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Walden University

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Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Karen D. Hudson

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Walden University
2017

Abstract

Nonresidential Fathers Parenting Their Children Residing in Shelters:

A Phenomenological Study

by

Karen D. Hudson

MSW, University of Pennsylvania, 1980

BA, Boston University, 1978

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

November 2017

Abstract

This phenomenological qualitative study explored the parenting role of nonresidential fathers of children living in shelters. Special attention was paid to the perceived contributions of these fathers to the overall health and general well-being of their children residing in shelters. Often separations of nonresidential fathers from their children in shelters decreased their contributions to their children's health and well-being. Increased knowledge of these parental roles and contributions can enhance programs and policies to support these fathers in improving the health and well-being of their children. In-depth semistructured interviews were conducted with 6 demographically diverse nonresidential fathers living in Philadelphia. The health-belief model, in conjunction with the revised health-belief model, was used as a theoretical framework for this study. The research questions were designed to explore nonresidential fathers' parenting roles, perceptions of their contributions, and the facilitators of and barriers to their parenting while their children resided in shelters. An inductive approach to data analysis informed study findings of nonresidential fathers' active participation and engagement in their children's lives, including involvement in their healthcare and health promotion. Perceived facilitators to their parenting role included internal and external motivators, whereas perceived challenges and barriers to their parenting role were externally based. Finally, study findings showed these fathers to be present and making significant contributions to the improved health and overall well-being of their children while they resided in homeless shelters.

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Dedication

I dedicate this dissertation to several very important people in my life: my late parents, Geneva Burney Maxwell and James E. Maxwell, for being my first teachers and for loving me, supporting me, encouraging my education, and teaching me about the important role and contributions parents can make in the overall growth and development of their children. I will forever be grateful to them for helping me become the person I have become.

To my sons David and Mark: I thank you beyond words. To my precious David, you have demonstrated the power of love through the important role that you have played by being a father figure to children that were not your own biological children. Your love and dedication to these children has been truly remarkable. Thank you for sharing yourself while sharing love and guidance as a loving father figure. I look forward to the father that you will be to your own child(ren) and my grandchild(ren). Thank you for this precious gift. Please keep sharing the love and lessons to all children. I will love you always. To my beloved Mark, whose life was taken at the young age of 26 years: losing you during my doctoral journey almost brought my dream of a PhD to an end. Mark, as both a police officer and firefighter, you gave so much to so many, including children. Thank you for your loving gift of service. I am saddened beyond belief that you aren't here to see me finish this journey and that I won't get to see the wonderful father that you could have been. I will love you always.

To Max, my love and life partner: thank you for picking me up and supporting me to continue this journey when I thought I couldn't. Thank you for the life lessons you have shared about fatherhood, its joys and challenges. You have been my rock! I don't think I'd still be here without you.

To my Almighty Father, from whom all blessings flow: you put me on this path and you have walked with me and even carried me through parts of this journey. I love and thank you, God, for blessing me and seeing me through this journey. I look forward to seeing where you will take me beyond this PhD. I am trusting you.

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To Children's Hospital of Philadelphia leadership: thanks for the ongoing financial support for this endeavor. And to my AMAZING Homeless Health Initiative team/friends: thanks for working alongside me over many years and for supporting me in this work. Many wonderful experiences working with children and families in shelter led to my many questions about the population, including the fathers. Thanks also to my colleagues who shared a passion with me for the fathers of the children in shelters. Your efforts, ideas, and thoughts along the way about this important population have been

appreciated. A very special thanks is offered to the nonresidential fathers who participated in my study. Your voice has been heard and will help others.

Finally, I'd like to thank my family, friends, and many supporters who cheered me on during this journey. Thanks for lifting me up when I needed it the most! You are all a part of my "village" and I could not have done it without your support. Thanks from a very grateful heart.

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Chapter 1: Introduction of the Study

Introduction

As a professional social worker with over 17 years of experience leading a community health outreach program, I have made numerous observations about human behavior that have invited questions worthy of naturalistic inquiry (Creswell, 2012; Patton, 2002). The community health outreach program, The Children's Hospital of Philadelphia Homeless Health Initiative, evolved from a phenomenon noted by healthcare providers (Children's Hospital of Philadelphia, 2017). These healthcare providers observed frequent and inappropriate use of the local pediatric hospital emergency room by families residing in nearby homeless shelters (Children's Hospital of Philadelphia, 2017). All too frequently, mothers residing in nearby homeless shelters would bring their children to the emergency room for routine care without the children's fathers. Families experiencing homelessness often consist primarily of a single mother and two children (Bassuk, DeCandia, Beach, & Berman, 2014). Inappropriate visits to emergency rooms for regular healthcare can impact the health of the public because they could delay timely treatment provision (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). In personal communications, healthcare providers explained to me that they began to wonder why children from local shelters were using the emergency room frequently, inappropriately, and in great numbers. After exploration and multiple discussions between healthcare providers and homeless service providers**,** the healthcare providers hypothesized that families were not able to prioritize primary and specialty healthcare, did not understand how to navigate the complex healthcare system, and did not know when to use the emergency room appropriately. Researchers reported similar

observations regarding increased emergency room use by those experiencing homelessness (Grant et al., 2007, 2013; Needle, 2014; Wood & Valdez, 1991).

Given this observation and understanding, the aforementioned community health outreach program was created to help families better address their healthcare needs, even while living in shelters (Homeless Health Initiative, 2016). The Homeless Health Initiative (Children's Hospital of Philadelphia, 2017) identified four primary program goals: (a) to provide quality, culturally effective acute medical services to children in shelters (b) help families access primary and specialty-care providers, (c) help families access insurance coverage, (d) provide health education for families and children. This program uses volunteer healthcare providers to offer medical care directly in homeless-shelter settings. Healthcare volunteers including pediatricians, dentists, nurses, and social workers offer education as a central component of healthcare and actively engage patients in their own environments (Children's Hospital of Philadelphia, 2017). These activities enable healthcare volunteers to better understand the social determinants of health including issues such as poverty, access to care, housing, and employment, while simultaneously resolving barriers to healthcare for the families (Marmot, Friel, Bell, Houweling, & Taylor, 2008).

Significant involvement in the building and implementation of this important community health outreach program aided healthcare volunteers in building relationships with shelter staff and the families residing within. For families, building relationships with healthcare providers removed a barrier to accessing regular healthcare (American Institutes for Research, 2015; Perlman, Sheller, Hudson, & Wilson, 2014; Wood & Valdez, 1991). Other barriers to securing healthcare included insurance, transportation,

and not knowing where or how to secure healthcare (Bassuk et al., 2014; National Center for Children in Poverty, 2009; Wood & Valdez, 1991).

In addition to these barriers, families, and mothers in particular, residing in homeless shelters had many individual stressors, including traumatic backgrounds, mental health and substance-abuse challenges, limited education, lack of organizational skills, and limited social support. These stressors also contributed to healthcare being used more as an emergency rather than a prevention activity (Hatton, Kleffel, Bennett, & Gaffrey, 2001).

Social isolation coupled with limited social support and resources can also contribute to poor health (Hwang et al., 2009). In contrast, researchers have shown that relationships and social support contribute to improved health (Umberson, Crosnoe, & Reczek, 2010). One area where women in emergency housing most perceive a need for social support is parenting. Specifically, Umberson et al. (2010) found that mothers' perceived notion that instrumental support, including money, time, or in-kind assistance, helped improve children's overall health through encouragement, accompaniment, and the offering of concrete help.

With this in mind, a goal of increasing social support for mothers, internally and externally, could encourage greater assistance to address their children's health needs (Grant et al., 2013). Considerations for building internal support for mothers and, ultimately, their children's health, might come from shelter staff; external social supports might come from nonresidential fathers, other family members, social-service providers, or healthcare providers. Each of these supports has the potential to help improve the health and well-being of CIS (Grant et al., 2013).

Further consideration of fathers' support to mothers and their children while they are residing in shelters is important (Paquette & Bassuk, 2009). Parenting is a very important role that provides children love, safety, protection, teaching, and nurturing. All of these aspects provide education, which are the building blocks for children to learn, to grow and develop, and to receive appropriate healthcare and, ultimately, improved health and well-being (Paquette & Bassuk, 2009). Parenting is also essential for teaching discipline; providing for basic needs including shelter, food, and clothing; and providing reassurance and safety for children (Bassuk & Beardslee, 2014).

Positive parenting contributions offered by fathers to children included role modeling and contributing to children's understanding of gender roles (Coley, 1998; Foley & Furstenberg, 1999). Fathers also contributed to children's improved language and cognitive-skill development, social skills, socialization, access to social supports and networks, academic achievement, and overall growth and development (Coley, 1998; Foley & Furstenberg, 1999). Increased involvement by fathers contributes to better cognitive and school functioning for their children (Black, Dubowitz, & Starr, 1999; Cabrera, Shannon, & Tamis-LeMonda, 2007; Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Carlson & Magnuson, 2011; Moore & Kotelchuck, 2004; Revell, 2015; Sherman & Harris, 2012). Fathers make important, unique contributions to the health and well-being of their children (Castillo & Sarver, 2012; Linn, Wilson, & Fako, 2015). Garfield and Chung (2006) explored the involvement of urban fathers in the healthcare of their children, and found that fathers who were present at their children's birth were more likely to be involved with their children as youngsters. Linn et al. (2015) offered a sociological and historical perspective on fatherhood as it has evolved over

time. They chronicled how women initially controlled the process of birth, but later fathers were drawn more into this process, especially as women entered the workforce in greater numbers. Their history later showed that changing parenting patterns and different parenting structures including single parenting, step-parenting, and cohabiting families supported fathers' parenting.

Experiencing homelessness and living in a shelter can separate mothers and fathers because of shelter policies that often do not allow fathers to reside in family shelters with mothers and their children. These policies eliminated the ability for the mother and father to parent together as a couple (Fonfield-Ayinla, 2009; Paquette & Bassuk, 2009; Schulz, 2009). Although they may be physically separated from parenting together as a result of residing in a homeless shelter, both parents can teach, nurture, protect, and contribute to the cognitive, social, physical, and emotional development of their children from their own residences (Hwang et al., 2009; Paquette & Bassuk, 2009).

Through work in the Homeless Health Initiative community health outreach program, I spent much time in homeless shelters. I was often on-site in shelters and observed fathers dropping their children off at the shelter after an evening or weekend pass with their children. My observations aligned with findings in the literature I reviewed, which showed the limited, yet positive, roles nonresidential fathers often play in the lives of their children living in shelters (CIS; Cabrera, Ryan, Mitchell, Shannon, & Tamis-LeMonda, 2008; Castillo & Sarver, 2012; Julion, Gross, Barclay-McLaughlin, & Fogg, 2007; Kaye, 2005; Paquette & Bassuk, 2009). The involvement of nonresidential fathers is important and relevant because when these men are supported and further engaged in their role as fathers, they can contribute positively to the overall health and

development of their children (Cabrera et al., 2000; Garfield & Isacco, 2012; Moore & Kotelchuck, 2004; Revell, 2015; Schulz, 2009). Choi, Palmer, and Pyun (2014) studied nonresidential fathers' involvement viewed through the lens of their accessibility, engagement, and interaction. They suggested child-support payments help feed, clothe, and socialize children, which can have indirect effects on children's behaviors. For example, children who are fed experience greater focus and concentration in school. Being adequately clothed can decrease the possibility of experiencing bullying and stigmatization, and money can also assist in paying for socialization activities, which can increase a child's ability to engage in social and recreational activities (Allen & Daly, 2002).

However, strong effects on child outcomes have not been fully demonstrated because of different populations of fathers studied and different methodologies used to study fathers. Notably, nonresidential fathers of children in emergency housing have not been studied. The absence of fathers links to children being more likely to drop out of school, be unemployed, become single parents at an early age, and generally have more negative child-development outcomes. (Booth & Crouter, 1998; McLanahan & Sandefur, 1994) When fathers are unavailable to provide financial, emotional, or concrete support or connections to the larger communities, children experience poor outcomes in health, cognitive, and social/emotional domains (Allen & Daly, 2007; Booth & Crouter, 1998; McLanahan & Sandefur, 1994). Differences in research findings result from studying different populations of children, undertaking different research methodologies, and observing different variables and measures. The frequency and type of father involvement, the quality of father–child relationships, and fathers' involvement in the

larger contexts of family, community, culture, and resources yield differing study findings (Allen & Daly, 2002).

Early research on fathers highlighted the effects of the absence of fathers and showed evidence that fathers' involvement has a direct effect on children's well-being, including enhancing children's cognitive, academic, psychological, and social outcomes. Prior to such studies, fathers primarily were viewed as unimportant to development (Amato & Gilbreth, 1999). More recent research has focused on father involvement and its impact on children's well-being (Allen & Daly, 2002; Ball & Moselle, 2007). Despite literature describing the important contributions of fathers and even nonresidential fathers, I found no literature on the role of parental contributions of nonresidential fathers of CIS. Given the growing numbers of children experiencing homelessness (Bassuk et al., 2014), I conducted this study to help close this gap in the literature.

Background of the Problem

Since the era of the Great Depression, homelessness has been identified as a social and public health problem in the United States (Grant et al., 2013). It was not until the 1980s, however, that homelessness became a more serious part of a national dialogue and agenda (Grant et al., 2013). Since the 1980s, the numbers of those experiencing homelessness have risen continually (Grant et al., 2013; Meanwell, 2012; National Coalition on Health Care, 2010, 2014). In 2010, the National Center on Family Homelessness (NCFH) estimated that 1.6 million children (1 in 45 children) experienced homelessness on an annual basis, with women and children being the fastest growing segment of this population. In November 2014, the NCFH reported these numbers had increased to 2.5 million children, or 1 in 30 children. The most frequent picture of a

family entering a shelter includes a single mother in her 20s with two children under 6 years of age, with limited education, employment, social support, and resources (Bassuk et al., 2014). Many of these mothers suffer from depression and experience interpersonal violence (Bassuk et al., 2014). Often, homeless shelter policies do not allow men in shelters (Paquette & Bassuk, 2009; Schulz, 2009). These policies prevent families from entering shelters together, thereby separating mothers, fathers, and children (Grant et al., 2013). A report compiled by the subcommittee of the Philadelphia Children's Work Group in 2010 offered no mention of fathers in its findings about the state of homelessness for Philadelphia's children and youth.

The problem is that little has been written about fathers experiencing homelessness, their parenting contributions to their children's well-being, and specifically on their involvement in the health and healthcare of their children (Bzostek, 2008; Garfield & Isacco, 2012; Greif & Bailey, 1990; Moore & Kotelchuck, 2004). Even less attention has been given to the experience of nonresidential fathers parenting their CIS (Bzostek, 2008; Paquette & Bassuk, 2009). I conducted this study to address this gap in the literature.

Research Questions

RQ1: How do nonresidential fathers describe their parenting role with their children while their children are residing in shelters?

RQ2: How do these nonresidential fathers perceive their contributions to their children while their children are residing in shelters? If fathers are involved, do they participate in any specific health-related activities with their children and how?

RQ3: What factors do these nonresidential fathers perceive to be facilitators of their parenting of their CIS?

RQ4: What barriers or challenges discourage these nonresidential fathers from parenting their children while their children are residing in shelters?

Purpose of the Study

In this study, I sought to make a scholarly contribution to the literature about a population not currently identified in the literature: nonresidential fathers of children residing in homeless shelters. The purpose of this study was to explore the parenting role of nonresidential fathers in the lives of their CIS to gain a greater understanding of the lived experiences of these fathers. The terms nonresidential fathers and fathers are used interchangeably throughout this study.

Theoretical Framework

Hochbaum (1958) described a study on public participation in medical screening programs that marked the beginning of the health-belief model (HBM). The HBM is a model that offers an opportunity to gain knowledge on a specific population of individuals including their demographic qualities, their behaviors, and their beliefs about the threat of illness, which could help inform practices to seek healthcare. Stated differently, people's beliefs that they may develop a medical problem that can be serious enough to warrant their attention explains and predict their behavior. Additionally, they must believe that changing a behavior or behaviors will offer some benefit for their health that can be gained with limited or minimal cost, financial or otherwise. The model also allows for exploring which cues might prompt action taken around health-seeking

behavior. Media messaging, in the case of fathers, often portrays fathers as invisible, and therefore can discourage nonresidential fathers' participation in their children's lives.

Further developing the HBM, Roden (2004) proposed a validated and revised version. This revised model aims toward young families, at-risk families, and nontraditional families. The prevailing emphasis in this revised model is on wellness and health promotion. Roden reconceptualized the HBM to deemphasize the key concept of perceived susceptibility or threat of disease/medical problem and replaced it with a perceived notion of health that promotes a wellness health orientation. Emphasizing wellness and health promotion, Roden explored a specific population to discern if preventative efforts toward wellness and health can improve overall health and well-being. The HBM, coupled with Roden's revised HBM, were an appropriate fit as a theoretical framework for this study. Chapter 2 includes more about this model.

Nature of the Study

I conducted a qualitative, phenomenological study to understand the lived experiences of nonresidential fathers of CIS. In this study, I sought to explore the role of parenting contributions of nonresidential fathers to the health and overall well-being of their children residing in homeless shelters without them. Given this purpose and goal, a qualitative phenomenological study was most appropriate because it enabled me to describe and explore the lived experiences of nonresidential fathers and their parenting roles while their children resided in homeless shelters.

Operational Definitions

Nonresidential fathers: Biological or step-fathers who are not residing with their children while their children are living in homeless shelters.

Assumptions, Limitations, Scope, and Delimitations

Assumptions

In this study I assumed the results from exploring the perspectives of nonresidential fathers would offer preliminary information regarding their thoughts and feelings about their parenting contributions to the health and well-being of their CIS without them. These results may aid in identifying other quantitative methods to support the study results or add to the knowledge gained from this population.

Limitations

Nonresidential fathers of children experiencing homelessness were difficult to find because doing so required me to use mothers in shelters to assist in identifying and finding these fathers. Once found, I thought securing their agreement to participate might be difficult, particularly if they were not providing financial support. If they participated, expecting honest answers for the study might have been a challenge if the nonresidential fathers felt judged or believed they could face legal trouble regarding child support and related issues.

Access to nonresidential fathers of children experiencing homelessness was difficult because identifying and gaining access to these nonresidential father through other social-support systems proved challenging without the relationships built with those in these systems, prior to commencing this study. Results of the study may not be generalizable to fathers experiencing homelessness and living in shelters with their children or to nonresidential fathers in areas other than the Philadelphia, PA, area.

