturing process accumulated on the high ledges that surrounded the factory floor and on the tops of machinery. The third shift cleaning crew would spend the night dusting and mopping. It was surprisingly hazardous work. Falls were common and a friend of Ms. J.'s that worked with her on the crew had begun to suffer seizures, which both women attributed to inhaling the toxic dust that rained over them as they cleaned.*
>
> *Ms. J. herself had fallen one night and badly damaged a disc in her spine. She took off as much time as she could afford, and tried to return to work, but could no longer manage the physically demanding labor. A doctor at the free clinic told her she would likely never fully recover from her fall.*
>
> *By her own admission, Ms. J. was never a "saint." She'd spent some time in the penitentiary and told me she could still hold her own in a fight against any man. But when she asked me if I wanted to see the medications she kept upstairs*

*in her bedroom, I declined: I'd watched her ascend the ten steps once already and I was unsure if she would be able to manage it again.*

*She fell often and hallucinated regularly from her prescribed medications. Uninsured, and with no income, Ms. J. relied on her adult daughters for support. The two women helped when they could, but Ms. J. spent most of her time alone, confined to her apartment, deeply depressed. After a lifetime of labor she had nothing. Work, which had once kept her among the righteous, was now impossible.*

*Ms. J. would eventually apply for disability. During her hearing, despite her doctor's confirmation that she should never work again, the judge proclaimed Ms. J. fit for employment. After suggesting that she could learn to make sandwiches on a cane, he denied her claim. She would gladly have worked, but Ms. J. knew that she couldn't stand behind a counter all day, even with the aid of a cane.*

*The last time I saw her she could no longer drive from all the medications she'd been prescribed. She spent her days off, she told me, learning things from the judges she watched on T.V. and praying for some relief.*

*-Fieldnotes from visits with Ms. J., Summer 2017*

## Conclusion

The embodied inequity of precarious labor is regularly explained away as a lack of personal responsibility (see Chapter 3), a deep irony considering many of the Laboring literally work themselves sick in an effort to remain among the righteous. But forms of precarity once considered the distinguishing problems of the very poor—job insecurity, difficulty living from paycheck to paycheck, a reliance of casual labor arrangements, etc.—have become more common among the working class (Allison 2013; Han 2018; Standing 2011.)

This iteration of working poverty is, as Shipler has noted, "a constellation of difficulties that magnify one another" (2004: 285). In the late capitalist economies of the modern South escaping poverty requires, among other things, stable employment, a living wage, robust health, affordable housing, reliable transportation, and a general lack of misfortune. The biographies of the clients I interviewed reveal that a lifetime of work will not necessarily lead to prosperity, or even guarantee that you can get by.

Spartanburg's Reserve Army of the Laboring is a local manifestation of inequity and precarious employment relations. Long spells gone without health insurance were embodied as trouble walking and bad backs and bad hearts, weak hands, absent teeth, trouble sleeping, depression, and nerve damage. Not all these things can be attributed to precarious work alone, of course. Mr. Bl. attempted to keep his depression at bay by drinking, starting when he got up in the morning, and had done so since he was in his early teens. Mr. Ca.'s COPD was likely related to the fact that he had smoked since the age of ten. Ms. O. had used crack cocaine for nineteen years before she got clean in prison. Nevertheless, the poor health of these interviewees was overdetermined by their poverty, a lack of access to care, and the embodied consequence of being part of a disposable workforce.

The people I interviewed were not the malingerers on “assistance” of popular imagination. They had worked for decades and many were being actively disabled by continuing to work.

Driving home from Ms. J.’s house one day the bumper sticker in front of me read:

**THIS IS AMERICA**
**WE DON’T REDISTRIBUTE WEALTH**
**WE EARN IT!**

In the next chapter I will examine how indifference to the common violence of precarious labor is sublimated by bad faith understandings of responsibility. I will then explore how the embodied consequences of inequality are often reframed as the result of risks willingly assumed (cf. Bourgois and Schonberg 2009; Garcia 2010), and rendered inevitable as consequences of market fluctuations and failures (cf. Adams 2013; Nguyen and Peschard 2003).

## A Concluding Apophasis

Around the time I began my dissertation fieldwork, a widely-circulated quantitative study (Case and Deaton 2015) reported that all-cause mortality for white Americans between the ages of 45 and 54, already high compared to countries such as France, Germany, Canada, Australia and Sweden, had increased since the late ‘90s. These other countries had continued to see significant reductions in mortality among this demographic.

Driving this rise in all-cause mortality in the United States, the researchers found, were increases in drug and alcohol poisoning (either by accident, or with an intent that was impossible to determine), suicides, and chronic liver diseases. The primary spur of this reversal was deaths among individuals with a high school degree or less. During this period, self-reported morbidity and reports of pain increased as well. White non-Hispanic Americans over the age of 65, by contrast, continued to see a declining mortality rate (Case and Deaton 2015).

By the time I had read the Case and Deaton paper in 2016 my research agenda was set and I had begun fieldwork. As a result I cannot directly address this phenomenon, nor, due to my research methods, can I offer any correlations. However, I do believe my dissertation data suggests that the growth of precarious labor arrangements and all its consequences should be considered as a possible factor in the surge of early mortality among this age group, coevals of the modern rise of precarious labor arrangements.

## Chapter 3. Interlude: The Bad Faith of Sight and Oversight

*"We must encourage the spirits of charity and volunteerism among our people, organizations, and institutions, including our houses of worship because government cannot and should not attempt to be all things to all people."*

*S.C. Governor Henry McMaster (2018)*

*"Moving able-bodied adults from welfare to work only serves to build a better South Carolina. With healthier lifestyles, better home lives, and financial independence, ultimately it provides hope, and that's a cornerstone of who we are as South Carolinians."*

*State Sen. Ross Turner and Senate District Rep. Dwight Loftis (2018)*

### Introduction

In the last chapter I argued that the members of the Reserve Army of the Laboring are a low-wage workforce, disabled by and abandoned to precarious labor arrangements, whose consequent physical deterioration leaves them evermore vulnerable to systems of exploitation. In this chapter I will examine how the State simultaneously governs, and distances itself from, the lives and exploitation of its working poor clients through opportunistic and injurious bad faith—willful self-deception that allows for the deflection of responsibility (Sartre 1956).

I will use the concept of bad faith to explain how the inequities of precarity are reimagined and reconfigured in the Upstate, and how consequent conceptions of autonomy and responsibility impact the health of Spartanburg's working poor. Below I argue that the profiteering on the bodies of the county's laboring population is sanctioned by a pervasive neoliberal logic that shifts the responsibility for the ravages of free market “successes” onto working poor individuals, while looking to charitable institutions to manage the destructive repercussions.

Often conflated with the idea of “false consciousness,” bad faith differs from the Marxist concept in that while the former refers “to *limits* to freedom,” the latter “problematizes agents’ *freedom in itself*” Molland (2011; 239 emphasis in the original). This distinction is important here, for while some interviewees may reasonably be accused of misrecognizing the exploitation of the Laboring as a class, this chapter is instead focused on how the Upstate disowns its responsibility for the plight of its working poor population (cf. Molland 2011).

In Spartanburg County the bad faith of precarious work is (re)produced through relentless scrutiny and willful blindness, referred to in this chapter as “sight” and “oversight.” Here, sight will refer to the things selectively rendered visible that allow for bad faith, while oversight will be used in both senses of the word: as a “failure to see” (Scheper-Hughes 1989: 207) and a burdensome supervision. Through these forms of bad faith the Reserve Army of the Laboring is simultaneously policed and abandoned.

This bad faith requires complicity and must be understood as a part of particular political-economic circumstances (Kleinman and Fitz-Henry 2007; Molland 2010). For as Peter Benson—in a slightly different context—has noted: “…the problem is not that [the pain] is invisible or its causes unknown, but rather that individuals and whole groups can have something at stake in actively overlooking and taking distance from other people’s suffering” (2012: 169).

## Bad Faith in the Upstate

Over the last decade 33 states—South Carolina among them—have reduced workers' compensation benefits, made medical care less accessible, and sought to deter disability claims through more stringent vetting (Grabell and Berkes 2015). In the once common labor contract, employers would pay injured workers' medical expenses and provide a portion of their wages while they recovered. Employees, for their part, would not sue. Such agreements have been eroding for decades (Mason and Salverda 2010). In 2007, for example, South Carolina increased the standard of evidence for repetitive stress injuries, capped the amount of compensation a worker could receive for shoulder and hip disablement, and made it more difficult for employees with back impairments to claim total and permanent disability (Qui and Grabell 2015).

This dismantling of worker protections was done in the name of curbing out-of-control spending and saving employers from frivolous claims, thereby fostering a business-friendly environment that would encourage foreign investment. Yet nationally, workers' compensation rates are the lowest they've been in 25 years, despite a substantial rise in the cost of healthcare. In South Carolina the average premium cost to employers per $100 spent on workers' wages declined from $3.42 in 1988 to $1.85 in 2014. In areas like the Upstate, these gutted systems of worker protections are increasingly leaving programs like Social Security Disability Insurance, Medicare, and Medicaid to pay the wages and medical costs of injured employees (Grabell and Berkes 2015).

Underlying these understandings of work and welfare is the specter of foreign manufacturing competition. “The verities of the world market,” South Carolina secretary of commerce Bobby Hitt explained, “sometimes can be a little bit tough” (Carolina Business Review 2018). In the former mill town of Spartanburg, the death of the textile industry is still fresh in the collective memory. This allows county manufacturers to assert that they are under constant existential threat while making record profits. In the face of this ostensible threat, Hitt has attributed the state’s recent economic recovery to courting foreign direct investment by promoting South Carolina’s “good labor climate” (South Carolina Chamber of Commerce 2016). This business-friendly climate, in part a result of the dismantling of worker protections, absolves corporations from many of the customary responsibilities of traditional work arrangements.

The consequent labor precarity is not without precedent. While many analyses of precarious work in the United States imply that the 1970s issued in an unprecedented shift in labor relations (Benach et al. 2014; Betti 2018 for a survey of the literature), accounts of mill life suggest that, at least in the Upstate, it was the brief spell of mid-century prosperity that was anomalous—a few good decades bookended by periods of insecurity and uncertainty. *(I realize that in Chapter 1 I suggested that the proliferation of precarious work in the U.S. represented “a sea change in the opportunity structure of the new economies of the American South.” My point* here *is that the resultant experience of precarity was not unprecedented. This was easily apparent from accounts of mill life in the archives of the Spartanburg County library. Millwork would make you sick, didn’t pay much, and while advancement was possible, many mill employees, particularly in the early decades of the 20th century, spent their lives just breaking even.*

*There is plenty of research to back up this assertion (Beardsley 1987; Dowd Hall et al. 1987; Eller 1982; Waldep 2000), but here I would like to provide a poem to make my point instead. It's a poem from a collection called* Eureka Mill*, which the author Ron Rash (1998: 49) wrote about the small Upstate community his family lived and worked in.*

*<u>Brown Lung</u>*

*Sometimes I'd spend the whole night coughing up*
*what I'd been breathing in all day at work.*
*I'd sleep in a chair or take a good stiff drink,*
*anything to get a few hours rest.*

*The doctor called it asthma and suggested*
*I find a different line of work as if*
*a man who had no land or education*
*could find himself another way to live.*

*For that I paid a half-day's wage.*
*Who said advice is cheap? It got so bad*
*Each time I got a break at work I'd find*
*The closest window, try to catch a breath.*

*My foreman was a decent man who knew*
*I could not last much longer on that job.*
*He got me transferred out of the card room,*
*Let me load the boxcars in the yard.*

*But even though I slept more I'd still wake*
*gasping for air at least one time a night,*
*and when I dreamed I dreamed of bumper crops*
*of Carolina cotton in my chest.)*

## Forms of Bad Faith

In the Upstate**,** a pervasive ideology of bad faith contrasts autonomy with dependence, renders the hardships of the working poor ordinary and inescapable, and asserts a purported absence of alternatives to precarity and exploitation. The result is a "culture of indifference," (Nguyen and Peschard 2003: 447) veiled by righteous neglect and feigned compassion. In the context of the modern Reserve Army of the Laboring, it is this bad faith that allows the State, despite invasive supervision in the form of scrupulous drug screenings, burdensome requirements, and means-testing, to remain blind to the structural inequities that (re)produce the ill-health of recipients of social services.[23]

This bad faith allows free marketeers to lionize the working class while cutting their protections. Bad faith also enables the State to suggest that not forcing the sick to work is a form of soft bigotry. Furthermore, it is bad faith that sanctions cuts to welfare programs in times of crisis because resources are scare and cuts to welfare programs in times of abundance because they aren't as immediately necessary.

Bad faith posits that the working poor don't exist. That is, it suggests that if clients work diligently and act responsibly they can't help but advance. To explain the common "aberration" of working poverty, a righteous scrutiny is employed to discover how laboring clients are complicit in their fate. "It's unfortunate," Bill Stanfield, CEO of the South Carolina non-profit Metanoia, told The Post and Courier, "because most Americans think that if you work hard and have a job, or two, then you'll be able to make ends meet" (Slade 2018).

This is not bad faith for bad faith's sake. It's strategic. It allows people that have

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[23] Another example of onerous oversight recently came to the fore when the Internal Revenue Service acknowledged that working poor tax payers face a disproportionate scrutiny and are audited at the same rate as the wealthiest 1% of Americans (Kiel 2019).

prospered in and from the era of precarious labor arrangements to credit *themselves* for their good fortune, and renounce responsibility for the suffering of others. This is how the working poor are rendered invisible as a population: through a Manichean worldview that divides individuals into the prosperous—working and righteous—and the poor—manifestly undeserving and underemployed.[24]

Most of the people relegated to the Reserve Army of the Laboring were once part of a mythic class of "hard-working Americans" glorified in U.S. political and popular culture (cf. Meek 2016). But when they sought aid from the state they forfeited this bad faith designation (cf. Thompson 2016).

Another form of bad faith is the bad faith of things left unexamined. This manifestation of oversight allows mechanisms and legacies of inequity to exist hidden in plain sight. For, one way to avoid addressing social problems, like the lack of mental health providers available to low-income residents, is to avoid producing data on how desperately these resources are needed. Another way is to determine what outcomes are being measured and how success is gauged. An audit culture like that of the South Carolina safety net can alter the institutions themselves; for satisfying audits can itself become the main metric of success at the expense of organizations' original missions (Lipsky 2010; Shore 2008; Shore and Wright 1997).

Bad faith also exists in rhetoric that suggests that laboring clients are an undue burden on their communities and should pull their weight if they are to receive care.

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[24] During my fieldwork a South Carolina church sign that read "Work Harder: Millions on Welfare Depend on You" made news throughout the state (Roldán 2017). The church's pastor later apologized.

This cruel idea of “cost sharing” suggests that working poor residents haven’t already paid a price and don’t already bear a disproportionate burden for it. But neoliberalism, as Becker points out, turns policy failures into “ideological successes” (2004: 271) and poor clients come to be viewed as failed consumers (Rivkin-Fish 2011) while broader social issues like economic inequality are framed through neoliberal logic as natural, and individualized as personal failings. In this way individuals at risk become “the sinners, not the sinned against, because of their apparent voluntary courting of risk," (Lupton 1993: 429). Furthermore, this rhetoric suggests that the State works within such thin margins of error that welfare cheats and malingerers are not merely a nuisance, but a danger to the very survival of the safety net. As a result deservingness is easily revoked.

In another common instance of bad faith, free marketeers publically abhor “dependence.” Yet neoliberalism quietly requires state intervention to make sure that markets are not interfered with (Adams 2013). It is the state that props up the regimes of reproduction that precipitate surplus populations, and it is the consequent immiseration of working poor populations that allows large corporations located in South Carolina to pay such low wages.

It is these forms of bad faith that obscure the mechanisms of oppression and, in turn, allow individuals and corporate entities to deny their responsibility—or even acknowledge that their actions are consequential.

## The Bad Faith of Business and The Business of Bad Faith

The existence of poverty among the working class is commonly understood as an inexorable consequence of employers being constrained by the demands of the global economy. The limited opportunities and low wages afforded to vulnerable workers are justified by a lack of training, skills, and education. This bad faith reckoning obscures the inverse relationship between the material welfare of the exploiters and the deprivation of those they exploit (Wright 1995). Ignored is the fact that the low wage work *is* benefitting someone, just not the working poor. Similarly overlooked is the fact that companies are externalizing the cost of the health crises they have contributed to. This is not an aberration, but rather than integral part of the economy that has produced a laboring reserve army.

In South Carolina, many manufacturers lured to the state with subsidies, tax abatements, and other incentives, do little other than provide jobs (cf. Shipler 2004). These companies venue shop for conducive business climates in areas where employees are unlikely to unionize, and manufacturers are drawn to the Upstate by promises of a labor force that does not organize (which isn't entirely true)[25] and works for low wages (which largely is). A right-to-work state, South Carolina is also a state with a history of tolerating inequity, particularly racialized economic inequality, which manufacturers benefit from, while avoiding the true expenses of keeping a precarious and ailing reserve army (Jaffee and Bensman 2016).

These "extra-economic interventions" are often necessary to keep surplus populations available, should they be needed (Smith 2011; 15). As Smith notes, "Often, to service global clients, a state may apply neoliberalism in one sphere while using precisely its instrumental understanding of social membership to exclude populations

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[25] According to a Bureau of Labor Statistics (2019) survey, South Carolina does however have the lowest unionization rate in the nation.

and places from neoliberal calculations" (2011: 9-10). Once considered measures the State could use to counterbalance the inevitable inequalities thought to be inherent in the capitalist economy, these interventions have come to be considered impediments to prosperity (Kingsolver 2016; Smith 2011).

As a result, work, and the courting of employers with expensive incentives, is posited as an unqualified good. "We are situated right now to have a great economic expansion and growth that will take care a lot of our problems," Governor McMaster said last year (Barton 2018). For providing 8,000 jobs to South Carolina, Bridgestone, Boeing, Michelin, and BMW received approximately $800 million in incentives and tax breaks (Wilkinson 2013).[26]

Some of these jobs are good jobs. Others aren't really jobs at all, but "fragments" of work (Small 2000:17), with irregular shifts, and ill-defined schedules, work that is entirely contingent on manufacturing orders or consumer traffic, and is unreliable as a result (cf. Schneider and Harknett 2019). Mr. S. had until recently worked for a subcontractor that produced parts for a major multinational manufacturer located in the county. The work had been strenuous he said, and new automation on the line meant that he had been forced to "do the work of three men" until his hip gave out and he could no longer keep up. "Didn't have no insurance," he said, "so you had to run the risk that you didn't get hurt." The subcontractor paid considerably less as well. "You know we don't make that much," he said, "But yeah, we had to try to keep up with [the subcontracting manufacturer], but they wasn't paying us for it."

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[26] As facingsouth.org (Kromm 2016) points out, this means that the four companies received around $100,000 per job created.

Manufacturers, in an effort to maximize profitability, rely on such "gainless occupation" (Comaroff and Comaroff 2002: 781) to operate. This is not the work that Turner and Loftis (2018), quoted at the top of this chapter, assert it is, the work that will provide "healthier lifestyles, better home lives, and financial independence." Instead these are often precarious jobs filled by the poor and the sick, their disabled bodies serving as the alibis for their vulnerable positions. Bad faith suggests that these jobs, essentially permanent stretch-outs, are designed to be endured for a lifetime. But according to interviewees, labor contacts were often upheld only until employees got hurt or sick and became a liability for their employers.

Not all these injuries are acute or traumatic. They are not all severed digits or broken backs, and an employer's responsibility for an injured worker is not always unequivocal. Ms O. had begun to have trouble with her hands and had gone to the company nurse of the chicken plant, who had diagnosed her with "a little arthritis," applied a topical medication, and sent her back to work. Injury claims are monitored, managed, and contained by these company nurses, and workers are incentivized to stay quiet about injuries, or risk being terminated if their health becomes a liability (Stuesse 2018). But Ms. O.'s hands kept getting worse from the repetitive work on the line. After repeated visits to the nurse, the plant doctor put her on light duty, which meant picking up the chicken parts that fell under the machines and taking them to the waste. But soon Ms. O.'s back, which she'd always had problems with, began to give out too and she had to return to the nurse. The pain was horrendous, she said. "It was, excuse my language, murder," she told me.

When Ms. O. was first hired she was asked about any medical conditions she had, and she'd noted her arthritis. When she went back to see the nurse for her back, the doctor found spinal arthritis and she was fired. "They had me there for failure to disclose," she said, "because I only put arthritis. Not arthritis of the lumbar. So there went my job and everything."

Large corporations can afford high turn-over among precarious employees like Ms. O. A result of the growth of sub-contracted labor, employers have increasingly absolved themselves from the responsibility of paying a living wage and from any liability for wrong-doing, exploitation, or work-related injuries. For example, Walmart, a frequent employer of Laboring interviewees, and where Ms. O. went to work after she was fired, is propped up by irregular and part-time workers that have few other job options and that routinely fall out of the workforce (Zieger 2012: 10). These workers remain unskilled, and if they are sick quickly lose their value to the company. In these circumstances asking for days off or for allowances due to your deteriorating physical condition can cost you your job, interviewees told me.

### Racialized Bad Faith

During my time in Spartanburg County I was regularly asked to explain my work, and once I had done so, was often informed that most people on welfare didn't need it.[27] When I tried to explain the predicament of uninsured working poor clients, I was regularly told, kindly, that I was being lied to. Someone had seen their neighbor, who

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[27] This was a common refrain at parties, at the gym, or at lunch. In these conversations "welfare" appeared to be used as an umbrella term for all forms of social assistance, including safety net care.

got disability, riding his sport bike up and down their road. Or frequently people would tell me that they had grown up poor too, and knew how it was, but that their mother was proud and would go without before reaching for a hand out. Why should they pay, they asked me, for others to live a life of idleness and comfort?[28]

For decades, a pervasive and persistent narrative has asserted that the tax dollars of hard-working white Americans are being spent lavishly on minority welfare (Alexander 2010). A form of the bad faith of oversight, this racialized narrative divides the county's population into willing workers and malingering welfare recipients, producing a strategic racial animus.[29]

For in the United States, the protections against the collateral damage of capital accumulation were never meant to be all-inclusive, and were originally drafted with white men in mind. Throughout the 20th century, African-Americans were regularly excluded from the protective governmental mechanisms set in place to deflect or mitigate injurious relations of capital. These protections were designed strategically: Black men and women were kept from the welfare rolls by calculated determinations that deemed certain types of work beyond the ambit of governmental regulation

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[28] But there were also people that immediately understood.

[29] I should note that the people mentioned above, the people that believed welfare to be largely unnecessary, were usually white, but not exclusively. Ms. T., a client I had interviewed for this ethnography and who was black, told me one day,

> You know what they need to do? They need to make them take a drug test if you get disability. Because I know ain't nothing wrong with you. I see you everyday. Everyday. And then you get your social security check and you smoking it up with the dopeman...Once they start making these drug tests, where if you get food stamps, you take a drug test. See how much more money they gonna save. Billions of dollars. Billions.

(Collins 2011).

This racism embedded in U.S. welfare policies continues to go largely unacknowledged (Black and Sprague 2018). Analysts (Brown-Nagin 2014; Hughey and Parks 2014) have suggested that the decision of states to forego Medicaid expansion was another instance of racialized exclusion, as the expansion would have substantially benefitted poor minorities, but was rejected in the name of opposing governmental overreach.[30]

The relationship between racist sentencing policies and persistent poverty is similarly overlooked. Since the initiation of the War on Drugs, African American incarceration rates have risen disproportionately. This was not due to an exploding crime rate, but is instead attributable to changes in sentencing policy (Ingraham 2017). According to Human Rights Watch, in seven states African Americans constitute 80 to 90 percent of all drug offenders sent to jail and in at least fifteen states, black men are charged at rates 20 to 57 times greater than that of white men (Alexander 2010). This is relevant here, because if you are convicted of a felony you can be denied access to public housing, food stamps, and to a variety of professional licenses. The four clients I interviewed that were convicted felons had a particularly hard time finding work. They took jobs in the informal economy, surviving off the maintenance work they did for their churches, or irregular manual labor done for cash.

Left unexamined, this bad faith of oversight allows ideas like the welfare queen

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[30] The expansion represented a "stranglehold on businesses, on insurance companies, and everybody else," McMasters said last year (South Carolina Educational Television 2018).

to continue to exist, in turn allowing legislators to suggest that the working poor need to pull their weight.[31] The state in turn can claim that the destiny of impoverished clients rests in their own hands, and that the tragedies of a life spent laboring are uncommon and deserved.

As a special United Nations report notes, allegations of welfare fraud in the United States are a constant refrain, yet faith in corporate actors, the beneficiaries of corporate aid, is high among the same government officials that malign welfare recipients (Alston 2018). Nikki Haley, the governor of South Carolina before McHenry, as U.S. ambassador to the U.N., rejected the report as "misleading," arguing that "being able to provide for one's self and family is empowering, both economically and spiritually" (Black and Sprague 2018). But this sentiment hides the realities of precarious work, and the necessity of welfare in the lives of many working poor Americans.

A strong economy is not likely to be the salvation of the working poor (Kalleberg 2011). Jobs are available in the Upstate, but many are precarious, and employment without benefits or a living wage is not particularly helpful for clients trying to dig themselves out of poverty. This often means that the Laboring must take multiple jobs, keep difficult, irregular hours, and work overtime without receiving commensurate pay, as employers continue to reduce the hours of employees to avoid having to pay for insurance (Tavernise 2013). And so, unable to escape poverty with part-time and precarious work, ineligible for disability, and without health insurance, often the only

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[31] I believe it's telling that few types of criminality generate popular opprobrium like welfare fraud in the Spartanburg County, and that accusations often have racialized overtones. By contrast, the largely white outlawry of the moonshiners, once common in the Upstate, is still celebrated and memorialized everywhere in the county.

way the laboring had to sustain themselves was to be reabsorbed into the work force and rely on safety net care.

## Bad Faith and the Safety Net

The ostensible aim of the county's safety net is to foster self-sufficiency among the poor, and a hypervigilance is employed to keep clients accountable and from living easily off the state. Work needs to be more lucrative than welfare, the argument goes, otherwise there is a disincentive to find and hold employment. "Foundational to this demonstration," South Carolina health officials wrote, explaining why the state has sought Medicaid work requirements, "is the hypothesis that employment leads to the economic and social mobility necessary to attain independence" (NASDDS 2019). But in Spartanburg it's hard to live on low-wage work. Yet, for laboring clients it is also impossible to live without it.

For care must come at a cost, it is argued.[32] But it is this work, and working these jobs while injured, that is keeping the Laboring poor. This policy does not fight poverty, but instead mires the laboring in immiserating work arrangements, for the jobs they are relegated to will likely not allow them to get out from underneath their debt, poverty, and health problems (Sweet et al. 2018). As a result, the Laboring rely of the county's healthcare safety net to stay employed.

During my fieldwork the aid of the safety net was regularly described by local

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[32] In his examination of American life, Terry Eagleton asserts that in the U.S. there is a pervasive idea "that people must be bawled out and knocked around if they are to give of their best" (2013; 91). The idea, apparently shared among many Upstate legislators, Turner and Loftis among them (2018), produces bad faith policies that slash welfare in an effort to get people to take precarious employment.

administrators as determined by the cold immovable calculus of capitalism. There was just not enough aid to go around, I was told. Consequently, care, the reasoning went, must come at a cost. Collins and Mayer (2010: 14) have characterized this as “trading civil rights for aid,” and I agree.  Welfare after all, is increasingly meant as a custodial institution (Collins and Mayer: 2010). Safety net administrators and directors were open about the main role of their organizations’ mission: to head off and deter unnecessary emergency room visits and to discourage dependence.

The county’s free clinic clients already knew they were viewed as malingerers and freeloaders. Ironically, this made them reluctant patients; they wouldn’t come in for just anything. Many also believed that there wasn’t enough care to go around, and they didn’t want to take an appointment from someone worse off. So they went without as long as they could. But as one free clinic care provider told me, “People don’t get well on their own.”

More than a few of the working poor clients I interviewed suggested that disability fraud was rampant and that benefits were too easy to come by. These interviewees believed that they themselves had no choice but to seek subsidized care, and at the same time, questioned the motivations of other clients using the same services, or bemoaned how many people were receiving aid (Brunson 2017 found this too). Ms. Q., a cashier at a local grocery store, believed that in her neighborhood people were getting disability for substance abuse and illiteracy:

> How in the world you gonna get a disability check because you a alcoholic? Nobody made you put that bottle up to your mouth. And that’s what they get disability for. Alcoholic. Or crack. Or someone that can’t read or write. They get it. Just like that (snaps). I’m serious. I wouldn’t lie to you. They’re the ones that

> get it and you be like, sitting there, looking at them. Then after about 30 minutes they broke. Next month. Same thing.

Interviewees like Ms. Q. argued that their own hard circumstances were anomalous, and that their case was a rare instance of a hardworking, tax-paying, citizen falling through the cracks, not a result of common and systemic inequity. For clients are not immune to bad faith, which I found often manifested itself among interviewees as a failure to recognize that others around them, those with them in free clinics and food lines and disability courts, may have suffered similarly devastating circumstances, and therefore were equally in need of help.

### The Bad Faith of Kind Abandonment

In the Upstate, aid is popularly portrayed as a form of condescension and therefore something that should not be accorded in the name of kindness and dignity. Through this bad faith reckoning, abandonment becomes a form a benevolence and concern. This idea that assistance harms the poor is pervasive and persistent. According to this logic, help from the State ostensibly comes in the form of policies spurring "self-sufficiency." The result is the abandonment of the Laboring in the name of personal autonomy.

Granted, precarity, the absence of the prospect of stability, is not a state limited to the working poor, but a defining condition of much of modern life (Allison 2013). Yet for some, positioned to take advantage of strategic insecurity, the era of non-standard work relations has been exhilarating and emancipatory. But precariously-employed clients are largely not equipped to benefit from this instability, and the risk management vulnerable Upstate residents are forced to engage in is dangerous in an economy of bad faith.

In such an economy, abandonment can often be construed as its counterfeit: the promotion of autonomy and independence. Opponents of the Affordable Care Act, for example, asserted that the ACA infringed on individual consumer freedom by not allowing citizens to forego purchasing health insurance (Horton et al. 2014). As a result, the working poor, who fall into the insurance gap, often don't have the choice of purchasing insurance at all. So while in South Carolina, the governor's office referred to Medicaid expansion as a "budget busting, job killing disaster" (Borden 2015; n.p.), the disaster of disabled working peoples' lives went unacknowledged.

The working poor require a hand up, not a hand out, according to this logic. It's another common bad faith irony, a "general irony of coercion imposed in the name of freedom" (Mensch 1981: 767). In an opinion piece written for the Greeenville News, State Senator Ross Turner and Senate District Representative Dwight Loftis (2018) used this logic to argue for "welfare to work":

> Moving able-bodied adults from welfare to work isn't "mean spirited." It's about speaking to the human spirit and encouraging people to make a better life for themselves and their communities. It is one of the most empathetic and compassionate things we can do. The Trump administration's action is designed to inspire, not hold down. It's about widening a path to self-sufficiency, not reinforcing a culture of dependence.

Here again is the common bad faith narrative that suggests that acts of abandonment are in fact forms of support. Implicit is also the idea that people need encouragement to make a better life for themselves. Furthermore, the health conditions of those on welfare are overlooked in these arguments, as is the culture of dependence that surrounds corporate capital. In these circumstances the mandated self-reliance and privatization of risk imposed by the State is rarely an asset for laboring workers. Much more often it is a liability and even a danger. It allows you to be abandoned with cause. This “governing through insecurity” is a form of neoliberal governance that provides the most meager of assurances of security while strategically increasing instability to facilitate economic exploitation (Lorey 2015:11). As Smith (2011) notes, it’s not governmentality for governmentality’s sake, it’s governmentality in the name of capital accumulation.

Precarity and precarious work arrangements are pervasive and ubiquitous, but experienced locally. The Laboring of upstate South Carolina have had to abandon aspirations of economic security and stable work to, in the most literal sense, survive. Their attritional labor at once reproduces and attenuates life.

The current prosperity enjoyed by South Carolinians comes at the expense of these badly-paid workers. It costs the Laboring their bodies. These sick and uninsured clients become maimed and crippled by years of hard work, and slide into the industrial reserve army when injured. There they work increasingly worse jobs because they have nothing else available; when you are desperate to work, you get desperate work. The Laboring sustain the low wage economy all the while putting up with immiserating loan agreements, exploitative work conditions, rationed healthcare, and unreasonable demands of employers. Consequently, a social and economic polarization has developed as the earnings gap has widened (Jaffee and Bensman 2016).

This growing disparity produces an environment primed for exploitation and coercive labor arrangements (see Chapter 7). Many interviewees told me they felt trapped, as switching jobs could be prohibitively expensive; a change in employment would require enough money to live on for the first couple of weeks before receiving a paycheck from a new employer. So clients were forced to tolerate abuse and poor wages, and do work that spilled outside of their job descriptions (c.f. Black and Sprague 2018).

