ABSTRACT

Title of Document:	“BEING ON TOP OF IT:” A QUALITATIVE EXAMINATION OF THE PROCESSES AND CONTEXTS SHAPING PEDIATRIC CAREGIVING AMONG LOW-INCOME, YOUNG, AFRICAN AMERICAN FATHERS
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Several studies have noted the positive relationship between father involvement and children’s health outcomes (Stewart & Menning, 2009; Bronke-Tinkew, Horowitz, Scott, 2009; Yogman, Kidlon, & Earls, 1995; Lamb, 1997; Dubowitz, Black, & Cox, 2001; Chenning 2008). Recent years have also seen a growing interest in the impact of adolescent fathers’ characteristics and involvement on children’s outcomes (Black, Dubowitz, & Starr, 1999; Fletcher & Wolfe, 2011). Few studies of public health or pediatric outcomes, however, have examined how fathers provide and shape healthcare for their children.

Through semi-structured interviews (n = 29), this study explored how low-income, minority young men care for their children’s health. Participants were recruited from two programs that provide integrative medical care, mental health services, and case management support for adolescent and young adult parents in the Washington, DC metropolitan area. Interviews were digitally recorded, transcribed, and entered into

Atlas.ti (Friese, 2014). Informed by grounded theory, data were analyzed over three phases of coding.

This study explored how the contexts in which young men fathered facilitated and complicated fathers' involvement in pediatric caregiving. These contexts included young men's relationships with the mothers of their children, family and kin-relationships, socioeconomic circumstances, community contexts, as well as proximity and distance from their children. This study found that young men developed their approaches to pediatric caregiving from their general health knowledge, prior caregiving experiences, personal health histories as well as their intimate familiarity with their children.

Taken together, the findings suggested a tripartite framework for describing fathers' involvement in pediatric caregiving. This framework also highlights common processes—constructing self as caregiver and a father, navigating coparent relationships, and engaging in medical visits—that young men used to engage in preventative, acute, and chronic caregiving. These common processes helped men negotiate contexts that often challenged their involvement in pediatric caregiving.

"BEING ON TOP OF IT:"
A QUALITATIVE EXAMINATION OF THE PROCESSES AND CONTEXTS SHAPING PEDIATRIC CAREGIVING AMONG LOW-INCOME, YOUNG, AFRICAN AMERICAN FATHERS

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TABLE OF CONTENTS

List of Tables v

List of Figures vi

Chapter 1: Introduction 1

Chapter 2: Review of the Literature 10
Historical Trends of Father Involvement Research 11
Parents' Roles in Pediatric Caregiving 14
Father Involvement and Children's Health 17
Paternal and Child Health 17
Fathers and the Health Care System 18
Fathers Engagement in Medical Decision Making 20
Developmental Considerations for Child 22
Fathers and Children with Chronic Illness 22
Young Fathers 27
Prevalence and Demographic Trends of Fatherhood among Young Men 29
Transition to Adulthood as a Psychosocial Context 31
Theoretical Framework: Symbolic Interactionism in Context 45
Symbolic Interactionism 45
Biopsychosocial Model 48
Purpose of the Study 48

Chapter 3: Research Design & Methodology 52
Methodological Approach 52
Community Characteristics 53
Field Sites 54
Teen Parenting Program 55
Parent Graduation Project 56
Sampling and Recruitment 58
Recruitment Strategy 58
Demographic Characteristics of Sample 60
Data Collection 62
Demographic Questionnaire 64
Semi-Structured Interview 65
Confidentiality 67
Data Analysis 68
Data Quality 71
Reflexivity 75

Chapter 4: The Tripartite Framework of Pediatric Caregiving: Specific Domains and Common Processes 79
Common Processes of Pediatric Caregiving 84
Awareness of Self as Caregiver in Daddy Mode 84
Caregiving through Kin & Emotional Work 88
Co-Parenting Dynamics: Coordinating Care with Mothers of Children 90
Expressions of Support: Fathers' Involvement in Pediatric Visits 101
Fathers' Perceptions of their Relationships with Healthcare Professionals 103
Employment and Physical Distance as Barriers to Fathers' Engagement in Pediatric Healthcare 112
Overview of Preventative, Acute, and Chronic Care Chapters 117

Chapter 5: Preventative Care 119
“Love’s a Part of Everyone’s Health:” Fostering Emotional Connections with Children 120
Diapering, Bathing, and Clothing: Routine Hygiene Caregiving 125
Accessing Healthy Food and Shaping Children’s Diets 132
Controlling Household Environments 141
Maintaining Children’s Health & Safety Outside the Home 147

Chapter 6: Acute Care 153
Monitoring and Targeted Assessment 154
“You Gotta Watch Him”—Monitoring Children’s Health 154
Peeping—Assessing Children’s Health 160
Personal Appraisals of Caregiving Capacity 166
Routine Convalescent Care 171
Executing and Adjusting Treatment Plan 172
Administering Medication 175
Daily Routine 181
Emotional Regulation & Coping: Fathers’ Responses to Children’s Acute Health Issues 186
Encouraging Emotional Regulation among Children and Other Caregivers 186
Emotional Self-Regulation: Coping with Personal Emotional Reactions 191

Chapter 7: Chronic Care 199
Case Examples of Contextually-Situated Chronic Caregiving 201
From Self-Blame to Learning the Ropes—Smith’s Story 202
“Nipped”—Delonte’s Story 214
Summary of Case Studies 222
Disease Management: Triggers, Environments, and Medications 224
Learning Triggers 227
Environmental Control 231
Trigger Inoculation 236
Medication Management 238

Chapter 8: Discussion 247
Limitations to the Study 248
Methodological Contributions 250
Research Contributions 251
Pediatric Caregiving: Reciprocally Beneficial for Fathers and Children 251
Pediatric Caregiving as Part of Fatherhood Role and Identity Construction 253
Negotiating Space, Distance & Proximity 254
Emotion and Kin-Work as Facilitators for Pediatric Care 255
Theoretical Contributions 257
Implications for Practice, Programming, and Policy 258
Areas for Future Research and Future Directions 264

Appendix A 268

Appendix B 270

Appendix C 271

Appendix D 275

Appendix E 284

Appendix F 285

Appendix G 294

References 302

LIST OF TABLES

Table 1 Demographic Characteristics of Sample.. 62

LIST OF FIGURES

Figure 1: Tripartite model of father involvement in pediatric caregiving 83

CHAPTER 1: INTRODUCTION

Social science has long been interested in fatherhood and particularly concerned about the impact of fathers on their children's development (Lamb, 2008). Scholarly interest in fatherhood can be traced to the emergence of social science as a distinct academic field around the turn of the twentieth century (Goldberg, Tan, & Thorsen, 2009; Lamb, Pleck, Charnov, & Levine, 1987). The scope, breadth, and depth of fatherhood research have grown since social scientists began examining fatherhood with the advent of the field (Goldberg, Tan, & Thorsen, 2009; Lamb, 2008). Rising concern about children in single-parent households combined with advancements in statistical and computational tools, led to increased efforts to quantify father involvement with the hopes of demonstrating the impact that involvement—or lack thereof—on child outcomes. Whereas the extant body of literature clearly documents the impact of father involvement on children's wellbeing, few studies have examined what fathers do for their children to promote these salutatory effects. Examining father involvement in pediatric caregiving offers opportunities to begin understanding how men's involvement in family processes shape children's health outcomes.

Fatherhood Among Young Men

Fatherhood research has largely drawn from samples of middle-aged, middle income, married fathers (Berger & Langton, 2011; Brown, Mangelsdorf, & Neff, 2012). When young men have been included in these studies, their data have generally been aggregated with older fathers (Gavin et al., 2002). However, as nonmarital births among young parents increased during the 1970's, policymakers and researchers began focusing

attention on child and mother wellbeing and health outcomes among young parents (Dudley, 2007; Elo, Berkowitz King, & Furstenberg, 1999). A small but growing body of research emerged in the wake of this concern to explore fatherhood among adolescent males (Dudley, 2007; Khurana & Gavazzi, 2011; Lewin, Mitchell, Beers, Feinberg, & Minkovitz, 2012; Lewin, Mitchell, Waters, Hodgkinson, Southammakosane, et al., 2014). Research about teen fathers has explored the factors that predict their childbearing, perceptions of parenthood, and dynamics of the coparenting relationship (Futris & Schoppe-Sullivan, 2007; Rhein, Ginsburg, Schwartz, Pinto-Martin, Zhao, et al., 1997; Goodyear, Newcomb, & Locke, 2002; Lewin, Mitchell, Beers, Feinberg, & Minkovitz, 2012; Paschal, Lewis-Moss, & Hsiao, 2010). A common drawback of many studies of adolescent fathers, however, is that they rely on mothers' reports and do not collect data from fathers themselves (Lewin et al., 2012; Mollborn & Lovegrove, 2011; Wayland & Rawlins, 1997).

Nonetheless, findings from studies of teen fathers suggest that the developmental, relational, community, and economic contexts surrounding young fathers may contribute to important differences in their experiences of parenthood. Whereas research has begun targeting adolescent fathers, few studies have examined parenting among men who are slightly older in their transition to adulthood. Recent scholarship has begun to define the period after adolescence between 18 to 30 years old—as a distinct developmental position (Arnett, 2004; Cohen, Kasen, Chen, Hartmark, & Gordon, 2003). Whereas young adults may not consider becoming a parent necessary for becoming an adult, demographic data suggest that these transitions co-occur for a substantial proportion of young persons. Birthrates peak between 18-29 years old, with 74.3% of all births

occurring to parents during this period and half of these births occur to fathers between the ages of 20-24 (Martin, Hamilton, Verntura, Osterman, Kirmeyer, et al., 2011). Compared to men with more socioeconomic advantage, the peak childbearing years occur earlier for minority and low-income men.

The status and tenor of men's relationships with the mothers of their children have consistently been associated with children's health and father involvement. Relationship quality also predicts maternal and infant outcomes, including gestational age at birth, infant birth weight, infant mortality and mothers' prenatal health behaviors (Alio, Salihu, Kornosky, Richman, & Marty, 2009; Alio, Kornosky, Mbah, Marty, & Salihu, 2010). Fathers who are in romantic relationships have higher levels of involvement with their children than men who are not in such relationships as well as those who are involved in new romantic relationships (Cabrera, Ryan, Mitchell, Shannon, & Tamis-Lamonda, 2008; Kotila & Kamp Dush, 2012). When young fathers' romantic relationships with the mothers of their children dissolve or deteriorate, their presence and involvement with their children may also decline (Gee, McNerney, Reiter, & Leaman, 2006; Kamp-Dush, Kotila, & Schoppe-Sullivan. 2011). Because romantic relationships among adolescent and young parents are often temporary, children born to unmarried, young parents may have less contact and receive less caregiving from their fathers (Collins, Welsh, & Furman, 2009). The quality of the coparenting relationship, however, may buffer against declines in father involvement in the wake of the dissolution of fathers' romantic relationships with the mothers of their children (Carlson, McLanahan, & Brooks-Gunn, 2008; Cooksey & Craig, 1998; Fagan & Palkovitz, 2011; Fagan,

Palkovitz, Roy, & Ferrie, 2009; Gee, McNerney, Reiter, & Leaman, 2006). This effect may be especially pronounced for young fathers (Fagan & Lee, 2013).

Co-residing with children has been found to be a strong predictor of father involvement (Tach, Mincy, & Edin, 2010). Residing with one's children affords parents opportunities to shape their children's daily routines, participate in mundane caregiving, consistently monitor and address their children's health needs (van Gent, 2008). Among single parent families, children are more likely to live with their mothers than their fathers and young fathers are less likely to live with their children than older men (Castillo, Welch, & Sarver, 2011; Guzzo, 2008; Lewin, Mitchell, & Ronzio, 2013). Transportation difficulties, community danger, financial barriers, coparenting relationship dynamics, and employment conflicts may present barriers to nonresidential fathers' visitation and involvement with their children (Mitchel, See, Tarkow, Cabrera, McFadden et al., 2007; Roy, 2004). Young men face an elevated risk of experiencing housing instability and this contextual factor may limit their options for providing caregiving for their children (Kolos, Green, & Crenshaw, 2009; Zerger, Strehlow, & Gundlapalli, 2008).

Father Involvement and Children's Wellbeing

Ideas of the fatherhood role have shifted over time but researchers have generally assessed father involvement by focusing on fathers' interactions, accessibility, and the assumption of responsibility for their children (Lamb, Pleck, Charnov, & Levine, 1987). Whereas researchers have defined and measured the fatherhood role in varying ways over time, interest in the impact that fathers have on their children's development and wellbeing has been a consistent theme across many of these studies. By and large, these studies have found that father involvement predicts positive child outcomes and buffers

against external factors that threaten to detract from children's wellbeing (Flouri & Buchanan, 2002).

Children's health, developmental progress, and general wellbeing are shaped by contextually-situated family processes (Schuster, Chung, & Vestal, 2011). Few studies, however, have examined how families negotiate the contexts in which they are embedded in order to promote the health of their members (Garfield & Isaaco, 2012; Moreno, Kelley, Landry, Paasch, Terlecki, et al., 2011). Despite their involvement being associated with children's health outcomes, fathers' participation in the processes around pediatric caregiving has received scant scholarly attention (Garfield & Isaaco, 2006). The impact of father involvement may be especially important for children born to young parents as they face an increased risk for experiencing developmental delays, behavioral and emotional problems, as well as acute health emergencies (Alio, Salihu, Kornosky, Richman, & Marty, 2009; Cabrera, Cook. McFadden, & Bradley, 2011; Ekeus, Christensson, & Hjern, 2004).

Child-centered health behaviors have received increased attention in recent years. Much of this research has centered on examining how children adopt and maintain personal health behaviors. Drawing from samples of older children and adolescents, prior research has examined parents roles in socializing children's dental care behaviors, diet and nutrition, sexual behaviors, as well as children's drug and alcohol use (Breslin & Adalf, 2005; DiIorio, Kelley, & Hockenberry-Easton, 1999; Friestad, Pirkis, Biehl, & Irwin, 2003; Goodman & Huang, 2002; Laster Holsey, Shendell, McCarty, & Celano, 2009; Listl, 2011; Nelson, Gordon-Larsen, Adair, & Popkin, 2005; Wardle, Jarvis, Steggle, Sutton, Williamson, et al., 2003). Parental factors—including socioeconomic

status, parenting styles, health beliefs and knowledge—have been associated with children's health behaviors (Pratt, 1973; Tinsley, 1992).

Parents play a central role in family processes around health. Few studies, however, have examined how family processes shape pediatric caregiving and parents' roles in children's health care. In developing a scale measuring family health behaviors, Moreno et al. (2011) found that family health behaviors were arranged across four axes: parent behaviors, mealtime routines, physical activity, and child behaviors. Whereas this scale includes items regarding parents' child-focused behaviors, it does not distinguish parents' pediatric care from their efforts to care for their own health. Pediatric caregiving generally falls into three domains: preventative, acute and intermittent, and chronic care (Schuster et al., 2011). Preventative care promotes children's health and mitigates risk for developing future health issues. Intermittent and acute care address children's discrete—and often temporary—health issues that range from minor to life-threatening. Conversely, chronic care addresses children's long-term health conditions and often require significant time and financial resources to manage (Leonard, Brust, & Sapienza, 1992; Su, Kemp, Varigos, & Nolan, 1997). Schuster et al. (2011) described parents as the hub connecting children to medical care and noted that they fulfill a multitude of roles that span arranging and facilitating children's doctors' visits, liaising with healthcare professionals about their children's health, as well as delivering home-based medical care.

Fathers and Children's Health

The interrelationships between maternal and child health have long received scholarly attention and have emerged as a discrete area of scientific inquiry, policy

priority, and program planning. The Maternal and Child Health Program was enacted as Title V of the Social Security Act of 1935 with the aim of promoting positive health outcomes among mothers and children (Health Resources and Services Administration, n.d.). Since then, substantial resources (i.e., grants, datasets, and interventions) have been dedicated to examining health—particularly unfavorable health outcomes—among mothers and children. Fathers, however, have not received comparable attention during the same period and are largely absent from this body of work (Lu et al., 2010).

Relatively little is understood about how paternal factors impact children's wellbeing. When father variables have been included in studies of children's wellbeing, researchers have often relied on mothers' reports of fathers' contact and involvement with their children (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). Using varying operational definitions of fatherhood, several studies have found that father involvement predicts children's cognitive, developmental, and educational outcomes (Bronke-Tinkew, Carrano, Horowitz, & Kinukawa, 2008; Day & Padilla-Walker, 2009; Flouri & Buchanan, 2004; Goncy & van Dulmen, 2010; McWayne, Downer, Campos, & Harris, 2013). Children with involved fathers also have fewer behavioral and mental health problems over the life course than those who have less contact with their dads and these effects endure longitudinally (Cabrera, Cook. McFadden, & Bradley, 2011; Dubowitz, Black, Cox, Kerr, Litrownik, et al., 2001; Howard, Burke Lefever, Borkowski, & Whitman, 2006). Related studies of non-resident, minority fathers suggest that men's involvement with their children has positive effects on child outcomes (Cabrera et al., 2011; Flouri & Malmberg, 2012).

A growing body of literature has examined fathers' experiences as caregivers for their children's health. In these studies, men have expressed concern about their children's heath and interest in providing direct medical care for their children (Broger, & Zeni, 2005; Garfield, Clark, & Davis, 2006). Whereas our understanding about father involvement in general pediatric care is limited, the literature examining the experiences of men with children who have chronic illnesses may offer insights into family processes shaping fathers' health caregiving. Vigilance features strongly in men's perceptions and behaviors around caring for children's health, particularly when they begin to suspect that their children may be ill (Cashin, Small, & Solberg, 2008). Vigilance, however, may not translate into direct care as mothers continue to provide the bulk of medical caregiving for their children (Knafl & Zoeller, 2000).

Gendered caregiving expectations, division of responsibilities, as well as work obligations may interfere with fathers' efforts to engage in their children's medical care (Goble, 2004). Fathers, then, may look to mothers to take primary responsibility for providing direct care, attending doctors' visits, and making medical decisions (Garfield & Isaaco, 2006; Goble, 2004). Fathers' deference to mothers may result from men's perceptions that mothers are better aware of how to care for their children because they spend more time with them (Goble, 2004). Although families have been found to rely on mothers to provide most of the direct care, fathers have reported that they too were involved with caregiving and benefitted from being able to care for their children's health (Sullivan-Boylai, Rosenberg, & Bayard, 2006).

Whereas a small body of literature has demonstrated that father involvement is associated with children's wellbeing, few studies have examined the processes by which

fathers contribute to these salutary effects. Furthermore, men's pediatric caregiving has seldom been considered as part of father involvement and remains understudied (Garfield, 2006). The contextually-situated processes that guide how fathers negotiate involvement in children's health represent social determinants of health that contribute to differential child outcomes. Understanding family processes as social determinants of health allows researchers to move beyond stating that certain family characteristics predict child outcomes. Examining process prompts investigators to examine *how* health behaviors are acquired, maintained, and changed in light of the contexts in which they are situated.

The present study contributes to a growing body of literature that explores the intersection of fathers and children's health. Through semi-structured interviews (n = 29), this study enhances our understanding of how contextually-situated family processes shape young adult fathers' involvement in their children's health. This study examines how men perceive their children's health as well as how pediatric caregiving features in their ideas of the fatherhood role. Additionally, the present study explores the contexts in which young fathers shape their efforts to care for their children's health. The findings from this study begin to elucidate how young fathers' participation in family processes contributes to differential pediatric health outcomes.

CHAPTER 2: REVIEW OF THE LITERATURE

Children's physical and mental health outcomes have been associated with father involvement (Garfield, 2006; Williams, Hewiston, Wagstaff, & Randall, 2012). Researchers have been particularly interested in outcomes among children in families where fathers are not married, are not co-residing with children, have children with multiple partners, and have limited access to financial resources (Guzzo & Furstenberg, 2007; Kotilla & Kamp-Dush, 2012; Tach, Mincy, & Edin 2010). Children born to adolescent parents have also received attention in the extant body of literature (Gee, McNerney, Reiter, & Leaman, 2007). A common limitation of these studies is that they overwhelmingly rely on mothers' reports; fathers' perspectives of their own involvement and their children's wellbeing are largely missing from these accounts (Gavin et al., 2002; Lewin, Mitchell, & Burrell, 2011).

Examining men's involvement in pediatric caregiving offers an opportunity to begin elucidating how father involvement, as a social determinant of health, contributes to children's wellbeing. The present study explored the contextually-situated processes of father involvement in pediatric caregiving among low-income, young men. This review begins with a discussion of how father involvement has been conceptualized and explored in prior research. As a component of involvement, this review also highlights the limited research concerning fathers' caregiving around their children's health.

The review then shifts to discussing fatherhood among young men. Prior studies have found that children born to adolescent and young parents face elevated risks for experiencing a host of health issues, including: low birth weight, infant mortality,

developmental, cognitive, and language delays, behavioral problem; and they are more prone to experiencing accidents (e.g., burns, falls, poisonings) (Botting, Rosato, & Wood, 1998; Ekéus, Christensson, & Hjern, 2004; Jenkins, Shatka, & Sorenson, 2006; Mollborn & Lovegrove, 2011). After highlighting the prevalence of parenthood among young men, the review discusses young adulthood as a unique developmental position that shapes fatherhood among young men. The review concludes with a summary of research examining contextual factors that are particularly unstable during the transition to adulthood and have been found to impact father involvement—including the coparenting relationship, fathers' residential patterns, and low-income men's access to financial resources.

The paucity of research examining young fathers' involvement in caring for their children's health and the health disparities facing children born to young parents warrant the present study. The findings from this project shed light on father-child processes that shape children's health outcomes. These findings suggest a theoretical framework that examines young fathers' caregiving experiences in light of the meanings they ascribe to the fatherhood role, their perceptions of the contexts in which they father, and their personal health experiences. This approach allows for exploration of how men's perceptions of health and fatherhood shape their caregiving experiences.

Historical Trends of Father Involvement Research

Ideas about the father role have changed over time (Lamb, 2008). These notions have changed in succession from characterizing fathers as moral leaders, to breadwinners, to masculine role models, to marital partners, and then to nurturers for their children (Lamb, 2008). As social science became differentiated from philosophy,

biology, and medicine at the turn of the twentieth century, researchers began exploring the impact of fatherhood on children's psychosocial development (Lamb et al., 1987). Fatherhood research emerged at a period when men's "masculine," sex-based roles as stoic, dominant, providers factored prominently in the zeitgeist around fathers' roles in their families (Lamb, 2008). Accordingly, fatherhood research during this period was broadly concerned with exploring fathers' embodiment of these traits and if men's ability to demonstrate these characteristics influenced child outcomes, particularly boys' identity development (Biller, 1970; Griswold, 1993; Mussen & Distler, 1959).

Following the Second World War, research shifted to examining how the inverse of father involvement—fathers' absence—affected children (Lamb, 2008). These studies generally found that fathers' absence contributed to poor child outcomes, particularly for boys. Whereas studies exploring fathers' presence and enactment of sex-role expectations and children's experiences largely relied on qualitative methods, there was a greater effort to measure fathers' involvement quantitatively beginning in the 1970's. At this time, researchers began questioning the simplistic nature of father absence studies and explored how variations in fathers' involvement, particularly the amount of time men spent with their children, affected children.

Since then, various constructs have been used to operationalize and measure father involvement. In their review of historical trends in father involvement literature, Lamb et al. (1987) identified three concepts to describe how researchers have defined father involvement: interaction, availability, and responsibility. Interaction concerns men's participation in direct caretaking activities with children (i.e., feeding, playing, helping children with homework). Whereas interaction refers exclusively to one-on-one

caretaking activities, and availability includes fathers' general accessibility to the child that allows the potential for interaction (Lamb, 2008). Responsibility is another lens researchers have used to examine father involvement. Responsibility refers to men's general sense of accountability for the wellbeing of their children. Lamb (2008) notes:

> Responsibility involves knowing when the child needs to go to the pediatrician, making the appointment, and making sure that the child meets this appointment. Responsibility involves making child-care and baby-sitting arrangements, ensuring that the child has clothes to wear, and making arrangements for care and nurturance when the child is sick. It involves more than ''helping out'' or ''baby-sitting'' (p. 31).

In addition to examining men's behaviors with and on behalf of their children, researchers have also explored affective aspects of father-child relationships. Although little research exists that illustrates exactly how fathers create emotional bonds with their children, several studies have demonstrated that the quality of these relationships predicts child outcomes. The extent of fathers' daily interactions with their kids has been found to predict children's attachment security (Brown, Mangelsdorf, & Neff, 2012). Fathers' connectedness and involvement with their children has also been associated with the development of pro-social behaviors, as well as reduced risk for experiencing externalizing and internalizing behaviors (Day & Padilla-Walker, 2009). Fathers' emotional closeness with their children has also been found to reduce risk of alcohol use and abuse among adolescents (Goncy & van Dulmen, 2010).

Recently, Marsiglio & Roy (2012) advanced an integrative conceptualization of father involvement that considers fathers' parenting behaviors, children's developmental positions, and affective dimensions of fathers' relationships with their children. Drawing on Dowd's (2000) conceptualization of nurturance, Marsiglio and Roy suggest that father involvement may be best understood by examining men's responsiveness to their

children's needs, the bonds they form with their children, as well as the sense of togetherness—or "we-ness"—that exists between men and their kids. As a dynamic framework that spans men's behaviors, understandings of the fatherhood role, and affective experiences with their children, nurturance offers a promising lens to examine father involvement for future studies.

There is considerable variation among men who fulfill the fatherhood role. As Coleman and Garfield (2004) note:

> A father may be a biological, foster, or adoptive father; he may be a step-father, grandfather, adolescent father, father figure, or co-parent father in a gay relationship; and he may be custodial or noncustodial, resident or nonresident, near or far….Father is defined broadly as the male identified as most involved in caregiving and committed to the knowing when the child needs wellbeing of the child regardless of living situation or biological relation (p. 1406).

The diversity of men's relationships to children contributes to variation in fathers' understandings of their roles towards children. This inclusive definition of "social fathering" allows for inclusion of the experiences of men who fulfill the fatherhood through kinship and romantic relationships with the children's mothers (Jayakody & Kalil, 2004; Roy & Burton, 2007). Per Coleman and Garfield's definition of father, the present study employed an inclusive conceptualization of "father" that does not necessarily connote a direct biological relationship with the children implied in this study.

Parents' Roles in Pediatric Caregiving

In general, children are healthier than adults and have fewer chronic health issues (Jameson & Wehr, 1993). Nonetheless, caring for children's health needs requires considerable attention and intervention, the bulk of which is provided by parents

(Schuster, Chung, & Vestal, 2011). However, few researchers have endeavored to develop and evaluate comprehensive definitions of pediatric caregiving behaviors that parents enact on behalf of their children. In the construction of a scale measuring family health behaviors, Moreno et al. (2011) identified four subscales describing family health: parent behaviors, mealtime routines, physical activity, and child behaviors. Parents' child-focused behaviors centered around their dietary choices for their children, parents' efforts to teach their children about proper nutrition, as well as modeling healthy eating and physical activity. The parent behavior scale included several items corresponding to their efforts to care for their children's health, particularly with regards to their dietary choices for their children and teaching their children about healthy food. With families as the unit of analysis, however, items regarding parents' behaviors on behalf of their children and themselves are intermingled, thus making it impossible to distinguish the unique contributions of parents' child-focused health behaviors from those that they enact to care for themselves.

Schuster et al. (2011) introduced a model that divided children's health needs and pediatric care into three domains: preventative care, intermittent care, and ongoing chronic care. Preventative care involves behaviors that promote children's health, provide health education and guidance, reduce unhealthy behaviors, and addresses disease prevention through screenings and immunizations. Intermittent care entails the diagnosis and treatment of acute illnesses that range from minor to life-threatening. Addressing their children's intermittent and acute health needs often involves office visits, emergency room visits or hospitalizations, as well as commensurate home health care and follow-up treatment. Children's ongoing chronic health care necessitates the management

of conditions that persist over the course of time. Similar to adults, managing children's chronic health needs requires the coordination of healthcare services, including therapeutic services, home health care, and specialized school-based services.

Parents also interface with the healthcare system as they care for their children's preventative, intermittent, and chronic health care needs. Parents play an integral, if understudied, role in their children's receipt of healthcare services and are responsible for a complex set of tasks during even the most routine of medical encounters. Schuster et al. (2011) note:

> Parents are responsible for scheduling the visit. They are responsible for arranging transportation. In most offices and emergency wards, parents are responsible for filling out all the necessary paperwork, displaying proof of insurance, and handling co-pays. Parents are expected to entertain or otherwise supervise their children while waiting, sometimes for hours, first in a waiting room and then in a patient room. They are expected to provide most or all of the relevant historical information to clinicians and to assist clinicians in the gathering of additional data, including talking with their child, comforting him or her during examinations or procedures, and helping collect urine or other samples (p. 97).

In addition to arranging, coordinating, and facilitating children's medical visits, parents are also responsible for monitoring changes in children's health that may not be readily observed by medical staff— including their responses to treatment—as well as communicating this information to providers. As children transition from direct medical supervision to home care, parents are expected to work with clinicians to develop plans for ongoing care, learn how to provide appropriate medical care at home, as well as schedule and attend follow-up visits, fill prescriptions, and arrange out-going lab requests (Schuster et al., 2011).

Father Involvement and Children's Health

Paternal and Child Health

Men's involvement in caring for their children's health represents an important, yet understudied aspect of fatherhood involvement. The connection between mothers' health and children's health has been acknowledged among scholars and policy makers since the turn of the twentieth century (Klaus 1993). Since then, an interdisciplinary field, federal and state agencies, as well as discrete policies have emerged to study and advocate for the interrelated health outcomes of mothers and children. These advancements spurred the development of robust literature examining the interrelationships among a multitude of maternal and child health variables. Fathers' experiences, personal health characteristics, and the interactions of their health outcomes with that of their children, however, have largely been ignored by maternal and child health literature (Lu, Jones, & Bond, 2010). When fathers have been examined in these studies, their involvement and participation has often been considered tangentially as covariates (Hill, Lynne-Landsman, & Boyce, 2013; Turney, 2011).

Several studies have documented the impact of father involvement and caregiving on children's health outcomes. However, these studies present unidirectional findings that do not account for how children's health impacts fathers' wellbeing (Garfield, Clark-Kauffman, & Davis, 2006). The findings of a small group of studies on the health of fathers of children with chronic illnesses suggest that similar relationships may also exist for fathers (Caldwell et al., 2004; Jordan & Lewis, 2005). These findings, as well as those identified in maternal and child health literature underscore the importance of exploring fatherhood as a factor that contributes to men's health.

Whereas our understanding of caregiving as a factor that shapes providers' health has grown in recent years, much less is known about how parents' personal health histories shape the care that they provide for their children. Parents' own health experiences throughout the life course may influence their perspectives about how their children's chronic illness should be approached. These attitudes and beliefs likely influence how parents care for their children's health. Fathers' experiences as patients and recipients of health care may shape how they monitor their children's health, respond to children's health issues, prevent illness, and promote wellness among their children.

Fathers and the Health Care System

The health care system represents an important setting for parents' involvement in their children's health. In addition to the hands-on monitoring of health behaviors, parents also engage the healthcare system on behalf of their children. Parents facilitate access to care by securing health insurance, making appointments, and providing transportation to visits (Sobo, Seid, & Gelhard, 2005). Additionally, parents act as liaisons between their children and healthcare professionals by reporting children's patterns, behaviors, and symptoms during visits, particularly when children have yet to acquire the language skills necessary to relate this information themelves. Few studies have examined how fathers, particularly low-income, minority men, engage the health care system. Garfield and Isaaco's (2006) study offers important insights about men's perceptions of their involvement as fathers in this regard. The authors noted that fathers thought that it was important that they attend well-child visits for several reasons, including "to gather information about their child, to support their child, for the opportunity to ask questions and express concerns, and to gain firsthand experience of the

doctor and the visit" (Garfield & Isaaco, 2006, p. e639). The vast majority of fathers have attended at least one well-child visit, with estimates ranging from eighty-nine to ninety-eight percent of fathers attending these appointments (Garfield & Isaaco, 2006; Moore & Kotelchuk, 2004).

Garfield and Isaaco (2006) noted that while most fathers were satisfied with their experiences taking children to well-child visits, many encountered barriers that complicated their engagement. Men may face "systemic barriers, such as inconvenient office hours and lack of access to their child's records and insurance information" (Garfield & Isaaco, 2006, p. e640). Men may also encounter difficulties navigating the systems necessary to gain access to healthcare, including complicated phone trees, insurance processes, or intake protocols (Sobo, et al., 2006). Inflexible work schedules were also identified as barriers to fathers' taking children to doctors' visits. However, married fathers whose attitudes favor a non-gendered distribution of parenting duties have been found to be more likely to be involved in this aspect of their children's health (Bailey, 1991). Different processes may occur, however, for low-income, non-residential, or unmarried fathers as their attitudes about gender roles may not be as salient given their unique relationships with the mothers of their children.

Pediatric visits represent a setting where fathers navigate relationship dynamics with their partners as well as with their children's medical providers. Relationship tensions with mothers have also been cited as a barrier for fathers (Garfield & Isaaco, 2006). This may be especially true for non-emergent health care encounters, such as well-child visits. Fathers may look to mothers for basic logistic information about children's medical visits (i.e., reasons for the visit, location and time of visits, who their children

will be seeing), as well as the results of those visits when they are not able to attend. Tension between parents may detract from mothers' and fathers' communication about these details.

Encounters with medical providers have also been found to present challenges to fathers (Garfield & Isaaco, 2006). Men may perceive that they are viewed with suspicion by medical providers. Fathers have reported experiencing difficulties communicating with their children's health care providers and perceiving that physicians do not value their perspectives as parents (Sobo et al., 2006). Taken together, these factors may compromise fathers' efforts to be involved in their children's medical encounters.

Fathers Engagement in Medical Decision Making

Parents bear the primary responsibility for making decisions regarding their children's health. The relationship between fathers and the mothers of their children may also influence men's engagement in making health decisions. Isaaco and Garfield (2010) found that fathers' sense that they were co-parents with the mothers of their children shaped how they engaged in routine health decisions for their children. The study also found that non-residential fathers were more likely than their married or residential counterparts to use detached narratives to describe their involvement in health decision-making processes for their children. Despite this increased likelihood, the authors found that some non-residential fathers developed narratives that included contributing to routine health decisions for their children (Isaaco & Garfield, 2010).

Hospital policies and health care providers may lead to situations in which fathers perceive themselves as bystanders to the decision-making process (Locock and Alexander, 2006). Some fathers have reported feeling excluded from medical decision-

making processes when they attend well child visits because physicians direct their questions to mothers by default without soliciting information from dads (Garfield, 2001). Fathers may also withdraw voluntarily from the decision-making process due to perceptions that mothers or others possess more accurate knowledge, or concerns about the co-parenting relationship, or that mothers bear responsibility for making some health decisions (Garfield & Isaaco, 2006; Goble, 2004; Hill, Higgins, Dempster, & McCarthy, 2009; Isaaco & Garfield, 2010).

Children's Health and the Coparenting Relationship

Children's health, especially when compromised, has significant implications for parents' dyadic relationships. Studies of married couples have found that relationship satisfaction may decrease during the period after their children are diagnosed with a chronic illness and may further deteriorate over time (Lavee & May-Dan, 2003; Yeh, 2002). Lavee & May-Dan (2003) found that marital satisfaction decreased in the first years after diagnosis but then increased to levels higher than baseline in the second and third years. Ultimately, however, relationship satisfaction declined if the illness persisted beyond four years. A few studies also suggest that there may be gender differences in parents' experiences of stress and relationship difficulties in light of their children's illness but have presented conflicting findings of differences in fathers' and mothers' reports of relationship satisfaction (Shapiro, Perez, & Warden, 1998; Brody & Simmons, 2007). Taken together, these findings suggest that children's health status affects parents and the co-parenting relationship. It is important to note, however, that the samples in these studies were drawn from married couples; the experiences and dyadic responses of unmarried, non-cohabitating parents likely differ. Variations in romantic status and

parental residential arrangements may shape parents role expectations of themselves and each other.

Developmental Considerations for Child

Children's age and developmental positions shape how parents care for their children's health needs. The developmental positions of their children intersect with fathers' involvement in health promotion, surveillance, and acute care, which translates into how fathers care for their children's health needs. Whereas parents, including fathers, bear primary responsibility for caring for children's health when children are young, the adolescent-parent relationship has been characterized as contentious and the pubertal years as a time when children seek greater autonomy, thus creating less family cohesion (Steinberg, 1986). By the time children reach adolescence, parents' health caregiving for their children may be largely comprised of general health oversight, monitoring, and reminders to enact health behaviors (Rew, Arheart, Thompson, & Johnson, 2013). Parents may also continue to coordinate adolescents' engagement with medical providers and may provide care for acute medical issues. As parents seek to monitor adolescents' health, they must also negotiate issues of privacy. Parents' violation of privacy has been associated with parent-child conflict (Hawk, Keijsers, Hale, & Meeus, 2009). The increased autonomy and preference for privacy among adolescents may complicate parents' care for their children's health (Ford, 2002).

Fathers and Children with Chronic Illness

Whereas few studies have explored how men incorporate caring for children's general health into their conceptualizations and enactment of the fatherhood role, a

growing body of research has examined fathers' experiences parenting children with chronic illnesses. Childhood cancer is among the most common chronic illnesses examined in these studies and some studies have examined the experiences of fathers of children with diabetes, muscular dystrophy, cerebral palsy, congenital heart disease, cystic fibrosis, Down's syndrome, autism, and HIV/AIDS. Prior studies have examined men's experiences surrounding diagnosis, their participation in management of their children's conditions, as well as social and emotional consequences of parenting children with chronic illnesses.

The period prior to receiving a diagnosis often involves recurrent symptoms, frequent doctors' visits, and uncertainty about how to best care for children (Cashin et al., 2008; Clarke, 2005). These experiences were found to be dynamic and shaped by fathers' dynamic understandings of their children's illness. Men have described heightened concern and worry about their children's health prior to receiving a diagnosis (Cashin et al., 2008). The diagnosis itself has also been found to stir up complex emotions, including shock, relief, and concerns about their children's futures (Goble, 2004; Sullivan-Boylai et al., 2006). While a diagnosis may surprise families, some fathers suspected that their children's health was compromised prior to receiving a formal diagnosis because they noted changes in children's behaviors, development, or affect (Clarke, 2005).

Mothers of children with chronic illnesses have been found to bear the brunt of day-to-day caregiving responsibilities (Bristol, Gallagher, & Schopler, 1988; Knafl & Zoeller, 2000; Quittner, DiGirolamo, Michel, & Eigen, 1992; Wallander, Varni, Babani, & Wilcox, 1989). In families where mothers provide the bulk of children's medical care, fathers may rely on mothers' expertise for guidance about making health decisions and

enacting caregiving for their ill children (Goble, 2004). The findings from Sullivan-Boylai et al.'s (2006) study of fathers whose children were diagnosed with diabetes echo these findings about gendered division of labor with regards to children's healthcare. Their qualitative study of fathers (*n* = 16) identified six categories describing fathers' reactions and responses to their children's illness:

> Fathers described the "shock and awe" of the diagnosis but they quickly "sucked it up" and moved on to learning about diabetes-related care. They described needing to "stay in the loop" to maintain management skills, especially when their partners provided most of the day-to-day management, described having partnerships in care with their partners/spouses, especially for problem solving and decision making around diabetes management. They were actively involved in the day-to-day disease management and benefitted from opportunities to participate in their child's care. Finally, they described…looking at the child first and the diabetes second (Sullivan-Boylai et al., 2006, p. 27).

Other studies have also noted that fathers with children who were experiencing chronic illnesses engage with their children's health on several levels, including direct monitoring and care, interacting with healthcare professionals, as well as managing additional administrative and financial responsibilities that result from medical encounters (Clarke, 2005).

Learning that one's child has a chronic or potentially fatal disease may cause significant emotion for parents. In a departure from previous editions of the Diagnostic and Statistic Manual of the American Psychiatric Association, the most recent version included learning that a loved one had a chronic or life-threatening illness among possible diagnostic criteria for post-traumatic stress disorder (PTSD) (Cabizuca, Marquez-Portella, Mendolwisz, Coutinho, & Figueira, 2009). A meta-analysis of 17 studies examined PTSD among parents whose children were living with life-threatening illnesses, Cabizuca et al (2009) found that parents of children with chronic illnesses were

more likely to meet clinical criteria for a PTSD diagnosis than parents of unaffected children. Among the studies that examined mothers and fathers separately, the meta-analysis found that 11.6% of fathers had PTSD compared to 19.6% of mothers. Additionally, fathers of children who have chronic illness face an increased risk of experiencing depressive symptoms and clinically significant depression than fathers of healthy children (Ferro & Speechley, 2011; Schneider, Steele, Cadell, & Hemsworth, 2011).

Parents of children with chronic conditions also experience more stress compared to parents of children without chronic conditions. A study comparing the stress levels and coping styles of parents of children who had autism, down syndrome with parents without affected children, found that parents' level of education predicted stress related to caring for a child with special needs (Dabrowska & Pisula, 2010). This association may be explained by an enhanced understanding of their children's condition and greater caregiver burden. Parents' education level has also been associated with treatment adherence (Ho, Bender, Gavin, O'Connor, Wamboldt et al., 2003). These elevated stress levels have also been found among fathers of children with chronic health issues (Wiener, Vasquez, & Battles, 2001). Men's stress related to their children's health was compounded by the adjustments families make to care for children's chronic illnesses. Fathers of children with chronic illness may experience more stressful life events than fathers of healthy children (Katz & Krulik, 1999). These stressful life events included perceived negative changes in family composition, family functioning, and financial status.

Prior studies suggest that concerns about family finances may contribute to fathers' elevated stress levels. In addition to higher medical costs, some parents, often mothers, may reduce their workforce participation to provide care for their children (Goble, 2004). Societal ideas about the fatherhood role that saddle men with the primary responsibility for financial provision may lead fathers to increase their work participation in order to ensure that their families are able to meet their needs while paying for additional medical expenses. This added work time does not come without cost, however—fathers report reducing the amount of time spent with friends, enjoying hobbies, and with their wives, in order to provide for their families.

There is evidence to suggest that having a child with chronic illness impacts fathers' perceptions of their families. Katz (2002) found that fathers of children with chronic illness reported less intimacy and lower relationship quality with their wives. The severity of children's illnesses has been found to impact the extent to which fathers perceive disruption in marital quality and family quality of life (Dodgson, Garwick, Blozis, Patterson, Bennett, et al., 2000). Katz and Krulik's (1999), however, research did not find significant differences of family functioning between fathers of healthy children and those with chronic illness.

The aforementioned studies have been drawn from samples of predominantly White, middle-class, college-educated, and married fathers. This sampling bias stands against evidence suggesting that minority children, those living below the poverty threshold, and children living in single-parent families face an increased likelihood of experiencing chronic illnesses (Newacheck & Halfon, 1998). Young, minority, and low-income fathers are largely missing across studies of caring for children's health needs;

further research is necessary to determine the extent to which the findings of prior studies resonate with those of these fathers.

Young Fathers

Whereas fatherhood research has increased substantially in scope and volume in recent decades, many of these studies have drawn samples of middle-income men in intact, nuclear families (Coley, 2001; Parikh, 2009). The body of literature around the experiences of adolescent fathers has also grown as policymakers and researchers became concerned with child and mother outcomes for teen parents. Children born to adolescent parents fare poorer in several domains across the life course. Infants of teen mothers have lower birth weight and higher mortality rates than those born to older parents (Alio, Salihu, Kornosky, Richman, & Marty, 2009; Alio, Kornosky, Mbah, Marty, & Salihu, 2010). During childhood, children of adolescent parents face an elevated risk of suffering unintentional and violent injuries in their homes and communities (Ekeus, Christensson, & Hjern, 2004). Studies have also found that children of adolescent parents are more likely to experience cognitive delays as well as emotional and behavioral problems than other children (Cabrera, Cook. McFadden, & Bradley, 2011; Dubowitz, Black, Cox, Kerr, Litrownik, et al., 2001; Howard, Burke Lefever, Borkowski, & Whitman, 2006). These deficits likely result from, and are exacerbated by, adverse socioeconomic contexts that confront many adolescent families and constrain their abilities to care for their children (Xie, Cairns, & Cairns, 2001).

Child wellbeing has been studied as it relates to maternal factors, including for children born to teen parents (Huang, Lewin, Mitchell, & Zhang, 2010). Little is understood about the fathers of these children but a growing body of literature is

exploring teen fathers' experiences (Lewin, Mitchell, Waters, Hodgkinson, Southammakosane, et al., 2014; Dudley, 2007). This nascent focus on teen fathers may, however, miss fathers who are slightly older. The partnering patterns of adolescent mothers indicate that they tend to select partners who are older than themselves. This suggests that examining fatherhood among young men in the years following adolescence may be an important part of understanding family process and child outcomes among this vulnerable population (Duberstein Lindberg, Sonenstein, Ku, & Martinez, 1997). Despite the growth of fatherhood research in general, and around distinct populations, young fathers remain an understudied population (Parikh, 2009). The recent focus on teen fathers stands in contrast to data suggesting that young adult men between the ages of 20-29 are between 3.5 and 4.9 times more likely to father children than men between the ages of 15-19 years old (Martin, Hamilton, Ventura, Osterman, Kimeyer, et al., 2011). A growing body of literature has recognized young fathers as a distinct group in need of scholarly attention (Johnson, 2001; Neilson, 2004; Parikh, 2009). Currently, there are few studies that have examined the experiences of young fathers in the years following adolescence.

Recent scholarship suggests that young men's psychosocial development as well as the contexts that surround them during this period contribute to parenting experiences that differ from fathers and mothers who have been examined in the extant body of research. This section discusses the prevalence of fatherhood among young men and reviews young adulthood as a psychosocial context that impacts how young parents approach caring for their children. Coparenting relationships, residential status, and financial and employment considerations are also discussed as they pertain to the

experiences of young men and how they address children's health as part of the fatherhood role.

Prevalence and Demographic Trends of Fatherhood among Young Men

Teen pregnancy began receiving attention as a public policy issue in the 1970's and coincided with growing concern about increasing numbers of single female parents, out-of-wedlock births, and rising welfare expenditures (Dudley, 2007; Elo, Berkowitz King, & Furstenberg, 1999). The prevalence of teen pregnancy and births has fluctuated over time. The period since the 1960's, however, has seen a general decline in the number and prevalence of teen pregnancies (Hynes, Joyner, Peters, & DeLeone, 2008). Teen birth rates declined during the 1960's, plateaued during the 1970's, but began increasing in 1986 (Hamilton & Ventura, 2012). By 1991, the teen birth rate reached 61.8 births per 1,000 women between the ages of 15 and 19 years old—a prevalence not seen since the early 1970's. Teen birth rates have fallen since that recent bolus and reached the historic low of 40.2 births per 1,000 in 2010 (Kost & Henshaw, 2012). A substantial proportion of teen pregnancies (18.3%), however, are second pregnancies (Gavin, Warner, O'Neil, Duong, Marshall, et al., 2013). Teen pregnancy and birth rates declined for all racial and ethnic groups during this time but substantial disparities persist among racial and ethnic groups. According to the Centers for Disease Control, teenage birth "rates in 2010 ranged from 10.9 per 1,000 [among Asian and Pacific Islanders], to 23.5 for non-Hispanic white teenagers, 38.7 for [American Indian and Alaska Natives], 51.5 for non-Hispanic black, and 55.7 for Hispanic teenagers" (Hamilton & Ventura, 2012, p. 2).

The fathers of children born to teenagers were also implicated in these concerns and a narrative emerged that described these fathers as financially and physically absent (Elo et al., 1999). Despite popular perceptions of these fathers, there have been few studies examining the demographic characteristics of the fathers of children born to adolescent mothers (Hynes, Joyner, Peters, & DeLeone, 2008). Martin et al. (2011) presented a rare summary of national birth rates by fathers' age. This analysis demonstrated that the births rate for fathers between 15 and 19 years olds rose from 18.8 births per 1,000 in 1980 to 24.7 births per 1,000 in 1990. The teen father birth rate has since declined and was 18.2 births per 1,000 in 2009.

Adolescents' age and gender have been associated with their likelihood of becoming teenage parents. Older adolescents give birth to the majority of children born to teenage mothers. Approximately 65.6% of teen parents are between the ages of 18 and 19, 32.5% of teen mothers are between 15 and 17, and 1.9% are less than 15 years old (Kost, Henshaw, & Carlin, 2010). Mothers have traditionally been indexed to determine the prevalence of teen parenthood, however, these figures may overestimate the prevalence of adolescent parenthood among young men. Males experience fewer teen births than young women (Hynes et al., 2008). This difference can be attributed to partnering patterns in which the fathers of children born to adolescent mothers are significantly older (Duberstein et al., 1997). In 1988, 21% of births to unmarried, minor mothers were fathered by men significantly older than their partner. Similarly, Elo, Berkowitz King, & Furstenberg (1999) found that fathers of children born to adolescent mothers were an average of 3.4 years older than their partners.

Data also suggest that minority men often become parents earlier than their White counterparts (Martin et al., 2011). African American men are substantially more likely to become fathers as teenagers than their White counterparts (Kost et al., 2010). Martin et al. (2011) found that American and Latino men experience earlier first births than White men. Whereas the fertility rate peaked for White men at 28 years old, fertility among African American and Latinos reached its highest levels at 20 years old. In 1980, the birth rates for young African American and White fathers were 40.1 and 15.4 births per 1,000, respectively. The rate for African Americans peaked at 57.8 births per 1,000 in 1991 and the teen pregnancy rate for White fathers reached in 1994 (19.4 births per 1,000). By 2009, the teen pregnancy rates for White and African American fathers had returned to levels comparable with those seen in 1980 (15.4 and 34.1 per 1,000, respectively). Despite the overall drop in teen pregnancy and birth rates, African American young men are still more than twice as likely than White men to become teen parents.

Transition to Adulthood as a Psychosocial Context

Whereas adolescents have received focused attention from researchers and policymakers, less is understood about parenting in the early years of adulthood. Erikson (1964) was among the first social scientists to acknowledge the unique developmental position of young adults. The developmental tasks associated with this period include identity formation, partnering, becoming financially independent, and developing a sense of personal responsibility. More recently, Arnett (2004) termed the period between 18 and 30 years of age as "emerging adulthood." As the most demographically dense time in the life course, this period has been characterized as a period of instability as young

persons navigate transitions in many domains, including movement through educational settings, engaging with the world of work, forming households, navigating partner relationships, and, for some, becoming parents.

Whereas Arnett's discussion of emerging adulthood has begun to elucidate the transition to adulthood among middle and upper class youth, his theory fails to address how low-income youth confront structural barriers as they become adults (Bynner, 2005). Fertility rates peak during the mid-to-late twenties and earlier for minority and low-income young persons (Martin et al., 2011; Sonnenstein, Pleck, & Ku, 1993). Little is known about how low-income parents understand their roles and negotiate challenging social and financial contexts as they form families. Fathers, particularly low-income, minority men are largely absent in the extant body of literature examining how young persons parent during young adulthood. The unstable relational and financial contexts commensurate with young adulthood disproportionately impact the lives of low-income, minority parents. The coparenting relationship, access to financial resources, and variations in residential status are discussed as contexts that impact fathers' involvement with their children, each with a discussion of how these contexts shape the parenting experiences of low-income, minority fathers.