Scope and Delimitations

This study was conducted with nonresidential fathers not living with their children who were residing in homeless shelters to address a gap in the literature. Fathers experiencing homelessness and residing in homeless shelters with their children were not considered part of the sample population in this study because some literature is available on this population of fathers. I used people-first language throughout the study to decrease stigma and to intentionally identify strengths of the children and families discussed. For example, instead of using "homeless fathers," "homeless children," or "homeless families," I used "nonresidential fathers of children experiencing homelessness," "children experiencing homelessness," and "families experiencing homelessness."

Significance of Study

Researchers showed that fathers' engagement in parenting includes fathers demonstrating trust, providing encouragement, actively participating in their children's lives, and offering financial contributions to aid in their children's development and general well-being (Amato & Gilbreth, 1999; Cabrera et al., 2000; Revell, 2015; Schindler & Coley, 2007). Measurements of children's well-being can include children's behavioral indicators such as anxiety or depression, and being withdrawn or aggressive (Bzostek, 2008).

In this research, I attempted to address the current research gap on engagement of nonresidential fathers and their parental involvement in the overall development, improved health and well-being, and quality-of-life dimensions of their children residing in homeless shelters by providing a context in which these fathers described and explored

their experiences (Garfield & Isacco, 2012; Roden, 2004). Given the sharp increase in the numbers of children experiencing homelessness, many more children could reside in homeless shelters with their mothers and often without their fathers (American Institutes for Research, 2015). This qualitative study may contribute to the research needed to understand the needs and concerns of nonresidential fathers of this most vulnerable and increasing population. This study could help homeless provider systems better understand the involvement of nonresidential fathers, including learning better ways to engage them during a particularly vulnerable time for their children. Results may help families as a whole because fathers' involvement may provide support for mothers, which, in turn, allows mothers to take better care of their children. This study has several positive social-change implications:

- First it enhances shelter providers' understanding of the role of nonresidential fathers and the positive contributions they make to parenting their children while their children reside in homeless shelters. This increased understanding can aid in efforts to develop and adopt new homeless service policies that invite the participation and contributions of nonresidential fathers when domestic violence is not an issue.
- Second, the study encourages greater father involvement in the lives of these children, thereby empowering nonresidential fathers to increase their involvement in their children's lives while they are living in homeless shelters (see Amato & Gilbreth, 1999; Bzostek, 2008; Philadelphia Strong Families Coalition, 2014).

- Third, this study may aid in allowing the voices of nonresidential fathers to be heard about their parenting role and contributions to the health and well-being of their children residing in shelters.
- Finally, study findings may lead to greater understanding for healthcare professionals of the impact nonresidential parenting may have on the social/ecological determinants of health, including economic and social conditions, thereby encouraging them to invite fathers to participate more regularly in their children's healthcare (see Ball & Moselle, 2007).

Public health has both an opportunity and a responsibility to promote and acknowledge fatherhood as important to a child's well-being.

Summary

Homelessness has been and continues to be a concerning societal problem. Embedded in this problem is that children and families are the fastest growing segment of the homeless population (Bassuk et al., 2014). Even while they are residing in a homeless shelter, focus should be paid to the physical, emotional, and health needs of children (Garfield & Isacco, 2012). This focus is especially important, given the knowledge that positive child outcomes in health and well-being align with father involvement, whereas current emergency-housing policies often exclude them (Amato & Gilbreth, 1999; Ball & Moselle, 2007; Ball, Moselle, & Peterson, 2007a; Garfield & Isacco, 2012; McLanahan, Garfield, Mincy, & Donahue, 2010; Pleck, 2007; Wilson & Prior, 2011).

I conducted this study to contribute to the literature on the experiences and contributions of nonresidential fathers. In Chapter 2, I offer a literature review to

synthesize what is known about family homelessness. Chapter 3 provides the research methodology used to conduct this study. In Chapter 4 I present the study findings and in Chapter 5 I discuss the results and provide recommendations for future action and research.

Chapter 2: Literature Review

Introduction

Homelessness continues to be a social problem requiring further attention. In November 2014, the NCFH reported an increase in the number of children experiencing homelessness on an annual basis. In 2010, 1.6 million children experienced homelessness, and that figure had increased to 2.6 million by 2014. The fastest growing segment of the homeless population comprises women and children, usually excluding fathers because shelter policies often do not admit men (Khadduri et al., 2009; Paquette & Bassuk, 2009; U.S. Department of Housing and Urban Development, 2009).

Literature-Search Strategy

I conducted the literature search for this review using databases accessed from Walden University and the University of Pennsylvania libraries. At Walden University, I used the CINAHL, Medline, and SocINDEX databases. At the University of Pennsylvania library I used the Scopus database. The common search terms I used for all databases were *homelessness, homeless families, homeless fathers, nonresidential fathers, parenting,* and *child well-being*. I selected additional sources to review from the references in the articles found.

Articles I reviewed included discussions of the state of homelessness and the experiences of families living in shelters. Only three articles referenced the experiences of fathers experiencing homelessness and parenting their children. Paquette and Bassuk (2009) identified the invisibility of nonresidential fathers of CIS. Schindler and Coley (2007) conducted a qualitative study on homeless fathers, exploring parenting and gender-role transitions and found that shelter services are often geared to women, which

could feel uninviting to men. My experiences working in shelters confirmed these observations. McArthur, Zubrzycki, Rochester, and Thomson (2006) conducted a qualitative research study with five fathers in Australia who experienced homelessness as the sole caretaker of their child(ren). The goal of their study was to gather the stories or lived experiences of these five fathers regarding homelessness and fathering. The absence of voices of nonresidential fathers in the scholarly literature marked the need for more research on this population group (see Paquette & Bassuk, 2009). In this study, I thus sought to address this gap in the literature concerning nonresidential fathers and their parenting contributions to their children living in shelters.

Related Dissertation Studies

I found four relevant dissertation studies using the SCOPUS database. In the first, *The Effects of Homelessness on the Mental and Behavioral Health of Children: A Phenomenological Study*, Dennis (2010) found the need for increased study of children and families experiencing homelessness. In the second dissertation, Julion (2002) addressed facilitators and hindrances to African American nonresident fathers' involvement. In the third dissertation, Glover (2016) explored young African American men's perceptions of fatherhood. I read these dissertations and used their findings to better understand this population. In the fourth dissertation study Brown (2008) engaged in a study of father involvement, paternal sensitivity, and father–child attachment in the first 3 years.

Synopsis of the Literature

The literature I reviewed documented the importance of paternal involvement in childrearing, generally drawing clear lines to improved physical, social, and mental

health outcomes for children who have two active parents in their lives (Allen & Daly, 2007; Choi et al., 2014; McLanahan & Sandefur, 1994). However, I found little about the role of fathers in the lives of children experiencing homelessness, and even less about the role of nonresidential fathers.

Coker et al. (2009) and Grant et al. (2007) conducted studies to describe the lifetime prevalence of asthma of fifth-grade children experiencing homelessness in New York. These researchers found evidence that children experiencing homelessness had higher rates of asthma than children who did not experience homelessness. Nickasch and Marnocha (2009) and Wood and Valdez (1991) explored the barriers to healthcare that homelessness creates, and conducted comparative analyses of healthcare access and healthcare services of those experiencing and not experiencing homelessness. They found that those experiencing homelessness often lack the resources necessary to meet their physical needs, and generally experienced more health problems than those not experiencing homelessness.

Other researchers (Bassuk & Rosenberg, 1990; Biswas-Diener & Diener, 2001; Perlman & Fantuzzo, 2010; Rafferty & Shinn, 1991; Schindler & Coley, 2007; Shinn et al., 2008) conducted similar studies regarding the health and well-being of families experiencing homelessness and reported similar findings. Meanwell (2012) and Grant et al. (2013) addressed how homelessness impacted families over time, including how experiencing homelessness negatively impacted the health and education of children. Additionally, researchers found that children experiencing homelessness have poorer overall health and nutrition; physical, mental, and developmental delays; and worse

educational outcomes compared to those who are housed (Grant et al., 2013; Rafferty & Shinn, 1991).

Violence and adverse environmental factors in the home and community also contribute to the less than desirable health of children experiencing homelessness (Park, Fertig, & Metraux, 2011). Children who are not experiencing homelessness and whose lives included positive environmental factors such as early childhood education, experienced higher developmental outcomes (Shinn et al., 2008). Additionally, support from social networks, as well as respect and support from healthcare professionals can play an important role in improving overall well-being (Biswas-Diener &Diener, 2001; Nickasch & Marnocha, 2009).

Families experiencing homelessness often consist of single mothers in their 20s with two children (Bassuk et al., 2014; Grant et al., 2013). This is the fastest growing segment of the homeless population (Bassuk et al., 2014; Meanwell, 2012). Additionally, 63% of women in homeless shelters experienced domestic violence, identified as a contributing factor to the increase in homelessness (Grant et al., 2013). Having been exposed to domestic violence, being older at the first experience of homelessness, and having larger families also contributed to the increase of these families in the child-welfare system (Park, Metraux, Brodbar, & Culhane, 2004). The increase in poverty and the decrease in affordable housing has also contributed to homelessness (National Coalition for the Homeless, 2009). The experience of homelessness may be shaped by gender, race, and ethnicity (Meanwell, 2012).

Given the large numbers of young CIS, I emphasized the importance of considering the parenting contributions of fathers in this study. A father might play a

supporting role in the lives of his children even when he is not living in a shelter with his family (Paquette & Bassuk, 2009; Schindler & Coley, 2007). More than half of the children residing in shelters funded by the U.S. Department of Housing and Urban Development are aged 6 and younger (Fantuzzo, LeBoeuf, Brumley, & Perlman, 2013; Volk, 2014). With so many children under the age of 6, the promotion of early childhood development is an important consideration for parents and for shelter staff alike because the early years lay the foundation for cognitive, socioemotional, and physical development (Bassuk et al., 2014; Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012; Volk, 2014). Promoting positive parenting skills during this time increases the likelihood of improving the developmental success of children (Volk, 2014).

Homelessness can disrupt families in many ways (Lowe, Thomas, & Salmas, 2015). Sometimes, parent homelessness can cause the placement of children into foster care (Low, 1999; Park et al., 2004; Schulz, 2009; Zlotnick, Robertson, & Tam, 2003). Formal and informal shelter rules and policies, developed to maintain order and control, often disempowered parents in and out of shelters (Meanwell, 2012). For example, some homeless-shelter practices or policies do not allow men and adolescent boys to reside in shelters with women and children (Barrow & Lawinski, 2009; Proffitt, 2012). These policies separate families and establish barriers that challenge fathers' parenting involvement. A possible reason for discouraging teenage boys residing in women and children's shelters is to decrease the possibility of romantic relationships and sexual boundaries being crossed by teenage boys and young mothers residing in the same shelters.

These practices sometimes force families to choose among three options: (a) staying together while living "doubled up," or staying with friends or relatives temporarily without their names being on the lease; (b) staying together in places that may be unsuitable for habitation, such as in a car or on the streets; or (c) facing possible separation by entering the shelter system (Grant et al., 2013; Paquette & Bassuk, 2009; Perlman et al.. 2012; U. S. Conference of Mayors, 2012). In shelter settings, mothers are usually expected to be with their children constantly, creating an excessive burden on mothers. Additionally, sometimes families feel the shelter blurs its boundaries by taking over the parenting role from the mother or father (Cosgrove & Flynn, 2005; Friedman, 2012 Proffitt, 2012; Schulz, 2009). Examples of this are when parents/mothers are not able to parent using their own rules, parents directives to their children are discredited and undermined by shelter staff, and parents are observed constantly and made to feel they are publicly parenting or parenting in a "fishbowl" (Cosgrove & Flynn, 2005; Fonfield-Ayinla, 2009). To further explain, parents in shelters are exposed to many rules themselves and to shelter staff members who watch their every move and interaction with their children (Cosgrove & Flynn, 2005; Fonfield-Ayinla, 2009).

Shelter policies and practices, like the ones described above, were designed and implemented to protect families and shelter staff. However, these policies also reduce familial support, which could include nonresidential fathers and nurturing relationships critical to the success of the sheltered families (Letiecq, Anderson, & Koblinsky, 1998; Schulz, 2009). The exclusion of the nonresidential father increases the responsibilities and the work of the mother alone, while simultaneously decreasing the self-esteem of the nonresidential father (Grant et al., 2013; Milburn & D'Ercole, 1991; Perlman et al., 2012;

Proffitt, 2012; Weinreb & Rossi, 1995). It is also possible that the stress of homelessness or poverty overwhelms support networks, including the contributions of nonresidential fathers (Letiecq et al., 1998). Overwhelming support networks can mean that a mother's great needs for monetary, material, and emotional assistance can feel exhausting to those individuals supporting them. That exhaustion sometimes results in a loss of support entirely, and may add an emotional dynamic of guilt from the giver or from the receiver.

Family separation was clearly identified as a risk factor for the development of mental and physical health problems in childhood and adulthood (Perlman & Fantuzzo, 2010). Homelessness was often a stressful and traumatizing experience for families and included exposure to interpersonal and community violence (Bassuk et al., 2014; National Coalition for the Homeless, 2009). Traumatic experiences for children often occurred when infants, children, and adolescents were exposed to chronic poverty, neglect, or harmful treatment (Bassuk et al., 2014; National Coalition for the Homeless, 2009). Even the burden of shelter living, crowded spaces, limited decision making, physical health issues, deaths of infants that occurred in shelters, and verbal or physical confrontations with staff or families in shelter, were traumatic for families residing in shelters.

Poverty and the separation of families, a possible consequence of homelessness, often influenced children's development and the future possibility of the children experiencing homelessness themselves (Grant et al., 2013; Paquette & Bassuk, 2009; Perlman et al., 2012; Schulz, 2009). Separation among families experiencing homelessness has important implications for family functioning and parental roles, in the

present and the future (National Coalition for the Homeless, 2014; Paquette & Bassuk, 2009; Schulz, 2009).

With all that has been written about families experiencing homelessness, researchers have dedicated little attention to fathers experiencing homelessness and living in homeless shelters and their parenting contributions to their children's health and well-being. Even less attention has been given to the parenting contributions of nonresidential fathers of children living in a homeless shelter (Paquette & Bassuk, 2009). The purpose of this study was to explore the parenting role of nonresidential fathers in the lives of their children who are experiencing homelessness and residing in a homeless shelter.

Literature Review

Overview of Homelessness and the Experience of Families

Chronic trauma including childhood abuse, domestic abuse, and community violence, as well as the trauma inherent in chronic poverty and homelessness itself, are common experiences for families experiencing homelessness (Bassuk et al., 2014; Grant et al., 2013; Levy & O'Connell, 2004; Meanwell, 2012). The chronicity of these problems can affect current and future behaviors, feelings, thoughts, and coping abilities of these families (B. A. Cowan, 2014; National Coalition for the Homeless, 2009). Additionally, special attention should be paid to the effects on children's overall development and success throughout life (Bassuk et al., 2014).

Common reasons for families arriving in shelters were domestic violence and safety issues or an inability to continue living "doubled up" (Grant et al., 2013; Paquette & Bassuk, 2009; Perlman et al., 2012; Perlman et al., 2012). These families were often living in tenuous or temporary situations, initiating the spiral downward toward

homelessness (Grant et al., 2013). Grant et al. (2013) identified domestic violence as a contributing factor to the increase in homelessness. Additionally, the U.S. Conference of Mayors (2012) reported that 28% of mayors in 25 cities cited domestic violence as a leading cause of homelessness among families with children. The U.S. Conference of Mayors (2012) cited domestic violence as a leading cause of homelessness among families with children. Many children in the United States experience homelessness, with families and children being the fastest growing segment of the homeless population (Bassuk et al., 2014; Grant et al., 2013; National Coalition for the Homeless, 2014; Paquette & Bassuk, 2009; Perlman et al., 2012). The NCFH reported a rise in the number of children experiencing homelessness from 1.6 million (1 in 45 children) in 2010 to the current 2.6 million (1 in 30 children) experiencing homelessness on an annual basis. Families with children younger than the age of 6 represented the majority of families with children who are experiencing homelessness (Khadduri et al., 2009; Volk, 2014).

Children often reside in shelters for many months and even up to years, and the first 5 years of a child's life shapes his developmental trajectories (Volk, 2014). While residing in shelters, children often do not have safe spaces to play and explore their environments (Perlman et al., 2014; Volk, 2014). Additionally, children have limited privacy with their caregivers due to often overcrowded living situations and staff monitoring in shelters (Cosgrove & Flynn, 2005; Volk, 2014). Given this knowledge, it is important that shelter providers consider the significant health and development contributions mothers and nonresidential fathers can make while their children reside in shelters. The importance of positive parenting to the overall development of children,

including physical, socioemotional, and intellectual development, must be emphasized (David, Gelberg, & Suchman, 2012; Perlman et al., 2014; Revell, 2015; Volk, 2014).

For young children, healthcare maintenance such as immunizations and annual well check-ups are important to promote development (HealthyChildren.org, 2017). Parental visits also promote important developmental activities, such as breastfeeding, developmental play, literacy, and outdoor play (HealthyChildren.org, 2017). Because children tend to reside in homeless shelters for an average of 3 to 6 months, assuring that shelter environments are able to support and offer these activities in a safe and healthy manner is important. These considerations introduce the greater healthcare needs of this population.

Health

Adults' health. Homelessness and poor physical and oral health often coexist (Grant et al., 2007, 2013; Hwang et al. 2009; Muñoz, Crespo, & Perez-Santos, 2013; Volk, 2014; Wood & Valdez, 1991; Wood, Valdez, Hayashi, & Shen, 1990a). Generally, homelessness contributes to poorer health because caring for one's health is often not a priority during a state of homelessness (Gelberg, Andersen, & Leake, 2000; Zlotnick, Zerger, & Wolfe, 2013). In fact, costs and consequences of poor health can also lead to homelessness (Zlotnick & Zerger, 2009). Park, Fertig, and Metraux (2011) suggested limited clarity exists on this latter connection. In efforts to better understand this connection, these authors conducted a longitudinal study to examine maternal health and maternal health behaviors among mothers who experience homelessness or are at risk for homelessness.