As a captive workforce, Spartanburg's laboring population are also often "exploited consumers" (Caplovitz 1967; xv). Payday lenders and check cashing businesses are ubiquitous throughout the poorer parts of the city. They are both a signal of and a contributor to the distress of impoverished neighborhoods. Granted, consumer credit is an important form of capital that allows borrowers to finance their educations, endure internships, secure transportation, and manage their health (Dwyer 2018). But the easy credit enjoyed by the well-off is largely unavailable to the working poor, who as a result become trapped in cycles of debt through high-interest loans and their repayments (Sweet et al. 2018). Laboring borrowers subsequently became mired in obligation to the point that they often lived outside even the most speculative of credit-based economies, arranging work informally, relying on parents to secure housing, and accepting usurious arrangements to get cars.[33]

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[33] During my fieldwork, former South Carolina congressman Mick Mulvaney became the Acting Director of the U.S. Office of Management and Budget, and was a dogged champion of pay day lenders. In the name of combating governmental overreach, Mulvaney attempted to waive Consumer Financial Protection Bureau restrictions on loan providers, and to reduce fines that had been imposed on South Carolina lenders for unethical practices (Crowell 2019; Rucker 2018). While a congressman from South

Unable to pay medical bills or other debts, many interviewees were regularly hassled by the paid proxies of creditors. Some of the men I interviewed had been to jail for failing to pay child support, a debt that can continue to accrue while incarcerated, keeping fathers caught in cycles of delinquency. The stress of their debts often showed in the lives of these interviewees and their families. One afternoon, lost and late to meet him at his house, I called Mr. Ca., but got his mother instead. Believing that I was a debt collector calling for her husband, also a Mr. Ca., she cussed me at length, screaming that I "needed to stop calling here" and quit harassing them.

Partly because they are steeped in debt, the Laboring must rely of the safety net for care. But the safety net is a stopgap solution (see Chapter 3). It is itself a system of bad faith that survives by discouraging people to take part in it. The scant health care of the safety net provides the state with some form of cover; it is not leaving the Laboring to die at least. Here foot-dragging, non-compliance, and inaction are not the weapons of the weak, but of the powerful. A negligence by requirements.

Because requirements are deterrents, ultimately. And the requirements imposed on clients implied that their health was a matter of agency and personal responsibility, rather than exploitation and hard luck. There were many ways to forfeit this right to health at the free clinic. If you had 3 "no-shows", exhibited drug-seeking behavior, came in intoxicated, smoked on the property, didn't bring your medications to an appointment, or used another health provider, you would be suspended from programs

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Carolina, Mulvaney had received $31,700 in campaign contributions from payday lenders (McCoy 2017).

for a period of time, sometimes up to a year. And now, increasingly, states are attempting to include the requirement of work (Weixel 2019).

### The Bad Faith of Workfare

Early in 2018, Governor McMaster petitioned the federal government to allow South Carolina to impose work requirements on recipients of the public health insurance program (Sausser 2018). “Whenever possible, we should always endeavor to help South Carolinians in need find their path to gainful employment and away from the temporary assistance of government,” a press release issued by the governor’s office read (Moore 2019). It would have been a reasonable statement had it not been situated in an economy of bad faith. It suggests that a job will alleviate the need for assistance and assumes that workfare will result in remunerative employment, which it often does not. But for champions of workfare, getting safety net clients even precarious jobs is a victory, no matter if it’s dead-end work, or if it will exacerbate fragile health conditions. Furthermore, these attempts at welfare reform ignore the free, labor-intensive care-work women do at home (Hill Collins 2000; Hochschild and Machung 2012; Lachance-Grzela and Bouchard 2010).

For decades now, attempts have been made to replace Welfare programs with Workfare initiatives requiring individuals to find gainful employment (Kalleberg 2011). The argument here, made by hopeful reformers, is that the underclass does not share the values of mainstream Americans, values of industry and responsibility, and therefore policy must compel the poor to assimilate through labor. Tellingly, there is no call for corporate responsibility.

## Conclusion

A few years ago, the novelist James Meek (2016), writing in the London Review of Books, declared that in our age of austerity, the myth of Robin Hood had been upended.

The constituent parts of the myth, Meek argued, remain unchanged: a disenfranchised population, exploited and overtaxed, a small group of individuals, idle and living off the labor of others, and an outlaw, frustrating the efforts of the unjust.

However, a modern inversion of the story of Robin Hood, according to Meek, reframes the rich as the oppressed poor, over-burdened and misused, while the poor are recast as the idle rich, living off the hard work of the employed and the largesse of the State.

The mythic hero has also been changed accordingly. Latter-day Robin Hoods champion the exploited affluent by denouncing politically correct agendas and puncturing bloated bureaucracies. Through this reimagining Reagan, Bannon, and Andrew Breitbart become the righteous bandits of their respective ages.

This myth is engendered and reaffirmed by stories of plunder. The details of the stories vary and are retold according to local political-economic realities. In the Upstate of South Carolina, these are accounts of disability fraud, undocumented immigrants, and welfare recipient royalty.

In these bad faith fables it is the poor that live in extravagance. And through this logic, unscheduled bathroom breaks on assembly lines become time theft, calls for a living wage are portrayed as vicious assaults on small business owners, and the destitute are resented for eating for free, albeit from foodbanks.

In the collective bad faith of the new precarious economy, conceptions of responsibility and citizenship have been disputed and reconfigured, and risks and responsibilities have been abdicated and transferred. The malingerer, the layabout, and the welfare cheat, are figures of bad faith. They are characters whose culpability allows for the externalization, both individually and collectively, of any responsibility for inequity. Through bad faith, actors deny themselves as subjects, as conspirators, or as accomplices in the production of human suffering (Molland 2011; Scheper-Hughes 1989).

The Laboring can be exploited *because* of their poor health. And their poor health is often a consequence of their exploitation. These safety net clients are a marginalized population, continually maligned, but also heavily relied upon in the county. It is this bad faith that allows people that have labored all their lives and endured quietly for years to be accused of being workshy and to be told that they are shirking their responsibilities of citizenship. In this way decades of employment are overlooked as clients are denounced as lazy, though they have literally worked their bodies to ruination. This is not always a deliberate and strategic deceit, but an opportunistic self-deception rooted in an “economy of bad faith” (Molland 2010: 213). For bad faith is, as Sartre noted, faith after all (1956).

The vulnerability of the Laboring is multitudinous. It is determined by poverty and pain, racism, dispossession, and debts. This vulnerability is in turn exploited for profit and left hidden through oversight, for the poverty of the Laboring benefits their employers. As a result it is not in the interest of capitalists to eliminate poverty, as they profit from this class exploitation (Wright 1995). Gas stations, chicken plants, motels, warehouses, landscaping crews, and assembly lines require and depend on their labor.

A lot of this work doesn't take much more than a body, one willing to endure. And a laboring workforce, thanks to a confluence of poor health care, few good employment options, and a state operating in bad faith, is always available. No recruitment is warranted, and incentives are unnecessary: this Southern reserve army is hungry for work, and sometimes just plain hungry.

# Chapter 4. The Second Order Disaster of Safety Net Care

*"It's good and bad," Ms. F. said.*
*"They do what they can," Mr. Bl. reported.*
*"They said they couldn't help me," Mr. R. told me.*
*"When you get it free, you accept what you can," Ms. Ma. said.*
*"And glory be to God, I had them in my corner," Mr. J. exulted.*

*—Collected Fieldnotes.*

The safety net is an important determinant of health in laboring life. Thousands[34] of working poor Spartanburg County residents rely on the free clinic and other charitable institutions to access healthcare and endure the precarity that accompanies low-wage labor. But the county's safety net is a multifarious institution and while some interviewees believed this collection of subsidized services to be literally godsent, for others, it represented a zone of abandonment.

This chapter examines the role of the safety net in the lives of Spartanburg's working poor. By employing Vincanne Adams' concept of the "second order disaster," I explore how uninsured clients are kept vulnerable through care that is both rationed and conditional and how being a member of the Reserve Army of the Laboring is bad for your health.

Much of the data for this chapter comes from the summer of 2016, which I spent observing at the county free clinic and visiting a handful of other local non-profit institutions. The interview data used below, with a few exceptions, was collected during interviews with safety net clients between 2016 and 2018.

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[34] Census Bureau estimates from 2018 suggest that around 41,000 county residents under 65 are uninsured. This amounts to about 12.9 percent of the county's population (United States Census Bureau 2018).

## Introduction

In *Markets of Sorrow* (2013), her examination of the privatization of Hurricane Katrina relief and recovery efforts, Adams never explicitly defines the term "second order disaster." But we can infer from her writing that she means something along the lines of "a disaster, often worse, that follows, but is not an inevitable consequence of, a preceding and related disaster." The second order catastrophe of *Markets of Sorrow* is the displacement and disenfranchisement of vulnerable New Orleanians that occurred after the storm, a consequence of a government-sanctioned privatization of social services. In this chapter the second order disaster is the safety net care of Spartanburg County.

The first order disaster is poverty, and the poor health that often results from low-wage work. This poverty forces uninsured workers to rely on the county's safety net, a fragmented and impoverished system of aid. Here access to medical treatment is guarded through means-testing and managed care, practices meant to reduce overuse and discourage dependence. By permanently relegating uninsured clients to this rationed care, forcing the Laboring to manage their chronic conditions with what is meant to be stopgap medicine, the safety net system (re)produces entrenched class inequalities.

To be clear, the safety net saves lives. Several organizations had reception areas papered with notes of breathless appreciation and it was not unusual for grateful clients to bring in baked goods and candy for the staff. "Without [the free clinic], Ms. R. said, "I'll be honest with you, without them I'd be dead right now. There's no doubt in my mind, I'd be dead right now."

But other clients felt frustrated and forsaken by the clinic. The safety net is meant to keep uninsured patients from inundating mainstream forms of care, from overwhelming the emergency room for example, and is ostensibly an alternative to insured fee-paying medicine. But often the safety net can do nothing for clients and can exacerbate conditions by keeping the deep need for healthcare among the county's working poor hidden. "I feel like some of the doctors up there don't give a shit, Mr. R. said, "They don't care. I mean, if they ain't making money, they don't care."

## The American Uninsured

Throughout the twentieth century the American Hospital Association and the American Medical Association repeatedly thwarted the introduction of social health insurance in the United States (Starr 1982). During World War II, government-mandated wage and price controls kept employers from offering pay increases, and as a result, fringe benefits such as health insurance and pension plans were implemented to attract employees (Kalleberg 2011). This employer-centered model of benefit allocation continues today.

Employment-based insurance serves class and industry interests as rises in healthcare costs are rendered largely invisible to the middle class while employers, benefitting from tax exemptions, automatically deduct health insurance premiums from their employees' paychecks (Horton et al. 2014). The uninsured, by contrast, must bear the full force of the inflationary costs of healthcare unaided. Among the world's major economies, the United States is the only country in which health benefits are primarily distributed through employers. In other, similar, economies health benefits are guaranteed through a right of citizenship (Papanicholas at al. 2018).

Over the last four decades, an erosion of collective bargaining, along with pressures for employers to reduce costs by jettisoning benefits, has resulted in fewer Americans receiving health insurance through their jobs (Kalleberg 2011). This phenomena has disproportionately affected the working poor; while rates of employer-provided health insurance have decreased for all workers since the late 1970s, reductions in non-wage benefits have been particularly high among blue-collar and service occupations (Appelbaum et al. 2003).

In 2010 the Affordable Care Act expanded employer-based insurance while broadening Medicaid eligibility to individuals on the edge of poverty. The ACA sought to expand Medicaid—care and benefits once largely limited to pregnant women and individuals with children—to include single and childless adults. However, several states—South Carolina among them—have chosen to forego Medicaid expansion, leaving many working poor individuals ineligible (Kaiser Family Foundation 2019).

The US safety net relies heavily on Medicaid—a means-tested government program that provides insurance for persons unable to afford healthcare—to subsidize the medical treatment of uninsured patients. But while the ACA has recently extended health coverage to millions of once-uninsured Americans, the state of South Carolina by foregoing Medicaid expansion, has left a gap in coverage for adults who do not qualify for Medicare, are not eligible for federal Marketplace coverage subsidies, and do not have employer-based health insurance (Kaiser Family Foundation 2019; National Women's Law Center 2014). The majority of individuals affected by the coverage gap are working poor—individuals employed at full-time or part-time jobs, but still living in poverty (Almgren and Lindhorst 2012; Garfield et al. 2019). As a result, those ineligible for Medicaid, but too poor to afford health insurance, must rely on safety net care.

### The Safety Net

The flexible labor arrangements characteristic of the new economy have left many of the working poor saddled with the responsibility of health management while reliant on residual and privatized forms of safety net healthcare (Garfield and Damico 2016; Shipler 2004). This care is often little more than triage, rationed medical aid provided in conditions meant to discourage dependence (Becker 2004; Garcia 2010). In an effort to improve the quality of medical treatment and contain costs, the U.S. safety net system has embraced managed care, adopting the private sector tenets of profitability and cost-efficiency. Managed care is often implemented in safety-nets to combat a purported overuse of, and dependence on, services by Medicaid recipients (Garcia 2010). To this end, patients are often reconceived as "clients,"—the new designation signaling a transfer of responsibility from the care provider onto the individual—and are tasked with becoming savvy and responsible consumers of care (Maskovsky 2000). This shift has been accompanied by a retrenchment of social services for the poor, as the public right to healthcare in South Carolina is increasingly being foreclosed upon by appeals for small government, fiscal austerity, and cost-efficiency. "Yes, health care is a problem," Governor McMaster said in 2018, "we have to get the free enterprise involved in it. We will be better off…the health care system can be very much better in this country without a huge monolithic bureaucracy strangling everything" (Barton 2018).

It is in this setting that the indigent and uninsured must seek care for the social suffering that results from precarious labor arrangements.[35] In these conditions of managed care, high risk, difficult, and cost-intensive patients are often deliberately excluded through bureaucratic and institutional obstacles (Becker 2007; Bourgois and Schonberg 2009), for health is a commodity in managed care, to be determined by the natural competition of the market with little government interference (Pellegrino 1999: 244).

> *I'm barely inside the free clinic before being identified as an outsider, an interloper not asking or providing aid, whose presence therefore seems to unnerve everyone, when one of the staff greets me with "you don't look like you belong here," which I come to learn they mean as a kindness. In these waiting rooms uninsured patients wear the evidence of their professions: the rakish spattered whites of housepainters, the collared polo shirts of fast food team members, housekeeping uniforms. Sometimes there are men there who do some kind of work that leaves their boots and jean cuffs looking like they've been dipped in powdered sugar.*
>
> *A nurse described the free clinic as "busting at the seams," but right now it's relatively quiet. In the waiting room the adults are solemn and silent. The*

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[35] The most common conditions treated at the county's free clinic are diabetes, hypertension, heart disease and arthritis.

> *children though, either oblivious to or unimpressed by the sober atmosphere, quickly find each other and begin to ratify a constitution for their temporary parallel society.*
>
> *A man comes in on his lunch break, in a hurry. He is dressed officiously for office work: slacks, tasseled loafers, and a dress shirt. Only, the cuffs of his pants are starting to unravel in the back from being stepped on, the shirt he is wearing is shiny with age, and his hair has grown too long. His insulin is about to run out, he says.*
>
> *-Collected fieldnotes from 2016-2018*

Clients were regularly reminded, and reminded themselves—in times of frustration—that the doctors and staff at the free clinic were all volunteers. The agreement of this pro bono care, sometimes left unsaid, often made explicit, is that clients forfeit their right to outrage, along with their rights to argue, to be seen in a timely manner, to voice frustration, and to be difficult. This is what Kim Hopper has called "…the tainted nature of the offer" inherent in such "local economies of relief" (2006: 218).

There was plenty to be frustrated about. It had been days and Mr. M. still hadn't received his medicine. "They long with your medicine," the sickly mechanic said, "They take a long time for you to get it...I've been asking [the clinic doctor] about why, and he told me, he said, 'Well, you look at it like this: We're doctors that are doing this for free. You don't know no other doctor that would do this for free'."

So while gratitude occasionally evaporated and decorum sometimes frayed after spending hours sitting in the waiting room, clients, who were regularly reminded that they were being seen for free, rarely spoke out about the slow and rationed care. In this way the volunteerism of the clinic staff served as a buffer against fits of indignation and accusations of poor treatment.

One day, for example, I copied down a sign in the free clinic waiting room that read:

> **TO OUR PATIENTS: IF YOU FEEL LIKE COMPLAINING BECAUSE YOU'RE TIRED OF WAITING, JUST THINK OF THE *VOLUNTEERS* WHO WERE HERE BEFORE YOU ARRIVED AND WHO WILL STILL BE HERE WORKING AFTER YOU GO HOME. WOULD YOU LIKE TO SPEND YOUR FREE TIME HELPING OTHERS WITHOUT GETTING PAID, AND THEN BE FUSSED AT FOR TAKING TOO LONG? PLEASE BE COURTEOUS TO THEM!**

Most of Spartanburg's safety net institutions are run by a skeleton crew of regular staff, fleshed out with a revolving cast of medical and lay volunteers. It was these volunteers that had to address the severe and complicated problems of the Laboring, problems that had been exacerbated by entrenched poverty and a lack of regular care.

Many of the lay volunteers identified themselves as church members. Most of the county's larger churches organize charitable works, and it is not uncommon to see someone in town wearing a t-shirt commemorating a mission trip to Nicaragua, or Cambodia, or Kentucky. A large portion of the rest of the volunteer staff were altruistic-minded retirees.[36] There were also a few college students coming in for credit and experience, often preparing for lives of service.

The volunteer staff was rounded out with doctors and nurses, who did pro bono

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[36] These populations were obviously not mutually exclusive.

work for a variety of reasons. Ms. Y, for example, a nurse at a nearby hospital, had always wanted to volunteer, and had finally decided to do so after her uninsured sister had suddenly become ill and died.

A retired doctor who volunteered with Ms. Y. told the local paper, “There’s a lot of satisfaction in [volunteering]. It’s just helping the patient. And that’s why most of us went into medicine years ago, was to see patients and help them. Obviously you’re not getting paid for it, but it’s the satisfaction of seeing a good result or taking care of someone who really needs help” (Hughes 2018). But while such altruistic motives were common among the volunteering staff, clients were still regularly subjected to suspicion and denigration.

### Care and Suspicion

As I mentioned in Chapter 1, I have reservations about questioning and being critical of the selfless and important work done in these safety net institutions. But while some clients thanked God for the free care they received, many interviewees told me about encounters with safety net staff in which they felt disrespected or ignored.[37]

In the waiting rooms of the safety net facilities I had personally witnessed clients being treated poorly, often by lay-volunteers. These volunteers were sometimes put in positions of great authority and responsibility, and while many members of this unpaid staff appeared deeply moved by their work, others seemed to have volunteered only for the opportunity to vet clients and make sure that everyone that entered the clinic was appropriately deserving of care. “At a lot of places [the volunteers] act like that’s their

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[37] This was a minority opinion among interviewees, but just barely so.

money, and that’s their stuff, and they really don’t want you to apply for [care] anyway,” Ms. B. said, “It’s like, they don’t want you to get it and they don’t want to give it to you either.”

On several occasions I recorded instances of clients being treated with contempt in my fieldnotes.

> *I saw a young volunteer, a regular who seemed to enjoy the authority, addressing a woman twice her age in a tone that would’ve been more appropriate for a clever dog… I’ve occasionally seen student volunteers berating clients who apparently were not appropriately appreciative of the free services being offered…I was sitting with a volunteer receptionist on the supply side of the welcome desk at a satellite of the free clinic. Five or six people sat quietly in wire chairs in the adjoining waiting room. Some of them had been waiting when I got there, and that had been a while ago. To pass the time I asked her, the volunteer, —a disproportionate number of safety net staff are women—questions about her work. I seem to remember these questions, questions about her responsibilities, her experiences, and her plans for the future, as innocuous, so I was surprised when this student-volunteer suddenly began maligning the clinic’s clients in a voice loud enough to turn heads in the waiting room behind her. The people that were treated here were by and large irresponsible and untrustworthy, and most lacked common sense she said, as I sat very still. As she continued I looked away. I tried to interrupt and change the subject, but she kept on. The circumstances that brought clients here were of their own doing, she opined. Once I’d exhausted*

> *my reservoir of verbal and non-verbal cues I tried telepathy: ‘please, please shut up.’ She would have been fired immediately from a doctor’s office, but as far as I know none of the clients complained about her offensive comments. Free clinic patients might be called clients, but they aren’t always treated as such.*
>
> *-Free clinic fieldnotes taken at various points between 2016-2018*

Among many volunteers there was forever the suspicion that clients would be fine if only they would exercise better judgment. Often I heard that the Laboring were authoring their own immiseration through a lack of thrift, temperance, common sense, and responsibility. Safety net staff regularly wondered, in private but aloud, if some of their clients even needed their care. Some of their charges arrived in late-model trucks and many had smart phones. Had they spent their money on the good clothes they came in with? On their done-up nails?

These calculations of deservingness were informed by the fact that a good portion of the paid safety net staff were, economically speaking, not too far removed from the clients they attended to—the exception being doctors and high administration. These staff members worked long hours, some were going to school or back to school, and some had escaped lives of poverty themselves. And though many of their jobs provided some form of benefits, having health insurance didn’t mean that healthcare was affordable for them. So when clients parked a nicer car next to theirs, they wondered.

## The Compromises of Safety Net Care

The medical safety net of Spartanburg is a product of devolution—a strategy of reform employed to displace the responsibility for the provisioning of social services from the federal level to the state—and "labor shifting," (Lamphere 2005) the assigning and designing of work in an effort to shift responsibilities onto unpaid individuals. Consequently, safety net care providers are left to address the most severe of health problems, cases that are often complicated by poverty and irregular access to medical care, in limited circumstances. In these settings, physicians rarely have time to unravel the complex etiologies of their clients' conditions, which are usually compounded by precarious employment and a lack of health insurance. "We're seeing more and more patients now. It's harder to find time to squeeze them in," a nurse practitioner told the Spartanburg Herald-Journal during my fieldwork (Gross 2016).

As a consequence, care at the safety net is often little more than immediate stabilizing medicine prioritizing treatment for the largest number of people. It is aid meant to keep clients from going to the emergency room constantly and from overwhelming disability courts, and is not meant to be an alternative to paying care. And for some clients it is no aid at all. Last year the free clinic's director admitted that, due to a shortage of doctors, the clinic was turning about 10 patients with acute illnesses away a week (Hughes 2018).

The rationed aid of Spartanburg's safety net is there to get you back on your feet, i.e. to help you to the point where you will no longer tax the county's social services and can rejoin the workforce, administrators told me. The constraints enforced by managed care made stabilization, not treatment, the end goal (Luhrmann 2000). According to these local administrators one of the most pressing objectives of the county's safety net was to reduce the number of emergency room "frequent flyers," individuals considered to have come in to local E.R.s too often and too unnecessarily.

But the Laboring were not "frequent flyers," who in Spartanburg County are typically male, around 30 years old, and mentally ill (South Carolina Public Health Institute 2011). By contrast, laboring clients would only come to the E.R. after much deliberation, usually when they were in severe pain and it was night and they were afraid they might otherwise die. "I'm in the floor," Mr. I. said, explaining the circumstances that led him to drive to the emergency room, "This is at home. I was in the floor, couldn't breathe, curled up, couldn't move, gasping for air, that lasted for maybe two to three minutes. And then when I finally got to where I could breathe, I was scared to breathe. Because it hurt. And you know, I had a heart attack and might have a heart attack again."

Clients risked accumulating emergency room bills because there they would be seen immediately, the care was superior, they were more likely to be treated by a specialist and, perhaps most importantly, because their condition had become intolerable. Ms. B. had reluctantly gone to the E.R. after the pain from a bloodclot in her lung became too much for her: "You just have to [go to the emergency room], or suffer, or die or whatever, bleed to death. You have to." Safety net organizations by contrast, Mr. E. said, would not always see you. "It's bad when you gotta sit there and let something get bad on you, just for [a safety net organization] to see you. You know? You can about die, before they do anything or accept the fact to look at you. But see, with the emergency room, insurance or without insurance, that's what they there for."

The conditions of the Laboring were stabilized in the county's emergency rooms. But once released, care often ended there. Mr. Wa. came to the hospital in pain and with swollen legs. Bloodclots had travelled through his heart and lungs and the doctors were considering amputation. "The normal stay was seven to ten days at the most," he said, "I was there 28 days. And then they finally released me. They put me on medication, Coumadin, Lortab, and Percocet. Which I can't afford. Couldn't afford them then."

Mr. Wa.'s leg wouldn't heal. The doctors at the hospital didn't know why exactly, but told him that he would have to stop working. But Mr. Wa. couldn't:

> That ain't gon' be me. That was my way of thinking. And I continued to work, go back in the hospital. I'm thinking I'm doing something about checking for the symptoms, because they told me about the symptoms, what can happen. They even told me about the sore. They say it can get so bad...and they sent the letter back to the house....So I called the E.R. and went back up there and they wouldn't treat me, because I didn't have any insurance. So I told them what the deal was. I had been up here, [the doctor from his original hospital stay] told me it wasn't a spider bite, and for me to come back. "Well, sir we can't treat you. You have no, no…" I forgot the word they used, but I wasn't in dying need of their assistance. I was just checking up on something. They wouldn't admit me, so they said, "The best we can tell you is get you a personal doctor and find out exactly what's wrong with your leg, because we don't know what it is." But come to find out it was from the blood clots.

Mr. Wa. couldn't afford a doctor. That is why he was in the emergency room in the first place. After he left the E.R. he tried to manage the best he could, but the last time I saw him his leg was getting worse and he was without medication.

Healthcare was regularly deferred by many working poor clients like Mr. Wa., as they were often unable to get time off to see a doctor and would probably be unable to afford the recommended treatment anyway. So interviewees rationed the medicines they did manage to procure from the E.R., often reducing the therapy's effectiveness substantially, if not entirely.

In the aftermath came bills that could not be paid. Almost without exception, the people I interviewed were all attempting to outrun or ignore large medical bills. This is common in the U.S., where medical expenses are the leading cause of bankruptcies (Mulligan and Castañeda 2017). "Those bills," Ms. B., who had tried to get the blood clot in her lung treated, said, "are just piling up. I don't consider those priorities, you know, because I still have to live. I have to look at my water bill and my electric bill, you know, I have to eat. I got to look at my priorities. And that's what I take care of." Mr. Ca., who lived close by, had a seizure and had gone to the hospital. Now he was constantly getting bills in the mail. "There's no way I can pay them," he sighed. So he tried to get back in at the free clinic.

## Care, Rationed and Qualified

The care that clients received from the safety net was uneven. At times it could, through a confluence of serendipity—like when a client came in with a condition for which there was a volunteering specialist on staff—be exceptional, but rarely was.

I would occasionally see this for myself. As an anthropologist, you sometimes get taken into peoples' confidence unwillingly. Or you accidentally get access to something you wished you hadn't been allowed to witness. This happened now and then during my fieldwork; occasionally I was shown someone's file or was told of a client's personal circumstance before I could protest. Then sometimes, during a tour of a facility, I would be unwittingly guided into a room where an examination was going on. On one such occasion I witnessed a health screening conducted by two medical students at a pop-up clinic at a local church.

> *The students, both nervous, though one much more than the other, were examining a man who wasn't feeling well. Their inexperience was plain: they kept consulting and correcting each other, reading the instructions on medical equipment, and had to summon the supervising doctor several times during the short examination.*
>
> *-Fieldnotes from safety net observations, 2017*

Another time I witnessed an intake interview, and wrote about it in my fieldnotes:

> *I was brought in to see an intake interview. Sometimes family members accompanied clients to their appointments, and in this instance a woman came in with her sick brother. The intake volunteer, a tall healthy-looking man of 70 or so, a retired mill executive and a volunteer from a local church, asked the prospective client a battery of questions about his personal and family history and the bag of medications he was asked to bring in. The client's younger sister, who was in her late 40s, answered most of the questions for him. The man looked tired and like he spent most of his time, maybe even his nights, outdoors. He had gallstones and was jaundiced and had dark circles around his eyes. His sister looked considerably older than she was (the volunteer had for some reason asked her age as part of the man's intake process.) After each question, the volunteer*

> *would moralize about the answer given, usually indirectly, but sometimes quite openly. This resulted in the interviewee being goaded into answering that he had never drank, smoked, or had taken drugs, answers that were met with congratulations by the intake volunteer, but turned out not to be true.*
>
> *-Fieldnotes from safety net observations, 2016*

I have included these examples, not to impugn the county's safety net institutions, or their altruistic staff, but to note that care could be poor here, especially due to volunteers' inexperience. Yet this substandard care that was supposed to be appreciated by clients. Michele Rivkin-Fish has called this the "moral economy of commodified health care" (Rivkin-Fish 2011: 193): Safety net care recipients are not to feel entitled to care and are instructed, either explicitly or tacitly, to be satisfied with inferior treatment provided in inadequate facilities, sometimes by poorly supervised students or lay-volunteers.

This moral economy produced a self-imposed rationing among some clients. Interviewees would question whether their conditions were severe enough to warrant taxing the free clinic's already limited resources. Ms. P. would defer care until things became intolerable, in an effort not to be a burden: "Because, you know, there's so many other people. And like I said, I have enough medical issues for several people."

For clients like Ms. P., continuity of care was difficult to maintain in the safety net organizations. The clinics' staff of volunteers rotated regularly and clients' work schedules, which were often made week to week and issued with little notice, were unpredictable, frustrating long-term plans. “It’s pretty much a crapshoot, as far as which doctor you're going to see,” Ms. F. said,

> You know, you're not guaranteed to see the same doctor every time you go there...and sometimes the doctors don't have the same opinions as far as how the treatment should go, you know, one doctor might say "Well, I don't think you need this medication." and another doctor might say, "Yeah, you really need to be on this medication." So it's like a tug-of-war sometimes.

Additionally, many clients lacked reliable transportation and were often at the mercy of others for rides to the clinic (cf. Gross 2016; 2017). The free clinic and the county sought to provide poor patients with a way to and from appointments, in the form of a van that had to be booked days in advance, but the effort was understaffed and underfunded. This meant that clients couldn’t reliably make appointments with doctors that had seen them before. “Transportation remains a barrier. It’s a countywide problem,” the director of the free clinic told the local paper in 2017 (Gross 2017).

Laboring clients usually had multiple health issues and would have to prioritize certain conditions over others; they wouldn’t be able to get everything treated all at once (cf. Saslow 2019). But they couldn’t take off when they wanted to, so some things just had to wait. “I have all these feminine medical issues going on with my body,” Ms. P. said, “which I’m kind of leaving. I really don’t know what to put first, but I know that, me internally, it’s not healthy. I know that.” When I asked Ms. C., who, among other things, had back issues and was having problems with her hands, how she prioritized what condition she’d see to at the free clinic, she replied, “However, or whatever is feeling really, really bad on me. I mean, worse than the other at the time. But I can see how someone would be like, ‘Well, I’ll just wait on this’.”

As a result of this deferring of care, safety net organizations had to regularly attend to severe and complicated cases, as the illnesses of uninsured interviewees were often poorly controlled. Consequently many of the Laboring experienced one health crisis after another (Almgren and Lindhorst 2012; Becker 2001). This meant that they continually suffered economic crises as well, for while the care at the free clinic was free, it was also limited.

The free clinic was forced to treat the effects of sustained inequality with temporary and conditional measures. The compromised care clients received was forever justified by the perpetual crisis that the state purportedly finds itself in. A local reverend I talked to considered the county's safety net services a "band-aid," nothing more.

And sometimes, as noted, it was less than a band-aid. The safety net is not the substitute for health insurance that policy makers might suggest it is (Lewin and Altman 2003). Nor is the safety net always last resort medicine. Sometimes it is no help at all. Often the clinic's waiting list was so long that treatment was effectively unavailable, as Ms. B. had found out.

> I never really got in to [the free clinic]. One time I had a bad tooth and they said it was a six-month waiting list. I tried to go get my medicine for my migraines. There was a six-month waiting list for that. And they had sent me up there for a prescription for something and then they said there was a backlog on it and it would be about a year before they see me and I needed my medicine then. So, that was just awful.

This meant that for the Laboring care was often ostensibly, but not practically available. Or the care that you did get, while appreciated, was itself often very limited. Mr. Pa. recalled his recent experience at the city's main free clinic:

> They talk to me, checked my blood. That's basically about it. Check my blood pressure, that's all. You know. They don't got no equipment to do no blood drawing and no machines to check you. Which…I like [the clinic]. You know, they nice people. They help. They gave me a blood pressure machine. You know what I'm saying? They helped me get my cane. So I mean, you got your benefits, but, I mean, if they can't do no blood work, they can't check your internal stuff, I mean, where can you get help with that at? That's the next question. And then they don't want to tell you nothing, they act like they don't know. [The doctor] told me, "Only thing I can tell you is, get three hundred dollars and go to a doctor." I mean, if I had three hundred dollars, I wouldn't have been coming to you from the start.

Many clients recalled similar appointments that ended with care providers prescribing regimens or offering advice that their patients could not possibly follow. "Y'all tell me to go for a follow-up," Mr. G. told the receptionist at the clinic, exasperated, "but y'all sending me to places that ain't accepting new patients."

This didn't mean that physicians and nurses weren't aware of, or weren't sympathetic to, the hard circumstances of their charges. These care providers were regularly asked to manage the most difficult and desperate cases and were themselves frequently frustrated by the lack of resources at their disposal, as they were tasked with addressing suffering that was often a consequence of deep-rooted social inequality and protracted economic disenfranchisement.