Co-parent relationship. Men's relationships with the mothers of their children have implications for their involvement with their children and for how men care for their children's health needs. Several studies have found that fathers who have romantic or friendly relationships with the mothers of their children are more involved in raising them (Cabrera, Ryan, Mitchell, Shannon, & Tamis-Lamonda, 2008; Fagan & Palkovitz, 2011). A study of African American men found that married and unmarried cohabitating fathers

spent similar amounts of time with their children (Perry, Harman, & Leeper, 2011). This study also found that married fathers' perceptions of themselves, experiencing low levels of parenting stress, having children with a sole partner, and religiosity positively predicted their involvement with their children.

Romantic relationships, especially among unmarried parents, are dynamic and may dissolve. Father involvement may decline substantially when men's romantic relationships with the mothers of their children end (Tach, Mincy, & Edin, 2010). Among unmarried, nonresidential fathers, the quality of men's relationships with the mothers of their children has been found to predict father involvement (Coley & Chase-Lansdale, 1999; Gavin et al., 2002; Kamp Dush, Kotila, & Schoppe-Sullivan, 2011). Perry et al. (2011) found that the support that African American men received from the mothers of their children was significantly associated with men's involvement. Black men who fulfill a social fatherhood role for children as a result of their romantic relationships with mothers may be more likely to play the part of social father if biological fathers continue to contribute financial support to the household, possibly because it mitigates their expected contribution (Jayakody & Kalil, 2004). However, the study also found that if biological fathers remain involved in the lives of children, social fathers were significantly less involved with the children.

The dissolution of the romantic relationship also has implications for how parents manage caregiving responsibilities (Graham, 1997; Graham, 2003). Cooperative co-parenting in the period following the dissolution of the romantic relationship has also been associated with paternal involvement among non-residential fathers (Sobolewski & King, 2005). Literature examining child outcomes following divorce offer insights about

the impact of the co-parent relationship on children's health. These studies have consistently found that parental conflict predicts poorer mental and emotional health, self-esteem, school performance, as well as behavioral problems among children (Hanson, 1999; Sobolewski & Amato, 2007; Strohschein, 2012).

Whereas co-parent relationship dynamics have been associated with children's mental health, less is known about how the quality of parents' relationships affects children's physical health. Nielsen, Hansen, Simonsen, & Hviid (2012) found that children whose parents have been divorced, as well as children whose parents have never been married, are more likely to experience infectious diseases than children whose parents remained married. The authors posited that the cumulative stress that children experience due to relationship changes between their parents may explain these children's increased vulnerability to negative health outcomes. The quality of parents' communication as their relationships change may also be compromised, which may impact how parents make decisions about and care for their children's health (Garfield & Isaaco, 2006).

Our current knowledge about relationships among young, low-income parents is limited. Relationships among adolescents may offer a window into understanding some of the dynamics and experiences of young parents during the young adulthood. There is considerable diversity among these relationships and,

> The term "romantic experiences" refers to a larger category of activities and cognitions that includes relationships and also varied behavioral, cognitive, and emotional phenomena that do not involve direct experiences with a romantic partner. This category includes fantasies and one-sided attractions ("crushes"), as well as interactions with potential romantic partners and brief nonromantic sexual encounters (e.g., "hooking up," or casual involvement in activities usually thought to take place with romantic partners, from "making out" to intercourse) (Collins, Welsh, & Furman, 2009, p. 632).

This diversity may impact how young persons understand, develop, and enact their roles as parents and coparents during transition to parenthood. Romantic relationships among adolescents have been characterized as short-term in duration and romantic relationships among young adults may be similar in this regard (Brown, Feiring, & Furman, 1999; Collins, Welsh, & Furman, 2009). The birth of a child introduces a long-term connection that often outlasts romantic relationships, thus creating a condition that runs counter to assumptions of adolescent relationships as temporary. Whereas several studies have documented that father involvement drops off after the dissolution of the romantic relationship, there is evidence to suggest that these declines may be less pronounced for some fathers, particularly African American men (Edin, Tach, Mincy, 2009).

Young adulthood, particularly ages 18-24, has been discussed as a period of identity formation as well as self-focus that may detract from partnering, and this may contribute to the high turnover rate in romantic relationships among young adults (Arnett, 2004; Davies & Windle. 2000). Navigating partner and co-parent relationships may be challenging for young parents. Interpersonally, young persons may also face relationship dynamics that challenge their abilities to parent children together. Adolescent parents may have difficulty using effective communication, problem solving, as well as conflict-resolution skills and may engage in behaviors that escalate conflict during arguments (Toews & Yazedjian, 2010). These dyadic dynamics may contribute to the elevated levels of interpartner violence observed among young parents (Saewyc, Magee, & Pettingell, 2004). Estimates of the prevalence of interpartner violence among adolescent parents range between 6% and 55% (Harrykissoon, 2002; Newman & Campbell, 2011;

Silverman, Decker, Reed, & Raj, 2006; Silverman, Raj, & Clements, 2004). In addition to increasing the likelihood of relationship dissolution, having a history of relationship violence places young parents at risk for experiencing unique stressors and negative health experiences associated with post-separation conflict (Jaffe & Crooks, 2007; Logan & Walker, 2004; Milan, Lewis, Ethier, Kershaw, & Ickovics, 2005). It is important to note, however, that these studies of interpartner violence among young parents have targeted adolescent relationships and much less is known about interpartner violence among parents who are slightly older (Duberstein et al., 1997).

Repartnering presents another dynamic that may impact how young parents coordinate care for their children. The dynamic nature of romantic relationships, particularly among young persons, may result in repartnering or having children with additional partners (Guzzo & Furstenberg, 2007). Both repartnering and multipartner fertility have been associated with decreased father involvement (Fagan, Palkovitz, Roy, & Farrie, 2009; Gibson-Davis, 2008; Kotila & Kamp Dush, 2012; Manning & Smock, 1999; Tach, Mincy, & Edin, 2010). The reduced levels of father involvement after these relationships end is in part due to residential arrangements of men and children as well as the difficulties incumbent in renegotiating boundaries around being “exes,” parents, and coparents. In addition to requiring additional financial, in-kind, and social resources, the contact and coordination required for coparenting with a former partner may be a source of tension and jealousy in parents’ new romantic relationships (Classens, 2007; Hill, 2007). Balancing new roles, particularly when access to resources is constrained, may detract from coparenting efforts and contribute to declines in father involvement.

The quality and supportiveness of the co-parenting relationship may be especially important for adolescent and young fathers (Gavin, Black, Minor, Abel, Papas et al., 2002). Mothers' reports of relationship quality have been associated with father involvement and support immediately after birth and during the first few years of their children's lives (Gee, McNerney, Reiter, & Leaman, 2006). Interestingly, the Gee et al. study did not find a similar association at either time point for fathers' reports and their involvement. A study of 1,540 young and adult fathers in low-income families, however, found that fathers who reported receiving high levels of coparenting support from the mothers of their children saw their children more frequently and were more engaged with their children than fathers who reported receiving low levels of support (Fagan & Lee, 2013). This effect was even more pronounced for young fathers as coparenting support contributed to greater positive effects for young men than for adult fathers.

Socioeconomic disadvantage: Financial and employment considerations. Material support and financial provision have been a part of fatherhood throughout historical iterations of how men's roles in their families have been understood. Prior to industrialization, notions of fatherhood centered around men as moral teachers and guides for their families (Lamb, 2008). Around the turn of the twentieth century, financial provision began to emerge as the dominant expectation for being a father. Men's roles as modeling masculinity and sex-role expectations replaced breadwinning as the dominant fatherhood expectation after World War II and thereafter as nurturant caregivers. Financial provision, however, "remains a key component of the father's role in most segments of society today. Even in the vast majority of families in which there are two wage-earners, the father is still seen as the primary breadwinner" (Lamb, 2008, p. 39).

Fathers' employment stability and income have been associated with the relationships that they have with the mothers of their children and, in turn, their involvement with their children (Coley & Hernandez, 2006; Levine, 2006). Fathers with the ability to provide for their children may be more likely to be involved with their children than men who are unable to fulfill the breadwinning role (McAdoo, 1997). In a study examining fathers' daily interactions with their children, McDonald & Almeida (2004) found that fathers who worked more hours spent less time with their children. The level of emotional support fathers provided for their children did not differ by the number of hours they worked. Fathers, however, did report being involved in a higher number of stressful events regarding their children (e.g. interpersonal conflicts, financial concerns) on days when they worked fewer hours. This finding suggests that fathers may experience conflict between their roles as providers and nurturers for their families.

Because breadwinning continues to feature strongly in notions of the fatherhood role, men may continue to assess their success as fathers in relation to their ability to provide materially for their children (Lamb, 2008; Roy, 1999). This aspect of the fatherhood role may be challenging for low-income, minority men whose economic opportunities may be limited by low educational attainment, limited work experience, and institutionalized discrimination that exclude them from the world of work (Johnson & Doolittle, 1996). Additionally, fathers may live in communities where employment opportunities are rare (Simms, McDaniel, Monson, & Fourtny, 2013).

A study conducted in 1993 found that when fathers are to secure employment, their earnings may place them in a position where they earn too much to qualify for public health insurance but too little to pay for private insurance for their children (Karp,

1993). This may be particularly true for fathers who co-reside with the mothers of their children as their combined incomes place them at risk for exceeding the upper bound of eligibility for public health insurance. Whereas the landscape of health insurance has changed substantially since the Affordable Car Act was enacted in 2010, the structural barriers facing low-income men, and the economic plight they face, has remained largely unchanged. At the time of this writing, no studies have examined how fathers' earnings, particularly among low-income men, impact children's insurance access in light of the changes afforded by the Affordable Care Act.

The growing disparity in earnings between young persons who come from high or middle-income families and those young men who come from poor families increasingly places young, low-income fathers at a disadvantage when trying to provide for their children (Bynner, 2005). Disproportionate disconnection from work and educational institutions among low-income, minority, young men also contribute to suppressed income levels among these fathers (Corcoran & Matsudaira, 2005; Jekielek & Brown, 2005). Disconnection at this early stage in their educational and employment careers places low-income, emergent adult males at higher risk for experiencing poverty, receiving cash assistance, and having children who are raised in single-parent households (Brown & Emig, 1999). Taken together, the limited economic opportunities available to young, minority men may place strain on their relationships with the mothers of their children and limit their options for being involved with their children (Roy, 1999; Roy, 2005).

"Hustling" represents a strategy that some young men employ to obtain financial resources in contexts where they face limited employment prospects and access to

financial resources (Whitehead, Peterson, & Kailee, 1994). The term has been used to refer to a wide range of activities—some legal, some not—aimed at securing financial resources. Hustling most often refers to selling drugs but may also include burglary, robbery, gambling, and other financially profitable activities that are not legally sanctioned. Contrary to popular notions of low-income men as participants in this underground economy that generally characterize their behaviors as deviant, hustling and the strategies necessary to accomplish it in dangerous contexts have been identified by some as expressions of resilience in the face of challenging socioeconomic and community contexts (Payne, 2008).

Hustling and engagement underground economies, however, placed young, urban, minority men at elevated risk for becoming involved with the criminal justice system (Alexander, 2011). Arrest and conviction records further disadvantage young men and fathers in already tight employment markets by subjecting these men employer biases and hiring policies—explicit and de facto—that largely exclude them from participating in legally-sanctioned employment markets, which constrains their abilities to navigate complex contexts to provide materially and instrumentally for their children (Simms, McDaniel, Monson, & Fortuny, 2013; Wilkinson, Magora, Garcia, & Khurana, 2009). Young men's limited access to financial resources as well as their prior experiences under the stigmatized and punitive nature of correctional supervision may disincline men from engaging with other social institutions, including healthcare (Parikh, 2009).

Residential status. The financial challenges facing young fathers and the dynamic nature of their relationships with the mothers of their children may contribute to variable housing stability among young fathers. Low-income families face a heightened

risk for experiencing unstable housing (Robbins & Barcus, 2004). Housing instability—as indicated by multiple moves within a short period of time, homelessness, not being able to pay rent, being evicted from one's home, and foreclosure—has been associated with increased risk for experiencing depression, anxiety, as well as harmful alcohol use among adults (Burgard, Seefeldt, & Zelner, 2012). Housing instability and poor quality housing also detract from children's wellbeing (Coley, Leventhal, Lynch, & Kull, 2013; Shinn, Schteingart, Williams, Carlin-Mathias, Bialo-Karagis, et al., 2008).

Fathers' residential status has been associated with their involvement with children and children's outcomes (Bronke-Tinkew et al., 2009; Dubowitz, Black, & Cox, 2001; Yogman, Kidlon, & Earls, 1995). General population trends suggest that African American children are about half as likely to live with their parents as White children and are more likely to live with their mother alone (Kreider & Ellis, 2011). Nonresidential fathers also earn significantly less than residential fathers and this effect is especially pronounced for minority fathers (Robertson, 1997).

Data from the Fragile Families and Child Wellbeing Study indicate that non-resident fathers increase their level of employment during the first five years of their children's lives (Percheski & Wildeman, 2008). Whereas there is significant evidence suggesting that mothers desire, actively solicit, and facilitate non-residential fathers' contact and involvement, research has found that mothers may also discourage fathers from engaging their children (Garfinkel, McLanahan, & Hanson, 1998; McLanahan & Carlson, 2002; Roy, 2005). Non-residential fathers' separation from their children has been found to contribute to their spending less time together and may shape their ideas about and enactment of the fatherhood role (Roy, 2006). These differences in contact

with their children may influence men's experiences caring for their children's routine health needs. Young, nonresidential fathers, however, are largely absent from the body of research exploring children's health (Garfield, 2006).

Securing stable housing may be especially challenging for low-income young adults. Young, low-income fathers are less likely to co-reside with their children than are older, socioeconomically advantaged men (Guzzo, 2008). When fathers do not live with their children, they may seek alternate arrangements to spend time with them, including having their children stay with them on some days throughout the week and visiting their children at mothers' homes. Housing instability among young parents—both mothers and fathers—may present barriers to fathers' visitation with their children. With little access to financial resources, young, minority men—particularly those who have yet to complete high school or have been previously adjudicated—are vulnerable to experiencing housing instability and homelessness (Cooke, 2004; Marr, 2012). Young fathers may be at a particular disadvantage for securing stable housing through social programs as they may not have custody of their children, may have been adjudicated, or in some cases may earn incomes that render them ineligible for receiving housing assistance (Calsyn & Roades, 1994; Sosin, 2003). Faced with such housing insecurity, some low-income young men may not have places to host their children for visits and must then look for extramural opportunities to engage with their children.

Young mothers are also vulnerable to experiencing housing instability and the residential changes resulting thereof may create additional barriers for father involvement (Institute for Children, Poverty, and Homelessness, 2013). The stability of mothers housing arrangements may depend on their access to financial resources (including public

assistance), their abilities to navigate relationships with householders, and the ability of supportive householders—who may themselves be facing financial hardship—to maintain stable housing (Berger, Heintz, Naidich, & Meyers, 2008). As mothers move in search of housing for themselves and their children, fathers may encounter barriers to seeing their children, including limited transportation, increased distance, or concern about neighborhood dynamics that threaten their safety (Roy, 2004).

Kin-Work & Emotion-work. Although some research has been conducted identifying the contextual challenges facing young fathers, few studies have begun to explore *how* fathers confront these contexts in order to remain involved with children. The related concepts of kin-work and emotion-work offer promising lenses for examining how young men navigate dynamic relationships with mothers of their children, socioeconomic disadvantage, and dynamic residential situations.

Kin-work refers to the work that families do to continue to exist over time, including reproduction, maintaining continuity of relationship over time, upholding intergenerational responsibilities for children and dependents, sharing instrumental and tangible resources, and reinforcing shared values (Stack & Burton, 1993). Much of the work on kin and emotion-work has centered on female family members' and parents' involvement in maintaining relationships but a small body of research has examined men as sources of support and providers of support for other kin (McCann, 2012; Roy & Burton, 2007). Roy (2004), however, found that fathers used kin-work to navigate community contexts to facilitate their continued involvement with their children and enhance their abilities to form relationships with their children over time. Furthermore a study of fathers in South Africa and the United States found that fathers' use of kin-work

unfolded through negotiations between fathers and mothers to determine ways that fathers could be involved with their children, a focus on children's wellbeing, and flexible father role expectations in which fathers fulfill multiple roles for their children (Madhavan & Roy, 2012).

Whereas some research has begun to examine men's roles in kin-work and maintaining relationships with their children, very few studies have examined men's roles in emotion-work in families. Similar to kin-work, emotion-work is aimed at preserving relationships among members of social groups—often families— and meeting the needs of their respective members. Emotion-work refers to the provision of emotional support, caretaking to meet the emotional needs of family members and is accomplished to help others "feel better" (Stevens, Minnotte, Mannon, & Kiger, 2006). Emotion-work involves attending to the thoughts, emotions, and behaviors of affected persons, expression care, concern, empathic listening, expressing emotions, and moderating emotional expressions that exacerbate unpleasant emotions experienced by others. Hochschild (1983) argued that emotion-work is largely the province of women in social groups and the vast majority of research on emotion-work in families has examined this phenomenon assuming women as the sole actors. However, just as men have been found to be sources of support in kin networks and kin-workers themselves, men may also be "emotion-workers" who provide support and moderate their own emotional experiences in service of supporting the wellbeing of other members of their social groups (Pfeffer, 2010).

Theoretical Framework: Symbolic Interactionism in Context

Symbolic Interactionism

I employ symbolic interactionism to examine how young fathers approach caring for their children's health needs. This study examined how fathers' perceptions of their children's health, understandings of fatherhood, as well as their views of their relationships with the mothers of their children, and the contexts surrounding them shape how they care for their children's health. Symbolic interactionism provided a useful framework for exploring the intrapsychic, social, and contextual factors that shape how young fathers, as members of the family system, contribute to their children's health care. Symbolic interactionism holds that shared meanings people develop about their worlds shape their lived experiences (White & Klein, 2002). These meanings, developed in social contexts, provide motivation for human behavior (White & Klein, 2002). This examination drew from the concepts of role to guide the analysis, particularly how fathers' motivations to care for their children, as well as perceptions of their children's condition and contextual factors shape their engagement in caring for their children's health.

The concept of role occupies a central position in symbolic interactionism and in this analysis. Role refers to "the shared norms applied to occupants of social positions" (Heiss, 1981, p. 95). These norms are comprised of expectations for the behaviors, emotions, and attitudes that actors—as well as others—hold in relation to the role (LaRossa & Reitzes, 1993). While containing stable elements, men's understandings about role are dynamic and change over time as past experiences inform actors' and

social groups' expectations for enactment of given social positions (LaRossa & Reitzes, 1993).

The clarity of these role expectations shapes how well an actor is able to enact behavior consistent with social norms, with clearer role expectation facilitating enactment of that role (White & Klein, 2002). Role clarity has important implications for the present study. Although caregiving has widely been cited as a component of the fatherhood role, fathers sometimes experience ambiguity about the expectations for their participation in children's health care, especially when they have little contact with their children (Garfield, 2006; Lu, et al., 2010). Unclear expectations about fathers' participation in children's healthcare may shape the health behaviors they enact on their children's behalf.

Two corollary concepts provide additional tools for examining the complexities of enacting roles in contexts where fathers' resources are stretched thin. Whereas role clarity may promote the enactment of expected behaviors, role strain and role conflict necessarily inhibit actors' ability to fulfill role expectations. Role strain refers to a lack of resources necessary to enact role expectations (White & Klein, 2002). Requisite resources vary widely across roles but those needed by fathers to care for their children's health needs may include access to healthcare, financial resources, time, health knowledge, parenting skills, ability to modify the environments where their children spent time, and positive relationships with the mothers of their children (Clark, Mitchell, & Rand, 2007). Relatedly, role conflict is based on symbolic interactionism's proposition that actors may inhabit multiple roles simultaneously. These various expectations lead to multiple—sometimes conflicting—behavioral expectations for actors (White & Klein,

2002). These conflicts may occur within a single role as well as among different roles actors hold. This dissonance may compromise men's enactment of the fatherhood role and is especially salient for this study.

The concept of the "looking glass self" was also employed in the present analysis. Drawn from Cooley's (1902) seminal work, the looking glass self "refers to the part of self that is capable of self-reflection" (White & Klein, 2002, p. 60). The self-awareness implied by this concept involves the comparison of one's own thoughts, emotions, and behaviors in relation to how others might perceive the subject. The concept of the looking glass self is useful for examining how young men position themselves within their constructions of the fatherhood role as well as how others might perceive their enactment of the role. Young men's awareness of themselves as fathers and the ways that others perceive them is especially important given the current—-and some might argue changing—zeitgeist around fatherhood and masculinity that has placed men's roles, particularly for young men of color, on the outskirts of caregiving for children (Goldberg, 2014; Herzog, Umana-Taylor, Madden-Derdich, & Leonard, 2007; Marsiglio & Roy, 2012).

Related to role and the looking-glass self, the present study also used the concept of identity to examine how young fathers approach pediatric caregiving as part of their experiences as fathers. Whereas role refers to the socially-constructed expectations for social positions, identity involves men's location of themselves within a given role; it is "the self-categorization of self as an occupant of a role and the incorporation, into the self, the meanings and expectations associated with that role and its performance (Stets & Burke, 2000). The concept of identity is useful for examining fathers' experiences as

caregivers because self-identification as caregivers for children's health provides motivation for fathers to enact these behaviors (Paisley, Petren, & Fish, 2014). The motivation that comes from identifying oneself as a father may enable young, low-income men to navigate substantial barriers and contextual complexities in service of caring for their children's health.

Biopsychosocial Model

Analyses also draw from concepts from the biopsychosocial model. The biopsychosocial model was initially developed to explain the complex, multi-factorial etiologies of mental illnesses and was eventually applied to examine physical illnesses as well (Ghaemi, 2010). This model holds that biological illness must be understood by examining the social, psychological, and behavioral features of the illness (Engel, 1977). Moreover the biopsychosocial model also posits that a given health issue is likely caused by the interactions of social, psychological, and biological circumstances a person is facing. By taking a broad, contextual view of how health issues develop and are maintained, the biopsychosocial model allows for the development of holistic understandings of illness and treatments that correspond to this systemic lens. These concepts will be useful for the present study in examining fathers' perspectives of their children's health and illnesses as well as their approaches to providing pediatric care to support their children.

Purpose of the Study

Fathers' involvement in caring for their children's health remains an understudied aspect of family functioning and children's health outcomes. Young, low-income fathers

have received increased scholarly attention in recent years, but few studies have examined processes that facilitate and challenge their involvement with their children, including their engagement in caring for the health needs of their children.

This study examined how young men understand health caregiving as a component of the fatherhood role. Of particular interest were men's socially-constructed perspectives of the fatherhood role regarding pediatric caregiving and how they enacted that role while embedded in contexts that both facilitated and challenged caregiving behaviors. Prior studies have identified family level factors associated with children's health outcomes and some studies have examined health behaviors among minority families (Adams et al., 2007; Bruzzese & Stepney, 2012; Laster et al., 2009; Yinusa-Nyahkoon, 2010). Fathers, however, are largely absent from research exploring their involvement in the healthcare of their children (Garfield & Isaaco, 2006). This gap may be due to perceptions that mothers provide the bulk of health caregiving. Whereas non-residential fathers may have fewer daily opportunities to care for their children's health needs, their caregiving experiences from a distance and during visits warrant attention.

The prevalence of teen parenthood and multifactorial vulnerability of children born to adolescent parents highlight the need for research that goes beyond highlighting the health disparities facing these children and begins to explain how they are maintained (Kreider & Ellis, 2011). This study advances our current understandings of father involvement by examining how men fulfill their ideas of caring for children's health. Specifically, this study explores how young fathers approach promoting positive health behaviors, monitoring their children's health, and addressing children's acute health needs as a reflection of their ideas about fatherhood and the contextual factors that impact

how they meet those expectations. These contexts include men's relationships with the mothers of their children, residential status, personal health histories, access to financial and health resources, health literacy, as well as the environments in which they father.

To my knowledge, the present study is the first to identify the processes by which young, low-income fathers gather information, contribute to their children's healthcare decisions, and provide care. The findings from this study inform our understandings of health disparities for a vulnerable population and begin to fill a gap in the literature around father involvement in children's health. The insights gained from this study begin to elucidate family processes that promote positive health behaviors as well as challenges that may contribute to poorer health outcomes among children of young parents.

Drawing from symbolic interactionism, the following research questions guided the present study:

1. What facilitates and impedes low-income, young fathers to care for their children's health needs?
    a. How do fathers maintain children's health and prevent illnesses and injuries among children?
    b. How do young men understand caring for children's health to be a part of fatherhood?
    c. How do fathers navigate space—distance and proximity—in order to care for children's health needs?
    d. How do the quality and tenor of low-income, young fathers' relationships with the mothers of their children facilitate and impede caring for children's health?

2. What strategies do low-income, young fathers employ to care for their children's health?

    a. How do fathers maintain children's health and prevent illnesses and injuries?

    b. How do fathers respond to the acute health needs of their children?

    c. How do fathers manage children's chronic health conditions?

    d. How do these processes overlap and how are they distinct from each other?

CHAPTER 3: RESEARCH DESIGN & METHODOLOGY

Methodological Approach

Fatherhood is inherently a social process that involves the father himself, his children, his family members, partners, and other actors. There is not a singular definition of the fatherhood role and its implications for caring for children's health; rather, each person develops personal understandings of this role in light of perceived social expectations, his personal experiences, and the contexts in which he is situated. Thus, conceptualizations of fatherhood are intensely personal and unique while often sharing commonalities with those understood by others. The present study drew from symbolic interactionism to examine how young, low-income men's perceptions of the fatherhood role as well as the contexts in which they father shaped how they care for their children's health.

The present explored young men's perceptions of their roles as fathers, particularly around their children's health needs. This study also examined the processes of how fathers constructed and navigated complex contexts in order to care for children's health needs. Symbolic interactionism holds that the meanings ascribed to roles, contexts, and situations are important for understanding how behaviors are initiated and maintained by actors (White & Klein, 2002). Following social-constructivist perspective afforded by symbolic interactionism, I employed qualitative methods to examine young men's constructions of meanings around their role as fathers, their perceptions of their children's health, and the contexts in which they enacted the fatherhood role (Roy & Kwon, 2007). In addition to lending themselves to examining the meanings that

individuals ascribe to their experiences, roles, and contexts, qualitative methods are also useful for exploring the processes of *how* phenomena occur and are maintained (Daly, 2007). This facility with exploring meaning and process positioned qualitative methods as the most appropriate for the present study's examination of pediatric caregiving as a part of the fatherhood role and how fathers enacted it in the face of challenging contexts.

Qualitative methods offer a range of tools for data collection and analysis for exploring meaning, context, and process (Daly, 2007). The present study collected individual, semi-structured interviews as they allowed for in-depth, detailed investigation of how young men constructed their roles as fathers, their perceptions of their contexts, and how these meanings enabled and constrained *how* men cared for their children's health needs. The semi-structured nature of the interviews also allowed for investigating emergent, unanticipated meanings, contexts, and processes described during individual interviews.

Community Characteristics

The present study was conducted through a fatherhood program based in a pediatric hospital in Washington, DC. The hospital was chosen due to its established history working with young fathers who were engaged with the healthcare system on behalf of their children. The hospital drew its patients from the Washington, DC metropolitan area. The patients who utilize its primary care clinic where the program was located are largely drawn from the lower income areas in the city, including Ward 5, Ward 7, Ward 8, as well as the areas of Prince George's and Montgomery counties that border the District.

A cresting wave of gentrification, however, is rapidly changing the landscape of the City and its denizens. Whereas the White residents represented 27% of the DC population in 1999, 35% of residents were White in 2011; the African American population decreased from 65% to 35% of the city's population between 1999 and 2011 (NeighborhoodInfo DC, 2014b). Interestingly, the teen birth rate in the City also declined during that decade; in 1999, teen births represented 15% of all births in DC and this decreased to 9.8% of births by 2011. These declines were not seen, however, in the poorest areas—Ward 7, and Ward 8—where gentrification had yet to take hold. In 1999, teen residents of Ward 7 and Ward 8 represented 21% of births in each ward; in 2011, teens gave birth to 19% and 18% of births in these Wards, respectively (NeighborhoodInfo DC, 2014b; NeighborhoodInfo DC, 2014c). Ward 5 experienced a decrease in the teen birth rate from 19% to 12% in the same time (NeighborhoodInfo DC, 2014a). The residents of the communities in Ward 7 (eastern Washington, DC) and Ward 8 (southeast Washington, DC) are predominantly African American and are among the poorest in the metropolitan area with the wards having median income of $34,700 in 2008 (Kerstetter, Reed, & Lazere, 2009).

Field Sites

Participants for the study were recruited through two program sites in the Washington, DC metropolitan area: the Teen Parenting Program and the Parent Graduation Project.[1] I collected varied experiences over several years working with

[1] "Teen Parenting Program" and "Parent Graduation Project" are pseudonyms.
[2] The Center for Health Equity provided a generous grant to cover the costs of transcribing eight of the interviews.
[3] Delonte's interview represents a case where I recognized a participant's vulnerability

young adult fathers in their communities prior to beginning the study. I began working with TPP in 2008. As an unpaid intern, I initially provided support for the father services coordinator on staff with the program. I joined the staff as a father services coordinator in 2009.

At the time of data collection, I led the father services component of TPP. In my various roles with the program, I provided case management services, mental health screening and treatment, as well as general support to fathers and their families. I also facilitated fatherhood groups and coparenting groups with TPP participants. My involvement with TPP also included providing services to fathers enrolled in the Parent Graduation Project. These experiences helped me understand the cultures of the communities where fathers cared for their children, their social relationships, community contexts, and the organizational policies—explicit and de facto—of the settings where they received medical services for themselves and their children. These experiences helped me understand the contextually-situated perspectives of the participants and supported the credibility of the findings.

Teen Parenting Program

The Teen Parenting Program (TPP) was situated in an outpatient clinic in a regional hospital. The program was founded in 1995 in response to a teen pregnancy rate for the surrounding metropolitan area that was twice that of the national average (Kost, Henshaw, & Carlin, 2010). The Teen Parenting Program was established with the goals of promoting positive health and socio-emotional outcomes as well as preventing subsequent pregnancies. The Teen Parenting Program employed the "teen-tot model," which served adolescent parents in a clinic-based setting and provided "health care,

family planning, counseling, encouragement for teenage [parents] to continue their education, assistance with obtaining services, and social support" (Akinbami, Cheng, & Kornfield, 2001, p. 382). Post-partum adolescent parents younger than 18 years-old were eligible for enrollment in the program and were eligible to receive services through TPP until they turned 21; children of teen parents were able to continue to receive medical care through the outpatient clinic after their parents graduated from TPP. The Teen Parenting Program was located at the main hospital campus as well as at two satellite locations in areas of the city with the highest teen pregnancy rates.

The Teen Parenting Program initially provided support services to teen mothers but expanded in 2001 to provide services to fathers as well. The expansion included adapting its outreach as well engagement strategies to meet fathers' needs and preferred avenues for receiving services. Because few fathers presented at doctors' visits, program staff solicited fathers' contact information and obtained permission to contact them from mothers and through engagement in public schools. Beginning in 2001, TPP staffed a male fatherhood coordinator who provided case management services, coordinated medical care, facilitated fatherhood support groups, and was responsible for building relationships with the fathers who were affiliated with TPP. The fatherhood service coordinator also facilitated weekly fatherhood support groups in Washington, DC public schools with high rates of teen pregnancy. These outreach efforts allowed TPP access to young fathers who may be less likely to attend well-child and other clinic visits.

Parent Graduation Project

Participants were also recruited from the Parent Graduation Project (PGP). The Parent Graduation Project was a school-based program that provided support to teen parents

attending public schools in Washington, DC. Established in 2005, the program aimed to increase school completion rates among teen parents by providing case management and social support to student parents. The Parent Graduation Project currently operated in 14 public schools with the highest prevalence of teen pregnancy in Washington, DC. Each program office was typically staffed by two coordinators who provided case management and assistance obtaining resources that supported participants' dual roles as parents and students. These services included: child care vouchers, WIC, TANF, housing, employment, job training opportunities, as well as assistance with the college application process.

The Parent Graduation Project also collaborated with governmental agencies and local community-based organizations to provide psychoeducational workshops around effective parenting, decision-making, managing challenging relationships with peers, partners and family members. In supporting this program goal, staff from the Teen Parenting Program facilitated groups for fathers enrolled in PGP, beginning in 2007. These groups were conducted during lunch and reached more than 75 young fathers since TPP began facilitating the groups. Conducted by male fatherhood service coordinators from TPP, the fatherhood groups addressed various topics, including transition to fatherhood, goal setting, father identity construction, building communication skills, job readiness, goal setting, negotiating difficult community contexts, coping with community violence, education about child custody and support policies, as well as strategies for navigating relationships with the mothers of their children. I facilitated many of these groups in my capacity as a father services coordinator with TPP.

Sampling and Recruitment

Recruitment Strategy

Prior studies examining the relationship between children's health and family processes have drawn from samples that are overwhelmingly comprised of mothers (Garfield, 2006; Lu et al, 2010). This may be due, in part, to perceived difficulties of recruiting men and fathers to participate in research because their lower rates of attendance at their children's doctors' visit (Mitchell, See, Tarkow, Cabrera, McFadden, & Shannon, 2007; Garfield, 2006). This study addressed recruitment challenges through a multifaceted strategy that included recruiting from two sites and engaging staff at each site in order to solicit participation in this study.

Recognizing the difficulty of obtaining a sample of young men who were fathers, the present study secured two recruitment sites. As a staff member of TPP, I was already embedded and had formed relationships with the men involved in that program. My role there involved facilitating weekly fatherhood groups at PGP, which allowed me to form relationships with young men in a school context as well. Whereas the young men recruited across both sites were drawn from the same geographical communities, the young men involved in the school-based program were not directly involved with fatherhood program housed in a healthcare organization. Including perspectives of fathers who were not directly engaged in a health-related fatherhood program allowed for the inclusion of perspectives of men who may not have had as much exposure to health information or may not have been as engaged with the pediatric healthcare system.

The TPP and PGP case managers (hereafter referred to collectively as "case managers") provided assistance identifying eligible fathers. The case managers worked

closely with program participants to coordinate medical care for teen parents and their children, identify community resources (i.e., employment, education, housing, social services), provide parenting support, and provide mental health services when necessary. Prior to data collection, I met with the case managers and informed them about the aims of the study and the eligibility requirements, namely that participants 1) self-identify as fathers—biological or social fathers, 2) be between the ages of 18-25 years old, and 3) have a child who was at least six months old. Case managers were instructed to emphasize to parents that their participation is voluntary and that they would receive the same services through program participants regardless of their decisions to participate in the proposed study.

Together with the case managers, I recruited fathers who presented at clinic visits and received services through each program. Fathers were informed that participation in the proposed study was voluntary and would not impact the services they receive through TPP and PGP. The majority of the participants for this study were recruited through these direct appeals; I personally recruited 21 fathers (TPP yielded 16 and PGP yielded 5), all of whom I knew through my previous work with them. The case managers at TPP also directly recruited fathers (n = 4) who presented at the clinic.

Prior research suggested that fathers would be less likely than mothers to present at either of these recruitment site programs (Garfield, 2006). Therefore, this study also recruited fathers indirectly through mothers who were members of the programs. Recruiting fathers through mothers has been identified as an effective strategy for engaging fathers and is consistent with program practices (Bronke-Tinkew, Burkhauser, & Metz, 2008; Lesser, Koniak-Griffin, Tello, Kappos, et al., 2005). The case managers

obtained mothers' consent to contact fathers regarding the study and obtained contact information for the fathers. They relayed the information to me and contacted fathers to explain the services provided through the programs as well as invite them to participate in the study.

Similar to the parameters established for the caseworkers, I explained to the fathers that their participation in the study was voluntary and that their participation would have no bearing on the services they received through either program. If fathers expressed interest in participating in the study, I arranged a time to meet with them to conduct the interview. Despite explaining the study to young women participating in the school-based group, no fathers were recruited indirectly in that setting; a small number (n = 4) were recruited indirectly through TPP.

Demographic Characteristics of Sample

The present study drew a sample of low-income, young fathers (n = 29). Findings from prior studies indicate that fathers of children born to teenage parents are significantly older than mothers (Duberstein et al., 1997; Elo, Berkowitz King, & Furstenberg, 1999). Therefore, this study included men who were between the ages of 18 and 25 years old. Eligible participants had children who are at least six months of age at the time of the interview. This lower bound allowed for fathers to have gained some experience caring for the health needs of their children. In order to capture the experiences of low-income fathers, men were eligible for participation if their household incomes fell below 200% of the federal poverty line. A summary of the demographic characteristics of the sample is included in Table 1.

The sample included fathers whose experiences were diverse in terms of their relationship and residential status as well as co-parenting experiences. Fathers were between the ages of 18 to 25 (*M* = 21.4 years, *SD* = 1.9) generally identified as African American (96.6%) and Latino (10.3%). The majority (75.8%) of fathers indicated that they had completed high school and about a third (31.0%) were currently enrolled in high school, college, or trade school. Whereas almost all (96.6%) of the fathers had been employed at one point, less than half (48.8%) were currently employed and the majority (75.9%) reported being unemployed or underemployed. All fathers in the study lived in households that were classified as low-income (less than 200% of the federal poverty line). There were considerable variations in fathers' residential status in relation to their children. Slightly more than a third (37.9%) resided with their children. Of these men, all but three also resided with the mothers of their children. Fathers (44.8%) also reported occasionally "staying" with their children or having their children spend the night with them at least one night a week.

There were 48 children in the present study. The majority (*n* = 16) of fathers had one child (*M* = 1.65, *SD* = 0.93) and one father had five children—three biological and two stepchildren. Children ranged in ages from 6 months to 11.4 years (*M* = 2.5 years, *SD* = 2.1 years). Male children (*n* = 49) outnumbered female (*n* = 18) children. In addition to their biological children, participants also reported serving as "social fathers" for children (*n* = 12). Social fathers are defined as friends, family (i.e., uncles, brothers) or family associates (i.e., romantic partners) who fill the fatherhood role for children (Jayakody & Kalil, 2002; Tamis-Lamonda & Cabrera, 1999).

Data Collection

The Institutional Review Boards (IRB) of the University of Maryland and Children's National Medical Center independently approved this study; the approval letters are attached as Appendix A and Appendix B, respectively.

Data for the present study were collected through a brief questionnaire soliciting demographic information and semi-structured interviews targeted around men's

Table 1

Demographic Characteristics of Sample

	Participants			
	N	%	*M*	*SD*
Age (years)	29		21.4	1.9
Race & Ethnicity				
African American	22	75.9%		
Multi-racial	6	20.7%		
Latino	1	3.4%		
Educational Attainment				
Some High School	2	6.7%		
Completed High School/GED	11	37.9%		
Completed Trade School	3	10.3%		
Attended Some College	4	13.8%		
Currently Enrolled High School/GED	5	17.2%		
Currently Enrolled College/Trade School	4	13.8%		
Financial Stability				
Ever Worked	28	96.6%		
Currently Employed	14	48.3%		
Underemployment	11	37.9%		
Unemployed	15	51.7%		
Living in households with incomes less than 200% of Federal Poverty Line	29	100%		
Hours Worked per Week (most recent job)			29.1	9.8
Average Hourly Wage			$10.51	$4.28
Residential Status				
Co-resided with child	11	37.9%		
Occasionally spent nights with child	13	44.8%		
Living separately from child	5	17.2%		
Relationship Status*				
Romantically Involved with Mother of Child	20	69.0%		
Not Romantically Involved with Mother of Child	14	48.3%		
Romantic Partner other than Mother of Child	8	27.6%		
Children				
Number of Children per Father	48		1.65	0.93
Age of Children (years)	48		2.5	2.1
Gender				
Male	29	61.7%		
Female	18	38.3%		
Unknown	1	2.1%		
Pregnancy & Mortality				
In utero	2	4.2%		
Deceased	2	4.2%		
Biological Relationship to Father				
Biological	35	74.4%		
Non-biological	12	25.5%		
Uncertain	1	2.1%		

* These numbers sum to more than 100% due to repartnering, multi-partner fertility. This reflects the dynamic nature of relationships among fathers and the mothers of their children.

experiences managing their children's health needs. Combined, the demographic questionnaire and interviews required approximately two hours to complete and fathers received $30 as compensation for their participation.

As the primary mode of data collection for the present study, interviews allowed for deep, within case investigation of the contexts in which fathers cared for their children's health needs as well as the processes by which they navigated those contexts to enact caregiving for their children (Daly, 2007). The semi-structured format allowed for focus on the fathers' interactions with their children's health while permitting the exploration of emergent themes and gathering of rich data about the understandings that men hold about their roles as fathers. The interviews were comprised of questions asking men about their ideas about children's health and the fatherhood role, perceptions of their relationships with the mothers of their children, as well as the factors that shaped how they were involved with caring for their children's health. These one-time interviews asked men to reflect on their experiences of pediatric caregiving over the course of their children's lives. Whereas the aims of the present study were not to explore changes over time, retrospective questions about children's health and men's caregiving over time allowed the present study to begin identifying how fathers might adapt caregiving patterns over time. Further, longitudinal study will be necessary to thoroughly examine how fathers' caregiving changes over time.

Demographic Questionnaire

Prior to beginning the interview, participants were asked to complete a brief questionnaire that gathered basic demographic information about the young men's dates of birth, self-reported race and ethnicity, number and ages of their children, educational

attainment, as well as their current employment statuses. This demographic questionnaire allowed for the systematic, efficient collection of detailed demographic information. The questionnaire also included a brief screen for physical and psychoemotional health issues and concluded with questions asking young men to identify services and resources that might be helpful to them. These items were included at the request of the TPP and will inform future planning of the fatherhood component of the program. The demographic and health questionnaire is included as Appendix F.

Semi-Structured Interview

Semi-structured interviews explored how men's perceptions of fatherhood roles, relationships with their children's mothers, and how their residential status facilitated caring for children's health as well as barriers to their involvement in children's care. Fathers' relationships with their children's mothers, particularly the romantic status and history, quality of communication and problem-solving, as well as extent of shared decision making around children's health were explored in the interview (Garfield & Isaaco, 2006; Isaaco & Garfield, 2010; Sobolewski & Amato, 2007). The interview protocol also explored how fathers' residential status affected their engagement caring for their children's health. Garfield & Isaaco (2012) found that fathers believed that co-residing with their children allowed them to have access to their children and care for their children's health needs. The interview protocol examined how men navigated separation from their children in order to address children's caregiving needs (Stewart & Menning, 2009). Informed by prior studies that found that fathers' understandings of the fatherhood role motivated their involvement with their children, the interview protocol asked about how men perceived their actions as caregivers as a part of the fatherhood

role, their beliefs about children's health, and their perceptions of barriers to engaging their children's health (Roy, 2006; Fagan & Palkovitz, 2007).

The interview protocol covered a broad range of topics and had eight general sections. The interview began asking men about their current living situations and the resources available in their neighborhoods (e.g., "Tell me about the neighborhood where you live now. How would you describe it? What is it like?"). The interview then moved to discussions about young men's transitions to fatherhood and how fathers' relationships with the mothers of their children changed over time (e.g., "After you learned that you were going to be a father, how did you prepare yourself to become a father?").

The bulk of the interview protocol explored fathers' pediatric caregiving experiences. The third section of the interview asked men to discuss their children's health beginning in pregnancy and acute health incidents and chronic illnesses that their children might have (e.g., "What was it like learning that your child had [a health issue]?). Next, the interview inquired about how fathers cared for their children's health issues, with particular attention to the division of labor among fathers, mothers, and other caregivers, taking children to medical visits, fathers' daily routines of pediatric caregiving when children were well and when they experienced illness or injuries (e.g., "On the day to day, how do you care for your child's health needs? What things do you do?"). The interview then transitioned to examining participants' ideas of the fatherhood role and how health caregiving featured into their ideas of fatherhood (e.g., "When you think of what it means to be a father, does caring for children's health come to mind? How is caring for children's health part of being a father?"). The interview then explored how fathers promoted children's health through caregiving activities that shaped their

daily routines with children, including feeding, bathing, and physical activity ("Families sometimes have feeding rituals. How does feeding your child(ren) fit into your daily routine?").

Next, the protocol explored men's own health experiences over the course of their lives from early childhood through present day (e.g., "Thinking back to when you were really young—elementary school or earlier—how would you describe your health?). The interview concluded with questions aimed at identifying how fathers changed their own health behaviors in service of promoting health among their children (e.g., "Are there things that you do but wouldn't want your kids to do the same?"). A complete version of the protocol is included as Appendix G.

Confidentiality

Prior to conducting the interviews, the researcher obtained informed consent from participants. Because the current study was governed by Institutional Review Boards of both the University of Maryland and Children's National Medical Center, the researcher obtained informed consent using forms required by both institutions. Informed Consent forms for the University of Maryland and Children's National Medical Center are attached as Appendix C and Appendix D, respectively. I explained both of these consent forms and participants signed both forms prior to initiating data collection.

The interviews were conducted in private, quiet rooms within participants' homes, program sites, or at other mutually-agreed upon locations in the community (e.g., libraries). The private location was necessary for ensuring high-quality audio recordings that would allow for accurate transcription. This privacy also promoted data quality by creating a space where men were able to discuss their perspectives and experiences of

fatherhood without interference from others or concerns about others' reactions to their comments.

During the course of conducting the interviews, the researcher determined that it would be appropriate to obtain a Certificate of Confidentiality through the National Institute of Child Health and Development (NICHD) due to the sensitive information that some participants disclosed. Generally stated, participants recruited early in the study disclosed sensitive information about how they obtained financial resources and maintained their personal safety in dangerous neighborhoods, which alerted the researcher to the necessity of obtaining a Certificate of Confidentiality. The Certificate of Confidentiality protects participants from compulsory disclosure to law-enforcement or other entities of their personally-identified information. It did not, however, release the researcher and affiliated staff from their obligations as mandated reporters. A copy of the Certificate of Confidentiality issued by NICHD is attached as Appendix E.

Data Analysis

Interviews were digitally recorded and transcribed by the researcher, a team of three trained undergraduate research assistants, as well as a professional transcription company.[2] The research assistants received training about the interview protocol so as to help them anticipate and become familiar with the content of the interviews they transcribed. Together, the undergraduate research assistants transcribed 21 interviews and the professional transcription company completed 8 interviews. The transcriptions were imported into Atlas.ti7, a software program that stores data and provides tools for

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[2] The Center for Health Equity provided a generous grant to cover the costs of transcribing eight of the interviews.

managing coding tasks. In order to ensure the confidentiality, participant names, as well as those of their children, partners, and locations were replaced with pseudonyms (Friese, 2014). All electronic records were stored in an encrypted drive on a password-protected computer. Similarly, all physical records, including endorsed informed consent forms were stored in a locked file cabinet within a locked office in the Children's Research Institute.

Grounded theory provided the overarching approach for analysis. Grounded theory analysis was accomplished through three waves of coding: open, axial, and selective (LaRossa, 2005). Open coding refers to line-by-line analysis of the interviews to identify men's perspectives, contexts surrounding those perspectives, behaviors, actors, and processes involved in caring for children's health needs (Daly, 2007). This stage of coding involved deep, within-case coding that both drew from my prior knowledge (from literature, my professional experiences working with fathers and gained during interviews and contained memos) as well as aimed to identify unanticipated themes present in the data. These open codes identified both a priori themes informed by previous research as well as emergent themes. In the present study, an example of an a priori code was "fatherhood role constructions—generativity" which referred to fathers' ideas about the fatherhood role based on their own experiences of fatherhood and desiring better for their children (Roy & Lucas, 2006). Open coding also involved identifying unanticipated themes that emerged from the information men provide in the interviews. "Daddy mode," was a term that a father used to describe how he purposefully adjusted his behaviors when he was around his children to promote their health.

Once themes were identified through open coding, the next phase, axial coding, involved the broad coding that examined codes across cases. This phase of coding identified relationships, similarities, and differences among the codes with the aim of distinguishing categories among the data (Daly, 2007). Through constant comparison—comparing an axial code to its counterparts and dimensions within it—this stage identified the dimensions of the axial codes by understanding the characteristics that distinguish categories from each other as well as identifying variation within each code (LaRossa, 2005). Furthermore, this wave of coding began to identify the conditions in axial codes happened and were maintained (Charmaz, 2006). Continuing with the example used to illustrate open coding where fathers' generative constructions of the fatherhood role and daddy mode were identified, these codes along with others describing young men's general notions of the fatherhood role, and their identities as fathers were combined during axial coding to form the axial code "positioning self as father" to highlight how situated themselves with respect to and within the role of fatherhood with the commensurate rights and responsibilities contained therein.

The final phase of analysis, selective coding, produced further abstraction of the concepts identified in axial coding (LaRossa, 2005; Daly, 2007). Selective coding yielded the four categories—the preventative, acute, and chronic domains of caregiving, as well as the common processes that occurred across domains—that explained the variation between and among the axial codes (Corbin & Strauss, 1990). This phase of coding produced a framework—the tripartite framework of pediatric caregiving— that explained the processes by which fathers are involved in caring for their children's health. Continuing the example from above, this study found that young men positioned

themselves as fathers across the acute, preventative, and chronic domains of care and this positioning helped fathers care for their children's health. Other processes—coordinating care with mothers and engaging the medical system—were similarly represented in each domain of the tripartite model. Together, positioning self as father, coordinating care with mothers, and engaging the medical system formed the selective code of "Common Processes" to describe processes that fathers used to navigate complex contexts to accomplish each domain of caregiving represented in the tripartite framework of pediatric caregiving.

Data Quality

Krefting (1999) identified credibility, dependability, and transferability as markers of the trustworthiness of qualitative data (Krefting, 1999). Credibility refers to developing accurate descriptions of phenomenon such that they resonate with those who share those experiences (Lincoln & Guba, 1985). As noted earlier, I spent several years working with the young men involved with the TPP program prior to beginning this study. The experiences and knowledge I gained through this work led me to collect deep, specific information about men's contexts—relationships with the mothers of their children, neighborhood dynamics, membership in crews, hustling, transportation, and poverty—that young fathers living in the Washington, DC metropolitan area often face. My extensive work with young men discussing coparenting relationships, school completion, securing employment, mental health issues, housing issues gave me insight into their lived experiences of navigating their contexts so that they were able to care for their children, including for their health needs. In addition to allowing for the collection of rich data about their experiences, my experience working with young fathers in the

City also allowed me to interpret the data in ways that resonate with their lived experiences.

I employed the strategy of providing "thick descriptions" throughout the analytic process to support the dependability of the study's findings (Krefting, 1999). First, throughout the course of the study, I maintained an audit trail that chronicled the recruitment and analytic decisions that I made throughout sampling, data collection, and coding. Outlining the decisions made throughout the recruitment and analytic processes support the dependability of the data collected in this study. This audit trail included maintaining a log of detailing how participants were recruited (i.e., site, how they were referred), efforts to contact participants, as well as the settings in which the interviews were conducted.

Second, I also recorded memos following the interviews that discussed information that may not have been captured in the audio file (e.g., neighborhood context, descriptions of the settings where the interviews were conducted, other persons present, my previous experiences and knowledge about the participants and their family contexts). I often recorded the post-interview memos on the same digital recorders I used for the interviews as I sat in my car in the neighborhood, while I drove home, (if I conducted the interview at a location in the community) or in an office at the hospital. These memos were generally short—usually lasting less than 10 minutes—and allowed me to capture in-the-moment insights, emotions, and reactions to the interviews.