Researchers used data from the Fragile Families and Child Wellbeing Study (McLanahan et al., 2010) to examine maternal health and maternal health behaviors among mothers who experience homelessness or are at risk of homelessness (Min Park, Fertig & Metraux, 2011). The study was conducted over a 5-year span with more than 2,600 families from 20 cities across the United States. During the study timeframe, 9.8% of the study population acknowledged at least one period of experiencing homelessness. Study participants completed questionnaires that gathered data about parental health, healthcare access, and housing. Data analysis revealed that homelessness has a limited yet notable effect on maternal health outcomes. The health and health behaviors of mothers are important because if mothers are not healthy enough to care for themselves, they may require assistance in caring for their children. That responsibility may rest on nonresidential fathers or other caregivers. Study findings showed that homelessness does impact maternal health outcomes (Min Park et al., 2011). Other researchers comparing adults experiencing homelessness with those who have low incomes who are housed have found mixed results about this connection. For example, women experiencing homelessness have been found to engage in HIV-risk behaviors (Kidder, Wolitski, Pals, & Campsmith, 2008; Schaefer Solle, 2015; Wenzel, Tucker, Elliott, & Hambarsoomians, 2007). Some common medical problems among adults experiencing homelessness include seizures, asthma, arthritis, chronic pulmonary diseases, musculoskeletal disorders, respiratory problems, hypertension, anemia, diabetes, and oral and dental health problems (Grant et al., 2007; Hwang, 2001).

Children's health. A systematic review conducted by Grant et al. (2013), in which researcher compared home-based versus shelter-housed children, found poorer

health outcomes in CIS. Many studies reported that children experiencing homelessness are at increased risk for physical, mental health, and educational problems (Coker et al., 2009; Paquette & Bassuk, 2009; Wood et al., 1990a). In addition to health conditions, children experiencing homelessness also experience a gap in access to healthcare services.

A study conducted by Weinreb, Goldberg, Bassuk, and Perloff (1998) found worse health outcomes for children experiencing homelessness than housed children. In contrast, Rog and Buckner (2007) identified similar health outcomes for homeless and housed children. Overall, findings suggested that homelessness negatively impacts mental and physical health in the short term, but these effects can decrease over time (Rog & Buckner, 2007).

Adults and children experiencing homelessness had increased emergency room use rather than primary care use (Grant et al., 2013). They also had decreased immunization rates, increased rates of lead exposure, hospitalizations, developmental delays, nutritional problems including increased hunger and food insecurity, asthma, ulcers, sexually transmitted diseases, obesity, and increased chronic health conditions such as asthma and chronic otitis media (Coker et al., 2009; Grant et al., 2007, 2013; Hatton et al., 2001; Montauk, 2006; Park et al., 2011; Perlman & Fantuzzo, 2013; Proffitt, 2010; Wood et al., 1990a). Despite these health problems, preventive measures can be taken to mitigate some health challenges; nonresidential fathers can actively participate in some of these (Wood, Valdez, Hayashi, & Shen, 1990b).

Consistent and regular physical activity for children and adolescents offers many benefits to improve health including protections against high blood pressure, high blood

cholesterol, obesity, and depression (Janssen & LeBlanc, 2010; Rhodes et al., 2016). Often homelessness occurs in the context of poverty accompanied by limited resources such as safe areas to play and learn to socialize with other children. Such limitations occur in personal living areas, schools, and shelter settings with limited access to appropriate and safe play space. These structural deficits contribute to diminished overall development in children experiencing homelessness, including providing limited opportunities to promote needed socialization and social support (Perlman et al., 2014). Children experiencing homelessness often lack the ability to socialize with other children, due to their transient lifestyles (Perlman et al., 2014). Physical activities for children and those in which can participate, including nonresidential fathers, can also bring needed social support to families experiencing homelessness (Rhodes & Quinlan, 2014; Rhodes et al., 2016).

Parental support of children's physical activity is important. Rhodes et al. (2016) conducted a quantitative study surveying more than 1,200 mothers of children aged 5–12, measuring attitudes, perceived control of support planning, and the intention to support. The researchers found that most study participants intended to support regular and consistent physical activity. However, more than half of participants failed to support this intention. Moving from intending to support physical activity to doing so may have been difficult due to a perception that the experience of supporting was not enjoyable or was difficult to do (Rhodes et al., 2016).

Thus, structured interventions that promoted participation could address this difficulty, needed to preserve the health of these children (Rhodes et al., 2016). One such physical-activity intervention found in the literature aimed to provide physical activity

supported by parents among children experiencing homelessness and residing in homelessness shelters. That intervention was an obesity-prevention program called Operation CHOICES (Children's Hospital of Philadelphia, 2017). The Operation CHOICES program consists of weekly nutrition education and physical fitness activities offered for children and adults separately in family homeless shelters in Philadelphia, PA (Bennett, Berrios, & Hudson, 2014). The program design was preventative in nature with the development of quantitative outcome measures a challenge because body-mass-index changes may not occur in the amount of time families lived in shelters.

A primary parenting function is attending to and providing for the healthcare needs of one's child. Given the above analysis, opportunity for parental involvement might improve these health behaviors and health outcomes in children. A role specifically for nonresidential fathers might be incorporated here.

Mental health/behavioral health. Mental health issues impact mothers and children experiencing homelessness (Bassuk, Buckner, Perloff, & Bassuk, 1998; Buckner, Bassuk, Weinreb, & Brooks, 1999; Grant et al., 2007; Harpaz-Rotem, Rosenheck, & Desai, 2006; Tischler, Rademeyer, & Vostanis, 2007; Weinreb, Buckner, Williams, & Nicholson, 2003). Nirui, Dudley, and Ferson (2011) conducted a small mixed-methods study, including a sample of 13 women and children experiencing homelessness. The researchers found high rates of suicidal ideation and suicide attempts and high rates of anxiety and depression of mothers. Nine of the 11 children included in the study had behavioral problems and mental health issues that measured in the clinical range, using the Child Behavior Check List. Despite their study findings from this small sample, they questioned the link between homelessness and mental health problems; they

especially wondered whether mental health issues were a result of homelessness or if mothers and children had mental health issues before experiencing homelessness.

Park, Metraux, Culhane, and Mandell (2012) conducted a study about the use of mental health services by this population and suggested one must account for the high proportion of children experiencing homelessness who have been in foster care when assessing the link between homelessness and mental health. More children experiencing homelessness were in foster care than the number of low-income children who are housed. Fitzpatrick, Myrstol, and Miller (2015) studied the mental health of those experiencing homelessness as it relates to social capital and the social connectedness of the homeless population. Social capital and social connectedness refer to the collective resources available to provide support and assistance. These resources could include emotional or concrete support. Examples could include financial assistance, advice giving, or assistance with caregiving. They suggested that social capital and social connectedness can decrease the negative effects of mental health in this population. These were important considerations in thinking about families experiencing homelessness and the role of nonresidential fathers, particularly because trauma backgrounds or other mental health diagnoses of mothers could negatively impact their ability to parent their children who may also have behavioral problems (Harpaz-Rotem, Rosenheck, & Desai, 2006; Tischler et al., 2007). Often mothers experiencing homelessness have witnessed trauma in their backgrounds including experiencing child abuse, domestic violence, or community violence. These traumatic experiences can often leave mothers with symptoms of depression or other mental health diagnoses (Grant et al., 2007; Tischler et al., 2007). Haskett, Perlman and Cowan (2014) suggested that these

and future studies can contribute to a greater understanding of the mental health and behavioral and emotional needs of these families, and to the improved skills of shelter providers in meeting the needs of families experiencing homelessness.

Mental health of children. Learning disabilities and behavioral and emotional problems are commonly observed in children experiencing homelessness, whereas developmental delays are frequent in children under the age of 5 (Bassuk & Rosenberg, 1990; Coker et al., 2009; B. A. Cowan, 2014; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993; Proffitt, 2010; Schulz, 2009; Vostanis, 2002; Wood et al., 1990b). Vostanis, Grattan, Cumella, and Winchester (1997) compared 58 formerly homeless/rehoused families to 21 low-income, stably housed families. The researchers found mental health problems were significantly higher in rehoused families of mothers and children than in stably housed families. Rehoused mothers and children had higher rates of mental illness than their housed counterparts: 26% vs. 5% and 39% vs. 11%, respectively. Study authors also noted families had limited social support.

As the population of children ages, these youth could be more heavily impacted by peer-relationship difficulties, social isolation, fewer friends and less social support, and alcohol and substance abuse, and have higher risk for anxiety disorders, suicidal attempts, and exposure to street violence (Vostanis, Tischler, Cumella, & Bellerby, 2001). These same issues of mental health disorders and substance abuse are often found in the parents of these children and youth (Gewirtz, 2007).

Increased rates of mental health challenges also emerged in mothers and children impacted by domestic violence and community violence (Vostanis et al., 2001). Researchers conducted a mixed-methods study including semistructured interviews,

questionnaires, and surveys to collect data comparing three groups of families who had experienced homelessness. The three groups included 48 families who were experiencing domestic violence, 14 families who had been victims of neighborhood/community violence, and 31 families that experienced homelessness through other routes. Study findings included high levels of psychiatric morbidity in the group experiencing domestic violence, with children found at 35.7% and mothers at 21.9%. The group comprising victims of community violence had an even higher finding: children had 52.2% psychiatric morbidity and mothers had 50%. The authors found social support to be a very important factor in improving the functioning and success of the families.

Education

Children's education. Children experiencing homelessness often have high truancy and lateness. Both factors can lead to developmental, behavioral, and academic problems, including grade retention (Bassuk & Rosenberg, 1990; Buckner, Bassuk, & Weinreb, 2001; Grant et al., 2013; Rafferty, Shinn, & Weitzman, 2004; Wood et al., 1990b). These problems often align with additional stressors such as loss of home and property, relationships, and routines with family, friends, and neighbors, and the disruption of school and community relationships (Gewirtz, 2007; Grant et al., 2013).

Research studies that compared academic achievement of children experiencing homelessness and children not experiencing homelessness found that the former performed worse on standardized tests than the latter (Herbers et al., 2011; Obradović et al., 2009; Rafferty et al., 2004; Rubin et al., 1996; Vostanis et al., 1997). Researchers also found that academic achievement in the short term was worse for adolescents experiencing homelessness than those not experiencing homelessness (Flouri &

Buchanan, 2004b). However, no differences emerged between the two groups 5 years after experiencing homelessness (Herbers et al., 2011; Obradović et al., 2009; Rafferty et al., 2004; Rubin et al., 1996; Vostanis et al., 1997). A longitudinal study conducted by Obradović et al. (2009) on the academic achievement of homeless and highly mobile students in an urban school district concluded the children were at higher risk of lower academic achievement than low-income and more advantaged students in the district. Obradović et al. completed the study using secondary data analysis of a data set collected by the Minneapolis Public School District.

Perlman and Fantuzzo (2010), through a population based study, contributed to the dialogue by considering the timing of first substantiated maltreatment reports, homelessness, and academic achievement and attendance of children at the end of their second-grade school year. The study sample included more than 12,000 students in a large urban school district. Study methods included the use of regression models to study the variables of academic achievement, attendance, substantiated child maltreatment, and controlling for poverty, birth risks, and demographics. The researchers found important relationships between the age at first maltreatment, episodes of homelessness, and academic achievement.

Rafferty et al. (2004) conducted a comparative longitudinal, mixed-methods study that considered school experiences and the academic success of 46 adolescents who had experienced homelessness and 87 low-income, housed adolescents between 1992 and 1993. The study goal was to measure achievement and other outcomes of the two groups through parent reports, self-reports, measures of the Wechsler Intelligence Scale for Children, and the New York City Department of Education standardized test scores in

mathematics and reading, before, during, and after homelessness. Previous research reported that children experiencing homelessness performed worse than low-income children who were housed. What was not clearly known was the difference between these two groups prior to and following homelessness. Both groups valued education and had academic achievement scores lower than the national average. Lower academic achievement emerged in the short term and was worse for those adolescents experiencing homelessness.

Herbers et al. (2011) conducted a mixed-methods study that examined quality of parenting, child executive functioning and intellectual functioning, risk status, and academic functioning, reported by teachers. Study participants included 58, children aged 4 to 7 and their parents who were residing in an emergency homeless shelter. The researchers conducted structured parent interviews. Additionally, parent-interviewer ratings and ratings by trained judges comprised behavioral scale ratings. Interviewer ratings comprised general impressions of parent behavior obtained during the 90-minute interview. Study conclusions showed an association between parenting quality and the academic success of their children. High-quality parenting, including reading to children, teaching and encouraging academic skills, communicating with teachers, attending school functions, and helping with homework can provide protective factors for children that can improve children’s social skills and school accomplishments (Arnold & Doctoroff, 2003; Supplee, Shaw, Hailstones, & Hartman, 2004). This could be another area where nonresidential fathers could make contributions.

Families experiencing homelessness often experience social isolation and have very limited social support (Bassuk & Rosenberg, 1988; Perlman et al., 2014). By

offering feedback, sharing, and helping parents to be successful, social support can contribute to improved well-being and can decrease negative effects that can result from stress (Biederman, Nichols, & Lindsey, 2013; Letiecq et al., 1998; Marra et al., 2009; Raikes & Thompson, 2005). This need for social support highlights another important reason to consider the support that might be offered by nonresidential fathers toward the improvement of the well-being of their children residing in homeless shelters.

Nonresidential Fathers and Children's Well-being

Greater than 5 million men from a multitude of culturally diverse backgrounds including age, race, marital status, and geographical residency contributed to the growing problem in the United States of being unable to offer financial support to children who live apart from them (Carson, McLanahan, & Brooks-Gunn, 2007; Mincy, Jethwani, & Klempin, 2015). Paternal absences are charged with encouraging children to grow into young people who are more likely to drop out of school, use drugs, take risks, become involved in the criminal-justice system, or become young parents themselves (Allen & Daly, 2007; Booth & Crouter, 1998; McLanahan & Sandefur, 1994; Wertheimer et al., 2003). Stated differently, fathers or father figures can play a significant role in the improved health and well-being of a child, measured by increased social, emotional, and cognitive achievement (Cabrera et al., 2000; Flouri & Buchanan, 2004a; Garfield & Chung, 2006; Lamb, 2004; Linn et al., 2015; Revell, 2015).

The Fatherhood Initiatives (National Responsible Fatherhood Clearinghouse, 2016) developed by President Obama's Center for Faith Based & Neighborhood Partnerships were developed to promote strategies that encourage support for fathers and families. In 1960, less than 8 million children were living in families where the father

was absent. In 2015, the number of children living in father-absent homes was approximately 24 million (U.S. Department of Justice, 2016). However, the absence of a father living with their children does not confirm the lack of contributions a father makes or can make to his children's overall development and well-being (Amato & Gilbreth, 1999; Julion et al., 2007; Kissman, 1998; McAdoo, 1997; Mincy et al., 2015).

Palkovitz and Palm (2009) explored the concept of transitions in fathering through a lens that viewed this construct and phenomenon as a long-term process. The transitional nature of this process was a continuous self-critical inquiry of how a father feels about himself and the world in which he resides. The self-critical inquiry also assessed how fathers perceived the world to see him and measured his competence and job performance. These researchers offered a glimpse into how fathers change and grow through their many transitional experiences. The authors considered transitions that arose from difficult situations such as separation, divorce, evictions, and serious illness. In particular, they considered particular developmental transitions that included cognitive, affective, and behavioral changes that result from life transitions. P. A. Cowan and Hetherington (2016) further described transitions as resulting from disequilibrium and conflict that ends in a successful developmental marker. Additionally, Wapner (1993) connected developmental success to a specific endpoint or goal. These constructs around "fathering" offered a lens through which to consider the experience of nonresidential fathers and the parenting of their children when they were residing in a homeless shelter.

Schindler and Coley (2007) conducted a qualitative research study using semistructured, face-to-face interviews with nine fathers living with their children in family homeless shelters. Additionally, they interviewed three shelter directors. The

researchers' goal was to explore and better understand the meaning behind the experiences of these fathers who were experiencing homelessness and also caring for their children while they all lived in a homeless shelter. Schindler and Coley used a theoretical framework of "responsible fathering" to emphasize financial and emotional support and its connectedness to the broader society (Doherty, Kouneski, & Erickson, 1998).

Fatherhood under unique circumstances. Fathers connected to homelessness face unique challenges (Paquette & Bassuk, 2009; Perlman et al., 2014; Schulz, 2009). Some fathers experiencing homelessness either parent their children while they and their children are living together in a homeless shelter or nonresidential fathers may remain involved and connected to their children who live in homeless shelters (Paquette & Bassuk, 2009, Perlman et al., 2014). Although some fathers may not be involved with their children prior to the children entering a shelter, those who remain connected are often labeled as invisible because they are not usually seen or invited to shelters or to participate in shelter activities with their children (Paquette & Bassuk, 2009). The literature does not offer information on the experiences of these nonresidential fathers parenting their children. This study sought to explore these issues.

Amato and Gilbreth (1999) conducted a meta-analysis of 53 published studies addressing nonresidential fathers and children's well-being. They reported four significant findings: (a) Fathers' child support payments positively aligned with children's well-being, (b) frequent contact of these fathers with their children showed no association with child outcomes, (c) fathers' feelings of closeness and authoritative parenting of their children positively aligned with children's academic success, and

(d) fathers' feelings of closeness and authoritative parenting of their children negatively aligned with externalizing and internalizing problems of their children.

The Fragile Families and Child Wellbeing Study drew similar findings. This large national longitudinal survey was conducted between 1998 and 2000 by researchers at Columbia and Princeton Universities. Researchers interviewed parents of nearly 5,000 newborns in large U.S. city hospitals. The study had an overrepresentation of unmarried, low-income parents (McLanahan et al., 2010). Researchers defined "fragile families" as those parents who were unwed at the time of the child's birth and who were at increased risk of economic and relationship instability. Researchers conducted follow-up surveys with the parents when their children were 1, 3, and 5 years of age. Survey data revealed that nearly one in 10 children experienced homelessness at least once and nearly one in four lived "doubled up" with others at least once (Grant et al., 2013). Four key aspects surveyed were the stability of the living arrangement, the quality of the relationship itself, the nonresidential father's involvement with his child, and the quality of the coparenting relationship.

Survey results showed that 5 years after the birth of their child, the majority of fathers were no longer involved in their child's life. Study data supported other findings that contributions by fathers of money and time spent are important to children's well-being and both have value. However, many fathers in the study were significantly challenged by financial contributions, due to increased high school drop-out rates and histories of incarceration. Even with these conditions, contact with their children, especially including positive and authoritative parenting, positively impacted and enhanced child outcomes.