Nor could a safety net doctor always act in the full capacity of a care provider. As Ms. Ma. pointed out, private doctors were also advocates that could certify and confirm their patients' ill-health. Safety net physicians, by contrast, could not support disability claims, for example. "[The free clinic] they don't help you, they only give you the necessary paper work to help you file," Ms. Q. said. You rarely saw the same doctor anyway, so it was nearly impossible to build a relationship with your physician.

## The Second-Order Disaster of Safety Net Care

As noted above, the safety net health care in the county is a second-order disaster. It is a calculated and deleterious response to poverty and precarity[38] that entraps vulnerable populations suffering in already disastrous conditions. The safety net treats the results of unequal access to healthcare, but does so with rationed aid that is often substandard, thus effectively becoming an institution that (re)produces inequity. Managed care, the economic rationalizing of aid, exacerbates this tendency through practices of cost containment, patient load management, and the provision of provisional treatment (Almgren and Lindhorst 2012; Becker 2004).

The city's free clinic was originally organized in an effort to offset, or at least mitigate, what were considered the inequalities inherent in capitalism. But the State's model of safety net health care does not represent a redistribution, but a rationing of care. It's not a space of decommodification, but of class-concentration. This is not a conspiracy theory of mine: The architects of the new safety net are quite open about the goal of their policies: to deter and discipline (Becker 2007; Nkansah-Amankra et al. 2013; Sered and Fernandopulle 2006).

It is by design that the state's social services are immiserating. They are meant to be: misery is meant to breed industry. The safety net of Spartanburg County serves both a tutelary and a disciplinary function. Several directors and administrators confirmed that one of the primary missions of their organizations was to instill clients with values of responsibility, self-sufficiency, and frugality.

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[38] Peopled almost entirely by caring and selfless care providers, lay volunteers, and administrator.

Thus, the safety net is not a system that is simply mismanaged or underfunded, but a deliberate attempt to produce particular subjectivities and notions of deservingness that exclude and discourage individuals from care. Horton—after Becker—has called it "governance through willful neglect" (2007: 293). In such moral economies of commodified health care clients are not to feel entitled to aid and have to be satisfied with substandard services provided in inadequate facilities performed by students and volunteers.

These safety net institutions in turn subsidize employers that pay wages that aren't enough to live on. Their conditional care underwrites and allows a system of precarious employment to proliferate. While corporations, brought to the Upstate with much fanfare by the promise of cheap non-union labor and low wages (Kingsolver 2016), often provide some of their employees living wages and health insurance, many of these employers also rely on local outsourced work. These subcontracted employment arrangements were often toxic, sustained by donated food and the pro bono work of physicians and nurses.

The physical, low-wage jobs the Laboring are relegated to will, over the course of a lifetime, likely run them down. And the risks of this work are increasingly being shifted from employers to employees (Kalleberg 2011; Weil 2014). The Laboring bear this risk only with the help of the safety net. But on-the-job-injuries are not the only risk associated with precarious employment: often these jobs do not pay enough for employees to treat routine illness or access preventative care. So the working poor are consequently forced to address their health conditions as emergencies. As a result, they live shorter, unhealthier lives (Becker 2004).

### The Pharmaceuticalization of Safety Net Care

In this context of scarcity, prescription drugs are used both as care and in lieu of care: Here pharmaceuticals are used to treat ill clients, but also function as a form of triage in a county where health services, particularly mental health services for the uninsured, continue to be cut (National Alliance on Mental Illness 2011).

In the county's safety nets, pharmaceuticals are both a form of treatment and a representation of the safety net's compromises of care. Clinics required patients to bring all the medications they were currently on to every appointment, which meant that many clients sat in waiting rooms with sandwich bags full of pill bottles and colorful pill planners. The consumption of these powerful prescription drugs, which sometimes produced distressing side effects, is often a requirement for the continuation of social and medical services in the United States (Hansen, Bourgois and Drucker 2014).

Patients were told not to ask the doctors for pain medication, a policy meant to stem prescription drug misuse and dependence among clients. Such policies also sought to preempt drug-seekers from making appointments and taking up the time and resources of the clinic, according to administrators. But many interviewees believed they needed some form of pain management to endure work, and, as Ms. Gi. put it, "to get through [the] days." These clients noted that they were often treated with suspicion when they asked about pain relief. "They always think you're out to get drugs," Mr. S. said, "you know, so you don't really get the treatment that you should get." Admittedly, I was sometimes suspicious myself: Mr. S. had a connoisseur's knowledge of pain pills, an unhealthy pallor, and an encyclopedic command of the minutiae of South Carolina's new prescription drug monitoring program,[39] so I wondered. Then I heard that one night a nurse had to have him removed from the emergency room for what sounded like drug-seeking behavior. But many other clients, including Ms. L., confirmed, that "It's really hard not having insurance and not being able to go to a doctor that will understand and be…understanding and sympathetic with your pain."

More often than not clients were told that they would just have to ride out their suffering. Or sometimes they were prescribed something mild that didn't help. "I feel what they got me on is a waste," Mr. D. said, "I don't feel like they is doing anything for me. I mean I take it because that's what [the free clinic doctors] want me to take." As a result, the clients that could, got pain pills from friends or family, or bought them from people they knew. What else could he do?, Mr. K. asked.

> But how I say, [the doctor] gives you prescriptions. When they give you prescriptions, now if you ain't got no insurance, how you gonna pay for it? How you gonna get it? Like I know people, when I moved up here, I know a couple of people, that I met, you know. Fishing wise, stuff like that. And I have to go to other people. And hopefully they got it, 'cause if they don't got it, what?

This self-treatment and diversion with prescription medications was not necessarily a way of avoiding compliance or undermining authority, but was instead often an attempt at normalcy and a way of approximating doctors' orders (cf. Biehl and Moran-Thomas 2009: 270); diverted drugs were often used to manage the pain of work, endure shifts,

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[39] The South Carolina Reporting & Identification Prescription Tracking System or (SCRIPTS).

and meet other responsibilities. Diversion was also a common strategy employed when medications didn’t seem to be working or were producing adverse effects, for follow-ups with physicians were often few and far-between for the Laboring; interviewees might not see a doctor for months, whether their medication was working or not.

Mr. K., for example, was relying on prescription drugs he got from family members and friends to manage his diabetes and his pain, but because he had to rely on unpredictable sources of medication, his conditions kept getting out of control. He had had to ask for diabetes medicine from a friend that worked at a pharmacy after he found himself unable to see one day while riding home from work:[40] “I don’t know if that was above board, you know, the way you supposed to do. The doctor didn’t see me, but [my friend] gave me medication what I had been taking.”

You could be overmedicated and undermedicated at the same time, clients told me. That is, prescribed several medications, but none that improved your condition much or managed your pain all that well. Yet for most clients these pharmaceuticals were their only semblance of care. Even if you did manage to find a doctor that would prescribe for pain, you might not have a way of paying for it. A prescription for pain medication, as Mr. U., a roofer, noted, was no guarantee that you would ever see that medicine: “I mean, just to even try to attempt to get any pain medication” he explained, “okay, the doctor in the hospital prescribed me Oxycodone. I went to the [free] clinic, took the bottle, my prescription and everything in there. ‘We can’t fill that,’ they said.”

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[40] This temporary blindness was a complication of his unchecked diabetes. His girlfriend eventually picked him up and brought him home. Once at home he tried to check his blood sugar, but it was too high for the monitor to register and just said “OVER.”

This was not unusual. It was common for interviewees to be prescribed drugs that they would not be able to afford. “The doctor tells you not to skip your medicine. How are you not gonna skip your medicine? You don’t have no money to buy it,” Ms. C. asked.

Yet, care providers became frustrated when patients did not comply with their orders. Ms. R. had run out of money and had had to start rationing her prescribed medication: “The [nurse] I talked to yesterday, she didn’t like it because I cut one of [her pills] in half. But I had to because my blood pressure was really low and I was almost out of it all weekend. So she understood why I did it, but she wasn’t happy that I did it.”

For many of the Laboring like Ms. R. it was often impossible to follow physicians’ orders. For one, it wasn’t unusual for clients to be on a half dozen medications, the result of their complicated and often intractable conditions and a lack of alternative therapies available to the free clinic. Ms. Gi. was dismayed that she was prescribed so much medication, but nothing for pain: “So I don’t understand,” she said rhetorically addressing a doctor that wasn’t there, “you want to put me on medication that causes me to not be able to get out of the bed and I can’t do anything? Versus prescribing a medication that I can get out of the bed with and go out and do something worthwhile?” The doctors did not take into account that she had to work all day, she said.

The drugs clients were prescribed in lieu of pain pills produced new and unexpected problems for patients (cf. Brodwin 2013). Ms. F. was on several prescribed drugs and wasn’t technically allowed to return to work while on the strong substances. Ms. G. had trouble sleeping on her medication and was perpetually exhausted. Mr. P.’s prescription made him jittery and anxious. But these clients were torn, and were hesitant to complain about the free care they were receiving.

### The "Difficult" and the "Deserving"

During my fieldwork I reread Clara Han's book on care in neoliberal Chile. In *Life in Debt* Han asserts that in impoverished parts of Santiago the "state's social debt to the poor had morphed into the poor's debt to the state" (2012:68). At times the state of South Carolina seemed to disown its responsibility for the physical and economic well-being of its impoverished citizenry in a similar way: an inability or disinclination to provide adequate care to the state's underserved had been transformed and concealed through narratives of non-compliance and unworthy, "difficult," or irresponsible populations (cf. Maskovsky 2000; Pellegrino 1999; Rylko-Bauer and Farmer 2002). The enervated and qualified aid of the safety net was consequently justified and excused by appeals to cost effectiveness, and notions of a "deserving" patient were produced or reframed accordingly, shifting responsibility onto poor clients (cf. Cruikshank 1999; Horton et al. 2001; Maskovsky 2000).

In the safety net system, deservingness is determined and affirmed through continual audit. Because there was so little available, care was jealously guarded. What was immediately noticeable at the clinics was that an inordinate amount of time was spent determining whether clients were actually deserving of care. "It seems like the state of South Carolina would rather spend money on hiring people to keep clients from getting aid, than providing aid in the first place," a nurse told me.

This rationing is in part due to a lack of resources, but can't be divorced from a pervasive ideology that suggests that the health and socio-economic conditions suffered by safety net clients result from a lack of initiative, their struggles presumably the consequence of idleness or immorality. Safety net staffs work hard and are dedicated to providing care for their charges, but care could be easily revoked if patients were deemed unworthy. This un-deservingness, I slowly discovered from informal interviews with volunteers, could come in many forms: absenteeism, an inability to follow doctors' orders, not showing an appropriate amount of temperance, or a lack of respect and gratitude. A deserving patient, by contrast, was sober, sensible, industrious, humble, frugal, very sick, and very poor.

This displacement of responsibility was deliberate. Under safety net managed care, individuals must regularly prove themselves "eligible" to receive treatment. The work of gaining access is shifted onto patients (Lamphere 2005; Shaw 2018; Strathern 2000) and the personal responsibility and need of those using the safety net or other entitlements are constantly being questioned and vetted, for the two-tiered healthcare system of the United States can only continue to function by discouraging the uninsured from seeking treatment (Becker 2007).

This system survives through purposeful exclusion. The rationing of care in the safety net is meant to keep clients from becoming dependent on the State. The calculated scarcity of these institutions also justifies the means-testing and the abandonment of "difficult" or "uncooperative" patients (Becker 2004; Bourgois and Schonberg 2009; Horton 2006)—the focus on adherence and compliance removes any liability for the health of clients (Maskovsky 2005). In this environment the deserving can easily become the undeserving, as clients must continually demonstrate improvement in their conditions and circumstances, lest they be considered idle or recusant (cf. Schram 2000).

## Conclusion: The Containment of Care

In her examination of chronically ill uninsured minority clients, Gay Becker (2007) found that patients without health insurance were being deliberately and systematically discouraged from accessing health care. She called this effort “containment,” and argued that this was how the state managed its “margins,” (Becker 2007: 300). Spartanburg County, similarly, relies of strategies of containment to control the overwhelming need for care among its uninsured citizenry.

Here, medical care is sometimes the only form of meaningful social support still available to the working poor (cf. Hansen, Bourgois and Drucker 2014: 76). Consequently, the precarious labor arrangements clients suffer must be addressed through medicine. The safety net keeps the suffering of working poor clients manageable and marginal; in Spartanburg, care for the uninsured occurs far from the city’s hospitals, in different, inferior spaces where limited services are replicated in lesser circumstances. The county’s main free clinic, for example, operates out of a large donated house that was once a home for “elderly women” (Gilmer 2010). Upstairs are rooms filled wall to wall with the manila folders of patients’ files.

The private healthcare system manages uninsured patients through the safety net, which is essentially an apparatus of containment. There, in the free clinics and philanthropic organizations, interviewees could ostensibly get care. But often they would take time off of work to come in to see a physician, and the physician would not always be able to help. Then, some pop-up clinics, like the one run by a prominent church in the county, only saw patients once a month, meaning that clients might have to wait weeks before they would be seen. As a consequence, their conditions would often aggravate, eventually forcing clients to the emergency room, where they would usually—but not always—be treated and referred back to the safety net.

The social safety net is ostensibly a compensatory institution, meant to offset the inequalities and vicissitudes of capitalist reproduction. In South Carolina however, the state's qualified distribution of medical care meant to support vulnerable populations effectively functions as a deterrent and aids in the exploitation of the Reserve Army of the Laboring.

As a workforce, the Laboring are vital, even necessary, to South Carolina's modern economy. Yet the plight of the state's uninsured working poor almost certainly goes under-recognized as the safety-net absorbs their cases, hiding the attritional nature of exploitative labor arrangements with the work of volunteers and free clinics. This rationed care produces and perpetuates enduring inequalities. For the safety net is a form of, rather than a defense against, the unequal access to care. It is temporary and imperfect aid meant as a last resort, but serves as the de facto health care system for the Laboring, treating the effects of sustained inequity with the conditional measures of managed care. The resulting inequalities produce compromised life chances and the Laboring remain poor and sick as a result (cf. Rylko-Bauer and Farmer 2002), for their disabilities and half-treated health conditions leave them unqualified and unfit for anything but precarious employment. Low wage work relegates clients to safety net care, and vice versa.

As a result, the Laboring regularly became entrapped in the second tier of a two-tiered system of health. Not only is access to services guarded in the safety net, but once the hurdles to access have been traversed, the care that is available is often sub-standard. Yet, clients must navigate this form of medical triage with patience, competence, and gratitude; they must be appropriately appreciative and identifiably gracious to establish their deservingness of free care. But often clients become frustrated and give up or drop out in disgust, get lost in the shuffle, become dissuaded by distant appointments, or are disqualified for non-compliance, or not showing up (Becker 2007).

The safety net literally saves lives, yes, but it is also a second order disaster, a source of short-term aid that must address complex and entrenched problems and often produces new vulnerabilities in the population it is meant to attend.

Again, I feel it necessary to reiterate that the safety net is full of dedicated, competent, compassionate people, many of them volunteers. They do difficult work in difficult circumstances. I do not wish, by calling the county's safety net care a "disaster," to disparage their efforts, nor do I want to indict the staff for the failures of the safety net system at large. But the difficult and unpaid work front line safety net providers do in an effort to make the system tolerable for their clients also perversely allows the system to perpetuate and be redeemed; their work is necessary for these institutions to survive (Hopper 2013), as free clinics, federally qualified health centers, and philanthropic organizations contain the suffering of individuals priced out of the private health care system.

The resultant safety net can be a zone of qualified abandonment. The free care in Spartanburg County maintains, and allows for, the exploitation of the Reserve Army of the Laboring, a cheap and desperate workforce, while helping clients endure, at least for awhile, letting them live quietly on the precipice of abject abandonment. “They don’t have much,” Ms. Ma. said of the county’s free clinic, “but I thank God for them every day.”

## Chapter 5. A Darkness Invisible and Overdetermined

*"You cry a lot," Ms. M. said.*
*"I cry because I can't do things like I used to," Ms. R. told me.*
*"Yeah, I've been depressed. Hard for me to make money," Mr. R. admitted.*
*"I've been through a lot of abuse in my life," Ms. G. sighed.*
*"I want to give up," Ms. W. cried.*

*—Collected Fieldnotes.*

### Introduction

Ms. A. spent her days off in a dark apartment that mirrored her dark moods. Like many interviewees, she kept her windows covered in the summer with sheets and heavy curtains in an effort to keep it cool, the 38 dollars a month it took to run the fan being beyond her means. Though interviewees didn't say so, curtains like these also kept neighbors from seeing the conditions within, which were usually neat, but then sometimes were not.[41]

Ms. A. was depressed. Like many laboring clients, her depression had surfaced over the course of a long decline in health during which she'd lost several jobs—a position as a cashier most recently. She had trouble walking and had difficulty standing, even for short periods of time, and it didn't take long for employers to realize that Ms. A. wouldn't be able to keep up with the work she was hired for. She had been considering killing herself.

In his ethnography of working poor Americans, David K. Shipler wrote that

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[41] I do not mean this observation to be signal for the values of the interviewees that kindly allowed me into their homes, and I want to be careful not to inadvertently insinuate a culture of poverty argument here. My point is that the disorder in the lives of the most deeply depressed clients I visited was often reflected in the state of their rooms.

depression was a “frequent companion of [their] poverty” (2004: 53). In this chapter I want to make the “strong case” for this argument, for the interviews I conducted suggest that among the Laboring depression was a frequent *liability* of poverty, often a *result* of precarious employment, not merely an epiphenomenon associated with it (cf. Geronimus et al. 2006; James 1994; Mullings 2005).

Below I will examine how exploitive labor arrangements, a dearth of mental health resources, unrelenting pain, and a parsimonious safety net all produce an environment that leaves laboring clients vulnerable to mental ill-health, for laboring life is often a life of unmanaged illness, unremitting poverty, and unchecked pain. It is therefore unsurprising that depression was common among the members of Spartanburg’s ailing reserve army, individuals whose lives were steeped in injurious misery and dispossession. To make matters worse, this depression was likely to go untreated, as mental health services were almost entirely unavailable for much of the county’s working poor population.

This chapter seeks to contextualize and contribute to a body of quantitative literature that has repeatedly established an association between low-wage work and poor mental health (cf. Butterworth et al. 2011; Lennon and Limonic 1999; Llosa et al. 2018; Moscone et al. 2016; Vives et al. 2013; Zabkiewicz 2009). The correlation between psychological ill-health and unstable, low-paying work, is well-documented, yet little is known of how uninsured working poor Americans manage their mental health problems. In the following sections I explore how the on-going precarious economic realignment of work comes to affect the mental health of those employed in low-wage jobs. I will argue that the mental ill-health of the precariously employed is not a matter of workplace stressors alone, as much of the public health literature implies (cf. Mayhew 2018; Rugulies et al. 2013; Vives et al. 2013), but is instead overdetermined by poverty and pain and, at least in the Upstate, a lack of regular healthcare.

Here I will not attempt to determine a direction of causality, but instead explore how depression is associated with membership in the Reserve Army of the Laboring. A slew of literature examines how disparate levels of income, education, and prestige are associated with health (Cohen et al. 2010; Matthews and Gallo 2011; Williams et al. 2016), but much of this work relies on socioeconomic status alone and therefore largely ignores how social and economic inequalities are produced and persist in relation to class asymmetry.

This chapter focuses primarily on depression, as my preliminary interviews with safety net care providers found major depressive disorders—a leading cause of morbidity and mortality throughout the United States (National Institute of Mental Health 2019; Strine et al. 2015)—to be the most prevalent form of mental illness among their patients. Furthermore, all the laboring clients I interviewed, save for one, told me that they were depressed, or that they had experienced depression recently.

I have not attempted to align clients' informal descriptions and intuitive understandings of depression with the authoritative definition of Major Depressive Disorder compiled in the Diagnostic and Statistical Manual 5 (American Psychiatric Association 2013)—though most interviewees met several, if not all, of the criteria used in screening tools like the PHQ-9, a common nine question tool used in primary care settings to determine whether a patient is depressed (Kroenke et al. 2001, see Appendix D). Instead, I relied on clients' own reckonings of their depression, as many of the Laboring were unable to see health professionals and have their conditions confirmed or diagnosed.

## Literature Review

The anthropology of mental health was once primarily concerned with the classification of mental health problems, the experience of mental illness, and how psychological suffering is comprehended and treated cross-culturally (Kleinman 2012). Increasingly however, anthropologists have begun exploring how psychological ill-health is manifested, understood, and managed among the dispossessed in the era of late capitalism (Allison 2013; Biehl and Eskerod 2005; Bourgois and Schonberg 2009; Garcia 2010; Han 2012).

A growing body of literature suggests that jobs of poor psychosocial quality, i.e. demanding jobs with little social support for which employees are inadequately compensated, are detrimental to mental well-being (Butterworth et al. 2011; Vives et al. 2013; Willette 2018; Zabkiewicz 2009). These studies have primarily looked to a lack of employee autonomy—the discretion to make decisions—and supervisor/worker relationships to explain the association between precarious work and poor mental health (Bonde 2008; Han et al. 2018; Lennon and Limonic 2017; Rugulies et al. 2013; Stansfeld and Candy 2006). These studies suggest that the interpersonal labor dynamics and the psychosocial stresses experienced at work are the principal vectors of mental illness. As noted above, how the individuals working these precarious jobs manage their mental health has gone unexplored, and how the working poor weather the mental distress associated with immiserating no-benefit employment using safety net care is rarely, if ever, studied. And while some analysts have suggested that many of the difficulties experienced by the working poor are the result of the existential and economic insecurity inherent in unstable and hyper-exploitative employment (Ehrenreich 2001: Shipler 2004), the relationship between the mental health of the employed poor and their position in disposable surplus populations has gone unexamined and undertheorized. Most analyses of the impacts of labor on mental health have instead focused on the detrimental consequences of unemployment (Murphy and Athanasou 1999—a meta-analysis) and job loss (Schaller and Stevens 2015, for example). Here I will examine the relationship between unstable employment and depression.

Much of the ethnographic work on mental illness conducted by anthropologists focuses on individuals existing outside spheres of economic production (e.g. Biehl 2007; Desjarlais 2011; Jenkins 1991; Kleinman, Das, and Lock 1997). Examinations of the mental health of *working* poor people by contrast, are few. Ethnographies that do examine the lives of the working poor, often note in passing that depression and anxiety are regularly present in the lives of low-wage, uninsured employees, but have left the mental health of this population largely unexplored (cf. Ehrenreich 2001; Newman 1999; Shipler 2004).

## Depression among the Upstate's Working Poor

The high level of untreated mental health problems among the Spartanburg's Laboring population is in part a result of having nowhere to turn to for help (Kitzmiller 2013). The unmet need for mental health services in the United States has increased dramatically over the last two decades (Roll et al. 2013), and poor and uninsured individuals have been disproportionately affected by this death of care (Cunningham et al. 2006; Lorant et al. 2003).

In the U.S., health center patients in the South are the most likely to have difficulty accessing care (Jones et al. 2014). A 2019 Mental Health America report examining patient access to mental health care in all U.S. states ranked South Carolina 49th (MHA 2019). The American Mental Health Counselors Association estimated that 192,000 South Carolinians with serious mental health and substance use conditions would remain uncovered due to South Carolina's refusal to expand Medicaid (Ollove 2014)

The veteran social workers I talked to in the county said that it was in the mid-to-late '90s that South Carolina started to make drastic cuts to behavioral health services. Then, between 2009 and 2011, the state reduced its general fund allocated for mental health by 39.3 percent, the largest cut of any state during this period (National Alliance on Mental Illness 2011). Ever since, South Carolina has floundered at the bottom of national surveys ranking states for access to care.

The lack of mental health services for Spartanburg's uninsured population has become a critical public health concern. The closure of a local clinic that treated the county's mentally ill residents led the city to be designated a Mental Health Professional Shortage Area for low-income residents in 2009.[42]

Consequently, individuals with severe unaddressed mental health issues frequently cycle between the city's emergency room and jail. According to the director of the city's detention center, approximately 32% of the inmates are incarcerated for crimes related to issues of unaddressed mental illness (Smith 2013). In 2013 an Upstate newspaper quoted a detention officer as saying that in Spartanburg repeatedly incarcerated mentally ill individuals serve life sentences – "30 days at a time" (Kitzmiller 2013).

For when it comes to access to care, Spartanburg County fares worse than its peer counties in the state. An analysis in 2013 estimated the unmet need for behavioral health services in the county at 84%, indicating that only 16% of the county residents that needed care were receiving it (Kulik and Thomas 2013).[43]

## The Depression of the Laboring

There were varying manifestations of depression among the clients I interviewed. Mr. C. was increasingly suicidal. Mr. Ca., deeply depressed in his own way, became sad at night, when he was alone and would think of his wife, who had recently

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[42] This determination was made by the Primary Care Office of South Carolina's Department of Health and Environmental Control. According to federal guidelines, a Mental Health Professional Shortage Area must have a population to psychiatrist ratio of 30,000 to 1 or worse (Health Resources and Services Administration 2018).

[43] In their 2013 report of the behavioral health needs of Spartanburg County, Kulik and Thomas use the figure of the a funnel to represent the county's inability to provide needed services. The great demand for behavioral health treatment in the county, they argue, is having to be addressed by a handful of providers. This funnel, the authors are warned by key informants, among them high-level administrators, could narrow "to a pinhole and is in danger of closing completely" (Kulik and Thomas 2013: 7).

passed. Ms. Lo., who worked at the gas station, woke up despondent every morning and found it hard to even articulate her suffering. “You have no idea what it’s like to be alone and have no money and have no home,” she told me.[44]

The depression clients experienced varied in severity from person to person. While some interviewees managed their painfully disordered moods relatively well, others seemed at times to have difficulty even mustering the energy to speak. Then for some clients depression was debilitating, while others told me they got by alright. Many clients used the term “depression” to describe a deep and chronic sadness that was made worse by their overwhelming circumstances, but could surface anytime. For others, “depression” seemed a kind of episodic and debilitating hopelessness that would arrive when they were in pain or worried.

What these Laboring clients had in common was a lack of resources to address their mental health. Many interviewees didn’t know where to turn. Others simply couldn’t afford care or were put on waiting lists that could be months long. Mr. D. had been hospitalized after he attempted to kill himself. Once released, he had trouble getting the medication he had been prescribed. “The free clinic can't fill it,” he said, “plus, I'm out of refills. They called it in at [a local drug store] over here, but I don't have the money to fill it.” Other clients might have had the money, but were unable to find the time to address their depression. Ms. F., for example, would wake up at 4:00 in the morning and drive across town to collect her cousin’s children—he would be in prison for another year, and his wife worked the night shift—then three and a half hours later,

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[44] Ms. Lo. was not homeless. She was referring to the fact that she would soon be unable to afford her apartment.

overwhelmed and exhausted, Ms. F. would leave for work, coming home around four in the afternoon. She had no time to talk to anyone about her depression, she said.

Whatever the cause of their depression, the mental ill-health of the Laboring seemed overdetermined by their low-wage work. For example, something had happened to Mr. Bl. in his early teens. He didn't want to say what exactly, but it had been traumatic, and he had struggled with depression and suffered bouts of anxiety ever since. He was now in his 50s. There'd been times when he'd been able to manage his mental health, times when he had okay jobs or when he'd lived in states where access to healthcare was available to people as poor as he was. But then his parents got sick and he had to come back to South Carolina. Uninsured, embarrassed, and with nowhere to turn to, he had started to seriously consider killing himself.

As mentioned above, every client I interviewed, save for one, had dealt with depression. This however, did not mean there was an easy correlation between precarious work and mental ill-health. There were interviewees, like Mr. Bl. for example, who had been depressed before they ever started working. Ms. N. said she'd always been depressed too, but that her chronic health conditions were making things worse. "I've always had this," she said, "but not to the extent to where you really have to sit down with a professional and talk to them about it." Ms. Lo. said her depression started in her late twenties, when she was employed in a good job. However, the majority of clients (34), who had become depressed, had done so, by their reckoning, due to the conditions they labored in.

The depression of interviewees may not have been precipitated by precarious work arrangements alone, but simply being a member of the Laboring seemed to overdetermine psychological suffering. Without a living wage or health benefits, clients struggled to manage their depression.[45]

The sources of stress that weighed on working poor clients were myriad. For while almost all the clients I interviewed were depressed, there were many disparate ways of being depressed among them, and clients would attribute the origins of their depression to a variety of things. Ms. M. was having trouble saving enough money to make rent and felt like a failure. Mr. E. was embarrassed by his circumstances and considered his depression a consequence of no longer being able to provide for himself. And for many interviewees, like Mr. M., it was hard, constantly being out of work on account of his health:

> And it was plenty of times, you know, laying there man, and you know, and I'm in pain. Real depressing. You know, I was there because, at that time I had just got out of the hospital again. Couldn't work. And I thanked God for [the free clinic], but then at the same time, I was depressed because I wasn't doing what I wanted to do. You know I wasn't able to. And that's work. And provide for myself. That's very depressing.

Clients worried too that their mental health problems might force them out of already precarious systems of labor. Mr. Ta., who worked construction, was having a hard time getting his medication and he didn't know why the free clinic wouldn't fill his

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[45] I realize that some may take issue with the language I'm using here; I know that there are people that feel that using the term "struggle" to refer to the experience of mental ill-health implies that individuals living with depression cannot live full lives. I do not mean to suggest this. But I do feel that "struggle" is appropriate here. Those with access to regular medical care and carefully modulated medication regimes and support groups and sick leave may have the opportunity to live fulfilling lives. The working poor, left without care, often struggle.

prescription. But without it, he found it impossible to work. Conversely, many of the Laboring were worried that they would have to work until the day they died. The thought kept Ms. H. up at night. “I worry a lot about my health and the fact that I know I am not getting enough sleep,” she said, “Yeah, and just about the future too, because as I said, if I continue with this health issue, I'm not going to be able to find another…a better job and put myself in a better position where maybe I could afford health insurance.”

Many, if not most clients felt like failures, and in interviews often compared their precarious lives to the relative stability of the lives of their parents. Previous generations had all done better than them, they said, with less. “She could *squeeeeze*,” Ms. R. said of her mother, “She could squeeze a dollar out of a dime. She was just real good at that. And my older brother he caught that. I never did.” It was a near-consensus among interviewees that their parents had had better jobs than they would ever have. “They had stable jobs,” Ms. V., a cleaner, said of her parents, “Mom worked and Dad worked. Things were just a lot better then. Especially with my mom. She was a plant worker.” Underlying this talk of parents was often a subtext that suggested that clients believed their depression to be a personal failure. “I feel like…you know, I feel hopeless,” Ms. N. said, crying,

> A lot of times I’m near tears. But, my family, there isn’t a history of that in my family. My family, Dad, my aunts, my grandma, there’s a history of “just keep going.” You know, just keep going forward, there are no other options. Breaking down, and I cry a whole lot. I feel the tension starting in the back of my head going…but again, I always look to, look to my mom and that. You know. They were pillars of strength. Stuff like that. And they surely came up in harder times than I did.

This psychic pain was often coupled with chronic physical suffering.

## Pain

“Everybody, particularly if you have pain, is gonna go through depression,” Mr. E. told me. His was not an ordinary pain, but a constant galactic agony that had left his life a slur of indistinct days. Such never-ending pain wore you down, Ms. N. told me. “That’s the kind of life I have, she said, “Nothing but pain…that pain drives you crazy.”

Such pain often seemed omnipresent among laboring interviewees. Ms. La. couldn’t afford prescribed medication to ease her discomfort, so she had to make do the best she could with over-the-counter drugs. “Some of them kind of work, some of them don’t work, some of them worked for a little while and then they don’t work,” she said. At night in bed, kept awake with pain, Mr. Ta. would get depressed. Ms. A. attributed her suffering to the long physically-abusive relationship she’d been in. She would likely never be pain free, she figured.

Living with chronic pain is bad for your mental health (Demyttenaere et al. 2007; Gureje et al. 2008; Helmer et al. 2009). You don’t sleep well, you’re often prone to hopelessness, and you can become susceptible to wild and confused thinking, I was told. In the face of ever-present pain and continual poverty, many clients, like Ms. W., felt hopeless. “I want to go out here and kill myself,” she said, “you know I need to talk to somebody about that, ‘cause I'm going through a lot right now. Financials and stuff like that, that's what I've been trying to explain...[mainstream care providers] require me to pay a fee, but I don't have no money for that. You know what I mean?”

Laboring clients lived in pain in part because safety net health care providers did not provide pain pills. I asked scores of physicians what their uninsured charges were supposed to do if they were in pain. The answer was always that they had to do without. This meant that many clients suffered, some episodically, others constantly.

Clients were embarrassed by their depression too. Mr. Sa., who worked at a warehouse, had a hard time telling the free clinic doctors about his moods, figuring they would just take his suicidal ideation for “theatrics.” Mr. G.’s embarrassment would regularly turn to rage at his own impotence, he told me. Mr. C., who was deeply depressed according to his own reckoning, said he would lie on the free clinic questionnaires. He didn’t want the staff to know about the severity of his suffering. He was embarrassed, but also afraid that he would be institutionalized if the staff knew just how depressed he was. “They hand you a form to check and see if you have any depression,” he said, talking about the free clinic,

> Which, if…I mean I had a lot of depression, but I normally fudged it, you know “I’m a little bit depressed,” but I’d be really depressed. Because there was no outlook...I was more depressed than what I let on.”
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> Henry: Why did you not tell them you were that depressed?
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> Mr. C.: Because I was afraid they would send me to [the county’s mental health center] or something. If you’re depressed, you don’t want to let on that you are as depressed as you are, I mean, unless you are super depressed and then you don’t care, but I, I guess I was just self-conscious, I’ve never had to do all this. It’s…it’s embarrassing.