I also wrote memos about emergent themes and ideas, and possible connections among the data throughout open, axial coding, and selective coding throughout the analytic process; I recorded these memos using the "memo" feature of Atlas.ti7. These

memos allowed me to document ideas about data as they arose, record my rationale for analytic decisions, and begin to see connections across the data. I archived the various iterations of the Atlas.ti7 file weekly so as to allow the tracking of ideas across the development of this study. This audit trail helped to create transparency about how the data were conceptualized and findings identified throughout the study.

The thick descriptions of fathers and their experiences in this study also support the transferability of the study's findings. Transferability refers to applicability of the findings to other persons embedded in contexts similar to participants in the original study (Lincoln & Guba, 1985). The "thick descriptions" of fathers' experiences and contexts supports the transferability of the findings by identifying the conditions in which father's behaviors are enacted and maintained, thus indicating others embedded in similar contexts might also share similar experiences as those outlined by this study. To the extent possible, participants were purposefully selected to obtain a demographically diverse sample in order to further support the transferability of this study's findings (Krefting, 1999). Noting that most of the participants were recruited from a fatherhood program (TPP) situated in a healthcare organization, I selected the second site (PGP) to gather perspectives of pediatric caregiving from fathers who were not directly connected to health caregiving. Given the literature suggesting that children are generally healthy, I purposefully sampled and explored fathers' experiences of having children with chronic health needs because I expected children in the present study to have few health issues (Schuster, Chung, & Vestal, 2011). The inclusion of Smith—a father whose child had pervasive physical and cognitive problems—represents efforts to purposefully sample

fathers to gather a wide range of experiences in support of the transferability of this study's findings.

Credibility and dependability of the study's data were supported by the triangulation of the data. Triangulation is grounded in the idea that data collected from multiple sources and through multiple methods will allow data cross-checked and confirmed as accurately representing the range of experiences (Knafl & Breitmayer, 1989). Redundancy and overlap in the interview protocol contributed to the quality of the data by offering opportunities to confirm the consistency of the information presented during the interviews. As a staff member of TPP, I also gathered anecdotal data about participants' fathering experiences and contexts through my previous interactions with fathers, other staff members who worked with the men and the mothers of their children. Whereas I sometimes recorded these data in a memo as if I were using it exclusively for the study, this information usually conveyed in the context of providing assistance to fathers through the program. Thus this information, while recorded for the purposes of the program, is not included among the data for this study.

I also employed peer reviewing to support the credibility and dependability of the study's data (Krefting, 1999). I developed relationships with fathers involved in the study over the course of several years and had a sense of who the fathers were outside of the data that they shared during the interviews. Furthermore, being embedded in the TPP program since 2008 allowed me opportunities to form understandings of men through conversations with colleagues and supervisors who also worked with their families and had extensive experience working with adolescent families. I had countless conversations with these colleagues as I questioned and interpreted the data. I also discussed the data

and analysis with peer doctoral students as well as a senior researcher with expertise about fatherhood and the transition to adulthood among disadvantaged young men. Peer reviewing helped to identify the dimensions of the themes that were uncovered throughout data collection and analysis. For example, debriefing emergent findings with a senior fatherhood researcher helped me identify emotion-work as a theme that cut across caregiving domains and processes. Furthermore, peer reviewing helped to identify negative cases that did not align directly with the model and consider how to conceptualize them. Peer debriefing with a group of doctoral students, for example, helped me conceptualize the co-parenting relationship in a manner that better reflected the reciprocal nature of these relationships than the largely unidirectional interpretation I initially advanced. I recorded the insights gained from peer reviewing through notes written during the meetings and memos I wrote following these conversations.

Reflexivity

In taking a social constructionist perspective, the present study assumed that meaning is developed through a social process. Just as fathers developed their ideas of the fatherhood role through their interactions with others, I conducted this study with a personal history and experiences in social contexts that shaped how I approached the data and extracted the findings. These prior experiences include my role as a staff member at the Teen Parenting Project, my role and position as a healthcare professional working at the hospital where many participants and their children received care, clinical perspectives as a therapist, as well as my personal histories with fatherhood and as a recipient of healthcare throughout my life. Throughout the interview and analysis stages, I wrote memos to document my thoughts and reactions to what participants shared, my

emotional experiences, perceptions and personal history of fatherhood, and intrapersonal interactions with the young men throughout the data collection and analysis phases of the project. These memos allowed me to document the intersections of my personal history, professional perspectives, and emergent experiences with the data as I encountered throughout the course of this project.

Prior to this study, I gained experience conducting research focused on the transition to adulthood among young men of color who were embedded in urban contexts. Through these experiences, I learned about how the complexity of the socioeconomic, relational, community, and structural contexts in which men living in urban environments in the mid-Atlantic region formed and maintained relationships, exchanged social support, as well as negotiated connection and disconnection from work and school (Roy, Messina, Smith, & Waters, 2014). These experiences helped to sensitize me to how young men navigated complex contexts to care for themselves and others as they transitioned to adulthood.

My experience working at the data collection site provided me insights about the patient populations the hospital serves as well as patients' experiences interacting with the health care system. For the past six years, I have been involved in the TPP program in various capacities. I facilitated support groups for teen parents, adolescent fathers, as well as assisted in the development and implementation of a psychoeducational co-parenting intervention. As a family service coordinator, I provided case management as well as mental health services to adolescent parents, particularly fathers. I currently serve as a father service coordinator and am responsible for developing connections with community organizations as well as providing direct services for fathers.

I am also a licensed marriage and family therapist. My clinical experience and insights sensitized me to men's emotional and relationship experiences as an important aspect of their personhood and fatherhood identities. The clinical skills I have acquired as a therapist helped me to create emotionally-safe environments for fathers to share their experiences and provided tools for maintaining this safety when discussing sensitive information. These skills helped me to know when it was safe to probe deeper about sensitive topics but also when to direct conversations away from areas where the context of our time together (i.e., a research interview, non-therapeutic relationship) would not afford adequate space for fathers to process intense thoughts and feelings.[3] Maintaining the balance of using clinical skills to elicit rich information while avoiding drifting into a clinical interview was challenging in some interviews. I found that having a detailed interview protocol and checking to make sure that I had answered each of the questions helped me avoid delving too deep into issues that we did not have adequate space to address. Additionally, knowing that my position as the fatherhood services coordinator for TPP allowed for me to return to fathers to initiate clinical relationships and helped me feel more assured of my decisions to address some issues lightly in the clinical interviews.

Regarding my personal history with fatherhood, my parents divorced when I was six years old. The dissolution of my parents' relationship and the resulting geographical separation required my mother to assume sole responsibility for caring for her children's health needs. This contributed to my limited personal experience with a father caring for

[3] Delonte's interview represents a case where I recognized a participant's vulnerability and unpreparedness to cope with intense emotions and therefore redirected the interview towards areas that I believed would be less triggering. His story and my response are discussed in depth in Chapter 7: Chronic Care.

his children's health. This lack of experience allowed me to investigate how fathers care for their children's health with limited preconceived assumptions based on my personal experience. However, my limited personal experience may have limited my ability to recognize or understand aspects of men's reports of caring for their children's health.

In understanding fathers' experiences with the healthcare system, it was important that I consider my own experiences negotiating access to healthcare. Upon my parents' divorce, my parents established a child support agreement that required my father to provide health insurance for my sister and me. My father's military insurance, however, was not accepted by doctors outside of a military base and we lived hours away from the nearest installation. I recall my mother expressing frustration that he would not provide viable health insurance and being concerned about the financial strain that carrying us on her insurance plan imposed. This experience has sensitized me to exploring how parents negotiate coparenting dynamics of caring for children's health, particularly when they are not romantically involved.

CHAPTER 4: THE TRIPARTITE FRAMEWORK OF PEDIATRIC CAREGIVING: SPECIFIC DOMAINS AND COMMON PROCESSES

Caring for children's health represents a central function of the parenting role. However, the caregiving experiences of men, particularly young fathers, are largely missing from our understandings of how parents maintain children's health (Garfield, 2001). The young fathers in this study were embedded in social, economic, and community contexts that constrained their abilities to care for their children's health. Romantic relationships among young adults are characterized by instability as they negotiate the vicissitudes of partnering, singleness, and repartnering (Arnett, 2004). The relationships among fathers in the present study and the mothers of their children were similarly unstable over time as they navigated periods of togetherness and romantic separation, friendship and hostility, as well as connection and disconnection with the mothers of their children. The dynamics of their romantic relationships and histories with each other also shaped their coparenting relationships, including how they communicated regarding children and divided caregiving responsibilities. When these relationships soured, some fathers encountered maternal gatekeeping that separated them from their children.

Young men's limited access to financial resources also inhibited their abilities to provide food, clothing, medications, and hygiene products to address their children's health at its most basic levels. Limited job opportunities, inconsistent earnings, and underemployment also compromised fathers' abilities to secure stable housing for themselves and their children. A great deal of pediatric caregiving occurs between

parents and children in the context of their homes. Spending extended time with their children and participating in their daily routines also allowed fathers to gather valuable information about their children—their habits, moods, dispositions—from which they were able to ascertain if their children's health might be compromised. However, 55.2% (n = 16) of fathers in the sample lived separately from their children and this separation limited their opportunities to participate in children's daily routines (e.g., feeding, bathing, playing) and respond to unexpected health needs.

Young men's constructions of fatherhood, prior caregiving experiences, and personal health histories provided an initial scaffold upon which fathers are able to build their individual approaches to pediatric caregiving. Men's own experiences with parents and fathers informed their ideas of fatherhood—both what they desired to emulate and sought to improve for their children (Hawkins & Dolahite, 1997; Roy, 2014). Young men also carried personal histories that shaped their perceptions of health, how to respond to illnesses, how and when to access medical care, as well as how to promote health among their children. Their prior experiences caring for children (e.g., as uncles, older siblings) may also gave men a sense of how to accomplish routine caregiving tasks, recognize children's cues, keep children safe, as well as respond when children's health might be compromised.

Taken together, the instability of their contexts required fathers to negotiate dynamic social, economic, and community factors in order to participate as caregivers for their children's health. Whereas fathers' contexts shifted, they remained keenly aware of the importance of their involvement in promoting healthy outcomes for their children. Several young men used the "being" or "staying" "on top of it" as a description of their

roles as fathers. Fathers used the term to describe their overarching sense of responsibility for remaining actively involved with children, observant of them, and responsive to their needs—of which health was one. Frank (22 years old), the father of a four year-old girl and one year-old boy, summarized his ideas about fathers' responsibility for pediatric caregiving

> You just have to be on top of it. Mom and dad when it come down to the child you just, basically, it's the same for real… Just make sure that he do his check ups, make sure that everything stay in order. Him not being overweight, not being underweight. Make sure he eating the right things, not always fast foods. You can get your fast foods but you not gonna just eat it everyday and junk food and stuff like this. Being on top of everything, making sure he good.

The simplicity of "being on top of it" as a statement belied the complexity of fathers' thoughts and experiences addressing their children's health needs. Caring for children's health needs required fathers to acquire knowledge about health and children, balance competing demands as fathers, partners, and young adults, maneuver around dynamic relationships with the mothers of their children as well as members of their social networks, as well as navigate financial, residential, and community contexts that complicated their abilities to take care of their children. The language included in this personal term suggests that fathers viewed their positions as fathers from both temporal and projective perspectives: "being on top" represented fathers' commitment to meeting their children's current and emergent needs; "staying on top" acknowledged their current involvement with children as well as recognized their commitment to maintaining involvement in promoting their children's wellbeing over time.

Pediatric health—and the caregiving required to maintain it—spanned broad ranges of knowledge and behaviors that parents enacted on behalf of their children. Similar to the expansive definition implied by "being on top of it," fathers' ideas about

caring for their children's health spanned wide-ranging conceptualizations of health and caregiving. Trey (23 years old) was a survivor of a chronic heart condition that required him to have a pacemaker. Having coped with health issues for the better part of his life, he understood that while all children encounter health issues—usually minor—some also faced conditions that persisted. His prior experiences contributed to an inclusive definition of how fathers were involved in children's health. He noted,

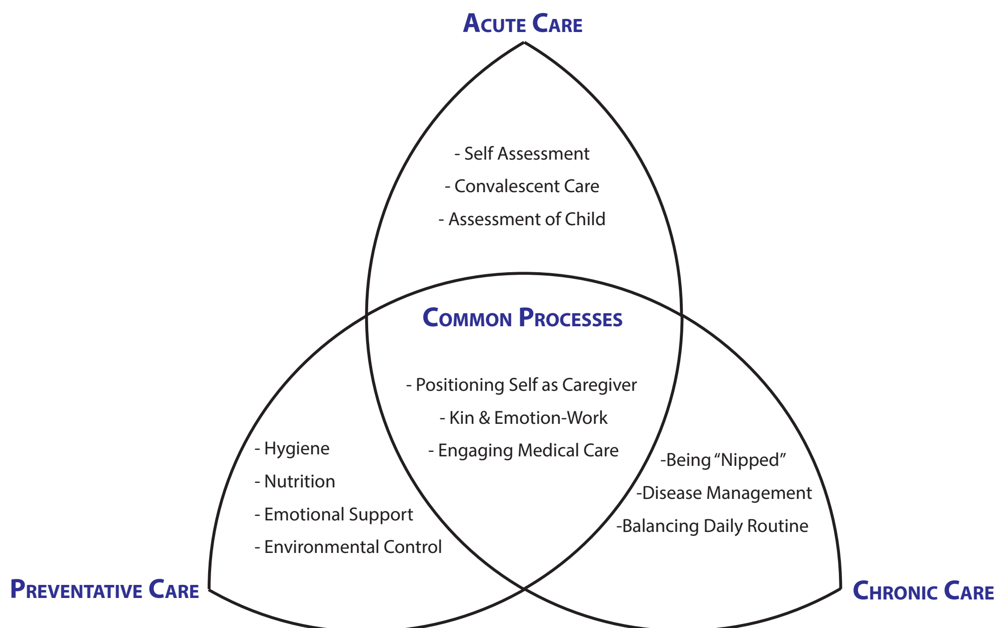
> There's a lot of different things [involved in caring for children's health]. It's mental. It's physical, and there's emotional….When people hear children's health, they might think you make sure that they have no sicknesses and all that, but there's a lot of different... Kids have health problems in different ways. Some have mental. Some have physical. Some have emotional...You just gotta be able, in order to care for it, you gotta keep a close eye on it and do the best you can to teach your kids the importance of what's going on around them, and what they need to know at their age so that as they get older they're well aware of these issues. You gotta let them know that you love them. You gotta do everything you can to keep them up to date on all those things. Physical: that's why you go to the doctor. Emotional: that's why you always around him. You try to show as much love as you can. Mentally: that's why you try to teach them school-wise and alphabets and all that because you want to always keep every part of their health up to date in every way that you can so that they can grow up to be as healthy as possible.

Trey's definition of pediatric health and caregiving resembles the broad-reaching, interdependent explanation of mental health provided by the biopsychosocial model (Engel, 1977). A key difference is however, is that instead of mental health sitting at the intersection of social, emotional, and psychological domains, fathers placed children's health at the intersection of a complex network of physical, emotional, psychological, and developmental indicators of health. Furthermore, Trey's remarks extend beyond a static description of the interrelationships between health domains and begin to identify the processes by which fathers address these needs.

Young men's expansive ideas of health contributed to fatherhood role

constructions that included a variety of caregiving behaviors that required awareness, attention, and being responsive to children's health needs. Similar to the model advanced by Schuster, Chung, and Vestal (2011), the present study found that fathers' involvement in pediatric caregiving fell across three domains of caregiving: preventative, chronic, and acute. This study also found that these unique domains converge around common caregiving processes that included being aware of self as a caregiver, coordinating children's health care with mother, and engaging medical care on behalf of their children. Figure 1 illustrates the tripartite model with preventative, acute, and chronic care converging around common processes. The remainder of this chapter will examine the common processes of pediatric caregiving with attention to how young men enact these processes while embedded in their contexts. This chapter will conclude with summaries of the subsequent findings chapters exploring preventative, acute, and chronic caregiving among fathers.

Figure 1: Tripartite model of father involvement in pediatric caregiving



Common Processes of Pediatric Caregiving

Awareness of Self as Caregiver in Daddy Mode

"Daddy mode" was a term that fathers used to describe their awareness of themselves as individuals whose behaviors—both personal and those oriented at caregiving—contributed to or detracted from their children's wellbeing. This self-awareness sat at the intersection of young men's understandings of their roles and perceptions of themselves as occupants of their roles as fathers. Although young men were constantly aware of their roles as fathers, their physical proximity and psychoemotional connections with their children—being in the presence of their children, enacting certain behaviors on behalf of their children, and otherwise being reminded of their connections to their children—made young men's identities as fathers more immediately salient and activated daddy mode.

Switching into daddy mode represented the behavioral transition from role-based expectations to contextually-salient, identity-driven caregiving. Daddy mode illustrates how fathering is situated in men's physical, psychological, social and emotional contexts (Marsiglio, Roy, & Fox, 2005). These contexts elicited different responses from fathers, including reflexive caregiving performed while in daddy mode. Daddy mode led men to purposefully observe children—their bodies, tuning into their emotions, and monitoring their environments while being aware of how their own behaviors could affect their children. Daddy mode made young fathers at once aware of their children, of themselves, the interactions thereof, as well as the implications of each for children's health.

Fathers drew a distinction between how they acted when their children were present versus when they were absent. Young men described being more mindful about their own behaviors while in the presence of their children. Fathers' descriptions of how they handled meals when their children were present offers a window in to how being around children led men to adopt behaviors that they might not otherwise.

Times when children were away afforded opportunities to relax the strictures imposed by daddy mode. The term, daddy mode was drawn from Twigs' (25 years old) interview. Twigs had long been romantically interested in Rita but she had not been similarly inclined until recently, after she ended a relationship with the father of her two children. As a function of his affinity for Rita and noting that the children's biological father did not support her or the children sufficiently, Twigs would occasionally provide financial as well as instrumental parenting support for Rita when the biological father of her children (two boys—an infant and a toddler) withdrew. With the advent of their relationship, Twigs assumed the role as social father for the children and spent more time caring for the children's daily needs. Referencing a comedy sketch by Kevin Hart, he described these adjustments as being in daddy mode. Twigs described daddy mode as,

> So it's just keeping in mind that some things you have to do, and even though most things that you might not feel like you should do, or you don't wanna do it, you gotta understand that's a kid. That daddy mode is serious… it's always on around the kids, and it's always in my mind. But whenever they're in daycare or something, you got time to unwind, relax, be fully you, don't always have to be alert, looking around…In your mind you always wanna keep things put up and stuff because the kids gonna come back eventually. But you also did just kinda like take a load off or whatever, just chill. And as soon as the babies come back, that's when you gotta be back in daddy mode full time, 100%. 'Cause you don't wanna be all staying in chilling mode or whatever.

The novelty of his fatherhood role made him aware of how he changed his behaviors when he was around Rita's children versus when he was a single, unattached

man. His narrative suggests that fathers drew a distinction between how they acted when their children were present versus when they were absent. In noting that he was mindful to "keep things put up" even when children are away, Twigs' narrative suggests that fathers maintained an awareness that their own behavior, even conducted independently of their children, could impact their children's health. Thus, fathers may continually experience "daddy mode," if to a lesser extent when children were not present.

Daddy mode highlights the reflexive nature of paternal caregiving. This feature of caregiving highlights the complex relationships between caregiving and health for fathers and children alike. In addition to affecting children's wellbeing, caring for children's health led men to consider their own experiences, health histories, and current health behaviors as they determined how to meet their children's health needs. Young men described being more mindful about their own behaviors while in the presence of their children. Whereas fatherhood was an overarching identity and fathers maintain a constant awareness of their children regardless of whether they were in their presence, Twigs' narrative suggests that fathers shifted into daddy mode, particularly when their children were present. This shift led men to become more conscious of their own health behaviors while in their children's presence and how these behaviors affected children's health. Isaiah (20 years old) shared how becoming a father and spending time around his son, Izzy (14 months old) led him to consider how his negative health behaviors might impact Izzy, even as an infant,

> I got better, I actually got better with not, not letting him…well I actually got better with not letting myself like drink or smoke. I actually stopped smoking cigarettes. I was smoking cigarettes, I don't even, I wasn't even picking. Now l look at cigarettes and it's like those are disgusting. Menthol is nasty. Menthol is this. So it's a lot of stuff that I had to do for him to understand. Even if he a baby he still watching me. If his eyesight not even that clear he still watch me. So

> therefore I had to, I stopped smoking cigarette, and I stopped drinking occasionally and everything. It's just I just stopped doing a lot of stuff like I stopped hanging with certain friends all because I got a child. And certain friends I had are type of people who want to party all day and who wants to drink all day. So its stuff I had to stop myself from doing for him to understand everything is not okay to do just because you see somebody else doing.

Daddy mode was as much about fathers monitoring their own behaviors as it was about monitoring and intervening in their children's health. Shifting into daddy mode led men to model healthy behaviors for their children, even if they were not behaviors that they ascribed to outside of their caregiving roles. Isaiah described how he changed his diet while around his son because he wanted to model healthy behavior for him,

> Eat the same food that you want the baby to eat, so if you want your baby to drink milk, you gotta practice drinking milk, too. So the baby can be like, "Alright, the mom's doing it, the dad's doing it, let me go ahead and try some of this stuff they called milk."…We try to get him to eat the vegetables and keep him away from soda, and junk foods, and stuff like that… I do that on purpose when he's around, so he can know that he gotta do it too…But like when he not around, I be having candy, drinking my load of soda, and stuff like that, chilling. But when he get back from daycare, you gotta get into daddy mode. You know, you can't be inside your own mode 'cause then he'll be like, "Man, that's not white. That's not milk" Then he's gonna want some of what you drinking, so that's the type of way we don't give it to him.

The dynamic nature of fathers' living arrangements—both across participants and within individual fathers' experiences—may have made fathers more aware of the ways they shifted into daddy mode. Alvin (19 years old) and the mother of his son, Shaunice, tried many times to maintain a romantic relationship work in service of being a family for their son, Alvin Jr. (whom they referred to as "AJ"). Although Alvin and Shaunice lived with their respective mothers, they would often—when together as a couple—stay with their son at each other's home. When their romantic relationship ended, Shaunice and AJ would return to living exclusively at her mother's house and Alvin would be relegated to arranging times when he could visit with his son. Through the course of several breakups

and reunions, Alvin developed distinctly different ways of going about his days when he with his son and when he was not. He described his focused attention on his son and meeting his needs,

> Nothing else matters at the moment…until he leaves from with me. …Most of the time he comes over here when people call or ask me to do stuff and I'm like I got my son. I'm not…I can't record, I can't, you know what I'm saying, I don't smoke, I don't drink, I don't do none of that….My whole focus goes on him like I gotta make sure he alright, making sure he's having fun, making sure he don't look sad or nothing like that, making sure he sleep if I feel like, not even if I feel like he tired, but sometimes I can feel the vibe of him 'cuz I pay attention to the vibe and the spirits of stuff in the room. Not that I'm crazy or nothing like that, but I can just feel certain vibes and spirits and things. I just make sure he's straight.

His varying experiences as a residential and non-residential father made Alvin acutely aware of how his attention shifted to his son when he spent time with him. The cognitive and behavioral shifts that fathers made when in daddy mode involved awareness of their children as well as cognizance of their own health and behavior. The awareness primed by daddy mode remained activated regardless of fathers' physical location—whether they were with their children or not. More broadly, this self-awareness motivated fathers to continue enacting health behaviors that enhanced or preserved their health and encouraged abstention from those that compromised their own wellbeing.

Caregiving through Kin & Emotional Work

Kin-work and emotion-work featured prominently in fathers' discussions of caring for their children's health needs. Purposefully cultivating collaborative relationships with children's mothers and other caregivers helped fathers remain access to their children and promoted opportunities for fathers to engage in their children's medical care. Kin-work also required fathers to address and manage intense emotions that arose

—in themselves, the mothers of their children, and other kin—as a result of complex relationship histories. Fathers' emotion-work also extended to their children. Emotions provided important information about children's health for fathers, particularly for preverbal children. Fathers also discussed caring for children's emotions by providing support, comfort, and building relationships with their children with the aim of promoting positive bonds and health outcomes for their children.

Navigating relationships with children's kin and caregivers, particularly mothers, had important implications for how young men engaged with their children's health. The vast majority of children in the study (n = 45) lived with mothers and very few (n = 3) with fathers exclusively. Fewer than half of the fathers (n = 13) in the present study, however, co-resided with their children and most were disconnected from some of the day-to-day aspects of caregiving. Communicating with the mothers of their children presented a way for fathers to remain apprised of changes in their children's health and development as well as created opportunities for men to spend time with their children and be directly involved with their children's healthcare. This kin-work that fathers—residential and non-residential—accomplished with the mothers of their children allowed men to exchange information about their children's health, provide input regarding children's medical care, and care for children's health needs.

Much of health caregiving—feeding, attending to hygiene needs, identifying and responding to health issues, and managing chronic conditions—unfolded during the course of parents' daily routines with children. Co-residing and spending extended time with children allowed fathers opportunities to participate in these aspects of their children's care as well as gather rich information about their children's health. Attending

to the relationship dynamics between themselves and the mothers of their children while balancing the complex intersections of their own emotions with those of their children and other caregivers—including mothers—represented a way for fathers to maintain access to their children, have opportunities to engage with them, and remain connected to their children's healthcare.

Co-Parenting Dynamics: Coordinating Care with Mothers of Children

Maternal factors may also impact fathers' abilities to participate in their children's care. Prior studies have found that the status and quality of fathers' relationships with the mothers of their children predicts father involvement, with pronounced effects for nonresidential and young fathers (Gee, McNerney, Reiter, & Leaman, 2007). Mothers may also limit fathers' contact with their children through gatekeeping (Schoppe-Sullivan, Brown, Mangelsdorf, & Sokolowski, 2011). Taken together, the dynamics of fathers' coparent relationship shaped how they coordinated caregiving with mothers about their children's health, made decisions about their health, and shared caregiving responsibilities.

Fathers identified communicating with the mothers as paramount for learning about children's health and coordinating their care. Frank (22 years old), one of the fathers who used the phrase "[being] on top of it" to describe fathers' responsibility for caring for children's health, noted that communicating with mothers was an important aspect of their pediatric caregiving. He shared,

> That helps, too, because when then they not with you, they with who? Mom. So you ask her questions, too. Y'all communicate, like "oh yeah, today he did this, something, this happened, this." You know, communicate with her. Both y'all…like, "last time I checked, he ain't have this right here so what happened?" "I don't know. We might need to call the doctor." "What's going on?" That helps

> you be on top of it, too. She may catch something that you ain't catch or you may catch something she ain't catch…If you really don't have too much communication with the mother of your child then it could be more harder than normal. It all depends on how y'all communicate, what's y'all relationship.

"Being on top of it" referred to fathers' overarching sense of responsibility for their children's wellbeing and making sure that children were healthy represented one aspect of their role as fathers. Frank's narrative also highlights how fathers acknowledged that mothers were a key part of their being involved in their children's health care. Communicating with their children's mothers offered fathers opportunities to share information about their children's health and development as well as identify and evaluate concerns that either they or mothers have regarding their children.

Fathers looked to mothers to relay information about their children's health. Brian (21 years old) missed most of his son's appointments and other medical encounters. He was certain, however, that he could obtain the information about his son's visits from his son's mother who attended the visits most often. When asked how he learned about his son's medical visits, he expressed confidence that his partner would inform him about what happened during the visit. He noted,

> By [my child's mother]. She will call me and tell me everything. Like if I need, like I got him and something happens, I need information, I just call her and she will just tell me. She will just tell me to go to her house and get the paperwork or something.

Although Brian was not able to attend the visit, he and his partner negotiated ways for him to learn about his son's medical care and be included, if remotely and indirectly.

Poor relationships with the mothers of their children, however, reduced fathers' access to information about their children's health. Los (20 years old) reported his relationship with his child's mother was sufficiently poor that they maintained as little

contact as possible and preferred not being in each other's presence for an extended period of time. Nonetheless, she shared limited information about their three year-old son's, L-Dubs[4], medical visits with him when Los called to check on their son. He shared,

> I mean she do tell. Like she always tell me about certain stuff. But she ain't been saying nothing lately like he went to anything like the doctors or nothing.
>
> (What does she tell you?)
>
> She just tell me how the checkups was, like if he had shots and stuff. He was probably crying. He probably tell yeah he had went to the doctors because I don't really want to hear it from her for real so I talk to him. He ball yeah "I got some candy from the doctors", "I got some shots. It hurt." Stuff like that. I tell him "but you a big boy, right? You ain't hurt. It don't hurt." He be like yeah it still hurt. You alright.

Los was largely disconnected from his son's health care and medical information. Although he may have known that his child had a doctor's visit, he was uncertain about who his son's pediatrician was or where his son received care. Disconnection from children's medical care left fathers with little information about their children's health status beyond what they were able to observe themselves. In lieu of gathering information about their children's health through medical visits, fathers relied on mothers to share this information. Fathers' reliance on mothers' reports may be viewed as reflecting their trust

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[4] Los referred to his son as "L-Dubs" because he likened his son to his "double." Although Los' use of "Dubs" as a suffix was unique among fathers in the sample, several fathers gave their children their names. The reader will notice throughout this work that initialed names (i.e., "AJ") are common. . In each of these cases, the names referred to the first initial of fathers' first name followed by a "Junior" suffix. For example, "AJ" is short for "Alvin Junior." These naming practices reflected a way that fathers sought to create a lasting legacy that outlasted their lives and connection with children—the longevity of which may be threatened by the contextual realities of community violence and elevated incarceration risks present in their communities (Alexander, 2011; Singh, Azuine, Siahpush, & Kogan, 2013). Eponymous names represented a way that fathers gave their children a piece of themselves and created a sense of "we-ness" (Marsiglio & Roy, 2012).

in mothers as caregivers, advocates for their children, and reporters. Alternatively, fathers' reliance on mothers to relay health information may be due to contexts that inhibit their abilities to be present at those visits. In these cases, fathers' reliance may reflect trust less than it reflects an acceptance motivated by necessity.

In addition to gathering health information through mothers, Los's story highlights how children themselves may become sources of information about their health as they get older. At three years old, L-Dubs was among the oldest children in the study but lacked the verbal skills to convey complex information about his doctors' visits to Los. Los's lack of information about his son's medical visit may have also bent his response to his son's sharing that he went to the doctor. When L-Dubs shared that he got candy and received shots at his latest visit, Los responded by attempting to socialize his son to be "a big boy," a line of conversation that ended the conversation about health.

Whereas Los' conversation with his son corresponded to his son's developmental position and language abilities, it did not allow him to gather detailed information about his son's health. Without knowing more about the nature of his son's medical visit, Los was not able to ask about his experience with the doctor and his health prior to and after the visit. What L-Dubs identified as a "shot" could have been an injection or a blood draw and the reasons for L-Dubs receiving either may differ whether he was attending a well-child visit or if he was ill. Knowing this background information may have led Los to ask different questions and learn more about his son's health through his conversation. His story illustrates how fathers may begin to turn to their children to learn about their health, even from an early age, when their access to health information through other channels was constrained. Los' story also highlights the problems resulting from

obtaining health information in this manner. The health information that young fathers—whose children are generally preverbal or nascent speakers— are able to obtain through their children may be especially limited or unreliable.

Limited access to information about children impeded fathers' abilities to respond to their children's health needs. The general health of children, however, may attenuate the detriments to children's health that could be caused by fathers' disconnection from information about their children's health (Schuster, Chung, & Vestal, 2011). The majority of children will develop typically and, while they encounter occasional illnesses or injuries, will not encounter conditions that significantly compromise their physical health over time. Thus, the caregiving knowledge that fathers acquire over the course of their lives may be enough to prepare them to address children's health. Even without the benefit of having granular detail about the health of their children, many young fathers may yet be able to be "good enough parents" (Winnicott, 1973).

Children's medical encounters and the communication between parents surrounding these events also provided opportunities for parents to discuss their children, even if they might not otherwise communicate. For some fathers, medical visits provided a context in which fathers exchanged health information about their children with mothers. Charles (20 years old) had an 18 month-old son but seldom spoke with his son's mother since their relationship ended. Their son's medical visits were among the rare moments where they spoke about their son and his health. Charles shared his frustration,

> The only time we talk about his health is when we at the doctor. That's the only time me and her has a conversation. I don't know why when we get there, it's like, "oh, this happened to him." That's when I be getting mad, like, look, you gotta tell me these things when they happen. That's not fair to me as his father not knowing what's going on with him.

His son's medical visits represented a setting where the dynamics of his relationship with his son's mother as well as his ideas about his role as a father intersected. Charles was frustrated about his lack of communication with his son's mother. Although not mentioned in this segment, his frustration may have been fueled by the hurt from the loss of his relationship with his son's mother, which changed the nature and frequency of their communication in general and about their son. His frustration about not being made aware of changes in his son's health in a timely manner also reflected a sense of responsibility for his son's wellbeing that emerged from his understanding of his role as a father. As Charles' experience suggests, children's well-child visits, then, could become filled with heightened emotional intensity as parents attended to their children's health needs while navigating their personal feelings about their partners, their coparenting relationships, and their roles as fathers.

Parents' communication became especially important when they needed to make medical decisions for their children. Fathers, however, identified making few medical decisions on behalf of their children. The overall health of children, including those in this study, largely explains this as few children encountered significant health issues, as suggested by Schuster, Chung, & Vestal (2011). Andre's (25 years old) 15 month-old son had several ear infections in the first year of his life. After consulting with his son's primary care physician, his son was referred to an otolaryngologist who recommended that he undergo surgery to have ear tubes placed. As new parents without previous experience dealing with significant pediatric issues, they were concerned that their son's hearing would be compromised but were frightened by the prospect of their son undergoing surgery. When presented with the decision about whether to have their son

have the ear tubes placed, Andre found himself resistant to the surgery because he was concerned that he might lose his son during the procedure. Alana, Andre's partner, however, wanted to proceed with the surgery. Andre discussed how they resolved their disparate positions and came to an agreement over the course of a few days,

> We sat down and talked about it for a couple days before we actually made the decisions and we actually talked about it without arguing or without any disagreements… We both came to—first we both felt different about it, but we both came to the same decision that it should get done and we got it done.

Andre's remarks provide an example of conjoint, collaborative decision making among young fathers and the mothers of their children. Like other fathers, he and Alana had a dynamic relationship history that included several periods of romantic separation, attempts to make their relationship work in service of preserving their family, spending considerable time together, and a sexual involvement—with different permutations of these dynamics at various points. Although their relationship status at the time when they made a decision about their son's ear tube placement is unclear, they continued to maintain at least some sort of connection, if just a cordial coparenting relationship, since their son's birth. Additionally, Andre and Alana had attended a prenatal dyadic intervention that aimed to promote positive communication and problem-solving among adolescent parents. It is possible that they were able to use strategies they acquired through the intervention to maintain a collaborative relationship throughout the changes in their relationship as well as when deciding about their son's surgery. Their participation in the prenatal intervention as well as their ability to maintain a collaborative relationship with each other may distinguish Andre's decision-making experience from that of other fathers. Delonte (21 years old), for example, had a very volatile relationship with his daughter's mother that ended when she initiated a

restraining order. This precipitated disconnection from his daughter and from participating in important medical decisions. His story is discussed at length in Chapter 7.

Gender Dynamics in Pediatric Caregiving

Fathers also indicated that parents and children's genders may shape how they make medical decisions for their children. Circumcision is among the first medical decisions that fathers and mothers make for their children. Given the trajectories of some of their coparenting relationships, it may have been one of the few medical decisions that parents made together. When I asked about these decisions, fathers indicated that mothers usually deferred to them about whether to circumcise their sons. Trey (23 years old) had a two year-old biological son[5] and recounted how he and his partner made a decision about whether to circumcise their son,

> I just felt like that was best for him to be that way [and] she agreed. It was my decision, and she felt that was my decision because I'm a man so I know more about that than a woman would.

Mothers' deference to fathers to make decisions about circumcising their sons may be due to the uniquely gendered nature of the procedure. This suggests that fathers and mothers may employ a gender-matching pattern of deferring when children's health issues were specific to males or females. This gender-matching strategy provided a space for fathers to contribute to the health decisions for their children, particularly their sons. Gender matching, however, did not allow fathers a similar space with regards to their daughters' health. Aside from circumcision, the early years of life did not require any normative, gender-specific medical decisions. While relatively far away, adolescence

[5] Trey also had two non-biological children—a four year-old girl and three year-old boy—from other partners. He was not, however, present for either of their births as he began relationships with their mothers after they were born.

represented the next developmental position when gender-matched decision-making became salient for fathers and mothers. In discussing their projective ideas about their involvement in their children's health, Trey and other fathers suggested that they might defer to mothers with regards to their daughter's medical decisions.

Young men's understandings and experiences of motherhood provided a foil against which they constructed fathers' role in pediatric caregiving. These gendered understandings of their roles as fathers emerged as salient and differentiated their caregiving activities from those of mothers. Perceptions that mothers had "natural" inclinations for caregiving provided salient explanations for gendered divisions of pediatric caregiving responsibilities. James (22 years old) had a five year-old daughter and a two year-old son. Whereas he had become estranged from his daughter's mother within a year of her birth and since had little contact with his daughter, he had remained romantically connected to his son's mother and had lived with her since she was pregnant. James situated his approach to pediatric caregiving within gendered role constructions. Upon further questioning about his differential expectations for mothers' and fathers' engagement in caregiving, he shared a belief that mothers were inclined to caregiving and thus better at addressing their children's health needs:

> It just fit them… It's like they natural instinct is to nurturing kids so I don't be tryna get in between that. I play a part in everything else. I just let her have that. I can give him the medicine but I just choose to leave that up to her. I'd rather for her to do it. Now if she's not here or if like if he going to my house and she leave and he need the medicine, then I can, I'll do that…I just rather for her to do it. At least she know how to do it and plus it's like she know how to do it and she mostly, she mostly doing it anyway…I just help out like hold his mouth open and like hold his arms down. She taking his temperature. Wipe his mouth and stuff like that. So that's what I do.

For some men, constructions of mothers as natural nurturers and caregivers were situated in the importance they ascribed to biological connections between mothers and children during the perinatal period. Within this perspective, mothers' connections to their children during gestation imparted maternal instincts and provided motivation for maternal caregiving. Andre (25 years old) had an 18 month-old son and noted:

> Well maybe it's like a, cause I think it's like a natural instinct, natural feeling. They carry, like they carry them for nine months, nine to ten months so it's like a natural feeling. A natural instinct for them to want to care about the health more than others…I mean I think moms just got it. I think I mean you can't, you can't say that dad can't be just as good as a mom but I think it's just something, it's like certain moms they just got it. It's this thing…I don't know what it is. It's just a natural instinct that they got that they care for they child.

Fathers also thought that mothers were more emotionally suited for addressing their children's health needs. Jamaal (20 years old) had a 22 month-old son, Chez, and was expecting a daughter. He cited gender-based differences in emotional expression to explain why mothers and fathers approached pediatric caregiving,

> I really think moms—excuse my language, females—are more affectionate than males, so I think that will play a bigger role in taking care of the kid's health. That's why they make all the doctor's meetings, stuff like that, but when it comes to taking the kids out to have fun and play around, I really think that that's the dad's thing. Mom wouldn't want to take the kid out, chase the kids around, throw the ball back and forth with him, and stuff like that. They would just want to take them out, let them run, and go socialize with all the other moms up there. The fathers are the ones that really interact with the kids during playtime.

Whereas perceptions that pediatric caregiving was a function of mothers' instinct or unique bonds, mothers' "natural" caregiving abilities provided opportunities for fathers to learn about how to engage in pediatric caregiving for their children. Smith looked to the mother of his 21 month-old son to gain a better understanding about how to care for him,

I watch her, how she positions him. I watch her soothing techniques, like she

> hums with him. She'll walk with him. Just things that don't come to men naturally. I just watch those types of things, just every little detail that I can pick up. I'm like a sponge when it comes to him.

Learning caregiving skills from his son's mother was especially important for Smith because he had been prohibited from participating in his son's medical visits and from even seeing him due to a child abuse case filed against him in the first few months of his son' life.[6]

Despite gender-based role expectations that some fathers described, others eschewed such approaches in service of ensuring that they remained "on top" of children's health. Frank (22 years old) had a son (3 years old) with a previous partner as well as an18 month-old with his current partner. When asked if he thought that gender explained the differences between what he and the children's mothers did for his children's health, he shared,

> Man, not really because both of them…Nah, it's not really no different for real. You just have to be on top of it. Mom and dad when it come down to the child you just, basically, it's the same for real.

Whereas gender-based role constructions may have informed parents' ideas about dividing their responsibilities for children's care, these understandings did not necessarily determine what parents actually did to address children's pediatric issues. Within a few months of moving back to the city from North Carolina, Leonzo (20 years old) began dating Nikeah, who had a three year-old daughter. He also maintained contact with his two year-old non-biological son from a previous relationship. Leonzo and his current partner soon had a son together, who was seven months old at the time of the interview. He lived in an apartment with Nikeah and their children and was studying for his GED

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[6] A richer discussion of the circumstances surrounding Smith's being excluded from his son's care is included in Chapter 5: Acute Care.

examination and training heavily to become an amateur boxer. He discussed having an egalitarian arrangement with Nikeah,

> We don't break it up like that. If somebody's Pampers need to be changed somebody has to do it, and if she is in the kitchen cooking I will do it, if I'm in back studying she'll do it. We don't really break it up. Most of the time I'm gone, because either I'm at work or the gym, but when I'm around I do most of that. I let her go in the back and get some rest while I take care of them.

Much of pediatric caregiving played out through spontaneous, chronic, and quotidian opportunities to address health needs. The contextual realities in which young men addressed their children's health needs confound determinations about whether gender-based division of labor among young fathers and mothers were a function of gender role constructions, a response to their contextual realities (i.e., dynamic nature of co-residential status, quality of relationship and communication with partners, and knowledge about children's care) facing them; fathers and mothers arrived at these arrangements through an iterative combination of both role construction and contextually-shaped lived experiences.

Expressions of Support: Fathers' Involvement in Pediatric Visits

Engaging with the healthcare system spanned each of the discrete domains of the tri-partite model. Well-child visits, sick visits, and emergency room visits provided contexts for fathers to care for their children's health needs. The majority of the fathers (*n* = 23) of study participants were recruited from the Teen Parenting Program (TPP), which was based on the teen-tot model of collocating and coordinating medical services for teen parents and their children (Akinbami, Chemg, & Kornfield, 2001; Lewin, Mitchell, Burrell, Beers, & Duggan, 2011). As an extension of this model, TPP also provided intensive case management services within a medical setting for adolescent

parents and their children. Each teen parent was assigned a case manager who scheduled medical appointments, helped adolescents identify community resources, and provided mental health services when needed. Because fathers were largely recruited from a medical setting and the Teen Parenting Program in particular, their narratives may reflect fathers who are most engaged with the healthcare system and may miss the experiences of other fathers. Nonetheless, their narratives begin to identify the processes of paternal involvement in the pediatric settings and the barriers that young fathers encounter in those spaces.

Fathers couched the importance they ascribed to going to children's medical visits in their general role as a parent. James (22 years old) had a four year-old daughter whom he was estranged from as well as an 18 month-old son with his current partner. Although he did not make his son's appointments and could not recall the doctor's name, he attended the vast majority of his son's medical visits. For James, it was part of his role as a father,

> It's good. I like it. I'm there every doctor's appointment, even when she was pregnant. From doctors' appointments when she was pregnant all the way up to now I been there. I probably can say, well since she been pregnant I probably missed one doctor's appointment. Since he's been born, I don't think I missed a doctor's appointment. I think I probably missed one doctor's appointment. That's probably because I had something actually important to do. Like probably fill out some jobs or something like that. But other than that I haven't missed not one doctor's appointment… I go because I need to see what's going on with my son. Just as a parent. Just to go as a parent. I'm concerned about my son. Making sure everything where as his health is right. Is he developing right? So that's why I go and for the support.

Fathers prioritized attending children's medical visits as they offered opportunities to make sure that their children were healthy, learn more about their children's health, and acquire skills for caring for their health. Keith (21 years old)

described how his daughter's (5 months old) well-child visits allowed him to keep track of her development

> I say it's important, because I feel like the doctor's is more like family time. I feel like it's an experience. I like just to be part of it. I just like to hear how my daughter doing. I like to hear how much weight she done gained, if she is doing alright with her, is she healthy, is she overweight, just hearing everything, hear how they think we're doing.

By virtue of providing information about their children's growth, children's medical visits allowed fathers to gauge how well they were doing in maintaining their children's health. With the majority of children in the study being generally healthy, doctors' reports about their children's health provided reassurance that they and their coparents were providing adequate care for their children. That fathers would find reassurance in doctors' reports is at once unsurprising and indicative of their positions of parenting in challenging contexts. Wondering how well one is doing to care for children is a common concern among parents, particularly first-time parents; young fathers shared in this experience of parenthood. However, the challenges young men faced as caregivers—fathering across distance, tense coparenting relationships, limited access to financial resources—as well as their children's exposure to disadvantageous social determinants of health distinguished their experiences as parents. Hearing from children's doctors that their children were healthy provided fathers with peace of mind that their children had not been impacted negatively by the contexts that surrounded them.

Fathers' Perceptions of their Relationships with Healthcare Professionals

In the best of situations, medical visits provided opportunities for fathers to be acknowledged as caregivers and welcomed into the medical setting. Keith and his daughter's mother, Tyeesha, were members of the Teen Parenting Project. The nursing

and medical staff of this program had experience working with adolescent parents and fostered a welcoming environment for adolescent parents—including fathers—by respecting their perspectives and roles as parent while acknowledging the unique challenges of being an adolescent parent. Although relatively few fathers presented at children's visits, the program retained specialized fatherhood staff to meet with fathers when they presented at their children's visits as well as provide ongoing case management, mental health, and supportive services. Including fathers in medical visits empowered men as parents and adults with whom important life and death decisions about their children were discussed. The sense of belonging supported by Keith's experience, however, may be rare in young fathers as institutional policies and biases (i.e., educational systems, community policing, and employment practices) exclude young, low-income men and marginalize their experiences (Anderson, 2008).

Medical visits may be a venue where fathers are able to engage in kin-work to create a sense of family with and around their children. Keith's narrative illustrates how medical visits also provided a context for fathers to reinforce connections with children as well as their mothers, particularly when contextual and relational barriers might have otherwise separated them.[7] Brian (21 years old) had a 22 month-old son but did not

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[7] At the time of the interview, Keith found himself concurrently balancing a coparenting—but sometimes romantic—relationship with his daughter's mother, Tyeesha, as well as his new partner, Candace. Tyeesha wanted to try to make their romantic relationship work for the sake of their daughter and Keith was largely complicit in fulfilling this role, at least while he was in her presence. Tyeesha, however, had recently learned that Keith was also maintaining a romantic relationship with Candace, which caused tension in Keith's relationships with both women. The distance between where Keith and Tyeesha lived is also of note—she lived in the southeast quadrant of the City but he lived in a outlying suburb some 20 miles away. With limited access to a car, the tension in their relationship disinclined both Keith and Tyeesha to make the considerable efforts needed to see each other. On top of the relational turmoil around

generally attend his pediatric visits due to his work schedule. After his son had a particularly difficult time receiving shots, Brian prioritized accompanying him to his next visit to provide additional support for his son and facilitate the encounter. He noted,

> When he first got his shot he was crying, so when I went with him the second time he finally got his last shots, and I was right there with him holding him he didn't cry. But when she said him and her went he was crying and she didn't like how the doctor was holding his arms and how the doctor was giving him shots, so that's what made me go the second time. I went. We sat right there. He didn't cry. He didn't do nothing. He just sat right there, and that just made me feel good, because since I was there he didn't cry. He took it like a big boy.

Fathers' calming presence on their children during medical visits was a common theme in young men's reports of attending children's medical visits. Given his son's previous experience receiving shots, Brian felt his son needed his support at the next time that he had to get shots. As a father and as a parent, Brian brought a comforting presence that helped his son during a difficult moment. Brian's reactions to his son's remaining calm conveyed his pride in his son as well as reinforced his bond with him—Brian attended the visit because he cared for his son and felt affirmed when his son was comforted by his presence. The emotion-work that he and other fathers contributed during their children's medical visits helped ease them through difficult procedures, gave them reassurance, and encouraged emotional regulation. In addition to reducing anxiety for children, fathers' ability to calm children helped ease procedures for medical staff and contribute to better quality care (see also Meckler, Leonard, & Hoyle, 2014).

Keith, he also had a pending criminal case stemming from a traffic stop where he was found with 80 grams of marijuana with a street value of about $800.00. This was enough to be charged with conspiracy to distribute narcotics. Although he did not know it at the time of the interview, he would ultimately be sentenced to two years in prison. Taken together, the prospect of losing his connection with his daughter and his partners may have motivated Keith to create family with and around his daughter.

For some fathers, supporting children and partners during medical visits coincided with feeling marginalized through their interactions with the healthcare system. Fathers feeling excluded from medical conversations about their children may lead fathers to position themselves in a supportive role in their children's medical encounters. Healthcare professionals' defaulting to mothers for collecting medical history and giving caregiving instructions contributed to fathers feeling somewhat marginalized in the medical setting. Alvin (20 years old) described his supportive role in medical encounters as well as his perceptions of how his son's providers interacted with him,

> It felt good just to know that I'm there like I know they pretty much gonna talk to her because she the mom and they pretty much there to check on him so they the one's that's pretty much involved, I'm just there as the backbone, you know what I'm saying. And that they might say oh and dad can you start trying to show him this and show him that, but I pretty much just try to be there as a backbone man, for real, for real. And I mean I soak up the information too and I pay attention too like I'm very, you know what I'm saying, attentive when it comes to that stuff.

Wayne (18 years old) shared a similar sentiment about how providers communicated during pediatric visits. Although he listened intently during his son's visits, he offered few comments, as it seemed to be a conversation between his son's mother, Natalie, and the doctor.

> Sometimes they mostly talk to Natalie, I just be chilling. I just be just sleep and they mostly talk to Natalie and I just be agreeing that's all for real…What she saying is right, but not all the time what she saying is right. I just be listening; I might not have no feedback I just be listening, like I said, I just be sleep. I just be in there dazed. Like I just be tired, that's all.

Wayne noted that the doctors focused their attention on Natalie and their son during his pediatric visits and that he had little to add to their conversation. His remarks, however, beg the question about whether doctors' exclusion of Wayne led to his detaching from the

medical encounter or whether his detachment led the doctors to rely on Natalie for information.[8]

Despite feeling somewhat excluded from their children's medical visits, fathers etched out meaning, importance, and purpose in medical contexts where their perspectives may be relegated to secondary or remain unsolicited by medical professionals. Alvin's understanding of his voice as secondary to that of his son's mother may have also been shaped by his experiences as a largely nonresidential father, who by virtue of not being involved in his son's daily routines as intimately as his son's mother, had less experience addressing his son's health issues on a day-to-day basis.

Whereas most fathers believed that their children received adequate medical care and were welcomed by their healthcare providers, some found the doctors' offices to be less welcoming to them. Tom (23 years old) shared his appreciation for how well his daughter's (3 years old) physician cared for her but also noted that he did not receive as warm a reception,

> Since she's been going to Dr. Karzi since she was born, I guess they know me. When I go to the hospital, they usually treat me nice. They always say that me and Bianca look alike and that she's pretty. So people usually have a warm spirit towards us. Gotten that, "where's the mother" attitude, or the "you're not

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[8] Although I am not privy to his medical records, he mentioned frequently using marijuana to treat anxiety and troubling thoughts that often came to his mind. This palliative drug use, combined with the lethargy he reported experiencing during his son's visits, may suggest depressive symptoms. These symptoms, if experienced while caring for his son, may have impeded his ability to recognize his son's health issues and report them to his physician. This understanding of his behaviors, however, only represents my impressions of his behavior—and that without the benefit of a formal assessment; there may be other interpretations of his behaviors and mood. The accuracy of this interpretation for Wayne specifically notwithstanding, this etiological pathway explaining habitual drug use among young men may apply to other young fathers who are embedded in historical, cultural, and socioeconomic contexts that inhibit their access to mental health services.