Edin and Nelson (2013) conducted a 2-year longitudinal, qualitative, ethnographic, fieldwork study with 110 inner-city, unwed African American and Caucasian fathers ranging in age from 17 to 60 who resided in either Philadelphia, PA or Camden, NJ. After the initial 2-year fieldwork study, the researchers followed-up over the next 5 years with in-depth interviews. Their findings helped challenge societal stigma that blames unwed fathers for the many problems often associated with children of unwed parents. These problems included poor school performance, teen pregnancy, increased school drop-out rates, problems with law enforcement, and unemployment. Through a thoroughly engaging and rich entrenchment in the lives of the men studied, the researchers uncovered several important and poignant themes (Edin & Nelson, 2013).

The men themselves defined "fatherhood" as a relationship, not merely the obligation to contribute money or provide authoritarian discipline and wisdom (Edin & Nelson, 2013). Fathers described "shame" from their own behaviors such as criminal activities, substance abuse, a lack of ability to contribute financially, their relationship status with the mother, and the child's disposition. These men also reported that a mother can operate in the role of gatekeeper by not encouraging or allowing the father to have contact or a relationship with the child. Given these challenges, for a nonresidential father to consistently fill the role of fatherhood, he must have a strong sense of emotional connectedness and commitment (Julion et al., 2007). These are strong considerations in exploring these challenges among nonresidential fathers of children who are residing in shelters.

The absence of a father living with his children should not lead one to assume a father lacks contributions to his children's overall development and well-being (Amato & Gilbreth, 1999; Paquette & Bassuk, 2009; Perlman et al., 2012; Perlman et al., 2014).

Paternal impact on child health and development. Figure 2 depicts the shared philosophy by Ball and Moselle (2007) of the evidence of the impact of fathers' involvement in children's well-being. The authors articulately described the links that fathers' involvement has on children across all spheres: cognitive, academic, psychological-emotional, and social-interactional. This depiction differs from results of other research studies.

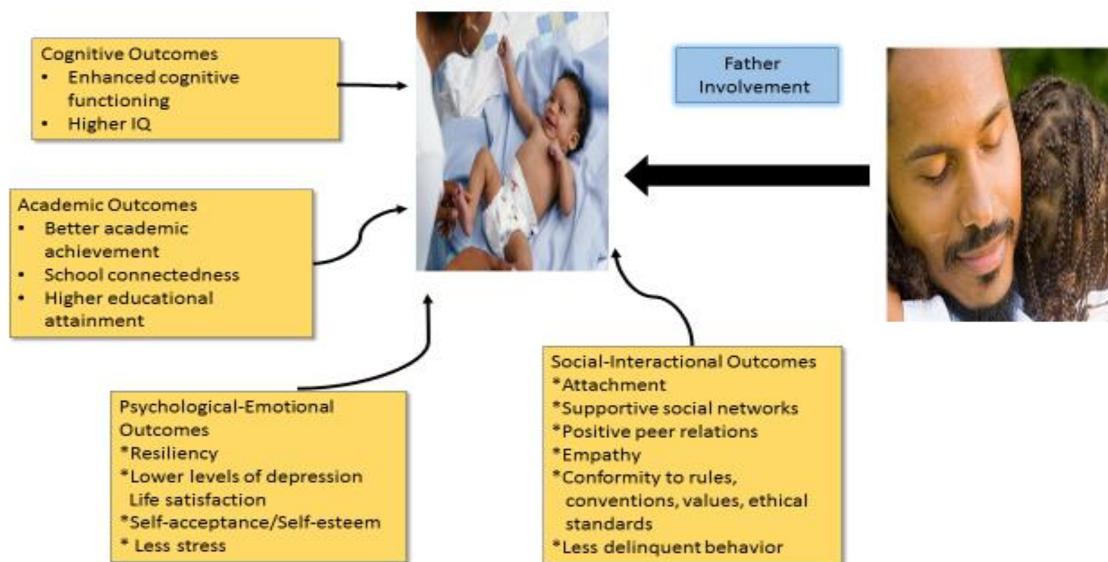

Figure 1. Evidence of direct effects of father's involvement on child well-being. Adapted from "Father's Contributions to Children's Well-Being" by J. Ball & K. Moselle, 2007, retrieved from http://www.ecdip.org/docs/pdf/PH%20FI%20Report%20brief.pdf, p. 12.

Despite the literature shared earlier that suggested an association between fathers' involvement and positive child development and behavioral outcomes in children's lives, some researchers believe this connection does not link to all aspects of development,

particularly in the realm of socioemotional development (Allen & Daly, 2007; Coley, 2001; Flouri & Buchanan, 2004a; Zick, Bryant, & Österbacka, 2001). However, Gottman, Katz, and Hooven (1997) found connections regarding socioemotional regulation and control by children to be positive. Differences in findings may accrue from methodological differences in studies, the specific variables emphasized for study, and differences in research instruments used. Much data was obtained from mothers or others and not necessarily from fathers or nonresidential fathers themselves (Choi et al., 2014; Julion et al., 2007).

Theoretical Foundation

The HBM is a cognitive theoretical model that offers aid in understanding how and why people seek to prevent, screen, or control illnesses or conditions of health (Glanz, Rimer, & Viswanath, 2008; Kline & Huff, 2007). The model contains six key concepts/constructs including susceptibility, severity, benefits, barriers, cues to action and self-efficacy: a concept added after the initial development of the model (Glanz et al., 2008). According to the HBM, people's belief that a medical problem can occur for them and can be serious enough to warrant their attention explains and predicts their behavior. Additionally, people must believe that changing a behavior(s) will offer some benefit to their health that can be gained with limited or minimal cost, financial or otherwise. Cues to action are also an important concept, implying that the changing of behaviors occurs as a result of events that trigger changes such as media messaging. The final concept is self-efficacy, or holding the belief that one can successfully make a behavior change that will impact their health, and is also a key component.

Theoretical Framework

Bassuk, DeCandia, Beach, and Berman (2014) and the National Institutes of Health (Health Communication Capacity Collaborative, 2005) described the HBM as a cognitive theoretical model, a premier theory regarding health behavior and one of the most widely used and recognized in the public health field. Developed in the 1950s by a group of U.S. Public Health Service social psychologists, its purpose was to explain why numbers were limited of people participating in programs to prevent and detect disease. At its core, health motivation is essential. This model helped in understanding how and why people seek to prevent, screen, or control illnesses or conditions of health (Glanz et al., 2008; Kline & Huff, 2007).

This model suggests a belief in the susceptibility of a condition and its serious consequences posed by a perceived threat to health and that a course of action would be helpful to reduce susceptibility to or the condition’s severity. One must also believe that the anticipated benefits of taking actions outweigh the obstacles to action. Then, one is likely to take action, believing such action will reduce their health risks (Glanz et al., 2008).

Roden (2004) proposed a validated and revised version of the HBM geared toward young families, at- risk families, and nontraditional families with a focus on wellness and health promotion. Roden reconceptualized the HBM to deemphasize the key concept of perceived susceptibility or threat of disease/medical problem and replace it with a perceived notion of health that promotes a wellness health orientation. This revised model emphasizes perceived behavioral control and behavioral intention. The revision of

the HBM seems a more appropriate fit as a theoretical framework for this study because it emphasizes wellness and health promotion (see Figure 2).

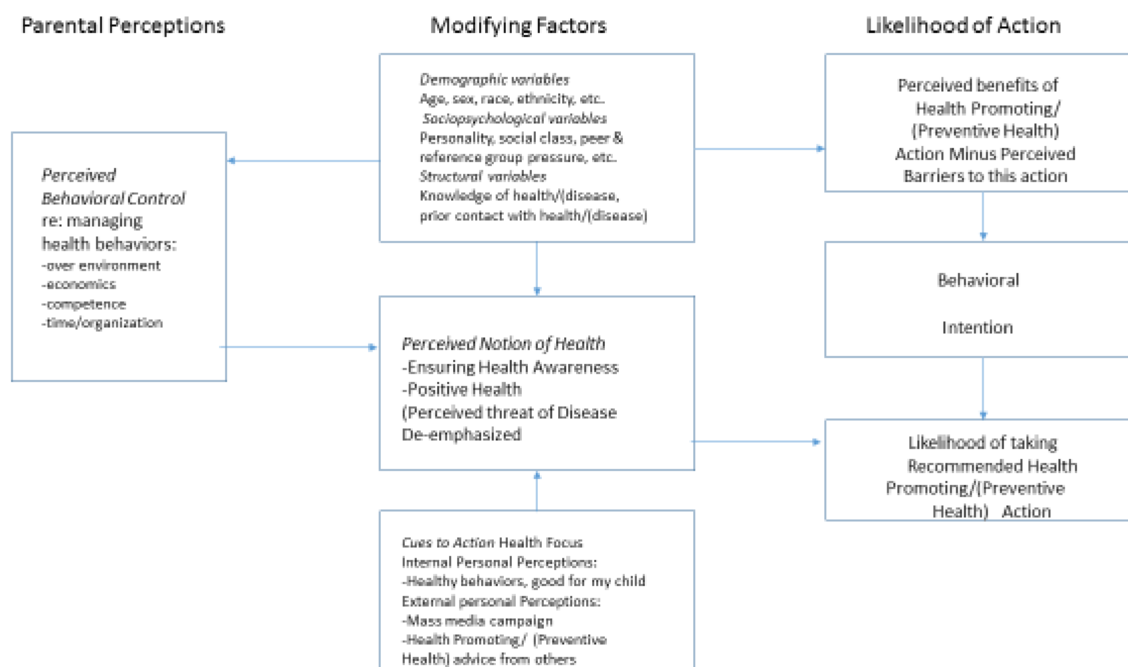

Figure 2. Revised health belief model for young families.
Note. From “Validating the revised Health Belief Model for young families: Implications for nurses’ health promotion practice,” by J. Roden, 2004, *Nursing & Health Sciences, 6,* p 248.

Application of the Theoretical Framework

The use of the HBM is popular in public health studies. A mixed-methods study conducted by Gross and Howard (2001) considered mothers’ healthcare decision-making processes and used the HBM as a theoretical framework to understand the experiences of mothers making decisions when their children became ill, requiring them to decide how to handle the dilemma of working or not working when their child was ill.

Tohotoa et al. (2009) used the HBM in their qualitative study to explore the perceptions of paternal support for breastfeeding. Specifically, the authors wanted to identify factors that encouraged or facilitated fathers’ support for their partner

breastfeeding while simultaneously exploring the barriers or factors that discouraged fathers' support of their partner breastfeeding.

I designed this research study in a fashion similar to the Tohotoa et al. (2009) study. Specifically, I explored the parenting contributions of nonresidential fathers to their children living in homeless shelters. The present research study sought to explore the facilitators and barriers to nonresidential fathers' ability to parent their children while the children live in homeless shelters.

Rationale for Selected Theory

The present study focused on exploring the ways nonresidential fathers of children experiencing homelessness contributed to the lives, health, and well-being of their children while their children resided in shelters without their fathers. Given the exploratory nature of the study focus, the revised HBM offered by Roden (2004) was appropriate, given its emphasis on wellness. Exploring paternal parenting and contributions to the health, wellness, and general well-being of their children fit a model that supported emphasis on wellness rather than disease.

According to the NCFH (Bassuk et al., 2014), the fastest growing segment of the homeless population is families and children; between 40% and 50% of the CIS are aged 6 and younger. Many of these children may be connected to fathers who do not live with them in the shelter (Paquette & Bassuk, 2009; Perlman et al., 2012; Schultz, 2009). I wished to explore more about the parenting contributions of these fathers. The Roden-revised HBM (2004) was an appropriate fit for the study because of its emphasis on the perceived notion of health. The research questions were explored with Questions 2, 3, and 4 aligning perfectly with the Roden revised HBM.

1. How do these nonresidential fathers describe their parenting role with their children while their children are residing in shelters?
2. How and what do these nonresidential fathers perceive their contributions to be to their children while their children are residing in shelters? If fathers are involved, do they participate in any specific health-related activities with their children and how?
3. What factors do these nonresidential fathers perceive to be facilitators of their parenting their CIS?
4. What barriers or challenges discourage these nonresidential fathers from parenting their children while their children are residing in shelters?

In this study, I explored themes such as how nonresidential fathers perceived their environments and their ability to maneuver in them. My goal was to aid in understanding to what degree fathers think their involvement contributes to the overall health and well-being of their children. Using an HBM orientation is conducive to learning how hard fathers try to connect or stay connected with their children while they live in shelters.

Literature-Review Synopsis

Additional research studies helped inform the design of the study, with emphasis on low-income fathers. The studies described below worked to discern fathers' lived experiences. Each of the studies described the meanings fathers applied to related phenomenon.

Bryan (2013) conducted a qualitative research study that explored the provider role, reported by 47 men of low income. Study participants explored and shared their construction, expression, and negotiation of their identities through a dual lens of father

and provider. Symbolic interactionism was the chosen theoretical framework to explore the shared norms and meanings identified by the men.

Tohotoa et al. (2009) conducted a qualitative exploratory study to better understand the meaning of parental support for breastfeeding, as viewed by mothers. A study participant pool of 76 participated in focus groups that explored the concept of support for breastfeeding. The most significant theme found that “Dads make a difference” (p. 1) in supporting breastfeeding. Subthemes revealed a need by the fathers to get the job done, offering encouragement for mothers to do their best, and paternal commitment to support the mothers.

Finally, Julion et al. (2007) conducted a qualitative research study that explored the involvement of African American nonresident fathers with their children. Four major themes emerged from fathers about their involvement including sharing and caring, providing guidance, providing support, and serving in culturally specific roles. Also of importance was the expressed level of dissatisfaction with their level of involvement.

The significance arriving from these studies demonstrated the desire to learn more about fathers’ views of parenting from different spaces, different father typologies, and specifically those of nonresidential fathers; however, no literature offered a specific concentration on learning about the views and experiences of nonresidential fathers of children residing in homeless shelters. This study contributes to a gap in the literature while expanding on learning about paternal views. This new learning can help inform and shape new policies and programs and assist in improving the overall health of the population.

The importance of active, positive parenting by fathers and its benefits for children is described in the literature (Lamb, 2004; Herbers et al., 2011). White, Brotherson, Galovan, Holmes, and Kampmann (2011) reported these benefits include helping enhance more secure infant attachment, emotional regulation in toddlers, self-esteem in middle-school-aged children, and school success for adolescents. The present research study explored financial contributions, physical contact, time spent, and evidence of positive and authoritative parenting of nonresidential fathers of CIS and the impacts of these contributions to the health and well-being of children experiencing homelessness and residing in shelters. These key concepts were found in the research literature about fathers and nonresidential fathers.

Summary

Nonresidential fathers represent one type of father (Cabrera et al., 2000). Given the changing landscape of "fathering," it is imperative to explore how different father types parent and subsequently contribute to children's overall development, attachments, and socioemotional and cognitive growth (Cabrera et al., 2000). This exploration was important to better understand the facilitators and barriers to this parenting role and function and including concepts of quantity and quality of involvement. Although little was known about nonresidential fathers' impact and impact on children's overall development (Cabrera et al., 2000), researchers and practitioners believed that parental conflict was likely to offset any child-development benefits offered by nonresidential fathers (Doherty et al., 1998). Paternal involvement by nonresidential fathers must be viewed from a multidimensional perspective inclusive of cultural beliefs, race, values,

and actions of fathers and social gains for communities (Cabrera et al., 2000; Coley, 2001; Coney & MacKey, 1998; Ninio & Rinott, 1988).

Chapter 3: Research Methodology

Introduction

In this chapter, I discuss the methodology I used in the study. In the earlier chapters, I introduced the many challenges faced by families experiencing homelessness. However, most work in this space has focused on residential female guardians, most frequently mothers. Researchers have documented the importance of paternal involvement in childrearing in general, drawing clear lines to improved physical, social, and mental health outcomes for children who have two active parents in their lives (Ball & Moselle, 2007).

However, little has been published about the role of fathers in the lives of children experiencing homelessness, and even less research has been published on the role of nonresidential fathers who are not sheltered with their children. Although nonresidential fathers may appear to be absent, they often are not and may be parenting from a distance (Paquette & Bassuk, 2009; Perlman et al., 2014). Additionally, African American nonresidential fathers are often described in the literature and in the media as uninterested, uncommitted, and uninvolved in the lives of their children (Julion et al., 2007). Researchers have documented several obstacles that prevent active parenting by nonresidential fathers; however, little is known about ways to overcome these obstacles and even less is known about what policies and programs might facilitate effective parenting by nonresidential fathers (Julion et al., 2007, Paquette & Bassuk, 2009). Obstacles included accessibility, economic barriers, racism, systems policies, and decreased self-esteem in the fathers themselves (Julion et al., 2007; Paquette & Bassuk, 2009). Housing and parenting (through social support) are considered social determinants

of health in the short term and over time. A better understanding of the paternal role in the lives of children experiencing homelessness could inform important interventions with short- and long-term health benefits.

Research Design and Rationale

In this exploratory study, I sought to describe the parenting experiences of nonresidential fathers to inform interventions, policy, and further quantitative work (Frankfort-Nachmias, Nachmias, & DeWaard, 2014). A qualitative approach was an ideal starting point to explore the experiences of nonresidential fathers because it allowed me to gain in-depth understanding, fill a void in the current literature, and give voice to an underrepresented population (see Creswell, 2012). Additionally, I had several important justifications for employing qualitative research in the public health arena; most importantly in this case was a need to employ qualitative approaches because I was trying to answer new research questions important to public health research and practice (see Faltermaier, 1997).

Once it became clear that a qualitative approach was most appropriate, I explored the array of qualitative data-gathering techniques and identified several types of qualitative inquiry: (a) narrative studies wherein the researcher collects stories from study participants, (b) case studies, (c) grounded-theory research, (d) ethnographies, and (e) phenomenological studies. I chose to conduct a phenomenological study because it was best suited to explore the common meanings or “lived experiences” of a concept or phenomenon of a group of people (see Creswell, 2012). Public health researchers often use the phenomenological approach as it is ideal for engaging and exploring understudied

groups, allowing researchers to develop “thick descriptions” (deep and layered) that can illuminate the human experiences (Fade, 2004).

In this study, my goal was to explore the parental role of a group of nonresidential fathers whose children were residing in a homeless shelter. Specifically, the goal was to learn from participants about their “lived experience” with the phenomenon of parenting their CIS from afar, and also to learn about their interpretations of these experiences (Patton, 2002). I used purposeful sampling to recruit participants (see Creswell, 2012; Patton, 2002). In this study, participants held information about the phenomenon because they experienced it (Creswell, 2012; Patton, 2002). Additionally, qualitative researchers widely use purposeful sampling when the goal is to identify participants with rich and unique experiences and perspectives on the phenomena of interest (Palinkas et al., 2015). The following broad-based research questions were explored with study participants.