The uncertainty and disability inherent in laboring life was very hard on interviewees like Mr. C. The chronic untreated health conditions and poorly controlled depression of clients had allowed their position in the world to become unfixed. As Wilkinson and Kleinman note, this loss of social roles is so debilitating because, deprived of these identities, “we are made lost to yourselves” (2016: 9). I always found this an apt phrase as many of the men and women I interviewed seemed to be, even as we were talking, looking inward, trying to find something inside themselves they misplaced. For clients’ pain and ill-health could render them someone they didn’t recognize. Ms. R., for example, was in bad shape. When you saw her, you had a hard time imagining that she would ever get well. “I got depressed because, my heart, the COPD,” she said, “it’s kind of like you gotta fifty pound ball on a chain and you want to leave and you can’t.” It made her afraid. Ms. R. believed her depression also came from an inability to get around and do things with her family: “I got depressed because I got grandkids and right now I don’t want to be around them, until I can actually spend time and do things with them. I can’t do that. I can’t even go fishing anymore. And that’s what me and the grandkids would love to do.” Ms. N.’s chronic health problems had similarly left her despondent, so much so that she had been contemplating suicide. “I can’t walk. I can’t sit. Can’t stand, can’t bend,” she said. Furthermore, because of her back troubles, she had been forced to start urinating standing up, “like a man,” she said, one of the many daily humiliations of her chronic ill-health.

### Living a Moral Life while Laboring

The depression of laboring interviewees was further exacerbated by the strategies they were forced to use to endure the poverty and ill-health associated with precarious work. For laboring life is full of moral dilemmas. Strategies of resilience were not purely pragmatic, but are informed by the individual moral codes of interviewees (cf. Panter-Brick 2014). Members of the ailing reserve army could spend all of their paycheck and still come up short and many clients sought to survive the resulting economic instability through a debilitating industry. But even this was often not enough. As a result, the Laboring had to regularly do things they felt conflicted about to meet the competing responsibilities of health and economic survival. I asked interviewees about these conflicts in interviews, in an effort to understand how they conceptualized their strategies of endurance.

Mr. P., embarrassed, told me he occasionally had to “scrape and bum” from family and acquaintances to get by. More than a few interviewees reluctantly relied on aging parents with fixed incomes to survive. But Ms. L. could not bring herself to ask her family for help. “Even my kids didn’t know what I was going through. They thought I was doing real good. I keep a smile on my face, to keep from crying. I keep a smile,” she said. So bills went unpaid and the ensuing phone calls went unanswered.

Many in the reserve army also depended on the informal economy (cf. Clark 2014), for diverted prescription medication, extra-legal work, and quick money. Ms. K., an assembly line worker, had contemplated selling drugs and “robbing,” but was kept from it by her strong faith. “Whatever God has for me, is for me,” she said. Despite these strategies, most of the Laboring remained in debt. As Mr. E. noted, this economic insecurity was in itself depressing. “With me there was never a suicidal type of depression,” he said,

> But there was a lot of depression, I had to go to churches and ask for help with power bills and stuff like that, and you feel, well I did, some people may not, but I felt worthless. Because I was having to borrow, I felt like I was bumming money from the Salvation Army or a church or something, to help me have power in the winter time. And you got a little bit of help with food stamps, but I still had to get

> out and go out and go to flea markets or something to make a little bit of money.

Despite appealing to various sources of aid, Mr. E. was still just barely getting by as a part-time custodian at a local church, and was deeply in debt. As the few studies of the relationship between mental health and debt have suggested, debt is an important socioeconomic determinant of health (Sweet et al. 2018), and was yet another reason the Laboring had to rely on the safety net.

### The Mental Health Care of the Safety Net

The Laboring lived lives of exposure, lives that often had to be lived frantically, as the low-wage employment they toiled in offered no real security, only a momentary reprieve from the immediate threat of hunger and homelessness. But it is not poverty, pain, and debt alone that informed the mental health the members of the county's reserve army. A cross-cultural study conducted by De Moortel et al. (2015) found that the relationship between social class and mental health varied according to a country's system of welfare. This work suggests that Spartanburg's safety net is an important determinant of the mental wellbeing of working poor clients.

When it came to mental health, the county's safety net institutions were often deeply understaffed. Furthermore, the success of the safety net was gauged by the number of patients seen, and by the reduction in E.R. visits by indigent clients. In this managed care mindset of productivity, "difficult" patients, which could include patients with unmanaged, untreated depression, became impediments to efficiency rather than cases that required increased care.

As a result, the Laboring were discouraged from seeking mental health care through systems of containment, and long waiting lists were common. It would be six months, even a year, clients were regularly told, before they'd could be seen by one of the two free clinic counselors. This would be too late for many; most clients didn't come to the clinic unless their condition bordered on the unbearable. For many, the prospect of an appointment six months from now was really no prospect at all.

For some clients this was only a disappointment, but for others this dearth of care could potentially be more consequential. Mr. V. was released from the emergency room, where he had been admitted for suicidal ideation, but was told that he wouldn't be able to see a safety net care provider for another month. When he did finally see someone, it was not a counselor, but a doctor. "You know, I don't talk to them in detail about it," he said, "I mean I tell them, just quickly, you know, they know I really struggle. But, like most [safety net] doctors, I mean they are doing a great job, they're doing a great job, but they don't have that much time. You know, they are not counselors." Without help, Mr. V. wasn't sure how he'd manage.

This lack of care was dangerous for working poor clients, already under tremendous stress and without access to appropriate mental health resources. Ms. J. said her untreated depression would regularly send her to a "dark place" and that during these times she'd just want "to get my pistol and kill myself, or just kill the ones that caused me all this hardship."

It should be noted that none of the clients I interviewed were experiencing psychotic depression. Spartanburg County does have a Mental Health Department that sees people with the most serious of mental illnesses and emotional disorders. But only one interviewee had ever been institutionalized there for their depression.

This is not to say that the mental health problems of laboring clients were trivial. Many interviewees had by their own accounts withdrawn into near-agoraphobia, an isolation that encouraged rumination and tended to exacerbate other health conditions. This self-removal was often an attempt to protect oneself from further pain (cf. Dolson 2015) and was a socially sanctioned coping mechanism for the members of the reserve army, in the sense that it was coherent with the Upstate's cultural reverence for individualism and self-reliance. It was also easy, as no one was looking for these marginalized interviewees, particularly once they fell out of the labor system. So many clients suffered quietly and alone, in increasingly dismal circumstances.[46]

**Treating Depression**

As Scheper-Hughes has noted, one function of medicine is as "a technical practice for 'rationalizing' human misery and for containing it to safe quarters, keeping it 'in its place,' and so cutting off its potential for generating an active critique" (in Holmes 2013: 193). And it was in the safety net that the depression and existential suffering of working poor clients, often a result of imbricated systems of exploitation, was rationalized and medicalized.

One way for the Laboring to have their experience validated was to get a diagnosis from a medical authority, i.e. to have their suffering co-signed by a doctor's

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[46] And these circumstances are dismal. But I do not want to overstate things here. The Laboring did not live the exposed lives of the homeless mentally ill shelter residents that Desjarlais (1994) wrote about, nor did they experience the vile abjection that Catarina, the young institutionalized woman Biehl and Eskerod (2013) met in Brazil, experienced. By comparison the Laboring lived lives a relative comfort. As a result, their suffering could often be overlooked, hidden, or dismissed.

prescription. A prescription did not guarantee that the people around them would understand their condition, or even believe the medical determination, but it gave clients something to hold on to. Obtaining such a prescription was difficult, laboring interviewees said.

In safety-net managed care, therapists' time, the most expensive component of mental health treatment, is carefully rationed, if available at all (Ware et al. 2000). In lieu of therapy, safety-net organizations increasingly rely on prescription drugs to treat uninsured individuals with mental illness (Brodwin 2013). Ethnographic research has repeatedly demonstrated that the pharmaceutical treatment of mental illness can complicate the lives of vulnerable patients and exacerbate their mental distress (Biehl 2010; Han 2012; Jenkins 2009; Schüll 2012).

Uninsured, and with only the safety net to rely on, the Laboring often found themselves attempting to manage their mental illness with prescription drugs and little else (cf. Angell 2011). The drugs could help clients get by. But without addressing their material welfare, recovery would be unlikely, care providers admitted.

For pharmaceuticals were blunt instruments. Sometimes they helped, clients told me, but not always, and they could make things much worse too. Interviewees that managed to be seen for their depression usually took several medications, some for their mental health, and others for physical conditions. These medicines could work at cross-purposes, and this became increasingly more likely the more medications that were prescribed. Ms. K. for example, took over a half-dozen medications for her depression, her arthritis, and her back, but worried that the drugs might cause her to be injured on the job. “I don’t want to be suicidal,” she said,

> Because if you go on a job, okay? All this medicine, I gotta work, or I’m gonna be homeless out there on the street, sleeping out there on the ground, I guess. I don’t know. So what you do? You in there working, trying to take a pill, you working, next damn thing, you have your damn finger cut off. You know? Would you have me on your job taking all these medicines?
>
> Henry: No ma’am.
>
> Ms. K.: I didn’t think you would. And then, you’ll be like, “What if I get hurt. What if I fall out?” But you gotta work, you gotta eat. You gotta work.

According to clients these drugs were not always prescribed with care either. Mr. Wa. believed that the safety net doctor he saw just guessed when it came to deciding which medication would suit him: “I mean they put you on medication, but so far as them figuring out what’s gonna work and what’s not gonna work, it just seems like to me it’s just a guessing game for them.” Ms. C. agreed. One day at a safety net clinic, while experiencing terrible side effects from the medications she was being prescribed, she frustrated an overworked care provider to the point where the woman angrily turned the computer screen to Ms. C., showing her a list of medications and, according to Ms. C., tightly said, “Just tell me what you want.”

Other clients could not even get in to the safety net to get medications. Ms. T., for example, had been trying to see someone about her worsening depression for months, but could not afford even the reduced rates of the safety net. Instead she took some of her mother’s medication to get by. As noted earlier, this was not a means of escaping sociomedical control necessarily—any help from a medical authority would likely have been welcomed—but was instead, like Ms. K.’s case suggests, an attempt to hold on to a connection with the "sane" world (cf. Biehl and Moran-Thomas 2009: 270); clients self-medicated in an effort to meet the responsibilities of life and health, as well as to ease their suffering.

This self-medication of mental health problems was frowned upon by the safety net institutions, in part because laboring clients did so without the approval or knowledge of their doctors and because their regimens were often counterindicated by medical science: clients drank with their medications, got pain pills from friends, isolated themselves from the outside world, and calmed their suffering with food.[47]

In this absence of available mental health services, Laboring clients also had to rely of family and acquaintances for aid as deinstitutionalization had increasingly shifted the context of mental health care to occur outside the clinic (Nazareno 2018, Warner et al. 2017; Yohanna 2013). As a result, untrained laypeople were regularly forced to become "proxy psychiatrists"[48] (Biehl et al. 2010: 325). Consequently, mental instability

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[47] It is therefore perhaps unsurprising that Vanderlip et al. (2014) found a significant association between depression and diabetes-related complications and mortality among safety net patients.

[48] This included myself, as I was the only person that many interviewees talked to about their depression. Some of the people I interviewed told me that they enjoyed being able to discuss their struggles with someone, that just having their suffering recognized was helpful. "It's been pretty rough," Ms. M. said, "and I'm glad they have people like you to tell the truth. And that is the God-ever truth." But these interviews weren't easy for everyone. Sometimes I would have to skip a bunch of questions or would change the subject when it seemed like the line of inquiry was becoming too painful for a depressed interviewee. I stopped Mr. Ma.'s interview, for example, about 15 minutes in and drove him home when it seemed like the questions were just becoming too much for him. He was a big man, and had played SEC football, but his voice became softer with each question I asked, almost to the point of being inaudible. Once he began sighing heavily and started looking away for what to me was a disconcerting amount of time before answering every question, I decided to terminate the interview. On the drive back to his house he seemed to recover himself a little. But this early interview, the third I'd done

is often experienced through domestic and social relations (Garcia 2010; Han 2012). Ms. B., for example, relied on her aging mother, who was sick herself, for care and rides across town. As noted earlier, this common reliance on overstretched or ailing family members for money, rides, and housing, was a constant source of shame and guilt for many interviewees.

**Conclusion**

The relationship between precarious work and depression isn't simple. The stress of low-wage employment has been found to be associated with depression, but some clients were depressed long before they were part of the Reserve Army of the Laboring. However, that's not to suggest that their depression was unrelated to their precarious circumstances. Here I have argued that it is the low wages and the lack of benefits that characterize unstable labor that effectively preclude poor employees from accessing regular healthcare, thereby overdetermining the depression so disproportionately found among the Laboring.

As a result, ill-health often accretes, and with it pain and infirmity, leaving clients susceptible to despair. Additionally, working poor clients must make do with the qualified care of the safety net, rationed care that may exacerbate patients' conditions, through the proscription against pain relief, or through the unsupervised overmedication noted above. The depression clients were abandoned to was also a

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for this ethnography, made me wary of causing interviewees unexpected or unnecessary pain. So at the end of each interview, I began to leave interested interviewees with a photocopy of a sheet of paper on which someone—I think I got it from a local church—had collected all the names and addresses of safety net institutions in the county that provided food, dental care, and other aid (Appendix E). But this never felt like enough.

depression determined by a lack of autonomy, stalled upward mobility, poor job prospects, and the embarrassments that accompany chronic, debilitating illness.

Laboring interviewees couldn’t take time off. Consequently, much of their suffering was done on their feet. The author William Styron, who struggled with depression himself, used the term “walking wounded” to describe the suffering of depressed individuals:

> For in virtually any other serious sickness, a patient who felt similar devastation would by lying flat in bed, possibly sedated and hooked up to the tubes and wires of life-support systems, but at the very least in a posture of repose and in an isolated setting. His invalidism would be necessary, unquestioned and honorably attained. However, the sufferer from depression has no such option and therefore finds himself, like a walking casualty of war, thrust into the most intolerable social and family situations. There he must, despite the anguish devouring his brain, present a face approximating the one that is associated with ordinary events and companionship. (1992: 122).

Much of the suffering of the Laboring is hidden, as their personal devastation must be endured while they work. During my own stints of precarious employment I found that the poor mental health of coworkers was often mistaken by employers for fecklessness, obstinacy, or peevishness. When it’s not ignored, the depression of low-wage workers is often simply taken for granted. In ethnographies of working poor life—many of them otherwise comprehensive and empathetic accounts of poverty (Ehrenreich 2001; Newman 1999; Shipler 2004)— the depression of economically vulnerable individuals is noted, but is otherwise considered unremarkable. “How could you not be depressed in these circumstances?,” the works of Ehrenreich, Newman, and Shipler seem to suggest. How can grueling shift work and the demoralizing search for affordable housing and a living wage not result in depression? But most clients hadn't always been depressed. Interviewees might have struggled to get by for much of their lives, but no one complained much about the work they had done before they had gotten sick. It was when their fortunes changed, abruptly through a fall or a diagnosis, or almost imperceptibly as their bodies started to fail them, that most interviewees had become depressed.

Their depression seemed to occur when the inducements to endure—a living, or near-living wage, meaningful respectable work, the prospect of retirement—began to vanish and the impending social death of laboring life and ever-mounting economic uncertainty became inevitable. Depression usually emerged when clients were asked to succumb quietly, and when the comforts deferred in the name of achieving or maintaining a righteous way of life were no longer offered.

For decades the work of interviewees had paid the bills and had kept them among the righteous. They had distinguished themselves, the deserving, from the disreputable, by the ability, and ostensibly the will, to work. To be self-sufficient and labor was to be virtuous. And this was in part what was causing such anguish among ailing interviewees: the realization that they might soon lose their ability to work. For not working was seen by many as a loathsome, almost unthinkable alternative.

### A Small, but I Feel Important, Aside

Most traditional ethnographies by anthropologists share a common narrative structure, an anthropological monomyth that begins with the ordeal of entering the field, followed by a crossing of thresholds of physical and psychic danger, and ending in insight and transformation. This is, of course, an orderly and artificial construction superimposed on an entropic experience. And while ethnographies have documented, among other things, the boredom (Lévi-Strauss 1955), longing (Altork 1995), and grief (Rosaldo 1989) experienced during fieldwork, the mental health of the ethnographer usually goes unremarked upon, leaving readers, often other anthropologists, to infer that their own struggles are anomalous.

With that in mind I wanted to include this little aside, just on the off chance that someone reads this dissertation before going into the field for the first time. I'm not entirely sure if or how it would help, but I know I'd feel remiss while writing a chapter on mental health if I didn't mention that there were days when *I* couldn't get out of bed. And days when I sat in parking lots wondering if I was gonna make it. Not suicidal entirely, but afraid that soon it might become too much. Then there were entire weeks when I couldn't catch my breath, when the only thing I could stand was the dark of my room.

There are lots of forms of care for this—whatever you call it. But personally I found solace in the accounts of the struggles of others. Probably most of all in the novels of W.G. Sebald. Sebald, a melancholy, peripatetic German eccentric, wrote books, some of them semi-autobiographical, about lonely and dying places, about bygone eras, and about suffering and muddling through. These novels helped me immensely, as Sebald, often a character in his own work, always seemed to be struggling himself and acknowledged this, quietly, but openly. His books brought me great comfort.

Admittedly, this was an idiosyncratic coping mechanism and would be a poor prescription if it was one. But it’s not. My larger point is that if you have to muddle through, know that even if we don’t always acknowledge it, it seems like many of us had to too. And if you are muddling through and can manage to recognize your pain in some small way, it may be a great consolation to someone else.

## Chapter 6. Slow Death: Waiting for Disability

*“My mother taught me, unless you’re crawling, you need to go work,” Ms. Ma. said.*
*“I’ve worked every single day since I was twelve. Worked hard,” Mr. Ca. noted.*
*“Hopefully I get my disability and I’ll be okay,” Ms. W. prayed.*
*“Applied. Got denied. Applied. Got denied,” Mr. M. recounted.*
*“My situation that I got, this is what I’m gonna die with,” Ms. J. said.*

*—Collected Fieldnotes*

### Introduction

This chapter is about Social Security Disability Insurance, which I will refer to here as “disability,” because that is what everybody I talked to called it. As the State continues its divestment in general assistance programs, disability benefits remain one of the few potential sources of cash assistance ostensibly available to the Laboring (cf. Whittle et al. 2017). During my fieldwork, 21 of the clients I interviewed applied for disability and three ended up receiving benefits. In previous chapters I have examined how the Laboring are obligated to enter systems of exploitation. Here I will show how laboring clients, having applied for disability as a last resort, were compelled to inaction, waiting sometimes for years, without a job or an income, for a decision from the State. This meant that applying for benefits was a gamble. Disability could provide clients a steady income, and importantly, regular access to healthcare, but the long periods without money coming in were hard on interviewees and did not guarantee a determination of disability.

In this chapter I will use Lauren Berlant’s concept of Slow Death—which refers to the “zone of ordinariness, where life building and the attrition of human life are indistinguishable” (2011:96) —to examine how the Laboring weathered this time spent in stasis, waiting for word from the State. For applying for disability could at once be a strategy of resilience, and a deleterious and involuntary withdrawal from righteous life at the same time.

Using the idea of Slow Death, which suggests that strategies of endurance often come at a cost, I will examine clients' experiences seeking and waiting for disability. These experiences are crucial to understanding the complexities inherent in Laboring life, as appealing to the State for disability benefits, a common strategy for surviving economic immiseration and managing ill-health, can itself be injurious.

Using data from client interviews and from the fieldnotes I took while visiting interviewees, I will outline the material and psychic costs applying for disability had on ailing members of the reserve army, and explore how these laboring clients are managed and disciplined by the State through seemingly interminable waits and ceaseless scrutiny.

### A Scene of Slow Death

> *Every window in the housing project was shuttered and the door in front of me didn't look like it had opened in years. In this neighborhood a knock will stop the conversation inside an apartment dead and front doors aren't unlocked until you identify yourself. "Who is it?!" a voice strained loudly, a sad bluff from the very sick man inside. I told him and he said to come around back.*
>
> *Mr. M. asked me if I had found the place alright. I had actually missed his road and quickly made a U-turn, in the process accidentally flushing two women*

*from behind a stand of trees. The women—sex workers, Mr. M. said—had hurried to get away, crossing the street into an adjacent courtyard.*

*His apartment was dark like a tomb and he kept the few pain pills he had accumulated upstairs, separate from his other medications, worried that someone might force the front door and steal them while he was out. He needed those pills badly, he said. It had come to the point where there were days when he couldn't get off the couch that served as his bed, much less work. He had always enjoyed his job as a mechanic, but now he could hardly walk.*

*-Fieldnotes from Mr. M. interview, 2017*

When I asked Mr. M. how he got by, he said, "I mean, you got the free medical clinic, but the medical clinic, they don't do but so much. You understand what I mean? Like if you need an X-ray or something? They can't do it. If you need blood work done, they got to send you to someplace else. So I mean, it's like…the things that you go through just to even try and get a little bit of help sometime ain't even worth it."

Mr. M. was blind in one eye, had lost a piece of his hand, and had suffered nerve damage in his leg. He also had terrible bouts of pancreatitis, which had long gone untreated. "Some days, I get in pain where I just lay on the chair," he said, "All day. Go to sleep, wake up."

The Laboring probably won't die on the job. Factory floors aren't coalmines and motel rooms aren't dangerous in the way oilrigs are. Instead it's slow death—"being worn out by the activity of reproducing life" (Berlant 2011: 100)—that is endemic among the Reserve Army of the Laboring. This experience is at once ordinary and extreme, an attempt at “life-making” (Belant 2011: 98) that is simultaneously attritional: Mr. M. endeavored to work despite his host of health problems, but his attempts to make a living while sick endangered his health even further. Then, one day, having reached the limits of his endurance, he grudgingly applied for disability.

### Appealing to the State

For laboring individuals, applying for disability is a social and economic risk. “I mean they’re gonna turn you down, Mr. P. said, “It’s like, what you gonna do for money for three years or two years, if it takes two years for you to get it? What you gonna do for money for two years? And plus you gotta see the doctors to prove that stuff’s wrong with you.” Many of the Laboring took this chance, not because they didn’t want to work, but because they felt it was the only way they could get meaningful healthcare. “Disability’s gonna help me.” Mr. D. hoped, “ Far as that’s concerned. I have to have blood thinner, they told me that. I have to have that.” Ms. F., who was deeply, dangerously, depressed, believed disability might literally save her life. “But it’s kind of hard, since I don't have no insurance. Hopefully I get my disability and I'll be okay, that's what I'm fighting for.” Mr. Q. who held several jobs and landscaped on the weekends, believed disability might keep him out of jail. He had been unable to work regularly after he’d gotten sick and as a result was incarcerated every few years for failing to pay child support. Disability, he felt, could keep him from being incarcerated again:

> I’m not supposed to be lifting anything. I’m not supposed to be in heat. Not supposed to be walking long distances. I’m supposed to keep my legs elevated. That’s what I can do physically to help it. And stay off on them, of course. But I wasn’t doing any of those, so I wind up back in the hospital, then out of work for a month, two months, you know. And then that’s when I got behind again [on paying child support], and I’ll be back and forth to jail.

Almost to a person, interviewees abhorred the idea of quitting their jobs and appealing to the State for aid. “They told me to stop working,” Mr. C. said, “But I didn’t. I been knowed about disability, but me being hard-headed...I continued to work.” But seeking disability was seen as a hedge against incapacitating illness and destitution: a chance at health, at the risk of months, possibly years, of waiting in deleterious poverty.[49] The process of obtaining disability benefits, however, was fraught with uncertainty.

Laboring clients new to and unfamiliar with the disability process often found the bureaucracy they encountered mysterious, even maddening. Inevitably, they would discover too late that they were eligible for some form of aid, or had made some kind of strategic mistake while applying. Furthermore, the documentation requirements were often onerous, requirements that seemed to be meant for individuals that didn’t move around much, were meticulous with their records, and regularly saw the same doctor.

The State was fussy about records and technical denials were common. Clients could easily be turned down for discrepancies in their work histories. “They said that I didn’t have all of my information correct,” Ms. O. said, “So, I guess it’s like too many inconsistencies. Because I had to go back, all these years and think about all the jobs that I had been on and all, you know, and I had to get up the doctor’s names, I had to get up, you know, everything.”

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[49] Applying for disability was not always clearly an intentional and strategic action. And often I wondered whether enduring these long expectant spells was a form of agency or the result of domination. For appealing to the State for aid was rarely done wholeheartedly. Nor were clients always aware of what exactly disability would entail.

The documents that clients did manage to collect rarely represented the full hardships they faced. “What’s on paper ain’t got nothing to do with my body,” Ms. V. said, “I know what I go through everyday.” In her disability hearing Ms. Ma. pleaded with the judge, “I have put my mother into financial hardship. It’s put me into a terrible depression. You know, I have a child I hardly ever get to see. My son has autism, I don’t get to take care of him, he’s having to take care of me.” But such circumstances were usually ignored, according to people that had been through the process.

Interviewees described disability hearings as only concerned with whether clients *could* work. Judges did not appear to take into account whether working would cause the health of clients to deteriorate or keep them from recovering care. These judges also appeared to regularly dismiss doctor’s recommendations and question medical determinations of disability. Interviewees shared a deep resentment for the fact that their claims were regularly rejected despite their doctors’ recommendations, their serious and debilitating conditions, and long, documented, histories of employment.

None of the clients I interviewed got disability the first time they applied, and most of their claims were summarily dismissed. This was to be expected according to interviewees familiar with the process**.** Ms. B. believed that there was a formula: “They actually turn you down three times. Mostly three times and then it’s denied. And then you have to get you a lawyer and then they get your money for you.”

It frustrated clients when, despite having painstakingly collected evidence of their disabilities, their claims were dismissed. The time and effort spent attempting to comply with the State’s burdensome requirements, had been for nothing, they said.

Clients also resented judges acting as paramedical authorities. “Now how can a judge tell you what’s wrong with your body?”, Ms. J. wanted to know.

These appeals for disability were further complicated by the fact that free clinic doctors did not weigh in on the disability claims of their patients. “They can’t say you’re disabled,” Ms. Mc., a clinic client, explained, “All they can do is treat you. They will not do anything to help you get disability. That’s not their function. Like if I went to a regular doctor, that doctor could help fight by their notes and things like that and say ‘This patient is disabled.’ When you have a doctor that’s telling them that, that makes a difference. I don’t have that.”

After being turned down, nine interviewees reapplied, now aided by lawyers who would receive a percentage of the payment should the application be successful. “If you ain’t got a lawyer,” Mr. F. told me, “you ain’t gonna get nowhere.” The fact that attorneys took their cases, attorneys that would not be paid unless they won, buoyed the hopes of clients: It was a propitious sign that a lawyer would champion your claim without any upfront money. It suggested that your case had merit and had a chance of being accepted.

Because the physicians at the free clinic could not advocate for their patients (this appeared to be clinic policy), lawyers counseled their clients to consult doctors outside the safety net. As Mr. S. noted, this meant that clients could be too poor to apply for disability:

> So, like I say it’s a process. They want you to go to a doctor. They keep a record of it. But like how I tell the lawyer, if you ain’t got no money, no source of income coming in, no kind of Medicaid, Medicare, doctors don’t see you. And if

> you don’t even got a doctor who gon’ see you? You explain to me how you gon’ keep going to a doctor. You understand what I mean?

While getting disability in South Carolina could be difficult for anyone regardless of class position or socio-economic status, there were particular aspects of Laboring life that made applying for disability especially hard on working poor clients. The waiting necessary for a determination was disproportionately onerous on the Laboring. Nearly all interviewees had been ailing for some time before they applied for disability, and without insurance their conditions had gone unattended, often for years. As a result of their increasing ill-health, their wages had declined and their hours had dried up during the years prior to appealing to the State. Consequently, few clients had the means to survive an indefinite period of joblessness as they waited to hear back about their claim.

A study by Coe et al. (2014) found that individuals with employed spouses were more likely to appeal their initial denials. But this study wasn’t of working poor families. Laboring families couldn’t live off one income, as the spouses of the clients I interviewed, without exception, worked low-paying jobs too.

In fact, some interviewees abandoned their claims and returned to work *because* of their employed spouses. Mr. J. had been waiting for nearly a year to hear about his appeal when he was forced to go back to the job that had injured him. The stress on his family had become too much, he said: “It was a long process, so that's why I went back to work. After about 11 months, I saw what my wife was going through, and your bills don't stop, and so I just went on back to work and just prayed about the ailments that I had.”

**Waiting on Something, or Waiting on Nothing, it’s Hard to Tell**

Life waiting for disability is disorienting, I was told. A major directing force in clients' lives, work, had disappeared. A client would no longer be a landscaper, a breadwinner, a taxpayer, or a coworker, only an anxious disability applicant. One day, Ms. E., who was suffering with a degenerative disc disease, described her life waiting for disability to me, "And now…I'm just sitting now. Pacing. Wondering, because you know now, they can always deny me again. For social security. Meaning that I worked all my life, but they still could deny me." This time spent waiting was a fertile time for hopelessness.

That this period is hard, is by design. The wait cannot be too comfortable, it has been suggested, or it might incentivize individuals to flee the labor force (Tanner and Hughes 2013). Part of what made the wait so difficult was that the process was so opaque. In the free clinic lobby, another site of long, expectant waiting, the rhythm of care could at least be observed; clients saw patients arrive and leave, rendering the interludes of inactivity intelligible. During the months spent waiting for a disability determination, by contrast, it was often unclear if clients were biding their time, had been forgotten, or had been abandoned altogether. "You cry a lot," Ms. M. said, "There are times you just cry and you don't even know why you're crying. But most of it's just because you feel, feel like a failure." It was nerve-wracking: after months and months, clients could suddenly find out that all this time had been a waste. Conversely, if you were waiting to hear, that meant you had at least not yet been forsaken.

During these long periods of uncertainty, clients would regularly second-guess their decision to stop working. For most, appealing to the State had been a strategy of last resort, not always a strategic effort at self-preservation, but just a way to survive. Ms. T.’s arthritis eventually just got so bad that it made it impossible for her to work: “I mean I used to work on machines, production line working on machines, and my hand got so bad I had to sit. And they pulled me off the line, and put somebody in my place. Then they sent me home and said, ‘You can't work with your hand like that.’ And it hurt, it just hurt like this. And I can't find a job.”

Applying for disability was a way of getting by. But it was also a way for clients to make sense of their distressing circumstances and, as their health failed, to imbue their new lives of involuntary and dizzying inaction with an ostensible direction and intentionality. They had nothing to do, but at least they were doing something: waiting. And waiting was a way to act on and make sense of the disenfranchising disability they were encountering, a form of order to explain the long stretches of nothing they experienced. Still, the long spells of listlessness and ennui got to many clients. “I get angry,” Ms. W. said, explaining what her wait was like, “and I get nervous, things get on my nerves, it's boredom, you know. And I keep thinking about it, it's making me feel like…I get mad, I don't know what to do.”

Clients continually wondered why it was taking so long. The months and months of not hearing back gave the impression of an office overrun with claims. The length of the wait suggested arbitrariness: the decision itself, including the review of the case, could probably be done in a matter of minutes, interviewees speculated. You weren’t always told why you were denied either. “They really don’t give a reason,” Ms. B. said ruefully, “They really don’t. I’ve looked at some of the paperwork...and it just says that it's denied. They don't really give a reason." Similarly, none of the interviewees seemed to know how much money they would receive, should they be deemed eligible for benefits. Most clients only had a vague idea of what disability was in the first place, and many, when I asked, didn't know exactly how they would benefit.

### Forced Inactivity

While they waited, interviewees were unable to be industrious in any way, as that might signal an ability to work. "It can be a double-edged sword," Ms. P. explained, "you gotta judge sitting there and you have your responsibilities. Momma has to have me there. There's just no…I have to come secondary. But you don't want a judge there again sitting there thinking, 'Well if you can do that, then you could work'." During these periods of inactivity, debts, formal and informal, accumulated and interviewees quickly exhausted the little money they had saved. Ms. L. had been turned down by the disability board and was unsure if she could stand another round of appeals:

> I'm already tired. Three years of waiting. Three whole years of waiting. So now, I go to get another lawyer. He told me if I start all over again I can possibly…he'll take my case if I start all over again. Which I gotta go see him the day before my birthday. So the three years that I waited, is gone. Gone! Nothing. And now if I start all over again…I owe so many people.

The State and the client waited at different tempos, as the administration determined the terms and timeline of redistribution. In this way, South Carolina's Social Security Administration wielded its "temporal power" (Bourdieu 2000: 228), allowing clients to agonize and wonder about their decision. And while my inquiries to the Social Security Administration in Spartanburg went unanswered, and I therefore can't confirm that waits were long and open-ended by design, it was obvious that the lack of transparency surrounding disability determinations was effectively a form of containment that traded on the debts, desperation, and despair of working poor clients.