> supposed to be here." …I've literally been asked, "where's the mother?" or like the WIC thing, like you can't get this because the mother's not here or looking at my insurance card for extra long, like do the names match up? I've always, I've never really took it to heart. Like I said, I know it's the nature of this area really. I take it with a grain of salt.

Fathers were keenly aware of others' perceptions of them as fathers and caregivers for their children. Attending children's doctors' visits placed young fathers squarely in the crosshairs of judgment where they encountered stereotypes about who they were as individuals, the care they provided as fathers, their relationships with the mothers of their children, and who they were as members of communities. Charles (20 years old) discussed what it was like for him and other men he knew to go to doctors' visits with their children,

> Because being at the doctors and people seeing that you have a kid, they automatically think that you're one of those people with a bad baby's mother and you probably a drug dealer trying to act like you a good parent. It's just a lot of stereotypes instead of somebody sitting down and actually trying to get to know you, they automatically judging you. So, a lot of young dudes don't want nobody just come off the back judging them.

In addition to medical providers viewing fathers through lenses tinted by stereotypes of young, urban men and fathers, some participants also reported receiving unsolicited attention from other patients. Charles also shared that he received undue attention from other parents, usually mothers, who were in the waiting room with him,

> It's real awkward because most of the females in there, like it's mostly females with their child and you rarely see a dude coming to the doctors for his child. You'll see him pick him up from school or pick him up from his mom's but you rarely see him at the doctors by himself. So, whenever I used to go in there, it seemed like all the mothers would flock towards me and be like, "Oh my God! It's so cute that you wanna hold your son and you do this. You a good father!" I mean, you got your kids. I don't want your kids plus my son [laughs]. So, it makes it awkward to go in there without them trying to hit on me or something like that. I just go in, sign in, and sit over in the corner by myself with him or put him at the little table with the toys and things.

The attention that fathers received during medical visits from a variety of persons contributed to that being an uncomfortable environment for some men. Inordinate questions, comments, gazes, and being overlooked represented microaggressions[9] that challenged their legitimacy as caregivers, fathers, patients, and parents. Nonetheless, fathers' perceptions of accompanying their children to doctor's appointments spanned a dialectic that emphasized the importance of their presence at children's medical visits while acknowledging their contextual realities as well as how others might respond to them as fathers. It is through this dialectical understanding that men were able, as Tom noted, to "take it with a grain of salt" and prioritize providing care for their children despite the challenging context that medical settings may provide for young fathers.

In the face of feeling marginalized as fathers through their experiences in the health care setting, some fathers responded by asserting themselves as caregivers and the legitimacy of their presence in medical settings. Angel (19 years old) had two children, a son (2 years old) and a daughter (1 year old). He recounted his early efforts to establish his presence with his son's providers,

> I talk to each doctor. I'm making sure the doctors know that I was committed. And they pretty much said, "Okay, this is a dedicated father"…For me, all the doctors realize that because I was always standing up. They needed help keeping Eric down for the shots or needed to hold him down while they check their ears and all that. That was my duty because I felt like I wanted to be right there. I needed to see exactly what the doctor was doing, and exactly what shots were being given, or exactly is his heart rate okay? I was literally in the doctor's face the whole time. I made sure I asked questions that I needed to know because if I didn't know, then I didn't feel right.

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[9] Sue, Capodilupo, Torino, Bucceri, Holder, et al. (2007) defined microaggressions as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults" (p, 271).

In addition to asserting himself as a parent for his son, he established his role in the encounter by facilitating his son's examinations. His remarks also suggest that Angel at least in part believed that attending his son's visits was important so that he could know about the medical procedures happening to his son and protect him against undergoing treatments he thought might harm him. When Angel and his partner divorced six months prior to his interview, he had little contact with his ex-wife and children. This disconnection extended to his children's health, which concerned him. Having been stonewalled by his partner when he asked about their appointments and health, he turned to the healthcare system to gather information about his children. He noted,

> I call the doctor. I call where I know that they go, like the children's hospital. The simple fact is that I am their father, so they both have to relinquish that information to me. So you know, I've been keeping tabs on them, making sure that they actually need it. But honestly, I feel like I should set Eric an appointment and Violet an appointment before she goes out. Although I think they said another six months. I've kinda been keeping tabs on it. I gotta make sure that I know when those appointments are because she's not going to-depending on if she's going to be down there not. I don't know what she's going to do about health insurance and all that. I think she's just going to transfer it. I'm still wanting to keep tabs on it. If she does, I'm a find some way to find a doctor that treats my daughter or my son because I need to know their health. Either way, I don't care if she's going to tell me or not.

Whereas some fathers felt alienated from engaging with children's health by virtue of their relationship contexts and through their interactions with the healthcare system, some men expressed feeling welcomed by the healthcare system. Angel's story suggests that he was aiming to establish legitimacy with his children's providers. His efforts to establish himself with his children's medical providers may be due to previous experiences engaging the healthcare system with his children or his looking glass self-awareness of how others perceive him as a father and his role in his children's health. Establishing themselves as involved fathers and maintaining relationships with medical

professionals represented a way that fathers were able to maintain access to their children and information about their health that might otherwise be compromised.

Similar to Angel, Luther (21 years old) lost contact with his daughter after her mother, Marquetta, absconded with her following a custody hearing a few months prior to his interview. Having been cut off from his daughter, he learned from Lauren, his daughter's case manager at the Teen Parenting Program, that she had not attended her two most recent appointments. Armed with this information, Luther petitioned the court for temporary custody based on medical neglect. During our conversation about his first encounter with his daughter's female medical provider, he affirmed thinking that he would have been treated better if he were the mother presenting at the visit,

> They would probably be more patient with her and talk to her as a female, like two best friends talking. They will be more relaxed with them versus with the father like they always have to, like I said, a father has a stereotype on them like they don't know what they're doing.
>
> (So you got that sense when you went this time?)
>
> No. A little bit, just with the doctor. Lauren is cool. That's my good friend. But with the doctor, as in like, I mean it's my first time going, I'm not going to judge her on the first time, but it kind of sort of did. Like the way she was talking to me, like she's talking to me, but, "I'm going to tell him this. He's not going to do what he's going to do or listen." Or like I said, she just is such a pro at this that she don't mean to come off that way. I'm giving her the benefit.

The support Lauren provided helped him navigate complex hospital policies and procedures as well as position himself to advocate for his daughter's health. These previous interactions helped buffer against feeling hurried, and dismissed by his daughter's providers. His and other fathers' experiences of feeling rebuffed by some providers highlights the need for practices that recognize and are inclusive of fathers in the pediatric visit. Alternately, his experience of feeling welcomed by other professionals

during the same series of encounters suggests that fathers feeling excluded from the pediatric setting is remediable; changes in policies, institutional practices, and improved patient-provider communication have the potential to help fathers feel more welcome at children's medical visits.

Employment and Physical Distance as Barriers to Fathers' Engagement in Pediatric Healthcare

Similar to prior studies examining men's engagement in pediatric visits, fathers in the present study identified work schedules as a barrier to their participation in children's medical visits (Garfield & Isaaco, 2012; Goble, 2004). Employment insecurity and the process of seeking employment contributed to fathers' inconsistent attendance at children's medical visits. Jamaal (20 years old) had been involved in hustling for much of his adolescence and was trying to transition into formal employment now that his son was a year old and he was expecting another child in a few months. Given his daughter's upcoming due date, he felt especially pressured to provide for his children and this drew him away from attending his son's recent doctor's appointment. He shared,

> I go to his visits. I do 'cause I would love to keep up-to-date with what's going on with him, inside and out. That's my first-born. That's my little boy. I didn't really care too much for back then because me and his mother was going through stuff, and I know that's not good for the kid. It's 'cause the mother and father aren't really bonding…I've been going to all the meetings lately, except for the one the other day 'cause she went to it. She went to Children's. I was looking for jobs again on the computer, so yeah. My main focus right now is just work 'cause my newborn. Babies are not cheap.

Fathers' perceptions that employers would not allow them time off to attend children's medical visits also led fathers to allow mothers to take children to their medical visits independently. While Paul (22 years old) worked early and long hours as a

traffic flagger, his partner, Sharon, worked as a bank teller and retail associate. Given the nature of his work, he did not believe that his employer would be willing allow him time off to attend his son's visit and that Sharon's employers would be more amenable to taking time off for their son. Together, they decided that Sharon would generally be responsible for taking their son (21 months old) to his doctor's visits. In discussing who took their son to his medical visits, he noted, "mostly Sharon, but I go if I'm not working. Sometimes she takes off, so she just goes. I'm working I am just going to go to work, but if I'm off, I'm going to go."

Separated by distance or otherwise unable to attend children's medical visits, fathers discussed using alternate strategies to learn about those encounters. Some fathers were able to participate remotely in these visits, thus allowing them to communicate directly with their children's medical providers. Trey (23 years old) was away at college during the first few months of his son's life and was unable to attend many of his son's early doctors' visits. Although he was not able to physically attend the doctor's visits, his son's mother called him and put him on speakerphone when the doctor visited with their son. He noted,

> When I was in college, I tried to stay as up to date as possible. I couldn't physically be there because they don't let cameras into the little offices and stuff like that because it's confidential, but by phone I would communicate, make sure talk. I'm just on top of it, 24/7. It's a never-ending job.

Fathers also used newer technologies to attend their children's visits remotely. Similar to Trey, Montana (21 years old) attended college in a different city than where his partner lived. Although he planned to attend his daughter's birth, she came unexpectedly early. Despite his best efforts to make the last train back to the city so that he would have a chance at attending her birth, the call that his partner was in labor came too late and he

was unable to make it home for another 36 hours. His partner and others who accompanied her to the hospital, however, used the videoconferencing functionality of her smartphone to allow him to be present, if remotely, during labor and delivery. Montana recounted,

> Well, it was pretty tough because I couldn't, like I wasn't here, because we, like I said, like I was telling you, I wasn't-- She had had her a whole month early, so I wasn't expecting her to come, so I couldn't get home. And then when she had her I was on FaceTime for a little bit, I was on FaceTime for a little bit. Then they cut it off and I was just thinking, "Oh man, what does she look like?" And then I had to wait a whole week to come home…I was FaceTiming up until she was about to come out. I seen her head come out and then they had to cut the camera… It was hospital policy, they couldn't record anymore.

Similar to how fathers looked to mothers to relay health information, mothers were a lynchpin in facilitating fathers' remote participation in children's pediatric visits. Given the dynamic, perhaps unstable, and uncertain nature of these relationships, the connections that fathers made through mothers to children's medical information were vulnerable to disruption. Montana's story illustrates how fathers used technology to navigate distance, to participate in their children's health care. Marsiglio, Roy, and Fox (2005) discussed similar strategies employed by military fathers who were deployed, those traveling for work, or otherwise separated from their children in order to negotiate the contextual barrier that space presented to their fathering. The biases, discrimination, and differential treatment from institutions ranging from school to employment to the justice system facing boys and men of color suggest that young men, like Montana, may be subject to unduly stringent or inflexible implementation of hospital policies that inhibit their efforts to engage with the medical system on behalf of their children (Anderson, 2008).

Summary

Parents play critical roles in facilitating their children's medical care. They create access by securing and maintaining insurance, provide medical histories—particularly for those children whose verbal skills have yet to develop fully, interface with various healthcare professionals, and enact directives prescribed by their children's medical providers. Across the preventative, acute care, and chronic care domains, fathers' presence at children's medical encounters allowed men to gather information about their children's health as well as learn what to expect as their children developed. Young men also noted that their presence helped their children and mother remain calm during uncomfortable procedures (e.g., examinations, injections) as well when the circumstances precipitating their visit were frightening (e.g., emergencies, surgeries).

The common processes described in this chapter occurred across the preventative, acute, and preventative domains. These processes were not, in themselves, direct care for children but instead enabled fathers to provide care. Taken together, the common processes of this model primed fathers to respond in their children's care, created and maintained fathers' access to children so that they would have opportunities for caregiving, and facilitated children receiving health care.

Daddy mode represented an overarching sense of self as both an individual and as a father. It recognized the stability of role constructions while acknowledging that an individual's enactment of a given role is both primed and bound by the contexts in which they are embedded (Stryker & Serpe, 1982). Recognizing their roles as fathers led men to be at once aware of themselves and their children as well as how their behaviors—even those not directly involving their children—impacted children's health. Young men's

discussions of smoking demonstrated how the stability of their awareness of themselves as fathers led some to change how, when, and even whether they smoked. These behavioral changes aimed at preventing negative health outcomes occurred at the intersection of fathers' awareness of their own behavior, the personal salience of their roles as caregivers, and understandings of children's health.

It may be harder for fathers whose children had chronic illnesses to "switch off" daddy mode. The ongoing nature of chronic conditions, especially when these conditions were severe or pervasive, led fathers to be constantly aware of and concerned about their children's health. When fathers were not able to care for their children's needs, thereby fulfilling the role expectations prescribed by daddy mode, this constant awareness manifested sometimes translated into constant worry about their children. When children's chronic illnesses posed a constant threat to children's wellbeing or functioning, daddy mode over time manifested as vigilant monitoring and disease management—even to the point of hypervigilance.

Children's health represented a setting where the quality of the coparent relationship could promote or inhibit father involvement, with direct consequences for wellbeing. Fathers' involvement in their children's healthcare was linked to the quality of men's relationships with the mothers of their children. This is consistent with research suggesting that the quality of the coparenting relationship largely predicts father involvement, particularly for young men (Gee, McNerney, Reiter, & Leaman, 2007). Managing relationships with mothers of their children represented an important aspect of fathers maintaining access to children and opportunities for care for children's health needs.

Aside from three children who resided solely with their fathers, the children in this study lived with at least their mothers, some with fathers as well. Because fathers were sometimes separated from their children due to living in different households and daily demands that separated them (i.e., work, school), mothers were a source of information about their children's health and caregivers in men's absence. Whether or not fathers co-resided with their children, successfully navigating these relationships allowed fathers to exchange information about changes in children's health, developmental progress, and upcoming appointments. Maintaining collaborative coparenting relationships with mothers also facilitated communication in high-stress moments such as when they encounter acute health issues.

The quality and dynamics of the coparenting relationship are especially important for children with chronic health needs. In addition to exchanging information about conditions, parents must also relay information about adjustments to children's disease management regimens, which may be complex, depending on children's conditions. These care regimens—including various therapies, medication management, and protocols for responding to symptom exacerbations—are likely to change as children grow and their conditions develop over time. Fathers' abilities to communicate and coordinate care with mothers represented a way that fathers acquired the necessary knowledge and skills to care for their children.

Overview of Preventative, Acute, and Chronic Care Chapters

The common processes discussed in this chapter occurred in each domain of the tripartite model advanced by the present study. The following chapters, however, will explore each domain of the model in detail. Chapter 5 examines fathers' involvement

with *preventative care*. This chapter discusses fathers' use of emotional caregiving as a means of promoting positive health outcomes for their children as well as how fathers attended to children's hygiene and nutrition needs. Fathers' efforts to limit children's exposure to hazards by controlling their children's environments are also explored.

Chapter 6 examines how fathers address children's *acute health care needs*, often resulting from illness or injury. The chapter begins with a discussion of the process and indicators fathers employ to assess their children's health and determine a course of action to address their emergent health needs. Next, the chapter explores fathers' evaluations of their own abilities to provide the requisite care and how these considerations shape their caregiving decisions. The chapter also discusses fathers' emotional experiences, coping, and caregiving for children when they encountered acute health. Chapter 6 concludes with a discussion of fathers' caregiving as their children convalesce in the days and weeks following the onset of acute health issues.

The final findings chapter explores how fathers care for children's *chronic health needs*. Chapter 7 begins with a discussion of the heightened awareness of children's health and how this translated into their conceptualizations of their caregiving duties. The chapter also examines how fathers learned to address their children's health needs conferred by their chronic illnesses, specifically medication management, specialized caregiving skills, and trigger management. The impact of caring for children's chronic health issues on fathers' daily routines are also be explored.

CHAPTER 5: PREVENTATIVE CARE

The first domain of the tri-partite framework, preventative care, included caregiving behaviors aimed at maintaining children's health as well as preventing illness and injury. Among its counterparts, preventative care encompassed routine and mundane tasks associated with parenting. The often-challenging residential, relationship, socioeconomic, and community contexts in which young fathers enacted these caregiving behaviors for their children, however, required navigation strategies that were anything but mundane.

Fathers identified five ways that they promoted the health of their children and aimed to help their children avoid illness and injuries. This chapter begins with a discussion of the emotional bonds that fathers formed with their children as a means to foster close relationships and keep their children from experiencing poor self-esteem, drug or alcohol use, mental health issues, or difficult transitions to adulthood—issues which some fathers acknowledged experiencing themselves. The chapter then moves to a discussion of mundane hygiene care and how the tasks of bathing, diapering, and clothing children were aspects of children's daily routines that fathers' contexts at times allowed them to participate in and at others created barriers to their involvement. This chapter also discusses fathers' perceptions of nutrition as a part of children's health as well as father's efforts to provide and prepare healthy foods for their children in the context of socioeconomic and residential limitations. The chapter concludes with discussions of how fathers intervened in their children's environments to prepare and maintain healthy spaces for their children to spend time. Fathers' discussions of environmental control also

reflected keen awareness of the dynamics, hazards, and safe spaces in their communities and how they navigated these factors to keep their children and themselves safe.

"Love's a Part of Everyone's Health:" Fostering Emotional Connections with Children

As noted earlier, fathers' perceptions of pediatric caregiving included attention to children's mental health and these understandings also extended to their ideas of preventative care. Of the 44 children in the study, 30 were under the age of three, and all but one were under the age of 10. Given the young age of these children, young men had little experience providing care to address discretely diagnosed mental health issues among their children. Thus, fathers' ideas about caregiving around their children's mental health were prospective in nature and focused on ways that they may prevent mental and emotional conditions from developing. This attention to children's emotional needs presented opportunities for fathers to engage in emotion-work with their children and model emotional regulation for their children.

The primary way that fathers identified to promote their young children's emotional health was to build connections with them and—almost more importantly—maintain these relationships over time. The emphasis on maintaining relationships with their children was largely drawn from their histories of disconnection with their fathers and experiencing the emotional consequences of these losses. Frank (22 years old) discussed how not having a relationship with his father made him especially sensitive to the pain caused by losing a father and he aimed to be present with his son so that his son would not experience similar pain. He shared,

> It pays a big toll as to how I am with my son now. Because like, when I was growing up, I played football. He was never at the games and sometimes you look forward to seeing him be there. Say you do something good you just be right there, you just look up to that. It make you feel better. As a child, you be like "yeah!" So different little things. Like the littlest things help. He always…Say, for instance your father tell you one thing but it never happen, you, like "dang, what's…." Then sometime you be thinking that it's something you did but you don't want the child to feel bad about himself, probably it was his fault or something… Wonder why you can't…why, what's going on…sometimes you get to questioning. Like, "Why?" And then another thing, say you see your next, your friend, they father right there, you could look be like, "dang. It look like they having fun together." And then you just be like, dang, I wish I had my father with me. It's just a whole lot too.

Fathers' sentiments of being motivated to remain present in their children's lives are consistent with prior studies noting generative themes in men' constructions of their fatherhood role (Roy & Lucas, 2006).

Emotion-work with their children represented a way for fathers to buffer against the hazards of growing up in the face of structural barriers, adverse socioeconomic circumstances, and the discrimination that pervaded their environments. Fathers believed that they could promote their children's emotional health by being present, forming, and maintaining relationships with their children. Charles (20 years old) grew up in the southeast part of the City—an area with the highest poverty rates, lowest performing schools, highest murder rates—and was worried that his son would be growing up there as well. This concern further motivated him to remain present in his son's life,

> He's already in the environment I used to be in. Where I live uptown but he lives in Southeast. I grew up in Southeast. I know how Southeast is. Even though, and even though it's way calmer from where I was coming up, even when I was coming up, it was slowing down but it wasn't as slow. So…who's to say what Southeast is now with them rebuilding and bringing more Caucasians into the neighborhood and whatnot. But even still, you still got people that's still there with that mindset, "I'm nothing, I'm a Black piece of trash," type. You know what I'm saying. I don't want him to grow up doing that because that' s how I felt. Like I had teachers that telling me that I wasn't gonna make it to see 21 and 18…At a young age. He don't need that, man. No child needs it.

Charles saw his involvement with his son as having the potential to protect his son from the deleterious effects of living in toxic structural contexts that stood to erode his son's self esteem, self-efficacy, and ideas of his future. Through his continued presence, involvement, and connection throughout the course of his life, Charles was saving his son—even from a young age.

Fathers sometimes encountered challenges to being emotionally present with their children, particularly when their own mental and emotional health was compromised. Personal histories of experiencing or witnessing trauma, losing close friends and family members, and for some men, the instability in their relationships with the mothers of their children caused emotional disruptions that made it hard to be emotionally present with their children. Jamaal (20 years old) had an extensive trauma history that included witnessing domestic violence between his parents, experiencing community violence as a witness, victim, and participant, as well as losing peers to violence. These emotional burdens contributed to and were compounded by his troubled relationship with his mother as well as with the mother of his child. Taken together, there is little wonder why Jamaal had been living with major depression for several years. He discussed how his mental health affected his ability to meet his child's emotional needs:

> I don't know if it's like a family trait or something, but we all like (inaudible) depressed. I might have put on the paper that I'm not 'cause I don't feel it right now, but I really think I have a disorder, a depression disorder. I don't feel as if I want to kill myself or anything, but sometimes I get real deep in thought about the bad stuff I go through, and it kind of shuts me down. I get real anti-social. I don't really wanna bother with too many people. I can't do that if my son asks me for something. I gotta respond to him. I gotta interact with him, let him know that daddy's still here. I'm not completely gone.

Jamaal's story also illustrates that fathers prioritized caring for their children's emotional needs even while facing emotional challenges of their own. His acknowledgement of feeling depressed is especially notable given the stigmas surrounding mental health issues that urban, African-American, young men confront when contemplating their mental wellbeing and possible care (Lindsey, Joe, & Nebbitt, 2010). That he verbalized his feelings—and those of his family members—as "depression" may suggest that he was experiencing especially acute symptoms. Other fathers were likely experiencing unidentified, undiagnosed, and untreated mental health issues but display symptoms (i.e., including anger, irritability, and using marijuana or other drugs to cope with emotional distress) that are often incorrectly labeled as "behavioral" disturbances instead of being identified as mental health issues (Prempeh, 2013). Attempting to be emotionally available and responsive to children's needs in the midst of experiencing one's own mental health issues required substantial, purposeful effort and represented a an internal context that challenged fathers' emotion-work with their children.

Jamaal recognized that his depressive symptoms inhibited his ability to respond to his child and be present for his son. His story highlights how fathers' health was inherently linked to their children; children's health outcomes are dependent on the wellness of their parents, including fathers. Whereas the iterative relationship between mothers and children's health has been examined in prior research, less is known about the interrelationships between fathers' and children's health (Pak & Allen. 2012). Jamaal's story suggests that understanding children's health cannot be separated from

examining fathers' health and involvement; as a corollary, father involvement should not be understood outside of examining men's health.

Driven by their difficult pasts with their own fathers and the mental health issues that some were experiencing, fathers included attending to children's attachment needs as an important part of caregiving. Fathers' notions of emotional caregiving were interwoven with men's ideas of health promotion and reflect a keen awareness of the importance of attachment and forming secure bonds with their children. For Tevin (19 years old), providing love was an important part of his caregiving as a parent. He noted,

> Love is a part of everybody's health. You know it shows cause I don't want him to feel like you know that he just has a little bit of my love you know so I give him all of my attention. You know, good for his health. I play around with him, you know holding him, hug him, take pictures with him. You know he practically took over my whole Instagram, you know me and him taking pictures and things like that and yeah and then sometimes we go out and have a little father-son day.

Tevin's remarks highlight fathers' intentionality around promoting their children's health through emotion-work. Whereas these actions are often overlooked as natural part of parenting, fathers' engagement in these behaviors reflected purposeful efforts to address their children's needs. Tevin's narrative also demonstrates that emotional caregiving that reached beyond the dyadic relationships between fathers and children. Including his son in his social media accounts and taking time to spend with him reflected Tevin's bonds with his child. With these public declarations, fathers affirmed their relationships with their children by communicating pride for their children, love, and their connections to others in their social networks. Fathers proactively cultivated emotional security by acknowledging their relationships with their children and introducing them to social circles where they received support.

Diapering, Bathing, and Clothing: Routine Hygiene Caregiving

Fathers' understandings of prevention also included attention to children's hygiene and nutrition. These mundane aspects of caregiving required regular, focused attention to recognize when to provide care, as well as flexibility in responding to children's mundane but unplanned (i.e., diapering) care needs, thus at once framing and interrupting fathers' daily routines with their children. Spending time with children provided fathers with opportunities to attend to children's routine hygiene issues but fathers needed to navigate complex contexts—residential status, community safety and resources, space and distance, relationships with children's mothers—in order to have access to their children and be involved in this aspect of caregiving.

When children stayed or were living with their fathers, feeding and attending to children's hygiene were often the first of many daily caregiving tasks they completed. Although Wayne (18 years old) did not usually sleep in the same house as his son, he lived in the same neighborhood and walked over to his son's house most mornings to spend the day with him. Separated from his son by virtue of their respective living situations, Wayne traversed this distance so that he could participate in his son's quotidian health routines. Wayne's discussion of pediatric caregiving began by highlighting how nutrition and hygiene fit into the time he spent with his son:

> Food, you know food clothing, hygiene's. Yeah food, clothing, hygiene's and that's it for real cause basically food and hygiene's and stuff like that and I keep my hygiene's up, I keep my hygiene up and I keep little Mark's too. Yeah mostly little Mark and me too. Like when I go out to eat or when I go in the house I put his clothes on and I might see a cold on his lip. He don't never want me to touch it but I do anyways, I don't care if he cry. So I'll get a wet, cold he be crying. I'm like chill. Sit him down, he be crying. Put lotion on him, on his face and then yeah he be good cause he just be waking up. His little eyes be crusty. I put lotion on him and I go to daycare, we good.

Wayne drew parallels between maintaining his personal hygiene and caring for his son's. This shared experience became a way for him to bond with his son and demonstrate competence as a caregiver. His narrative also illustrates how daily hygiene routines provided opportunities for noticing abnormalities and monitoring for changes in children's health. His narrative also speaks to how addressing children's hygiene needs fit into fathers' daily routines. Wayne dropped out of school and was out of work but Natalie was still attending school, if inconsistently. Although not always the case, many of her absences resulted from her childcare—usually Wayne—falling through. These childcare hiccups—and disruptions in Wayne's daily caregiving— often followed their arguments. When Wayne and Natalie were getting along well, the lack time constraints imposed by work or school allowed Wayne to spend many of his days watching his son while Natalie went to school. Arriving early in the morning afforded him the opportunity to take care of some of his son's morning routine and allowed Natalie to depart on time.

Children's age shaped the type and intensity of fathers' involvement in maintaining children's hygiene. Infants largely determine the timing of feeding and sleeping patterns during the immediate postnatal period (Fiese, Winter, Sliwinski, & Anbar, 2007). Over time, parents shape infants' routines and schedule (St. James-Roberts, Sleep, Morris, Owens, & Gillhan, 2001). As much as regular bath times and meals shaped the daily rhythms of the time that fathers spent with their children, caring for children's hygiene also required flexibility to address unexpected issues that arose, particularly when children were young. Whereas changing diapers became a routine part of fathers' daily care for infant children, addressing these needs while they were outside the house (i.e., running errands, taking children to appointments) could be complicated by

the lack of community resources available to fathers to facilitate their parenting. Tom (23 years old) was a single parent with a 3 year-old daughter. Although his daughter had been potty trained for some time prior to the interview, he discussed how men's restrooms were not equipped to support fathers' caregiving efforts,

> I go into bathrooms and they don't have the changing table like they would have in the women's bathroom, or seat covers or little stuff that I notice where the whole system is…like programs like this don't really exist for men. That whole WIC thing really is for women. When I got it, they looked at me crazy but I needed support.

Tom was keenly aware of the resources that were not available to him as a father. This awareness was heightened by experiences and knowledge that there were resources available to support mothers' roles as caregivers that were not targeted towards fathers. His narrative highlights how gendered expectations of pediatric caregiving translate into structural barriers that inhibit fathers' abilities to care for their children's needs. Nonetheless, Tom's narrative illustrates fathers' responsivity and creativity when faced with barriers to their caregiving efforts (Marsiglio & Roy, 2012).

Consistent with prior research examining low-income fathers and families, fathers in the present study reported that mothers expected them to contribute materially to their children's care, which included providing diapers (Roy & Burton, 2007). Young men, however, faced financial challenges that impeded their abilities to purchase diapers for their children. Fathers' inability to consistently provide diapers for their children became a source of conflict between young fathers and mothers. As discussed earlier, Wayne spent most days with his son but his current disconnection from school and work largely enabled this. Unemployed, Wayne had little access to financial resources and was often unable to keep up with how quickly his son needed a new box of diapers. He noted that

this issue often contributed to conflict between with his son's mother, Natalie, including early in the morning on the day of his interview,

> Like this morning she say the pampers, they bout to go away and I was thinking in my head like yeah you gonna let it waste then you gonna call the nigga. Then she just went shopping last week and I was spending time with Mark, I'm talking bout the whole Saturday. From ten that morning to seven that night she was with her friend going shopping. I'm like okay. So I'm spending time with him. So I bring him in the house, I see her friend leave. I'm like okay since you go shopping today why you ain't get him no pampers? Huh? Why you ain't get him no pampers? She ain't have nothing to say so I was alright. I take little Mark out the house. I take him to the playground. Came back in the house at nine. Washed him up and then I left man cause all this is about him. So I tell why you ain't buy him no pampers? She said she ain't have nothing to say.

Wayne's narrative highlights how the financial limitations facing both fathers and mothers constrained their abilities to provide for their children and contributed additional stress to coparenting relationships. Navigating these additional stressors presented an additional task for fathers and this kin-work helped fathers maintain access to their children so that they could engage in children's quotidian care.

Some fathers expressed reluctance or uncertainty, at least initially, about addressing children's hygiene needs, largely due to concerns about their concerns about hurting their children and being able to accomplish these tasks well. By the time of the interview, these activities had become routine for fathers but they acknowledge facing a steep learning curve during the transition to parenthood. Some fathers looked after younger siblings or family members prior to becoming parents and these experiences helped ease them into the overarching responsibility of caring for children's daily hygiene needs. Smith (21 years old) explained how caring for his nieces and nephews gave him a base of caregiving information he thought would help him care for his son,

> I was ready because I have ten siblings all together, so it's a whole gang of us. I raised my nephew and two of my nieces while my sisters worked very strenuous

> hour jobs. And this was like they were in their very younger years, so I was bottle-feeding them, and it was the baby. So I was already ready before he even came… I can change a diaper. I can make a bottle. I can take them to the doctor's. I can go down the checklist to see what was wrong.

Fathers with less experience, however, were less familiar and comfortable caring for their children's hygiene needs. James (22 years old) had a five year-old daughter from whom he was disconnected and an 18 month-old son with his current partner. He conceded that he was uncomfortable and at various points uninvolved with caring for their hygiene needs. He noted,

> Even though I had a daughter, even though we had our first son but it was like I'm still a new father because I wasn't really a father too much to both of them. So I was still a new father so it was like I had to get in the habit and even Porsha, my girl, she was saying that she felt like that I just wasn't ready and I was telling her it's not like I wasn't ready it's just that I'm still new to this. I don't want to sit here and so anything. I will change his pamper. I don't know if I'm changing him right. Even with my daughter. I didn't really change my daughter. I had my mother to changer her, I had my sister to change her, I had Porsha to changer her. I didn't really touch my daughter and I felt more as not touching my daughter than my son cause it's a girl and knowing that her mother ain't right upstairs so that's what really made me not do anything. I didn't want to touch her.

James' fear about being accused of molesting his daughter led him to withdraw from caring for his daughter's hygiene needs; these concerns combined with his lack of knowledge about pediatric hygiene caregiving carried over to inform how he cared for his son. In a different contexts—coparent relationship and child gender—where he was not worried about being accused of abusing his child, however, he was able to learn how to care for children's health needs. Over time and with opportunities to practice caregiving skills afforded by living with his son and the security of his relationship with Porsha, James developed confidence about his ability to provide care for his son. His confidence about his recently-acquired caregiving skills stood in stark contrast to how he felt about

caring for his daughter. Describing his confidence about being able to care for his son's mundane health issues, he shared, "now, I got it down pat."

Montana (21 years old) was away at college when his daughter was born and for the first few months of her life. Although he was able to come home a couple times during each semester and spent all of his time with his daughter, these brief visits were not enough to help him begin feeling comfortable changing, bathing, and clothing his daughter. He noted,

> Like for instance, like when she was first born I was scared to like pull her arm too much putting her shirt on, and now I'm still like that. I give her a bath, I don't mind it, giving her a bath, but the clothes, I just feel like I'm too rough, I'm hurting her, but it's not hurting her. Like my fiancé said the other day, "She's not small anymore. She's not a month anymore. You're not going to hurt her." But it's all about being comfortable, being comfortable.
>
> (What do you think helps you get more comfortable?)
>
> Having my fiancé there helping me, helping me do things that she does on an everyday basis when I'm at school, that helps me get comfortable with it. Like now I am home for a break, this is my first time keeping her like by myself the whole day, like the whole day is just me and her. It's usually been a couple hours, but not the entire day. Now it's the whole day, because my fiancé is at school. She goes to school from, she leaves out about 9:00, gets back at about 4:00, so this is my first time consistently every day it's just me and her, me and her.

Montana's narrative suggests that mothers' perspectives and caregiving experience helped fathers acquire skills and gain confidence addressing children's hygiene needs. It seems, however, that experience and practice caring for their children's needs was most helpful in helping fathers transition into caring for children's hygiene needs.

As much as fathers acknowledged the importance of maintaining children's hygiene, there were times when they were unable to make sure that this was maintained. Unsuccessful emotion and kin-work with the mothers of their children sometimes

presented the conditions where fathers were not able to participate consistently in children's preventative care. Angel (19 years old) was recently divorced from his wife, the mother of his two children. Following their divorce, she and the children moved in with her mother who lived in an outlying area in an adjacent state. Without a car, Angel was unable to go see his children and found that his contact with them depended on her bringing the children to him. During one of these occasional visits, Angel noticed that his son's (2 years old) dental health was lacking,

> When he comes back, I found out that because all she did was give him milk to drink, his two front teeth are seriously rotten. You can see the inside. They're off. I'm like what was you doing that actually made my son like this?

In general, and barring an undiagnosed condition, his son's dental issues could have been prevented through regular brushing. Angel attributed his son's poor dental health to his mother's negligence. He also noted that his daughter was also experiencing poor hygiene,

> My daughter's hair was dirty as hell when I went to go get her, hair stunk. I literally just washed my daughter's hair. I was in there just washing my daughter's hair because I'm like, alright, this is what needs to be done. Because the simple fact is that I don't see why my daughter's hair is that damned dirty, but hey, I guess you're doing whatever you're doing.

Few other fathers distrusted the mothers of their children to this extent, although some disagreed with some of the mothers' decisions. Spending time with children allowed fathers opportunities to participate in children's daily hygiene routines and ensure that their children were well cared for. It is important to note that the dental and general hygiene issues that Angel observed likely happened over an extended period of time. Separation from children—particularly when extended over time— impeded fathers abilities to monitor children's hygiene and ensure that they were receiving adequate care.

Accessing Healthy Food and Shaping Children's Diets

Descriptions of healthy diets for children aligned with generally-accepted notions of healthy diets that emphasize the consumption of fruits, vegetables, and lean proteins while limiting foods with high levels of fat and sugar. Young men's involvement in monitoring and shaping their children's nutrition began early, often during prenatal period. This involvement represented one of the first ways that fathers enacted emotion and kin-work with mothers in order to care for their children's health. Fathers were attentive to the amount of water that their partners drank and the types of food that their partners consumed during pregnancy. Isaiah (20 years old) attended a prenatal parenting class with his partner, Tamara while she was pregnant. Those classes emphasized teamwork and encouraged parents to seek ways that they may work together for their children, including around prenatal nutrition. Isaiah discussed how he encouraged Tamara to eat healthy food:

> I just think when he was not here I just made sure Tamara just ate stuff that was healthy cause normally Tamara, she just, when she went through crave moments all she wanted was Taco Bell. What Taco Bell gives you a lot of stuff like it gives you your vegetables, which is your lettuce, tomatoes I mean your food and stuff, Taco Bell gives you a lot. But KFC or Popeye's or and I let her eat Chipotle but far as like carryout this day, I mean Popeye's this day then Popeye's the next day then Popeye's after that, no. Wouldn't go down like that. Its gonna be Popeye's this day, its gonna be a home cooked meal that day, another home cooked meal after that day and then it'll be Taco Bell or whatever else she wanted. So I mean I just had to make sure she, her and me and her mother both made sure she ate what she supposed to eat…It's like she ain't have no choice but to sit right there and be like "ahh I got to eat this." So she, she eat it. She made sure he ate a lot. So we ain't really have to worry bout going to the hospital unless she had to have her checkup about Izzy on how he doing, stuff like that. I mean she took its more so she took care of herself. If she knew she had to eat that, she knew she had to eat that. You know if she didn't want to eat it she knew she still had to eat it. So basically it was more so like she went with the flow. She found out what he wants and then after that she just kept doing it. Water, stuff like that.

Isaiah's narrative highlights the delicate balance that young fathers aimed to strike between accommodating their partners' cravings and promoting healthy eating for their partners. His narrative also indicates that other family members and kin reinforced healthy prenatal eating habits, thus reinforcing fathers' efforts to promote the health of their unborn children.

As much as fathers aimed to promote healthy eating during pregnancy, they recognized that their influence was limited by their partners' receptivity to their input. Tamara's brother, Jamaal (20 years old) and his partner were pregnant with their second child at the time of the interview. He found that his partner's dietary decisions sometimes diverged from his ideas about healthy eating:

> I mean I could try to in a way. I tell Nina to drink lots of water, like the daughters tell her to eat more healthy, but that's her body. She does what she wants to do. If she wants to go eat McDonald's, she's gonna go eat McDonald's. I see how it can make you excited; she wants to go eat McDonald's, so she does that. I don't think it's good to drink coffee while you're pregnant, and she kinda still does that. So I try to suggest food and drink for her. She does what she wants to do. I try to promote her health. I could do more when she's out of Nina's belly, you know.

Although fathers were able to influence mothers' health behaviors, including nutrition, prenatally, Jamaal's discussion highlights that this ultimately fell outside of their direct locus of control.

Isaiah and Jamaal's narratives also illustrate how the community spaces in which young men fathered limited the food options available and, at times, constrained their abilities to provide healthy food for their children. Promoting healthy eating habits for their partners and later children was particularly challenging given the limited food options available in communities where expectant fathers and mothers lived. Living in food deserts—areas with inadequate access to fresh, affordable food, which, in the urban

context is usually characterized by the lack of access to full-service grocery stores—contributed to the unavailability of healthy food options for young fathers and their families (Ashbrooke & Roberts, 2010; United States Department of Agriculture, N.D.). There were few full-service grocery stores in the neighborhoods where fathers lived. Of the 43 grocery stores in the City, only 12 were located in geographic proximity to where most of the fathers[10] (n = 22) in the present study lived; there were 19 grocery stores in the two wealthiest areas (Ashbrook & Roberts, 2010).

Fast food chains, carryout restaurants, and convenience stores, however, were widely available in these communities. These establishments, while affordable and accessible, had fewer healthy items available for purchase. As Isaiah's discussion indicates, fathers aimed to limit how often they purchased fast food for the mothers of their children and encouraged home-cooked meals as healthier alternatives.

The birth of their children presented opportunities for fathers to shape their children's diets more directly. Isaiah (20 years old) lived with his son and child's mother in her mother's three-bedroom apartment. Isaiah was exceptionally conscious of nutrition and had developed unique ideas about holistic nutrition to maintain his health. The importance that he ascribed to nutrition extended to his approach to feeding his son, Izzy. When discussing how he was involved in feeding his son, he noted:

> Make sure I feed him his bananas. Make sure he get a cup of milk, probably in the morning, at night. But during the day he eats his vegetables or he gets home-cooked meals. Like, we don't too much of the carryout like we go to McDonalds

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[10] The remaining fathers (n = 7) lived in an adjacent state but reliable information about grocery stores in their areas is unavailable. Anecdotally, it bears noting that the areas where these fathers lived were not "walkable" communities, thus requiring fathers to have access to a car or public transportation if they desired to go to the grocery store. Public transportation in the outlying areas of the state, however, was scattered and far inferior to that which was available in the City.

> and buy French fries or Wendy's and buy a burger or something, we don't do too much of that. It's mainly what we got in the house we gonna work with. Make sure he gets his protein, his vitamin, all that in one meal. I mean the whole meal might not be healthy. Of course you got some meat or some starch on there but I mean it don't be like gravy with a bunch of fat and stuff like that—chicken, fish and stuff. Sort of stuff like that. But like pork chops or what else would I say…Like ribs or stuff that got pork and bacon lot of stuff that got lots of fat on it? Naw cause we know he ain't gonna, he ain't gonna do well to it …If you went, I mean you been in my kitchen I know you seen like wheat bread, bananas, grapes, apples, oranges, stuff like that. And a lot of vegetables.

As alluded to in the comments above, fathers preferred home-cooked meals over feeding their children fast food. Home-cooked meals allowed fathers to have greater control over what their children ate and to ensure that their children were consuming foods they deemed nutritious.

Who cooked these meals offers insight into the fathers' roles in their families, the division of labor between fathers and mothers, as well as fathers' daily routines and residence with their children. Fathers discussed sharing the responsibility for cooking with other members of their households and with the mothers of their children. Jamaal (20 years old) moved in with his partner, Nina, and their son at her parents' home about three months prior to his interview. Although her parents disapproved of their relationship, they allowed Jamaal to move into their home when his mother kicked him out after a series of arguments about his behavior. This also coincided with Nina becoming pregnant with their second child. Having moved into their house, Jamaal, Nina, and her parents had a tacit agreement that he and Nina would function as an autonomous family unit for most matters, including food and cooking. He noted,

> Who Cooks??? We up in there usually doing the cooking for our family, but we kind of buy groceries for ourselves. We kinda living in somebody else's house; we're trying to work on our own. We're starting our family, so goodbye groceries for ourselves. We cook with ourselves. Everybody else does what they do.

Jamaal was both resident and guest in Nina's house. Given his tenuous status and the anticipated arrival of their daughter, both Jamaal and Nina felt pressure to alleviate the burden that their presence might have for her parents, thus contributing to cordoning off food and cooking responsibilities in the house. With this arrangement, both he and Nina cooked meals for their family.

Whereas most fathers discussed doing at least some cooking for their children, some fathers noted that others tended to cook more often. Tevin (19 years old) lived with his parents. His son and his partner stayed with him throughout the week but went to spend the weekend with her family in a nearby city. Whereas he might warm prepared food for his son, he noted that his mother and partner did most of the cooking for their son,

> Well I really don't cook like that so either mommy or my mom you know cook things like that or I probably make you know little some something for him, like chicken nuggets and things like that, but mainly mom and my mom.

Fathers' residential status with relation to their children also contributed to how they divided cooking responsibilities. Alvin (20 years old) generally saw his son, AJ, every day but AJ usually stayed with his mother. The weekends, however, provided opportunities for AJ to spend the night at Alvin's house. Whereas AJ's mother cooked his meals for him during the week, Alvin cooked for him on the weekends. He noted,

> For the most part, he don't really stay too long. He'll just come over on a daily basis, but he always goes like home with his mom. And when he's here, it's just wake up…. Like I wake up, he wake up or I wake up first and then I pretty much try to like tidy up the house and figure out what we're going to eat for breakfast and if we going somewhere, I make sure he's nice and fresh. But if we just laid back then we just, you know what I'm saying, I just wake up, cook, let him walk around do what he do, watch TV, and feed him. Make sure he nice and full and then we just kick it.

Co-residing with fathers allowed men opportunities to incorporate cooking for their children into their daily routines. By contrast, living separately presented fewer opportunities for fathers to participate in this aspect of caregiving. Living separately or raising their children in households that were not their own also left men with less control over nutritional choices for their children. Delonte (21 years old) spent most days with his son and partner in the apartment where she lived with her mother and grandmother. Although he was able to cook some meals, particularly when her mother was absent, he was not able to cook as often when she was home. He did not, however, like the way that she cooked. He shared,

> It's like, sometimes it's her, sometimes it's me. Because her mother don't…see, I cook like my grandmother, like my grandmother could cook. I cook like my grandmother and her mother don't like it. Like, I like my stuff real, real, real done. Like her mother stuff wanna be soft and all that. I don't like it like that because then if I touch the soft part, I'm gonna spit it out because I be thinking it's not done. And my grandmother taught me how to cook—and my mother…Like her mother, her sausage, sometimes it be red meat in the sausage.

Fathers navigated kin relationships to obtain the spaces necessary for providing (directly or through kin), preparing, and serving nutritious food for their children. Fathers may be concerned about the quality or preparation of the food that their children consumed while in others' care. Cooking for their children represented a way for fathers to control what their children ate as well as contribute to the households where their children spent time.

Fathers' personal dietary habits also led some men to feed their children less-healthy foods. Andre (25 years old) enjoyed sugary snacks and drinks, and would often bring them for his son when he came to doctors' visits. Our interview occurred during one of these visits and discussed what he fed his 18 month-old son:

> Depends. I ain't gonna lie. Me, I give him snacks. I give him cookies. During the day I give him cookies, chips and stuff. Fruit snacks and all that, I ain't gonna lie I don't feed him healthy a lot of times. But I do make sure he get a full dinner, like he does love his greens and vegetables. He eats them. He eat all the food groups. He eat healthy.

Andre's penchant for unhealthy snacks translated in the snacks that he provided for his child and was aware that these were unhealthy, especially as often as he gave them to his son. Andre noted, however, that mealtimes provided an opportunity to feed his son healthy foods. The discordance between Andre's reports about his son's mealtime and inter-meal diet highlights substantial variation in the types and quality of foods that some young fathers made available to their children.

Food insecurity challenged some fathers' efforts to provide adequate food for their children. Faced with this constraint, fathers and their families limited the types, quantity, and circumstances under which they would consume food. This strategy was aimed at conserving their resources so that young children had at least some access to healthy foods. Los' (20 years old) family had had a history of housing instability during his childhood and moved more times than he could remember. He currently lived with his mother, stepfather, and older sister in an apartment in the southeast section of the city. The small amount of cash and nutrition assistance they received were not enough to provide adequate food for every member of Los' household. In describing how his family navigated food insecurity, Los noted:

> Yeah. We be struggling sometimes but we alright though.
>
> (Not really alright, you just alright.)
>
> Yeah, just making it pass.
>
> (How do you guys do that?)

> I mean, we just got to make sure we don't eat up everything. Care about the other person in the house. Make sure they have something to eat too, know what I'm saying?
>
> (Are you often hungry?)
>
> Oh naw, I be alright. Like me, I make sure I eat but I make sure my mother eat most definitely. Like I wish I had a job, help out around the place and stuff. That what I been looking for lately.

Los' narrative[11] suggests participation in coordinated kin-work to share limited resources among the members of the household. Limiting food intake and considering the needs of other household members represented a means for fathers experiencing food insecurity to stretch limited resources. Fathers and families with young children may experience additional pressure to conserve their food intake because not only was there another person to share with, they also aimed to provide nutritionally-dense food for children. Los further explained that despite the food insecurity facing his family, he and his family found a way to ensure that they had adequate food during his three year-old son, "L-Dub's," visits:

> I mean, like yeah but sometimes in my house we be running short on food sometimes, but we be cool about. Because he don't never be over there all the time, so when he do come we make sure we got enough food for when he staying over there and stuff. Like all the stuff he like to eat and stuff.

Healthy foods—including fresh produce that fathers discussed including in their children's diets—however, tend to be more expensive than less nutritious, calorie-dense foods accessible to low-income families and widely available in low-income communities (Cortes, Milano-Ferro, Schneider, Vega & Caballero, 2013; Rao, Afshin,

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[11] Discussing his family's food insecurity was challenging for Los. I had worked with Los for about two years at a local high school prior to this interview but had not known until that day that his family did not consistently have enough food to eat. As I spoke with him about this, I got the sense that he was embarrassed that his family experienced this issue.

Singh, & Mozzafarian, 2013). Meeting these needs can be especially challenging for young fathers because their access to financial resources and employment is limited. Moreover, nonresidential fathers are often ineligible (due to not having established custody, undeclared paternity, and public assistance policies stipulating that only one parent may receive assistance for a given child) for nutrition or supplemental cash assistance that would aid them in providing food for their children during visits. Thus, food resources may be especially strained for fathers and their households when their children visit and may exacerbate food insecurity in the time leading up to visits.

Faced with difficult decisions about how to manage scarce resources, Los' example suggests that some fathers and families facing food insecurity prioritized the nutrition of younger children at the cost of nutritional quality or food availability among older family members. Although Wayne (18 years old) did not live with his child, he visited his 18 month-old son, who lived with his mother and maternal grandparents almost every day. Wayne limited what he ate so that his son and the mother of his child would have adequate food:

> So what I do, like times hard for me. I don't, to be real with you I don't eat myself. My health problems messed up. I don't eat. I eat left over food, old food and him and Natalie, they eating healthy. I eat noodles every day. That's not good for me. I might have left over food or I might have food I'll buy way before I pick him up and I'll put it on the table.

Wayne's remarks suggest that fathers may limit the quantity of food they consume as well as conserved food resources by selecting low-cost foods for themselves or food that they perceive as "extra." As Wayne acknowledged and experienced, however, these low cost foods may not contribute positively to men's health over time. Prior studies examining food resource management among families have similarly found

that families ration food or forgo meals in service of ensuring that the youngest children have food (Cappelini & Parsons, 2012; Devine et al., 2006). The self-sacrifice of fathers found in the present study also resembled mothers' prioritization of meeting children's needs in the face of limited financial resources and time demands (Roy, Tubbs, Burton, 2004). The present study, however, represents the first to uniquely identify these food management strategies among fathers.

Controlling Household Environments

Whereas most aspects of pediatric caregiving involves behaviors directed at children, environmental control reflects fathers' attention to external factors around children that stand to detract from their health. Children spend the vast majority of their time indoors, particularly in their homes and maintaining a clean and safe environment within their homes represented a way that fathers helped prevent illness and injury among their children (Xue, McCurdy, Spenger, & Ozkaynak, 2003). Poor housing conditions,[12] overcrowding, and fathers' variable living situations, however, challenged fathers' abilities to make sure that their children's home environments were healthy.