Research Questions

RQ1. How do nonresidential fathers describe their parenting role with their children while their children are residing in shelters?

RQ2. How and what do these nonresidential fathers perceive their contributions to be to their children while their children are residing in shelters? If fathers are involved, do they participate in any specific health-related activities with their children and how?

RQ3. What do these nonresidential fathers perceive to be the facilitators or those things that make the parenting of their CIS easier?

RQ4. What barriers or challenges discourage these nonresidential fathers parenting their children while their children are residing in shelters?

Research Methodology

I conducted a qualitative, phenomenological study because I sought to understand the lived experiences of nonresidential fathers in parenting their children who lived in homeless shelters. Specifically, I sought to explore the role of parenting contributions of nonresidential fathers to the health and overall well-being of their children residing in homeless shelters without them.

I conducted a series of one-time, 1-hour, in-depth, semistructured interviews with a purposeful sample of nonresidential fathers who were in contact with their children residing in urban shelters that housed mothers and children in Philadelphia. I conducted no additional follow-up with study participants except to share a brief one-to-two-page summary of the findings, as requested by the Walden University Institutional Review Board IRB. I collected limited demographic information (including age, housing status, and number of children).

Role of the Researcher

Creswell (2012) suggested the “researcher is the key instrument” in a qualitative study (p. 175). Therefore, the role of researchers and how they see themselves and position themselves in a qualitative study is critical (Creswell, 2012; Marshall & Rossman, 2010; Patton, 2002). As with any research instrument, researchers must take care to consider assumptions and biases that are inherent in the data collection (Creswell, 2012). As the researcher and the research instrument, I was reflective about the process throughout the research, assisted by keeping my biases and judgments in check (see Marshall & Rossman, 2010).

Having worked for the past 17 years as the leader of a community health outreach program that brings free healthcare to urban women's and children's shelters in Philadelphia, I had access to shelter directors and to mothers residing in shelters with their children. My professional background in social work aided me in developing rapport and making connections with participants, and afforded me access to those who could become study participants or lead me to nonresidential fathers as potential study participants.

It was necessary for me, as the research instrument, to reflect on my role and privilege, and to make a conscious effort to connect with the community as a researcher and not as a professional social worker providing services to this population. It was also important for me to rely on my professional experience, but not to leverage it to take advantage or place undue pressure on potential study participants. Reviewing research procedures with a qualitative research expert to discuss biases and address them before data collection and analysis was important (see Creswell, 2012; Marshall & Rossman, 2010; Patton, 2002).

As I designed this study, I stayed focused on its purpose, which was to describe and explore the parenting experiences and roles of nonresidential fathers of children residing in shelters. I planned to conduct semistructured interviews with at least 5 to 10 nonresidential fathers.

Participant-Selection Logic

I employed a purposeful-sampling approach. That is, I leveraged shelter staff to help recruit participants in shelters. My contacts were leveraged with shelter staff in three Philadelphia shelters. Shelter directors agreed to allow me to place recruitment flyers in

shelter common rooms and bulletin boards. Additionally, I leveraged contacts with other social-service agencies that served men, specifically requesting to hang flyers for recruitment of potential study participants. I conducted all interviews in a safe, private location convenient to participants (e.g., a study room at a local library, a local park, or a comfortable location identified by the study participant). Each participant received a $20 gift card to a local supermarket or pharmacy chain.

Sample Size

Sample size in qualitative research studies depends on several factors including the type of qualitative approach and the resources available to conduct the study such as funding and available study staff (Marshall & Rossman, 2010; The Triangle Addmin, 2015). Researchers require no definitive number for a qualitative sample size (Creswell, 2012; Marshall & Rossman, 2010; Mason, 2010; Patton, 2002; The Triangle Addmin, 2015). The guiding principle to determine sample size for a qualitative study is reaching saturation, the point at which no new information or themes derive from the interviews (Guest, Bunce, & Johnson, 2006; Mason, 2010; The Triangle Addmin, 2015). Qualitative researchers explore meaning and do not offer general hypotheses (Mason, 2010). Marshall and Rossman (2010) noted that a small sample size is helpful in exploring rich cultural descriptions, as was the case with this study. I conducted this study with six study participants. Guest et al. (2006) explained that when the study sample is homogenous, as in this case, a sample of 5 to 10 participants was sufficient: all respondents spoke English and were nonresidential fathers, at least 18 years of age, and all from Philadelphia (a single northeastern urban setting). I excluded any potential study

participants who were under 18 years of age and were residents of any of the following facilities: prisons, treatment facilities, nursing homes, or assisted-living residences.

Data-Analysis Plan

All interviews were audio recorded and transcribed verbatim by an external certified transcription agency, Rev Transcription Inc., a certified transcription agency (Rev, n.d.). I stored all audio files and transcripts on a password-protected laptop in a locked office. I de-identified participants and checked all transcripts for accuracy. Thematic codes emerged in two ways: a priori (informed by the literature and interview guide) and through line-by-line reading of a subsample of interview transcripts. I assigned each code an explicit definition to ensure coding reliability. I uploaded all transcripts to NVivo 11 (QSR International, Doncaster, Australia), a software program used to facilitate qualitative analysis. Using a constant-comparison approach, I coded completed interviews before conducting later interviews (Marshall & Rossman, 2010; Patton, 2002).

Ethical Considerations

I submitted the study for review and approval by the Walden University IRB. After receiving Walden University IRB approval, I described the study in detail to all potential participants and read aloud the consent form to each participant to ensure low literacy was not a barrier to informed consent. The consent form addressed audio recording of the interviews. I assured participants that their participation was voluntary and they could stop participating at any time (even during the interview). I explained that all risks associated with participation in the study were minimal and might include them being upset by the nature of the conversation. The interview began only after participants

had a chance to ask questions, consent to participation, and sign the consent form. If a participant were to become upset by the conversation, I planned to refer them to available supportive services. I am a licensed social worker with experience navigating delicate conversations and referring individuals to supportive services as needed.

I removed identifiers from all data, including demographic information, audio recordings, and the resulting transcripts. All data, as well as informed-consent documents, are in my locked office on a password-protected computer and will be kept for 5 years post study. Consent documents are not linked to data in any way and are stored in separate encrypted files. I assigned each study participant a unique study identification number. Only members of my committee and I had access to the data. I will respect the privacy of all study participants and not disclose any confidential information related to participants to anyone who is not on the dissertation committee (see Appendix A).

Issues of Trustworthiness

A qualitative-research colleague with over 15 years of experience reviewed the study design. Members of my dissertation committee approved the coding and analysis plan. I employed a constant-comparative approach during data collection and analysis (Marshall & Rossman, 2010; Patton, 2002). This approach assured that I reflected on data collected early in the study, and in prior related studies, throughout the analysis phase of the study. In qualitative work the researcher should address study quality, rigor, and trustworthiness (in the quantitative arena this would fall under the heading of rigor) and dependability (referred to as reliability in the quantitative arena). Researchers often ensure those characteristics of their study through triangulation, that is, gathering

perspectives of other stakeholders, and through member checking by returning to study participants to check understanding of the information they shared. In this setting, participants were quite transient, so member checking was not an ideal method. A third method of ensuring reliability is through expert oversight (Creswell, 2012; Davies & Dodd, 2002). My committee reviewed the study design, data collection, and analysis.

I reviewed procedures with a qualitative-research expert in the Philadelphia area. The study has limited transferability, as data accrued from a small sample of nonresidential fathers in Philadelphia. The experiences of nonresidential fathers in other urban settings, in rural settings, in suburban settings, and in other parts of the country may differ.

Procedures

The following study procedures served as a guide to recruitment, data collection, and data analysis.

1. Sent an information letter describing the study and its nature and purpose to family homeless-shelter directors or their designees to request permission to hang a flyer advertising the study to mothers who reside in the shelters.
2. Was available to any shelter residents to discuss the study in further detail, if requested.
3. Requested interested potential study participants contact me to schedule an interview. A follow-up phone call 1 week prior to the scheduled interview and the day before the scheduled interview confirmed the interview date, time, and location.

4. During the initial engagement part of the interview, each participant received a copy of the letter describing the study.
5. Discussed the consent form, answered any questions, and secured signatures on the consent form from study participants.
6. Conducted the 1-hour interview, ensuring privacy by asking the questions listed in the interview protocol (see Appendix B).
7. Audiotaped the interviews, which were transcribed verbatim and analyzed using NVivo 11 (QSR International, Doncaster, Australia) a software program used to facilitate qualitative analysis.

Summary

A paucity of literature describes the role of fathers in the lives of children experiencing homelessness and even less on the role of nonresidential fathers. Given this gap in the literature, this study was well situated to contribute to the literature about nonresidential fathers of CIS (Paquette & Bassuk, 2009; Perlman et al., 2014). A qualitative research study design was best suited to explore a phenomenon, namely the lived experiences of nonresidential fathers. This design allowed for in-depth understanding, additions to the current literature, and giving voice to nonresidential fathers, an underrepresented population (Creswell, 2012). Additionally, employing qualitative research in the public health arena, most important in this case, was appropriate to help answer the research questions (Faltermaier, 1997).

Chapter 4: Findings

Introduction

Researchers have written little about the parenting contributions of fathers experiencing homelessness and their children's well-being, and specifically their involvement in the health and healthcare of their children (Bzostek, 2008; Garfield & Isacco, 2012; Greif & Bailey, 1990; Moore & Kotelchuck, 2004). Even less attention has emerged on the experience of nonresidential fathers parenting their children who are residing in a homeless shelter (Bzostek, 2008; Paquette & Bassuk, 2009). Completing this study was exciting in its very nature for what was learned, shared, and will hopefully be used to improve the lives of CIS and of their nonresidential fathers. In this chapter, I present my process for completing this study and my findings.

Purpose of the Study

I conducted this study to make a scholarly contribution to the literature about a population not regularly identified in the literature: nonresidential fathers of children residing in homeless shelters. The purpose of this study was to explore the parenting role of nonresidential fathers in the lives of their children who are residing in a homeless shelter, with particular attention to perceived contributions to the children's health. Additionally, I sought to explore the facilitators of and barriers to fathers' parenting role to gain a greater understanding of the lived experiences of these fathers. Through this study, I sought to illuminate the parenting experiences and perceptions of the experiences of nonresidential fathers while also giving them a voice, which is too seldom requested by those in the general public.

Research Questions

The following four research questions were explored through semistructured interviews.

RQ1: How do nonresidential fathers describe their parenting role with their children while their children are residing in shelters?

RQ2: How do these nonresidential fathers perceive their contributions to be to their children while their children are residing in shelters? If fathers are involved, do they participate in any specific health-related activities with their children and how?

RQ3: What factors do these nonresidential fathers perceive to be facilitators of their parenting their CIS?

RQ4: What barriers or challenges discourage these nonresidential fathers from parenting their children while their children are residing in shelters?

Setting

Upon receiving approval from the Walden University IRB to commence this study (#05-15-17-0146265), I sent a letter in May of 2017 describing the nature and purpose of the study (see Appendix C) to designated shelters that serve women and children, and to selected agencies that offer programs that serve fathers. Again, I have worked for the past 17 years as the leader of a community health outreach program that offers free healthcare to children in urban women's and children's shelters in Philadelphia. This work has provided me access to shelter directors, staff, and mothers residing in shelters with their children. I leveraged my contacts with local shelter directors in Philadelphia, requesting they hang my recruitment flyers in their locations

where mothers in shelters and fathers in programs might see them (see Appendix D). In Chapter 2, I identified several challenges addressed in the literature, indicating that these nonresidential fathers might be difficult to find. Furthermore, I recognized that once found, securing their agreement to participate might be difficult.

Mincy et al. (2015) suggested that if fathers are not providing financial support, they may be reluctant to be identified. They also suggested that if nonresidential fathers participated, expecting honest answers for the study might be a challenge if they felt judged or believed they could end up in legal trouble. With all these challenges in mind, I worked to find nonresidential fathers primarily through mothers in shelters. I entered each of these interviews with these concerns in mind, while feeling grateful and honored that they were willing to participate in an interview with me. My hope was that mothers in shelters who were in contact with their children's fathers might see the flyer and share the information and invitation to participate in the study. I knew some of the mothers in shelters through my work leading the community health outreach program in the shelter. In this report of findings, I will refer to nonresidential fathers as solely fathers.

The flyer requested all interested in the study to contact me for more information. Several mothers in shelters reached out for more information. All were serving in the role of gatekeeper. Edin and Nelson (2013) described this phenomenon where mothers serve in the role of gatekeepers of fathers, that is, not encouraging or allowing the father to have contact with their children or build a relationship with them. A parallel process of gatekeeping by mothers appeared to be occurring with me, whether consciously or not. My plan in hanging the flyers in shelters where mothers could see them was essentially paving the way for this same phenomenon of gatekeeping. However, I addressed

questions regarding the study with some mothers suggesting that their children's father would be interested in talking with me. Some mothers thought their children's fathers would not be interested in talking with me. I asked the mothers to encourage the fathers to talk with me directly about the study and to make their own decision about participation in the study.

Serving as the researcher and the research instrument required my constant vigilance regarding my potential biases and reflection throughout the research process. I made continuous efforts to keep my biases and judgments in check (see Marshall & Rossman, 2010). Keeping a research journal of my experiences and thoughts regarding this process proved invaluable.

I used a purposeful-sampling strategy augmented by snowball sampling. This group of participants is historically hard to find. I did not have a pool of nonresidential fathers to choose from, and there is no registry or group with which these men are engaged. I purposefully sought nonresidential fathers through connections in the shelter setting described below. Another participant referred one study participant to me; this was the sole participant who engaged in the interview through snowball sampling.

All study participants became known to me through shelters and not father-serving programs in Philadelphia. Three mothers encouraged their children's father to discuss the study with me, and even initiated the call to me in the presence of the fathers. I was then able to speak with the fathers and share information about the study, complete my prescreening, and schedule a date and location for the interview. I made certain fathers knew their participation in the study was completely voluntary and their choice alone. I also made it clear to mothers that whether or not they encouraged their children's

father to participate, if fathers chose not to participate there would be no negative impact to their child, such as prohibiting receipt of services by my community health outreach program. I confirmed the scheduled meeting date and time by phone. Two other fathers were introduced to me through staff in shelters. Thus, my professional background as a social worker and a leader of this community health program may have aided me in securing study participants, yet the challenge of finding and interviewing these six fathers proved to be far more difficult than I had expected with this vulnerable population.

Although I am a novice researcher, I have strong social work skills that helped me connect with and build rapport with mothers and prospective participants. I felt at ease engaging several participants in deep, rich dialogue. However, the conversation seemed to fall short of my hopes in two of the interviews. I found it challenging to keep my research hat on, collect information, and not treat the participants as clients. This took a great deal of restraint, but I believe I accomplished that task.

As the research instrument, I continuously reflected on my role and privilege to connect with this community of fathers as a researcher and not as a professional social worker providing services to this population. It was important for me to rely on my professional experience, but not leverage it to take advantage or place undue pressure on potential study participants. I reviewed research procedures with a qualitative-research expert to keep a check on my biases and address them before and during data collection and through data analysis, which was critically helpful for my reflection in this study.

Demographics

The study methodology I outlined in Chapter 3 included a plan for the recruitment of between 5 and 10 participants, with the goal of reaching thematic saturation. I chose

this sample number because of the homogeneity of the sample targeted for interviews (see Guest et al., 2006). All study participants were English speaking, nonresidential fathers of children residing in shelters, at least 18 years of age, and from Philadelphia, PA. Below is a composite of the six study participants who ranged in age from 26 through 50, with a median age of 36. The length of family stay in shelters ranged from 2 months to 2 years. One father reported being engaged to the child's mother, and served as a father figure to the identified child. The remaining five fathers reported being the biological fathers of the CIS. Two fathers reported being married, whereas three of the fathers reported actively coparenting the children with the children's mothers.

Data Collection

I provide brief scenarios of each study participant's entry into this study. I recruited a total of six study participants for data collection, following sustained effort and challenge. I gave each participant a pseudonym and a number for use throughout the writing of the study findings to protect their anonymity.

John is a 49-year-old single African American father of three children aged 9, 10, and 13, all of whom he is coparenting with the children's mother. John did not report having any other children outside of the shelter. He currently works full-time and reports never having experienced homelessness. He took great pride in telling me that he would be turning 50 years of age in the next few weeks and was hoping to celebrate his birthday with his children. John reported previously being in a relationship with his children's mother, who is currently living in a shelter with the children. He reported they lived together as a family for about 10 years, with John having been responsible for caring for the children following the birth of the youngest child while the mother was incarcerated.

After the mother's discharge from incarceration, the couple separated; the mother entered and exited another relationship and eventually experienced homelessness with her children. John reports remaining involved in parenting his children throughout these life experiences.

Wayne is a 26-year-old married African American father of a 7-year-old daughter. Wayne did not report having any additional children outside of the shelter and was not currently working. Wayne described having experienced homelessness once as a child. Currently, he and his wife have made a decision to enter a shelter, seeking help to secure housing. The mother and daughter resided in a family shelter for women and children, whereas Wayne resided in a nearby shelter that serves only men. He reported seeing his wife and daughter daily.

Marcus is a 38-year-old single Caucasian father of two sons aged 7 and 9 who he coparents with the children's mother. Marcus reported having at least one other child that he does not see. He currently lived with a coworker and worked full-time, many weeks working more than 40 hours. He reported having experienced several episodes of homelessness in his life. He and the mother of his sons previously resided with the children's maternal grandparents until family issues prompted Marcus and his family to leave that home. At that time they experienced homelessness for the first of several times. Marcus' sons and their mother resided in a women's and children's shelter. Marcus reported seeing his sons almost daily.

Allen is a 28-year-old engaged Liberian father figure of the 4-year-old son of his fiancé. He reported being the father figure for this son since the son was just several months of age when they become a couple. Allen reported that he had at least one other

child from a previous relationship. Allen also reported experiencing homelessness previously and also residing in a shelter for single men and a temporary stay in a shelter with his son and son's mother. He was currently working odd jobs as they became available. Like Marcus, Allen described a time in the past when he, his fiancé, and their son lived with their maternal grandmother until family issues necessitated their departure from that home, and began their entry into experiencing homelessness. Allen reported that his son and son's mother recently left the shelter and now they are all residing with family members.