While waiting for disability you were expected to forfeit much of your former life. Ms. Ma.'s friend's daughter had been refused disability after celebrating her birthday one night. "She has MS," Ms. Ma. explained,

> And she has been in front of the judge once and got turned down again. But she had friends that wanted to take her out for her birthday and took her out to a concert. And she was at the concert, posted pictures on social media, and the judge pulled up her Facebook page and said, "If you could celebrate then, you can work." And that's one night! You know, and he doesn't know what she might have paid for after that as far as when she got home, and her body and stuff, but she just wanted one night, you know?

Afraid of having their applications for disability denied, many interviewees led adjourned lives, rarely venturing out of their houses for weeks or even months. As a result, clients seeking disability were often accused of indolence, of sitting around doing nothing all day, they said. But this was one of the reasons they stayed home: they were constantly being surveilled or sousveilled—"watched from below" (Hoffman 2006: n.p.)—by neighbors that studied their movements, by acquaintances that perused their social media, and by proxies of the State that looked for evidence of fraud.

Clients like Ms. Ma. also sat at home because there was nothing else for her to do. Taking a job to survive the months of waiting could threaten her chances of receiving disability and then healthcare.[50] So while waiting on disability, clients mostly

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[50] If you are determined by the State to be engaging in "substantial gainful activity," you are considered ineligible for benefits. For 2018 the Social Security Administration reckoned substantial gainful activity to be $1,180 a month (Social Security Administration 2019). This amount is tethered to the national average wage index. In

stayed at home. With no income, no means to go anywhere, and no way to support their families, interviewees become isolated and depressed. “It's hard to get around when you need to go places,” Ms. T. said,

> And you can't depend on people. Or you just don't have no transportation, it's frustrating to me because I don't have no car. And then money, that's the problem, how am I supposed to support myself? I don't have no income and how am I supposed to help my family? I depend on the Lord. That's all I can do, but it's kind of hard.

The months spent waiting to hear from the disability board were lived in suspension and passed in deprivation, clients said, anxiously biding your time, wondering if you’d qualify for aid. These periods of inactivity and financial insecurity nearly always aggravated the health conditions of clients.

### The Health Effects of Waiting for Disability

Living so close to the bone is bad for your health, and during these long immiserating waits the lives and bodies of interviewees fell apart in myriad ways. No one’s condition improved while they waited to hear from the disability board. Ms. Cl. applied for disability online and got rejected six months later. She then appealed, but wouldn’t get to go before the judge for another 18 months. She couldn’t walk well and because she had difficulty getting around, she spent most of her time alone, isolated in her modest studio apartment. Ms. Q., down the street, had been waiting on her disability determination for 18 months. You sleep a lot, she told me, but rarely well though. Ms. R. didn’t know if she would survive the wait. “I’ve been turned down

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2015 it was $1,090, in 2016 it rose to $1,130, and in 2017 it was $1,170 (for sighted individuals). Many clients avoided taking up any kind of work for fear of appearing ineligible for disability, that is, being able to survive being employed.

already," she said, "But at that time all I had was congestive heart failure at thirty-five to forty percent. That was a little over a year ago. Since then, my heart failure has gone to 15 to 20 percent with COPD and the enlarged heart and um, the heart valve and now the low blood."

Most clients also reported gaining unwanted weight during these periods of uncertainty, which often exacerbated their already poor health. For food was a rare comfort during these anxious times and clients indulged when they could. Many interviewees lived on avenues and streets lined with gauntlets of fast food restaurants, where meals were relatively cheap and abundant, and subsequently interviewees often became unwell from the changes in blood pressure and blood sugar that accompanied their weight gain during this time of mandated indolence.[51]

This liminal period could also be a truly lonely time for clients, as relationships frequently fell apart under the strain of the seemingly interminable waits. Mr. I. had had a "friend-girl"[52] that left him when he could no longer support the both of them. Ms. J. had a "former fiancé" that didn't come around much anymore now that she was sick. After two years of not hearing one way or another, Ms. Q., separated from her husband, had become so depressed that she often seemed on the verge of crying every time we talked. The prospect of disability was her last hope, she explained. "It's hard making it by myself," she said.

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[51] It was the people that didn't put on weight or lost weight that you tended to worry about.

[52] The first time I heard the word I thought it was an accidental transposition. But Mr. I. used the term regularly.

## Enduring the Wait

A significant portion of the public health research on risk and resilience has assumed particular actions to be either inherently resilient or objectively maladaptive (Wexler et al. 2009; Wulff et al. 2015).[53] But examining the resources working poor individuals use to cope with hardship is not a simple matter of tallying successes amid adversity. For resilience can be “perverse”, as sources of endurance may simultaneously liberate and entrap those attempting to escape socio-economic marginalization (Panter-Brick 2014: 443).

Efforts to contest inequity and survive lives of immiseration are rarely unqualified successes and can often be injurious in themselves. Previous ethnographies of resilience among the working poor, for example, have documented pathological fortitude (James 1994), the complicated miseries of “success” (Sennett and Cobb 1973), and the embodied distress that results from attempting to meet the conflicting responsibilities of race, class, and gender (Mullings 2005). The following sections explore how strategies for surviving economic inequalities and ill-health can often be deleterious.

## Strategies and Resources for Surviving the Wait

Many families combined welfare and work to survive. The welfare of one family member might subsidize the employment of another, allowing a laboring client to continue to work (cf. Newman 1999). Some working individuals, for example, unable to afford childcare, healthcare, or housing, relied on welfare-recipient relatives in order to

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[53] There are however, numerous exceptions (Among them Geronimus et al. 2006; James 1994; Mullings 2005).

stay employed. These arrangements, were both boon and burden for Laboring employees.

The strategies and resources that the working poor women and men of Spartanburg County used to manage uncertainty in the absence of secure employment and health insurance were often harmful. For these strategies of endurance were usually efforts of extreme self-reliance. In lieu of medical care, clients invested in cures ordered from infomercials, bought herbal supplements from gas stations, or relied on diverted prescription drugs of obscure provenance, bought or bartered from coworkers, family, or acquaintances.[54]

I realize that this may seem like a contradiction, that clients rely on their families and networks of acquaintances, but at the same time are often forced to manage their ill-health alone. This is because families and friends are both assets and burdens. As noted in previous chapters, Laboring individuals often had people relying on them for help. In addition, very often these networks of support were made up of other impoverished and laboring persons, people that could provide very little support. Ms. Lo., for example, relied on her family to get by. But she knew there were limits, as they were struggling too:

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[54] No matter how desperate clients were, they had to be careful how they managed their pain, for it could jeopardize their case. A friend of Mr. O.'s had his claim denied after he admitted to self-medicating with marijuana: "He couldn't afford to go to a doctor, he couldn't…and had terrible pain so he every once and a while would smoke a little weed, to help with pain. And he was being honest, trying to show the judge how much pain he was in because he had no way to get medicine. Well, [the judge] used to be a prosecutor. He denied him down in a heartbeat. Because it's illegal! So, but they don't see past that. I mean, what choice, did this guy have?"

> To be honest with you, diabetic supplies is very expensive. For the last three years I was struggling. And I asked my aunt, she will give me some of her test strips. She'll help me with that, it ain't no problem, but she's got to use her test strips too. I thank God for that, she help me out with that. The money, they got bills to pay too, but I say I need $5 to get some test strips, it's just hard, some people don't have money, they got bills. I understand, that's why I'm praying, I hope I get my own insurance and don't have to worry about all this.

Thus, family could serve as a buffer from misfortune and a lack of access to services (Shipler 2004). Ms. M.'s aunt lent her money to pay bills. Ms. V.'s mother and step-father let her live in the trailer behind their house. Ms. G.'s mother had a car and drove Ms. G. to her doctors' appointments.

But having uninsured family members could burden the rest of the family, and many of the Laboring relied on already impoverished systems of support, and suffered disproportionately as a result. When she finally got some money together, Ms. W. got a car and began paying the debts she had accrued over the years. She would have to be careful, she told me. Once her family discovered that she had received her money, they would likely start coming around asking for things, and she was still trying to get on her feet.

As Ms. W.'s example suggests, networks of support were not always beneficial. Ms. N. rarely talked to her family anymore. There had a one point been a disagreement over some money, among other things. Mr. H. had to leave his partner, who he had been supporting, after his work dried up. Ms. I. stayed in an abusive relationship in part because she couldn't afford to live on her own. Other interviewees too hinted that their unsafe living arrangements were only tolerated out of desperation (Sered and Fernandopulle 2006: 57 found something similar).

But roommates, whether they were relatives or not, kept the rent affordable and could keep an eye on interviewees with serious health conditions. And sometimes, client said, the people you lived with got food stamps and shared them. If you were poor you needed to rely on other people to survive, Mr. Bl. declared, because when the work slowed down, “if you don't have a spouse, someone with another check coming in, you in trouble.”

As a result clients often felt trapped, unable to work, but required to have some way of paying bills. It made it hard just to get by, Ms. M., said. “Making people wait makes problems,” she added, “In society. Because people wants to go out and start stealing. At the Walmart, or whatever, stealing soap, tissues, whatever they need to try to survive and all that.” Furthermore, credit was often no longer available to the waiting, working, poor. Once dependent on debt, most interviewees had been effectively banished from systems of strategic risk. Credit, even the usurious credit that the working poor are often confined to, no longer served as a resource for managing insecurity during the wait for disability.

This meant that for many, waiting eventually became impossible. Clients needed enough resources to wait out the State, yet the ability to outlast these long periods without work could also suggest a lack of need. “How have you been getting by?” was a question often asked of the Laboring, both by friends and at disability hearings, they told me.

There was often no good answer. Interviewees just had to find ways to survive. So they took jobs under the table or engaged in little hustles, risking their disability claims and their health. To get money while waiting for disability, the clients I interviewed also sold their cars, moved into smaller apartments, pawned assets, and took roommates or lived with their parents, and rationed food.

With no income, the homes of clients often fell into disrepair. Ms. B. lived in a tightly packed trailer park at the edge of town in a trailer without a door, which had come off the hinges and now sat propped up against the wall. She couldn’t afford to fix it. I meant to ask, but forgot, but at night I imagine that she gingerly set the door back in the frame for some privacy and at least the illusion of security.

Ms. B.’s door was just one of the myriad and quotidian expenses that arose during her time waiting. Even if you had money for food, she said, this new form of unemployed poverty could not be endured without a long list of items that you had always taken for granted. Ms. W. enumerated them for me one day. She had started getting them from a locally-run charity that was a few blocks from her apartment.

> “…toilet paper, paper towels, toothpaste, toothbrush, deodorant...I thank God for what they've done for us, if it wasn't for them, I don't know where I'd be at. Because I didn't have no money to buy this stuff. Excuse me, pads for ladies and deodorant for men. Yeah, thank God for that, ‘cause I don't have no money. They got cold medicine for adults, or NyQuil, or asthma medicine, or anything like that. They got a box full of that stuff. Reading glasses and stuff.

Other things, like door repair, often had to go unaddressed.

### Resentment and Disillusion

After decades of working and paying taxes, many of the Laboring still somehow found themselves owing. Interviewees were often dismayed and angry when they realized that though they were taxpayers and citizens they could make few claims on the state. “I paid taxes…” Mr. R. sputtered, irate that his decades of work afforded him nothing in return. “It kind of makes it look like you don’t do nothing to deserve it,” Ms. A. said,

> But, all my life I worked and took care of my home. And that was what I was meant to do, and took care of my children. I mean, I was a homemaker. My husbands paid taxes. They paid taxes on me and my daughter and my son. And two of my granddaughters. You know, they took care of me and my children. They paid taxes. So why does that not count?

These Interviewees were often embarrassed to find themselves having to apply for disability and relying on charity while they waited. Many waiting clients eventually had to rely on churches, philanthropic organizations, food stamps, and family members just to get by, as reserve armies always require a system of welfare to sustain them during periods of underemployment (Magdoff and Magdoff 2004). But this welfare must remain conditional and uninviting to keep the reserve army ready and incentivized to enter the labor force under the conditions dictated by capital. So the life waiting on disability was never comfortable.

Almost all of the interviewees that had applied for disability were eventually rejected (Only three out of the 21 clients that applied started receiving benefits during my times in Spartanburg.) If you are forced to return to work, you did so even more desperately, and with a gap in your work history. And it couldn’t be good if you have to apply for disability again, clients said—the fact that you applied once and then went back to work. Though I couldn’t confirm this one way or the other.

Once determined by disability courts to be able-bodied, the Laboring had no other choice than to stay employed, for they had been deemed ineligible for government assistance. Because of their chronic conditions they were more likely to be let go at work now, than to get raises.

These Laboring interviewees were often the focus of resentment themselves. Clients were regularly talked about, they said, by neighbors and employers, and people that didn't even know them, as if they weren't really poor, because some of the Laboring still had cars, many had smartphones, and everyone had a T.V.

Their poverty was hidden in this way. This relative material comfort belied their economic precarity. Interviewees applying for disability might still have hairdryers, and stoves, and sectionals—although as mentioned earlier, they regularly sold off assets to make ends meet— but these laboring clients now had to worry about how they were going to pay the light bill, or get around with gas being so high. And some went hungry. Not always, but occasionally. So it was hard to tell just how desperate some people were.

Again, this is why it is instructive to examine the Laboring as a class, rather than a group of individuals of common socio-economic status. Because, from a distance, the Laboring can seem to share the trappings of people getting by. But insecurity is contextual (Hadley and Patil 2006). Clients waited for disability in front of T.V.'s, yes, but they also couldn't afford to see a doctor. Many sat in their houses on broad couches, but only because they had nowhere to go and no money to spend.

Many interviewees suffered precisely because they couldn't seem to get it together in an economic climate that was now ostensibly amenable to employment. One day I asked Ms. C., who had spent several years in prison, about the county's job market. "Yeah, it's promising," she said—just not for her: "I don't know how promising it is for someone that has an injury already and a prison record. That stopped me from getting plenty of jobs and plenty of houses." This was hard on interviewees; as the local economy recovered, the poor prospects of laboring workers were increasingly considered self-inflicted, as opportunities purportedly went begging. There were jobs to be had, people around town said—friends, care workers, and acquaintances—as they wondered aloud about working poor clients' willingness to work.

But rarely did the Laboring complain about the work they had done, at least in interviews, and rarely had these jobs been easy. The poorly-paid work was often tedious and dull, and many interviewees were regularly exposed to toxins and abuse. They had worked these jobs for decades, until they were forced to stop. "I mean, I've been an automotive mechanic for thirty years or more," Mr. R. said, "Working on cars you get in all kind of crazy positions, twisting, I've been in knots under dashes. I'd love to be at work, but I just can't do it."

During my fieldwork I discovered another deep resentment among people only marginally higher on the socio-economic scale than the working poor. This common animosity seemed to be the result of the fact that despite being employed full-time or nearly full-time, these lower-middle class workers often made little more than their neighbors on disability, and could themselves not afford meaningful healthcare.

One day, for example, while she was at a mainstream clinic recruiting doctors for her safety net program, a visiting charity director was treated very poorly by the clinic's secretary. The director was taken aback, she remembered, until toward the end of her visit a nurse approached her to apologize on the secretary's behalf and explain: The clinic’s frontline workers didn’t have insurance themselves, the nurse said, and the woman at the reception desk, who was suffering from a serious health condition, had just been rejected for support by the director’s charity because her secretarial salary had been deemed too high to be eligible for care.

This secretary was not alone. Many frontline safety net workers were in precarious positions themselves. I know, for example, that the person administering the prescription drug plan that some client-interviewees sometimes used wasn’t insured. This larger resentment toward laboring clients seeking disability seemed primarily a result of the uneven and stratified approach to expanded healthcare access in the state.[55]

### Conclusion, Getting Disability, then Precarious Life Continued

Ms. W. had been waiting for her money for four years when she finally got it. But getting disability is not an unequivocal victory, she reminded me. She was still just barely getting by. Once you got a little money, people start coming around and calling you all the time, she said. The years spent waiting had taken a toll on her health and much of her time was now spent in appointments with doctors and specialist. She needed diabetic supplies, hearing aids that worked, and a CPAP mask to sleep. She also needed to see someone about her heart trouble, her high blood pressure, and the cataract that had been bothering her. She was able to buy a used car now to get to

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[55] It should be noted, that while the working poor are often in closer physical and economic proximity to welfare recipients, the laboring individuals I interviewed did not necessarily take a kinder view to the plight of the un/underemployed either, and resented them their purported easy lives of leisure (cf. Newman 1999).

appointments, but had to park it down the block, as to not alert others of her meager windfall.

Contrary to popular perception, life on disability is not a life of ease. For disability is conditional. While receiving benefits did offer a certain amount of stability for the few clients that managed to secure them, mistakes occurred, payments were delayed, and regular post-award reviews were required to remain eligible for aid (c.f. Whittle et al. 2017).

Once on disability, clients had to maintain an appearance of infirmity and incapacity and continually reaffirm, often through the renunciation of the good life, that their claims on the State were legitimate (c.f. Manji 2017). To be clear, I am not suggesting that interviewees' impairments were an act. I just mean that clients had to present themselves in ways consistent with the conceptions of disability held by neighbors, former co-workers, and the State, or risk resentment and sanction. This meant, among other things, not drinking, or going out, or being too idle, or being be too able, or seeming too at ease. It was also best if clients didn't appear to thrive or benefit too much from disability. Finally, you didn't want to appear to have recovered, and thereby risk your hard-fought access to care.

Disability became more attractive to the Laboring as their prospects increasingly diminished. As their health got worse and they got older, it became harder and harder to find work, any work. Mr. P., recovering from a back injury, could not find anyone that would hire him:

> I’m at an age now that most people, they don’t hire older folks over 55 and I’m 59. They figure you’re fixing to retire, you can go to Wal-Mart maybe and get a job at the door greeting people or something. But I, I still can’t stand that long. I have a problem with just standing. But a lot of people won’t hire an elderly. And so, once you get 59, and you can’t find a regular job and you can’t do what you used to do.

As de-skilled employees, the Laboring are not missed as they waited for disability. And not everyone had the time to outwait the reluctant state. The threat of amputation was looming for at least two clients. But not everyone was beyond hope. Many interviewees figured that they could likely have gone back to work if they had regular access to healthcare, as many of their conditions were only debilitating because they went unmanaged.

But the longer the Laboring were forced to wait, the harder it became to just get by. During the wait for a decision on their case, the requirements of dutiful citizenship—to not take under-the-table work, or divert medications, or use the emergency room for care, for example—often drifted even further out of their reach, as poverty and poor health are, to use Desmond and Western’s term, “mutually determining” (2018: 308) and the compounding injuries of class that kept the working poor poor were magnified when they were forced to stop working. Stories of these long waits circulated among clients and had a chilling effect on potential applicants, keeping some interviewees from applying at all. It was hard not to infer a disciplinary aspect to this waiting, or to wonder if the long waits for a decision relied on the desperation of Laboring clients.

## Chapter 7. Conclusion: “Good” Employees, Disciplined by Desperation

*“People are struggling,” Mr. G. told me.*
*“You can’t just up and go to no doctor,” Mr. T. sighed.*
*“Your bills don't stop, and so you gotta go back to work,” Mr. J. said.*
*“We hurting. We see it now, but we didn’t see it back then,” Mr. B. remarked.*
*“I’m trying to do the best I can,” Ms. L. said.*

*—Collected Fieldnotes.*

### Introduction

The uninsured members of the Reserve Army of the Laboring have been deskilled by their infirmities and entrapped in indebtedness. The evermore-precarious jobs they must take as a result of their unattended health conditions are, at once often the only form of deliverance available to them, as well as a source of continuous pain, debility, and poor health. This final chapter is about the resultant desperation of the Laboring, and about how an injurious synergy of precarious labor and qualified safety net care renders impoverished uninsured employees into a tractable and exploited work force.

Laboring clients are often “good” employees in the sense that they must tolerate poor pay out of desperation, take hard work because they have no alternative, and stay quiet in the face of exploitation (c.f. Higgins 2005). Their poor health renders these interviewees a pool of dependent employees that have little recourse when forced to take split shifts, work hours that go unaccounted for, and not report violations, injury, or illness. Consequently, client-interviewees regularly sacrificed their health in unrecognized acts of fortitude just to stay employed. These clients could be exploited *because* of their poor health, and their poor health was often a consequence of their exploitation and the state's policies of abandonment.

The Laboring are subject to another mode of desperate discipline as well: A moral economy[56] of volunteer care that precludes working poor clients from making demands of their safety net care providers. This moral economy can keep the suffering of working poor clients manageable and marginal while stemming the need for medical aid among the uninsured poor.

I will argue here that South Carolina's ailing reserve army is disciplined by these two interrelated forms of desperation. The unmanaged health conditions of the Laboring have relegated Spartanburg's working poor population to bad work with low wages, unpredictable schedules, and the ever-present risk of termination (cf. McAllister 1998). These intersecting forms of labor insecurity have created a debilitating dependence among clients that can force them to absorb an evermore-disproportionate amount of the uncertainty inherent in precarious labor arrangements. The health of interviewees often declined as a result, leaving them increasingly desperate, forcing clients to become amenable patients.

The wage-labor contracts interviewees entered were a form of lawful subjection, as the terms of these arrangements were dictated, and the "agreement" was therefore considered willful and voluntary. But as Banaji points out, this consent is often a fiction; "since labour-power is never disembodied, what employers buy when they 'buy' 'labour-power' is command over the use of workers' bodies and their persons"(Banaji 2003: 71). These contract arrangements have the appearance of an agreement and the

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[56] A moral economy is a set of assumed reciprocal obligations (Minkler and Cole 1997).

enforcement of contracts is done in the name of consent and fairness—another instance of bad faith. For if a worker fails to fulfill the obligations of a contract entered unwillingly, this is still considered a dereliction of the employee’s obligations. But left hidden is the reality that labor contracts are often agreed upon under coercive circumstances. Desperate laboring interviewees, for example, due to their poor health, often have no other recourse but to take increasingly-exploitive work.

It is not my intention to draw a line between free and unfree labor in this conclusion. Instead I want to bring attention to the coercion inherent in circumstances considered voluntary. For without the idea of the noncompulsory contract, you might begin to ask, why would anyone work these low-wage jobs? In the case of the Laboring, I found that it is due to a desperation that stems from their poor health.

### Disciplined by Desperation

With no sick days available to precariously employed interviewees, and the prospect of a loss of a few days’ income unthinkable, members of the reserve army were particularly vulnerable to exploitation. The company Ms. T. worked for had started deducting the time it took for her to get in and out of her safety gear from her lunch break—interviewees often noted that their allotted breaks were slowly being chipped away—but Ms. T. could say nothing, lest she be fired. Mr. J., an upholstery technician, had had emergency surgery after he got hurt on the job one night. “For about like 12 weeks afterwards it was painful,” he recalled, “and [the manufacturer’s name] were constantly telling me they could only hold my job for so much. For so long of time.” Still injured he was forced to return to the production line. “I just had to work myself through it," he said. When I asked Mr. A., who worked at a warehouse out in the county, why he hadn't asked for light duty after he'd suffered a serious back injury, he laughed. "They'd of probably shoved me out the door if I had," he said.

Caught between ill-health and immediate financial ruin, interviewees like Ms. T., Mr. J., and Mr. A. were forced to quietly sacrifice their bodies. "It's like a necessary evil. For me I had to have a job," Ms. O. explained about her work at a processing plant, "but almost everybody…people would be in there with such swollen wrists and hands and the nurse would just put this antiseptic on it and wrap their hands up and then they had to put their gloves back on and send them back to the job." Her hands now, she said, were "useless."

Mr. L.'s health had similarly declined as he attempted to stay employed while injured. When he could no longer work construction due to his bad back, he took a job in a receiving department, driving a forklift, but was let go when the physical demands of this new job became too much for him. Mr. L. spent the next seven years living in shelters and Missions, taking whatever work he could find. He had lasted two weeks at his most recent job, unloading container trucks, until the pain became too much to bear. Now, unable to find steady employment, he had become deeply depressed. He'd just spent nearly a year doing piecework at the city's vocational rehab center, but his job prospects hadn't brightened like he thought they would. During this time he had gotten in bad shape. Coughing spells could make his legs go numb and he would sometimes collapse. Getting up from a chair was a process. The last time we talked he had become desperate enough to consider applying for disability. "I've been going through this for

10 years and I haven't decided to go to sign up for no kind of disability 'cause I want to work. But this is about the last straw," he said hoarsely.

As financial pressures mounted, laboring clients were left with evermore-undesirable strategies of endurance, strategies that provided increasingly short-lived relief from destitution. Ms. F., for example, had had to lie to get a new job, telling the interviewer at the warehouse that she was fit to lift loads of 40 pounds when she was not supposed to lift anything over 10 by doctor's orders, on account of her back. "Course I had to," she explained,

> They ask you the question "Are you able to lift 40 pounds?" and I had to lie and say yes, because I'm not supposed to lift more than 10 lbs. But I needed a job, so...you know, sometimes we have to tell the white lies to do what we have to do. That's what I did. It was a lot of, a lot of lifting at that job.

Ms. F. managed the physical labor for a few months, but was eventually let go. With her warehouse wages she had been able to pay her bills, but just barely. Now she was back looking for work again, and struggling to get by.

Because they were desperate for work, laboring interviewees like Ms. F. did not report injuries or illness, and worked through pain and sickness. Ms. G., for example, was employed at a discount variety store, but believed she would soon be let go on account of her seizures: "As far as [the store], I could fall out and have a seizure, they're not gonna fire me for it, but they are gonna come up with some reason [to let her go]. Because they are going to have all this commotion going on in their store. I mean, I ain't…how am I supposed to work?"

It was from experience that laboring interviewees learned to keep quiet about injuries, as many clients had at some point been summarily fired jobs after they got sick or hurt. Mr. U. had been let go after he injured his back:

> I'm always having to climb all over buildings, and that was being limited by the doctors. So my boss called me up and said he was going to come up and just review my files with me. That was on a Monday. We worked Monday through Friday. Friday morning he fired me. Said he needed somebody that could do the job and he was sorry that I was sick but he couldn't do anything about that.

Ms. N. had had trouble keeping pace on the production line and was fired, only to be fired again. "I can't keep up with it," she recalled,

> 'cause my hand hurting and stuff. And I'm trying to... my hand hurting and I can't do nothing. So I put that [brace] on it, and it helped, but not that good. So they pulled me off the line, so I was doing something else, but then they finally lay me off, 'cause they said they don't need me no more. So I got laid off, then I went to work at [another company in the county], but then my hand got tight, you know, then I dropped things on the floor a couple times and they wrote me up for that and I told him, I can't help it 'cause my hands, I can't do nothing with it so I had to take my time, then when I try to work back in [my hands] got back tight, so I can't do nothing about it. So I got fired.

Mr. Sa. had trouble with his hands too, and had been reluctant to tell his supervisor. Eventually he was let go. "Did they know you had carpal tunnel?," I asked.

> Mr. Sa.: No.
>
> Henry: You didn't want to tell them?
>
> Mr. Sa.: Well, not really, because I was working temporary. I wasn't actually working for the company.

The company, Mr. Sa. knew, was under no obligation to keep him if they found out he was having trouble with the work. So he said nothing and suffered in silence.

The precarious employment the Laboring were relegated to was more often than not attritional work, and without health insurance it was ultimately unsustainable. For while production work may ostensibly be organized with ergonomic safety in mind, it was an open secret that in these precarious jobs, awkward postures, while officially discouraged, were often necessary to fill production quotas. “It’s hectic. You go on these jobs and you be on them all day,” Ms. B. said, “and they really don’t pay that much. But, in order to survive, to get food and a roof over your head you gotta do what you gotta do.”

The work wore you down quick, interviewees said. Ms. C., who was in her mid-forties, did light industrial assembly, and believed that she had already become too old for the work:

> You know, I can’t…sometimes I find myself, just my hands are just like numb. Sometimes I find my hands just like numb and my wrists, like I said, is just continuous pain all the time. You know. It’s…I’m older now and I’d like to think that, “Well [Ms. C.’s first name] you can handle this. You can handle this, it’ll be alright. People are going through much worse than this.” But the pain is here and I can’t deny it.

Often this difficult work was scheduled in grueling shifts, forcing the Laboring to tolerate strange or unpredictable hours. Desperate to keep their jobs, interviewees had no choice but to take opening shifts when they had closed the night before, and regularly endure short weeks that would not pay enough to get by, or pick up long shifts that would leave them without sleep. “I have a split schedule, so my sleeping pattern isn't really good,” Ms. H. explained,

> But I had to do that, in order to work 40 hours a week. In order to pay my bills. I have like a couple of hours of free time before I have my second shift. And that is Sunday evening until Friday night. So I only really have Saturday to myself. And then I have Sunday morning, that's okay too but then I have to work Sunday afternoon.

Many laboring interviewees, unable to schedule fulltime work, had to take several jobs to get by. For, as mentioned in a previous chapter, many of the low-wage jobs interviewees worked weren't really jobs at all, but fragments of work (Small 2000), and the pay was unreliable as a result (cf. Schneider and Harknett 2019)."I've kept two or three jobs at one time," Mr. S. said, explaining how he got by,

> Not full. One full-time job, and then this and that, like my landscaping. I'd go up here after work on the weekends. But I had two, three jobs. Most of my life. Outside of here in the last, I'd say five to six, seven, eight years, I've been narrowing it down to maybe two. And that would be whatever job I'm on and then on the weekends I go out and do a yard or two or in-between.

Ms. V. had worked multiple jobs as well, until she had to stop due to her health. "I used to work two jobs," she said, "I worked at [names of the two employers] in 2010 for 10 years, I would clean there. I like it, but it's not good money. It ain't good. They were about to let me go, because I missed too many days because of my sugar." Having two jobs, didn't mean you could live comfortably, she said, but you could just about survive.

Most interviewees had been able to endure these conditions for decades, but as they got older and sicker, the taxing nature of their work compounded. Mr. Bl., had returned to his job delivering furniture, but was having a harder and harder time. "I can still do work up here," he said, "but if you see me, if you drop a pencil on the floor and I have to pick it up...it's hard for me to get down there. I got to spread my legs and if there's something like this here [a desk] I'll grab it to reach down to the floor because my lower back is just, I broke it a couple of times when I was in my early twenties and I never really paid for it I guess." Mr. B. was struggling too. He had started to have trouble walking a few years ago, which he attributed to several decades worth of long shifts. “Just getting old you know,” he said of himself and his coworkers, “they tell me from working in the plants, 12 hours a day 6 days a week, being on those floors, you got people having knee surgeries, foot surgeries, hip surgeries, so... I've done mine. I've done about like 30 years in the plant.” Laboring employees like Mr. B. endured because they had too. Despite their poor health they would rarely be absent, as their low pay did not allow them to take time off from their precarious positions.

## A Moral Economy of Volunteer Care

Because they are desperate workers, the Laboring are forced to embrace the risks inherent in precarious work. As desperate patients, members of the uninsured reserve army must suffer the compromises of the qualified care of the safety net. That is, clients must remain grateful in the of face obvious short-comings of care, regularly tolerate advice that is not practical or even actionable, and make due with the county’s underfunded medical aid. These expectations are signaled and justified through a moral economy of volunteerism.

In Spartanburg County, this moral economy has left the state’s safety net unassailable to accusations of neglect and inefficacy. For the rationed care of the safety net is conditional: in return for this volunteered medical treatment, clients are obligated to become autonomous agents of their own health and to assume responsibility for their social and economic circumstances (cf. Adams 2013; Han 2012; Petryna 2013).

A decades-long erosion of workers’ rights has forced poor South Carolinians to tolerate exploitation, domination, and disenfranchisement at the hands of their employers, and the volunteer-run clinics of the safety net have allowed their clients to endure the consequences. As a result, the problem of under-insurance goes under-recognized as patients, even patients with life-threatening conditions, stop seeking care, discouraged and disenfranchised (Becker 2007). The failure of the safety net is conceived as the failure of the clients, re-conceptualized as issues of non-compliance or the result of a lack of dedication or need among patients. These inequalities were rendered natural and inevitable in the ostensibly apolitical space of the safety net.

In South Carolina, the state's qualified distribution of volunteer medical care, meant to support vulnerable populations, effectively functions as a deterrent and aids in the disciplining and exploitation of the Reserve Army of the Laboring. Desperate clients like Mr. Pa., deterred by meager care and distant appointments, rarely used the safety net unless their conditions were unbearable. "It's a push come to shove thing," he said, "You know. If you go and try and go there, just say right now I go to the doctor, I ain't got no insurance. Well, they gone give me an appointment. They gone set the appointment waaay off, you know? Two weeks, three weeks from now."

But there was no clear target for clients' resultant frustrations. The safety net institutions, most interviewees believed, were just making do with the resources they had. "They do what they can," Mr. Bl. said of the free clinic. Ms. Ma. agreed, "You know, they do what they can," she said, "but they're very limited. I mean they are just incredible and the people are incredible but they are just very limited." Furthermore, interviewees were reluctant to criticize the safety net staff that were donating their time. When I asked Mr. Cl. about the care he had received at the free clinic, he said it was not nearly as good as insured care. But then he stopped and reminded himself, “I mean they like volunteer for [the free clinic],” he said, “…they volunteer their time.”