When possible, fathers responded to these contexts by removing environmental hazards themselves (e.g., cleaning, dusting, blocking off stairs or doorways). Alvin (19 years old) lived in a two-bedroom apartment with his mother and grandmother while his

[12] Unfortunately, little statistical information is available about the quality of the housing stock in the City. A report generated by the American Association of Retired Persons suggests that a higher proportion of DC residents live in inadequate housing (i.e., overcrowding, incomplete plumbing) than residents of other states. Rent also represents a greater proportion of DC residents' monthly income than those living in other areas of the country.

son lived in a nearby neighborhood with his mother. When thinking about how he prevented his son from getting sick, he shared:

> I just try to keep him in a healthy environment man, like if I feel like it's too cold outside, we might not go out. It's like, my room pretty much room temperature man. It's always like this, even in the summertime, but in the winter it feels good that it's like this. So I just try to keep him in and make sure my room's clean and when I used to go over his mom's house I make sure it's clean too. I clean up over there too.

Alvin's remarks illustrate fathers' attention to environmental factors both inside and outside of the home impacted their children's health. Environmental control refers to fathers' efforts to prevent illness and injury by mitigating the risks that children's physical contexts posed to their health and wellbeing. Fathers' environmental control behaviors included paying attention to weather conditions that may impact children's health, removing environmental hazards from their homes and other places where children spent significant time, as well as protecting children from community contexts that threatened children's safety. Young fathers' inclusion of cleaning as a way that they promoted their children's health is striking in light of gendered understandings of domestic work and parenting that relegate these tasks to mothers. The findings from this study suggest, however, that caring for their children's health needs required young, low-income men to enact the fatherhood role in ways that defied "traditional" notions of fatherhood and gender-based, domestic divisions of labor.

Environmental control also included keeping children away from hazards that threatened their safety within the home. Proactive efforts to promote safety included safety-proofing areas where children spent time. Whereas doing this for the entire house was not often possible, fathers accomplished this by creating boundaried safe spaces for their children within their homes. Within these boundaries, they created safety in a

variety of ways, including placing plastic plugs in outlets, removing hazardous materials, and moving furniture. Fathers preserved these boundaries by using physical barriers that would keep children confined to certain areas as well as through verbal warnings to children when they ventured outside of their designated safe areas. Brian (21 years old) lived in a small, two-bedroom apartment with his mother. He shared how he relied on both boundaries and monitoring to keep his son safe within the house.

> We all be here or upstairs in my room, and I can always keep my eye on him. I don't never leave him. If we down here I sit on the couch and watch TV, leave him right here with me to play, or if we're in the basement I go in the basement and he would just play in the basement, but I would just never leave him by himself…He can go anywhere in here, except for the kitchen and the bathroom, but anything else.

Brian's narrative highlights that fathers' safe zones were not necessarily static locations but fathers recreated and adjusted them as they moved about in their home. Despite their best efforts, fathers could not anticipate every danger that their children might encounter while in the home. Therefore, fathers relied on their monitoring efforts to intervene when the home environment presented an unexpectedly dangerous situation or their children discovered a hazard that fathers had not previously noticed. Denzel (18 years old) lived in the basement apartment of his mother's townhouse. His 10 month-old daughter recently began crawling and he discussed his efforts to maintain a safe space around his child as she played:

> I'm [going] to definitely pay attention to what she do and what she surrounded by. Sometimes I be down here playing a game, I'll put her on the floor to crawl around and then she'll just probably go to an outlet with one of those little cords. Then I hurry up, just put the controller down, just bring her, and drag her from it or something like that. She'll fuss about it, couple seconds later she'll be over it then she'll be playing with something else. Mya's the type of baby, you show her anything she'll grab it. She might try to bite it or eat it or just hit you with it, but you put it in her face she going to interact with it. I just try to be careful not to show certain things and leave certain things around.

The presence of children peaked fathers' awareness of otherwise mundane objects in their environments that could be dangerous to their children. Fathers also understood that their supervision was required to keep their children from encountering these hazards. Denzel's narrative also suggests that at least some of fathers' monitoring of children and their environments occurs while parents are doing other tasks. His remarks were made in the context of discussing his hobby of playing videogames and enjoying having his daughter with him while he played. As much as he tried to anticipate her behavior and preemptively remove hazards, Mya inevitably found things that could hurt her. Whereas Denzel insisted that he was able to catch his daughter before she encountered objects that hurt her, his remarks suggest that fathers may be distracted from their efforts to control their children's immediate environments when they were simultaneously attending to others tasks and activities. The division of parents' attention and lapses in supervision may place children at greater risk for experiencing preventable injuries (Landen, Bauer, & Kohn, 2003; Morrongiello, Corbett, McCourt & Johnston, 2006).

The dynamic nature of fathers' relationships with mothers and the extent to which they "stayed"[13] with their children, however, threatened their abilities to engage in children's daily routines and directly shape their children's home environments. Alvin (20 years old) had long lost count of the number of times he and Shaunice, his son's mother, had broken up and resumed their romantic relationship. When they were together as a couple, Alvin would stay at Shaunice's house—up to days at a time—so that he

[13] Fathers referred to "staying" as spending a night (or a few) at a place that was not their home.

could be involved in his son's daily life. However, when their relationship soured, Shaunice not only rescinded the access he previously had but would allow him to have very little contact with his son at all. With the dissolution of their romantic relationship and Alvin spent less time with his son, thus leaving much of the daily tasks required to care for their son to Shaunice. When asked what she would say she did to care for their son's health, Alvin responded,

> She probably would say everything, you know what I'm saying, cuz he do live with her. She make sure he eat and go to bed on time, and that he, you know what I'm saying, washed up and nice and clean and got clean clothes. If I don't do it, I used to like wash all his clothes, but then so all that stuff got in the way. She felt like she could do it herself now like she don't want to have to, I guess she don't want to have to owe nobody credit for nothing. But that's any mom now and days. If it like "I can do it myself", when in all actually you can't, but that's probably what she would say. I wouldn't even kind of expect her to give me credit for none of that. I just feel like I'm supposed to be there to comfort them and hold them down and just be… She do everything man, she do everything. It's not really too much that's required because all you really gotta do is make sure he eat healthy and is clean and sleeps, but at the end of the day there might be a lot that goes into that too.

Alvin's remarks highlight one of his most pressing grievances with Shaunice and a constant point of conflict for them: he felt that Shaunice focused on the things he was not doing and failed to acknowledge the caregiving he provided. Moreover, Alvin believed that Shaunice excluded him from many aspects of caregiving had opportunities been available. This conflict and others led Alvin and Shaunice to end their relationship and for Alvin to become ever further removed from his son's quotidian caregiving except for weekends and days when AJ came over. Alvin acknowledged that there were few things that he needed to do to address his son's daily environment and general caregiving because his son primarily lived with his mother. Fathers' ability to stay with their children allowed them to engage in daily housekeeping and caregiving tasks typically

associated with maintaining a household with children. This residential arrangement, however, often hinged on the romantic relationship between parents and was often among the first coparenting caregiving arrangements to end when those relationships ended.

The physical conditions where young, low-income fathers raised their children also impacted their abilities to control their children's environments. Smith (21 years old) and his partner, Arlene, had a son with complex health needs stemming from an injury he suffered in the early months of his life.[14] In the midst of the criminal investigation and procedures against Smith, his parents kicked him and Arlene out of their home. They could not live with Arlene's family due to her extended family's housing instability but also because of the tumultuous nature of her relationship with her extended family and Smith's conflictual history with them. With nowhere to go, they turned to the City's homeless services agency. Most families entering the shelter system would be initially placed at a large, central homeless shelter[15] until they were either placed in one of the few transitional or permanent housing units available in the City or dropped out completely from the shelter system, which usually meant that they moved in with family members in a neighboring state. Families would often stay at this shelter for well over a year.

This may have been one of the few times that having a child with severe special needs proved to be an advantage for Smith and Arlene. Smith, Arlene, and Jackson were immediately placed in a hotel room that the City rented to accommodate overflow families when the shelters were full during winter months. What was supposed to be a

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[14] Smith's story is discussed in detail in Chapter 6.

[15] This shelter had long been plagued by poor living conditions, criminal activity, disputes and between residents. In the months preceding the interview, recently, a young girl was kidnapped from the shelter; she has yet to be found. Politicians had made promises to close the shelter but there were no alternatives to house its residents, who numbered more than 1,000.

temporary stay while the housing agency found them a permanent home turned into a year in a dark hotel room cramped with two beds and all of their respective belongings, including Jackson's wheelchair and medical equipment. Keeping the small space tidy was a challenge for Smith and Arlene and persistently spurred their disagreements. Combined with the stresses of caring for a child with complex health needs not having adequate financial resources to meet their needs, let alone change their current station, their disagreements on how to divide household responsibilities threatened, at many times, to precipitate the dissolution of their relationship.

Maintaining Children's Health & Safety Outside the Home

The majority of the children in the present study were preschool age or younger and thus fathers believed that they were vulnerable to changes in body temperature. This became especially important for fathers during colder times of the year, as when the data for this study were collected (September 2013 to April 2014). The colder weather during this time may have primed fathers to discuss the importance of making sure that their children had appropriate clothing during this season, particularly for when they would be outside. Alvin (20 years old) reflected on his recent trip to the mall and how his goals for shopping now included considering his son's needs for the upcoming winter:

> And like as far as thinking about stuff that he might need of course, like yesterday I was looking at a like some winter jackets, pea coats and stuff like that I'ma pick up for him. And his mom expressed that she wanted to get some Nike boots and some Timb's for him, so I was like alright, you know what I'm saying, he gonna need it and it ain't nothing but like forty, probably forty- forty five dollars at the most.

Having adequate winter clothing for one's children may be especially important to fathers given their children's daily routines, both when they were with them, their

mothers, and with other caregivers. Children may travel with their parents on public transportation to various places throughout their day, including daycare, to visit with other caregivers, and on routine errands (Roy, Tubbs, & Burton, 2004). Unreliable service, wait times, and lengthy walks from bus or rail stops translated into children spending an extended amount of time exposed to cold or inclement weather. Knowing that their children may be exposed to cold weather heightened the importance of providing adequate clothing for their children.

Alvin's narrative also highlights the dynamic nature of young fathers' access to financial resources. Fortunately for Alvin and his son, the winter came at a time when he had been employed consistently for a few months and he had managed to save some money. Having these resources allowed him to bear the costs of the winter coat and footwear that his son would need for what would turn out to be a particularly harsh winter in the area. Had it been a few months earlier or later when Alvin found himself unemployed, the costs of these items—modest by his own description—would have proven unaffordable.

Fathers' were also concerned about the safety of the communities where their children lived, visited, and traveled. Conflict between feuding neighborhood "crews,"[16] community violence, and heavy police presence threatened young men's sense of

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[16] The City was unique among urban centers in that it did not have a large presence of gangs in the traditional sense. Instead, the city had "crews." Whereas the definition of "crews" is elusive and beyond the direct scope of the present investigation, one can think about these groups as micro-gangs. In general, these groups were comprised of a relatively small group of youth from tightly-bound geographic areas—usually single blocks, housing projects, or for the largest crews, sub-neighborhoods. Traveling through these areas could be precarious for young men as safety—even with a given block—could be variable, dependent on who was around, who witnessed their passing through, dynamic changes in territory control, and recent feuding between rival crews.

personal security and safety for their children. Delonte's (21 years old) behavior during his interview demonstrated the concerns and uneasiness fathers felt about the neighborhoods where their children lived. The crews in his neighborhood—the same crews with whom he was formerly affiliated—were embroiled in a long-standing feud with the neighborhood crews where his girlfriend and son lived. He separated himself by disconnecting—almost completely—from peers, school, and work. By isolating himself from peers, he hoped to keep himself safe and alive so that he could be there for his son, DJ, who was now a year old. This purposeful disconnection resulted in his spending most of his time inside the house. Despite disconnecting from his peers and community, he was concerned that enemies from his past would recognize him in the community and exact revenge for his actions or for those of other members of his former crew.

Despite his fears, he spent most days at his girlfriend and son's house—albeit inside their apartment. We conducted the interview in a car parked outside of his girlfriend's apartment because, as a visitor, he did not feel comfortable requesting a private location in the apartment. As we were talking, we saw his girlfriend and son walking along the sidewalk and took a break to talk to them. Upon returning to the interview, we shared that he is "always worried about [his son] because of the neighborhood" where he lived. As the interview progressed into the late afternoon, Delonte's responses became short and he expressed feeling anxious as he watched an increasing number of young men congregating outside.[17] He eventually became so

[17] It was approximately 4:00pm when the block began becoming more populated with youths. The young men that we watched come on the block looked to be between the ages of 16-20 years old and were gathered in groups of two to four along the sidewalk. Some young men were talking with each other while leaning against the wrought iron fence and others walking about casually. Although I am uncertain about whence each of

uncomfortable by the activity outside that he agreed that it would be best to drive to a local, well-lit drug store parking lot to continue the interview.

Fathers' perceptions of neighborhood safety contributed to concerns about their own safety when they visit their children as well as the safety of children themselves. These concerns may lead fathers to restrict how they interact with their children in the community. For his part, Delonte avoided traveling with his son in that space unnecessarily and preferred to spend time with him indoors or, more rarely, take him to his own home where he felt safer. Delonte's tightly circumscribed safe space echoes Roy's (2004) findings that the low-income fathers in the present study were concerned about neighborhood safety and constrained the areas where they freely traveled and spent time in their communities to those most familiar and proximal to where they lived.

Whereas fathers like Delonte were able to adjust how they spent time together in an effort to keep their children safe in unfamiliar neighborhoods where they felt unsafe, their worries continued and even escalated when they were not present. Continuing with Delonte's story, he reported that shootings were a regular occurrence in his son's neighborhood and that someone had recently been shot in the hallway of the twelve-unit building where his son lived. This occurred on a day in the past week when he was staying at his mother's house. Although he did not know the victim and his son was not hurt, this incident reinforced his fears and heightened his anxiety about his son's safety in that neighborhood:

> It's crazy. That's why I be paranoid. I come over here because of my son over here to spend time with him and everything. She's trying to get her own place,

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the young men came, the time coincided with school dismissal and the time required for them to travel from the local high school. Perhaps some of the men had returned from school and joined with others from the community.

> trying to find a place. She don't like to be around here neither…I be worrying a lot because I don't know what's gonna happen.

Confronting concerns about safety, fathers naturally desired to move their children into safer neighborhoods and fewer threats to the security of their children. Limited housing available to them and other low-income families, however, prevented fathers from relocating and attenuated their efforts to control their children's environments.

Summary

This chapter discussed fathers' efforts to maintain their children's health and prevent illnesses or injuries that would detract from their wellbeing. Emotion-work, kin-work, as well as navigating space and distance with their children as well as the mothers of their children helped fathers overcome contextual barriers that constrained their involvement in the routine, often mundane, aspects of preventing illnesses among children. The dimensions of preventative care identified by this study include fostering emotional connections with children, attending to routine hygiene caregiving, shaping children's diets, as well as controlling children's exposures to environmental hazards within and outside their homes.

Young men's discussions of their access to spaces where they could attend to preventative health needs uncovered important information about the contextual realities in which they fathered as well as navigation strategies they employed to care for their children. Living with children afforded opportunities to participate in daily routines that sustained children's health and wellbeing, including mealtimes, bathing, and cleaning the house. Few fathers (*n* = 5), however, were themselves householders. This not only placed fathers at risk of losing housing or having inconsistent access to housing but also limited

their abilities to create spaces where children could eat, sleep, play, and where fathers could attend to children's hygiene needs. Although most fathers in the study reported spending time with their children regularly, they may not be present with some of these caregiving activities (i.e., bathing) because their visits did not coincide with the times when preventative care routines typically unfold.

As persons who were not householders and often only tenuously attached to households, fathers sometimes had little direct control over the spaces where their children spent time. An important finding from this study is that fathers used kin-work with various persons to navigate the contextual barriers to involvement in pediatric caregiving imposed by having little control over their households, unstable housing situations, and living separately with children. Although kin-work has been used to describe processes by which fathers maintain access to their children, this study represents the first to identify kin-work as a means that fathers were able to promote children's wellbeing, if remotely. From asking household members who smoke to change their behaviors around children, to discussing the types of food children eat with caregivers, to coordinating clothing purchases with mothers to make sure that children would be warmly dressed during cold-weather months, fathers employed kin-work to influence the behaviors of those responsible for their children when they were not able to accomplish the tasks themselves.

CHAPTER 6: ACUTE CARE

Consistent with prior studies of children's health, fathers in the study reported that their children were generally healthy (Schuster, Chung, & Vestall, 2011). But despite parents' best efforts to prevent illness and promote their general health, children often encounter occasional illnesses, injuries, and emergencies that require parents to provide medical care. As such, in this study, children experienced occasional illnesses, injuries, and emergencies that required fathers to provide medical care.

This chapter identifies four core dimensions of acute care—"watching and peeping," self-assessment, routine convalescent care, and emotional regulation. "Watching" and "peeping" were terms that fathers used to describe their health monitoring and targeted assessment efforts. In addition to assessing their children, fathers also appraised their own abilities to provide the care that their children needed in light of their health knowledge, prior caregiving experiences, and the resources that they had available to them. The routine convalescent care that followed spanned a broad range of caregiving activities including executing treatment plans, administering medications, and incorporating caregiving into their daily routines. Fathers also reported that they attuned themselves to recognizing and regulating their children's emotions as well as other caregivers'—particularly mothers—and their own feeling in service of facilitating their children's acute care.

Similar to preventative care, young fathers enact acute care in contexts that, at times, facilitate awareness and responsivity to children's health issues. However, the complicated, dynamic, and challenging nature of these contexts—contentious

relationships with children's mothers, living separately from children, and having limited access to financial resources—created barriers to fathers' capacity to provide acute care.

Monitoring and Targeted Assessment

Recognizing when children were experiencing health issues represented an important step in acute care. Young men described two processes—"watching" and peeping—that helped then identify when their children's health might be compromised and the nature of the health issue, respectively. Watching and peeping were related processes that centered on fathers observing their children's health. Marked by vigilance and constant awareness of children, watching referred to fathers' overall monitoring of children's health through both purposeful and incidental observations. Peeping often followed becoming aware—through "watching," mothers' or other caregivers' disclosures, as well as children's reports—that children might be experiencing a health issue. In both of these processes, fathers drew on their prior caregiving and health experiences as well as their intimate knowledge of their children to gauge their children's health. Fathers' contexts, especially their relationships with mothers and their residential situations, facilitated fathers' watching and peeping but often presented challenges that fathers needed to negotiate to address their children's health. Each of these processes is described below.

"You Gotta Watch Him"—Monitoring Children's Health

The importance of watching one's child emerged from fathers' reports of how they cared for their children's health. The extant body of literature about parents' watching of children has tended to focus on injury prevention among young children two

to six years old and on the buffering effects of parental supervision against adolescents engaging in at-risk behaviors (Laird, Criss, Pettit, Bates, & Dodge, 2008; Whereas both injury prevention and risk mitigation concern children's health, fathers in the present study attached different meanings to watching their children as a part of how they cared for their children's health.

For fathers, watching was aimed at identifying when children are experiencing health issues as an important aspect of their pediatric care. Watching included an overall awareness of their children's health and purposeful observations of conditions or symptoms that suggest that children's health may be compromised. These purposeful and incidental observations were marked by vigilance, which primed fathers to notice children's health issues through quotidian activities and interactions with their children. Fathers described this vigilance as constantly paying attention to their children's health and noted that this could be a heavy burden. Remaining vigilant and watching children, however, was frustrated when fathers were separated from their children, as in Trey's (23 years old) case. He discussed how he was constantly concerned about the asthma of his daughter with his ex-partner, which made her health something that was always in the back of his mind despite having ended his relationship with her mother,

> You never stop worrying, man. You never stop worrying. You never stop. As a parent, it's always something that's always in the back of your mind, man. It's never something that leaves you. If I write a poem, it's going to be okay. Or if I watch TV, it's gonna be fine. I don't have to think about it no more. There's always gonna be something you worry about. You can never cope with a serious problem like that.

His daughter's asthma contributed to the heightened—perhaps hypervigilant—remarks about vigilance but he and other fathers shared the ever-present concern and awareness about their children's health. Being separated from his daughter further

exacerbated his concerns as he did not participate directly in her care nor spend time observing her as he once had. Although Trey had yet to reach this point, the emotional toll of constantly paying attention and worrying about children's health could be exhausting for fathers when protracted over time.

Playing, feeding, spending time, and attending to hygiene needs offered opportunities for fathers to recognize that their children were acting differently or displayed symptoms that their health might be impaired. Charles (20 years old) discussed the importance of watching and monitoring his son,

> You gotta watch him. You never know…everybody has their own way of coping with things, letting people know what's wrong with them. Step one is just watching him. Two, monitor different things.

Monitoring children's health required fathers to be simultaneously observant of various aspects of children's wellbeing, including physical symptoms, behaviors, and emotions. This awareness was also couched in fathers' knowledge of their children's baseline health. Watching involved comparing emergent information gathered through observations with their general health knowledge as well as what they knew to by typical for their children. Intimate familiarity with children's temperaments, behaviors, routines, emotions, and general health provided baselines for alerting fathers to changes in children's health status. Paul (21 years old) lived with his son and partner at her mother's house. He worked long hours as a road flagger and his partner worked as a bank teller but he was able to spend time with his son in the evenings after he returned from work. Although he spent few hours each day with his child, he was there regularly with his son and developed an idea of his son's usual routine and habits. Aberrations in his son's normal behavior alerted him to when he might not be feeling well,

> I just watch my son sometimes. I just sit there and watch him. I know when he's not talking or playing something is wrong, and lazy, because my son has a lot of energy. [And] sleeping a lot. That's it really.

Observing children allowed young men to learn their about their children—their temperaments, preferences, emotional expressions, playing styles—and this knowledge helped fathers recognize when children might be ill. With the majority (*n* = 30) of the children in the study younger than age of three years old, attention to children's non-verbal cues was especially important for recognizing early signs of illness in their children. Fathers attended to differences in children's attention-seeking behavior and how their children sought to be close with them to ascertain if children were not feeling well. Django (25 years old) discussed differences in how his daughters acted when they were ill,

> Porsha and Renee will just go right to sleep. She don't care. She'll just go to sleep, and she'll be up under you. She'll cling to you. "Daddy, daddy, give me a kiss. Daddy, daddy…" She's just so clingy. Renee, she'll go to sleep, too, which she'll just basically she'll whine for a long time. And Breanna, she'll whine but she won't refuse it. She will fight and battle her sleep. She won't go to sleep at all. She's that stubborn woman that will stay up regardless, and she'll milk everything that you got. She will want to be spoiled period.

Learning and recognizing children's emotional responses and cues required deep, specific knowledge of their children. As Django's narrative suggests, fathers were alert to small, seemingly unimportant variations in children's behaviors and moods as these changes were useful for identifying when children were not feeling well. Fathers shared that their children's emotions were useful for identifying when they were not feeling well, particularly when children were preverbal. Montana (21 years old)'s daughter, Rachel (7 months old), was born during the summer before he left to go to college in West Virginia. Separated by distance, he used video-chatting to visit his daughter

virtually and spoke frequently with his partner Jamille, Rachel's mother, about their daughter. The combination of virtual visits, conversations with Jamille, and rare in-person visits allowed Montana to learn about his daughter, even while physically absent. Through these contacts, he began learning about his daughter and was able to develop understandings of her normal behaviors and moods, which helped him ascertain when she was not feeling well. He shared,

> It's because she's not acting normal, she won't act normal. Like if she is sleepy, like when she's playful she's playful, she is talking, but when she's sleepy she'll get cranky, she'll whine. If something is wrong with her she'll whine. And if she is screaming crying something is really wrong with her. She is a funny sleeper, so it takes her, I hold her, I'll rock her, and if she feels like she is not going to sleep she will cry, cry, cry until she feels like she is comfortable, and that's the only way you'll know. That is the only way you'll know something is wrong with her.

As Montana's narrative suggests, watching children to determine when their health might be compromised drew from fathers' intimate knowledge of their children and this familiarity was born out of the relationships they formed by spending time and interacting with them. When Montana and other fathers described comforting children when they noticed that they were fussy and then monitoring children's responses to their efforts to console them they were tapping into the relational space that they conjointly occupied in those moments with their children. These intimate watching moments were couched in larger histories they have co-constructed together and the "we-ness" of their relationships that they uniquely shared (Marsiglio & Roy, 2012).

Despite fathers' best intentions to monitor their children's health, fathers acknowledged that they were not always able to identify when children's health was impaired. Continuing with Charles, the importance he ascribed to watching for changes in

his son's health was balanced with a belief that he might not always recognize when his son's health was compromised,

> You can never tell when a kid is healthy or they're not. A kid can look as healthy as possible, but be the sickest child in the world. Just can't tell. It doesn't have a look to it. It doesn't have a look. Only the parents know. It doesn't really have a look to it because right now Rajon… can have a serious mental health issue, meaning he can have an anger problem. I might not know he have it because it hasn't come along yet. So that's why I say it doesn't have a look to it.

Charles alternately expressed doubt about being able to recognize illness and confidence that parents implicitly know that their children were not feeling well. His narrative illustrates how fathers' approaches to caregiving involved observing children's health and anticipating children's needs. Fathers also acknowledged that they were not able to anticipate all of their children's health issues or the care they required but were committed to providing that care as they learned.

Charles' doubt about being able to know when his son was experiencing health issues may have been informed by witnessing his father's health decline due to multiple sclerosis. Once a robust, large man who owned a small landscaping and general contracting business, his condition rendered him unable to work and his cognitive functioning deteriorated—even to the point of being verbally abusive and sometimes forgetting who his son was. Witnessing his father's health decline represented a major, unexpected loss of his father as he once knew him—as well as the bond that they shared. Losing his father in this way made Charles keenly aware that health is not promised, even for children.

Even in the best of circumstances, a degree of uncertainty about children's health, what to do to care for children, and concern about children's wellbeing is commensurate with being a parent (Dodgson, Garwick, Blozis, Patterson, Bennett, et al., 2000;

Winnocott, 1973). Health-related losses made the general landscape of health—their own as well as those around them—uncertain. Young men fathered in contexts—relationships that were unstable, variable housing security, inconsistent access to social support, limited financial resources, communities where untimely death, loss, and trauma were common—that, at time, exacerbated the uncertainty that fathers felt about their abilities to intervene to care for their children's health. Similarly, this uncertainty made it difficult for fathers to trust their perceptions of their children's health, particularly when they believed that their children were doing well.

Peeping—Assessing Children's Health

Fathers conceptualized careful observation of children as part of how they cared for their children's health. These observations allowed them to identify when their children were experiencing health issues and when further assessment was warranted. Leonzo (20 years old) had a seven month-old son with his girlfriend and also acted as a father for her daughters (3 and 2 years old). He discussed how aberrations from her normal appearance and disposition led him to initiate more a targeted assessment of his youngest daughter's health,

> She would look miserable and that's how we're able to see something is going on. Or, like I told you before, the kids are real active and joyful, playful, and being around you will know if something ain't right, because they like to play happy, but when they just-- That's when you've got to feel their head and something is wrong.

After becoming aware through watching or through observation that children may be ill or injured and, peeping followed. Whereas watching alerted fathers to *whether* their children might be experiencing health issues, peeping helped fathers determine *what* might be happening with their children. Similar to watching, peeping included purposeful

observations as well as the comparison of emergent information to what fathers knew to be their children's usual behaviors. These observations and comparisons, however, moved beyond identifying that something might be awry with their children and were targeted at determining what was causing their children's symptoms. Testing hypotheses to determine what might be causing a child's distress represented a way for fathers to ascertain their children's current health needs and determining the care that would be required to address these needs. At 18 months, James' (22 years old) son did not have the language skills to explain why he was not feeling well, thus requiring James to observe and tests hypotheses to figure out what might be causing his son's distress. He shared how peeping helped him figure out if his 18 month-old son was not feeling well,

> What I do to peep is sometimes I just sit back and actually look at him. Like if he cry I won't pick him up right then and there. I'll actually let him do a little bit so I can distinguish what okay this what he, this the type of cry that he do when he hungry, then this the type of cry that he do when he's wet... I just do little tests. Like, let's say if he, let's say if he crying: if I go check his diaper and he's not wet that means that's not that type of cry. If I go, I get a bottle and put it up and he cry the same but louder that means he's hungry. So it's like I just do type of test to see what he'll want to do. If he crying [and] I pick him up and he'll calm down then I put him back down, he'll cry, when I pick him back up he'll calm down he just wanna be held. He just want some attention. Just actually peeping out what could be wrong with him cause I don't think you would really peep or really understand what's really wrong with him, you just going to they needs right then and there. You got to know something. You got to do something to figure out what's wrong and how do you know what's wrong.

The questions, steps, hypotheses, and conclusions that James reported resemble algorithmic approaches that physicians use to determine diagnoses (Dickerson & Carolina, 2010). Peeping focused both on the nature and severity of the condition as well as fathers' perceptions of their ability to address their children's needs. Fathers gathered information from a variety of sources—children's mothers, familiarity with their children, children's emotions, and from children's self-reports—to inform their

assessments of their children's health. This information provided an entré into providing acute care for their children.

Testing hypotheses involved in peeping presented a way for fathers to differentiate what might be happening for their children and determine the subsequent steps to take in addressing their acute issues. The differential component of peeping was a skill that fathers learned with time as they gained familiarity with their children and learned more about health. Tom (23 years old) reflected back on when his daughter, now 3 years old, was an infant and he learned how to test and determine what his daughter needed,

> And then paying attention to her temperament. Like, if she's acting different than she usually act…naturally sometimes she'll be irritable. Naturally, I'll have an attitude. I be like, I wish she stop whining but it could mean various things. I learned that a lot when she was a baby because sometimes she'll be crying for a long time and I'll be like, I know she can't need to be changed because I just changed her. I be like, I just fed her. When I walking, she be crying, crying, crying. crying, crying. Then finally, I would check her diaper and it was wet where she had peed again. That was just, I had to learn. You have to pay attention and cover all your bases.

Not knowing what their children needed and how to provide that was initially frustrating for fathers but through experience and learning from their children, fathers were able to learn what various cries meant as well as times when their young children were not feeling well.

Cuing into children's emotions was one way that fathers were able to recognize the onset of pediatric health issues. As fathers provided care, they used the information they gathered through children's expressions of emotion to gauge the severity and sometimes the source of children's distress. Andre's (25 years old) son had had several

ear infections in the first 18 months of his life and Andre had learned to use his son's responses to soothing as a way of determining the severity of his illness:

> If he's irritated and won't calm down I know I can't handle it. If I know, if I get him to calm or maybe get him to sleep or anything, get him to sleep, get him to laugh, play you know, I know he's okay. I know it's something that can be managed but if I can't, but if he just crying and constantly, constantly, constantly cause I don't like for my son to cry, I really don't then I know it's something that's out of my control and I'ma need to get some help.

The attention that fathers paid to children's emotions helped young men determine when their children were experiencing distress, assessing the conditions severity as well as the effectiveness of their caregiving, and determining if their children required medical intervention. This attention to emotions is especially important for fathers of preverbal or nascent speakers as they do not have the facility with language to convey health information. The emotion-work represented by fathers' cuing into children's dispositions and moods—from monitoring to assessment and throughout treatment—helped men provide support and address children's health in ways that were responsive to their developmental positions and abilities.

Whereas peeping helped fathers determine a course of action and treatment for their children, James' story suggests that assessment may yield information that fathers recognize as important but were unsure about how to address. James (22 years old) had a five year-old daughter, Quanisha, with a previous partner. His relationship with Quanisha's mother was rife with tension, which resulted in James rarely seeing his daughter—even less so since he began a relationship and had a child with his current partner. James had not seen his daughter in over a year at the time of the interview and expressed concerns that arose during Quanisha's most recent visits. He shared,

> I just don't know what really going on far as with her. Like she'll have rashes, like real bad rash like in the private area and its like, like I said before I'm not touching down there. I don't want to touch down there. So it was like one day I was giving her a bath and she was saying it was burning and it was like, burning? Like wow. So I called her and she was like well she's just moist down there. Moist? What three year old moist down there? I'm not understanding so like it just, it like it get me frustrated. It actually get me to the point that just pop up at the house one day. Like because I really have a feeling that it's something going on just like I told her and I told her, I said, if I find something's going to my, happening to my daughter. Someone touches my daughter, it's not gonna be pretty.

James' story suggests that fathers observed symptoms but sometimes lacked sufficient health information and child-specific information to adequately interpret what they observed. His story illustrates how fathers' inability to accomplish kin-work with the mothers of their children and traverse space inhibited their abilities to monitor their children and remain apprised of their emergent health issues. Living separately and having poor relationships with the mothers of their children detracted from young men's abilities to peep their children as well as the environments around them in order ensure that they are healthy. Without knowing about his ex-partner's current relationships and trusting her decision-making—both around relationships and caregiving—James was faced with the troubling thought that something untoward might be happening to his daughter. Separated by physical and relationship conflict with her mother, James had little way of knowing what was really happening with his daughter.

His story of having a poor relationship with the mother of his daughter and the ripple effects that that disconnection had for his involvement with his daughter represents a negative case supporting the importance of emotion-work for fathers' participation in pediatric caregiving. James reported only spending time with his daughter once or twice a year, due primarily to his poor relationship with his daughter's mother. At its most

benign, the poor relationship between James and his daughter's mother contributed to distrust of her caregiving decisions; more troubling is the proposition that disconnection from his daughter's mother contributed to his not being able to recognize and intervene if his daughter was being mistreated or experiencing abuse. He was left carrying the weight of unresolved questions about his daughter's wellbeing. Asking these tough questions of his daughter's mother would stress an already tense relationship; doing so would risk completely severing contact with his daughter and eliminate his opportunities to help if his daughter was indeed being hurt. Not questioning his daughter's care allowed him to maintain his tenuous relationship with his daughter but risked her continued abuse. At the time of the interview, James' was still wrestling with how to confront his daughter's mother regarding the cause of his daughter's rashes.[18]

The severity of James' concerns about his daughter's safety and wellbeing during the extended periods when he was separated was unique among the narratives represented in the sample. Concerns about children's wellbeing that arose in the context of distrust of children's mothers and distance from their children, however, was not uncommon. As discussed in the Preventative Care chapter, Angel (19 years old) discovered that his children's hygiene needs appeared to have been neglected in the several months that intervened between when his ex-wife took their children following their separation and

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[18] Some of the questions that were raised about James' story during initial drafts of this chapter were, "what was the resolution? Was everything okay?" The discomfort that the reader feels left without knowing the "outcome" of James and his daughter's story gives a small window into the questions that swirled around in James mind as well as the uncertainty that fed his worrying about his daughter. Perhaps some of the same strategies that the reader uses to move past this question (i.e., "I *hope* she's okay,") are the same ways that fathers used to cope when uncertainty and worry met with seemingly insurmountable contextual barriers. As a holder, redactor, and interpreter of his story, I am left with the same uncertainty as James and the reader; I do not know what happened with James and his daughter.

his most recent visit with them. As demonstrated by the experiences of nonresidential fathers in this study, ambiguity about their children's health, circumstances that surround them, and the care that they receive complicate fathers' abilities to intervene in their children's health care. Precipitated and maintained by poor relationships with the mothers of their children, the ambiguity described in the present study may contribute to contexts where child neglect, abuse, and mistreatment persist because fathers are unaware or unable to intervene on behalf of their children.

Personal Appraisals of Caregiving Capacity

Assessment also included fathers gauging their own abilities to provide the care that children needed. Faced with their children's illness, fathers drew from their previous caregiving experiences as well as child-specific and general health knowledge to determine if they were equipped to address their children's needs or needed to seek external support. When fathers determined that they were unable to address a certain health issue individually, this allowed young men to look to kin-work as well as the healthcare system. Isaiah's (20 years old) son, Izzy (14 months old) was admitted to the hospital when he was two months old for pneumonia, a week before his first Thanksgiving. The memories of this experience were still fresh when his son began wheezing a few months later and this led Isaiah to take him to the emergency room. Remembering how quickly his son's health deteriorated during his previous illness led Isaiah to believe that he would not be able to provide the care Izzy needed in that moment. He recounted,

> I took him to the emergency room…let me see…twice, after the pneumonia thing. The second time I took him to the hospital because he was starting to get his rattling again so the last thing I wanted was the pneumonia to come back. I took

> him to the hospital and then I took him to the hospital again when, of course, he had a little breathing problem like he was having an asthma attack or something and I couldn't deal with it.

Isaiah's narrative highlights how young men's histories caring for their children's health shaped how they evaluated their abilities to address children's current health needs. His story also suggests that major health issues may lead fathers to be more cautious in their estimations of their abilities to provide care.

When fathers recognized that their children had an illness or an injury that they believed was within their capacity to handle, fathers discussed attempting to treat prior to soliciting assistance from medical providers. While changing his 15 month-old son's diaper, Andre (25 years old) noticed that he developed a rash. He initially tried several over-the-counter medications but found that none of these were effective and that the rash worsened. When his attempts failed, he took his son to the doctor. He noted,

> Actually last week, a few days ago he had a rash, had a rash around his butt, around his thighs and genitals and I was real nervous. I was like hold up, what this you know is and all the cream, the butt paste, the hydrocodone cream. I got everything I could buy at a CVS, at an over the counter drug store to help it and it wasn't working and it looked like it was just making it worse and worse. It wasn't looking right so I got concerned and we came to the hospital and I found out we had fungus and he had to get some antifungals cream and everything was okay after that.

Andre's narrative demonstrates how fathers first looked to home-based care to address children's acute health issues and then, if these efforts failed, solicited help from children's medical providers. Drawing from his prior experience caring for his son's rashes, he initially thought that his son's rash was similar to other rashes but learned otherwise after initial attempts to treat did not resolve it. At that point, he realized that he needed to get medical help for his son. In contrast to Andre's confidence about

addressing acute health issues, Wayne (18 years old) was inclined to seek medical care for his two year-old son as one of the first steps of addressing acute health issues,

> When he gets sick we might take him, I probably take him to the doctors and they get us a prescription. Every time he get sick we just take him to the doctor, they give us prescription. They give him prescription, get him the medicine he need and he be good and then they might keep it or they might throw it away cause it might be old.

For Wayne, the certainty of having a prescribed treatment regimen allowed him to identify what needed to be done to care for his son's health and gain confidence about his ability to care for him. Fathers also obtained direction and support from members of their social support networks. Young men's social networks, however, were not always consistent sources of support for addressing children's acute health needs. John (19 years old) remembered when his son, Francis, was six months old had difficulty breathing while he was visiting him at Isabel's house. Despite John and Isabel's pleas and the emergent nature of Francis' breathing difficulties, Isabel's father, however, refused to give them a ride to the emergency room for several hours while Francis was in distress. He recounted,

> It was nighttime. It was like around ten or nine. Her dad drove us there, but he complained about it. He was like oh he doesn't have nothing and stuff. He just lazy, he just always be like, "oh you know he don't have nothing, just give him medicine. He'll be okay." Yeah so he drove us, he gave us a ride and then he went and picked up.

Isabel's home was approximately a mile away from the hospital thus getting a ride from her father was more expedient than calling an ambulance. A similar situation happened at a later date when Francis again needed to go to the emergency room. Despite living within minutes of her house, Isabel's father refused to pick him up on the way to the hospital, thus leaving John to make his way to the hospital late at night when public

transportation was less accessible. John was ultimately delayed in his arrival to the hospital and was not able to contribute to the medical decisions regarding Francis' care that evening. Despite his relationship to Francis and Francis' relationship to his grandfather, James was unable to bridge his own relationship with the grandfather through kin-work. James' story, situated in the events of a specific night, illustrates that fathers' efforts at kin-work were not always successful at creating access to their children's care and that these "failures" may be due to a multitude of factors. In James' case, the confluence of kin's perceptions of children's health as well as James' tenuous relationship with Francis' grandfather contributed to James being left out of his son's care that evening.

Kin-work, then, improved the likelihood of receiving assistance for their children but did not necessarily guarantee getting the necessary support for their children. His experience highlights how young, low-income fathers' may be dependent on family's tangible and instrumental support to help them care for their children. To some extent, this experience demonstrates a failure—or at least a limitation of kin-work--even when fathers were able to navigate kin relationships effectively, they and their children were still subject to kin-members' access to resources, ability to provide assistance, willingness to share, and even personal whims.

Fathers also identified poor relationship quality with the mothers of their children as a factor that impeded their efforts to care for children's acute health issues. I met Luther (21 years old) two weeks after he obtained temporary emergency custody of his daughter following a search for his daughter that lasted several months. Luther's transition into caregiving for his child distinguished his story from other men but he

encountered many of the same barriers to involvement with his daughter that other men faced. In many ways, his is a story about how disrupted kin-work could lead to separation from children and disconnection children's health care. His relationship with his daughter's mother had been going well until they found out that they were pregnant about seven months after they began dating. The relationship, however, began deteriorating when they disagreed about whether to continue the pregnancy—Luther wanted to continue their pregnancy and she desired to terminate but could not afford the procedure without his financial assistance. He chose not to provide the assistance due to moral objections. Understandably, their differences about whether to continue the pregnancy caused a major rift in their relationship. They decided, however, to continue their relationship throughout the pregnancy.

Luther waited until a few weeks after Kaiden was born to end their romantic relationship because he was concerned that she might harm herself or engage in risky behaviors that would endanger their unborn child. Although they tried to coparent for about a month, Taleah then absconded with their daughter (six months old) and hid her at a friend's home so that Luther would not be able to find her. Given her resistance to having their daughter and her sudden disappearance, Luther was deeply concerned about his daughter's wellbeing and petitioned the court for temporary emergency custody of their daughter, which he was granted. After a week of investigative work, Luther eventually located his daughter and, with the help of county sheriffs, reunited with his daughter.

Luther knew that his daughter needed medications but the circumstances around how Luther was reunited with his daughter did not allow him to get the medications when

he got his daughter. Luther knew from attending his daughter's postnatal appointments that her pediatrician practiced in the outpatient clinic at Children's Hospital. Although he had yet to personally connect with the program, he also knew that Taleah was a patient of the Teen Parenting Program and had a case manager, Jessica, through the program. He contacted her to schedule an appointment with her doctor. Luther recounted what happened when he sought information about Kaiden's medications during her doctor's visit,

> So after the doctor prescribed medicine, she prescribed three medicines, one allergy medicine, one for her face, and one for her arms and legs, but the medicine carried two different strengths. So after that I asked them, they asked what kind of insurance, I said, "I honestly don't know." So I tried to ask my baby's mother while I was at her doctor. She wasn't trying to cooperate. So the doctor pulled up like, "Yeah she's got Medicaid." I explained to the doctor how the baby's mother is not cooperating. They were like, "Okay, well don't worry about that. We'll work something out. Where would you like your medicine to go?" I said, "You can send it to Target in Jamestown." So she did that.

Relationship tension between fathers and mothers, however, was common. Luther's story illustrates how poor relationship quality and gatekeeping between fathers and mothers may present a barrier to fathers obtaining information about their children's health. Taleah's decision not to provide Kaiden's medications or even relay information about her prescriptions also demonstrates that mothers' decisions may, at times, jeopardize children's health.

Routine Convalescent Care

Caregiving around helping children recover from illness or injury represents another aspect of acute care. Routine convalescent care generally happened at children's homes and involved three processes for fathers: executing a treatment plan, administering medications, and adjusting daily routines to accommodate caregiving for their children's

temporary health needs. Each of these processes unfolded in complex relational, housing, economic, and community contexts that at times facilitated the care that fathers provided but more often complicated their caregiving efforts.

Executing and Adjusting Treatment Plan

Having assessed children's conditions and determined a course of treatment, convalescent care largely involved executing the treatment plan, monitoring for change, and adjusting treatments. Fathers described a range of activities in their children's treatment plans, including: wound care, administering medications, applying ointments, washing, adjusting children's diets, limiting children's activities, and promoting rest. Jamaal recounted executing the discharge plan that he and his partner received when their son fell down the stairs and received six stitches to close the wound. He described carrying out the doctors' orders for the stitches,

> They just told us to let the stitches do what they do. The scar is going to close up after a while. They said the stitches was gonna dissolve or whatever, and pull off the last bit of it after the wound heals.

As fathers treated their illnesses and injuries, they monitored their children for changes in their condition. In Jamaal's case, he and Nina lived separately but she traveled with their son to his house almost every day when they were together as a couple, which they happened to be at the time of Chez's accident. Jamaal's mother was a bit annoyed[19]

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[19] I gathered that Jamaal's mother was annoyed by Nina's presence from conversations with Jamaal beyond our interview. From his description, her annoyance seemed to be relatively minor and manifested as her speaking to Nina curtly as well as, at times, suggesting that she spend more time at her home. Part of his mother's annoyance may have stemmed from their home being overcrowded as two of Jamaal's sisters, their children, and at times partners lived in an apartment that was no more than four bedrooms. I witnessed Jamaal's mother's annoyance firsthand when I arrived his house after Nina asked me to do a home visit at Jamaal's home to meet with both of them about

by Nina's constant presence in her home but worked long hours and tolerated Nina's presence because she wanted her Jamaal, her grandson, and Nina to be able to form familial bonds and routines even if they did not yet have the resources to be independent. Jamaal's unstable relationship with his mother and tenuous position as a resident[20] in her home led him to avoid weighing in on Nina's presence; his ambivalence about his relationship with Nina did not provide motivation for him to say much.

The dynamics between Nina and Jamaal's mother notwithstanding, Nina's presence afforded Jamaal opportunities to monitor his son's recovery. As uncertain as his living situation was, his history of formerly being involved in a crew and his lack of financial resources seemingly trapped him there. In contrast, Nina had more access to financial resources and social support from her family than did Jamaal. She was also a young woman and a person who had not been involved in community violence as had Jamaal, which placed her at a lower risk of incurring harm when she moved about the community (Eitle, D'Alessio, & Stolzenberg, 2006). In many ways, Nina was the only one who had the resources to traverse the dangerous terrains in the three or so miles that separated their homes. Her efforts to bring Chez to Jamaal, as well as Jamaal's willingness to tolerate a person whom he was alternatively interested and disinterested in spending time with, allowed him opportunities to change his son's bandages, wash the

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a year prior to our interview. Jamaal's mother answered the door and I explained that Nina scheduled an appointment. Jamaal's mother's frustration was evident as she yelled up to Nina, "Nina! There's someone here from Children's saying that you told him to come here. I told you that you need to stop having people come to my house!" As an aside, it was during this rather awkward encounter that I learned that Jamaal's sister, Tamara, was the mother of another participant's, Isaiah (20 years old), son when he came down the stairs as I was standing at the door.

[20] Jamaal's mother kicked him out on at least one prior occasion, which resulted in him being homeless for about a month and required him to sleep at friends' homes and outside when that was not possible.

area, apply ointments, and monitor the progress of Chez' healing. Their combined efforts to navigate distance and economic barriers represent how this family accomplished kin-work so that they could conjointly care for their child's health.

Ideally, treatment precipitated improvement in children's symptoms but when children's conditions did not respond or worsened, fathers sought to adjust the treatment. Angel (19 years old) a father of two—a son (2 years old) and a daughter (1 year old)—remembered when his son developed a rash while he was married and living with their mother, Kasey:

> Because you know after they told us about, it was like started using it different. Maybe it was probably the lotion. I think it was kinda the Johnson & Johnson because I think he was having a reaction to it, so we started taking steps in changing his lotion, making sure we washed him a little bit better. Because we were washing him good at first, but maybe we was just thinking we was washing him maybe a little too not enough probably. So we started washing him more. We got the prescription for the Cortisone-10. We start regular with that, and we started seeing a little bit difference. We just kept going with it, and then it started changing from a lot to just different little patches.

When fathers perceived that they were able to handle their children's health issues, treatment began with home-based interventions and eventually involved a doctor if the symptoms persisted. Whereas adjusting treatment to ensure that children are improving may be advisable in many cases, the final clauses of Angel's statement highlight a vulnerability of this approach: frequent or rapid adjustments of treatments may not allow enough time to see a treatment effect. Having attempted various treatments for their son's rash, Angel was feeling a bit anxious wanting the rash to abate. Fortunately, however, he and his partner saw their son's symptoms improve and therefore stayed the course. Angel's remarks highlight collaboration between his narrative of providing care for his son while he and the mother of his children were together differed

substantially from the disconnection from pediatric caregiving he reported after they separated. For Angel and other fathers, being in the same place as their children and maintaining positive relationships with children's mothers were crucial for being able to address children's health needs.

Administering Medication

Medication may be indicated as a part of a child's course of treatment. When fathers determined that their children were experiencing minor illnesses, over-the-counter medications were among the first things that fathers considered to treat their children. Charles (20 years old) had extensive experience dealing with the health issues of a family member. His father had muscular sclerosis and his condition had been deteriorating rapidly over the past few years. Despite moving out of his fathers' house when he was 14 years old due to his father becoming increasingly labile (which was likely one of the first symptoms of the onset of his father's condition), Charles regularly went over to his father's house to check on his health. His intimate experiences coping with his fathers' health may have primed him to be able to recognize when his son was ill and determine how to treat it. Charles discussed the onset of his 17 month-old son's recent illness and how medications featured in his response:

> That'd be the first thing I think about. Taking his temperature and medicine…Like, right now we had to go get cough medicine for him because he didn't really have a fever, he wasn't throwing up or nothing but he had a strong cough and wheezing. So I figured he was not only congested but he have a sore throat. So I went out there and got some cough medicine for him and gave it to him. It made him go to sleep, well it helped him go to sleep.

Charles' narrative highlights a complex and nuanced process for determining that his son needed medication and what symptoms to target with this treatment. Having observed a positive outcome (or at least a response that resembled his son's usual

sleeping behavior), Charles concluded that he had chosen a medication that was effective for addressing his son's illness. His ability to assess his son's health, determine a course of treatment, and evaluate its effectives reflects his health literacy. His experiences suggests that fathers' responses to children's health issues sit at the nexus of their perceptions of their children's general health, current symptoms, intimate knowledge of their children's usual, baseline behavior and dispositions, as well as their knowledge about health and access to the resources they know will address children's conditions.

Convalescent caregiving also required fathers to obtain and administer medications per the prescribed instructions. As fathers discussed their roles in pediatric caregiving, they placed importance on being able to get the medicines their children needed. Procuring medication represented a discrete task that fathers understood how to execute but sometimes encountered barriers to obtaining their children's medications. Twigs (25 years old) had recently begun dating Rita, a woman with two children. As her partner, he was transitioning into his role as a social father and provided a substantial amount of instrumental support for her and her children. He described visiting several pharmacies to fill his son's medication only to find that they did not have the drug in stock.

> The prescription thing was kind of wild because we went to CVS, they said they don't have it, there's not such thing. When to Giant, they said the same thing: they don't have it, there's no such thing. [Rita] was getting kind of irritated like, "Man, why would you prescribe me something that nobody has, and this and that. My baby needs attention. His eyes messed up, and they keep on telling me everywhere I go they do not have it." So then we tried Rite-Aid, and I told her after Rite-Aid, if they still don't have it, then we just gonna go back to the hospital to tell them that we need something different 'cause everybody don't have. But Rite-Aid happened to have it, so that was cool.

Poorly stocked neighborhood pharmacies impeded their ability to obtain medication in a timely manner. Rita's son had a common pediatric illness—conjunctivitis—and the medications typically used to treat it similarly common; there was no reason for Rita, Twigs, or her son's physician to expect that a pharmacy might not have the medication in stock. Whereas Twigs and Rita's story does not support generalization, their experience leads one to question whether this is a phenomenon or a unique occurrence and, if it is indeed a phenomenon, how widespread it might. Given the growing body of research on food desserts and poorly stocked grocery stores in low-income communities, it stands to reason that a similar trend has been occurring with pharmacies in the Washington, DC metropolitan area—"medication deserts" (Amstislavski, Matthews, Sheffield, Marako, & Weedon, 2012).