Jerry is a 50-year-old African American father of 11-year-old twin daughters who currently lived in a shelter with their mother. He shared coparenting responsibilities with the mother. He also has at least one other child through another relationship. Jerry previously experienced homelessness for about 2 years until recently. He currently resides by himself in a room he rents. He and the mother of his daughters are coparenting their daughters and he reported seeing his daughters several times per week.

Jordan is a 27-year-old married African American father of a 1-year-old daughter and is the step-father of three sons aged 12, 16, and 17 years of age. He reported having no other children. He worked part-time and reported being the primary caretaker for their daughter. Jordan reported experiencing homelessness in the past along with his wife, creating a separation of them between a women's and children's shelter and a men's shelter. He originally came from the South and had no extended family members in the region. The family was recently discharged from the shelter.

Table 1

Demographics of Study Participants

Name	Age	Race	Partner status	# of children in	Status of homelessness
John #001	49	African American	Coparenting	3	Never homeless
Wayne #002	26	African American	Married	1	Formerly homeless
Marcus #003	38	Caucasian	Coparenting	2	Formerly homeless
Allen # 004	28	Liberian	Engaged	1	Formerly homeless
Jerry #005	50	African American	Coparenting	2	Formerly homeless
Jordan #006	27	African American	Married	1	Formerly homeless

A series of 1-hour in-depth, semistructured interviews were planned as a part of the original methodology of a purposeful sampling of nonresidential fathers who are in contact with their children residing in urban shelters that house mothers and children in the City of Philadelphia. No further follow-up was planned with study participants except for a brief 1–2 page summary of the study findings, as requested by the Walden University IRB. The original plan also included the collection of limited demographic information including age, housing status, and number and ages of children. Interviews ranged from 30 to 60 minutes each, conducted using the interview guide (see Appendix B). I conducted each interview in a convenient and safe location of the participants' choosing. All participants chose a community, neighborhood, or park setting where we both felt comfortable, rather than in a library or indoor setting.

Additionally, the original plan included that each participant would be given a $20 gift card to a local supermarket or pharmacy chain. All six study participants were given a $20 gift card after signing a consent form at the beginning of the interview. I gave the gift cards before the interview because I did not want study participants to feel

obligated to continue the interview at any time beyond their comfort and choice to do so, despite signing the consent form. For me, distributing the cards first was an added level of removing coercion, an ethical issue very important when interviewing vulnerable populations.

I took time and care to share the introductory letter with each participant and discuss how the study results would be used and shared at the conclusion of the study. Following the study purpose, I addressed any questions and discussed the process of sharing study results at the conclusion of the study. Then, I secured signed signatures on the consent forms. All original consent forms are stored in a locked cabinet in my locked office.

All data were audio-digitally recorded and transcribed verbatim by an external transcription company, Rev Transcription, Inc. All transcripts are stored on my password-protected laptop and housed in a locked office. I uploaded and analyzed all transcripts using NVivo 11 software program to facilitate data organization.

Revision in Data Collection

I sought and received approval from the Walden University IRB to conduct this study. During the break between the previous quarter and the quarter in which I was to conduct the study, I sent flyers to shelter directors and social-service programs that serve fathers. However, as the quarter began, I had not had any inquires. I also learned that some housing had become available in the city and many of the families I knew who were living in shelters were moving out of shelters. I had hoped to have completed several interviews before the new quarter began. I began to feel concerned. Soon after the start of the new quarter, I shared my concern with my dissertation chair and I questioned

whether a request for a change in procedures from the IRB should be sought. The decision was made to submit a request to the IRB for amendment. The request was to include recruiting nonresidential fathers, 18 or older, whose children were currently living in shelters and fathers of children released from shelters within the past 4 months. The IRB approved this change in procedure, keeping the same approval number. However, during the interviews, I asked the fathers to reflect on their experience of parenting their children when their children were living in shelters, either currently or recently sheltered.

Negotiating access is a critical step in research, allowing a researcher to secure and engage study participants. This beginning step in my research study was more challenging than I had anticipated. Harding (2013) noted that negotiating access occurs on two levels—gaining access to institutions and to individuals—and usually requires more time than planned. For my study, gaining access to shelters was easy whereas negotiating access to individual fathers was difficult.

Data Analysis

I employed a constant-comparative approach during data collection and analysis (Harding, 2013; Marshall & Rossman, 2010; Patton, 2002). This constant-comparative approach helped ensure my constant reflection on the data collected early in the study and began my analysis by reading and rereading the transcripts that were transcribed verbatim. The constant-comparative method is useful in identifying similarities and differences among the transcribed interview data (Harding, 2013). The initial steps involved reading the transcripts for accuracy and then deidentifying the transcripts. I then read the transcripts a second and third time, allowing me to make some initial notes in the

margins identifying possible similarities. This process began to lay the groundwork for developing codes for the data. I summarized the interview transcripts after highlighting information found in the transcripts. Tables 2, 3, and 4 summarize highlights of the six transcripts, followed by results from the thematic analysis.

Table 2

Summary Highlights of Interviews With John and Wayne

#001 John	#002 Wayne
Kids are a bundle of joy and a pain in the butt	Has a close relationship with his daughter
Has kids on Tuesdays and Thursdays for 3 hours and also every other weekend	Didn't have his father in his life
Describes a wonderful relationship with kids	Cares for daughter's well-being
Has faith in the mother's ability to keep the children safe and healthy while in the shelter	Gets his foundation from the Bible
Misses being around his children daily because they all had lived together for 10 years	Relationships have gotten stronger since the shelter stay
While the kids are in shelter, John likes to spend time with them, take them out to eat, play with them, ride bikes, and go to the mall with them	Contributes to the child's health and serves as a role model in life
Loves having them stay for overnight weekends	Often helps the child with academics while in the shelter
Is concerned about their health; specifically asthma and allergies	Wants to be a positive influence
Contributes to being a role model to his children	Attends all doctor and dental visits
Helps the children stay healthy by pushing water, exercise, and trying to eat healthy	Has a strong interest in nutrition and fitness, healthy diet, and exercise
Wants his children to know that he is in their life	Goes to the gym with his daughter all the time
Wants his children to see he didn't just brush them aside	
Having time to think more when not with his children allows him to worry less	Has a strong faith in God
Feels that shelters should allow fathers to visit inside the shelter, including eating dinner with them, doing school work, witnessing special events, and being included in holiday events	No privacy in the shelter
	Parenting in public is difficult
	Shelters should offer more community events in which fathers are invited to participate
	Shelters should improve their cleanliness and improve nutrition
	Fathers should be invited and encouraged to help kids with academics during shelter stays

Table 3

Summary Highlights of Interviews With Marcus and Allen

#003 Marcus	#004 Allen
Has a good relationship with his children	Has been the father figure and parent of another man's child since the child was 3 months of age
Wants to be both a father and a friend to his children; wants to have fun with them	Describes a very close relationship with his child both before and after the shelter
Episodes of homelessness occurred because he was too stubborn to apologize and go home	When the mother and child were in shelter and the father was in another shelter he made active attempts to see his child and mother daily; though transportation was a barrier
After the mother and children went into the shelter, the father says the oldest son became a "mama's boy." He now encourages this son to look out for mom and his younger brother in their father's absence	Understands that some women have experienced domestic violence, making it impossible for fathers to visit in the shelters
Activities with children prior to being in the shelter included cooking, playing with phones and computers, Pokemon, playing video games, and tucking them into bed at night	Has also learned from the mother that some of the other mothers in shelter report making up domestic violence to get into shelters faster and get help with housing faster
Encourages his older son to take up a sport	When the father was unable to visit he would call the shelter because the mother's cell phone did not get reception in the shelter
Wants to take children camping one day	Activities with his child prior to the last shelter stay included reading to him and feeding him
Activities with children while in the shelter include visiting with the children in front of the shelter and in the maternal grandmother's neighborhood; goes to children's school events	Attempting to reach his fiancé by calling the shelters was futile because no information would be given to him, increasing his level of worry and anxiety about his child and fiancé
Sees his children almost every night for about 2 hrs. in their former neighborhood, then accompanies the family back to the shelter on public transportation	Has engaged with the child's biological father to encourage his participation in the child's life
Understands that some mothers in the shelter have experienced domestic violence and believes this is why fathers can't visit in the shelters; understands the reason but doesn't like it	Describes taking the child to early doctor appointments to get him immunizations
Has an older son he "walked out on" when he met his current children's mother	Repeatedly tried to get the paternal side of the family involved with the child
Previously participated in all of children's healthcare	Has a 9-year-old daughter from a previous relationship and describes attempts with this child's mother to be involved in the child's life
Felt shelters provided no privacy for families to interact with each other	Has been together with the child's mother, his fiancé for 5 years

#003 Marcus	#004 Allen
Not really worried about their health while in the shelter, but worries about everything else including the neighborhood in which the shelter is located	Both father and mother have experienced homelessness together on multiple occasions in an effort to secure help to get housing
Tries to make sure his children eat properly while living in the shelter	Sent to a men's shelter away from his family; there he felt unsafe and uncomfortable and eventually left the shelter to stay with a friend
Shelters should give fathers time to visit	
Shelters should invite fathers in for holiday meals	

Table 4

Summary Highlights of Interviews With Jerry and Jordan

#005 Jerry	#006 Jordan
Described a loving relationship with his children	Describes the relationship with his child while in the shelter as hard and easy at the same time
He sees his children every weekend, Friday through Sunday	Initially stayed with a friend while the mother and child went into the shelter in the hopes that the shelter would help the mother secure housing faster
Prior to the shelter the father described spending time, going on trips to places like Penns Landing and the art museum, and laughing more with his children	Later, the father could no longer stay with the friend and ended up in a men's shelter
After the shelter the father described doing similar activities and has bought his children bicycles and gotten them phones	Reported being the primary parent for the child while the child was in the shelter because the mother worked while in the shelter
He reported that he talks to them twice a day	In his role as primary caretaker, he took the child to health visits and day care when he had to work, to the WIC program for food assistance and nutrition guidance
He reported they often call him just to share news of their day including getting their nails done and making jewelry and always ask him for something	Doesn't feed his child soda or juice; just milk, water and fruit; no candy, chips, or junk food but sometimes he offers her a cookie
Is concerned about his children's health while in the shelter because they live with others in close quarters	Understood that some of the mothers in the shelter had experienced domestic violence, making it difficult for fathers to be able to enter the shelter building

#005 Jerry	#006 Jordan
Father takes comfort in knowing that the hospital is so close to the shelter	During the shelter stay the father attended a parenting class with the mother at their local primary care center; father was 1 of only 2 fathers attending the class, rendering him uncomfortable
Reports that his children's asthma has been triggered twice while in the shelter, leading to hospital events	Described his parenting responsibility as something he just had to do
Reports one of the twins has an unknown bump; he wonders if it could be a bug bite	
Tries to participate in health visits but sometimes has to work	
Worries about his children being depressed about being in a shelter	
Tries to see and visit the children as often as possible, even during the week	
Cooks meals for his children, and bakes cakes for them; is concerned that the shelter doesn't serve healthy meals	
Encourages them to ride their bicycles and jog as a way to stay healthy	
Describes his faith in God as helping him to parent; also had this faith prior to and after the shelter	
Believes that coparenting with his children's mother is important	
Believes barriers to visiting his children in the shelter include travel. The cost of getting from his shelter to the shelter where his children are is difficult, and curfew time makes visitation by fathers difficult	
Feels that shelters should make fathers feel they can visit their children anytime	
Formerly experienced homelessness and lived in a shelter; now he rents a room of his own	

Coding is a critical tool for qualitative inquiry, as it identifies similarities, differences, relationships, and common themes that emerge. Harding (2013) offered a four step process for coding data.

1. Reading transcripts and identifying initial categories
2. Writing codes alongside the transcript, including summarizing

3. Reviewing the list of codes and categories

4. Identifying findings

In addition, I developed a codebook to further inform the analysis (MacQueen, McLellan, Kay, & Milstein, 1998). I developed the codes for the codebook using two methods: a priori or being informed by the literature and through a line-by-line reading of the interview transcripts. Table 5 shows the codebook. Following the development of the codebook, including definitions, transcript data were entered into NVivo 11 software for assistance with organization of the data and identification of the themes that emerged from the data. The themes appear in the subsequent analysis section along with direct quotations offered by study participants, a type of member checking, and a way to decrease my personal bias in reporting and interpreting study-participant feedback.

Coding Analysis

I developed the codebook by reviewing the transcripts and initial note taking (see Table 5). I identified the codes, their definitions, and possible subcodes for consideration. No discrepant cases emerged in this study.

Table 5

Codebook

Code: Key code—Children in shelter (CIS)	Definition	Possible subcodes
Parenting prior to the shelter experience	Used this code when the respondent spoke about their parenting experience or behaviors before coming into the shelter	
Family history	Used this code when the respondent talked about their family of origin	Parents Siblings In-laws
Being parented	Used this code when the respondent spoke about anything related to their own parents or other adults who “parented” them	

Code: Key code—Children in shelter (CIS)	Definition	Possible subcodes
Relationship with mother of CIS	Used this code when the respondent described their relationship with the mother or any details about how they interacted with the mother	Romantic Co-parenting Financial
Parenting children not in the shelter	Used this code when the respondent spoke of parenting other children not currently in the shelter	
Parenting CIS	Used this code when the respondent spoke about fun activities done with their CIS	
Relationship with CIS	Use this code when the respondent spoke of feelings toward or about their children	
Health of CIS	Used this code when the respondent spoke about anything related to the CIS's health.	Current health issue Chronic health issue Preventive health Prior health issue Mental health issue
Role in CIS's health	Used this code when the respondent spoke about their role in their CIS's health	Logistical—escorting to medical appointments/Practical—promoting a healthy diet
Role in CIS's social determinants of health (SDOH)	Used this code when the respondent spoke about their role in their CIS's general well-being and the things that are considered the SDOH	Education Housing Financial support Parental employment
Barriers to parenting a CIS	Used this code when the respondent spoke about any challenges to parenting as a result of living in a shelter	Shelter rules Financial Transportation
Facilitators to parenting a CIS	Used this code when the respondent spoke about any things that helped or could help them parent when with their CIS	Internal External
Feelings about parenting a CIS	Used this code when the respondent mentioned any words of emotion about parenting	
Parenting and obligation	Used this code when the respondent spoke about attitudes and values about parenting	
Being a role model	Used this code when the respondent spoke about being a role model for their CIS, other children, and others in their community	
Faith	Used this code when the respondent mentioned anything about faith or God	
Privacy	Used this code when the respondent spoke about being alone or alone as a family	
Good quotations	Used this code when quotations highlighted identified themes	

Evidence of Trustworthiness

In qualitative research, the researcher should be certain to address issues of trustworthiness of the study data by ensuring study quality and rigor, credibility, confirmability, and dependability (Shenton, 2004). Often such trustworthiness occurs through the following means:

- triangulation or gathering data or perspectives of other stakeholders
- member checking, allowing participants to check the accuracy of the information they shared by allowing participants access to field notes, journal writing of the research, and interviewing transcripts, and securing their feedback before proceeding into the final phase of the report
- audit trails are a step-by-step documentation of the research process
- expert oversight offers guidance on the research process

Credibility

Strategies ensuring credibility offer specific procedures used in data collection and analysis and stem from successful research completed earlier. I performed member checking during the semistructured interviews by summarizing what I heard members/participants say and ask them to confirm that what I heard and understood was correct. Reflexivity or positioning myself in the study also adds to study credibility. As the researcher and the research instrument, positioning myself in this study comes from my work experience, training, relationships within this homeless service provider community, and my perspectives gained through my work with families experiencing homelessness.

Transferability

Shared study data may contextualize this study; however, other factors impact the ability to fully compare this study to other study findings. This study has limited transferability of findings because these data were collected from a small sample of nonresidential fathers in Philadelphia. The experiences of nonresidential fathers in other urban, suburban, rural, or other parts of the country may yield different findings. However, these findings have value as little information describes this very hard-to-reach population.

Dependability

Study processes that allow sufficient detail for study replication are ensured in this study through audio digital recordings of the interviews, transcripts, and study documentation. Capturing the data in these formats, along with study notes, provides a reliable account of the experiences shared by fathers. Recall bias is not a barrier because these recordings captured fathers' voices and stories.

Confirmability

Researcher bias is inherent in all qualitative research (Marshall & Rossman, 2010; Patton, 2002; Shenton, 2004). To ensure study findings are the result of the experiences of the participants and not the researcher's ideas and preferences, I employed rich descriptions from the words of study participants including direct quotations. Triangulation and expert oversight also helped ensure confirmability. Reflexivity, constant reflection, and checking on biases were used throughout the data collection and analysis. For example, as I summarized findings, I returned to the data, under the supervision of a qualitative research expert, to assure I was not reading into, or

overanalyzing what participants said. Additionally, I share quotations in support of all summative statements to ensure participants' voices are reflected honestly in the findings.

Results

As another way to gather data to assist the data analysis, I developed Table 6, detailing the frequency of the codes. I identified the number of transcripts (sources) analyzed and the number of references in the sources in which the code is mentioned.

Table 6

Frequency of Codes Used in the Transcripts

Code	Number of sources	Number of references
Parenting prior to shelter experience	4	11
Family history	6	32
Being parented	2	6
Relationship with mother of CIS	4	9
Parenting children not in shelter	6	14
Parenting CIS	2	6
Relationship with CIS	5	24
Health of CIS	4	13
Role in CIS's Health	5	8
Role in CIS's Social determinants of health (SDOH)	5	27
Barriers to parenting a CIS	5	15
Facilitators to parenting a CIS	3	4
Feelings about parenting a CIS	6	78
Parenting and obligation	2	3
Being a role model	6	18
Faith	5	12
Privacy	6	19
Good Quotes	6	16

Thematic Categories Emerging from the Data

I organized the identified codes into four thematic categories, presented using Roden's (2004) revised HBM with minor modifications to the original Health Belief Model. Roden described parental perceptions, modifying factors and the likelihood of actions taken while emphasizing the nature of preventative efforts of health and wellness not just disease prevention. The final thematic category is social determinants of health (SDOH) and addresses paternal identification of the SDOH that most impacts CIS. I offer data supporting each finding. Table 7 briefly describes the thematic categories and the codes in the categories, as well as exemplar quotations. Through the interviews, participants shared more common experiences, despite differences in the fathers' ages, race, partnership status, number and age of children, and homelessness status. A core theme seemed to emanate from the interviews of the importance of fathering CIS, despite the challenges imposed by living in a shelter.