This moral economy of volunteerism kept clients patient. It also disciplined interviewees by keeping them disinclined from seeking care. Many clients echoed Ms. H. sentiment when she said, “I'm hoping that I'll be able to find a higher-paying job and get insurance on my own. Because [the free clinic] is very helpful, but I just look at it as, if I'm out of their way, they can help other people.” Ms. E. too, regularly deferred care until things became intolerable: “Because, you know, there’s so many other people.”

## Conclusion

The safety net care system is a system that renders the catastrophic into the ordinary (cf. Povinelli 2011). It naturalizes the social suffering and ill-health of the working poor by managing the systemic crisis of poverty-related ill-health, always keeping it just this side of disaster. This medicalization of inequity renders social problems into individual pathologies, and turns crises into the commonplace. For many clients, the safety net did not so much catch them as slow their descent so their fall wasn’t immediately deadly. For many of the Laboring this provisional care was likely all they would ever have.

As a result, the wide-spread exploitation and consequent ill-health related to precarious labor arrangements remains ordinary, occurring through attrition rather than calamity: debility or death after years spent working in a poisonous mist of polish, or particulate, or paint.

Consequently, the plight of the Laboring is often more easily recognized by actuaries than acquaintances. Here ethnographic fieldwork can help render visible and explain those aspects of exploitation and Slow Death that are effaced and obscured in contemporary, neoliberal capitalism. Ethnography can reveal how in the modern South, poverty does not have to be abject to be debilitating or deadly**.** With that in mind**,** this ethnographic work has sought to complement, contextualize, and build upon quantitative analyses that have established associations between precarious labor and poor health.

The precarity experienced by members of the reserve army is easily overlooked and often elided, as the poverty of the Laboring is not abject poverty (Shaefer and Edin 2013), nor is the laboring life the life of exposure that accompanies homelessness (cf. Desjarlais 2011) or absolute social abandonment (cf. Biehl 2013). Nor is the health of the Laboring determined by an outright absence of care (cf. Livingston 2012), or the immediate consequence of catastrophe (cf. Adams 2013). Instead, the attritional labor that members of the reserve army are relegated to simultaneously reproduces and attenuates life.

Also overlooked is the role that underinsurance and ill-health plays in maintaining a vulnerable, desperate, and tractable low-wage work force. For the continued immiseration of South Carolina’s working poor is not an aberration, but rather an integral part of an economy that has produced this laboring reserve army.

The plight of the Laboring is not the result of mischance, but of exploitation and domination. The ill-health of clients renders them into “good employees” as this reserve army is compelled to tolerate precarious labor arrangements for a lack of alternatives, enduring the onerous working conditions and low wages that benefit employers. In addition, a moral economy of volunteer care precludes these working poor clients from making demands of their care providers, while precarious labor arrangements and the stripping of workers' protections have obligated laboring Upstate residents to remain tractable and compliant in the face of exploitation and immiseration. The safety net tempers expectations and silences dissent through this moral economy.

When I asked safety net administrators why their charges were referred to as "clients," I was told that it was a way to recognize the autonomy of patients. But safety net patients are not allowed to make demands and cannot bargain as they are not in a position to walk away. If anything, they are clients in the other sense of the word: dependents. They are called clients, but instead must act as supplicants.

## Coda

This dissertation is the culmination of my graduate career, but feels like the beginning of something, more than anything. As I wrote the preceding chapters a new ethnographic agenda began to emerge, spurred by the host of questions that went unanswered during my fieldwork due to limits of time, resources, and access. I would like to conclude by charting a tentative direction for my future research.

Capitalism is often a monolithic and iniquitous force in this dissertation. The voices of managers and manufacturers are heard only indirectly through the stories of the Laboring. Without nuanced and emic understandings of the logistics and dynamics of administering and developing systems of low-wage work, an examination of precarious labor is incomplete. The next step in this ethnographic project would be to “study up” on these employers.

Similarly, the State is only heard from second-hand in this ethnography, through the experiences and resentments of laboring clients. As a result this complex and multivalent entity can come across as impenetrable, unknowable, and often spiteful in the chapters above. Future research would explore South Carolina’s safety net health care system from the perspective of state administrators, legislators, and officials, in an effort to render legible the competing, sometimes contrary, actions of the departments of the capital “S” State.

My next project will likely also see me return to the free clinic and other philanthropic organizations, for although this dissertation is about safety net medicine, there was much of this subsidized care that I was not able to observe. For while free clinic physicians were on the whole kind and patient, they were also busy, and occasionally suspicious. Rarely was I able to sit down with volunteering doctors for more than a few minutes at a time. Furthermore, with few exceptions, all I saw of safety net operations were staff offices, parking lots, and waiting rooms. Of the direct interactions between clients and care providers I saw very little, and as a result I have relied heavily on the recollections of interviewees to get a sense of what these appointments were like. Consequently, there are many questions I have yet to systematically ask of care providers. In future studies I would like to interview safety net staff about their experiences providing medical care in a setting of rationed aid; about the effects of unstable employment and a lack of insurance on their patients’ health; and about the strategies and resources clients use to manage their medical crises and mental distress in lieu of regular access to healthcare.

Finally, in this dissertation I have used a broad brush to sketch the experience of laboring life common among working poor clients in Spartanburg County. As a result, readers might find a curious silence on the experiences of race and gender in the preceding pages. In subsequent work I would like to focus on how legacies of racism, and the gendered expectations of work inform the lives of the county's laboring workforce. In this dissertation, however, my project, while recognizing that the experiences of working poor clients are complex and diverse, was to underscore patterns and commonalities shared among the Laboring population.

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I still talk to Ms. W., and she is doing better, but her time spent laboring is evident. It's likely that her decades of work have permanently ruined her health. And although she's now on disability, things are still hard. She seems to be still waiting, but I can never entirely figure out on what. Sometimes I am not sure she knows herself. "I'll get there," she'll always say to me. But it's never entirely clear where "there" is.

# APPENDICES

## Appendix A: Biographical Sketches of Interviewees

**Demographic Breakdown of Interviewees:**

| | African-American | White | Total |
|---|---|---|---|
| **Female** | **14** | **8** | **22** |
| **Male** | **10** | **14** | **24** |
| **Total** | **24** | **22** | **46** |

**Note:** An asterisk (*) next to a name denotes a key informant.

**Mr. A. (African-American, late 50s)** Mr. A. was a tall, slim man, suffering from pancreatitis. He had been living at the mission when he heard about my research from Mr. H. He had worked a number of jobs in Spartanburg and in the surrounding county, a few of which had provided health benefits. He believed that there were a lot of job opportunities in the area and that people that did not have steady employment were likely not applying themselves. Mr. A. was an anomaly among the clients I interviewed in that he was the only interviewee to have never suffered from depression.

**Ms. A. (White, mid-40s)** Ms. A. was lonely and deeply depressed. She'd been a homemaker most of her life, she said. Now she was divorced, and estranged from her adult son, her only family left in Spartanburg. To manage her severe back pain, Ms. A. bought products she saw on T.V., like Australian Dream, a cream for arthritis relief. She couldn't stand the South Carolina heat and swore to herself that she wouldn't spend another summer in Spartanburg.

**Mr. B. (African-American, early 50s)** Mr. B. had accumulated a variety of medical problems over the last decade, including a severe recurring respiratory allergy that had almost killed him one night outside a local emergency room. Despite his failing health, Mr. B. still worked long hours, and he attributed his recent hip problems, which had left him unsteady on his feet, to his years of work at one of the county's plants.

**Ms. B. (African-American, late 40s)** Ms. B. lived in a dilapidated trailer park off a main thoroughfare, surrounded by used car lots and industrial buildings. Her trailer was small and clean, but lacked a door, making the structure seem like more of an emergency shelter than anything. Ms. B. lived with her boyfriend, who sat in a chair nodding off throughout our interview. She was a room attendant at a hotel, and had worked in restaurants.

Ms. B. suffered from depression and anxiety along with a host of other physical ailments. When she talked you saw that her front teeth were dying. The park she lived in was a little run-down, but didn't look particularly dangerous. However, Ms. B. would regularly halt our conversation, suddenly and nervously, when she heard a noise outside.

**Mr. Bl. (White, mid-50s)** The first time I met Mr. Bl. he told me he had tried to kill himself the previous month. He had struggled most of his life with anxiety and depression, he said, and took a bunch of prescription drugs, some prescribed, some diverted. He had been employed at a local furniture store until his depression and alcoholism overwhelmed him. During my time in Spartanburg he worked a few nights a week at a gas station. Opposed to receiving food stamps for most of his life, he now grudgingly accepted them.

**Ms. C. (African-American, Mid-40s)** Other than the few years she spent in prison on drug-related charges, Ms. C. had worked on assembly lines and in plants nearly her entire adult life. Like many interviewees, she had arthritis in her hands, and it made her assembly work difficult. And like most of the interviewees with felonies on their record, she had had a difficult time finding gainful employment after being released from prison.

**Mr. Ca. (White, early 40s)** Mr. Ca. lived at the end of an aging trailer park. His trailer looked, from the outside, like it had been abandoned and been left to be reincorporated into the woods. Mr. Ca. was a tall man with black teeth. During our first interview he revealed that he was just over forty, which I wouldn't have guessed. He seemed to be many lifetimes older.

Mr. Ca. lived with his deceased wife's brother, who I never saw. He was, according to Mr. Ca., in the back sleeping, even though what must have been a good-sized dog barked and scratched from within the bedroom for the entire hour I was there.

Mr. Ca. answered my question with "sir" several times. He had started smoking at age 10 and now, 30 years later, struggled to even get to his mailbox. His wife had cirrhosis of the liver, as did he. He said he'd been depressed since his wife's death a couple of years ago and was very forthcoming about how difficult it had been for him, mentioning that the first time he had gone to the free clinic he had cried in front of the doctor.

Mr. Ca. was trying to get on disability, but had had no luck. He had frequent seizures making it difficult or dangerous to do any construction work, his previous occupation. He had installed carpet for a long time and believed the fumes from the glue used to connect the seams of carpet may have contributed to his condition, though his father and his aunt suffered from seizures as well.

**Mr. E. (White, mid-50s)** Mr. E. was embarrassed by his circumstances and considered his depression a consequence of no longer being able to provide for himself. He was, until recently, also in great pain much of the time, which Mr. E. figured to be another source of his depression. The pain, he said, had been so severe that Mr. E. could hardly remember the last two years. A philanthropic organization had paid for his back surgery and he was doing better. But his new job cleaning at a church, which was about all he could manage right now, he said, did not pay much.

**Ms. E. (White, early 40s)** I texted Ms. E. the day of our interview to confirm our appointment at the library. She texted back immediately asking if we could start 15 minutes earlier than agreed upon, which was unusual. I said that would be fine and arrived early at the library. Once there Ms. E. texted me again saying she would meet me at the original time.

She was desperate for the money, she said. At the end of our short interview she seemed overjoyed when I handed her the little envelope with a twenty-dollar bill in it. She was the only interviewee ever to look at the money before parting; she took the bill out of the envelope and shook it happily. Her mood, which had been erratic during the entire interview—she teared up unexpectedly several times—became manic. Few questions interested Ms. E.; the only thing we talked at length about was the hassle of using local public transportation.

As the interview was winding down—after about half an hour I couldn't think of anything else to ask—Ms. E.'s husband called and she spoke to him nervously for a few minutes. She told him the interview had gone over the agreed upon time (an hour), which it hadn't—we'd only been there for barely 30 minutes, and said she was almost done. The interview was nearly unusable.

**Mr. F. (African-American, early 50s)** Mr. F. had applied for disability and been denied. The process was impossible to successfully navigate, he said, unless you had a lawyer. Once denied, Mr. F. had no choice but to go back to work, despite a myriad of health problems. He didn't disclose these problems—many of them likely the result of his poorly-managed diabetes—to his supervisor at the plant. He would be fired if he did, he said.

**Ms. F. (African-American, early 50s)** I met Ms. F. in one of the small study rooms of the main branch of the county library. Sitting down, she appeared much younger than her age (50), but when she stood or walked, which she did slowly and gingerly, she seemed to age suddenly. Despite her fragile health, Ms. F. worked a job at a warehouse and took care of her cousin's children several days a week. The boys, she said, were a handful and she would be glad when she was released from the obligation.

**Mr. G. (White, early 50s)** Mr. G.'s embarrassment of his circumstances would regularly turn into rage, he told me. He had had a bad experience with the free clinic recently. His back had gone out and the clinic staff, unable to treat Mr. G.'s complicated condition, referred him to a specialist. The specialist, Mr. G. told me, turned out not to be accepting new patients. With nowhere to turn, Mr. G. became angry and easily frustrated.

In an effort to find steady work, he applied for a security guard course, which he paid for out of his own pocket. But on his first assignment he found out that being a security guard often requires computer skills and Mr. G. had never been good with computers. He left the job soon after being hired. He was now working little manual labor gigs here and there, when his back allowed.

**Ms. G. (African-American, mid-40s)** Ms. G. had moved to Spartanburg from the West Coast several years ago to be with her ailing mother. Yet it seemed like it was her mother that now took care of Ms. G., driving the younger woman to appointments and supporting her financially.

Ms. G. suffered from bipolar disorder and had occasional seizures, and was often tired during our interviews. She had insomnia and sometimes drank to go to sleep. She also had osteoarthritis, long bouts of bronchitis, and trouble with her knees. When I asked her if she felt she was better off financially than her parents were at this point in their life, her answer was an empathetic "no."

**Ms. Gi. (White, early 50s)** Ms. Gi. came to the interview dressed in all black and had a large tattoo of Calvary on her arm. She was going to cosmetology school with a bunch of 20-year-olds, she said, explaining her attire.

She had been a homemaker for much of her life. Now, after being separated from her second husband, Ms. Gi. was on her own. She had grandchildren in the area, but didn't seem to be in contact with them. She'd been in an abusive relationship, she told me, and was going to school for a job in which she likely wouldn't last (due to her many physical ailments such as arthritis and neuropathy). She had suffered from depression all her life, she said.

**Mr. H. (White, late 50s)** For much of my fieldwork Mr. H. had lived at the mission, trying to get his life back in order. But once he became too sick to work, he transformed into a fixture downtown, where I would regularly see him navigating the sidewalks in his motorized wheelchair.

For a year or so he seemed alright. But then he began to deteriorate rapidly. The doctors at the free clinic gave him only a few months to live, but he was still alive six months later. Then I got a text from him out of the blue. Could I bring a stylus to the hospice on the county line? He was unable to use his phone with his fingers anymore and he wanted to contact his family. I barely recognized him when I saw him; he was so thin. Despite his circumstances he let me ask him questions about his life.

His family was not going to come see him it seemed, and so we made plans to talk again soon. A few days later his text ceased.

**Ms. H. (African-American, late 40s)** Ms. H. was originally from the East Coast. She was recently divorced and aside from the serious health condition that had brought her to the free clinic—uterine fibroids—she seemed healthier than most of the interviewees that I had interviewed. She had a piecework job, and her paycheck fluctuated accordingly each month. Sometimes, during lean months, she was forced to skip meals. Nevertheless, Ms. H. volunteered her time when she could, most recently for the Red Cross.

**Mr. I. (African-American, early 50s)** Mr. I. had had some recent health scares. And like many interviewees, he had been to the emergency room recently. He felt like he was having a heart attack, he said (he had had one once before). A few months earlier he had injured his hand and went to the E.R. in the middle of the night after the pain became unbearable. To manage his on-going pain issues, Mr. I. would get prescription medications from friends, or sometimes buy them from acquaintances. Buying pills, he said, was expensive, and he couldn't always afford them. His pain was poorly managed as a result.

**Mr. J. (African-American, early 50s)** Mr. J. was tall and imposing and used a cane to get around while he was recovering from hip surgery. Over the years he had suffered a long list of injuries. Some from accidents he had been in—he didn't drive anymore, but it was unclear whether that was because of his medical conditions or his DUI—others, including hip problems and carpal tunnel syndrome were the result of decades working in the plants. He was also depressed, but had gotten help, in the form of Prozac and talk therapy. He said he found it helpful to have someone to talk to.

Mr. J. had applied for disability, but after almost a year he had to return to work; he couldn't manage any longer without an income. (Mr. J.'s wife made a little over 10 dollars an hour, which ended up disqualifying him from certain forms of safety net aid).

Mr. J. had worked in the plants and mills for decades, but on a bad hip he now struggled with the long hours (12 hour days during the busy season, often 7 days a week). He said he was nearing the end of his life, although he was only 53.

**Ms. J.* (African-American, mid-50s)** To get to Ms. J.'s neighborhood you drove past a set of abandoned project houses: tan, split-level, identical and empty. Her neighborhood, Ms. J. said, was a drug-trafficking area. There were two bright yellow signs posted on her house warning potential intruders that they should be less concerned about the dog in the yard and more worried about the armed owner within. Each sign featured a picture of a pistol, so that while reading them you were looking down the barrel of the gun.

Ms. J. suffered from a degenerative disc disease and had difficulty standing. She had recently fallen down her stairs a few times. During our first interview she showed me all her medications, which filled two dopp kits. Eventually the side effects of these medicines would leave Ms. J. unable to work. The last time I spoke to her she had applied to disability and talked about the depression that came from being alone and unemployed.

**Ms. K. (African-American, early 50s)** Ms. K. really shouldn't have been driving, she said, due to all the medications she was taking. But she had no other way to get to work; she'd recently split from her fiancé and her children all lived in the neighboring county. Ms. K. worried about taking all those drugs she had been prescribed. She needed them to manage her pain and depression, but was not supposed to work around machinery, which was her job, while on them. Yet these drugs also allowed her to continue to work despite her arthritis and her bad back and her depression.

**Mr. L. (White, mid-50s)** Mr. L. had suffered a serious back injury at work several years ago, lifting heavy equipment off the bed of his truck. He returned to work the next day, and managed to stay on the job for a few more weeks. But eventually the pain, which turned out to be the result of a ruptured disc, left him unable to work. His health and his job prospects had spiraled ever since.

Mr. L. had spent the last few years working odd jobs and staying at the mission. He woke up deeply anxious, he said, and had been depressed to the point of wanting to end his life. Nevertheless, Mr. L. continued to look for work, taking training courses and applying to the county's vocational rehabilitation program. He used to be happy, he said. He was never depressed before he injured himself, he told me.

**Ms. L. (White, late 40s)** Toward to the end of my time in Spartanburg, Ms. L., sick, depressed, and at her wit's end had reluctantly applied for disability. Not even her grown children knew how much pain she was in or how much debt she had accrued. She regularly suffered severe migraines and still had leg pain from a car wreck she was in a decade ago. The free clinic doctors, she said, refused to give her anything for her pain.

**Mr. La. (African-American, mid-50s)** Mr. La. had recently had hip surgery. It was his second. His first surgery, a hip replacement, had failed when his hip came out of place. He also suffered from spinal stenosis, a painful pinching of the spinal cord, and from carpal tunnel syndrome. Despite these ailments, Mr. La. had been pressured by the plant that employed him to come back to work shortly after his last surgery. Ensuing health complications had forced Mr. La. to regularly call in, or take days off, and he was sure he would be let go soon.

**Ms. Lo. (White, late 40s)** Ms. Lo. said her depression started in her late twenties, when she was employed in a good job. Now she struggled to get by, working at a gas station at night. Ms. Lo.'s family helped her when they could, but they were poor themselves, and sometimes they needed money from her. Like many of the laboring women I interviewed, Ms. Lo. had an abusive partner. She stayed with the man, she intimated, because she couldn't manage financially on her own.

Ms. Lo. had trouble managing her diabetes and was forever tired, she said.

**Mr. M.* (African-American, mid-40s)** Mr. M. lived right off an industrial exit, in a large housing complex that appeared to be almost completely devoid of people, save for some men and a woman standing on the corner. The few cars parked in largely empty parking lots suggested that people did live there. But the windows of most apartments were closed up and covered.

Mr. M. was talking on the phone as he let me in. Trying to get himself an ID card, he said. The windows in the room were covered with thick curtains that made the apartment seem a bit like a tomb.

From what Mr. M. said, the neighborhood must not have been particularly safe. He closed the back door telling me, cryptically, that you never knew when kids would try to force it. He kept the few pain pills he had upstairs, separate from his other medications. You never know if you'll find your medication in the house when you return, he said.

Mr. M. was blind in one eye, suffered from pancreatitis, and had been in a severe car accident that kept him from getting a job. A doctor had written a note stating that he was unable to walk more than 100 feet at a time. He had a pin in his leg and walked with a cane (donated by a philanthropic organization). He had been trying to get on disability off and on since 2002, he told me.

**Ms. M. (African-American, late 40s)** Ms. M. had become increasingly desperate. She had worked a series of minimum wage jobs, most recently doing custodial work. But when her back went out, a long-standing injury that she attributed to a car wreck she had suffered as a teenager, she had to quit working. Ms. M.'s family would sometimes help her with bills, but it was not enough and so she decided to apply for disability. When I met her she had recently been denied, but was in the process of hiring a lawyer. She didn't know how much longer she could wait, she said.

**Mr. Ma. (White, mid-50s)** Mr. Ma. was so depressed that I eventually cut our interview short. He was a big man, so it didn't surprise me when he told me he had played college football. He wore the shorts and shirt of the team he had played for, along with pale medical hose for his varicose veins. He was originally from up north, but had been living in Spartanburg County for decades and had no plans of leaving.

As an interviewee, Mr. Ma. wasn't as forthcoming as others. But he tried to answer all my questions. He had been having trouble with his heart the last few years, and his condition made him anxious and depressed. Occasionally he would unexpectedly fall out.

On the way home Mr. Ma. asked to stop at a Chinese restaurant by the interstate. He said he hadn't had a good meal in a while, and the place had a $6.99 all you could eat lunch buffet.

**Ms. Ma. (White, early 50s)** Ms. Ma. was deeply tanned and dressed for tennis when we met. But she'd never played. She had back issues, COPD, and an aortic thoracic aneurysm she had to keep an eye on.  She would not have had time anyway; her days were spent taking care of her mother and her son, who was on the autism spectrum. Eventually, Ms. Ma. applied for disability. She believed that it was the judge that made all the difference in disability hearings.

**Ms. N. (African-American, mid-50s)** Ms. N. had bravely persevered through daunting adversity her entirely life, yet felt like a failure. Her devastating depression had been with her her entirely life, she said, but had recently been exacerbated by her poor health and a bad break up. She took a half-dozen medications for her various conditions, and the drugs left her dazed and dizzy, but still in near-constant pain. As a result she rarely left the house, other than to drive to work.

**Ms. O. (African-American, late 40s)** Ms. O. lived on a quiet street about a mile from downtown. The houses on the street were big, but old and disheveled, and Ms. O. lived in a converted garage behind one of them. She would usually dress in shorts, tennis shoes, and a t-shirt, often featuring some kind of a palmetto or a breast cancer ribbon. She had been addicted to crack cocaine for almost two decades and had spent 5 years in prison, where she found religion. Ms. O. had had a very difficult life, but she told me about it freely. She was stoic throughout most of our time together, but rarely looked at me when she was talking about the hardships she'd experienced. Usually she stared off behind me, seemingly reliving events as she was recalling them.

**Mr. P. (White, late 50s)** Mr. P. used a cane to get around. He was getting old, he said, and couldn't work like he once could. He was embarrassed about his circumstances: unable to keep a job, and reliant on family and acquaintances to get by. His bad back and the pin in his leg—the result of a serious car accident many years ago—left him unable to stand for very long. He had thought about applying for disability but didn't believe he could wait out the State. Overwhelmed by his circumstances, Mr. P. had tried to kill himself. Now he was on medication.

**Ms. P. (African-American, late 50s)** Ms. P. said she was falling apart. She had "feminine issues," and nerve pain, and an on-the-job accident in the '80s had left her with severe back problems. Yet Ms. P. was reluctant to tax the safety health care system, for fear that she might be taking the spot of someone more deserving.

Ms. P. took care of her mother as much as she could. Her extended family, her aunts and uncles, were of little help, she said, and they believed that Ms. P. was exaggerating her ill-health. Eventually, sick and overwhelmed and with no one to help take care of her mother, Ms. P. decided to apply for disability. The last time I saw her, she was still waiting.

**Mr. Pa. (African-American, mid-40s)** Mr. Pa. was very sick and slurred his words, sometimes I had difficulty understanding what he was saying. The free clinic had told him that they couldn't do much for him, and that Mr. Pa. should try to get some money together to see a specialist. But Mr. Pa. seemed in no shape to work. He had trouble walking, and while his responses to my questions were clear and thoughtful, his movements and speech were halted and slow. Among his many ailments, Mr. Pa. had COPD, and he tired easily. During our interviews I sometimes became anxious as his breathing would regularly turn into a wheezing pant.

**Mr. Q. (African-American, early 50s)** Mr. Q. had been in and out of jail several times in the last few years, the last time for failing to pay child support. Despite working several jobs, some of which were under-the-table arrangements, Mr. Q. regularly failed to make enough money to make the support payments.

He mowed yards on the weekend, he said, and did landscaping work for a few regulars. During the week he worked construction for a man he knew from church. He was grateful for the work, he told me, but it didn't pay much. It did however afford him some flexibility as to his schedule, which was necessary, as Mr. Q., prone to severe migraines, had to regularly miss work.

**Ms. Q. (African-American, early 50s)** Ms. Q. was lonely and depressed. She had divorced her husband recently, and like several other interviewees, now relied on her parents for financial support. She had heart trouble and suffered a variety of diabetes-related complications. Long unchecked, her chronic conditions had multiplied. She was losing hope, she said.

Eventually, Ms. Q. applied for disability.

**Mr. R. (White, mid-50s)** Mr. R. was missing some teeth and needed a cane to walk. But he seemed healthier overall than Ms. R., his partner. He had been fired from his job after arguing with a woman at work, a woman who, according to him, had lied and cost him his unemployment. The disagreement had something to do with the amount of work Mr. R. did. He was hurt and couldn’t do as much work as he once could, he told me, seemingly trying to convince me.

Mr. R. had back trouble that had been left untreated and had resulted in nerve damage and hip troubles, and he said he was going to apply for disability. Once our interview ended, he asked me if black applicants had a better chance of getting disability. I said everyone seemed to get rejected the first time. He then added that he wasn’t racist: he had black friends, but said he knew a “slick” guy who had gotten it on his first attempt and wondered why.

**Ms. R. (White, mid-50s)** Not all interviewees looked sick, but Ms. R. definitely did. She was thin and wan and shaky. Her and her partner slept in their truck in the driveway of a friend’s house. Ms. R. had heart trouble: heart congestion, fluid on the heart, high blood pressure, and a slow heartbeat. Her condition had made her depressed and anxious. She had recently been let go from a job waiting tables, and I wondered to myself whether it might have been because of her sickly appearance. She appeared so sick that during our interview I became anxious for her. Despite her frail condition, Ms. R. was patient with me and thoughtful about her answers to my questions, and at the end of the interview said that she had enjoyed the process, although she had come close to crying several times during our visit.

**Mr. S. (White, late 40s)** Mr. S. lived in an apartment complex with an idyllic name set along a road populated only by other apartment complexes with idyllic names. His complex was slightly run down. There was no sidewalk to connect the apartments, which were clustered around the remnants of an old tennis court.

Mr. S. kept his apartment dark, perhaps to keep out the heat, but I don’t remember it being particularly hot that day. There were no lights on in any of the rooms. He brought a lamp missing its shade into the living room for my interview so I could see my notes while we talked. We sat in two chairs facing each other. The living room was stacked with boxes. The couch was piled with clothes. The apartment was his ex-mother-in-law’s, a woman he got along with well.

At one point during our interview, Mr. S. scratched his leg to the point where it started bleeding. His neck was also swollen quite a bit and his pupils, something I usually don't notice on people, were particularly small. He told me a couple of times that I should keep his interviewee fee. He was the only client to do this. I told him I was obligated to give it to him.

At one point during the interview, we were interrupted when his cousin, who worked at the hospital, called him wanted to sell him some prescription pills.

**Mr. Sa. (White, late 50s)** Mr. Sa. said he would "fudge" the depression questionnaires safety net providers regularly asked patients to fill out. He didn't want to be institutionalized, he said, and he believed that his condition would be dismissed as "dramatics." But his depression, he admitted, was severe. During our interview he talked about how hard it was to find employment in your late 50s. If you are older and partially disabled, how are you expected to find work?, he asked me.

Like many of the people I interviewed, Mr. Sa. seemed to be estranged from his family. He no longer talked to his son, and consequently never saw his grandchildren. I tried to ask him about this, but he was evasive.

**Ms. T. (African-American, mid-50s)** Ms. T. had lived a hard life, but seemed to refuse the idea that others around her, her neighbors in her modest neighborhood for example, could suffer similar circumstances. She identified the people that walked by her house while we sat out on her porch as drunks, drug addicts, malingerers, and welfare scammers. Like many interviewees, Ms. T. had arthritis in her hands. She would eventually lose her job on the assembly line after the pain in her hands became unbearable. She now had trouble holding almost anything.

Unemployed, broke, and with no way to get around, Ms. T. became depressed. She longed to see someone about her worsening mental health, she said, but couldn't afford it.

**Mr. Ta. (White, late 40s)** The pain in Mr. Ta.'s legs and hands would keep him up at night. Neuropathy, he said. You don't want to have that, he told me several times. He was always tired as a result.

Mr. Ta. was also depressed much of the time, and his depression made it difficult for him to work. He had always enjoyed working with cars, and had worked in a garage for a while, but now mowed yards and took informal construction work here and there. He was unclear about why exactly he no longer worked as a mechanic. He had been to prison for a little while, but would not say much about it.

**Ms. V. (White, early 40s)** Ms. V. wasn't physically fragile, or she was, but she seemed much more fragile in an existential sense than anything. It was hard to explain. Her voice was shaky, and I couldn't always understand her. And sometimes it seemed like she couldn't understand me. She was pale and her attention could shift unexpectedly. Her nail polish was chipped to the point that it was almost gone on some of the fingers, and somehow that felt significant to me. At times she seemed so delicate that it made me nervous for her, and I couldn't imagine her moving about the world.

Ms. V. said she was depressed. The two jobs Ms. V. had worked didn't pay much and she lived in a trailer behind her parents' house. She had been a cashier once. Now she didn't feel like she could work; she had ulcerative colitis and feared having an accident. She was also depressed. An overwhelming lethargy kept her from looking for a job, she said.

**Mr. W.* (White, mid-50s)** Mr. W.'s whole family was from Spartanburg County. His father, who died when Mr. W. was young, had been a warehouse supervisor at one of the county's largest mills. Mr. W. had worked construction, until he slipped a disc in his back. He had gone to a doctor, but was told that his injury was not serious enough to warrant surgery.

In an effort to find steady employment, Mr. W. signed up with the county-run vocation rehabilitation program. There he did piecework, sometimes for less than minimum wage (he said you have to get good at the work before you can make any money). The program gave you a certificate if you completed a certain number of hours. Once Mr. W. earned his certificate the program began to send him out to jobs. But with his bad back he was physically unfit for any of the work.

**Ms. W.* (African-American, mid-40s)** Ms. W. could not hear all that well when I met her—she had been partially deaf from birth—and over the course of the next two years her hearing seemed to get worse and worse. She always talked about getting hearing aids; hers had broken sometime before I knew her, and she was unable to afford new ones. At one point her hearing got so bad that when we met it seemed like she just guessed at my questions.

Ms. W. lived with her boyfriend in an apartment building that always smelled of carpet glue. Over the course of my fieldwork I talked to Ms. W. dozens of times and came to know a lot about her life. She had had a traumatic adolescence. She'd been raped, had a boyfriend "jump on her," (she was vague about what that meant), and had a difficult relationship with her mother.

Ms. W. had been depressed nearly all her life. After her mother had turned her out, she had trouble sleeping. The depression medication she got from the free clinic kept her tired, she said. She also had a host of physical health problems: arthritis, migraines, a bad back, high blood pressure, heart issues, trouble breathing, regular infections, sleep apnea, vision problems, and a bad knee.

Ms. W. told me she was fired from several jobs for being unable to hear. Due to her deafness she missed meetings, misunderstood instructions, and unintentionally ignored alarms. During these periods of joblessness, she had thought of killing herself, she said. Then, about a half a year into my fieldwork she applied for disability and over the course of the next year and a half we waited. At the end of 2018 she was approved.

**Mr. Wa.* (African-American, late 40s)** I picked Mr. Wa. up from the Mission and drove to the library for our interview. He couldn't walk the few blocks because of a painful sore on his leg, the result of the “traveling blodclots” that had been plaguing him since around 2002.

In our interview, Mr. Wa. was very forthcoming. He seemed happy to talk. He had worked all his life, he said, and had always been very active until he began having health issues. Mr. Wa. had done a few stints in jail for failing to pay child support. He said that this was due to the fact that he couldn’t work regularly. The work he did do, landscaping, construction, etc., he did for his pastor, and it paid poorly.

Mr. Wa. said that he suffered from depression due to his dwindling prospects. A few years ago he would have been “embarrassed” to participate in an interview like the one we were engaging in, he told me. Twenty dollars, he said, “wasn’t nothing then.” But now he was considering applying for disability.