Securing the requisite treatment for Rita's son required persistence in the face of a lack of access to medications for even the most mundane of childhood illnesses. Twigs' story of traveling to several stores to find medication highlights the importance of access to transportation in fathers' provision of care for their children. Twigs[21] was among the few fathers who drove and had access to a car; other fathers who relied on public transportation may not have been able to travel between pharmacies to get the

[21] Although unemployed at the time of the interview, Twigs may have been among the more resourced young men in the sample. He lived with his mother and his father in a row house located in a neighborhood that was experiencing a pronounced wave of gentrification at the time of the interview. He also acquired a trade—painting—during his stint at JobCorps and had only recently become unemployed. As he spoke during his interview, I could not help but wonder if Rita might be exploiting his obvious and long-standing affection for her in order to secure tangible and instrumental support for her and her children. I lightly probed about the history of their relationship and her motivations for being in a romantic relationship with him but his answers were unclear. If this were, indeed, the case, Twigs and Rita's story illustrates how low-income mothers may "kin-script" men in their communities to provide support as a means to garner resources for their families (Roy & Burton, 2007).

medication. His story may also highlight a lack of health literacy as he could have called the pharmacies to see if they had the medication in stock instead of driving to each store—that is assuming that he had access to the phone numbers for the stores.

In addition to limited access to neighborhood pharmacies presenting a barrier, the costs of medications may challenge fathers' abilities to procure medications for their children. This may be especially relevant for over-the-counter products used to treat minor medications as these may not be covered by insurance policies. Whereas some private insurance policies may include health spending accounts and other ways of paying for over-the-counter health products, the public plans that provided coverage for the majority of children in the study did not have such benefits. Reflecting on his son's last illness before he and his wife divorced, Angel (19 years old) discussed the importance of getting medication for his children, regardless of the cost,

> I made sure if I had to go get his medicine, I got it, no matter how much it cost or what I had to do to go get it. I did what I needed to do for my son. If he had a cold and I didn't have the money, go to CVS, look around, slip it in your pocket, walk the fuck out. I did what I had to do. You'll be like, "That's bad. That's wrong." Damn sure, anybody-and one thing that I learned from my mother, no matter what the hell you gotta do, do you what you have to do for the sake of your kids….No matter how you getting that money, or no matter how you're getting their medicine, no matter who you gotta talk and what you gotta do-do what you gotta do. That's one rule I live by.

For Angel and other young men, being able to provide medication for their children during their times of need was an important expression of their ideas of fatherhood, notably being able to provide for their children. Young men and their families, however, raised their children in economic and social contexts that limited their access to financial resources. As in Angel's case, fathers who found themselves stuck between a lack of financial resources and the imperative of caring for their children's

health sometimes needed to assume extraordinary risks (e.g., participating in the underground economy, stealing, hustling), in order to provide the treatments their children needed.

Thus, what may be perceived at first glance as property crimes, may reflect for low-income, young men an attempt to provide for their families. By assuming role responsibility for procuring medications for their children, young men assumed behavioral risks so that others—usually the mothers of their children or other primary caregivers—did not need to imperil themselves. Thus, young fathers' willingness to assume risk in providing for their children represented a way that they hedged against the simultaneous threats of economic adversity and losing primary caregivers.

Father also discussed administering medication is also part of their involvement in pediatric caregiving. Administering medications required fathers to know the proper dosages, timings, and parameters under which children should receive medication (i.e., if the medication should be taken with food). This aspect of caregiving may also necessitate marshaling mathematical (i.e., measuring, arithmetic) as well as clinical skills (i.e., applying ointment). Jamaal's (20 years old) son was diagnosed with neonatal conjunctivitis due to a gonorrhea infection[22] within the first couple days after his birth.

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[22] As alluded to earlier, Jamaal had a complex relationship with Nina. The nature of how their relationship began may have precipitated their son's eye infection. He recounted,

> I used to be one of those types, I-get-a-lot-of-girl type dudes. And Nina, you know I met her. . She just was in the middle of it. . She walked right into the middle of it. I told her that I am a player. . If you want to play the game, you can play the game. . If you get your feelings hurt because of something you chose to do… She wanted to play. . After a while, she started adapting, adjusting. . She started swinging with me, being one of those five or six girls that was in there, doing what everybody else was doing. Used to have sex, orgies, stuff like that…After a while, I started noticing she around all the time. I started feeding into her. . One time she was talking to me when we were having intercourse. .

This required Jamaal and his partner, Nina, to give their son eye drops throughout the day for the first couple weeks of his life. He noted how administering this medication became part of his emerging health monitoring patterns and daily routines with his son:

> Yeah, I would give it to him sometimes before and after just to be sure. It wasn't like a certain amount-well it was a certain amount-but it wasn't a certain amount of times a day we could give it to him. It was a certain amount you could give to him. So when he wake up, if he can't open his eyes, or if he had gooey stuff in his eyes when he tried to open his eyes, just give him stuff. So it was sometimes before or after every meal, and when he got out of the bath, just to be sure, just give him some. Whenever I had my attention on him, I just remembered the medicine, and gave him the medicine.

Whereas some fathers felt confident about their abilities to administer their children's medication, the complexity of administering medications made others men resistant, if initially, to engaging in this aspect of pediatric caregiving. Fathers were largely concerned that they would over or under-medicate their children, improperly administer, or otherwise compromise their children's health if they made a mistake providing medication. Although James (22 years old) had a five year-old daughter, he felt inexperienced when it came to caring for his 18 month-old son's health needs. He shared how his discomfort around administering medication to his son led him and the mother of his child towards a gendered division of pediatric caregiving labor:

> She give him the medicine. I really don't be tryna do that because I leave that up to the mother…Cause I don't want to give too much medicine, I don't want to give less medicine and then I think that's just fit for a mother to do… It just fit them. It's just, it's like they natural. It's like they natural instinct is to nurturing kids so I don't be tryna get in between that. So you know what I'm saying, I play

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> She just told me to release into her. . It sounded good while I was doing what I was doing, so I fed into and did it, and that's how Chez came into the picture.

Although Jamaal conceded that he and Nina had had several sexual partners, he claimed that he had never contracted a sexually-transmitted infection and suspected that Nina may have had partners outside of their common sexual partners. Consequently, Jamaal had a low level of distrust for Nina, which may have contributed to his ambivalence about their relationship.

> a part in everything else. I just let her have that. Like I be like I can give him the medicine, I just choose to leave that up to her. I'd rather for her to do it. Now if she's not here or if like if he going to my house and she leave and he need the medicine, then I can, I'll do that. But I basically like to leave that up to her.

Whereas fathers generally seemed comfortable with applying topical medications (i.e., creams, ointments, drops), young men who expressed reluctance were concerned about medicines that that were ingested or required measurement. Fathers then may turn to mothers to provide the bulk of the medication-related caregiving and may provide assistance as well as support for mothers' efforts. The gendered division of pediatric caregiving in this regard reflected fathers' use of kin-work to solicit help to address children's needs that they did not believe that they were able to provide themselves. Despite these concerns and fathers' looking to mothers to lead their children's medical routines, James' remarks highlight men's willingness to learn how to give their children medication.

Daily Routine

Fathers also acknowledged how caring for children's acute health needs intersected and, at times, conflicted with their daily activities. Depending on the nature and severity of their children's illnesses, acute care may require fathers to engage in additional caregiving behaviors not that were not usually part of their caregiving activities with their children. Tevin (19 years old) graduated four months prior to his interview but, contrary to his plans, he had not been able to secure a job. This allowed him to be available to stay home with his son, Mo (16 months old) when he recently had a minor stomach bug. He described how caring for his son's recent bout with a stomach virus made his days with his son different than usual,

> That's the main thing that got me…[was] changing pampers…cause, you know, it might go through and mess up his clothes. I got to change his clothes, give him another bath everything like that and like things like that for real. Really I ain't, couldn't really go outside you know do nothing so I stayed in the house, took care of him…. in the house cooling, watching TV, gave him little Pedialite popsicles and things like that. Then when he got better then, you know took him outside with me.

Addressing his son's health was time-intensive and led to Tevin restricting behaviors that he might customarily do. For Tevin, this included going to look for jobs downtown, going to the library to use the computers to search for jobs, spending time with friends, as well as going places with his son. Tevin's story also highlights how young fathers and mothers arranged their schedules to provide the time-intensive care required to help their children recover from acute health issues. At the time of the interview, Mo, Tevin's son, primarily lived in Virginia with his mother, who was enrolled in college there. Tevin decided to have Mo come to spend the week with him because he was not working and was available to care for him. Although he would have preferred to be working, underemployment offered Tevin opportunities to care for his son's acute health issue. As Tevin's case illustrates, some men used the "extra" time afforded by underemployment to spend with their children. This caregiving represented a way for fathers to contribute to their caregiving provided a way for fathers to provide for their children's wellbeing despite facing a lack of financial resources. The complex caregiving arrangement that Tevin and his partner arranged also demonstrates fathers' use of kin-work to meet their children's needs.

When fathers were able to secure employment, inflexible and unpredictable work schedules required that fathers seek alternate means to provide acute care while they were away. Django (25 years old) had four children—two biological daughters (5 and 4 years

old) with a previous partner, a stepdaughter (20 months-old), and a biological son (seven months-old) with his wife—and was expecting another child in a few months. Django first joined the Teen Parenting Program when he and the mother of his daughters, Jordan, first became parents.

It soon became apparent to program staff, myself included, that they had complex relational and personal histories that complicated their abilities to relate to each other in a healthy manner. Staff suspected that both Django and Jordan had cognitive delays (which Django later confirmed for himself) and soon learned that they had experienced several incidents of domestic violence—they would, over the course of their involvement with the program, be involved in several more. Shortly after the birth of their second daughter, Django disclosed that Jordan had been using drugs and had begun to spend more time away from their home and their daughters. Eventually, Django and Jordan separated and the girls came to live with Django at his mother's house; Jordan, by Django's account, was completely absent from the lives of their daughters.

At the time of the interview, Django had sole custody of his daughters and they lived in the household he established with his wife. As a security officer, he worked a shifting and inflexible schedule that sometimes made it impossible for him to attend his daughter's medical visits. Because their mother was largely absent from their lives, he looked to his wife as well as other family members or kin to take his children to the doctor. Fathers were able to manage their children's health by engaging their children's kin to supplement the care that fathers provided for their children. He shared,

> Now if I can't make it or something like that, if I gotta work or something, and Brittany can do it, then yeah. If we can both do it the same time, we do it. If she can't do it, and I can do it, I do it. Or if we both can't do it, and we know that the appointment is really important and that this appointment needs to be taken

> seriously, then we'll ask either my mother to do it or we'll find some type of arrangement, possibly their godparent. But we'll find some type of arrangement, something that we trust.

Django's narrative illustrates how fathers used kin-work to marshal social support networks to help them address children's health needs when they were unable to provide care themselves. Although Django's discussion generally focused on his biological children, his statement might also apply reciprocally—that he would take his wife's children to the doctor if she were unable to do so. His story highlights how young men not only benefit from social support but also contribute to social support and caregiving in their kin-networks.

Transportation limitations also shaped how fathers cared for their children's health needs. The confluence of fathers' residential status and limited access to transportation inhibited fathers' abilities to address their children's acute health issue. All but two of the fathers relied exclusively on public transportation to travel to visit their children, take children to medical visits, and accompany children to those visits. Fathers encountered two major problems when accessing public transportation. Firstly, public transportation was costly and these costs were increasing sharply. In the two years preceding their interviews, the local transit authority raised bus fares by 16.7% (20.0% if the cash payment surcharge is included; cash was the only method of payment for many fathers) and rail fares by 10.3% (Washington Metropolitan Area Transit Authority, 2015). With little and inconsistent access to financial resources, scraping together money for bus and rail fare could present a barrier to fathers going to see their children.[23]

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[23] Fare-jumping—hopping over turnstiles at rail stations—represented one way that fathers navigated the challenge of needing transportation but not having money to pay for fares. Although I did not explicitly collect data on men's fare-jumping, my anecdotal

Secondly, buses and trains ran irregularly and their schedules often did not align with fathers and children's daily routines. Buses and trains ran most frequently during standard work hours, Monday through Friday. With school, work, and children's daycare, fathers usually needed transportation during later hours during the workweek and on weekends when public transportation was less available.

Trey encountered these transportation difficulties at an especially inopportune moment. Although Trey (23 years old) was not Kasey's (four years old) biological father and had since ended his relationship with her mother, he maintained a close relationship with Kasey and still remembered when she was rushed to the emergency room because she had trouble breathing. Unfortunately, this emergency happened in the middle of the night when the buses and trains had stopped running and he was across the city at a friend's house. He recounted,

> One of the most scariest moments of my life. I'll never forget it. My daughter was about close to a year old, and she had a health scare. She has asthma, but at the time we didn't know that. She's just growing and everything's fine. And her breathing was messing up, and it was just a scary thing. I remember getting a phone call about 12:00 midnight. No buses were running. Nothing was going on here, so you wasn't able to catch the bus. So me and a friend of mine immediately got up and rushed to the hospital. I mean we walked almost an hour straight to get to Children's Hospital. It was a long walk, man. I mean my knees never been that sore a day in my life, man. I mean, we didn't just walk we ran. I mean, we ran and walked. It was half and half. We was really trying to get there. It was a real scary moment. I thought I was going to lose her, man. And when was in the hospital man, we found out that she had asthma.

Trey's narrative highlights the difficulties that young, low-income men faced when fathering across distance and attending to children's unexpected, acute health

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experience with fathers suggests that it, while a last resort, was not uncommon. I also know from my work with fathers as a case manager in the Teen Parenting Program that two of the young men—Trenton (21 years old) and Angel (19 years old)—had been arrested for fare-jumping.

needs. Trey and his friend were approximately six miles away from the hospital when they learned that his daughter was in respiratory distress and was heading to the hospital. He and his friend also took significant risks traveling by foot at that hour as they traveled by foot through unfamiliar areas where the presence of community violence and policing threatened their safe, successful passage.

Emotional Regulation & Coping: Fathers' Responses to Children's Acute Health Issues

In addition to attending to children's discrete medical needs, fathers also navigated complex emotions—of children, mothers or other caregivers, and themselves—in the midst of addressing children's acute health needs. Fathers' emotion-work in acute care also involved regulating heightened emotions in order to quell discomfort and facilitate care, providing support and warmth when children or mothers experienced physical or emotional discomfort, as well as coping with their own emotions so that they were able to respond well to their family's emergent needs.

Encouraging Emotional Regulation among Children and Other Caregivers

Acute health issues could be distressing for children and caregivers alike. The emotion-work involved in helping children and mothers regulate emotions during these moments reduced the distress they experienced. Encouraging children and other caregivers to remain calm and helping them avoid emotional escalation helped to create emotionally safe spaces where parents were caregiving for children's acute needs.

As discussed earlier, attending to emotions offered fathers a window to determining how well their children were doing and if their children were not feeling

well. In addition to comforting children during these moments, fathers also sought to regulate children's emotions by projecting confidence that children were okay and would be okay. Projecting confidence was particularly salient in fathers' descriptions of how they handled situations when their children sustained minor injuries (i.e., falls, scrapes, bumping into objects). Alvin (20 years old) discussed his response when his son fell or otherwise may hurt himself:

> I try to not make it seem like if he just falls to where it's like on his body and stuff, like don't fall and hit his head or hit nothing or nothing like that, I just try to not make it too serious so he can just shake it off. So he can just be tough about it.

Upon seeing his son fall, he assessed his son's injuries and determined that his son had not suffered harm within an instant. When Alvin perceived his son's injuries to be minor, he modulated his response to help his son cope with the discomfort he experienced. Because his son's injury was so minor, Alvin's assessment and projection of confidence that his son was okay happened almost instantaneously. There were other situations, such as when Jamaal's son Chez suffered a gash above his eye, where fathers encouraged children that they were okay even in the face of serious health issues—and when fathers themselves were not feeling completely confident.

In addition to helping his son cope with pain in the moment, Alvin's response aimed at encouraging his son to "be tough" also highlights fathers' teaching children how they ought to respond when facing health issues. Children's gender, however, may have shaped fathers' socialization around being tough. Two years prior to the interview, Tom (23 years old) and his sister (21 years old) adopted their younger half-brother, Amos, from his grandmother whose declining health impeded her ability to care for him adequately. Tom was also the primary custodian of his three year-old daughter, Bianca.

Although Tom knew his brother prior to assuming guardianship, he seldom spent time with him and when he did, their interactions reflected traditional peer dynamics between siblings. Perhaps due to the novelty of his caregiving and custodial roles in relation to his brother or the uncertainty about being a parentified sibling, Tom defaulted to discussing his ideas of caring for Bianca's health. When prompted to draw comparisons between how he approached caring for Bianca and Amos's health, he noted:

> I'm naturally going to be a little more protective of her. So, maybe not health as far as sick but health as far as in injured. I might be more, "oh that' swollen, let me take you to the hospital." Whereas, not to sound bad, but you got a little bump or bruise, on you Jared, you'll be alright, brush it off, well pay attention to it. Get some ice on it. Whereas I might be more, "we going today" with Bianca. Where let's wait this out, let's see what's going on with the boy…Because he's a boy. Because he's older. I know, like, because I'm a boy. I don't know. I know that' kinda how I am…bump or bruise or whatever, tape it up and keep it moving. I don't want him to be soft, I don't want him to be scared to say if something's wrong neither. I guess it's finding a balance.

Tom attributed the differences in how he might respond to minor health issues for his daughter and his brother to their respective genders and ages but it was also possible that Tom was still trying to figure out his role as a formally-parentified caregiver for his brother. Young fathers' approaches to addressing acute health needs brought to bear young men's ideas about gender, their constructions of their roles as protectors, and their experiences with their personal health. Although Tom acknowledged the possibility that age differences explained how he treated his daughter and brother, much of his discussion about acute caregiving centered around children's gender. His narrative reflected a desire to teach sons to "be tough" and "brush off" pain and injury as a means of them to avoid becoming emotionally soft, thereby exposing them to vulnerability.

Fathers also expressed the need to encourage other caregivers, particularly mothers, to regulate their emotional responses when their children were experiencing

acute health issues. These efforts to shape the emotional experiences and expressions of mothers constituted emotion-work (Lewis, 2008). Fathers' efforts at promoting emotional regulation for mothers and other caregivers were often aimed at reducing children's distress and facilitating care. Remaining calm and encouraging emotional regulation also helped fathers accomplish caregiving tasks for their children.

Leonzo (20 years old) had a six month-old son with his girlfriend and assumed a fatherhood role in relation to her two and three year-old daughters as well. Growing up, he cared for his mother who had a seizure disorder and, while these were scary for him to witness as a youngster, they helped him to recognize when his eldest daughter had her first seizure and remain relatively calm as he solicited help. His girlfriend, however, was not as familiar with seizures and became emotionally escalated while he was calling 911. He noted,

> Well, I did call 911, but while she was screaming I couldn't talk to them, I couldn't really say what I wanted to say to them, because she was yelling. It was hard to say it was a seizure. I was just like, "There is something wrong with my daughter." I couldn't really think like I wanted to, because she was yelling and screaming, so I had to tell her to calm down. And once I told her to calm down she did. That's when I was able to say, "Yeah, I think it's a seizure." And so on.

This medical emergency required Leonzo to accomplish several caregiving tasks within the span of minutes, even seconds. The intensity of his girlfriend's emotional response, however, inhibited Leonzo's efforts to get help for his daughter. Deescalating emotions served the practical purpose of reducing distractions that distracted from assessing children's health, determine a course of action, and then providing care.

Young men were concerned that mothers' heightened responses may lead children's emotions to escalate and exacerbated their children's condition. Jamaal (20 years old) lived with his son, Chez, and girlfriend at his mother's house. He described his

girlfriend's response when he, Nina, and his mother converged on Chez after hearing him fall:

> I don't know if she was upstairs at the time, or what, but all I know is I heard a boom, a scream. I rushed out of my seat and went to go tend to him. He was on his back with blood just running all over his face. I'm like, "How did this happen?" Nina, she's [emotional], so she just overreacted. It wasn't overreaction. She did what any mother would do. But she was just snatching him up, pulling him out of my arms. Like no, you need to have him steady, stable, like not having him feed of your energy like that. You do all that screaming and yelling, he's going to do the same thing. And when the heart races, the blood pumps faster, and he has a gash in his head. You don't want him to lose too much blood out of his head. So my mother grabbed him, held him in her arms, calmed him down, put a cool rag on his gash.

Although Jamaal understood Nina's peaked emotions, he and his mother were concerned that Nina's frantic response would escalate Chez's emotional distress and heighten his physiological responses. Having personally and vicariously experienced countless community violence in Caveat Habitator[24], Jamaal and his mother were sensitive—perhaps hypersensitive in this case—to the possibility of Chez's emotional response contributing to a detrimental loss of blood. Jamaal's mother had been injured in a drive-by shooting a few months earlier,

> They had a couple drive-by shootings, a couple deaths. My mother got shot. Yeah she was one of those people that got shot in front of that nickel store in front of The Tock. Yeah, she was one of the five or six of the people that got hit right there. She got shot three times in her legs. I was at work when she called me and told me. I had to rush back home from work. She called and told me and made me really frantic. She called like, "Jamaal, come on. Get your son. I just got shot."

Similar to how she responded to Chez's cut, Jamaal's mother also remained calm and collected when Chez was injured. As a lifelong resident of the neighborhood Caveat

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[24] Caveat Habitator had a long history of community violence beginning in the 1980's when crack cocaine entered the urban communities across the country. This particular neighborhood became a major center of drug dealing in the city and has been plagued with drug-related violence since. This neighborhood was among the most violent (i.e., homicides, assaults) in the City (Metropolitan Police Department, 2013)

Habitator in Washington D.C. and former leader of a small "crew," Jamaal himself was intimately familiar with the traumatic injuries resulting from community violence. His concerns about his son's heart rate and risk of blood loss may reflect his experiences growing up in an area with a long history of drug-related violence, particularly in recent years. Having witnessed, survived, and at times perpetrated violence in his community, Jamaal had experienced the injury and loss of several peers. Directly and indirectly witnessing peers experience violence sensitized him to perceive his son's blood loss as a concern as well as informed his knowledge that lowering his son's heart rate would mitigate his risk of losing too much blood. Through their experiences—both personal and vicarious—Jamaal and his mother developed emotionally-measured responses to such injuries, which they applied in Chez's injury. A projective interpretation of their context and trauma-driven response to Chez's injury was that Jamaal and his mother were modeling for Chez how to respond to injury should he experience the same community violence they survived (Self-Brown, LeBlanc, David, Shepherd, Ryan, et al., 2012).

Emotional Self-Regulation: Coping with Personal Emotional Reactions

Fathers' emotion-work also extended to moderating their own emotions in response to children's health issues. Men's emotional experiences as fathers and as caregivers are largely absent from the extant body of literature (Garfield & Fletcher, 2011; Johansson, Rubertsson, & Radestad, & Hildingsson, 2012). The emotional reactions that Jamaal described, however, highlights the linked nature of fathers' emotions and their children's wellbeing. His story also demonstrates the emotional intensity that may accompany addressing children's health issues, particularly when unexpected, acute and severe. In addition to providing emotional support and coaching

during acute issues, fathers also moderated their own emotional expressions in order to help their children remain calm during these stressful events. This self-regulation of their emotions also constituted emotion-work that fathers accomplished so that they were able to respond to their children's emergent health needs. Similar to the stoicism that young men socialized their sons to display, fathers tamped down their own emotional experiences so as to avoid further distressing their children.

In particularly intense moments, emotional regulation made it easier for fathers to care for their children's health. Denzel (18 years old) and Destiny were beginning a romantic relationship when she became pregnant with their daughter, Mya (10 months old). Destiny moved from her father's home into Denzel and his grandmother's home during her pregnancy. Her father, however, passed away soon after Mya was born. Despite their attempts to make a romantic relationship work for Mya's sake, Joseph decided that he wanted to dissolve their relationship so that he could explore other romantic interests.

With no other family members in the area, Destiny was at risk for becoming homeless. Although Destiny and Joseph would have preferred to live separately given the change in their relationship status, Denzel's mother insisted that she remain living there as it was best for Destiny and the baby; his mother was displeased that her son would end his relationship with Destiny merely to pursue relationships with other women and thus was less concerned about his residential preferences. However, having to coexist and coparent in such an uncomfortable environment helped Joseph and Destiny develop problem-solving skills that they might not have otherwise developed if they lived

separately. He applied the strategy of remaining calm in the face of heightened emotions from another person to the care he provided for his daughter. He noted,

> Like, if she was ever to get hurt like playing around, I understand that you remain calm, see what's going on, don't panic and just you know keep your composure while trying to keep hers. Don't overdo it, just stay in your lane and be supportive, take care and do what you gotta do. But remain calm that means some type of level where you're okay with yourself and you know that your daughter's okay with it…even though she might be freaking out, you cannot do the same thing. You can't be, it can't be two mad people at the same time, and it just won't work out. Somebody just got to be calm and normal and the other person can just remain mad. But somebody just got to be ahead of somebody at some type of point.

Whereas Denzel moderated his emotions in service of being able to provide care for his daughter, fathers also coped with the emotional intensity of their children's illness by downplaying the severity of the issue or disconnecting from thinking about what was happening with their children. Alvin's (20 years old) son, AJ, spent the first few weeks of his life in the pediatric intensive care unit due to complications resulting from his mother's untreated urinary tract infection. Maintaining a positive outlook was very important to Alvin and he coped with his son's illness by blocking off thoughts and feelings about his son's heath at that time. Describing the period following AJ's birth, he noted,

> When it was time to go, he couldn't go home with us because I think… I forgot what they said what was wrong with him. Umm…. what did they say that was wrong with him? That's how you can tell that I don't really care about negative stuff like even when they said something was wrong with him, I ain't really look at it that way. Oh that what it was! Women get the urinary tract infection from like not being able to pee or being able to but at different times and I guess it kind of like passed over into him as they were giving birth.

Alvin's difficulty recalling his son's illness at birth stands in contrast to the vivid detail with which he described other details surrounding AJ's birth. He explained this difference by sharing that he chooses not to dwell on negative experiences. Despite his

difficulty recalling details of his son's early illness, he shared that he remained with his son at the hospital for a week following his birth and visited him throughout his subsequent stay in the pediatric intensive care unit. His narrative suggests that some fathers provided emotional support for their children by remaining present while cognitively and emotionally tuning out—either contemporaneously or retrospectively—to difficult details of their children's health.

Fathers also coped with intense emotions around their children's health by withdrawing. Charles' (20 years old) son, Adam, was cyanotic at birth and initially unresponsive. He described his thoughts in those tenuous moments,

> Oh man…I don't even…I can't even tell you how I felt. I was just like, I had so many things running through my head. It was like, damn. Did I just spend all this time with this crazy broad for him to come out dead? And I was like, nah, God wouldn't do me like that. That's all I was thinking, "God ain't gonna do me like that." And the last thing I remember was everything being quiet. It was real quiet. Everybody, nobody was saying nothing, all you heard was the doctors at the little table with him trying to get him to say something.

Although doctors were eventually able to rouse him, they immediately whisked Adam away for further evaluation and treatment. Charles recounted how he responded to his son's health issues in the moments following his birth,

> They had to bring him one of them incubator thingies and they put him in there and took him to a place called the NICU. So they took him to the NICU and we couldn't see him for about, it had to be about three hours. We couldn't see him for three hours. They said they had to operate on him, do something. So…while we waiting, I got twisted. I got drunk. My mother's godson came with her and me and him are like brothers so he came up there and was like, "man, I know you're stressing. Man, here goes some liquor." So he had me a little Gatorade bottle with some liquor in it. I drunk it. I took it to the head because I never seen-like, I was ready him being born, but I wasn't ready to see him come out blue and not saying nothing.

Charles was unprepared for what he saw when his son was born. He was terrified that he might lose his son within hours of his birth but was unable to do anything to

change his son's health. His first moments of fatherhood were filled with shock, fear, and—perhaps most devastating—feeling powerlessness to effect change about a person whom he loved dearly. Instantaneously saddled with a deep connection and love as well a grave responsibility for his son yet being unable to contribute—and separated—from his son's care, getting drunk presented a way for Charles to withdraw and cope with the intense stress and fear that he experienced. Withdrawing, however, attenuated his ability to remember details about his son's health at birth, including what caused his son's cyanosis.

Whereas Charles was present when his son experienced his health issue, knowing that children were experiencing acute health issues but being unable to be with them during these difficult times was emotionally intense for fathers. For some men, separation from their children occurred as a result of poor relationship quality with the mothers of their children, maternal gatekeeping, and physical distance. Angel[25] (19 years old) was recently divorced from the mother of his two children, a boy (2 years old) and a girl (1 year old). After several incidents of domestic violence, Kasey decided to take the

[25] As noted in the Methods chapter, I obtained a Certificate of Confidentiality during the course of the study. This was largely in response to my interview with Angel. We sat on plush, black leather couches in the living room of the apartment he recently began renting with his new girlfriend. At the conclusion of our interview that lasted a bit longer than two hours, I stood up to gather my belongings and glanced down and found a pistol sitting on the coffee table adjacent to my seat. I asked Angel about the pistol and his response both reassured and deeply concerned me: "Oh that? That's an air pistol that I use to shoot targets here in the living room. My real gun is in the safe in the bedroom closet—but don't tell my girlfriend, she doesn't know. Don't worry, it's not loaded. I've got one, no two clips there and—wait, there's one in the gun." I then spent about 45 minutes learning about his motivations for having a gun, listening to his history experiencing and perpetrating violence in the community, and attempting to convince him to allow me to dispose of it for him. Despite my best attempts—which were almost successful—he was not ready to part with his gun. Anticipating that other men may share similar stories, I subsequently chose to obtain a Certificate of Confidentiality to further protect participants' confidentiality.

children and move out of the home they shared with Angel's mother. She moved in with her mother who lived in a nearby state accessible only by car. Kasey called Angel one day a few months prior to his interview to inform him that his son had a seizure and was going to the hospital. Angel cried as he remembered this,

> Because when she was gone, when she was down there with her mother, my son had a seizure. My son has never shown signs of having a seizure ever. And the simple fact is when I got that phone call, I was at work. I cried because for one he was so far away. I couldn't do nothing. I couldn't do nothing but cry. That shit made my heart bleed out. It crushed me. It really made me feel like I just wasn't there. It made me feel like everything that-I was just a bad parent because I wasn't there.

The distance that kept Angel from being able to visit his son at the hospital was very distressing for Angel. His narrative highlights the deep connections that fathers formed with their children. He also demonstrated how young men's ideas about their roles as fathers included supporting and caring for children's health needs; not being able to do so caused emotional distress for fathers.

Taken together, regulating children's, caregivers, and their own emotions during acute health incidents served several purposes. Emotional regulation during acute health incidents reflected fathers' awareness that their children were experiencing difficulty and a desire to ease discomfort by staunching emotional responses that would heighten children's distress. The emotional support and work that fathers accomplished with themselves, mothers, and other caregivers as a way to care and facilitate care for children's health needs—including acute needs—represents a novel finding in research concerning emotion-work, fatherhood, and health.

Summary

This chapter discussed how kin and emotion-work as well as navigating space and distance facilitated fathers' involvement in four domains of acute care—monitoring and assessment of children's health, self-appraisals of caregiving capabilities, routine convalescent care, and emotional regulation. The common processes of kin-work, emotion-work, navigating space, distance and proximity, as well as engaging medical care unfolded in complex social, relational, community, and housing contexts that complicated fathers' efforts to address children's acute health needs. Identifying when their children were ill and forming working hypotheses about what might be ailing their children allowed men to determine of they were able to provide the requisite care or if they should solicit assistance from others—caregivers or medical professionals. Fathers also discussed helping children recover from acute health issues by executing treatment plans and administering medications. Young men's emotion-work with their children as well as the mothers of their children also emerged as salient in men's descriptions of how they cared for their children's health needs.

The findings from this study highlight caregiving at intersection of emotions and health, particularly around children's acute health needs. Drawing from their deep knowledge of their children's usual temperaments and behaviors, fathers used emotions to recognize when their children might be experiencing acute health issues as well as to assess what those issues might be. Likely due to the young age of many children in the study, fathers in the study reported that their children were usually happy, playful, and emotionally expressive. The finding about fathers' use of emotions for assessing their children's health begs the question of how health monitoring and assessment might differ

for fathers of children whose emotional expressions did not follow typical patterns (e.g., children on the autism spectrum, children with pervasive cognitive delays).

In addition to informing fathers about their children's health, fathers also discussed purposefully intervening with children directly as well as other caregivers, usually mothers, to reduce the detrimental effects that heightened emotions might have on children's health. This emotion-work represents a substantial contribution to the extant body of research that has situated emotion-work largely in the province of women and mother (Lois. 2010). Whereas fathers believed that it was important for them to moderate the emotions of those involved in their children's care, young men's stories suggest that they may have difficulty processing the complex emotions incumbent with experiencing children's acute health issues as well as the burdens of having to perform emotion-work for everyone around them during difficult moments. Few studies, however, have examined the toll of emotion-work for those responsible for enacting it; exploring fathers' strategies coping with their own emotions and the toll of emotion-work for them offers a promising area for future exploration.

CHAPTER 7: CHRONIC CARE

As discussed in previous chapters, preventative and acute care were a part of pediatric caregiving for all children. More than half of the children in the study (n = 27), however, also encountered chronic health issues that required fathers to provide specialized caregiving. Chronic illnesses have been defined as physical, mental, or cognitive conditions or illnesses that while treatable, are not curable and therefore requires ongoing management over time (Goodman, 2001). Commensurately, fathers' descriptions of caregiving around children's chronic health needs had the longitudinal concern for children's health as well as vigilant monitoring and similar responses present in their experiences of preventative care. The possibility of children experiencing exacerbations of their symptoms that disrupted their daily functioning or even threatened their lives, therefore requiring intervention conferred similarity to fathers' experiences of acute caregiving. The ongoing nature of chronic caregiving to manage children's conditions and stave off symptom exacerbations, however, distinguished chronic caregiving. Furthermore, the heightened emotional experiences of worry and hypervigilance due to the specter of children's health vulnerability also set chronic caregiving apart from acute and preventative caregiving.

Children's chronic health issues heightened fathers' awareness of their children's health and underscored the salience of the roles as caregivers for their children as well as the importance that they ascribed to remaining involved with their children so that they could preserve their children's wellbeing. Monitoring their children's conditions and providing routine disease management were critical for mitigating the effects of pediatric

chronic illnesses on children's physical, psychological, and social functioning (Goble, 2004). Unfavorable community, relationship, and structural contexts, however, presented barriers to fathers and often frustrated their attempts to provide care. In light of the contextual elevated caregiving duties required and the challenges they faced, kin-work was an important means by which fathers were able to secure the additional resources—financial, skill, and social support—necessary for their children's chronic health needs. Kin-work also represented a means by which young men were able to gain information about their children as well as influence the behaviors of other caregivers for their children when their contexts inhibited fathers from providing care themselves.

Asthma was the most common chronic illness among children in this study. This is consistent with national statistics indicating that asthma is the most common chronic illness among children and that African American children bear a disproportionate burden of the illness (Akinbami, 2006). Thus, many of this chapter's findings reflect the experiences of fathers whose children have asthma. Some of these findings may be condition-specific but the processes they apply to caregiving and the contexts in which they unfold likely resemble those among fathers of children with other conditions.

This chapter begins with case examples of two fathers, Smith (19 years old) and Delonte (21 years old), to discuss chronic caregiving among young men. Their stories—while exceptional due to the circumstances and severity of their children's illnesses—highlight how residential, relationship, structural, as well as socioeconomic contexts may challenge fathers' efforts to care for their children's chronic health needs. Smith and Delonte's narratives also highlight how fathers attempt to navigate these contexts as well as how those efforts are frustrated. Whereas the case examples focus on two fathers

whose children have significant chronic illnesses, the remainder of the chapter broadens its scope to discuss other fathers whose children has less severe illnesses, usually asthma. Sensitized by the prevalence of asthma among children in the study, the chapter transitions to a discussion of how fathers manage their children's conditions through environmental control, trigger management, and medication management. Couched in the same contexts as the men described in the case study, the chapter concludes with a discussion of how chronic caregiving, particularly medication management, both structured and interrupted fathers' plans and daily routines with their children.

Case Examples of Contextually-Situated Chronic Caregiving

Children with pervasive developmental and physical issues require additional specialized skills to address their specific health issues. Although there were only two fathers—Delonte and Smith—whose children had pervasive chronic health issues, their stories suggest that young fathers have steep learning curves in order to care for their children's health needs. Smith and Delonte encountered their children's chronic illnesses while embedded in similar contexts as the other fathers in the study. The severity of their children's conditions, however, taxed their social, financial, and relationship resources, which heightened the constraints these challenging contexts placed on their abilities to care for their children's chronic health needs.

These two intrinsic case examples illustrate how fathers' distinct contexts intersect with the care of children who have chronic health needs (Stake, 1995). Moreover, these in-depth case examples demonstrate how fathers develop complex daily routines of maintenance, persistence, awareness, and caution while having few resources available to them.

From Self-Blame to Learning the Ropes—Smith's Story

Smith was a 21 year-old father of a child with chronic health issues that required substantial medical attention. Whereas some of Smith's experiences resonated with those of other young men, the etiology of his son's condition, the severity of symptoms, and the specialized care that his son, Justin, required distinguish Smith's narrative.

His story, however, began unexceptionally. Smith grew up in the Washington, DC with his mother, father, and seven siblings—of whom he was the youngest. He met his partner five years prior to the interview when he and Arlene attended the same high school. Not knowing exactly what he wanted to do but knowing that he did not want to go to college after high school, he enrolled in JobCorps to earn a certificate in culinary arts. Very much connected to Arlene who was still in high school at that point, he made several trips back to Washington, DC to visit her and it was during one of those visits when their son, Justin (21 months old), was conceived.

Smith left JobCorps after almost getting into a physical altercation with another young man at JobCorps, within a few months after learning that Arlene was pregnant. His choice to leave JobCorps allowed him to return to DC and support Arlene throughout her pregnancy. Justin was born via cesarean section and, by all accounts, was healthy at birth. Aside from an emergency room visit in the hours immediately after being discharged from the neonatal unit, Justin was a healthy, typically-developing infant during the first few months of his life.

A fateful night and the investigation. His developmental trajectory, however, was permanently altered due to a traumatic brain injury that he suffered on a fateful night while under Smith's care. Smith shared what happened that night,

> I was watching my son one day, and he went into cardiac arrest. Me being the new parent that I am, I panicked. I was trying to shake him to get a reaction out of him, which wasn't the best thing to do at the time, but I was a very, very new parent at the time. And I was just completely and utterly destroyed by that moment. So got the ambulance. The ambulance came. They took us over to the Integrated Clinical Center. From there, they helicopter-lifted Jason from the southeast part of town to Specialize Pediatric Care Center.

During the interview, Smith explained shaking his son as an emotional response to uncertainty about what to do to care for Justin when he became unresponsive. He shared that the medical examinations determined that Justin had brain and retinal hemorrhaging, brain swelling, and rib fractures due to non-accidental trauma. Accidental or not, the implications of Justin's injuries were profound. Justin spent about three months in the pediatric intensive care unit at a regional children's hospital, during which time he underwent surgeries to abate intracranial bleeding. As his condition stabilized, he was transferred to a local pediatric facility that specialized in caring for children with acute complex health needs, where he stayed for an additional four months. As the months of hospitalization continued, the prognosis for his recovery became more certain. Justin ultimately had lasting health issues resulting from the injuries he sustained, including vision, hearing, and speech impairments, developmental delays, frequent seizures, and physical disabilities that required that he be transported in a wheelchair. He also had a gastronomy tube placed during the seven months when he was hospitalized.

During his initial consultations with the emergency room staff, Smith admitted that he shook his son and explained that he did so as an attempt to rouse him. This activated mandatory reporting procedures. A criminal investigation was opened almost immediately after Justin was admitted to the hospital, which lasted throughout much of his hospitalization. Smith soon found himself at the center of the investigation and

realized early on that the child-welfare and police investigators were leaning towards blaming him for his son's injuries. He recounted the questions he faced during his initial interview with investigators in the hours and days following his son's admission to the hospital,

> What are y'all's living habits? Who usually watches him? Do you have anger issues? Is there domestic violence going on in the relationship? Is there drug, substance, alcohol abuse? Do you have any mental history? Any problems of that sort? Just basically your typical investigation questions, but if I could say something they was probably already leaning towards me before the end of the interview was already ever.

The various investigators that Smith spoke with in the days and weeks that followed repeated these questions. Although Smith acknowledged the routine nature of their questions, he also sensed, even from his first conversation, that his fate had largely been determined from the outset of the investigation, perhaps even before he spoke to a detective.

Smith's story was complicated by his son's short, yet eventful, medical history prior to his injury. Justin's first exposure to violence happened on the day when he was discharged from the hospital. Arlene (Justin's mother) had a strained relationship with her mother and extended family, largely due to their disapproval of her relationship with Smith. These tensions escalated with the news that the couple was expecting. Despite these tensions, Smith and Arlene agreed that Justin would reside primarily at Arlene's house. On the day when Justin went home from the hospital, it was only a matter of hours before conflict escalated among Arlene's family members. Smith recounted,

> She called me few hours after him being discharged from the hospital, and she said, "you need to come get your son because this is a hostile environment over here. I'm just being grilled, bombarded. I just want you to come get him and take him home with you. Because he's just been born, he's fragile, he's delicate." All this noise and mayhem, she just didn't want him around it. So when she called

> me, I got a ride up there. As we pulled up, I could kind of see that it was already about to be a situation because as I was walking up, her mom was like, "You don't even need to come over here. Just go home." And I was like "no." I'm here to get my son, so I'm not leaving until I get my son. I guess at which point Arlene heard me from inside, so she tried to bring-she put Jason's snowsuit on, and she tried to hurry up and bring him out to me, so I could get him. At which point, like twelve different hands totaled him like this, and about like twelve different hands-I got people slapping me, people pulling him, and throughout the whole thing, there's only one memory that will stick with me. I could just remember smelling like a waft of liquor throughout this whole thing.

During the struggle, Justin got caught in the crossfire among his family members and was dropped in the midst of the fracas. Within hours of being discharged from the neonatal unit, he returned him to the hospital—this time to the emergency room. Physicians conducted an examination and cleared him for discharge without noting any ill-effects of his fall or the struggle amongst his family members. Smith's mention of heavy alcohol use reflected a pattern among Arlene's family members, including her mother who lived with alcoholism and became aggressive, at least verbally, when she was drinking; outside of Smith and Arlene, Justin's grandmother was Justin's main caregiver and spent extensive time with Justin individually, perhaps even when inebriated.

Smith attributed the old cranial bleeds and healed fractures discovered by physicians in their evaluation following Justin's injuries primarily to his being dropped in the early domestic violence incident. Although Smith reminded the doctors of Justin's involvement in domestic violence; Justin's doctors, however, dismissed the earlier incident as the cause for the previous injuries because his medical records did not indicate that these injuries had been present. Retrospectively, he also wondered if his son suffered the injuries while in the care of Arlene's family members, especially given the violence and frequent alcohol use among her family members. For Smith, these factors established

plausible deniability but he was not able to substantiate his suspicions or convince investigators of their importance during the criminal investigation. Smith initially spoke with doctors and later investigators in the hope that the information he provided would help his son's recovery. As the investigation progressed, he realized—maybe too late—that his candidness during these early conversations may have led investigators to conclude that he was culpable.

The aftermath: Separation from Justin and court proceedings. In addition to being the target of investigation, Smith simultaneously encountered hospital policies and practices ostensibly designed to protect especially vulnerable children from further harm. Smith noted that medical staff,

> Would move him to certain rooms where he could only have one visitor, or they would put him on units where he couldn't have visitors, just because they know I was coming or they knew I was going to try to come when I called. They told me they couldn't release any information even though I had the passwords and all that for his medical information. They wasn't trying to tell me anything.

It was not long into the investigation until these restrictions were superseded by a protective order that barred him from having any contact with his son or any other children. This order extended throughout the course of the investigation and ensuing criminal proceedings, thus preventing him from having contact with Justin or any other children. As a result of the investigation and the protective order, Smith was barred from the hospital throughout the course of Justin's lengthy inpatient stay.

Smith's suspicion that he would ultimately be charged for his son's injuries proved true. He was charged with aggravated assault, which carried a possible sentence of 10 years in prison. After almost three months being separated from his child, he pleaded guilty to the lesser charge of second-degree cruelty to children with grave risk at

this lesser charge. While still a felony, this plea deal resulted in probation and—most important to Smith—relieved the protective order and allowed him to be reunited with Justin.

Smith faced an overwhelming amount of stress in the months following his son's injury. Smith was at once uncertain about his son's prognosis and felt blamed for his son's condition. He described how his perceptions of himself changed in this period as a response to the criminal investigation and the restrictions placed on his parenting of his son,

> I just felt like a real child abuser. I just felt like a criminal. I just felt like a predator. You know what I'm saying? And it wasn't really my fault, but it really made me feel that way. It made me feel like a registered predator.

During his interview and despite my probes, Smith never disclosed being concerned about how to navigate the legal case where it seemed that his guilt had been presumed. Instead, his thoughts centered around Justin's wellbeing and his role in compromising it,

> I just blamed myself. I was thinking that I ruined his childhood. I robbed him of his sight, his childhood, his physical abilities. That's just pretty much how I felt. I really felt like it was my fault for a long time. I really did, but I really felt as though it was my fault. And it really wasn't.

Smith missed his son. He was scared. He blamed himself. He worried and felt guilty that he had ruined his son's childhood. Justin's chronic health issues and the emotional weight Smith carried precipitated a significant decline in Smith's mental health. Smith's mental health declined as he simultaneously wrestled with feelings of guilt for his role in his son's injuries, felt alienated from his son and support, uncertain about his son's wellbeing, and—perhaps most damning—was powerless to change any of these. Smith described this acutely low period in his life during his interview,

> I've never felt any lower in my life. I felt completely helpless. I was spiraling completely out of control, just alcohol, drugs, the wrong crowd, trying to take my mind off of it. I didn't even want to be in my own house because that's where the incident occurred. I didn't even want to be in my own room where it happened. I just kept staying with family, staying at my sister's house because she lives in walking distance of my mom's. So, everybody was just trying to support me at that point.

He acknowledged that his family attempted to provide support for him during this time but the emotional and tangible support he received from his kin could not begin to touch the depth of his pain. The efforts of Smith's family to provide emotional support for him during this time, however, were not enough to outweigh the substantial stress that he carried. Smith turned to drugs and alcohol to drown the overwhelming thoughts and feelings he carried about his son. At their most dangerous, his depressive symptoms precipitated what may have been a tacit suicide[26] attempt as he "tried to drink [himself] to death. [He] got really high" in the days and weeks following his son's injury and the pending investigation. Whereas he acknowledged having at least passive suicidal ideation during this period, it is unclear that he made an attempt using drugs and alcohol. The intentionality of his drug use notwithstanding, Smith was clear about the reason he used drugs, "I was just searching to fill that void of him, and I wasn't doing it with the right things at the time. But it was pretty much how I felt like I could cope with it."

Smith's experience highlights the interdependence of fathers and children's health. His actions undoubtedly precipitated the injuries that caused his son's pervasive disabilities. The emotional weight of worrying about his son's health, guilt about having caused his son's disabilities, and being separated from his son led to what was likely an

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[26] Although I did not formally inquire about present suicidal ideation during the interview, my clinical judgment and work with him beyond the scope of the interview (as a staff member at the Teen Parenting Project that he and Arlene participated in) suggested that he was not experiencing suicidal ideation at the time of the interview.

episode of major depression. Although he was reunited with Justin and his health eventually improved, albeit with significant permanent effects, Smith's mental health as well as the substance abuse issues he acquired in those early, uncertain months persisted long after his legal status and Justin's health stabilized. The felony conviction that resulted from his criminal case prevented him from getting a job and he had been unemployed for more than a year at the time of his interview. His inability to provide for his family triggered a second, enduring wave of depressive symptoms.

Smith maintained his innocence throughout the investigation and court case. Perhaps due to the strength of her connection to Smith, having little social support outside of him, or due to some other factor, Arlene chose to believe that Smith had not harmed their son, at least not maliciously. Her belief that Smith had not harmed their child and their increased conjoint commitment to remaining together created an "us against the world" mindset that motivated their defiance against the restrictions set by their family. Whereas this early adversity may have driven many other couples apart, their shared experience may have drawn them closer as a couple and coparenting team. While Smith was separated from their son, Arlene bore the sole responsibility of interfacing with Justin's providers, learning how to care for his complex health needs, monitoring changes in his health, and caring for Justin. They did, however, find ways for Smith to covertly spend time with his son. He recounted working with Arlene to dodge the various forms of supervision imposed on their family since Justin's injury,

> Most definitely working around everything, which was not the best idea at time, and I don't recommend it. But just again, when you're young, and you really want to do something, you're gonna do it. It was like being chased by the police. It was really like being chased by the police. She's ducking, just running the end of my house, ducking into here. We gotta make her leave out the backdoor with him, and make sure nobody's watching. And just even when I'm with him, I gotta keep

> most of his clothes on in case somebody like a social worker knocks on the door. We gotta hurry up and shuffle him out, hurry up and get her and him out. Because, at that point, they were going to charge her with a failure to protect.

Both Smith and Arlene assumed significant risks through these visits. For Smith, getting caught meant that he faced the risks of lengthening his sentence. Arlene risked being charged with a crime herself, which would have likely resulted in Justin being removed from her custody. Arlene facilitated these visits in spite of the risks she faced, which allowed Smith to continue forming a relationship with his son, and begin to learn how to care for his health needs. That Arlene assumed such risks to facilitate Smith's relationship and caregiving suggests that she anticipated that he would continue to be engaged as a caregiver for their son. In some ways, her early, risky facilitation of his relationship with Justin represented an investment in Smith as a caregiver and a way that she aimed to create a social support for herself as well as their son.

Reuniting with Justin: The learning curve. These surreptitious visits notwithstanding, Smith was largely uninformed about how to care for his son when he was reunited with him. Having been separated from his son in the aftermath of injuries, Smith discussed feeling "behind" and having to learn several new and unexpected skills to care for his son,

> I was pretty much dumbfounded with everything with his health until he came home, and I could first-hand witness it. But I wasn't the greatest at first, but I got really good at the little stuff like giving him his meds and all that. And then the other stuff, it comes kinda later, like the suctioning.

Arlene's extensive interactions with medical providers allowed her to learn the intimate details of Justin's various health issues as well as acquire specialized skills (e.g., suctioning secretions, administering medications) necessary for caring for him. Having been excluded from participating in his son's medical care for such an extended period of

time, Smith knew very little about how to care for his son's health when the protective order was lifted. He talked about how, despite the information that Arlene shared with him about their son's condition, he felt unprepared to care for him when he was about to resume caring for Justin:

> Don't discredit me for this, but I think she's got the best of the best as far as the training for him because she was there for every minute-every minute, every step. That's why she could come in here right now and suction it all out, and it'll take her like two minutes when it takes me like five or six minutes. So even though I'm good and know my stuff, I'm not as good as her. But that's what I'm working on. And actually, I can shave at least three minutes off because I've been practicing with the suction lately, so you know, I've actually gotten way better because I used to just hand him to her. I used to be like, "Baby, you need to suction him off." I don't like doing that to him because you gotta stick the thing down his throat, and he gets uncomfortable.