Table 7

Thematic Categories

Paternal Perceptions
Modifying Factors
Likelihood of Actions
Social Determinants of Health

Thematic Category 1: Paternal Perceptions

This category explored fathers' perceived control or ability over their environments and their child's health behaviors while they reside(d) in a shelter. All fathers in this study shared their parenting experiences, including their participation in the

healthcare of their children. All fathers spoke of having greater control over their children's environment and their healthcare prior to living in a shelter while simultaneously describing efforts to continue their control and influence where possible. However, many were somewhat unsure of all of the medical details and looked to mothers to have this knowledge. Wayne and Jordan described very active parenting around medical appointments including preventative care. All fathers described an increased level of worry about the health of their children while living in a shelter, feeling they were at greater health risk due to living in close quarters with others and due to the challenges with bed bugs and increased risk of infection and respiratory ailments. However, given these concerns, John, Marcus, and Jerry expressed complete faith in the children's mothers to maintain the children's health and safety in the shelter. All expressed a desire to be able to do more to ensure and protect the health of their children but felt empowered to do as much as they could in this realm.

Also, noteworthy is the distinction that John and Marcus made about concerns for the mental health of their children, as well as their physical health while in the shelter. Embedded in thinking about the paternal perceptions of control, fathers offered statements that demonstrated their level of care and concern about their children as people. Several fathers—John, Wayne, Marcus, and Allen—spoke about their experiences being parented by their own fathers and using these experiences—positive, negative, neutral, or absent—to influence how they were choosing to parent their children. Jerry spoke about the positive impact and influence his mother had on his life and that he wanted to have on his children's lives. Several examples of direct quotations offered by fathers described their experiences of parenting their child living in a shelter,

being parented, parenting prior to living in a shelter, feelings about parenting, and their relationships with their children.

Code: Parenting CIS. John shared concern about the mental health of his children as part of his parenting responsibility.

> I see that they're a lot happier. They're a lot happier because they see that I'm around and just because they're in a shelter that I just don't want nothing to do with them. They see that I haven't brushed them to the side.

Allen shared a concern about trying to control things in the environment as best he could including how his child and family are seen by others in the community, including schools and child-welfare agencies.

> People, places like that, we ain't really try to put them in our business, because a lot of people talk, and I don't want them to look at my son in a different way. I know a lot of people in that building, they get a smile in your face, but behind your back they probably talk bad about you. I just told my fiancé, "We're not gonna let these people get involved in our business with our kid." That's one thing my mom always told me, "Don't never let them know stuff like that. Next thing you know they be calling DHS where we living and stuff like that." That's just how it is.

Marcus shared a concern about the safety of the neighborhood where his family is residing in a shelter and his inability to be there with the family to protect the mother and children.

> Now it's the neighborhood they're in. If somebody tries to do something to her I don't know. … He stepped up and has been crazy good at taking care of his mother. I told him that you gotta take care of mommy. I can't be there. It's your job now, you watch out for your brother and you take care of your mommy. And he does.

Code: Being parented. John shared that his own father was not present in his life and he now wants to be actively present in his children's lives.

> I want to be in their lives because I don't want them growing up to say, "My dad this. My dad didn't do this. My dad didn't do that. My dad wasn't here for me. My dad didn't do that for me. My dad wasn't in my life period."

Marcus shared his experience of being parented and how it impacted his desire for his parenting experience with his children. "I didn't have both my parents. It's always one or the other. Holidays were hectic. First mom's then dads and it's just too much. I don't want them to have to do that."

Code: Parenting prior to shelter. Marcus recalled and shared his experience parenting around his children's evening routine, prior to them being in the shelter.

> I think they could allow the fathers … give us a time limit that we're allowed there to be with our family for dinner and tucking them in and the little things. I always tucked the kids in, every night since they we're the babies. I'd do it. I guess if I think about it, it bothers me. I don't think about it much.

Code: Feelings about parenting. Allen described, in a very emotional way, his feeling about parenting and being judged. “Every man is not the same. Don’t judge us by that person not taking care of his responsibility and make it look like we the bad ones, because every father is different.”

Relationship with CIS. John shared his relationship with his children when he was present with them and when he was not. John and his children’s mother and children had lived together for 10 years. “

> I wouldn’t say all the time, but periodically, they’ll cross my mind, and I’ll pick up the phone and call, make sure they okay. All together really I miss them. … Just because they’re in a shelter don’t mean that they don’t deserve to be loved by they dad.

Thematic Category 2: Modifying Factors

This category explored the experiences described by fathers that they could and did employ to help solidify their perceived notion of health and general well-being. This included efforts to ensure greater health awareness to improve their parenting abilities and contributions to their children. All fathers believed that keeping good communication with their children’s mothers allowed for their increased knowledge of the needs to keep their children safe and healthy, increase and encourage healthy behaviors and activities, and thereby promote health. All fathers believed that going to as many health appointments as possible would increase their knowledge and their visibility to healthcare and other service providers on behalf of their children. The following quotations help illuminate modifying factors identified below.

Code: Facilitators. Jordan was the only father who discussed attending a parenting class along with his child's mother. He described new learning but a simultaneous discomfort with being the only father in the group. "She was in the parenting class, and she took me and I only saw like one dad like the whole time."

John shared that efforts by shelters to be more inclusive of fathers with their children in the shelter would enhance knowledge of what their children are going through while simultaneously encouraging fathers to be there for their children.

> One day, maybe I think they should have some type of open house, like make a announcement or pass out a flyer or something, "We're having a open house on this such-and-such date at this such-and-such time, and we invite you, the fathers, to participate."

Code: Barriers. Allen described several challenges and barriers that did arise or could arise from the separation of him from his family in the shelter.

> I said, I gotta come all the way from North Philadelphia, downtown to meet you every time, then come to Southwest and drop him off to school. Where we gonna get all the money from to do all this? … Not separating them. When you separating them, how are we together? I live in another shelter for nine months. They live in another shelter for nine months. I haven't seen them for nine months or communicated with them. By the time y'all find somewhere for us to live, we won't even know each other like that. I'm like, "Dang, I forgot about you." Our life is moving on. Nobody want to go through that. That's too much. That's a big

> burden. By the time I see my son, he looking at another man, calling him daddy, because I've been in another shelter for nine months, not talking to them.

Code: Faith. Wayne shared that leaning on his faith helped him push through the experience of parenting his daughter while his wife and child reside in a different shelter, located not far from the shelter where Wayne is currently residing. "Just keep looking to God. That's literally where it starts and where it ends."

Code: Health of CIS. For these fathers, health was a priority, and efforts at prevention were intentional. They shared specific concerns related to life in a shelter for their children. Wayne and John spoke directly to their concerns about the physical health of their CIS. "We keep her up to date on her shots. We practice hygiene. We make sure we take the proper precautions, because we are living in close proximity with other people who aren't really healthy" (Wayne)

> I worry about their asthma. They have asthma. I have asthma. They have allergies. I do, I worry about their allergies, I worry about their asthma. Right now, this is the weather where they really can start wheezing because it's hot, it's humid, and it can be a little bit uncomfortable. (John)

Code: Relationship with the mother. Marcus describes telephonic communication patterns with his children and not knowing the degree to which the mother was involved in the children's efforts to call him. John then shared a similar concern, stating he thinks about the children often and wishes to call them but does not

do so because he wants to be respectful of the split time the children have with both their parents, even when mother encourages him to call them anytime.

> They only call me when they want to know when I'm coming to get them or what time I'm coming to get them. Nine times out of 10, I believe, I don't know, I don't know if they ask mom, "Can I call dad and see what dad up to?" but in my own mind, I need to call them a little bit more, more than I do, let them know I'm here for them and daddy does care.

> She tells me to sometimes pick up the phone and call them if I can call them on a everyday basis. Sometimes I don't, because I try to give her space and get them to adapt to living without me around 24 hours a day.

Code: Privacy. As described in the literature, several of the fathers shared concerns about feeling they are "parenting in public," devoid of the privacy of parenting in the family. "Well, there are more people in our vicinity, close to us, so we don't really have that element of privacy, as we usually did, but for the most part ... it has its challenges."

Thematic Category 3: Likelihood of Actions

Code: Parenting as an obligation. Wayne described that the role of parenting does not stop because of the shelter. "Even though we're in the shelter, and we do have goals and financial struggles, that's not going to stop us from being parents."

John also described that parenting is, and occurs if it has to do with the children.

> If it's got something to do with my kids and it's important … remember I'm saying my kids. If it's got something to do with the kids and it's very important, then I'm all for it, if it'll help them in the long run, or any other kid, not only just my kids, any other kids. Like I said, I try to do the best I can.

Code: Role in CIS's health. All the fathers expressed the need to be involved in the health, general well-being, and health-promoting activities of their children, no matter how small the effort. John described encouraging the promotion of a healthy diet, including the importance of water and of exercise.

> Try to make them eat proper foods. I try to make them drink this instead of that sugar Kool-Aid. Water is one of your best liquids to drink. I try to make sure they drink plenty of water. Lena, "It makes me go to the bathroom a lot, dad." "Well, you'll be all right. Water's good for you."

> Exercise. I try to run around with them. They riding they bikes. That's good. That's healthy. Dad, why you always got us trying to exercise?" I said, "Because we all need to exercise. I need to exercise. Exercise is good for you.

Wayne extended this idea of health improvement to include taking his child for more health visits than he might if they were not living in a shelter. Wayne and several of the other fathers expressed concern about more health issues that might be possible as a result of living in close quarters in a shelter with many people.

> At the slightest bit of illness, we will console her more than we would by ourself. Like she has a cold, okay, we'll see what's going on here, make sure there's nothing more serious. We definitely do take more trips to the family doctor than we normally would, just as a precaution.

Marcus shared his concern and desire to attend doctor appointments if they were more than a regular check-up. "I'll take off work for them to go to the doctor, just to help her. I mean unless it's a regular check-up I might miss it."

Thematic Category 4: Social Determinants of Health

All fathers expressed concern that the physical shelter environments were not healthy places and thereby increased the risk of greater health problems and concerns for their children. All the fathers also shared the struggle of needing to work or looking for work as a necessity that impacted their ability to see their children as much as they would like. The fathers shared an overall sense that their children needed them more, now that they were in a shelter. The fathers said they were doing the best they could, working to balance these obligations and the reality of their situation (Edin & Nelson, 2013).

Wayne described a sense of care for the overall health of his daughter. "I really care for my daughter's well-being, and her mother, as well."

Allen shared two examples of how living in a shelter impacted his son's attendance at school. The literature reports that living in a shelter and traveling from the shelter to the local school can often make children late or absent from school (Rafferty et al., 2004).

> We started him off in kindergarten. No, he go to school next year, because he just turned four that year, so we put him in school early. He's hyper a lot, and he has to be around kids. The only reason why he stopped going, because of the shelter situation, because by the down here and then school. It was inconvenient for both of us at the time. We ain't have no car at the time. It was like, "Wow." It was really frustrating. … He had a lot of late misses and he couldn't graduate. I was upset about that.

Summary

The purpose of this study was to explore the parenting experiences of nonresidential fathers of CIS. Nonresidential fathers of CIS shared their lived experiences of parenting their children who were living in shelters through in-depth semistructured interviews. These interviews allowed for the multidimensional exploration of parenting through the lenses of attitudes, beliefs, values, and recall about their upbringing, the possible impact of their personal histories on their current parenting, and the facilitators and barriers to parenting their CIS.

To answer the first research question, fathers described their parenting role with their children while their children were residing in shelters. All fathers began their description of their parenting role by describing their children using words such as " lovable," "wonderful," and "bright." They also described their relationship with their children as "wonderful," "good," "close," "super tight," and "hard and easy." All the fathers appeared to express pleasure and delight from their children, evidenced by their words and smiles.

The second research question explored how the fathers perceived their contributions to their children while their children were residing in shelters. If the fathers were involved, did they participate in any specific health-related activities with their children and how? The fathers described contributions including showing their children that their father "is there," showing up and not abandoning them while they live in a shelter, being a role model and an influence, and being a father and a friend. All discussed wanting to give their children a better life and exposing them to positive experiences and new places. All the fathers discussed being involved in the healthcare of their children including accompanying them to doctor and dental visits, being there with them for overnight hospital stays, and being protective of their mental health status by doing all they could to keep their children from being sad or depressed while living in the shelter.

The third research question explored the factors fathers perceived to be facilitators of parenting their children who were living in shelters? The answer to this question lay in internal and external realms. Two fathers talked about how their faith in God was at the core of helping them parent their children before and during the children's stay at the shelter. Additionally, several fathers identified that their children's mothers were a source of strength for them in parenting their CIS, standing united in this parenting effort. Other external considerations for facilitators to parenting their CIS included ideas for shelters to be more inclusive of fathers. Suggestions included allowing fathers to visit regularly and participate in regular shelter activities like providing homework assistance, eating meals with their children, and being invited to holiday celebrations in the shelter. Several fathers expressed frustration with the rules and regulations that kept them out of the

shelter, leaving them to feel they had done something wrong. Conversely, several other fathers expressed understanding of the rules to keep fathers out because of domestic violence reportedly experienced by many of the mothers in the shelter at the hands of a man. Interestingly, with all of the questions raised by the fathers about the rules and regulations, only one father openly questioned the staff about these rules in attempts to advocate for himself.

The final research question described and explored the barriers or challenges that may have discouraged these fathers from parenting their CIS. They described and explored several barriers or challenges. The greatest of these barriers was shelter rules and regulations that eliminated the ability of these fathers to visit in the shelters. Other barriers included financial challenges in travelling to shelters or living accommodations in different parts of the city to visit their CIS on a regular basis. For those fathers experiencing the challenge of not working but seeking work, this challenge was even more pronounced.

One father noted the difficulty of being able to communicate by phone with their family in the shelter. He described that his fiancé was unable to secure reception in the shelter to be able to use her cell phone and the father was not able to reach her directly by calling the shelter. The shelter staff served as gatekeepers, making it difficult to reach the mother or learn anything about the mother and child. This same father also described that staff at the city-intake level were unhelpful and posed many barriers to keeping his family together in a shelter. Finally, none of the fathers described the mothers of their children as being a barrier to parenting their CIS.

Chapter 5 provides a more in-depth discussion of the study findings, an analysis of the findings in relation to the theoretical model, and a discussion of the integration of the findings with the literature. Additionally, in Chapter 5 I offer study limitations, recommendations for further research, and the implications for positive social change engendered by this study.

Chapter 5: Discussion

Introduction

The purpose of this study was to describe the parenting role of nonresidential fathers to explore their perceived contributions to their children residing in homeless shelters, and to explore the facilitators of and barriers to this parenting experience. I gave particular attention to fathers' contributions toward the health of their children. In this chapter, I provide an in-depth discussion and analysis of the study findings and connect the findings to the literature, the research questions, and the theoretical framework of the revised HBM. Additionally, I discuss study limitations, recommendations for future research, and implications for positive social change.

Despite finding literature on nonresidential fathers (Mincy et al., 2015), I found no literature about this specific subsegment of this population, that of nonresidential fathers of CIS. Given that children and families comprise such a large segment of the homeless population, with most CIS aged 5 and younger, learning more about nonresidential fathers' parenting contributions to this population of children bears great significance (Bassuk et al., 2014; Volk, 2014). Only two of the six fathers who participated in this study had children 5 or younger. I am not challenging the earlier finding by the NCFH; rather, the fathers participating in this study had children over and under the age of 5. I conducted this study to expand knowledge regarding this population and to make a scholarly contribution to the literature.

Background context for the study included recognition that positive parenting is critically important to the overall development of children, including physical, socioemotional, and intellectual development (Perlman et al., 2014; Revell, 2015; Volk,

2014). It is also important to acknowledge that routine healthcare, including immunizations, check-ups at various developmental stages, and annual examinations are important to promote development, particularly in young children (HealthyChildren.org, 2017). In the present study, Jordan, father of a 1-year-old, spoke of serving in the role of “Mr. Mom” while his wife worked a full-time and a part-time job and he worked a part-time job. Jordan shared experiences of taking their daughter to the pediatrician alone on many occasions and feeling the stigma of being the only father in the doctor’s office. When thinking about this new parenting role and responsibility of meeting with doctors and healthcare providers, Jordan shared, “I had to learn it quick. Yeah, I had to learn on my own.”

Children often live in shelters for many months and sometimes years, and the first 5 years of a child’s life have a great influence on the child’s development (Volk, 2014). The mothers and children in the present study resided in shelters from 2 months to 2 years. During shelter stays, children often have limited privacy with their caregivers, due to often overcrowded living situations and routine staff monitoring of all actions (Cosgrove & Flynn, 2005; Volk, 2014). In resonance reports in the literature, Wayne stated, “Well, there are more people in our vicinity, close to us, so we don’t really have that element of privacy, as we usually did, but for the most part … it has its challenges.” Given this knowledge, it is important that shelter providers consider the significant health and developmental contributions mothers and nonresidential fathers can make while their children are residing in shelters.

Lamb (2004), when studying the role of fathers in child development, identified categories of father involvement that included responsibility (being involved in decision

making on behalf of the child), availability (the access of fathers to their children and vice versa), and engagement (the types of activities that occur between fathers and children). In the present study, all six fathers shared stories of their lived experiences that included actions of responsibility, availability, and engagement. However, the availability dimension appears to hold the greatest challenge for fathers due most often to their work schedules and shelter rules and regulations.

Allen talked about his experiences at the city level in attempts to enter a shelter with his fiancé and her 4-year-old son. He shared a desire to be more involved in his son's life by stating,

> They had painting program, art program, art and craft, stuff like that I would like to do with kids. It's nothing wrong with that, because we're just killing time, and we're making it better for our kids. Who gonna say a father don't know how to bake cookies with their sons? I'll take it. Not only a mother can do that. We can do other things too.

Amato and Gilbreth (1999) found that contact between nonresidential fathers and their children was not the predictor for improved well-being, but rather the nature of the contact (e.g., offering advice, being involved in school and health activities, and helping with homework) is a better predictor of enhanced child well-being. The Fragile Families and Child Well-Being Study (McLanahan, Garfinkle, Mincy & Donahue, 2010; Waldfogel, Craigie, & Brooks-Gunn, 2010) showed that residential and nonresidential fathers spend less time than mothers engaged in educational activities with their children,

with nonresidential fathers spending even less time with this engagement than residential fathers. This evidence might support John's suggestion:

> When the kids having study skills, like if they're doing homework in the shelter, dads should be allowed, I think we should be allowed to participate in that when the kids are doing their homework. We should be allowed to come in and participate one hour or 30 minutes or 45 minutes. We should be allowed to come in and be with them when they're doing their homework.