**Mr. U. (White, mid-50s)** Mr. U., by his reckoning, had been let go from his last job after he injured his back. The work had required him to climb ladders and navigate roofs and once his employer found that Mr. U. could no longer keep up with the demanding work he was fired.

Mr. U. relied on diverted pain pills to manage his back pain. He had gotten a prescription for Oxycodone from a doctor but was unable to afford to fill it. Mr. U. also suffered joint pain and his ankles would swell up to the point where he was unable to walk without the assistance of crutches. During our interview he told me that he had been to the E.R. three times in the last few months.

## **Appendix B:** Interview Questions

**Note:** Below is the set of interview questions I used for client interviewees. “Grand tour” questions are in bold. I did not ask these questions in the order they are found in below, instead I always began by asking interviewees if they had grown up in Spartanburg. If they had, I would then ask them how the town had changed over the years. If respondents did not grow up in the city, I asked them where they were from originally. From there I would begin to work through the questions in whatever order emerged organically.

### ***Work***

***What do you do for work?***
***Have you always done this work?***
***Could you describe a typical day for me?***
***Is the work you do physically hard? Mentally? Emotionally?***
***Are you paid enough to live on?***

The companies you work for, how are they doing financially?
How old were you when you started working?
How are/were you treated at your job(s)?
Have you ever worked at Voc. Rehab.?
How well did/do you know your co-workers?
Have you ever used a temporary staffing agency to find work?
Did the decline of the textile industry affect you personally?
Have you ever attempted to get a job for the health insurance it provides?
Have you ever been part of a union? Would you join a union?
(If injured on the job) Was your injury avoidable?
Were you ever compensated for a job-related injury?

### ***Health***

**How is your health?**
**When did you start having health problems?**
**How do you feel during the day?**
**How do you feel at night?**
**How does your illness/injury affect your life?**

When were you diagnosed with these conditions?
Do they run in the family?
Did you get immediate medical care for them?
Do you, or have you ever, suffered from Depression or Anxiety?
Have you ever been diagnosed with a mental illness?

### ***Safety Net Institutions/Insurance***

**Where do you go for health care?**
**How did you hear about them?**
**How was the care there?**
**How do you manage without health insurance?**

Have you ever had health insurance?
Do you live differently because you don’t have health insurance?
Has being uninsured affected your relationship with your family in any way?
Have you ever used the emergency room? How was your experience there?
How have you been treated at the safety nets?

### ***Personal Life***

**Did you grow up in Spartanburg County?**
**(If applicable) How has Spartanburg changed since you were young?**
**How do you get to work? To the grocery store?**
**How are people that you know doing financially? Friends, family, neighbors, etc.**

Where do you get your groceries from?
What is your living situation like? Do you live with other people?
Do you care for anyone? A parent? A child?
Are you married?
What is the neighborhood that you live in like?
Have you ever thought of leaving Spartanburg County?
Do you know people around you in similar positions (financially, health-wise)?
Are you better off, financially, than your parents?
How have your children done better in this economy?
Are you in debt?
Have collection agencies ever contacted you?
Have you ever had to go without food?
Do you feel financially secure?
Did the Great Recession affect you personally?

**Appendix C:** Spartanburg Demographic Data

### Spartanburg City Racial Composition/Hispanic Ethnicity, 2016 (5 Year Average)

| | |
|---|---|
| White, Non-Hispanic | 44.8% |
| Black, Non-Hispanic | 48.1% |
| American Indian | 0.2% |
| Asian | 1.6% |
| Two or More Races | 1.2% |
| Hispanic of any Race | 3.7% |

*Source: Spartanburg Racial Equity Index (Brady 2018)*

### Spartanburg County Racial Composition/Hispanic Ethnicity, 2016 (5 Year Average)

| | |
|---|---|
| White, Non-Hispanic | 69.1% |
| Black, Non-Hispanic | 20.5% |
| American Indian | 0.1% |
| Asian | 2.2% |
| Two or More Races | 2.3% |
| Hispanic of any Race | 6.3% |

*Source: Spartanburg Racial Equity Index (Brady 2018)*

### Spartanburg City Poverty Status in the Past 12 Months, 2017 (5 Year Estimates)

| | |
|---|---|
| White, Non-Hispanic | 13.1% |
| Black, Non-Hispanic | 35.0% |
| American Indian | 0.0% |
| Asian | 14.1% |
| Two or More Races | 50.1% |
| Hispanic of any Race | 33.5% |

*Source: American Community Survey, Table S1701 (US Census Bureau 2019)*

### Spartanburg City Mean Income in the Past 12 Months, 2017 (5 Year Estimates)

| | |
|---|---|
| White, Non-Hispanic | $34,326 |
| Black, Non-Hispanic | $14,855 |
| American Indian | $15,364 |
| Asian | $16,057 |
| Two or More Races | $10,772 |
| Hispanic of any Race | $15,963 |

*Source: American Community Survey, Table S1902 (US Census Bureau 2019)*

### Spartanburg City Unemployment Rate, 2017 (5 Year Estimates)

| | |
|---|---|
| White, Non-Hispanic | 5.4% |
| Black, Non-Hispanic | 10.5% |
| American Indian | 32.4% |
| Asian | 9.9% |
| Two or More Races | 19.2% |
| Hispanic of any Race | 0.5% |

*Source: American Community Survey, Table S2301 (US Census Bureau 2019)*

### Spartanburg City Percent Uninsured, 2017 (5 Year Estimates)

| | |
|---|---|
| White, Non-Hispanic | 9.7% |
| Black, Non-Hispanic | 13.9% |
| American Indian | 20.7% |
| Asian | 38.0% |
| Two or More Races | 24.1% |
| Hispanic of any Race | 24.9% |

*Source: American Community Survey, Table S2701 (US Census Bureau 2019)*

**Appendix D:** South Carolina’s Leading Causes of Death (2017)

| **Leading Causes of Death** | **Deaths** | **State Rank*** |
|---|---|---|
| Heart Disease | 10,416 | 16th |
| Cancer | 10,356 | 14th |
| Accidents | 3,147 | 13th |
| Lower Respiratory Diseases | 2,983 | 12th |
| Stroke | 2,691 | 4th |
| Alzheimer’s Disease | 2,549 | 6th |
| Diabetes | 1,535 | 12th |
| Kidney Disease | 950 | 16th |
| Septicemia | 882 | 10th |
| Suicide | 838 | 25th (tie) |

*Source: CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)*

* Ranking from highest to lowest

## **Appendix E:** Patient Health Questionnaire-9

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**________________________________________ **DATE:**________________

| Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | add columns | | + | + |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

| | | |
|---|---|---|
| **10.** If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | ________ |
| | Somewhat difficult | ________ |
| | Very difficult | ________ |
| | Extremely difficult | ________ |

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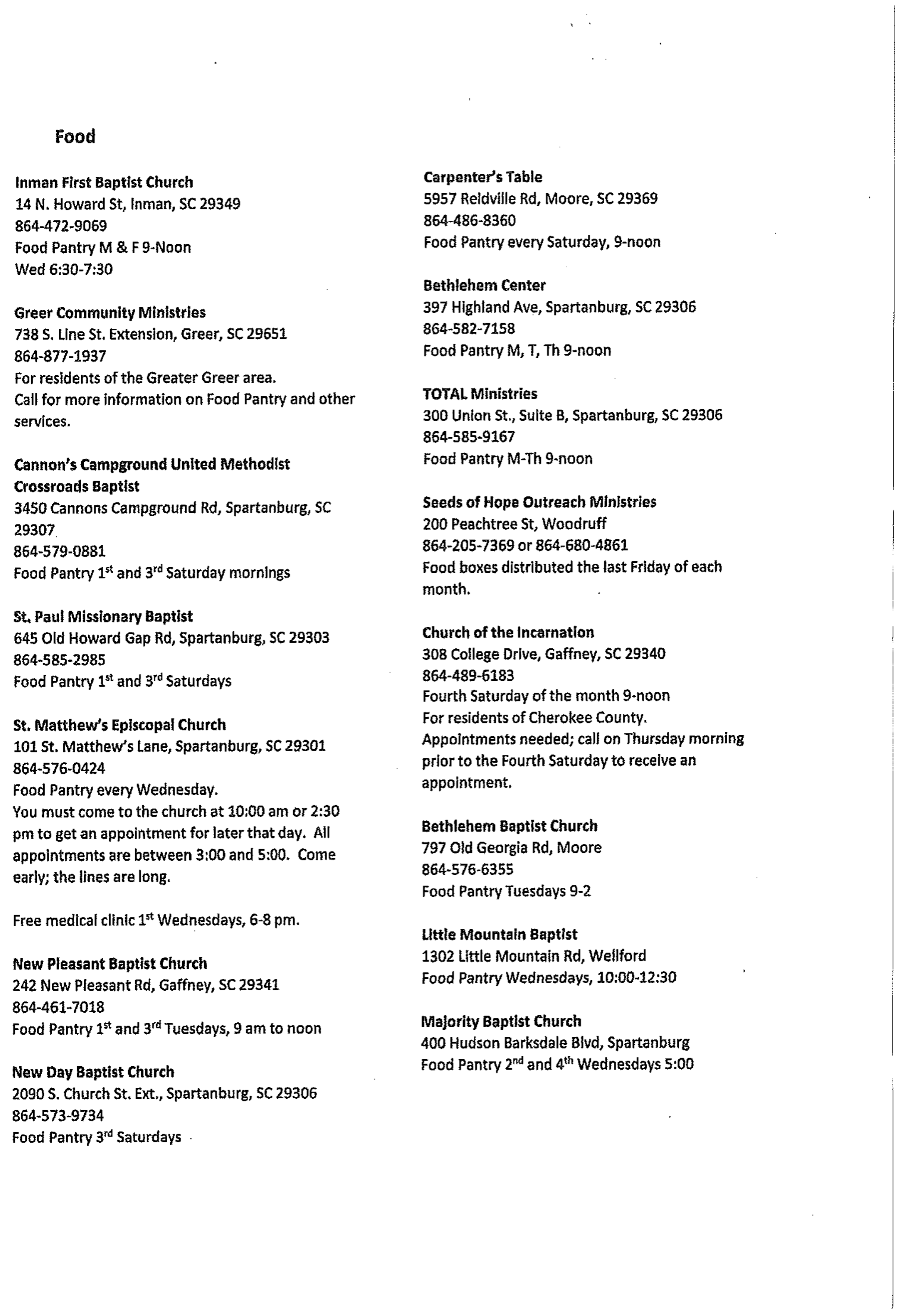
**Appendix F:** List of Charitable Institutions

**Note:** This list was compiled and circulated by a local church. The free clinic is, for some reason, not included on it.



## Food

**Inman First Baptist Church**
14 N. Howard St, Inman, SC 29349
864-472-9069
Food Pantry M & F 9-Noon
Wed 6:30-7:30

**Greer Community Ministries**
738 S. Line St. Extension, Greer, SC 29651
864-877-1937
For residents of the Greater Greer area.
Call for more information on Food Pantry and other services.

**Cannon's Campground United Methodist**
**Crossroads Baptist**
3450 Cannons Campground Rd, Spartanburg, SC 29307
864-579-0881
Food Pantry 1st and 3rd Saturday mornings

**St. Paul Missionary Baptist**
645 Old Howard Gap Rd, Spartanburg, SC 29303
864-585-2985
Food Pantry 1st and 3rd Saturdays

**St. Matthew's Episcopal Church**
101 St. Matthew's Lane, Spartanburg, SC 29301
864-576-0424
Food Pantry every Wednesday.
You must come to the church at 10:00 am or 2:30 pm to get an appointment for later that day. All appointments are between 3:00 and 5:00. Come early; the lines are long.

Free medical clinic 1st Wednesdays, 6-8 pm.

**New Pleasant Baptist Church**
242 New Pleasant Rd, Gaffney, SC 29341
864-461-7018
Food Pantry 1st and 3rd Tuesdays, 9 am to noon

**New Day Baptist Church**
2090 S. Church St. Ext., Spartanburg, SC 29306
864-573-9734
Food Pantry 3rd Saturdays

**Carpenter's Table**
5957 Reidville Rd, Moore, SC 29369
864-486-8360
Food Pantry every Saturday, 9-noon

**Bethlehem Center**
397 Highland Ave, Spartanburg, SC 29306
864-582-7158
Food Pantry M, T, Th 9-noon

**TOTAL Ministries**
300 Union St., Suite B, Spartanburg, SC 29306
864-585-9167
Food Pantry M-Th 9-noon

**Seeds of Hope Outreach Ministries**
200 Peachtree St, Woodruff
864-205-7369 or 864-680-4861
Food boxes distributed the last Friday of each month.

**Church of the Incarnation**
308 College Drive, Gaffney, SC 29340
864-489-6183
Fourth Saturday of the month 9-noon
For residents of Cherokee County.
Appointments needed; call on Thursday morning prior to the Fourth Saturday to receive an appointment.

**Bethlehem Baptist Church**
797 Old Georgia Rd, Moore
864-576-6355
Food Pantry Tuesdays 9-2

**Little Mountain Baptist**
1302 Little Mountain Rd, Wellford
Food Pantry Wednesdays, 10:00-12:30

**Majority Baptist Church**
400 Hudson Barksdale Blvd, Spartanburg
Food Pantry 2nd and 4th Wednesdays 5:00

## Free Meals

**Holy Communion Lutheran Church**
1430 John B. White Sr. Blvd.
Free community dinner each Thursday 5:30-6:30.

**Spartanburg Soup Kitchen**
136 S. Forest St.
864-585-0022
Daily, 11:30-12:30

## Low-Cost Dental Care

**Divinity Care Facility**
446 Arch St, Spartanburg, SC 29301
864-948-9700

**Miracle Hill Mission**
189 Forest St, Spartanburg, SC
864-583-1628
1st Saturday of each month, opening at 7:30 am
Free

**Palmetto Denture Care**
975 N. Church St, Spartanburg, SC
864-582-4308
Daily, 9:00-3:30
Start at $70 for extractions
$40 for X-rays

**Regenesis Family Dentistry**
550 S. Church St, Spartanburg, SC
864-398-4185
MWF 7:30-5:00; T 7:30-7:00
1st evaluation and X-ray $68-$128
Extractions $41-$74
Surgery $74-$135

## References Cited

Adair, Vivyan

2002 Branded With Infamy: Inscriptions of Poverty and Class in the United States. Signs 27(2): 451-471.

Adams, Vincanne

2013 Markets of Sorrow, Labors of Faith: New Orleans in the Wake of Katrina. Durham: Duke University Press.

Aiken, Linda H., with Douglas M. Sloane, and Jennifer L. Klocinski

1997 Hospital Nurses' Occupational Exposure to Blood: Prospective, Retrospective, and Institutional Reports. American Journal of Public Health 87(1): 103-107.

Alexander, Michelle.

2010 The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York: New Press.

Allison, Anne

2013 Precarious Japan. Durham, NC: Duke University Press.

Almgren, G. R., and T. Lindhorst

2012 The Safety-Net Health Care System: Health Care at the Margins. New York: Springer.

Alston, P.

2018 Statement on Visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights.https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23881&LangID=E, accessed February 4, 2019.

Altork, Kate

1995 Walking the Fire Line: The Erotic Dimension of the Field- work Experience. *In* Taboo: Sex, Identity, and Erotic Subjectivity in Anthropological Fieldwork. Don Kulick and Margaret Willson, eds. Pp. 107-139. London: Routledge.

American Psychiatric Association 2013

2013 Diagnostic and Statistical Manual of Mental Disorders (DSM-5). https://www.psychiatry.org/psychiatrists/practice/dsm, accessed July 1, 2018.

Ando, Emiko, Yuko Kachi, Norito Kawakami, Yoshiharu Fukuda, and Tomoyuki Kawada
2018 Associations of Non-standard Employment with Cardiovascular Risk Factors: Findings from Nationwide Cross-sectional Studies in Japan. Industrial Health 56(4): 336-345.

Angell, Marcia
2011 Illusions of Psychiatry. New York Review of Books. July 14 http://www.nybooks.com/articles/archives/2011/jul/14/illusions-of-psychiatry/?page1⁄41, accessed June 1, 2015.

Appelbaum, Eileen, with Annette Bernhardt and Richard J. Murnane, eds.
2003 Low-wage America: How Employers are Reshaping Opportunity in the Workplace. New York: Russell Sage Foundation.

Banaji, J.
2003 The Fictions of Free Labour: Contract, Coercion, and So-Called Unfree Labour. Historical Materialism 11(3): 69–95.

Barton, Tom
2018 “Among the Unhealthiest States, How will Candidates for SC Governor Improve Care” The State. https://www.thestate.com/news/politics government/article219357935.html, accessed Jan 6, 2019.

_______
2018 SC Governor Candidates want to Boost SC Economy, add Jobs. How Both Say They’ll do it. The State. https://www.governing.com/topics/finance/gov-state-budgets-federal-funding-2015-2018-trump.html, accessed August 20, 2019.

Beardsley, Edward H.
1987 A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South. Knoxville: University of Tennessee Press.

Becker, Gay
2001 Effects of Being Uninsured on Ethnic Minorities' Management of Chronic Illness. Western Journal of Medicine 175(1): 19-23.

_______
2004 Deadly Inequality in the Health Care “Safety Net”: Uninsured Ethnic Minorities’ Struggle to Live with Life Threatening Illnesses. Medical Anthropology Quarterly. 18(2): 258-275.

_______
2007 The Uninsured and the Politics of Containment in U.S. Health Care. Medical Anthropology 26(4): 299-321.

Behar, Ruth
1996 The Vulnerable Observer: Anthropology that Breaks your Heart. Boston: Beacon Press.

Benach, Joan, with Alejandra Vives, M. Amable, Christophe Vanroelen, and Carles Muntaner
2014 Precarious Employment: Understanding an Emerging Social Determinant of Health. Public Health 35(1): 229-253.

Benson, Peter
2012 Tobacco Capitalism: Growers, Migrant Workers, and the Changing Face of a Global Industry. Princeton, HJ: Princeton University Press.

Bentley, Rebecca, with Emma Baker, and Zoe Aitken
2019 The 'Double Precarity' of Employment Insecurity and Unaffordable Housing and its Impact on Mental Health. Social Science & Medicine 225: 9-16.

Berlant, Lauren
2011 Cruel Optimism. Durham, NC: Duke University Press.

Bernard, H.R.
2006 Research Methods in Anthropology: Qualitative and Quantitative Approach. New York: Alta Mira Press.

Betti, Eloisa
2018 Historicizing Precarious Work: Forty Years of Research in the Social Sciences and Humanities. International Review of Social History 63(2): 273-319.

Biehl, João
2007 Ex-Human Reflections on Vita: Life in a Zone of Social Abandonment. City & Society 19(1): 81-85.

_______
2013 Vita: Life in a Zone of Social Abandonment. Berkley: University of California Press.

Biehl, João, and Amy Moran-Thomas
2009 Symptom: Subjectivities, Social Ills, Technologies. Annual Review of Anthropology 38:267–288.

Biehl, João and Torben Eskerod

2005 Vita: Life in a Zone of Social Abandonment. Berkley: University of California Press.

Biehl, João, with Peter Locke, Michael MJ Fischer, Vanessa L. Fong, Angela Garcia, Adam M. Geary, Andrew Gilbert et al.

2010 Deleuze and the Anthropology of Becoming. Current Anthropology 51(3): 317-351.

Black, Rachel, and Aleta Sprague

2018 Republicans' Fixation on Work Requirements Is Fueled by White Racial Resentment. Slate. https://slate.com/human-interest/2018/06/trump administrations-fixation-on-work-requirements-for-snap-benefits-is-part-of-a long-racist-policy-history.html, accessed May 26, 2019.

Bonde, Jens, and Peter Ellekilde

2008 Psychosocial Factors at Work and Risk of Depression: A Systematic Review of the Epidemiological Evidence. Occupational and Environmental Medicine 65(7): 438-445.

Borden, Jeremy

2015 Senators Renew Push for Medicaid Expansion Debate. The Post and Courier. https://www.postandcourier.com/politics/senators-renew-push-for-medicaid-expansion-debate/article_26878abf-14ad-5ec6-b1c8-0cfa6a166cf0.html, accessed Jun 17, 2018.

Bourdieu, Pierre

2000 Pascalian Meditations. Stanford, CA: Stanford University Press.

Bourgois, Philippe, and Jeffrey Schonberg

2009 Righteous Dopefiend. Berkeley: University of California Press.

Brady, Kathleen

2016 The Status of Public Health, Spartanburg County South Carolina. Spartanburg Community Indicators Project. http://www.strategicspartanburg.org/files/The%20Status%20of%20Public%20Health,%20Spartanburg%20County%202016%20Update.pdf, accessed July 6, 2017.

_______

2018 Spartanburg Racial Equity Index: A Review of Predictors and Outcomes. Metropolitan Institute as USC Upstate. http://www.strategicspartanburg.org/data/Spartanburg-Racial-Equity-Index.pdf, accessed October 3, 2019.

Braveman, Paula

2012 Health Inequalities by Class and Race in the US: What can We Learn from the Patterns? Social Science & Medicine 74:665-667.

Brodwin, Paul

2013 Everyday Ethics in Community Psychiatry: Voices From the Front Lines of Community Psychiatry. Berkeley: University of California Press.

Brunson, E.

2018 "Texans Don't Want Health Insurance." *In* Unequal Coverage. J. Mulligan and H. Castañeda, eds. Pp. 177–202. New York: NYU Press.

Bucholtz, Mary

2000 The Politics of Transcription. Journal of Pragmatics 32(10): 1439-1465.

Bureau of Labor Statistics

2019 Characteristics of Minimum Wage Workers 2018. Bureau of Labor Statistics. https://www.bls.gov/opub/reports/minimum-wage/2018/home.htm, accessed August 5, 2019.

_______

2019 Union Members—2018. Bureau of Labor Statistics. https://www.bls.gov/news.release/pdf/union2.pdf, accessed August 1, 2019.

Butler, Judith

2009 Performativity, Precarity, and Sexual Politics. AIBR: Revista de Antropología Iberoamericana 4(3): i–xiii.

_______

2015 Notes Towards a Performative Theory of Assembly. Cambridge, MA: Harvard University Press.

Butterworth, P., with L.S Leach, L. Strazdins, S.C. Olesen, B. Rodgers, and D.H. Broom

2011 The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey. Occupational and Environmental Medicine 68: 806–812.

Calvao, Filipe

2016 Unfree labor. Annual Review of Anthropology 45: 451-467.

Caplovitz, David

1967 The Poor Pay More. New York: The Free Press.

Carolina Business Review

2018 South Carolina Secretary of Commerce Bobby Hit Interview. UNC TV. April https://www.youtube.com/watch?v=2LdUALo3qBU, accessed Jan 7, 2019.

Case, Anne, and Angus Deaton

2015 Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the 21st Century. Proceedings of the National Academy of Sciences 112(49): 15078-15083.

Canivet, Catarina, with T. Bodin, M. Emmelin, M. Moghaddassi, and Per-Olof Östergren

2016 Precarious Employment is a Risk Factor for Poor Mental Health in Young Individuals in Sweden: A Cohort Study with Multiple Follow-Ups." BMC Public Health 16(1): 687.

Clark, Erin Marie

2014 Anthropological Theories of Low-Wage Work. Journal of Human Behavior in the Social Environment 24(1): 26-37.

Coe, N.B., with S. Linder, K. Wong, and A.Y. Wu

2014 How do People with Disabilities Cope while Waiting for Disability Insurance Benefits? IZA Journal of Labor Policy 3(1): 1-27.

Cohen, Sheldon, with Denise Janicki-Deverts, Edith Chen, and Karen A. Matthews

2010 Childhood Socioeconomic Status and Adult Health. Annals of the New York Academy of Sciences 1186(1): 37-55.

Collins, Patricia Hill

2000 Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment, (2nd Edition). New York: Routledge Press.

Collins, Jane L. and Victoria Mayer

2010 Both Hands Tied: Welfare Reform and the Race to the Bottom of the Low Wage Labor Market. Chicago: University of Chicago Press.

Comaroff, Jean, and John L. Comaroff

2002 Alien-Nation: Zombies, Immigrants, and Millennial Capitalism. The South Atlantic Quarterly 101(4): 779-805.

Crowell, Charlene

2019 Enact Payday Loan Rules. South Florida Times. http://www.sfltimes.com/finance/enact-payday-loan-rules, accessed October 4, 2019.

Cruikshank, Barbara

1999 The Will to Empower: Democratic Citizens and Other Subjects. Ithaca, NY: Cornell University Press.

Cunningham, P., K. McKenzie, and E.F. Taylor

2006 The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illnesses. Health Affairs 25: 694-705.

Dahlhamer, James, with Jacqueline Lucas, Carla Zelaya, Richard Nahin, Sean Mackey, Lynn DeBar, Robert Kerns, et al.

2018 Prevalence of Chronic Pain and High-impact Chronic Pain among Adults—United States, 2016. Morbidity and Mortality Weekly Report 67(36): 1001.

De Moortel, D., with H. Vandenheede, and C. Vanroelen

2014 Contemporary Employment Arrangements and Mental Well-being in Men and Women across Europe: A Cross-sectional Study. International Journal for Equity in Health 13(1): 90.

Demyttenaere, Koen, with Ronny Bruffaerts, Sing Lee, Jose Posada-Villa, Vivianne Kovess, Matthias C. Angermeyer, Daphna Levinson et al.

2007 Mental Disorders among Persons with Chronic Back or Neck Pain: Results from the World Mental Health Surveys 129(3): 332-342.

Desjarlais, Robert

1994 Struggling Along: The Possibilities for Experience among the Homeless Mentally Ill. American Anthropologist 96: 886-901.

________

2011 Shelter Blues: Sanity and Selfhood among the Homeless. Philadelphia: University of Pennsylvania Press.

Desmond, Matthew, and Bruce Western.

2018 Poverty in America: New Directions and Debates. Annual Review of Sociology 44: 305-318.

Dickinson, Maggie

2016 Working for Food Stamps: Economic Citizenship and the Post-Fordist Welfare State in New York City." American Ethnologist 43(2): 270-281.

Dolson, Mark S.

2015 Trauma, Workfare and the Social Contingency of Precarity and its Sufferings: The Story of Marius, a Street-Youth. Culture, Medicine, and Psychiatry 39(1): 134-161.

Dwyer, Rachel E.

2018 Credit, Debt, and Inequality. Annual Review of Sociology 44: 237-261.

Eagleton, Terry

2013 Across the Pond: An Englishman's View of America, New York: W. W. Norton & Company.

Ehrenreich, Barbara

2001 Nickel and Dimed: On (Not) Getting By in America. New York: Metropolitan Books.

Eller, R.D.

1982 Miners, Millhands, and Mountaineers: Industrialization of the Appalachian South, 1880–1930. Knoxville, TN: University of Tennessee Press.

Ferguson, James

2013 Declarations of Dependence: Labour, Personhood, and Welfare in Southern Africa. Journal of the Royal Anthropological Institute 19(2): 223-242.

Flamming, David

1992 Creating the Modern South: Millhands and Managers in Dalton, Georgia, 1884–1984. Chapel Hill: University of North Carolina Press.

Frederickson, Mary

1982 Four Decades of Change: Black Workers in Southern Textiles, 1941 1981. Radical America 16(6): 27-43.

Gallup-Healthways

2017 State of American Well-being: 2017 Community Well-being Rankings. https://wellbeingindex.sharecare.com/wp-content/uploads/2018/03/Gallup-Sharecare-State-of-American-Well-Being_2017-Community-Rankings_vFINAL.pdf, accessed June 2, 2018.

Garcia, Angela

2010 The Pastoral Clinic: Addiction and Dispossession along the Rio Grande. Berkeley: University of California Press.

Garfield, Rachel, Kendal Orgera, and Anthony Damico

2019 The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid: An Update. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/, accessed May 5, 2019.

Geronimus, Arline T., with Margaret Hicken, Danya Keene, and John Bound

2006 “Weathering” and Age Patterns of Allostatic Load Scores among Blacks and Whites in the United States." American Journal of public health 96(5): 826 -833.

Giermanski, James R., and Peter Lodge

2002 An Analysis of NAFTA and Textile Closings in North Carolina. Journal of Textile and Apparel, Technology, and Management 2(3):1-5.

Gilmer, Jason

2010 The Blessings as a St. Luke’s Free Medical Clinic Volunteer. Spartanburg Herald-Leader.https://www.goupstate.com/news/20100827/the-blessings-as-a-st-lukes-free-medical-clinic-volunteer, accessed October 12, 2018.

Giraudo M, with A. Bena, Leombruni R, and G. Costa

2016 Occupational Injuries in Times of Labour Market Flexibility: The Different Stories of Employment-secure and Precarious Workers. BMC Public Health 13(16): 150.

Glaser, Barney G., and Anselm L. Strauss

2017 Discovery of Grounded Theory: Strategies for Qualitative Research. New York: Routledge.

Goodnough, Abby

2017 The Adults a Medicaid Work Requirement Would Leave Behind. The New York Times. https://www.nytimes.com/2017/02/25/health/medicaid-work requirement.html, accessed May 23, 2018.

Grabell, M. and H. Berkes

2015 Inside Corporate America’s Campaign to Ditch Workers’ Comp. ProPublica. https://www.propublica.org/article/inside- corporate-americas-plan to-ditch-workers-comp, accessed October 14, 2015.

Graif, Corina and Stephen A. Matthews

2017 The Long Arm of Poverty: Extended and Relational Geopgraphies of Child Victimization and Neighborhood Violence Exposures. Justice Quarterly 34(6): 1096-1125.

Gross, Daniel J.

2016 Gross 2016: Growing Demand for Services Strains Free Clinic’s Budget. Spartanburg Herald-Leader. https://www.goupstate.com/news/20161116/ growing-demand-for-services-strains-free-clinics-budget accessed December 15, 2016.

_______

2017 Second St. Luke’s Clinic Gives Spartanburg County Patients Another Care Option. Spartanburg Herald-Leader. https://www.goupstate.com/news/20170411/second-st-lukes-clinic-gives-spartanburg-county-patients-another-care-option, accessed August 5, 2019.

Gureje, Oye, with Michael Von Korff, Lola Kola, Koen Demyttenaere, Yanling He, José Posada-Villa, Jean Pierre Lepine et al.

2008 The Relation Between Multiple Pains and Mental Disorders: Results from the World Mental Health Surveys. PAIN 135(1-2): 82-91.

Hadley, Craig, and Crystal L. Patil

2006 Food Insecurity in rural Tanzania is Associated with Maternal Anxiety and Depression. American Journal of Human Biology 18(3): 359-368.

Hall, Jacquelyn Dowd, with James Leloudis, Robert Korstad, Mary Murphy, Lu Ann Jones, and Christopher B. Daly

1987 Like a Family: The Making of a Southern Cotton Mill World. Chapel Hill: University of North Carolina Press.

Hall, Matthew, with Emily Greenman, and Youngmin Yi

2018 Job Mobility among Unauthorized Immigrant Workers. Social Forces 97(3): 999-1028.

Han, Clara

2012 Life in Debt: Times of Care and Violence in Neoliberal Chile. Berkeley: University of California Press.

_______

2018 Precarity, Precariousness, and Vulnerability. Annual Review of Anthropology 47: 331-343.

Han, Kyu-Man, with Cheolmin Shin, Ho-Kyoung Yoon, Young-Hoon Ko, Yong-Ku Kim, and Changsu Han

2018 Emotional Labor and Depressive Mood in Service and Sales Workers: Interactions with Gender and Job Autonomy. Psychiatry Research 267: 490-498.

Hansen, Helena, with Phillipe Bourgois, and Ernest Drucker

2014 Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma Under Welfare Reform. Social Science & Medicine 103: 76-83.

Harvey, David

2000 Spaces of Hope. Edinburgh: Edinburgh University Press.

_______
2005 A Brief History of Neoliberalism. New York: Oxford University Press.

_______
2017 Marx, Capital and the Madness of Economic Reason. New York: Oxford University Press.

Hayes, Jack Irby, and James Hayes
2001 South Carolina and the New Deal. Columbia, SC: University of South Carolina Press, 2001.

Health Resources and Services Administration
2018 Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of December 31, 2018.

Helmer, Drew A., with Helena K. Chandler, Karen S. Quigley, Melissa Blatt, Ronald Teichman, and Gudrun Lange
2009 Chronic Widespread Pain, Mental Health, and Physical Role Function in OEF/OIF Veterans. Pain Medicine 10(7): 1174-1182.

Hernández, Diana
2016 Poor Families, Housing, and Health. The University of Wisconsin–Madison Institute for Research on Poverty. https://www.irp.wisc.edu/resource/poor-families-housing-and-health/, accessed August 1, 2019.

Higgins, R.
2005 Bodies for Rent: Labor and Marginality in Southern Louisiana. Anthropology of Work Review 26(3): 12–22.

Hochschild, Arlie, and Anne Machung
2012 The Second Shift: Working Families and the Revolution at Home. New York: Penguin.

Hoffman, Jascha
2006 Sousveillance. The New York Times. https://www.nytimes.com/2006/12/10/magazine/10section3b.t-3.html, accessed June 15, 2017.

Holmes, Seth
2013 Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States. Berkeley: University of California Press.

Hopper, Kim

2006 Redistribution and its Discontents: On the Prospects of Committed Work in Public Mental Health and Like Settings. Human Organization 65(2): 218-226.