Smith's narrative highlights how caring for children's chronic health needs, particularly when it requires specialized skills, often exceeded fathers' initial, general knowledge about caregiving and required young men to learn new skills. Kin-work with mothers of their children and other caregivers helped men secure sources of support and information necessary for acquiring the specialized knowledge and skills for caring for children's chronic health needs. When fathers were unable to attend children's medical visits or are otherwise separated from their children, mothers were often the primary source of this caregiving information. Smith's positive and continuous relationship with Arlene allowed him to observe her caregiving and turn to her for instruction about how to care for their son.

Smith's narrative and ability to acquire skills from asking and watching Arlene reflects the nature and quality of their relationship. Despite the trials they endured, they remained romantically connected throughout. They eventually resumed living together at Smith's parents' house when the protective order was lifted and eventually sought

emergency shelter and were placed in a hotel room through the city's housing office. This close, extended contact allowed Smith daily opportunities to observe and learn caregiving skills from Arlene.

In terms of Justin's daily care, his pervasive developmental and physical health issues required substantial attention from his parents. Smith and his partner needed to suction secretions, clean his son's gastrostomy tube, as well as maintain various equipment necessary for Justin's care. Initially, however, Smith did not know how to do these things for Justin. He discussed how these activities shaped his day,

> It's tedious because just the simplest little things, just a family outing, could turn into a disaster if his feeding bag is not charged. You know? He has a feeding bag that has to be charged. It has to stay clean of course, and you know I just gotta maintain all of it. What I do every night is I get all of his equipment. I plug it up to make sure it's fully charged because I don't know what the next day will hold. I clean it out. I put my gloves on. I clean it out. I clean his chair out. I redraw his meds for the next morning, so I don't have to while I'm half-asleep and accidentally give him the wrong dose or anything like that. I redraw all his meds. I get his feeding bag for the next day because he changes bags every day. The night before, I get his feeding back, and I run the milk through so that all I gotta do is put it in and hook it up.

Much of Smith and Arlene's days were consumed with caring for Justin's health. These tasks were a lot for Smith and Arlene to manage, which contributed to regular arguments between them about caregiving duties. These arguments became part of Smith's daily routine as much as caregiving and were a primary source of conflict between Smith and Arlene. The conflict they experienced reflected the added stress that parents of children with chronic health issues experienced both individually as well as in their relationships (Bellin, Kub, Frick, Bollinger, Tsoukleris, et al., 2011; Dabrowska & Pisula, 2010; Quittner, Opiparo, Espelage, Carter, Eid, et al., 1998). Whereas there is some dispute about whether having a child with a chronic illness contributes to the dissolution of

romantic relationships between parents, children with chronic illnesses are less likely to co-reside with both a mother and a father (Cohen and Petrecu-Prahova 2006; Swaminathan, Alexander, and Boulet 2006). The challenging contexts surrounding Smith and Arlene's relationship—the etiology of their son's illness, their limited access to financial resources, and disconnection from most family members—made their story especially unique. Their abilities and choice to remain connected to each other—romantically even—throughout the challenges that they faced together and as a family may speak to personal and relationship resilience that would be exceptional for any parents, let alone those who are embedded in such challenging contents.

Smith's narrative also highlighted how common heath caregiving tasks could also be more complicated for children with chronic health issues and interrupt fathers' daily plans and routines. Smith (21 years old) took his son, Justin, for a visit with his grandmother who lived in a neighborhood across the city. Smith's son had significant physical and developmental disabilities that required him to use a wheelchair for transportation. Whereas Smith anticipated and made accommodations for the added challenges of using public transportation for the 90-minute trip, he had not anticipated the acute hygiene incident that occurred in the midst of their traveling:

> I was coming from here, Rochester Avenue, over to southeast, where my mom lives. I got over there on Alaska Avenue, and he doo-dooed everywhere on the bus. I mean everywhere. I had to get off the bus. I didn't want to leave it on him, so I had to get off the bus. I'm at the bus stop trying to hold him so he doesn't hurt himself or go into a seizure or anything. So I'm at the bus stop trying to wipe him and make sure. We get back on the bus, come back home, he did it again.

At face value, addressing an unexpectedly messy and inconvenient diaper while in public is a common experience among parents. Justin's disabilities and the requisite accommodations, however, complicated an already challenging caregiving moment.

Justin's emergent hygiene needs compounded the complexity of his trip with his son and ultimately delayed his trip several hours. Smith's narrative also illustrated fathers' abilities to simultaneously consider several aspects of children's health as they provide care for their children. As Smith addressed his son's hygiene needs, he was also cognizant that the bumpiness of the bus ride and sudden movements involved in exiting the bus may have triggered one of his frequent epileptic seizures, which would have further exacerbated the hygiene issue. This response also suggests that fathers triaged their children when confronted with complex situations and prioritized attending to the most critical health issue followed by other, less acute issues.

"Nipped"—Delonte's Story

Similar to Smith, Delonte (21 years old) had children with chronic illnesses. The severity of his daughter's illness, however, differentiated Delonte from other fathers. I met Delonte when he and the mother of his then-pregnant partner, Lili, attended a dyadic, prenatal, coparenting intervention aimed at promoting positive relationship skills among adolescent parents. Whereas I believed that DJ was Delonte's first child, I learned through his interview that DJ was, in fact, his second child and he had a daughter, India, from a previous relationship. As I learned about his daughter, I asked about her health at birth and Delonte noted that her doctors identified that India had a serious heart issue days after she was born,

> Her heart. Something was wrong with her heart. Something wrong with her heart. …They ain't tell us that much because I left. I don't know what happened. After that I left after that. After they said that she had something wrong with her heart. I had an emergency to go to.

Delonte knew that something was wrong with his daughter's heart but was uncertain about the exact problem. There were several factors that likely contributed to his lack of knowledge about her health. Firstly, his relationship with her mother had long been volatile with amicable periods marked by romantic connection, communication, and collaboration interspersed with periods of separation where contentious dynamics interfered with their abilities and desires to communicate with each other. Delonte was also hustling[27] at that time; neighborhood violence, concerns about bringing danger near his daughter, and disapproval from his daughter's mother may have presented barriers to his involvement in his daughter's care.

He also faced some cognitive and learning challenges that may have impeded his ability to develop general health literacy as well as child-specific knowledge. From our previous work together, I knew that Delonte had been enrolled in a special education program throughout much of his school career. The beginning of the interview also illustrated these challenges—when I handed him the informed consent form, Delonte pointed his pen at the words as he read, thus allowing me to observe that he was

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[27] "Hustling" generally refers to obtaining financial resources through activities often deemed illegal (Whitehead, Peterson, & Kailee, 1994). These activities include but are not limited to: selling drugs, robbery, and theft. Young men identified "being outside" or "in the streets" as temporal contexts for hustling. They discussed experiencing dissonance about hustling as a means of providing financial resources for their children but noted that the activities themselves were inconsistent with their fatherhood role constructions and long-term goals. Having children sometimes led men to "stay inside" to remove themselves from hustling and the streets. This could be a gradual transition punctuated by stints—hopefully brief—of returning to hustling in order to meet short-term or emergent financial needs, as in Delonte's case. More rarely, fathers who were employed also used the term to refer to working hard at legally-sanctioned jobs, an ode to the long hours and work ethic commensurate with "outside" work.

struggling to read through the text.[28] Lacking basic literacy inhibited Delonte's ability to read written materials that may have been given to him by his daughter's mother or even spell his daughter's condition so that he could learn more about her condition on his own.

Fearing loss. Delonte's fear of losing his daughter has also contributed to his withdrawal from learning about his daughter's condition and caring for her needs. He described his emotionally-driven reactions to her chronic illness in the days and months after her birth,

> I start acting…acting…crazy and everything. I hope she don't leave me and all that. Everything I think about the heart, if they say something wrong with your heart, you gonna pass away. And then I was like, I hope she don't get…

His fear of losing his daughter was so profound that he could not bring himself to accompany his daughter to the hospital when she underwent surgery to correct her heart abnormalities. Reflecting on that experience, he shared his fear of losing his daughter during surgery:

> Because I think she was going to leave me. I'm scared to see…I'm scared to do something if she go to surgery because my grandmother went to surgery and she passed and I ain't want her to for real.

Delonte's recent loss of his grandmother, who raised him, primed him to be worried about his daughter. He had been devastated by the loss of his grandmother and could not bear the prospect of losing his daughter.

India was also diagnosed with asthma a few months after her surgery. Given her other health issues, the doctors warned Delonte and India's mother that her condition was particularly severe and required close monitoring. Delonte noted,

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[28] I quickly offered to read the informed consent form to Delonte because I was concerned that he would aim to save face by moving to the signature area to endorse it without understanding its terms.

> It was real, real, real bad. The doctor told us to watch over her, like, everyday and watch over her because it was real, real, real, real bad. She could die. We was talking, "do this," "do that," "do that," "do this."… It was struggle on me because I was doing all of the work and get…like, I gotta be…She had a job. She quit because her daughter had asthma. She quit and then she blame it on me to do all the work. And I trusted her to be with my daughter. Now I can't trust no females like that-or other people.

The severity of India's condition required a great deal of supervision, which led India's mother to stop working in order to provide the support that her daughter needed. Needing to provide additional resources to allow for India's mother to stay home with their daughter, Delonte increased his hustling, spending more time in the streets, moving more product, and taking greater risks to earn the money he needed for his daughter.

Conflictual relationship. After several attempts to make their romantic relationship work, Delonte and India's mother ended their abusive relationship in 2009 when she sought a protective order against Delonte after an incident of inter-partner violence. A combination of knowing their violent history, awareness of his lingering anger toward her, ignorance of his parental rights, and distrust of the court system kept Delonte from seeking visits with India despite his continued provision of financial support for his daughter and ex-partner. The restraining order that India's mother initiated at the conclusion of their relationship led Delonte to—aside from occasionally providing financial resources—withdraw from visiting and caregiving for his daughter, despite her significant health needs.

Fear realized: Losing India. Delonte's lack of communication with India's mother and separation from their daughter proved fateful; his daughter died in 2010 when she was four years old due to an asthma attack. Delonte did not, however, learn about her

death until two years later. He recounted receiving the call from his ex-partner's foster mother informing him that India died,

> She didn't tell me. She moved out of the city a month ago, a year ago. After that, they called me, "She moved out of the city." Cause, I was looking, looking for my daughter because I was doing side jobs, taking, taking my daughter out and…. I'm talking to my friends and got a weird call and the mother called me and said, "Your daughter passed." I said, "I don't wanna hear that." She said, "for real. Your daughter passed." And I said, "When?" She talking about 2010 and it's 2012 and you talking about…

The year that Delonte learned of his daughter's passing had been a very tough year as he lost his father as well. Our interview happened within a year of his learning of his daughter's death and his father's passing.[29] The compound losses of his grandmother, father, and daughter provided a historical context for Delonte's constant worry about his son's health. Delonte's story highlights how young men's previous health and caregiving experiences informed responses to their children's chronic health issues. His story illustrates how witnessing the impact of chronic health issues on family members' health

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[29] As noted earlier, I was surprised to learn that he had a daughter, let alone that she had died. From my previous work with Delonte, I knew that he was still experiencing intense grief—perhaps depression—related to the loss of his grandmother and father. My previous experience with him as well as my clinical judgment led me to believe that having an extended conversation about his daughter may have triggered troubling thoughts and intense emotions that exceeded his abilities to cope. Therefore, I chose to probe just enough to get the highlights of his story with India and allow Delonte to lead his sharing. Whereas this strategy helped contain emotions and thoughts that may have been overwhelming for Delonte, it did not allow me to collect as detailed information about his daughter as I would have liked. In particular, I wanted to know more about her health condition, the caregiving required to address her needs, as well as what Delonte did to care for her when she was alive and he was able to spend time with her. An example of the ambiguity that remains in Delonte's story is regarding the extent of his daughter's illness: he alluded to India having physical disabilities but this was unclear from his remarks. Ultimately, I believe that prioritizing Delonte's emotional safety was the more ethical and responsible decision, even at the expense of collecting the most detailed data. Most importantly, it was respectful of him as a person, particularly one whose grief made him vulnerable.

and functioning as well as losing loved ones due to illness, heightened some men's responses to their children's chronic illnesses. These prior experiences may also complicate young fathers relationships with children's mothers, other caregivers, and medical providers, particularly when these histories confer the contexts of loss and distrust.

Learning that India died was especially hurtful when Delonte considered the risks that he assumed to provide for his daughter and the trust he placed in her mother. Wanting to provide for his daughter, Delonte increased his involvement in hustling, primarily selling drugs, which placed him on the front lines of violence in his community. He assumed the risks of becoming a victim of violence, perpetrating violence to protect himself, as well as maintain his territory and that of his associates. The tools of his trade and his product—weapons and drugs—also made him a target of police activity. He continued to engage in hustling after his relationship with India's mother dissolved because he wanted to provide for India, even if he was not able to be physically present with her. Delonte's anger was, in part, stoked by having exposed himself to these additional hazards when she had long passed. He noted,

> Yeah, I knew because I went to the hospital with her and everything. I said, I'm gonna shoot and I'm gonna be on the streets tryna get some money to feed my daughter and all that. I said "can you take care of my daughter?" Then I come home and I'll help you out. Find out later that she wasn't taking care of her for real. She had another nigga in the house and everything. She left and went to get some eggs and she pulled in and my daughter wasn't on the machine. Then she came back and said she did. Then, the mother want to call me and say all that. I hung up on her—I don't want to hear all that.

New relationship and new baby. Delonte's perception that India's mother failed to provide adequate care for her asthma and her subsequent failure to inform him that his child passed made it very hard to trust his new partner, Lili. Delonte met Lili in 2011 and

their son, Delonte Jr. (whom they referred to as DJ), was born in the Fall of 2012. Delonte's prior experiences of loss, however, made him wary of Lili's ability to care for DJ and contributed to constantly feeling worried about DJ's wellbeing when he was not around. He noted,

> I be worrying a lot because I don't know what's gonna happen. I lost my daughter and I don't want to lose my son. And…it's crazy…She was on the machine. The mother took the machine off and then she can't breathe and then she passed in the house. The ambulance came. I'm still pissed and mad.

At the time of the interview, Delonte was living with the compound, unresolved grief of having lost three of his closest family members. He was especially angry at India's mother for failing to provide adequate care for their daughter. Delonte's hurt and anger about losing his daughter provided a context that sometimes overshadowed his ability to think about and evaluate his new son's health.

Being nipped about his son. His history of losing close family members as well as his daughter led to Delonte being very uncertain about the longevity of his relationships with his son and Lili. His emotional experience of parenting could be characterized by constant worry that his son might encounter similar health issues as his daughter did and, ultimately, fear that he might pass away, thus deepening an already profound emotional wound. Being "nipped"—which he defined as feeling uncertain and worrying too much about an issue—represented how he navigated a history of loss, distrust, and grief towards promoting his son's health. Delonte began feeling "nipped" about his son, Delonte Jr.'s health after he began displaying early signs of having asthma and had been prescribed asthma medications. He discussed how the onset of symptoms led him to experience a constant concern about DJ:

> This wheezing thing. That stuff scare me. Because it's too crazy. I be nip all the time, every day when I be at home and he be over here. I be nip, like. Because Lili is young and everything. Real young. She listens to people on the streets and they don't know what they talking about. Like her cousin, she got kids and she all that. She don't know how to take care of her kids for real and Lili listen to them and I be over there nip, like, oh my god, I hope my son be okay.

Coping with his emotional responses while navigating in his coparenting relationship with Lili in the context of distrust represented substantial emotion-work that included moderating his anxiety while communicating his concerns to Lili, negotiating their shared approach.

Navigating dangerous communities and daily routine. Delonte resolved the constant anxiety he felt about DJ's health by spending considerable time with his son. Although he did not officially reside with Lili and his son, he spent most days and several nights a week at the two-bedroom apartment that Lili shared with DJ, Lili's mother, and grandmother. In prioritizing providing direct care and supervision for his son, Delonte assumed substantial risk traveling to and from Lili and DJ's home due to his history and reputation hustling in his neighborhood. Feeling nipped led Delonte to travel across the city frequently, despite not feeling safe moving about in areas much outside the blocks surrounding his mother's home.

The recent and ongoing neighborhood conflicts both gave cause and heightened his concerns for his personal safety. His history as one who was formerly involved in these neighborhood feuds contributed to his feeling unsafe while outside. Additionally, his purposeful disconnection from former associates in an effort to preserve his safety and remain alive for his son's sake may have also interrupted his access to knowledge about the latest neighborhood conflicts, thereby impeding his ability to avoid emergent threats. Taken together, these factors led Delonte to feel vulnerable when traveling about

his neighborhood and beyond. Being nipped, however, proved so motivating for Delonte that he relegated concerns about feeling personally unsafe in service of caring for his son.

Summary of Case Studies

In many ways, the circumstances of Smith and Delonte's stories as fathers of children with chronic health issues were exceptional and distinguished from other participants. Both men discussed being disconnected from their children's health information—albeit for different reasons—which inhibited their abilities to care for them. Justin and India had, by far, the most severe chronic health conditions among the children in the study. Justin and India were the only children in the sample whose chronic illnesses contributed to significant physical and cognitive issues. They were, however, embedded in relationship, neighborhood, and relationship contexts that were similar to other fathers whose children's health issues were less severe.

Smith and Delonte's relationships with the mothers of their children illustrate how these relationships helped fathers overcome barriers to being involved with caring for children's chronic health needs. The way that Delonte's daughter passed—from inadequate disease management—in the wake of maternal gatekeeping and separation from his daughter highlights the importance of maintaining collaborative coparenting relationships among parents of children with chronic health needs. Collaborative relationships facilitated fathers acquiring the caregiving skills—sometimes specialized (e.g., administering medication via a nebulizer)—and knowledge necessary for caring for children's chronic health issues. These skills and knowledge positioned fathers as caregivers who had the abilities to respond to a range of children's health needs. Fathers'

relationships were conduits for critical information about their children's health; for some children, like India, these relationships could be a matter of life and death.

Young fathers' emotion-work was not confined to their relationships with their children or even to their relationships with mothers. Instead, fathers considered the emotions and relationships with their own kin as well as others. This was particularly important for fathers of children with chronic health issues because their children required additional caregiving beyond what was commensurate with raising children without chronic conditions. While the extent of their children's illnesses was exceptional, their stories demonstrate how fathers' emotional experiences may impact fathers' own health and abilities to care for their children's needs.

Smith and Delonte's stories also highlight structural barriers that may inhibit young, low-income fathers' abilities to engage in caring for their children's chronic health needs. Both Delonte and Smith faced legal cases that separated them from their children. Whereas the protective order against Smith explicitly prevented him from spending time with his son, Delonte's order only restricted his contact with his ex-partner, not his daughter. His lack of knowledge about the family court system as well as his rights as a parent may prevented him from pursuing visitation with his daughter. Even if he had known that he was able to pursue visitation through the family court system, he, like many of the fathers in the study were reluctant to engage the courts due to concern about the surveillance that it would add to their lives that are already heavily surveilled by various systems. Like Delonte, fathers may also be concerned about engaging the family court system due to personal or vicarious histories with the legal system.

The remainder of this chapter will draw from the wider experiences of other fathers whose children had chronic illness. The impact of chronic caregiving on fathers' personal daily routines and the time they spent with their children will be discussed. The chapter will conclude with a discussion of fathers' efforts to prevent exacerbations of their children's chronic health conditions by managing their triggers.

Disease Management: Triggers, Environments, and Medications

Disease management represents a dimension of chronic caregiving that distinguished it from other aspects of parental caregiving. Children, particularly those who are younger, are dependent on parents to help them manage their condition. Disease management among fathers was marked by regular caregiving interventions aimed at remediating a condition, preventing symptom exacerbations, as well as stabilizing children's health when symptoms appear.

Asthma is the most common chronic illness among children and asthma or pre-asthmatic symptoms[30] were similarly represented among children in the present study (Akinbami, Moorman, & Liu, 2011). Much of fathers' discussions around disease management concerned managing their children's asthma. The elevated prevalence of asthma in the African American community made asthma very common in fathers'

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[30] The majority (*n* = 43) of children in the study were younger than four years old and differential diagnosis of asthma in children younger than four is challenging (National Asthma Education and Prevention Program, 2007). Children of this age are often unable to complete diagnostic tests (i.e., spirometry, testing exhaled nitric oxide) reliably, if at all. Whereas five years old is generally considered the youngest age when assessment via spirometry is administered, physicians may tentatively diagnose younger children based on clinical and parent-reported histories, including family atopy and comorbid conditions (i.e., eczema, allergies). If an asthma diagnosis is suspected, physicians may prescribe asthma an asthma medication regimen; abatement or improvement of children's symptoms support a tentative asthma diagnosis hypothesis.

personal health histories and their vicarious experiences of asthma among family members, kin, and community members (Akinbami, Rhodes, & Lara, 2005). The prevalence—even ubiquity—of asthma in their experiences contributed to a normalization of asthma as a part of childhood and led some fathers to minimize, at least initially, the impact that asthma would have on children's health.

Both Jamaal (20 years old) and his 22 month-old son had asthma. Noting his personal experience with asthma as well as the prevalence of asthma in his family, Jamaal was not surprised when he learned that his son had asthma.

> I wasn't surprised. My whole side of the family has asthma, my mother, my little sister, older sister, my little brother-my little brothers, only one of them ever had asthma. But I had it, too. It's a family trait thing, so it didn't really come to a surprise to me. We gotta treat him when he shows signs, just gotta treat him.

Drawing from his personal and vicarious experiences with asthma, Jamaal relied primarily on surveillance and treating his son's symptoms. These prior experiences and the perceptions that his son's asthma was relatively mild led him to prioritize these strategies over preventative medication management.

Isaiah (20 years old), whose partner happened to be Jamaal's sister, gained a different perspective from his prior experiences with asthma. He found out that his son had asthma when he was hospitalized when he developed pneumonia within the first few months of his life. He shared

> I took it as [his] mother's and father's generation running through him because I had bronculitus [sic] and his mother has asthma so I took that as nothing new. I just took it as I just got to make sure I stay on his game the same way I would stay on my own or as in I would stay on my siblings and them taking they medicine. I just mainly took it as an okay I can deal with type situation. I mean, its asthma can, and I mean asthma can kill you if you don't treat it the right way so me growing up with a bunch of asthmatics I mean it just helped me learn that asthma is not to play with. When I found out I was more so as an ain't nothing new type situation. That's what took it as—like that ain't nothing new.

Similar to Jamaal, Isaiah was not surprised by his son's asthma. For Isaiah, the severity of his son's early pneumonia as well as his prior experience managing his siblings' medications led him to emphasize the importance of managing his son's medications. The responses of Delonte, Jamaal, and Isaiah demonstrate the diversity of fathers' reactions to their children's chronic illnesses and how their histories—personal and vicarious—provide a context that shape how they approach caring for children's chronic health issues.

Having a child with a chronic illness heightened fathers' awareness of children's health as a part of their caregiving roles as fathers. This heightened awareness then impelled fathers to be deliberate about caring for their children's health. Of his three children (one biological), Trey (23 years old) expressed the most concern about the health of Kasey, his four year-old, non-biological daughter who had asthma. Having experienced countless bouts of acute symptom exacerbations and several trips to the emergency rooms when she was younger, Trey was aware that Kasey's asthma was serious and required firm efforts to address. Discussing her asthma, he shared,

> Dealing with my daughter's asthma, the most…is dealing with that the most. Because you're like you just don't know man. Because like I said, I grew up with a health problem. You just gotta be on top of it. You just don't ever know because hers is not no small asthma problem. It's a high-risk thing…She don't have no pump or anything. She's able to regularly breathe. It's just that you have to stay on top of it because it's like her oxygen-she's able to be a normal kid, but it's so serious as to where tomorrow she'd be in the hospital. It's something that you gotta constantly watch, keep scheduling doctor's appointments on the regular, make sure you're on top of your game, and be paying close attention, just one of those.

Being "on top" of his daughter's asthma involved caregiving activities that ranged from monitoring to taking her to doctors' visits. Not knowing when symptoms of

children's chronic disease would appear was among the most disquieting aspects of having children with chronic illnesses and produced elevated levels of anxiety in parents (Kunz, Greenly, & Howard, 2011). Trey's remarks suggest that fathers' responses to the unpredictable and serious nature of chronic illnesses may be to increase their surveillance of their children, even to the point of hypervigilant monitoring of their children—both directly and through frequent consultations with medical providers (Pelcovitz, Libov, Mandel, Kaplan, Weinblatt, et al., 1998).

At the same time as this vigilant observation of their children gave fathers peace of mind, it may also detract from their overall quality of life, and strain fathers' relationships with the mothers of their children (Crespo, Carona, Silva, Canavarro, & Datillio, 2011). Young fathers of children with chronic health issues carried the additional burden of knowing their children were ill but, due to contextual realities—living separately form their children, poor relationships with the mothers of their children, lack of access to financial resources to travel to see them, as well as a lack of knowledge or access to children's medical providers— not being able to be present to observe their children and intervene when necessary. Thus, the contextual barriers around young fathers may frustrate their efforts to enact their fatherhood role constructions of "being on top" of children's health. Thus fathers were left to carry the weight of knowing their children were ill but not having much recourse to alleviate their concerns by helping their children.

Learning Triggers

Fathers discussed the importance of identifying the environmental and behavioral factors that precipitated symptom exacerbations. As fathers learn about their children's

chronic conditions, they become aware of factors that precipitate symptom exacerbations. Shaping children's environments and their behaviors featured in men's discussions of how they prevented their children from experiencing adverse exacerbations. For some young men and their children, understanding their children's triggers came with diagnosis of the chronic disease. At the time of the interview, Keith's son was six months old and had been diagnosed with glucose-6-phosphate dehydrogenase deficiency (G6PD) a few weeks prior to the interview. When asked about his son's illness, Keith had difficulty identifying and describing the condition:

> What was that? It's something, PHD-6 or something. I forgot what it's called. I forgot. I forgot the name of it. (*What are the symptoms or what are the…?*) Something with like lima beans and fava beans and stuff that he can't have. (*Okay, so is he allergic to them or he just can't have them?*) I forgot the name of it. It's a list of stuff he can't have. (*What else is on the list?*) I'm not sure. There is something that they said he had. It's common though. I forgot the name of it.

Keith's responses during the interview suggest that he had little knowledge about his son's condition. This may, in part, be due to the nature of the condition and his son's developmental position. With hemolytic anemia as the medical issue associated with G6PD, Keith may not have observed outward symptoms that indicated that his son was experiencing an exacerbation. At six months old, his son may not, in fact, have experienced pronounced symptoms related to G6PD. His son was only beginning to consume solid food and thus had had little exposure to the dietary triggers. Also, like most infants, his son had been relatively healthy since birth and had not had fevers or received medications that may trigger an anemic response. Taken together, the novelty of the diagnosis and his son's relatively unaffected health to date may have made it so that G6PD was an abstract condition for Keith, thus contributing to his scant knowledge regarding it.

Whereas Keith was beginning to develop a cognitive awareness of his son's triggers through consultation with his son's medical provider, other fathers discovered their children's triggers through caring for their children. John's (19 years old) son had frequent rashes and was diagnosed with eczema early in infancy. Through careful observation, conversations with his son's mother, and consultation with medical providers, John and the mother of his son determined that his rashes were exacerbated by fragrances that were in many of the lotions and crèmes that they used. He noted,

> Like he always get like rashes or something in his face and stuff. Yeah so we would always be in the hospital. Like the only thing we do now is cause he got eczema so you know we just, that's the only thing. We just put him some cream and stuff…the doctors they gave us one cream for the eczema like to moisturize the skin but that didn't work so we just end up buying our own eczema cream and then I bought him some, it's like some powder that you put on his tub, yeah its some eczema powder…We just went to the store cause the doctor was like, cause basically he was something allergic to like fragrance. So we can't put like lotion with fragrance and stuff. So we just, me and Isabel just went to the store, you know we just started looking for it creams without you know, no actually find eczema cream, we just like you know let's just try this. You know we got, one time we got like six different lotions to see which one worked and stuff.

John's narrative highlights the process of trial and error through which fathers learned how to care for chronic illnesses among their children. Carefully monitoring for changes in their children's symptoms before and after treatment allowed fathers to assess the effectiveness of these treatments and, as in John's case, may alert fathers to factors trigger those symptoms.

Young men's own experiences living with chronic illnesses also sensitized them to their children's triggers, particularly when they shared similar diagnoses. When his son, Dayquan, was diagnosed with asthma, James (22 years old) used his own experiences living with the condition to help identify factors that precipitated symptom exacerbations. James drew parallels between his son's triggers and his own:

> I know he do have them symptoms that I do. Like he can't be in heat too much long like he can't be in heat that long. Like and I know in the house it get hot in here at night and I notice that's the only time he really do it when it's actually happening. When he got air, like when it's actually air coming through it be good. But when it's hot in here that's when the coughing come through. So I guess I have to get a fan or something.

James' narrative suggests that fathers' prior experiences with chronic illnesses informed the associations they formed between triggers and the symptoms that their children displayed. In addition to sensitizing young men to recognize their children's triggers, fathers' personal histories with chronic illness also informed how they approached addressing said triggers and mitigating their impacts on children's health. For James, he knew that both he and his son were vulnerable to changes in temperature so he proposed finding ways to cool the room where his son slept. Fathers' sympathetic recognition of children's triggers highlights the importance of their caregiving perspectives and approaches as they, through their histories as patients and survivors of chronic health issues, allow them to respond to children's chronic health issues with a sensitivity conferred by experience. The atopic nature of pediatric asthma as well as its high prevalence among boys of color suggests that many young, low-income, minority fathers may themselves be survivors of asthma (Bjerg, Hedman, Perzanowski, Platts-Mills, Lundback, et al., 2007; Ungar, MacDonald, & Cousins, 2005). Fathers' personal histories coping with asthma, as well as their vicarious experiences with kin who have asthma, may inform fathers' ideas about trigger management.

Learning about children's triggers by trial and error also happened through inadvertent exposure. Jay (22 years old) recounted the event that caused him to understand both that his son had asthma as well that his own smoking triggered his son's exacerbations:

> I was smoking a cigarette one time and he was wheezing. I thought, "Oh snap." You know what I'm saying? And then my mom was like, "Hello, I think he has asthma. We need to take him to the hospital." And because I've got asthma too, I had my inhaler, and I pumped it in his mouth and he started breathing good. I was like, "Man we got to go to the doctor's. I got to find out some stuff." Took him, yeah he got asthma. Good thing I had my pump.

Prior to this incident, Jay always smoked outside and away from his son but his son happened to join him on the porch that day. This moment presented several realizations to Jay—he discovered that his son had asthma, that his asthma symptoms were triggered by cigarette smoke, and that his son responded well to the same inhaled rescue medication that had been effective for his own exacerbations. The confluence of witnessing his son's distress as well as consideration of his own health and behaviors led Jay to stop smoking—"because my son needs to be here." Thus, Jay's identity as a father and his commensurate duty to his son motivated him to change his health behaviors when, perhaps, little else could have spurred such change.

Environmental Control

Asthma was the most common chronic illness among children in this study. Prior studies of parents' involvement in asthma management have identified environmental control—reducing the presence of triggers (i.e., allergens, dust, smoke, molds, cold air, dander, pollen, roaches) in the spaces where children spend considerable time, particularly their homes and bedrooms—as a component of parents' efforts to limit their children's exposure to elements in children's environments that may trigger exacerbations (Asthma Task Force at the Children's Hospital of Denver, 2012; Everhart, Kopel, & McQuaid, Salcedo, York, et al., 2011; Teach, Crain, Quint, Hylan, & Joseph,

2008). Accordingly, environmental control emerged as a salient theme for fathers in the present study.

Young fathers discussed seeking to manage environmental factors in order to prevent exacerbations and improve health upon learning that their children had asthma. Managing children's triggers sometimes involved behaviors that were not discretely caregiving but instead changed the environments around children and, in some cases, children's behavior. Fathers reported limiting their children's exposures to triggers through housekeeping, their own health behaviors, moderating children's behaviors, and advocating for their children with others who shared their children's environments represented ways that fathers were able to reduce their children's exposures to triggers.

Housekeeping featured into fathers' discussions of how they limited their children's exposure to environmental triggers. That housekeeping tasks emerged as salient for young fathers' experiences of preventing children's exposures to triggers may be due to the prevalence of pediatric asthma among children in the study. Andre (25 years old) smoked cigarettes and was aware that the smoke may lead to an exacerbation. Unlike Jay, Andre had not stopped smoking but described his efforts to reduce his son's exposure to secondhand smoke:

> Whenever I'm around I make sure like cause, because I like to smoke cigarettes I make sure I don't do that around him. I make sure I change my clothes…I'll take whenever I smoke a cigarette I make sure I take a shower. Especially when I'm in the house I'll take a shower, change my clothes and…I make sure everything, I make sure all his clothes clean, my sheets changed. Change the sheets, change the blanket and all that just so it won't, just so he won't catch no germs or don't get no dust. Whatever dust up in the house it don't make him more congested.

Andre sought to minimize the effects of his health-compromising behavior on his son, Aaron (15 months old) given the potential impact on Aaron's health. The

adjustments that Andre and Jay made around their personal health and caregiving behaviors highlight a reciprocal relationship between fathers' personal and caregiving behaviors and children's health. Having a child with a chronic illness heightened fathers' awareness that their actions and health behaviors impacted their children's health. Similarly, having and caring for a child with chronic health issues led men to evaluate and adjust their own behaviors.

Fathers' residential status had implications for how they controlled the environments where their children spent time. Few of the young men in the sample were primary or co-householders with their partners and instead lived as members—intermittent or full-time—of others' households. With these living arrangements, young men fathered in spaces that were not theirs and over which they had varying levels of control. In response to the constraints of not having their own spaces in which to raise their children, fathers focused their trigger mitigation efforts on factors that were within their ability to directly influence. As described earlier through Jay's example of stopping smoking as a result of discovering that it triggered his son's asthma, moderating their own behaviors represented a domain where fathers were able to effect change in order to reduce children's exposures to triggers.

Whereas fathers' positions within their households often left them with little direct control over their children's environments, fathers discussed advocating for environmental changes with other members of their households. This represents a form of kin-work by which fathers were able to marshal resources and buy-in among household members to create safe, healthy spaces for their children (Roy, 2004). Tevin (19 years old) lived with his mother, father, son (Mo, 15 months old), and mother of his child in a

three-bedroom apartment. Whereas Tevin and his partner did not smoke, his mother smoked regularly. Tevin reported that Mo's physicians had not officially diagnosed him with asthma due to his young age but had prescribed asthma medications and a daily treatment regimen. Nonetheless, Tevin believed that his son likely had asthma and knew that cigarette smoke exacerbated his son's symptoms. Therefore, he and his parents decided to adjust their behavior to limit Mo's exposure to secondhand smoke:

> All smoking goes into other rooms. If my mother is smoking she goes in her bathroom and turns on her fan. You know or if we having like a little get together, things like that, all smoking goes on the balcony.

Noting his son's susceptibility to secondhand smoke, Tevin's kin-work helped his family create alternate routines to reduce Mo's exposure to a trigger. As I conducted the interview in Tevin's apartment, however, I observed a heavy smell of smoke and haze that lingered in the apartment. The walls were also yellowed from decades of tar and nicotine that had since hardened. Despite Tevin's advocacy and the resulting behavior changes in his family, Mo was still exposed to potentially high doses of secondhand smoke. His experiences highlight the challenges young fathers faced when trying to control environmental triggers in spaces that were not their own, even if they were, like Tevin, members of their households. Moreover, Tevin's story highlights the power dynamics that fathers encountered at the intersection of navigating housing and preventing children's exacerbations through environmental control. There were some environmental factors and behaviors that fell within fathers' loci of control but their efforts may be undermined by the behaviors of other members of their children's households.

Without the ability to directly prohibit certain behaviors and faced with few alternate housing options, young men relied on kin-work to preserve collaborative relationships with other members of their households to create the most beneficial environments possible for their children (Roy, 2004). Kin-work allowed fathers to influence the behaviors of the people around whom their children spent considerable time. By working to establish, manage, and nurture relationships with their children's kin, they were able to create relationships by which they controlled—albeit remotely—their children's environments. Conversely, kin-work also allowed fathers to gather information about their children's interactions with the environments where they stayed.

Liaising with other caregivers, particularly those who are not as intimately familiar with their children's health, represented an important way that young men helped their children avoid triggers that would exacerbate symptoms of their chronic illnesses. Tom (23 years old) was his daughter's primary caregiver and lived at home with his adoptive mother. He shared that his daughter had had, in his words, "a light wheeze" since birth. Four years old at the time of the interview, Bianca still had a wheeze but it was relatively controlled through medication and Tom's careful attention to environmental factors that triggered her wheezing and shortness of breath. With his mothers' persistent prodding and assistance, they had been able to minimize Bianca's exacerbations while at home. Through his experience with his daughter, he knew that cold air was one of her triggers and discussed his preference that she avoid being unnecessarily exposed at school:

> Whereas the kids will go out and play recess all day in the 40° weather with the windows blowing, but I would prefer Bianca not be out there That cold air makes her congested and leads to wheezing and asthmatic problems.

Weather provided a context for Tom's remarks: the day of his interview, November 13, 2013, had been among the first "cold" days of the winter season. The recent change in weather made knowledge about cold as his daughter's trigger more salient and reminded him to inform his daughter's preschool teachers that she should remain inside during recess on cold days.

Tom's narrative also highlights fathers' use of kin-work to help them control children's exposure to environmental hazards. Whereas much of the body of research on father involvement in caregiving for children's pediatric and chronic health needs highlights mother-to-father communication regarding how to care for their children's health, Tom's experience suggests that fathers were similarly agentic in communicating direction for children's care with other caregivers (Garfield & Isaaco, 2012). That fathers both direct and follow caregiving regimens for their children highlights the importance of kin-work in fathers' caregiving. Maintaining positive, working relationships with their children's caregivers when they were not present was crucial for ensuring that these other caregivers help their children avoid environmental hazards that threaten their health. Thus, in some contexts, men became "kin keepers" who maintained relationships, in part, to ensure that their children would receive care that fathers could not provide themselves.

Trigger Inoculation

In addition to learning their children's triggers and controlling children environments to minimize exposure to triggers, fathers also employed the complimentary strategy of purposefully exposing their children to factors that triggered symptom exacerbations with the hopes that this would increase their children's resilience to the trigger. This trigger inoculation occurred while fathers carefully monitored their

children's symptom response and titrated their exposure. By introducing, facilitating, or permitting exposure to triggers in controlled contexts, fathers believed that, over time, children would become resistant to the trigger's negative impacts thereby improving their health.

Jamaal's son, Chez, was almost two years old and had been diagnosed with asthma when he was about twelve months old during an asthma-related emergency room visit. He had moderate asthma that was exacerbated by cigarette smoke and physical activity. Despite knowing that Chez may experience symptom exacerbations resulting from physical activity, Jamaal discussed allowing him to run around under close supervision,

> [I] keep him on surveillance. If we outside and he's running around, and I see him getting a little faint of breath, I'm a just you know sit him down, give him some cool water, let him hit his pop a couple times, and then let him go back and see how he acts. You know 'cause after a while if he keeps running like that, and his body gets used to him moving like that without having to pump, he's gonna grow out of it. So I just hope that he will. I mean I know he will— if he keeps active 'cause my little sister, she has severe asthma as well. She doesn't do as much moving around as I do, so when her asthma gets bad, it gets bad. Like she could wake up the next morning real faint of breath, and her asthma pump won't even work, nebulizer, that won't work. She'll have to come to the hospital to get some type of special albuterol or some type of special medication for the asthma. I just want to keep him active, so he won't have to worry about if he gets faint of breath.

Rather than limiting his son's physical activity, Jamaal facilitated his exposure to this trigger under carefully monitored and controlled conditions. Through close observation, Jamaal was able to administer care—rest and medication—at the earliest signs of exacerbation and then allow Chez to resume being physically active. Jamaal's monitoring, symptom treatment, and titration of exposure illustrate how fathers inoculated their children against triggers. His narrative also highlights the goal-directed

nature of trigger inoculation. His personal history as a person with asthma and witnessing it vicariously through his sister contributed to his belief that regular physical activity would help improve his son's respiratory functioning and avoid severe exacerbations in the future. By allowing and facilitating children's exposure to triggers under controlled conditions, trigger inoculation represented a way that fathers promoted their children's health longitudinally.

It bears noting that trigger inoculation was only reported among fathers of children with asthma and in relation to physical activity as a trigger. This may be due to the general and well-known health benefits of physical activity, which distinguished it from other triggers (i.e., smoke, dust) that have no such benefits. Given the nature of the condition and physical activity as at once a salutatory activity and trigger, inoculation may be a unique caregiving response to asthma. Further study is needed to ascertain if trigger inoculation occurs among parents of children with other chronic conditions.

Medication Management

Managing chronic disease often involved medication regimens aimed at remediating the condition, reducing symptom acuity, and preventing symptom exacerbations. Maintaining awareness of the types, dosages, delivery techniques, and timing of dosages were important aspects of medication management. Fathers discussed deliberate efforts to learn how to administer children's medications and how they gained confidence performing these duties for their children. The scheduled nature of controller medication regimes also provided structure for fathers' daily routines with their children. When these regimens failed to prevent exacerbations, fathers' daily routines with their children were suddenly disrupted.

As the father whose child had the most complex medication regimen, Smith's narrative warrants further attention as it highlights structural barriers that some fathers encounter when attempting to learn how to care for their children's chronic health needs. In discussing his motivation and strategies for learning how to administer medications for his son, Smith also demonstrates how young fathers navigate barriers to their caregiving. The protective order against Smith as well as hospital policies prevented him from participating in his son's medical care or attending his son's doctors' appointments. Therefore, he looked to Arlene to relay information about Justin's health (i.e., current health status, diagnoses, prognoses, and procedures he would undergo). With Arlene as his sole connection to his son's medical providers, Smith also looked to her to learn skills necessary for caring for Justin. When the protective order was lifted, he was able to begin learning and participating in his son's caregiving. He focused his initial efforts to engage with caregiving on learning to manage his son's medications. He noted,

> We was talking about [Justin's health], but it was like at that point-honestly, that was the only thing that I hadn't had experience with was a child was that type of injuries. You feel me. I knew how to change a diaper. I knew how to make the formula. I knew how to keep him quiet. You know what I'm saying, but I did not have any idea how to care for a child with special needs whatsoever. I was dumbfounded at first, but my ambition was me getting to watch him by myself, so I started drawing meds, I started memorizing names, I started going through doctor's papers, and now I'm just-you can ask me anything, and I know about it.

When possible, fathers drew from prior health and caregiving experiences to inform how they cared for their children's health, including with regards to chronic health issues. As Smith noted, however, having a child with chronic health issues presented challenges and required a skill set that could not be obtained from prior experience. Smith's narrative highlights fathers' motivation to care for children's health and to acquire the requisite skills to address their children's complex health needs.

Medication management involved discrete tasks that were accomplishable though clear directions and careful measurement. The discrete nature of medication management may have been less intimidating than other caregiving tasks such as suctioning, changing Justin's gastrostomy tube that may be uncomfortable for his son. He may have also been motivated to attend to medication management first because both he and Justin returned home around the same time. Justin's coming home was a major transition for Arlene as well. She had continual support from medical providers—doctors and nurses—throughout Justin's hospitalization and his coming home represented the beginning of their family adjusting to home-based caregiving. Whereas Justin's condition had stabilized, his doctors were still adjusting his medications to find the best combination.

Learning medication management provided a clear way for Smith to find his role as caregiver for his son in their reunited family. At the time of the interview, Smith's son took nine medications daily, each of which had a specific dose and schedule. Smith learned the importance of recording these medications, their dosages, and schedules so that he could care for Justin. He noted,

> How I started off, I started off really, really slow. I had a paper, and I'd be like, "Okay, this one, this one, this one, this one…" And then there was task of them switching them around, so before I could actually memorize them and the dosage and what they do, they switched them around a fair amount. So that kept me guessing. But as they kinda set in, I memorized them: the doses, what they do, side effects, all that.

Justin's medication regimen changed often as his doctors adjusted dosages and changed medications in order to accommodate his growth as well as better control Justin's symptoms. Whereas writing down the medications helped Smith gain proficiency managing his child's medications, it is important to note that much of this information—particularly in the months immediately following the suspension of the protective order—

was obtained secondhand through reports from Justin's mother.[31] Fortunately, this worked well for Justin because Arlene was an exceptional historian and caregiver who maintained regular contact with their son's physicians. Additionally, Smith and Arlene maintained a close relationship throughout the trials that separated Smith from their family and shared a great deal of information about their son's care. This suggests that in cases where fathers relied on mothers for information about children's medication regimens, their abilities to provide appropriate and prescribed care were as good as the information they received.

Fathers also turned to technology to help them manage their children's medications. Tevin (19 years old) supplemented writing by taking pictures of his son's medications with his phone. He shared,

> I mean cause I writes 'em, I even writes 'em down or they be in my room you know and when the doctor say you know this medicine, this medicine, I looks at the prescription you know sometimes write it down or even take a picture of it you know. Like you know just to keep it case if an emergency. Got to go to the hospital you know ambulance be like oh yeah any medication? Pull out my phone, he take this, that, that you know. Like that instead of you know oh I got to find this bottle, find that bottle. You know all that trouble.

Recording images of their children's medications represented a way that fathers could maintain and organize critical information about their children's health. Where young men may not remember or be able to bring all of their children's medications with them, storing information on cell phones made this information accessible and could ensure accurate dosages and reporting, when necessary. The ubiquity of cell phones,

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[31] Smith's reliance on Arlene for information about Justin's medication regimen was due, in large part, to a clerical oversight; although the hospital and criminal justice system had processes in place to communicate when a person should be prohibited from entering the hospital, the same communication did not happen when the protective order was lifted and Smith was legally permitted to resume contact with his son.

accessibility, portability ease of use for storing information about children's medications also came with some vulnerability. If these devices were lost or stolen, fathers would also lose the data. Whereas that data may be recreated with minimal effort by retaking the pictures, replacing the devices could be cost-prohibitive, especially with limited financial resources.

Caring for children's chronic health issues both provided a rhythm for young fathers' daily routines and could interrupt their days with unexpected health issues. Daily medication regimens were a common component of managing chronic illnesses and controlling symptoms, including those among children. Children's asthma control plans typically required that parents administer medications at set times during the day and this routine framed fathers' days with their children. Tevin (19 years old) discussed the importance of administering his son's asthma medication at proper intervals despite his son's objections,

> I mean well I give him his medicine on time, even though he doesn't like it and he screams when I, you know the little tube with the mask at the end? Yeah he screams but you know he gotta take his medicine so I give him his medicine you know and I keep up with his medicine.

Administering medications structured fathers' time with their children. Isaiah (20 years old) described how administering his son's asthma medication required multiple doses throughout the day and night,

> As the asthma, we definitely know he got to get his asthma puff and I mean every four hours. So every four to six hours. He gets it in the morning when he get up, he gets it around twelve thirty, one o'clock and then he gets it again at like five and at night we'll give it to him like around ten. So there for we probably got to wake him up out his sleep just to give it to him.

Whereas controller medication regimens provided predictability in fathers' time with their children, exacerbations of their children's chronic illnesses added variation to

men's daily routines. These unexpected health events required immediate attention and drew fathers into discretely health-oriented caregiving. The extent to which addressing exacerbations drew fathers away from their daily routines depended on several factors, including the severity of the symptoms, what was required to address the symptoms, as well as fathers' caregiving abilities. Minor exacerbations generally required a lower level of intervention and had less of an impact on fathers' daily routines, particularly when fathers were familiar with how to treat the symptoms. This was the case for the majority of the asthma exacerbations reported among fathers. As Jamaal discussed, surveillance often helped him catch his son's symptoms before they escalated and was able to address them through low-level responses (i.e., giving his son water, rest, and administering emergency medication). Addressing these minor exacerbations was relatively straightforward and did not interfere much with fathers' routines with their children.

Severe symptoms or those that did not respond to initial treatments required additional intervention, including taking children to the hospital. During one of John's (19 years old) first nights taking care of his son, Francis (six months old at the time of the incident but one year old at the time of the interview) began having trouble breathing. His son's breathing distress awoke John out of his sleep. He shared,

> Yeah and then he was sleeping and I was watching TV and then out of nowhere he just start like going [demonstrates sounds] and I was like I gave him the asthma pump, you know and then thirty minutes later he does it again and stuff so then that's when I left her house and then that's when, no Isabel came and then he was sleeping and she saw him doing it and she was like "what?" and then we gave him the asthma pump again. Then that's when like he didn't do it for like three hours and that's when he started doing it again and then that's when we just took him to the hospital and then they had him with like the mask and stuff.

Awoken by his son's breathing irregularities, John first attempted to treat his son's symptoms with the medication that his pediatricians prescribed during an earlier

visit. After several attempts to treat with limited success, he and Isabel (Francis' mother) took their son to the emergency room. Similar exacerbations and emergency room visits followed, although John was uncertain about how many or when these happened. These long—as well as frightening and stressful—emergency room visits illustrate the unpredictability of children's chronic illnesses and how acute exacerbations substantially altered fathers' daily routines. John's uncertainty about how many times he visited the hospital for his son's asthma may also suggest that such trips and interruptions become normalized in fathers' ideas about fathering and caring for their children's chronic health issues.

Conclusion

This chapter examined the third domain of the tri-partite framework of pediatric caregiving: chronic care. The chapter began with two case studies that highlighted how fathers' involvement in children's chronic disease management unfolds in relationship, social, and structural contexts often constrained young men's abilities to care for their children's health. The case studies also illustrated the additional caregiving support needed for children with chronic health needs—when unfavorable, young men's contexts complicated their abilities to provide this much-needed support. The chapter also discussed disease management, particularly around asthma, the most common pediatric chronic illness and most prevalent among children in this study. The disease management strategies of learning triggers, controlling children's environments, trigger inoculation, and medication management were identified as those that fathers used to respond to children's chronic health needs.

Smith's story navigating hospital policies, the criminal investigation, and legal proceedings begs the question about whether he would have experienced the same treatment had his socioeconomic station been different. From systems that collect blood samples and track food purchased among families receiving Supplemental Nutrition Assistance Program and Women, Infants and Children (WIC) benefits, drug testing attached to receiving public assistance, family court involvement, and the heavy presence of law enforcement in urban communities, many aspects of low-income families' lives are subject to institutional surveillance in ways that more-advantaged families are not (Garey, 2009; Nelson & Garey, 2009; Special Supplemental Nutrition Program for Women, Infants, and Children, 1999; United States Department of Agriculture, 2002; Windsor, Dunlap, & Armour, 2012). Low-income and minority families are overrepresented among those connected to the child welfare system and are less likely to receive favorable decisions when involved in this system (Boyd, 2014; Font, Berger, & Slack, 2012; Miller, Cahn, & Orellana, 2012). A large body of research has also demonstrated that young, low-income, minority men often receive differential treatment in the criminal justice and child welfare systems (Dumont, Allen, Brockman, Alexander, & Rich, 2013; Henry, 2006; O'Donnell. Johnson, D'Aunno, & Thornton, 2005). His personal culpability notwithstanding, the systemic discrimination that low-income, minority, unmarried, young men face may have inexorably bent Smith's trajectory through the child welfare and criminal justice systems towards the presumption of guilt from the outset, with little hope of an alternate outcome. Whereas his was a specific, complex, and exceptional case, his experiences navigating healthcare, child welfare, and criminal justice systems may indicate larger injustices facing young, minority fathers

when their children enter these systems. It may be impossible to conclusively determine where culpability—individual and system—lie in Smith's case but his experience highlights the need for critical examination of how young men interact with these systems as well as how actors in these systems regard young fathers.