Many of the studies I reviewed showed that children experiencing homelessness are at an increased risk for physical, mental, and educational problems (Coker et al, 2009; Paquette & Bassuk, 2009; Wood et al., 1990a). All fathers in the present study seemed attuned to this and planned and implemented parenting experiences that supported enhancement of physical and mental health. They also reported regularly engaging in or encouraging physical activity for their children. This finding aligns with the research findings offered by Janssen and LeBlanc (2010) that showed the many benefits that physical activity offers for improved health.

Using the revised HBM as a theoretical framework provided a context in which to analyze study data. I identified four key thematic categories and 18 codes from the data. The four key thematic categories were (a) paternal perceptions, which included the codes of parenting CIS family history, being parented, parenting prior to shelter life, parenting children not in shelter, feelings about parenting, and relationships with CIS, being a role model, (b) modifying factors, which included the codes, facilitators, barriers, faith, health of CIS, relationship with mother of CIS, and privacy; (c) likelihood of actions, with the

codes parenting as an obligation and role in the health of the CIS; and finally (d) social determinants of health, role in CIS's SDOH. I also included quotations that poignantly expressed fathers' thoughts even if they did not fit into the four thematic categories. I discuss these thematic categories and codes in further detail in this chapter.

Summary of Key Findings

Here, I offer the summary of key findings embedded in the research questions that comprised the foundation of the study.

RQ1: How do nonresidential fathers describe their parenting role with their children while their children are residing in shelters? All six nonresidential fathers interviewed reported being quite involved in parenting their children residing in shelters, despite the challenges posed by the shelter setting. These fathers shared examples of parenting their children prior to and after living in shelters, noting minimal limitations to their parenting practices before they entered shelters. They described a feeling that their children needed them now even more than they did prior to living in shelters. The fathers explored how their relationships with their own fathers impacted their increased desire to be present for their CIS. They expressed a sense of pride in parenting their CIS, despite the feelings of shame and hurt they experienced by needing to pick up or drop off their children a block away from the shelter, making them feel as if they "did something wrong" or "were bad people." The overall sentiment expressed by fathers was that, contrary to the stigma and labeling of " deadbeat dads," they were doing the best they could by staying involved with their CIS and they expressed pride in that (see Edin & Nelson, 2013).

RQ2: How do these nonresidential fathers perceive their contributions to be to their children while their children are residing in shelters? If fathers are involved, do they participate in any specific health-related activities with their children and how? The fathers in this study offered detailed descriptions of the contributions they make to their children's lives that included helping them feel loved, safe, and healthy, physically and emotionally. They all expressed serving as role models to their children and reported a desire to demonstrate strength in the midst of adversity, the crisis of living in a shelter. It is possible that at least five of the six fathers could draw on their own experiences of homelessness that could make them more sensitive to the feelings and needs of their CIS.

RQ3: What factors do these nonresidential fathers perceive to be facilitators of parenting their CIS? Study findings indicated that this answer is best summarized by describing internal motivations that aided these fathers in their role of parenting their CIS. The internal motivation came from faith in God and also the mothers of their children who were described as facilitators of their parenting. Fathers did not identify any external facilitators of their parenting such as agencies or people. However, several fathers shared experiences of being parented by their own fathers, which may have provided motivation for parenting of their own children.

RQ4: What barriers or challenges discouraged these nonresidential fathers from parenting their children while their children are residing in shelters? Study findings showed that external barriers included shelter rules and regulations that kept fathers from visiting their children directly in shelters. Additionally, the barrier or challenge of finances impacted the amount of traveling across the city to get to and from their shelters or places of residence and to the shelters where their children were residing.

Interpretation of Findings

Findings from this study align succinctly and confirm the literature on multiple levels. In the study, I found that all six fathers described being involved in their children's lives while they are residing in shelters. The fathers described being engaged in parenting tasks including being with their children, talking with them, advising them, demonstrating care and concern for them, demonstrating interest in their lives, demonstrating emotional connection, helping with homework, providing socialization experiences for their children, helping their children secure necessary healthcare, and encouraging healthy behaviors and the promotion of improved nutrition. They also described taking action to provide for the improved mental health for their children during shelter stays. As Jerry described, "My role is to make sure that they ain't sad. Make sure they understand what's actually going on."

Another father in the study, Allen was the father figure for the 4-year son of his fiancé. The feelings and actions expressed by Allen confirm the literature findings that fathers and father figures can have a significant role in contributing to the improved health and overall well-being of a child (Cabrera et al., 2000; Flouri & Buchanan, 2004a; Garfield & Chung, 2006; Lamb, 2004; Linn et al., 2015; Revell, 2015). Study findings also confirmed that nonresidential fathers may remain involved and connected to their CIS, even if they do not see the children (Paquette & Bassuk, 2009; Perlman et al., 2014). The literature often describes these fathers as invisible fathers because they are usually unseen or uninvited to participate in shelter activities with their children (Paquette & Bassuk, 2009). The voices of all six of the fathers in this study supported this literature finding. Marcus described with great emotion, "It would be better so the government

could see not the worst, but the good in us. It's not what you hear. It's what you have to see. That's where people get a lot of things wrong in life."

Another area of alignment between the present study findings and those of qualitative researchers Edin and Nelson (2013) is that all fathers in the present study described parenting in terms of a relationship with their children; not merely an obligation to contribute money. The literature describes that a mother can act as a gatekeeper to the father having contact with his children; from the present study, it was clear that shelters also act in the role of gatekeeper. A nonresidential father desiring to fulfill his role as a parent despite these circumstances must have a strong sense of emotional connectedness in addition to strength and commitment (Julion et al., 2007).

In addition to confirming knowledge from previous research findings, the findings from this study also contribute to new knowledge offered through the voices of an often hard to reach, and often labeled invisible population of nonresidential fathers of CIS.

Theoretical Framework

Roden (2004) proposed a validated and revised version of the HBM. This revised model is geared toward young families, at-risk families, and nontraditional families and focuses on wellness and health promotion as the prevailing emphasis. Roden reconceptualized the HBM to deemphasize the key concept of perceived susceptibility or threat of disease/medical problems and replaced it with a perceived notion of health that promotes a wellness health orientation. The emphasis on wellness and health promotion explores the understanding by a specific population that preventative efforts toward wellness and health can improve overall health and well-being. The HBM aids in understanding the motivations to seek help when a perceived threat of illness exists.

In the present study, this revised HBM, in conjunction with the HBM, was used as the theoretical framework to discern the paternal perceptions of behavioral control around their parenting interactions with their CIS. In the study, nonresidential fathers shared their perceptions of their control over their environments including their CIS through codes relating to how they parented their children prior to being in a shelter, their feelings about parenting and being parented, and their relationships with their CIS. The model afforded an opportunity to identify the demographics of study participants including age, race, marital and coparenting status, and ages of the children. Most importantly the model allowed for reviewing how fathers thought about the healthcare needs of their CIS. Additionally, this study underscores new knowledge about the health-seeking behavior of fathers on behalf of their CIS and then to reflect on the relationship of these actions related to their own experiences of being parented.

The model also allowed considering the cues that prompted fathers to action, internal and external. Their own experiences of being parented and their coparenting relationships with the mother of the CIS impacted this response. The likelihood of their actions around healthcare and health promotion occurred for the child if the father perceived benefits. One father told his children that exercise was good for them and that is what motivated him to push them to exercise. This study allowed for exploration and discussion of the social determinants of health including health, education, and the impact of neighborhood environments on health and safety.

Limitations of the Study

Qualitative research, by its nature, is exploratory (Creswell, 2012), and the aim of this study was to better understand the parental role and parental contributions made by

nonresidential fathers with a specific focus on contributions made to their children's health during the time the children reside in homeless shelters. The study sample included only a small sample of six participants ranging in age from 26 to 50, of different races and marital statuses, and all residing in Philadelphia. Participants shared their stories and lived experiences. All nonresidential fathers in the present study, despite their legal marital status, were invested in coparenting their children along with mothers. Nonresidential fathers not in close relationship with their children's mother, but potentially having a support system of another mother or of a grandmother as a part of their parenting "village," were not part of this study and were excluded from the study. The study has limited generalizability to other nonresidential fathers who may be of younger ages, different races, and live in different parts of the United States. Studies completed with slightly different populations of nonresidential fathers may net different study findings, even if all study procedures mirror those of the present study and include steps taken to ensure trustworthiness similar to the present study.

Aspects of trustworthiness embedded in the present study included member checking, reflexivity, research journaling, and documentation of study processes. Other considerations regarding trustworthiness included considerations of bias reduction throughout the study process including in the questions asked, the participants, and the researcher. Several sources of bias were considered and thoughtfully planned for. One source of participant bias was that of social desirability, such that fathers might have responded to my questions in ways they thought I might like for them to have answered. I directly told participants at the beginning of the interviews that I hoped they would be honest and feel comfortable sharing their honest thoughts and actions. I advised them that

there were no right or wrong answers. Throughout the interviews, I attempted to make participants feel comfortable to share honestly. I also remained vigilant about the potential for confirmation bias, which can occur when a researcher develops a hypotheses that they seek to prove through the research. I worked with a qualitative-research expert to be thoughtful about preventing this bias from occurring. However, even with the best of intentions, any research process embeds bias, posing a potential study limitation.

Recommendations

Given the study findings, I offer several key recommendations for future research. First, future research could explore the parenting role and contributions of nonresidential fathers from other parts of the country. Also, researchers could study nonresidential fathers of younger ages (18–24) or other races, such as Latino or Asian nonresidential fathers.

Additional considerations for future research might include exploring more deeply the links between fathers' perceived and actual contributions to their children's health and their impact on improved health outcomes for CIS (Ball & Moselle, 2007). Researchers have conducted studies exploring the effects of a father's absence on child development. Future research could look at this link between a father's presence and participation in active parenting and its relationship on child development. Another research consideration might be to more carefully review, over time, the nature of the contact between nonresidential fathers and their children and study the direct impact of this contact on health outcomes. A final research consideration might be to study ways to better support these fathers in their role of improving the health and well-being of their children.

Implications: Positive Social Change and Recommendations for Practice

At the individual level, this study allowed the voices of nonresidential fathers to be heard. Several of the fathers interviewed expressed thanks for allowing their voice to be heard and also mentioned they would like to be involved if future opportunities are presented to help others. At the family level, this study hopefully encouraged the fathers to continue or enhance their participation with their CIS, despite the barriers and challenges that abound. At the organizational level, this study has helped me consider how our community health outreach program might encourage the involvement of fathers during our health visits and health-education workshops. These considerations would have to occur in collaboration with sharing study findings with shelter directors and providers and those at the city department that supports families experiencing homelessness to determine how one might encourage participation of nonresidential fathers. To consider inviting nonresidential fathers' participation in the Children's Hospital of Philadelphia Homeless Health Initiative community health outreach program, which brings free health care to CIS, we would need approval from the shelters for father to gain entrance to the shelters. Hopefully, these study findings will encourage shelters to rethink and change policies that exclude fathers from visiting their children on-site during on-site health visits and at other times.

Other researchers may find these results and the study methodology informative as they design studies that seek to engage nonresidential fathers in health-promotion activities in support of improving child health outcomes. Additionally, people working in the shelter setting may use these findings useful as they develop programs designed to better engage nonresidential fathers in parenting their CIS. Finally, public health as a

profession has an opportunity and responsibility to promote and continue study of fatherhood and its importance to children's overall health and well-being.

Summary and Conclusion

This study was undertaken to explore the parenting role of nonresidential fathers and their perceived contributions to the health and well-being of their children residing in shelters. The study also sought to explore the facilitators of their parenting role as well as the challenges to this parenting role. The six nonresidential fathers were a diverse group, aged 26 to 50, of African-American, Caucasian, and Liberian descent, married and separated by shelter, in various coparenting relationships. All but one had experienced homelessness. The children of the fathers ranged from 1 to 13 years of age. This small study sample shed light on dispelling the stereotype that these fathers of CIS are invisible, uncaring, and uninvolved with their CIS. All expressed active participation in their children's lives in the areas of engagement in activities, inclusion in some decision making, and contributions to health and the social determinants of health including health, wellness, and education.

The literature supports the notion that CIS have worse health and educational outcomes than children not residing in shelters (Bassuk et al., 2014). Additionally, families experiencing homelessness often can experience social isolation and have limited social support (Bassuk & Rosenberg, 1988; Letiecq et al., 1998; Perlman et al., 2014; Raikes & Thompson, 2005). This study helped in promoting understanding that nonresidential fathers might provide some necessary social support and other types of assistance to mothers and CIS. By offering feedback, sharing, and help needed to parent successfully, social support can offer a contribution to improved well-being and help

decrease the negative effects that can result from the stress of homelessness (Biederman et al., 2013; Letiecq et al., 1998; Marra et al., 2009; Raikes & Thompson, 2005). Such information highlights an important reason to consider strategic inclusion and support of nonresidential fathers that may help in the improvement of the well-being of their CIS. Very importantly, this small study highlighted that fathers not living with their CIS does not confirm the lack of contributions nonresidential fathers makes or can make to their children's overall health, development, and well-being (Amato & Gilbreth, 1999; Julion et al., 2007; Kissman, 1998; McAdoo, 1997; Mincy et al., 2015).

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Appendix A: Letter to Participant

Date:

Study Number of Participant:

Dear (Name),

My name is Karen Hudson and I am a doctoral candidate at Walden University. I am conducting dissertation research that explores the parenting role of nonresidential fathers of children residing in homeless shelters. While there is limited research found on homeless fathers who reside with their children in homeless shelters there are no research studies found that discuss nonresidential fathers of children living in homeless shelters. This research will provide insight into the parenting role and contributions of nonresidential fathers of children living in shelter.

I realize that your time is important to you and I appreciate your consideration to participate in this study. In order to fully understand your experience we need to meet for a one hour interview. Interviews can be held at a location of your choosing and will not require you to do anything you don't feel comfortable doing. The meetings are designed to simply get to know you and learn about your experience of parenting your child (children) while they live in a shelter. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. My telephone number is [redacted]. You can also email me at [redacted] I look forward to hearing from you.

Karen Hudson

Doctoral Candidate
Walden University

Appendix B: Interview Guidelines

Introduction:

Hi, my name is Karen Hudson. Thank you for agreeing to be part of this interview. I am a doctoral candidate at Walden University and I am interested in learning about your experiences parenting your child(ren) that live in a homeless shelter without you. Your answers will be kept confidential which means that what you share with me today will not be linked to your name or the name(s) of your children, or anyone related to you. You can refuse to answer any question or to stop the interview at any time. Again, thank you for sharing your thoughts and experiences. Do you have any questions at this point?

I am going to review the consent form with you.

Continue with consent procedure and again ask if there are questions.

Interview Protocol

Date:____________________________

Location:_________________________

Name of

Interviewer:____

Participant study ID:____

Let's start with a few background questions so that we can get to know you.

1. Can you tell me how many children you have that are currently living in a homeless shelter?________________
2. What are their ages?_____________________
3. Have you ever experienced homelessness or lived in a homeless shelter?

4. If so, when and for how long?______________________________

5. What is your age?_______________

Research Questions and associated interview questions

RQ1- How do these fathers describe their parenting role with their children while their children are residing in shelters?

Interview Questions:

Please tell me about your relationship with your child(ren)?

Please tell me about that relationship before they moved into the shelter?

Can you describe your relationship since he/she/they have or after they had moved into the shelter?

How often do/did you have contact with your child? Is this amount more or less than before they moved into a shelter?

What does/did that contact look like?

PROBES:

In-person, phone, text)

What kinds of things do/did you talk about?

Do you have any concerns about your child(ren)'s health?

RQ2- How and what do/did these fathers perceive their contributions to be to their children while their children are/were residing in shelters? If fathers are/were involved, do/did they participate in any specific health related activities with their children and how?

Interview Questions:

Please tell me about your role in your child(ren)'s life?

How would you describe your contributions to your children while they live/*lived* in a shelter?

How do/did you participate in your child's healthcare related activities (medical and dental appointments) If so, what does that look like?

Tell me what you do/did to help your child stay healthy?

RQ3- What factors do/did these fathers perceive to be facilitators of their parenting their children in shelter?

What helps you in your role of parenting your child(ren) while they are in shelter?

PROBES: Maybe people or agencies?

What does that help look like?

What could shelters do to help fathers be more involved in the lives of their children?

What could shelters do to help keep children healthy?

RQ4- What barriers or challenges discourage them parenting their children while their children are residing in shelters?

How would you describe the things that make/made it difficult for you to parent your child while they are/were living in a shelter?

PROBES: the child's mother, shelter staff, lack of money for transportation, child's lack of interest in seeing them, etc.)

Appendix C: Letter to Community Agency

Date:

Dear (Name),

My name is Karen Hudson and I am a doctoral candidate at Walden University. I am conducting dissertation research that explores the parenting role of non-residential fathers of children residing in homeless shelters. While there is limited research found on homeless fathers who reside with their children in homeless shelters there are no research studies found that discuss non-residential fathers of children living in homeless shelters. This research will provide insight into the parenting role and contributions of non-residential fathers of children living in shelter.

I am writing to formally ask for your assistance and permission to allow flyers regarding my research study be hung in the shelter and/or program areas that serve families including fathers. If you are willing to allow me to hang these flyers in your agency I am requesting your written documentation indicating the same.

Should you have any questions or wish to reach me I can be reached at [redacted] or you can also email me at [redacted]. I look forward to hearing from you soon.

Many thanks for your assistance.

Best,

Karen Hudson

Doctoral Candidate
Walden University

Appendix D: Flyer

Doctoral Research Study

Study Goal

- To learn about the experiences of non-residential fathers parenting their children who are living in homeless shelters

Who can participate?

- Are you at least 18 years old?
- Do you have a child or children 18 years old or younger that are currently living in a homeless shelter?
- Do you live at a different address than the shelter where your child lives?

Benefits of Participation

- You can help further the understanding of the experiences and needs of non-residential fathers and their children living in shelters
- You will receive a $20 gift card for your participation

What will be asked of you?

- You will be asked to participate in a 1 time 1 hour face- to- face interview to share your parenting experiences

If interested please contact: Karen Hudson 000-000-0000