Horton, Sarah and J.C. Barker

2010 Stigmatized Biologies: Examining the Cumulative Effects of Oral Health Disparities for Mexican American Farmworker Children. Medical Anthropology Quarterly 24 (2): 199–219.

Horton, Sarah, with Joanne McCloskey, Caroline Todd, and Marta Henriksen

2001 Transforming the Safety Net: Responses to Medicaid Managed Care in, Rural and Urban New Mexico. American Anthropologist 103(3): 733-746.

Horton, Sarah, with Cesar Abadia, Jessica Mulligan, and Jennifer Jo Thompson

2014 Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical Anthropological Approach to the U.S.'s Affordable Care Act. Medical Anthropology Quarterly 28(1):1–22.

Hughes, Conor

2018 St. Luke's Free Medical Clinic Experiencing Doctor Shortage. Spartanburg Herald-Leader. https://www.goupstate.com/news/20180628/st-lukes-free-medical-clinic-experiencing-doctor-shortage, accessed February 25, 2019.

_______

2019 St. Luke's Free Medical Clinic Sees Success Through Free Psychiatric Treatment. Spartanburg Herald Leader. https://www.goupstate.com/news/20190624/st-lukes-free-medical-clinic-sees-success-through-free-psychiatric-treatment, accessed October 1, 2019.

Hughey, Matthew W., and Gregory S. Parks

2014 The Wrongs of the Right: Language, Race, and the Republican Party in the Age of Obama. New York: New York University Press.

Illich, Ivan

1981 Shadow Work. London: Marion Boyars.

Ingraham, Christopher

2017 Black Men Sentenced to More Time for Committing the Exact Same Crime as a White Person, Study Finds. https://www.washingtonpost.com/news/wonk/wp/2017/11/16/black-men-sentenced-to-more-time-for-committing-the-exact-same-crime-as-a-white-person-study-finds/?noredirect=on, accessed March 15, 2019.

Jaffee, David, and David Bensman

2016 Draying and Picking: Precarious Work and Labor Action in the Logistics Sector. The Journal of Labor & Society 19(1): 57-79.

James, Sherman A.

1994 John Henryism and the Health of African-Americans. Culture, Medicine and Psychiatry 18(2): 163-182.

Jenkins, Janis

1991 The State Construction of Affect: Political Ethos and Mental Health Among Salvadoran Refugees. Culture, Medicine and Psychiatry 15(2): 139-165.

Jones, Emily, with Lydie A. Lebrun-Harris, Alek Sripipatana, and Quyen Ngo-Metzger

2014 Access to Mental Health Services among Patients at Health Centers and Factors Associated with Unmet Needs." Journal of Health Care for the Poor and Underserved 25(1): 425-436.

Julia, Mireia, Christophe Vanroelen, Kim Bosmans, Karen Van Aerden, and Joan Benach

2017 Precarious Employment and Quality of Employment in Relation to Health and Well-Being in Europe. International Journal of Health Services 47(3): 389-409.

Kaiser Family Foundation

2019 Where are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults. https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/, accessed December 22, 2018.

Kalleberg, Arne L.

2011 Good Jobs, Bad Jobs: The Rise of Polarized and Precarious Employment Systems in the United States, 1970s-2000s. New York: Russell Sage.

Kalleberg, A. L., and S.P. Vallas, eds.

2017 Probing Precarious Work: Theory, Research, and Politics. *In* Precarious Work. Pp. 1–30. Bingley, UK: Emerald

Khazan, Olga

2018 Being Black in American can Be hazardous to your Health. The Atlantic. https://www.theatlantic.com/magazine/archive/2018/07/being-black-in-america-can-be-hazardous-to-your-health/561740/, accessed June 3, 2019

Kiel, Paul

2019 IRS: Sorry, But it’s Just Easier and Cheaper to Audit the Poor. Propublica. https://www.propublica.org/article/irs-sorry-but-its-just-easier-and-cheaper-to-audit-the-poor, accessed October 5, 2019.

Kingfisher, Catherine, and Jeff Maskovsky

2008 Introduction the Limits of Neoliberalism. Critique of Anthropology 28(2): 115-126.

Kingsolver, Ann E.

2010 Living Wage Considerations in the Right-to-Work State of South Carolina. Anthropology of Work Review 31(1): 30-41.

_______

2016 "Zones of In/visibility: Commodification of Rural Unemployment in South Carolina." *In* Anthropologies of Unemployment: New Perspectives on Work and Its Absence. Kwon, Jong Bum Kwon and Carrie M. Lane, eds. Pp. 118-134. Ithaca, NY: Cornell University Press.

Kitzmiller, Felicia

2013 Spartanburg County Jail Takes on Mental Health Issues of Those in Custody. Spartanburg Herald Journal, April 13.

Kleinman, Arthur

2012 Medical Anthropology and Mental health: Five Questions for the Next Fifty Years. In Medical Anthropology at the Intersections: Histories, Activisms and Futures. Marcia C. Inhorn and Emily A. Wentzell, eds. Pp. 116- 129. Durham: Duke University Press.

Kleinman, Arthur, and E. Fitz-Henry

2007 The Experimental Basis of Subjectivity: How Individuals Change in the Context of Societal Transformation. *In* Subjectivity: Ethnographic investigations. J. Biehl, B. Good, & A. Kleinman, eds.Pp. 52-65. Berkeley: University California Press.

Kleinman, Arthur, with Veena Das, and Margaret Lock, eds.

1997 Social Suffering. Berkeley: University of California Press.

Koranyi, I., with J. Jonsson, T. Rönnblad, L. Stockfelt, and T. Bodin

2018 Precarious Employment and Occupational Accidents and Injuries – A Systematic Review. Scandinavian Journal of Work Environment & Health 4: 341 350.

Kroenke, Kurt, with Robert L. Spitzer, and Janet Williams.

2001 The PHQ-9: Validity of a Brief Depression Severity Measure. Journal of General Internal Medicine 16(9): 606-613.

Kromm, Chris

2016 Nikki Haley's Troubled Economic Record in South Carolina. Facing South. https://www.facingsouth.org/2016/01/nikki-haleys-troubled-economic-record in-south-car, accessed July 6, 2019.

Kulik, Tracy, and Virginia Thomas

2013 Behavioral Health Needs Assessment: Spartanburg County, South Carolina. Final Report and Business Plan. Collaborative Research.

Lachance-Grzela, Mylène, and Geneviève Bouchard

2010 Why do Women do the Lion’s Share of Housework? A decade of Research. Sex Roles 63(11-12): 767-780.

Lambert, Craig

2015 Shadow Work: The Unpaid, Unseen Jobs that Fill your Day. Berkeley: Counterpoint.

Lamphere, Louise

2005 Providers and Staff Respond to Medicaid Managed Care: The Unintended Consequences of Reform in New Mexico. Medical Anthropology Quarterly 19 (1): 3-25.

Lennon, Mary Clare, and Laura Limonic

1999 Work and Unemployment as Stressors. A Handbook for the Study of Mental Health: 284-294.

Lévi-Strauss, Claude

1961 Tristes Tropiques. New York: Criterion Books.

Lewchuk, Wayne

2017 Precarious Jobs: Where are They, and How Do they Affect Bell-being? The Economic and Labour Relations Review 28(3): 402-419.

Lewin, Marion and Stuart Altman, eds.

2000 America's Health Care Safety Net: Intact but Endangered. Washington D.C.: National Academies Press.

Li, Tania Murray

2010 To Make Live or Let Die? Rural Dispossession and the Protection of Surplus Populations. Antipode 41(1): 66-93.

Lipsky, M.

2010 Street-level Bureaucracy: Dilemmas of the Individual in Public Services. New York: Russell Sage Foundation.

Livingston, Julie

2012 Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic. Durham, NC.: Duke University Press.

Llosa, Jose A., with Sara Menéndez-Espina, Esteban Agulló-Tomás, and Julio Rodríguez-Suárez

2018 Job Insecurity and Mental Health: A Meta-analytical Review of the Consequences of Precarious Work in Clinical Disorders. Anales de Psicología 34(2): 211-221.

Lock, Margaret

2001 The Tempering of Medical Anthropology: Troubling Natural Categories. Medical Anthropology Quarterly 15: 478-492.

Lorant, Vincent, with Denise Deliège, William Eaton, Annie Robert, and Marc Ansseau

2003 Socioeconomic Inequalities in Depression: A Meta-Analysis. American Journal of Epidemiology 157(2): 98-112.

Lorey, Isabell

2015 State of Insecurity: Government of the Precarious. London: Verso Books.

Luhrman, T.M.

2000 Of Two Minds: An Anthropologist Looks at American Psychiatry. New York: Alfred A. Knopf.

Macfarlane, G.J., with G. Norrie, K. Atherton, C. Power, G.T. Jones

2009 The Influence of Socioeconomic Status on the Reporting of Regional and Widespread Musculoskeletal Pain: Results from the 1958 British Birth Cohort Study. Annals Rheumatic Disease 68(10):1591–1595.

Maciag, Mike

2017 How much Do States Rely on Federal Funding? Governing. https://www.governing.com/topics/finance/gov-state-budgets-federal-funding-2015-2018-trump.html, accessed August 20, 2019.

Magdoff, Fred, and Harry Magdoff

2004 Disposable Workers. Monthly Review 55(11): 18-35.

Manji, Kainde

2017 Social Security Reform and the Surveillance State: Exploring the Operation of 'Hidden Conditionality' in the Reform of Disability Benefits since 2010. Social Policy and Society 16(2): 305-314.

Marx, Karl

1992 Capital: Volume 1: A Critique of Political Economy. London: Penguin.

Maskovsky, Jeff

2001 “Managing” the Poor: Neoliberalism, Medicaid HMOs and the Triumph of Consumerism among the Poor. Medical Anthropology 19(2): 121-146.

Mason, Geoff, and Wiemer Salverda

2010. Low Pay, Working Conditions, and Living Standards.” *In* Low-Wage Work in the Wealthy World. Jérôme Gautié and John Schmitt, eds. Pp. 35-90. New York: Russell Sage Foundation.

Matthews, Karen A., and Linda C. Gallo

2011 Psychological Perspectives on Pathways Linking Socioeconomic Status and Physical Health. Annual Review of Psychology 62: 501-530.

May, C., with V. Brcic, and B. Lau

2018 Characteristics and Complexity of Chronic Pain Patients Referred to a Community-based Multidisciplinary Chronic Pain Clinic." Canadian Journal of Pain 2(1): 125-134.

Mayhew, C.

2002 Exploration of the Links between Workplace Stress and Precarious Employment. In C. L. Peterson (Ed.), Work Stress: Studies of the Context, Content and Outcomes of Stress (pp. 1-8). New York, NY: Baywood Publishing Company, Inc.

McAllister, Jean

1998 Sisyphus at Work in the Warehouse: Temporary Employment in Greenville, South Carolina. *In* Contingent work: American Employment Relations in Transition. Kathleen Barker and Kathleen Christensen, eds. Pp.221-242. Ithaca, NY: Cornell University Press.

McCoy, Kevin

2017 Mick Mulvaney: Payday Lending Campaign Contributions Pose No Conflicts of Interest. https://www.usatoday.com/story/money/2017/1/04/mick-mulvaney-payday-lending-campaign-contributions-pose-no-conflicts-interest/920056001/, accessed October 4, 2019.

McMaster, Henry

2018 2018 State of the State. South Carolina Office of the Governor. https://governor.sc.gov/news/2018-01/2018-state-state, accessed March 10, 2019.

Meehan, Katie, and Kendra Stauss, eds.
2015 Precarious Worlds: Contested Geographies of Social Reproduction. Athens: University of Georgia Press.

Meek, James
2016 Robin Hood in a Time of Austerity London Review of Books 38(4): 3-8.

Mensch, Betty
1981 Freedom of Contract as Ideology. Stanford Law Review 33: 753–72.

Mental Health America
2019 Ranking the State. Mental Health America. https://www.mentalhealthamerica.net/issues/ranking-states, accessed July 6, 2019.

Minchin, Timothy J.
2012 Shutdowns in the Sun Belt: The Decline of the Textile and Apparel Industry and Industrialization in the South. *In* Life and Labor in the New New South. R.H. Zieger, ed. Pp 258-288. Gainesville: University Press of Florida.

Minkler, Meredith, and Thomas Cole
1999 Political and Moral Economy: Getting to Know One Another. In Critical Gerontology: Perspectives from Political and Moral Economy. Meredith Minkler and Carroll L. Estes, eds.,pp. 37–49. Amityville, NY: Baywood Publishing Company.

Molland, Sverre
2011 ‘I am Helping Them’:‘Traffickers’,‘Anti-Traffickers’ and Economies of Bad Faith." The Australian Journal of Anthropology 22(2): 236-254.

Moore, Eva
2019 SC Wants to Make People on Medicaid Prove They’re Working.What’s Wrong with That. The Post and Courier. https://www.postandcourier.com/free-times/cover_story/sc-wants-tomake-people-on-medicaid-prove-they-re/article_1b8a1158-def1-5a6c962c, accessed August 26, 2019.

Moscone, Francesco, with Elisa Tosetti, and Giorgio Vittadini
2016 The Impact of Precarious Employment on Mental Health: The Case of Italy. Social Science & Medicine 158: 86-95.

Muehlebach, Andrea
2013 On Precariousness and the Ethical Imagination: The Year 2012 in Sociocultural Anthropology. American Anthropologist 115(2): 297-311.

Mulligan, Jessica, and Heide Castañeda, eds.
2017 Unequal Coverage: The Experience of Health Care Reform in the United States. New York: New York University Press.

Mullings, Leith
2005 Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem." Transforming Anthropology 13(2): 79-91.

Muntaner, Carles, with Edwin Ng, Seth J. Prins, Katia Bones-Rocha, Albert Espelt, and Haejoo Chung
2015 Social Class and Mental Health: Testing Exploitation as a Relational Determinant of Depression. International Journal of Health Services 45(2): 265-284.

Murphy, Gregory C., and James A. Athanasou
1999 The Effect of Unemployment on Mental Health." Journal of Occupational and Organizational Psychology 72(1): 83-99.

National Association of State Directors of Developmental Disabilities Services
2019 South Carolina Submits 115 Demonstration for Community Engagement Requirement. NASDDS. https://www.nasddds.org/news/south-carolina-submits-1115-demonstration-for-community-engagement-requirem/, accessed August 4, 2019.

National Women's Law Center
2014 The Coverage Gap Poses Risks to Low Income Women's Health. https://nwlc.org/blog/coverage-gap-poses-risks-low-income-womens-health/, accessed April 25, 2016.

National Institute of Mental Health
2019 "Depression Statistics." National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/major-depression.shtml, accessed August 6, 2019.

Nazareno, Jennifer
2018 Welfare State Replacements: Deinstitutionalization, Privatization and the Outsourcing to Immigrant Women Enterprise. International Journal of Health Services 48(2): 247-266.

Newman Katherine
1999 No Shame in My Game: The Working Poor in the Inner City. Vintage; New York.

Nguyen, Vihn-Kim, and Karine Peschard
2003 Anthropology, Inequality, and Disease: A Review. Annual Review of Anthropology 32: 447- 474.

Nkansah-Amankra, with Stephen, Samuel Kwami Agbanu, and Reuben Jonathan Miller
2013 Disparities in Health, Poverty, Incarceration, and Social Justice Among Racial Groups in The United States: A Critical Review of Evidence of Close Links With Neoliberalism. International Journal of Health Services 43(2): 217-240.

Ollove, Michael
2014 Nearly 4 Million Seriously Mentally Ill Still Without Insurance. Kaiser Health News. https://khn.org/news/stateline-mental-health/, accessed July 26, 2018.

Panter-Brick, Catherine
2014 Health, Risk, and Resilience: Interdisciplinary Concepts and Applications. Annual Review of Anthropology 43: 431-448.

Papanicolas, Irene, with Liana R. Woskie, and Ashish K. Jha.
2015 Health Care Spending in The United States and Other High-Income Countries. JAMA 319(10): 1024-1039.

Pellegrino, Edmund
1999 The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from Professional to Market Ethic. Journal of Medicine and Philosophy, 24: 243–264.

Petryna, Adriana
2013 The Right of Recovery. Current Anthropology 54(7): 67–76.

Povinelli, Elizabeth
2011 Economies of Abandonment: Social Belonging and Endurance in Late Liberalism. Durham, NC: Duke University Press.

Qiu, Yue, and Michael Grabell
2015 Workers'Compensation Reforms by State. ProPublica. https://projects.propublica.org/graphics/workers-comp-reform-by-state, accessed September 5, 2018.

Quinlan, Michael and Claire Mayhew
1999 Precarious Employment and Workers' Compensation. International Journal of Law and Psychiatry 22(5-6): 491-520.

Rash, Ron
1998 Eureka Mill. Corvallis, OR: Bench Press.

Rivkin-Fish, Michele
2011 Learning the Moral Economy of Commodified Health Care: "Community Education," Failed Consumers, and the Shaping of Ethical Clinician Citizens. Culture, Medicine, and Psychiatry 35(2): 183-208.

Roll, J.M., with J. Kennedy, M. Tran M, and D. Howell
2013 Disparities in Unmet Need for Mental Health Services in The United States, 1997-2010. Psychiatric Services 64(1): 80–82.

Rosaldo, Renato
1989 Grief and the Headhunter's Rage. Culture and Truth: 1-21.

Rose, Gillian
2006 Visual Methodologies: An Introduction to the Interpretation of Visual Methods. 2nd ed. London: Sage.

Rose, Nikolas
1996 Governing "Advanced" Liberal Democracies. *In* Foucault and Political Reason: Liberalism, Neoliberalism and Rationalities of Government. Andrew Barry, Thomas Osborne, and Nikolas Rose, eds. Pp. 37-64. Chicago: University of Chicago Press.

Rosen, Eva
2017 Horizontal Immobility: How Narratives of Neighborhood Violence Shape Housing Decisions. American Sociological Review 82(2): 270-296.

Rucker, Patrick
2018 Mulvaney-led U.S. CFPB Slashes Payday Lender Penalty: Sources. Reuters. https://www.reuters.com/article/us-usa-cfpb-payday/mulvaney-led-us-cfpb-slashes-payday-lender-penalty-sources-idUSKBN1JO17J, accessed October 5, 2019.

Rugulies, Reiner, with Birgit Aust, Hermann Burr, Johannes Siegrist, and Ute Bültmann
2013 Adverse Psychosocial Working Conditions and Risk of Severe Depressive Symptoms. Do Effects Differ by Occupational Grade? The European Journal of Public Health 23(3): 415-420.

Rylko-Bauer, Barbara, and Paul Farmer
2002 Managed Care or Managed Inequality? A Call for Critiques of Market-Based Medicine. Medical Anthropology Quarterly 16(4): 476-502.

Sartre, Jean-Paul
1956 Being and Nothingness. New York: Philosophical Library.

Saslow, Eli
2019 ‘Urgent Needs from Head to Toe’: This Clinic had Two Days to Fix a Lifetime of Needs. The Washington Post https://www.washingtonpost.com/national/the-clinic-of-last-resort/2019/06/22/2833c8a0-92cc-11e9-aadb-74e6b2b46f6a_story.html, accessed August 1, 2019.

Sausser, Lauren
2018 South Carolina Wants to Impose Work Requirements on Medicaid Beneficiaries. The Post and Courier. https://www.postandcourier.com/health/south-carolina-wants-to-impose-work requirements-on-medicaid-beneficiaries/article_f3ea7be0-f6f3-11e7-99ba 676672dbc0de.html, accessed March 10, 2019.

Schaller, Jessamyn, and Ann Huff Stevens
2015 Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics 43: 190-203.

Scheper-Hughes, Nancy
1989 Death Without Weeping: The Violence of Everyday Life in Brazil. Berkeley, CA: University of California Press.

Schneider, Daniel, and Kristen Harknett
2019 Consequences of Routine Work-schedule Instability for Worker Health and Well-being. American Sociological Review 84(1): 82-114.

Schram, Sanford
2000 In the Clinic: The Medicalization of Welfare. Social Text 18(1): 81-107.

Schüll, N.D.
2012 Addiction by Design: Machine Gambling in Las Vegas. Princeton, NJ: Princeton University Press.

Sennett, R. and J. Cobb
1973 The Hidden Injuries of Class. New York: Vintage.

Sered, Susan Starr and Rushika Fernandopulle
2006 Uninsured in America: Life and Death in the Land of Opportunity. Berkeley: University of California Press.

Shaw, S.

2018 The Responsibility to Maintain Health. In Unequal Coverage, edited by J. Mulligan and H. Castañeda, 207–30. New York: NYU Press.

Shipler, David

2004 The Working Poor: Invisible in America. New York: Knopf.

Shore, Cris

2008 Audit Culture and Illiberal Governance: Universities and the Politics of Accountability. Anthropological Theory 8(3): 278-298.

Shore, Cris, and Susan Wright

1997 Policy: A New Field of Anthropology. In Anthropology of Policy: Critical Perspectives on Governance and Power, eds. Cris Shore and Susan Wright, 3-41. New York: Routledge Press.

Singer, Merrill

1995 Beyond the Ivory Tower: Critical Praxis in Medical Anthropology. Medical Anthropology Quarterly 9(1): 80-106.

Slade, David

2018 A Decade After Recession Hit, SC Incomes haven't Recovered. The Post and Courier https://www.postandcourier.com/news/a-decade-after-recession-hit-sc-incomes-haven-t-recovered/article_b6b12c42-b6b5-11e8-920f-cfbce6291c3e.html, accessed June 26, 2019.

Small, Linda Marie

2000 Disenfranchised Workers: Pioneers on America's Internal Frontiers. Anthropology of Work Review 20(2): 17-24.

Smith, Gavin

2011 Selective Hegemony and Beyond- Populations with "No Productive Function": A Framework for Enquiry, Identities: Global Studies in Culture and Power 18(1): 2-38.

Social Security Administration

2019 "Gainful Employment Activity." Social Security Administration https://www.ssa.gov/oact/cola/sga.html, accessed June 1, 2019.

South Carolina Chamber of Commerce

2016 Union Free S.C. South Carolina Chamber of Commerce. https://www.scchamber.net/advocacy/union-free-sc, accessed January 27, 2019.

South Carolina Educational Television
2018 Medicaid Mix-Up: Governor Debate Heats up Over Federal Aid Questions. McClatchy. https://www.mcclatchydc.com/news/politics-government/article220207310.html, accessed October 5, 2019.

South Carolina Public Health Institute
2011 A Report on Frequent Users of Emergency Rooms in South Carolina. South Carolina Public Health Institute. http://imph.org/wp-content/uploads/2011/02/Report-on-Frequent-Users-of-ED-in-SC-FINAL.pdf, accessed May 14, 2016.

Standing, Guy
2011 The Precariat: The New Dangerous Class. London: Bloomsbury Academic.

Stansfeld, Stephen, and Bridget Candy
2006 Psychosocial Work Environment and Mental Health—a Meta-analytic Review. Scandinavian Journal of Work, Environment and Health 32: 443–62.

Starr, Paul
1982 Transformation of Defeat: The Changing Objectives of National Health Insurance, 1915-1980. American Journal of Public Health 72(1): 78-88.

Strine, Tara W., with Ali H. Mokdad, Lina S. Balluz, Raquel Crider, Joyce T. Berry, and Kurt Kroenke.
2015 Depression and Anxiety in the United States: Findings from the 2006 Behavioral Risk Factor Surveillance System. Psychiatric Services 59(12): 1383 1390.

Strathern, Marilyn
2000 Afterword: Accountability . . . and Ethnography. In Marilyn Strathern (ed.) Audit Cultures. London: Routledge. 279–304.

Stuesse, Angela
2016 Scratching out a Living: Latinos, Race, and Work in the Deep South. Vol. 38. Berkley: University of California Press.

_______
2018 When They're Done with You: Legal Violence and Structural Vulnerability among Injured Immigrant Poultry Workers. Anthropology of Work Review 39(2): 79-93.

Styron, William
1992 *Darkness Visible: A Memoir of Madness*. New York, NY: Random House.

Sweet, Elizabeth, with Christopher W. Kuzawa, and Thomas W. McDade
2018 Short-term Lending: Payday Loans as Risk Factors for Anxiety, Inflammation and Poor Health. SSM-Population Health 5: 114-121.

Tanner and Hughes
2013 St. Luke's Free Medical Clinic Experiencing Doctor Shortage. https://www.goupstate.com/news/20180628/st-lukes-free-medical-clinic-experiencing-doctor-shortage, accessed July 7, 2017.

Tavernise, Sabrina
2013 Cuts in Hospital Subsidies Threaten Safety-Net Care. The New York Times. https://www.nytimes.com/2013/11/09/health/cuts-in-hospital-subsidies-threaten-safety-net-care.html, accessed June 4, 2018.

Taylor, Stephen Wallace
2016 "Stretch-out." South Carolina Encyclopedia. Last modified November 18, 2016 http://www.scencyclopedia.org/sce/entries/stretch-out/

Thébaud-Mony, Annie
1999 Contracting and Subcontracting by the French Nuclear Power Industry. International Journal of Occupational and Environmental Health 5(4): 296-299.

Thompson, Derek
2016 Can Paul Ryan's Pleasant Language Sell His Divisive Policies? The Atlantic. https://www.theatlantic.com/politics/archive/2016/03/paul-ryan-donald-trump makers-takers/475089/, accessed July 17, 2018.

Turner, Ross and Dwight Loftis
2018 "Moving Able-Bodied People from Welfare to Work isn't 'Mean-Spirited.'" Greenville News, March 9, 2018. Accessed Jun 12, 2019. https://www.greenvilleonline.com/story/opinion/2018/03/09/opinion-moving-able-bodied-people-welfare-work-isnt-mean-spirited/361037002/

Van Arsdale, David
2016 The Poverty of Work: Selling Servant, Slave and Temporary Labor on the Free Market. Leiden: Brill.

Vanderlip, Erik R., with Wayne Katon, Joan Russo, Dan Lessler, and Paul Ciechanowski
2014 Depression among Patients with Diabetes attending a Safety-net Primary Care Clinic: Relationship with Disease Control." Psychosomatics 55(6): 548-554.

Vives A, M. Amable, M. Ferrer, S. Moncada, and C. Llorens
2013 Employment Precariousness and Poor Mental Health: Evidence from Spain on a New Social Determinant of Health. Journal of Environmental and Public Health: 1-10.

Vosko, Leah F.
2000 Temporary Work: The Gendered Rise of a Precarious Employment Relationship. Toronto: University of Toronto Press.

Vosko, Leah F., Martha MacDonald, and Iain Campbell, eds.
2009 Gender and the Contours of Precarious Employment. Vol. 8. New York: Routledge.

Waldrep III, G. C.
2000 Southern Workers and the Search for Community Spartanburg County, South Carolina. Urbana: University of Illinois Press.

Ware, Norma C., with William S. Lachicotte, Suzanne R. Kirschner, Dharma E. Cortes, and Byron J. Good
2000 Clinician Experiences of Managed Mental Health Care: A Rereading of the Threat. Medical Anthropology Quarterly 14(1): 3-27.

Warner, Joanne, with Nina Rovinelli Heller, Elaine Sharland, and Sonya Stanford, eds.
2017 The Historical Context of the Risk Paradigm in Mental Health Policy and Practice: How Did we Get Here? *In* Beyond the Risk Paradigm in Mental Health Policy and Practice. Pp. 1-14. London: Palgrave.

Weil, David
2014 The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It. Cambridge, MA: Harvard University Press.

Weixel, Nathaniel
2019 South Carolina seeks Trump admin permission for Medicaid work requirements. The Hill. https://thehill.com/policy/healthcare/447781-south-carolina-seeks-trump-admin-permission-for-medicaid-work-requirements, accessed August 7, 2019.

Wexler, Lisa Marin, with Gloria DiFluvio, and Tracey K. Burke
2009 Resilience and Marginalized Youth: Making a Case for Personal and Collective Meaning-making as Part of Resilience Research in Public Health. Social Science & Medicine 69(4): 565-570.

Whittle, Henry J., with Kartika Palar, Nikhil A. Ranadive, Janet M. Turan, Margot Kushel, and Sheri D. Weiser

2017 The Land of the Sick and the Land of the Healthy: Disability, Bureaucracy, and Stigma among People Living with Poverty and Chronic Illness in the United States. Social Science & Medicine 190: 181-189.

Wilkinson, Iain, and Arthur Kleinman

2016 A Passion for Society: How We Think about Human Suffering. Berkeley: University of California Press.

Wilkinson, Jeff

2013 State House for Sale: Big businesses pay off in jobs, political contributions. The State. https://www.thestate.com/news/business/article13827995.html#storylink=cpy, accessed October 15, 2018.

_______

2016 Proposal to Raise SC's Minimum Wage Killed. The State, April 27: B1.

Willette, Ross

2018 Precarious Employment Arrangements and Adverse Physical Health Outcomes: The Influence of Work-related Psychosocial Factors that Can Impact Health. American Journal of Medical Research 5(2): 58–63.

Willging, Cathleen E., with Howard Waitzkin, and Ethel Nicdao

2008 Medicaid Managed Care for Mental Health Services: The Survival of Safety Net Institutions in Rural Settings. Qualitative Health Research 18(9): 1231 1246.

Williams, David R., with Naomi Priest, and Norman B. Anderson

2016 Understanding Associations among Race, Socioeconomic Status, and Health: Patterns and Prospects." Health Psychology 35(4): 407-411.

Wohlfarth, Tamar

1997 Socioeconomic Inequality and Psychopathology: Are Socioeconomic Status and Social Class Interchangeable? Social Science & Medicine 45(3): 399 410.

Wohn, Alice JH

2001 Towards GATT Integration: Circumventing Quantitative Restrictions on Textiles and Apparel Trade under the Multi-Fiber Arrangement. University of Pennsylvania Journal of International Economic Law 22: 375-419.

Woolf, Virginia

2002 On Being Ill. Ashfield, MA: Paris Press.

Wright, Erik Olin

The Class Analysis of Poverty. International Journal of Health Services 25(1): 85-100.

Wright, Melissa W.

2006 Disposable Women and Other Myths of Global Capitalism. New York: Routledge.

Wulff, Katharine, with Darrin Donato, and Nicole Lurie

2015 What is Health Resilience and how can We Build it? Annual Review of Public Health 36: 361-374.

United States Census Bureau 2018

2018 Spartanburg, South Carolina. United States Census Bureau https://www.census.gov/quickfacts/fact/table/spartanburgcountysouthcarolina,US/PST045218, accessed August 16, 2019.

Yates, Michelle

2011 The Human-As-Waste, the Labor Theory of Value and Disposability in Contemporary Capitalism. Antipode 43(5): 1679–1695.

Yohanna, Daniel

2013 Deinstitutionalization of People with Mental Illness: Causes and Consequences. AMA Journal of Ethics 15(10): 886-891.

Zabkiewicz, Denise

2009 The Mental Health Benefits of Work: Do they Apply to Poor Single Mothers? Social Psychiatry and Psychiatric Epidemiology 45(1): 77-87.

Zieger, R.H., ed.

2012 Life and Labor in the New New South. Gainesville: University Press of Florida.

## VITA

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### EDUCATION

2010 M.A. (Anthropology) University of Montana
2007 B.S. (Anthropology) Eastern Kentucky University

### AWARDS/PRIZES

2019 Harold K. Schneider Graduate Paper Prize Honorable Mention
2017 ADTSG Graduate Paper Competition Honorable Mention
2017 University of Kentucky Dissertation Enhancement Award
2014 Daniel R. Reedy Quality Achievement Fellowship Award
2011 Fulbright Award (Netherlands)

### TEACHING POSITIONS HELD

Taught as a primary Instructor:

APP 300: Appalachia and/in Memory
ANT 160: Cultural Diversity in the Modern World
ANT 101: Introduction to Anthropology

Taught as a teaching assistant:

AAS 400: Film Studies: Black Life Matters
ANT 431: Ethnographic Field Methods
ANT 160: Cultural Diversity in the Modern World

### PUBLICATIONS

Quintero, Gilbert, **Henry Bundy**, and Michelle Grocke
2019 "I Want to See Those Memories": Social Affordances of Mobile Phone Cameras and Social Network Sites in Collegiate Drinking. Contemporary Drug Problems 46(2): 180-197.

**Bundy, Henry**
2018 Review of *Christian Bend,* by Karen Spears Zacharias, *Journal of Appalachian Studies* 23(1): 251-252.

**Bundy, Henry** with Gilbert Quintero

2017 From Mundane Medicines to Euphorigenic Drugs: How Pharmaceutical Pleasures are Initiated, Foregrounded, and Made Durable. International Journal of Drug Policy 49: 109-116.

Miller Clousser, Jessica, with Jennifer Swanberg and **Henry Bundy**

2015 Keeping Workers Safe: Does Provision of Personal Equipment Match Supervisor Risk Perceptions? American Journal of Industrial Medicine 58(8): 886 896.

Schoenberg, Nancy E. with **Henry Bundy**, Jordan A. Baeker Bispo, Christina R. Studts

2014 A Rural Appalachian Faith-Placed Smoking Cessation Intervention. Journal of Religion and Health 54(2): 598-611.

Quintero, Gilbert with **Henry Bundy**

2011 "Most of the Time You Already Know": Pharmaceutical Information Assembly by Young Adults on the Internet. Substance Use and Misuse 46 (7): 898-909.