The narratives represented in this study suggest that space was as much about the physical areas where fathers cared for children as it was about fathers' abilities to navigate relationships with those around their children. Whereas all fathers may have valued creating these safe and healthy spaces for their children, doing so was critical for fathers of children with chronic health issues because special accommodations (i.e., ramps, storage for medication or machinery, maintaining allergen-free spaces) were sometimes needed to be make children's environments suitable. Space—distance and proximity, access and control—represented a context in which fathers' chronic caregiving was situated (Marsiglio, Roy, Fox, 2005). Kin-work and close collaboration with those who spent considerable time around their children offered opportunities for fathers to influence the conditions present in their children's environments when fathers were not able to change or control children's environments themselves.

CHAPTER 8: DISCUSSION

The goal of this study was to gain a greater understanding of how young, low-income men cared for the health needs of their children. Specifically, this study explored the processes by which young men cared for their children's health while embedded in contexts that facilitated and impeded their efforts. These contexts included fathers' relationships with the mothers of their children, relationships with other kin, socioeconomic circumstances, as well as proximity and distance. This study also aimed to examine the iterative formation of men's approaches to fatherhood and caring for children's health needs through constructing roles as fathers, drawing upon prior experiences as caregivers.

This study contributes to bodies of research examining fatherhood role construction, men's involvement in families, and to literature that explores men's perspectives of fatherhood by situating their experiences in the contexts that surround them (Marsiglio, Roy, & Fox, 2005). By examining fathers as caregivers and merely the effects of their involvement on children's health, the present study represents one of the first to explore how men care for their children's health (Garfield & Isaaco, 2012). Moreover, this study stands among the few that examine the processes of parents' pediatric caregiving for children in the context of the home (Fiese, Winter, Anbar, Howell, & Poltrock, 2008). The present study's examination of normative, mundane caregiving around children's health, as well as fathers' responses to acute and chronic issues, further distinguish the present study and its findings (Schuster, Chung, & Vestal, 2011).

The findings from this study offer important implications for programming around father involvement as well as for programs aiming to promote the wellbeing of children born to young parents. This study also has implications for medical professionals and organizations that provide health services to young parents and their children. Finally, the findings from this study suggest that substantial changes to federal legislation, specifically the Family Medical Leave Act, would better enable young fathers to engage in their children's caregiving.

Limitations to the Study

This study provides insights into how young fathers construct and enact their roles as caregivers for their children's health while embedded in complex social, community, economic, and personal contexts that often complicate their participation in children's healthcare. Nonetheless, there were limitations to the present study.

The sampling employed for the study represents a potential source of bias. All of the participants were recruited from communities in the Washington, DC metropolitan area. Thus, the experiences of fathers reflected in this study represent those of fathers within a discrete geographical area and communities. Similarly, the majority of the participants were African American. Also, each of the participants in the study was connected to a healthcare or educational institution. Their institutional connections as well as the similar health messages they received may have skewed their responses towards convergence around similar themes about pediatric caregiving. Fathers embedded in other social and community contexts (e.g., those living in other urban contexts, rural fathers) or those disconnected from institutions may have experiences that differ from those represented in this study. Future studies should explore the experiences

of fathers who are more disconnected from work, school, healthcare, and the mothers of their children to ascertain if the framework advanced by this study describes their experiences.

The characteristics of the children in the study also represent a limitation to the study. The majority (n = 29, 61.7%) of the children were male. Prior research suggests nonresidential fathers may be more involved with their sons than daughters, but that this difference largely disappears after the first year of life (Lundberg, McLanahan. & Rose, 2007). The gender distribution and age of children in the present study may reflect the differences observed by Lundberg et al. (2007). Although the present study did not explicitly explore how children's gender contributed to differences in how they approached the fatherhood role and their involvement in children's health, it is possible that fathers of girls had different experiences of pediatric caregiving than fathers of boys. Further analysis may uncover differences in fathers' pediatric caregiving depending on their children's gender.

Fathers' approaches to pediatric caregiving likely change over time as children develop physically and cognitively as well as acquire language skills. The cross-sectional design and restricted age range of the present study, however, did not allow for examination of how fathers' involvement in caregiving changes over time. Studying fathers' experiences of pediatric caregiving longitudinally would have allowed for examination of how their perspectives, approaches, and role constructions changed over time.

Methodological Contributions

The limitations notwithstanding, the present study was able to gather data from participants whose experiences are underrepresented in the extant body of literature. Young, low-income fathers have been identified as a hard-to-study population and little research has been done to examine the lives of young, low-income men, particularly the perspectives of young men who are also fathers (Berger & Langton, 2011; Davies & Rhodes, 2004). The success of this study in recruiting a sample represents a process finding with implications for research methods when working with hard-to-study populations. Identifying, recruiting, and collecting rich data about intimate topics from young fathers was largely a function of the longitudinal relationships formed between themselves and the researcher as well as the case managers. These relationships were formed well before the study began and have extended beyond when data collection concluded. Through my established relationships with fathers as a case manager, fathers knew me in other contexts and as someone who cared about them as people, not merely as a researcher merely interested in *taking* information with little benefit to them beyond a modest stipend.

The success of this study in reaching a hard-to-study population underscores the importance of researchers being embedded and invested in communities beyond the scope of a given project. Embedding within a community positions a researcher as a member of a community with a close ear to the experiences, concerns, strengths, and challenges of community members. This intimate knowledge of the lived experiences common to members of a given community positions a researcher to develop inquiry that

is meaningful, relevant, and has application for communities whose voices are often muted in the discourses of public health, family, and general social science research.

Research Contributions

The common processes of fathers' involvement in pediatric caregiving represent the most important contribution of the present study. Whereas fatherhood research has identified the complicated relationship, socioeconomic, and structural contexts facing fathers, the common processes identified by the present study begin to explain *how* fathers are able to create opportunities and remain involved with their children. These common processes occurred across each of the domains of caregiving and may transcend pediatric caregiving altogether, reflecting more general processes of meaning making and caregiving that men engage in when co-creating their lived experiences of fatherhood with their children, social networks, and contexts. Preventative, acute, and chronic caregiving were specific expressions of fatherhood interpreted through the contexts in which young men were embedded.

Pediatric Caregiving: Reciprocally Beneficial for Fathers and Children

The findings from this study contribute to a growing body of research examining the interrelationships between fathers and children's health. Studies examining the effects of father involvement on wellbeing have generally examined the impact of father involvement on children's outcomes but the narratives included in this study suggest that men may benefit from their relationships and caregiving for their children. This study found that some young fathers adapted or stopped their own health behaviors (i.e.,

smoking, diet, being “outside” or hustling) that they perceived as interfering with their roles as fathers or possibly detracting from their children’s health. The timing and impetus for these decisions differed among fathers—some behaviors were changed prenatally, some after children were born, and still some fathers only adjusted their behavior after noticing that their children were experiencing health issues directly related to their behavior.

Timing notwithstanding, fathers initiated these changes with their children’s health in mind. Some fathers intentionally changed their behaviors because they realized that their behaviors placed them at risk for untimely separation from their children (i.e., incarceration, death); other fathers realized that their behaviors were directly and negatively impacting their children’s health. Motivated by their children, changing their own health behaviors stood to promote their children’s health with the added benefit of improving their own health. This finding suggests that becoming a father and caring for children’s health needs may precipitate reciprocal processes that are mutually beneficial and protective for children and their fathers alike. This reciprocal, mutually-dependent process illustrates a fundamental underpinning of the maternal and child health field—that the health of parents and wellbeing of children are inherently linked (Garfield & Fletcher, 2011; Lu, Jones, Bond, Wright, Pumpuang, et al., 2010). Fathers, however, have been largely omitted from this body of research; this study represents one of the first to demonstrate considerations of children’s health as a motivating factor for change in fathers’ health behaviors.

Pediatric Caregiving as Part of Fatherhood Role and Identity Construction

This study identified how young men construct their roles as fathers and caregivers in response to the unique, complex contexts in which they enacted the role. Caregiving, including nurturing behaviors around children's health, have largely been situated in mothers' roles with little attention being given to how fathers care for their children's health (Schneider, Steele, Cadell, & Hemsworth, 2011). This study, however, finds that maintaining children's wellbeing is central to men's notions of their roles as fathers. Additionally, this study provides insight into how young construct their ideas of their roles in caregiving from their personal experiences as sons, as recipients of healthcare, as well as their experiences of taking care of their children's health. Young men also negotiated—and renegotiated—their expectations for their caregiving roles as they navigated relationship, socioeconomic, structural, and community contexts that often frustrated their efforts to remain involved with their children.

The present study also adds insight to our current understandings of young men's constructions of themselves as fathers and how they position themselves, individually, within relation to the fatherhood role. The discussion of daddy mode illustrates how young men's identities as fathers remain stable across contexts and confer an overarching awareness of their responsibilities to their children. Proximity to children—particularly when fathers were spending time with their children may lead to the heightened salience of their identities as fathers and motivate them to make health decisions for themselves that they might not otherwise make. This suggests that the salience of the fatherhood role may serve as a protective factor for fathers who are embedded in contexts that not only complicate their fathering but may also detract from their own health. Further exploration

of the relationships between fathers' contextually-situated identities as father impacts their health. Better understanding these relationships will help explain health behaviors and outcomes among young men and may have implications for older fathers embedded in similar contexts.

Negotiating Space, Distance & Proximity

The iterative processes by which fathers constructed the fatherhood role and their personal identities as fathers in light of the contexts in which they were embedded in, children's health, and their experiences caring for children's health offer insights into men's motivations for caregiving and how they positioned themselves in relation to their children (White & Klein, 2002). The findings from this study underscore the importance of understanding that fatherhood is situated in complex contexts (Marsiglio, Roy, & Fox, 2005). Fathers negotiated space, distance, and proximity to children in order to address children's acute, preventative, and chronic health needs. The caregiving behaviors associated with acute, preventative, and chronic care (i.e., changing diapers, feeding, comforting during uncomfortable medical procedures, bandaging wounds) involved a great deal of physical intimacy and proximity to children. Without the benefit of living with children and the organic opportunities to engage in pediatric caregiving that arise throughout the course of parents' daily routines with children, the majority of fathers found themselves negotiating general involvement with their children, including pediatric caregiving, across spaces and distances that separated them.

The issues of space, distance, and proximity are, to some extent, indicators of how well fathers were able to navigate other contexts that challenged their abilities to be present with their children to address their health needs. Having access to sufficient

financial resources would have allowed fathers to secure places where they could host children as well as abilities to travel to see children when they did not reside with them. This, however, was not a reality for most fathers involved in the study as the vast majority were underemployed and had limited access to employment or financial resources.

Fathers used emotion and kin-work to close or traverse distance between themselves and their children by negotiating ways for fathers and children to spend time with each other, thus providing opportunities for fathers to engage in the mundane aspects of caregiving that comprise much of children's quotidian heath routines (Madhavan & Roy, 2012). When fathers were not able to be physically present, emotion and kin-work allowed fathers and mothers to develop novel approaches to traversing the distance (e.g., video-chatting during children's medical visits). Fathers also used emotion-work when in close proximity to their children by providing comfort, projecting confidence, and reassuring children—and mothers— during difficult health situations. To the extent that fathers were able to perform emotion and kin-work—and the extent to which mothers received—fathers' efforts influenced how space and distance presented as contexts for young fathers as well as the ease to which fathers were able to surmount these contexts.

Emotion and Kin-Work as Facilitators for Pediatric Care

Fathers used emotion-work across preventative, acute, and chronic care as a means to facilitate their children's healthcare. Prior research has largely overlooked the emotion-work that men do in their families (Pfeffer, 2010). The present study, however, finds that emotion-work permeated men's constructions and enactment of the fatherhood

role. Consideration of the psychosocial impacts of their long-term involvement with their children motivated men to create and maintain bonds with their children as a function of the fatherhood role; attending to and recognizing children's emotions helped them identify when their children, particularly those who were preverbal, might be experiencing health issues; desires to minimize children's psychological and emotional distress during uncomfortable medical procedures led fathers to prioritize attending their children's medical visits.

The present study also found that fathers engaged in emotion-work with their children's other caregivers, particularly mothers, in order to maintain access to their children. Similar to prior research, the present study found that fathers used emotion and kin-work to remain involved with their children (Roy, 2014). The present study's findings suggest however, that kin-work represented a way for fathers to create social capital for their children. Fathers used kin-work with children's mothers and other caregivers to learn about their children's health and how to manage their health, particularly when fathers were separated from their children. Fathers sought to influence how others cared for their children's health needs when they were not able to directly control the care their children received by carefully navigating relationships with children's caregivers (Roy, 2004). Maintaining positive, collaborative relationships with children's mothers, their partners, extended family, and friends offered ways for fathers to create the most beneficial environments possible for their children. When men's daily routines, extra-familial obligations, and contexts separated them from their children, emotion and kin-work were ways that fathers were involved in their children's health care.

Theoretical Contributions

The framework for fathers' involvement in pediatric caregiving offered by this study is a significant contribution to our understandings of fathering among young, low-income men. This framework draws from Schuster, Chung, and Vestal's (2011) description of three domains of caregiving—routine preventative, intermittent acute, and ongoing chronic—required for children with chronic health issues. The tripartite framework advanced by the present study situates these caregiving domains in the socioeconomic, residential, relational, and social contexts surrounding young fathers. Whereas Schuster et al. (2011) described *what* parents do to care for their children, the framework in the present study identifies common processes that explain *how* young fathers care for their children while embedded in contexts that often challenge their efforts to care for their children's health.

The flexibility of this framework allows for examination of how a wide range of contexts facilitate and inhibit fathers' involvement in pediatric caregiving. By positioning fathers' constructions of their caregiving role as a process, this framework allows for exploration of men's motivations as caregivers and the iterative enactment of role as men evaluate their positions as fathers, their experiences with their children, and knowledge they acquire about pediatric caregiving and health (Howarth, 2002). Relationships among young adults are often characterized by instability and the young men in this study had similarly dynamic relationships with the mothers of their children. Emotion-work, however, offered young men opportunities to navigate the variable terrain of these relationships so that they could maintain access to their children, exchange information about their children's health, and coordinate care for them. Limited access to financial

resources threatened fathers' involvement in caring for their children's health from being able to have safe, secure, and consistent places to care where they could care for their children, to paying for over-the-counter medications, to having access to transportation—public or private—necessary to spend time with children and address their health needs or accompany them to their medical visits.

The study's findings have implications for how fatherhood role as a role and individually-held identity has been approached by researchers, policymakers, and practitioners alike. The findings of this study counter notions that fathers are absent, silent, or otherwise uninvolved with pediatric care for their children. To the contrary, study finds that maintaining and restoring children's wellbeing was a central aspect of the fatherhood role. Men couched their ideas about fatherhood and identities as fathers in their abilities to care for their children's health and went to great lengths to attempt to overcome contextual barriers that stood to frustrate their efforts. The findings of this study suggest that caregiving for pediatric health and fatherhood are closely aligned in men's understandings of their roles and identities as fathers. Taken together, the findings from this study suggest that examining men's involvement children's health and pediatric caregiving provides a valuable lens for understanding the fatherhood role and the commensurate identities that men form in response to it.

Implications for Practice, Programming, and Policy

The findings of this study of low-income, young fathers' involvement in pediatric caregiving have important implications for mental health practice, medical practice, programming around young men and families, as well as policies regarding pediatric care. Regarding clinical practice, the present study's findings that fathers participate

actively in emotion and kin-work with their children, mothers, and other family members highlights the need for expanding current notions of men's roles in their families. At present, emotion-work represents a largely unacknowledged part of men's roles in their families (Roy, 2004). Greater awareness among clinicians about men's roles in emotion and kin-work will empower them to provide support for aspects of their experiences that are often overlooked. This support may take various forms including, probing about the support that men provide and exchange with kin and the mothers of their children, pyschoeducation to enhance listening and problem-solving skills, as well as dyadic or family therapy to help men and families identify strategies for strengthening their mutual capacities for emotion and kin-work.

Fathers' discussions of feeling marginalized in healthcare settings indicate the need for approaches to patient care that are inclusive of fathers experiences as caregivers, participants in their children's health care, and consumers of health services. Healthcare professionals including administrative staff, nurses, and medical providers must be trained to include fathers in all aspects of pediatric visits, just as they would mothers. Greater awareness of incorporating fathers into medical visits through communication cues (i.e., where healthcare staff direct their gaze during conversations, to whom they seek to gather information about children) would begin to help fathers feel welcomed and included in children's care (Coleman & Garfield, 2004). When fathers are not able to be present for medical visits, physicians may also ask the presenting caregiver about how they will relay the information about the visit to other caregivers, including fathers. While this strategy does not reach fathers directly, it may encourage presenting caregivers to relay information about the child's health to fathers.

Healthcare organizations (i.e., outpatient clinics, private practices, hospitals) should also consider policy changes that facilitate father involvement in children's medical care. Extending hours into the early evening may allow fathers who work during the day to have greater opportunities to accompany their children to medical visits (Coleman & Garfield, 2004). Medical providers may also consider using alternative avenues to engage fathers who are not able to attend children's medical visits. With the wide availability, portability, and technological capabilities of cell phones, they may offer opportunities to include fathers in children's medical visits. Physicians may call fathers during these visits to allow fathers to share their perceptions of their children's health, hear mothers' perspectives, as well as learn about their children's health directly from pediatricians. The young men in the study also discussed using videoconferencing as a way to connect with their children and participate remotely in medical visits. Whereas unfamiliarity with available technologies and privacy concerns have often stymied attempts to include videoconferencing into the medical visit, there has been a movement and growing acceptance of teleheath, eHealth, and cybermedicine platforms (i.e., video consultation) as viable for conducting medical visits (Henk, 2002; Lewis, 2006). Incorporating these as means to access fathers remotely offers opportunities for physicians to bridge distance between fathers and pediatric encounters.

The findings from this study speak to the need for programs that support fathers' involvement across all domains of pediatric caregiving. Young men, particularly fathers, are underrepresented in the extant body of research in part due to the difficulties identifying and recruiting them to join studies (Coley, 2001; Patel, Doku, Tennakoon, 2003). Young men's connections to the programs where they were recruited were key for

the success of the present study. That young fathers—who face elevated risks for disconnection from work, school, and other institutions—would engage with these programs speaks to the viability of programs and their abilities to provide resources which young men find useful. The general educational, case management, mental health, and coparenting support that these programs provided helped men fulfill their roles as fathers, including caring for the health needs of their children. Similar to the implications for healthcare professionals, fathers' unique needs as caregivers should be assessed and incorporated into program planning from the outset. sAs a corollary, staff implementing these programs should receive training that sensitizes them to implicit biases they might have about fathers involvement with children as well as how to engage fathers throughout the duration of the program—from enrollment through graduation.

Smith and Delonte's stories of coping with children who have severe chronic illnesses suggest that they, and others like them, would benefit from additional support. Although very specific examples and cases that may not represent the experiences of a large number of young men, their accounts of feeling complex emotions, bearing elevated levels of worry and stress, as well as the challenges they encountered when learning how to care for their children's health issues are consistent with prior studies exploring the experiences of men whose children had chronic health needs (Broger & Zeni, 2005; Goble, 2004; Katz & Krulik, 1999). These programs should provide emotional support through peer support groups, assistance navigating healthcare systems, education about chronic disease management, help learning caregiving tasks, as well as assistance securing stable employment so that they can provide for the additional needs of their children. Given the instability of romantic relationships among young persons, programs

engaging young fathers should also provide conjoint therapy to enhance their abilities to coparent, communicate, and collaborate around problem solving irrespective of the status of their romantic relationships (Rauer, Petitt, Lansford, Bates, & Dodge, 2013).

The family-centered medical home[32] model has received increased attention in recent years as promising for improving pediatric health outcomes for patients and is likely a harbinger of where best practices of outpatient pediatric care are headed (Stille, Tucchi, Antonelli, Cabana, Cheng et al., 2010). In providing coordinated, comprehensive, family-centered primary care that facilitates collaboration between patients, providers, and community organizations, this model resembles the services provided by the Teen Parenting Project[33] (Toomey & Cheng, 2013). Fathers, however, are largely missing from discussions of family-centered medical home model. As a group who are less likely to present in pediatric care settings (but are often involved with their children's care outside of the medical setting), fathers warrant special attention and efforts to engage them in children's medical homes. Young minority men may face especially challenging barriers to organically engaging with primary care (Guthrie & Low, 2006). Future research, conceptualizing, and grantmaking around this model should include consideration of how to meaningfully engage fathers in the pediatric care setting and provide supports for their unique needs.

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[32] The family-centered medical home has been defined as, "care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective; delivered or directed by well-trained physicians who provide primary care and manage and facilitate essentially all aspects of pediatric care, with a physician known to the child and family and able to develop a partnership of mutual responsibility and trust" (Stille et al., 2010).

[33] Tina Cheng, M.D.—a leader in the movement to adopt the family-centered medical home model—was the first director of the Teen Parenting Project. This relationship partly explains the similarities between the Teen Parenting Project and the family-centered medical home models.

The findings from this study have implications for federal policy, specifically the Family Medical Leave Act (FMLA). The Family Medical Leave Act allows for up to 12 weeks of unpaid leave to allow for employees following the birth of a child or to care for a family member who has a serious illness (Department of Labor, n.d.). Furthermore, employees must work for an organization with at least 50 employees and must have been employed there for at least a year (defined by 1,250 hours), if non-consecutively. Young fathers, however, may not be able to take advantage of the protections afforded by FMLA. Young, low-income men—including the fathers in the present study—face challenging employment landscapes and tenuous connections to work (Berger & Langton, 2011). Thus, low-income, young fathers whose employment histories may be checkered with short-term jobs do not qualify for leave under the law. Even if young fathers meet the eligibility requirements, the low wages they earn—the average was $10.51 among fathers in the present study—often make taking unpaid leave unaffordable (Chung, Lui, Burton, Cowgill, Hoffman, et al., 2012). Furthermore, FMLA only provides leave for serious illnesses but not for routine visits or to provide care during short-term acute health issues (e.g., colds, injuries).

The Family Medical Leave Act can be improved in several ways to provide protection for young fathers as well as promote their involvement in children's pediatric caregiving. Firstly, paid medical leave is essential for young, low-income fathers to take advantage of the law. The recommendation for paid leave is not new by any stretch and has gained momentum in recent years as stands to benefit families across the socioeconomic spectrum (Schuster, Chung, & Vestal, 2011). Additionally, the protections allowed by FMLA should be expanded to allow for employees to take leave in order to

care for routine health issues or minor illnesses. This is particularly important for workers earning the lowest wages, especially part-time employees, as they are less likely to have paid time off (Tompson, Benz, Agiesta, & Junius, 2013). Many of the employment opportunities available for young fathers fall into this category where employer-sponsored benefits are scarce or young men's tenures at a given organization do not allow them to accrue these benefits.

Much of the recent movement to expand family medical leave has been delegated to states. President Obama recently announced $2.2 billion in funding opportunities for individual states to build infrastructure to support expanded coverage of FMLA to include providing paid medical leave for employees (White House, 2015). In addition to creating administrative infrastructure for up to three years, these grants will provide $35 million for states to conduct feasibility studies of extending paid leave to persons already covered by FMLA. Whereas this policy change may benefit middle class families and those stably connected to the world of work, young fathers who are tangentially connected or employed at a given employer for short stints still will not be able to take advantage of the new provisions.

Areas for Future Research and Future Directions

The results of this study offer several avenues for further research. This study focused on fathers' experiences after their children were born. The findings of the study, particularly men's discussions of making dietary choices for their children, suggest that fathers' involvement in promoting their children's health begins well before birth. Future analyses of the data collected for this study will include examining fathers' motivations and experiences supporting mothers and their unborn children during the prenatal period,

experiences of their children's birth, as well as how men prepared to care for their children's health needs once their children were born.

As noted earlier, the cross-sectional design of the study presented a limitation for understanding how fathers' pediatric caregiving changes over time as children grow and age. My continued connection with the fathers involved in the study allows opportunities to follow them over time and to conduct interviews at various points as their enactment of the fatherhood role and their children develop. Longitudinal data collection would also allow for greater examination of how and if fathers' involvement with their daughters' health caregiving differs from what they provide for their sons as they grow older.

Additionally, the cross-sectional design of the study does not allow for examination of the trajectories of children's chronic illnesses and father involvement over time. I am particularly interested in examining fathers' involvement in children's asthma management over time. Many of the children in the present study were too young for physicians to make conclusive diagnoses of asthma but the early indicators and environmental factors (e.g., exposure to secondhand smoke) suggest that they will meet diagnostic criteria when they grow older. Examining fathers' perceptions of their children's symptoms, their beliefs about asthma, their ideas about their roles as caregivers, as well as how fathers coordinate asthma management with other caregivers—and how these change as fathers contexts change and children grow older—will begin to explain how asthma is managed in the context of the home. This focused analysis will also provide insights into how family processes may contribute to the elevated asthma prevalence and severity that has been among low-income, African-American, and single-parents (Akinbami, 2006; Claudio, Stingone, & Godbold, 2006)

More than half of the fathers in the study ($n = 16$) lived separately from their children. Young men's experiences of caregiving likely differed from mothers' and examining mothers' perceptions of how fathers fit in to their children's caregiving would be useful for triangulating the findings of the present study and developing richer understandings of how pediatric health is maintained among young parents, particularly when one parent lives separately from the children. Interviewing mothers about their perceptions of young men's involvement in pediatric caregiving offers an opportunity to gather rich information not only about how fathers care for their children but to better understand similarities and differences regarding perceptions of father involvement, gender differences in caregiving, and how young parents negotiate their relationships to care for their children's health needs. The next steps of this project include interviewing mothers about their experiences of caregiving and coparenting with the fathers involved in this study.

Summary

Pediatric caregiving represented a major component of young men's ideas about their roles and identities as fathers. Kin-work—the process of building and maintaining child-centered relationships with other caregivers in children's social networks—represented a way that fathers were able to secure connection with children, remain apprised of their health needs, and create opportunities necessary for involvement in pediatric care. Traversing space, distance, and proximity with their children also featured in fathers' narrative about caring for children's preventative, acute, and chronic health issues. Navigating these common processes created opportunities for fathers to observe children's health, identify potential health issues, anticipating their needs in the future,

and, inasmuch was possible, prepare to meet those needs. Whereas fathers carried some prior knowledge about caregiving into parenthood, they largely learned how to care for children's health along the way, as children, mothers, and men themselves grew and developed, as they encountered new experiences, as their relationships changed, and their contexts changed.

This study uncovered the multidimensional nature of young fathers' involvement in pediatric caregiving. It explored how men's understandings of their roles as father and their situation of self within those roles positioned them as caregivers for children's health. This research also examined how fathers used emotion and kin-work to maintain involvement in their children's care as well as facilitate the health care for their children. The present study also explored how fathers navigated contextual and institutional barriers in order to participate in their children's healthcare—both at home and in medical settings.

The qualitative methods employed and the findings from this study represent an important first step towards understanding young men's contextually-situated experiences as caregivers for their children's health. In addition to offering a framework for examining young men's pediatric caregiving experiences, the flexibility offered by the tripartite model may also be useful for exploring the caregiving experiences of parents in general, including fathers embedded in other contexts and perhaps even mothers' perspectives. Future research, policy, and practice must continue to recognize the complexities of the contexts in which young men father as well as the strategies they employ to navigate challenging circumstances in service of caring for their children's health.

APPENDIX A

INSTITUTIONAL REVIEW BOARD

1204 Marie Mount Hall
College Park, MD 20742-5125
TEL 301.405.4212
FAX 301.314.1475
irb@umd.edu
www.umresearch.umd.edu/IRB

DATE:	June 18, 2013
TO:	Kevin Roy, PhD
FROM:	University of Maryland College Park (UMCP) IRB
PROJECT TITLE:	[457852-1] Young Dads and Children's Health Project
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	June 18, 2013
EXPIRATION DATE:	June 17, 2014
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # 6 & 7

Thank you for your submission of New Project materials for this project. The University of Maryland College Park (UMCP) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure which are found on the IRBNet Forms and Templates Page.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of June 17, 2014.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

Generated on IRBNet

If you have any questions, please contact the IRB Office at 301-405-4212 or irb@umd.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Maryland College Park (UMCP) IRB's records.

Generated on IRBNet

APPENDIX B

IRB: Application Review Results

IRBear@childrensnational.org
Sent: Wednesday, September 18, 2013 11:01 AM
To: Waters, Damien

Your IRB Application has been approved.

ID: Pro00004051
TITLE: Young Dads and Children's Health Study

The IRB has approved the application for the above named study. This approval, and the consent form(s), are granted for the period of 9/18/2013 to 9/16/2014.

Warning: This is a private message for Children's National Medical Center parties only. If the reader of this message is not the intended recipient you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(301) 565-8452

APPENDIX C

Project Title	*"Young Dads and Children's Health Study"*
Purpose of the Study	*The purpose of this research project is to better understand what dads think about caring for their children's health and how they address their children's health needs. The health information you share about your child will help us examine how young dads perceive their children's health as well as the things they do to care for their children. The information you share about your own health will be used to help us understand how your own health experiences inform your approach to caring for your children's health.*
Procedures	*You will first complete a brief questionnaire asking you to provide demographic information (i.e., name, address, birth date, race, ethnicity, employment status, educational status). The questionnaire will also ask questions about your relationships with the mothers of their children as well as your personal health. After completing the demographic questionnaire, you will complete an interview that will ask you to discuss your ideas about children's health and how you care for your children's health. Sample questions include:* *1. Parents sometimes divide up caregiving responsibilities and that can be true for caring for children's health. Are there certain things that you usually do for your child's health and other things that mom usually does?* *2. When you think of what it means to be a father, does caring for children's health come to mind? How is caring for children's health part of being a father?* *The interview session will last about 120 minutes at a site of your choosing. The sessions will be digitally-recorded. Your interview will then be transcribed and the digital recording will be destroyed. You will receive a $30.00 gift card to a local retailer for your participation in the interview.* This research project involves taking photographs of you. The photographs will be stored by Dr. Roy and will be used in presentations of the study interviews for academic audiences. Please select one of the following: ___ You agree that you may be photographed during his/her participation in this study. ___ You do not agree that you may photographed during your participation in this study.

Potential Risks and Discomforts	*There are no known risks for participating in this study. You may, however, experience mild discomfort when discussing some topics. Please inform the interviewer if a question makes you feel uncomfortable and you will not be required to answer that question.*
Potential Benefits	*There are no direct benefits to you. However, we hope that, in the future, other people might benefit from this study through improved understanding of how fathers, particularly young dads, are involved in caring for their children's health.*
Confidentiality	*Any potential loss of confidentiality will be minimized by storing all forms in a locked cabinet within a locked office. All digital information, including the recording of this interview and its transcript, will be kept on a password-protected computer and will be stored on an encrypted drive. Only the principal investigator (Dr. Kevin Roy), co-investigator (Damian Waters), and study team members will have access to the information you share during your interviews. Only these people will be able to read the transcript of your interview.* *If we write a report or article about this research project, your identity will be protected to the maximum extent possible.* ***Certificate of Confidentiality*** *We will do everything we can to keep others from learning about your participation in this research. To help us further protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. The researchers can use this Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, for example, if there is a court subpoena. The researchers will use the Certificate to resist any demands for information that would identify you, except as explained below.* *The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of Federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA).* *You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the*

	researchers may not use the Certificate to withhold that information. *Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to do so by law. The Certificate of Confidentiality will not be used to prevent disclosure to state or local authorities of child abuse and neglect, whether current or in the past. Additionally, the Certificate of Confidentiality will not be used to prevent danger of harm to self or others.* *A Certificate of Confidentiality does not represent an endorsement of the research study by the Department of Health and Human Services or the National Institutes of Health.*
Medical Treatment	*The University of Maryland does not provide any medical, hospitalization or other insurance for participants in this research study, nor will the University of Maryland provide any medical treatment or compensation for any injury sustained as a result of participation in this research study, except as required by law.*
Right to Withdraw and Questions	*Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.* *If you decide to stop taking part in the study, if you have questions, concerns, or complaints, or if you need to report an injury related to the research, please contact the investigator:* ***Kevin Roy, PhD*** *1142T School of Public Health Building* *University of Maryland* *College Park, MD 20742* *Email: kroy@umd.edu* *Phone: 301-405-6348*
Participant Rights	*If you have questions about your rights as a research participant or wish to report a research-related injury, please contact:* **University of Maryland College Park** **Institutional Review Board Office** **1204 Marie Mount Hall** **College Park, Maryland, 20742** **E-mail: irb@umd.edu** **Telephone: 301-405-0678**

	This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.	
Statement of Consent	*Your signature indicates that you are at least 18 years of age; you have read this consent form or have had it read to you; your questions have been answered to your satisfaction and you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.* *If you agree to participate, please sign your name below.*	
Signature and Date	**NAME OF PARTICIPANT [Please Print]**	
	SIGNATURE OF PARTICIPANT	
	DATE	

APPENDIX D

CHILDREN'S NATIONAL MEDICAL CENTER

Department of General and Community Pediatrics
111 Michigan Avenue, NW
Washington, DC 20010
(202) 476-5000

IN A CLINICAL RESEARCH STUDY & AUTHORIZATION TO USE PROTECTED HEALTH INFORMATION

TITLE OF STUDY: "Young Dads and Children's Health Study (YDACH)"

PRINCIPAL INVESTIGATOR: Amy Lewin, PsyD, Center for Translational Science

INTRODUCTION: We would like you to be part of a research study at Children's National Medical Center. Before you decide whether you want to be part of the study, we want you to know why we are doing the study and if it will help you or your child. We also want you to know about any risks (what might go wrong) and what you will be asked to do in the study.

This form gives you information about the study. Someone from the Generations program will talk to you about the study and answer any questions you have. We will ask you to sign this form to show that you understand the study. We will give you a copy of this form to keep. It is important that you know:
You do not have to join the study;
You may change your mind and drop out of the study any time you want
If we make any important change to the study we will tell you about it and make sure you still want to be in the study.

A. PURPOSE OF STUDY

We understand that fathers play an important role in caring for the needs of their children. Caring for children's health is one of the things that parents do for their children. The proposed study aims to learn more about young fathers' thoughts about their children's health, what they believe fathers should do to care for their children's health, and what they do to care for their own children.

You are being asked to participate for this study because you are between the ages of 18-24 and have a child who is at least six months old. The information you share through the questionnaire and interview in this study will help us better understand how young men approach caring for their children's health needs and how we can better support young dads as they care for their children's health.

B. PROCEDURE

If you are interested in participating in this study, a member of our research team will call you and schedule an appointment to meet and interview you about yourself, your child, and your experiences as a parent. After describing the study and getting your consent, we will ask you to complete a questionnaire that asks about your educational and employment history, asks you some basic information about your children, and asks you about your health history. After completing the questionnaire, you will complete an interview with a member of the research team. During that interview, we will ask about your personal health history and experiences interacting with the healthcare system (i.e., doctors, nurses, making appointments). Similarly, we will ask you about your child's health and how that has changed over time. We will also ask about your ideas of what it means to be a father and about the things you do as a father, especially what you do to care for your child's health. The interview will ask you about your relationship with the mother(s) of your child(ren) and how your relationship with her affects what you do as a father. The interview will be recorded using a digital recorder and then transcribed. Due to the nature of the study, only fathers who agree for the interviews to be digitally-recorded will be allowed to participate. The questionnaire and interview will take approximately 120 minutes to complete.

C. POTENTIAL RISKS/DISCOMFORT

There are minimal risks related to participating in this study. It is possible that you may experience mild discomfort when discussing certain topics during the interview. You will not need to answer any questions that make you uncomfortable. If you become uncomfortable, please let the researcher know and we can pause or stop the interview. There is also a risk of other people getting information that you share during our interview. This risk is very small because the interviews will be recorded on digital recorders that only the YDACH study staff will have access to. Only YDACH study staff will be able to listen to these recordings and will only use them to transcribe your interviews word-for-word. We will also assign disguised names (pseudonyms) to you as well as your child, mother of your child, and any other people or places you mention. We will refer to you by that disguised name for any reports we write or present from this study in order to further protect your privacy. We will destroy the digital files of your interview once we have transcribed all interviews and assigned pseudonyms. The information you discuss during our interview will not be entered into your medical record nor will it be shared with your doctor, your child(ren)'s doctor, or any other person who works with you/your family at Children's National Medical Center (i.e., case managers, social workers). We will do everything we can to make sure that the information you share during the interview remains confidential and that no one outside of our research team can access any of the information your share during this study.

D. VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. There will be no penalty or loss of benefits to which you are otherwise entitled if you decide to withdraw from the study. You and

your child will get the same health care regardless of whether you do or do not participate in this study.

E. POTENTIAL BENEFITS

There are no direct benefits to your family from participating in this study. However, we hope that, in the future, other people might benefit from this study through improved understanding of how fathers, particularly young dads, are involved in caring for their children's health.

F. ALTERNATIVES TO PARTICIPATION

The alternative to participation in this study is to not participate.

G. QUESTIONS – WHO TO CALL

We want you to ask questions about any part of this study or consent form either now or at any time in the future. If you have any questions about this study, call the Principal Investigator, Dr. Amy Lewin, at (202) 476-3106 and/or the Co-Investigator, Mr. Damian Waters at (202) 376-3316. If you believe you have been injured as a result of being in this study, you should call the Principal Investigator, Dr. Amy Lewin, at (202) 476-3106. If you have any questions or concerns about your rights in this research study at any time, please call the Office for the Protection of Human Subjects at (301) 565-8452, the Chief Academic Officer, or the Chair of the Institutional Review Board of the Children's National Medical Center. The last two parties may be reached at (202) 476-5000.

H. CONFIDENTIALITY

We will keep the records of this study confidential. This includes everything you write or tell us. We will not tell anyone you are in the study. Only the people working on the study will know your name. All of the forms and papers with your name or information on it will be stored in a locked cabinet within a locked office. All digital information, including the recording of this interview and its transcript, will be kept on a password-protected computer and will be stored on an encrypted drive.

After we interview many fathers, we may talk about their experiences at professional meetings or write about them in scientific articles for other doctors or researchers to read. At times, we may use a quote that a participant makes during the interview in order to help the audience understand the caregiving experiences of young, low-income fathers. When we talk about what was shared during the interviews, we will never mention anyone's name and will remove any information that could help someone figure out who you are. We will use a fake name (i.e., pseudonym) when using a quote from any interview.

The federal government can review the study records and medical records to make sure we are following the law and protecting the children in the study and to make sure our

results are correct. Your medical records and those of your child(ren) are confidential, but just like any medical record; there are some exceptions under state and federal law. This is true if you mention a plan to hurt yourself or someone else. This is also true if you share that you or any child has been abused—in the past or currently, or if we learn of a sexual relationship between someone under age 16 and someone a4 or more years older. In these cases, the law requires that we make a report in order to keep people safe and get help for those who need it.

Certificate of Confidentiality

We will do everything we can to keep others from learning about your participation in this research. To help us further protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. The researchers can use this Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, for example, if there is a court subpoena. The researchers will use the Certificate to resist any demands for information that would identify you, except as explained below.

Any potential loss of confidentiality will be minimized by storing all forms in a locked cabinet within a locked office. All digital information, including the recording of this interview and its transcript, will be kept on a password-protected computer and will be stored on an encrypted drive. Only the principal investigator (Dr. Kevin Roy), co-investigator (Damian Waters), and study team members will have access to the information you share during your interviews. Only these people will be able to read the transcript of your interview.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

To help us protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. The researchers can use this Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, for example, if there is a court subpoena. The researchers will use the Certificate to resist any demands for information that would identify you, except as explained below.

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of Federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA).

You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information.

I. Payment for Medical Care for Research-related Injury:
Children's National Medical Center cannot promise that the risks we have told you about or other unknown problems will not happen. If you think that something unexpected happened because you were in the study, please call the Principal Investigator at (202) 476-3106 or the Chief Academic Officer of the Children’s National Medical Center at (202) 476-5000. If something unexpected happened resulting directly from your participation in this research study, we will give your child any urgent medical emergency treatment needed if the injury is reported in a timely manner. The Hospital will seek payment from your health insurance company or other third-party payor for any medical care or services you receive. The Hospital has no program to provide you with any additional payments as a result of any injuries.

J. COMPENSATION

You will receive a gift certificate for $30 to a local store to compensate you for the time you spend doing the interview.

K. ADDITIONAL ELEMENTS

Through the study you may learn of community services that you would like which require that you pay for them. If you choose to use these services, you would be required to pay for them, as they would not be paid for by the study.

<u>Research Subject Advocate</u>:
The National Institutes of Health supports a Research Subject Advocate or RSA for the research study that you are being asked to join. The RSA, Dr. Tomas Silber, is here to help you with your questions or concerns about taking part in this research. Dr. Silber does not work for the doctors who are doing this research and they do not pay him. He is here only to help and protect you and your child during any research.

You may contact Dr. Silber at any time. This can be before you decide to take part in the research, during the study, or even after you finish the study. You can call Dr. Silber at 202-476-3066 or reach him by e-mail at tsilber@cnmc.org.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

In 1996 the government passed a law known as The Health Insurance Portability and Accountability Act (HIPAA). This privacy law protects your individually identifiable health information (Protected Health Information or PHI). The privacy law requires you to sign an agreement so researchers can use or share your and your child’s PHI for research purposes. This describes to you how information about you or your child may be used or shared if you are in a research study. It is important that you read this carefully and ask a member of the research team to explain anything you do not understand.

I authorize Dr. Amy Lewin, Mr. Damian Waters, and their research staff to create, access, use, and disclose my PHI for the purposes described below.

Protected Health Information that may be used and shared includes:
Information that identifies you such as name, address, telephone number, date of birth, Social Security number, and other details about you
Information that relates to your health or medical condition from your medical records and Information obtained from the study procedures outlined in this consent form, for example: things done to see if you can join the study such as physical exams, blood and urine tests, x-rays and other tests, and any other medical information we learn from you about your health history and family history
Laboratory results obtained on specimens collected from you (blood, urine, tissue)
Questionnaires or surveys you complete T Interviews conducted with you by members of the research team
Audio/ video recordings
Other:
Educational level
Social circumstances (i.e., relationship with children's mother, sources of support).

The Researchers may use and share my Protected Health Information with:

The Principal Investigator, other Investigators, Study Coordinators, and all administrative staff in charge of doing work for the study;
Government agencies that have the right to see or review your PHI, including but not limited to the Office of Human Research Protections and the Food and Drug Administration;
Children's National Medical Center Institutional Review Board;
Audit Committee of the Children's National Medical Center Institutional Review Board;
¨Quality Improvement Program Coordinator and other staff in the Office for the Protection of Human Subjects at Children's National Medical Center.

In addition to the above people and organizations, the Researchers may also use and share my Protected Health Information with:
Doctors and staff at other places that are participating in the study. The name(s) of the other place(s) that are participating in this study are
The Data Safety Monitoring Board (a group of people who examine the medical information during the study)
The Medical Monitor for the Study (a person who reviews medical information during the study)
The Patient Advocate or Research Ombudsman (person who watches out for your best interest)

Also, your or your child's primary physician will be contacted if during the course of the study the researcher learns of a medical condition that needs immediate attention.

Should your health information be disclosed to anyone outside of the study, your information may no longer be protected by HIPAA and this Authorization. However, the use of your health information will still be regulated by applicable federal and state laws.

Storage of PHI in a Database:

We would like to store personal health information collected from you in this study in a database for future research which will be kept for the life of the study. The database is maintained by the Generations Program at Children's National Medical Center.

Please indicate your approval of any or all of the following by initialing next to the statement:

My personal health information may be stored in the above named database for future analysis related to this study.	Yes	No	Initials: ______
My personal health information may be stored in the above named database for future analysis related to the Generations Program.	Yes	No	Initials: ______
My personal health information may be stored in the above named database. Researchers may contact me to request my authorization for future studies that are not related to this study or the disease named above.	Yes	No	Initials: ______
My personal health information may be stored without any of my identifying information for Use in other studies of other diseases.	Yes	No	Initials: ______

If you agree to participate in this research study, the research team, the research sponsor (when applicable) and the sponsor's representatives, may use Personally Unidentified Study Data. The Personally Unidentified Study Data does not include your name, address, telephone, or social security number. Instead, the researcher assigns a code to the Personally Unidentified Study Data. Personally Unidentified Study Data may include your date of birth, initials, and dates you received medical care. Personally Unidentified Study Data may also include the health information used, created, or collected in the research study. The research team or the research sponsor may share the Personally Unidentified Study Data with others to perform additional research, place it into research databases, share it with researchers in the U.S. or other countries, or use it to improve the design of future studies. They may also publish it in scientific journals, or share it with business partners of the sponsor and to file applications with U.S. or foreign government agencies to get approval for new drugs or health care products.

You do not have to sign this Consent/Authorization. If you decide not to sign the Authorization, you will not be allowed to participate in the research study.

After signing the Consent/Authorization, you can change your mind and:

Revoke this Authorization. If you revoke the Authorization, you will send a written letter to Dr. Amy Lewin to inform her of your decision. You may send this letter to:

Dr. Amy Lewin
Department of General and Community Pediatrics
111 Michigan Avenue
Washington, DC 20010

If you revoke this Authorization, researchers may only use and disclose the PHI that was collected for this research study before you revoked the Authorization.
If you revoke this Authorization your PHI may still be used and disclosed if you should have an adverse event (unexpected side effect).
If you change your mind and withdraw the Authorization, you will not be allowed to participate in the study.

You will not be allowed to review the information collected for this research study until after the study is completed. If you are not allowed to review your information during participation in the study, when the study is over you will have the right to access the information.

This Authorization does not have an expiration date.

If you have not already received a Notice of Privacy Practices from Children's National Medical Center, you may request a copy and will be given one. If you have any questions or concerns about your privacy rights, you may contact the Children's National Medical Center Privacy Officer at 301-572-6348.

CONSENT/AUTHORIZATION:

I am the participant or I am authorized to act on behalf of the participant. I have read the information and will receive a copy of this form after it is signed.
By signing this form, you agree that you have talked to someone from the Generations program about the study and understand it, and want to be in the study. You agree that we have talked to you about the risks and benefits of the study, and about other choices. You may drop out of the study at any time and no one will mind, and nothing will change about your child’s medical care other than not being in the study. Copies of this form will be:

(1) kept in the study file by the Principal Investigator;

(2) given to you to keep.

Please call the Principal Investigator, Dr. Amy Lewin at (202) 476-3106 or the Co-Investigator, Mr. Damian Waters if you have any questions.

Printed Name of Participant: ________________________
Medical Record Number: ________________________________
Signature of Participant: _________________________________Date:_____________
(Participant must be 18 years of age or older)

Witness (to signatures): _________________________________Date:_____________
(may be investigator)

Translator's Signature (if, applicable): ____
Language: ____

INVESTIGATOR'S AFFIDAVIT: I certify that I have explained to the above individual(s) the nature and purpose of the study, potential benefits, and possible risks associated with participation in this study. I have answered any questions that have been raised.

Printed Name of Individual Obtaining Consent: _______________________________
Title: _______ Signature: ________________________________ Date: ____________

APPENDIX E

CERTIFICATE OF CONFIDENTIALITY
CC-HD-13-92
issued to
University of Maryland College Park
conducting research known as
Young Dads & Children's Health Study

In accordance with the provisions of section 301(d) of the Public Health Service Act 42 U.S.C. 241(d), this Certificate is issued in response to the request of the Principal Investigator, Dr. Kevin Roy, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Dr. Roy is primarily responsible for the conduct of this research.

Under the authority vested in the Secretary of Health and Human Services by section 301(d), all persons who:

1. are enrolled in, employed by, or associated with the University of Maryland College Park and their contractors or cooperating agencies and

2. have in the course of their employment or association access to information that would identify individuals who are the subjects of the research pertaining to the project known as Young Dads & Children's Health Study

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

This qualitative research study examines how young, low-income men perceive their roles as fathers and the behaviors they enact to address their children's health needs. The study will draw from semi-structured interviews (n = 40) that explore how young fathers navigate coparenting relationships, challenging financial contexts, and community factors that shape their caregiving around children's health.

A Certificate of Confidentiality is needed because sensitive information will be collected during the course of the study. The certificate will help researchers avoid involuntary disclosure that could expose subjects or their families to adverse economic, legal, psychological and social consequences.

All subjects will be assigned a code number and identifying information and records will be kept in locked files at the Institution.

This research is currently underway and is expected to end on 08/31/2016.

As provided in section 301 (d) of the Public Health Service Act 42 U.S.C. 241(d):

'Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals.'

This Certificate does not protect you from being compelled to make disclosures that: (1) have been consented to in writing by the research subject or the subject's legally authorized representative; (2) are required by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or regulations issued under that Act; or (3) have been requested from a research project funded by the National Institutes of Health (NIH) or the Department of Health and Human Services (DHHS) by authorized representatives of those agencies for the purpose of audit or program review.

This Certificate does not represent an endorsement of the research project by the DHHS. This Certificate is now in effect and will expire on 08/31/2016. The protection afforded by this Confidentiality Certificate is permanent with respect to subjects who participate in the research during the time the Certificate is in effect.

Date: 12/13/2013

Steven Hirschfeld, MD PhD
Associate Director for Clinical Research
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Page 1 of 1

APPENDIX F

(YDACH) ID Number: ______________________________	Date: ____________________
Interviewer: ______________________________________	Pseudo:___________________

CONTACT INFORMATION SHEET

Name: ______________________________

Address: ______________________________

____

Best Way(s) to Contact You (Circle all that apply):

Phone   Text   Email   Facebook

Phone 1: ______________________________

Phone 2: ______________________________

Alternate Phone: ________________________

Email: ______________________________

If we were not able to reach you using your phone number, who else could we call to get in contact with you?

1. Name: ______________________________ Phone: ______________________________
2. Name: ______________________________ Phone: ______________________________

YDACH General Questionnaire—December 2, 2013

(YDACH) ID Number: ______________________________ Date: ____________________
Interviewer: ______________________________________ Pseudo:__________________

DEMOGRAPHIC QUESTIONS

Name: ____________________________________ Date of Birth: ______________

Gender: ________________________

Primary Language Spoken: ______________________ Other Languages Spoken: _______________________

Which best describes your race/ethnicity? (*Check all that apply*):

☐ African American ☐ Latino/Hispanic (Origin: _______________) ☐ Caucasian ☐ Other __________________

EDUCATIONAL HISTORY

What is your highest level of school that you have completed?

☐ Some High School (highest grade completed): _________
☐ GED
☐ High School Diploma
☐ Trade/Vocational School. Which trade/vocation? _______________________
☐ Some College. How many years?_______________________
☐ College Graduate. What degree? _______________________

Are you currently in school? ☐ Yes ☐ No

If yes, what degree/training are you currently pursuing?

☐ GED
☐ High School Diploma
☐ Trade/Vocational School. Which trade/vocation? _______________________
☐ College. What degree? _________________________

YDACH General Questionnaire—December 2, 2013

(YDACH) ID Number: ______________________________	Date: ____________________
Interviewer: ______________________________________	Pseudo:__________________

EMPLOYMENT INFORMATION

Have you ever been employed? ☐ Yes ☐ No

Current Job

Are you currently employed? ☐ Yes ☐ No

Job 1	
Where do you work?	
Start Date:	
How many hours per week?	Hourly Wage:
Is this a Summer Youth Program Job?	☐ Yes ☐ No
Did you work as many hours as you desired?	☐ Yes ☐ No

Prior Employment

Beginning with your MOST RECENT position, tell us about your job.

Job 2	
Where did you work?	
Start Date:	End Date:
How many hours per week?	Hourly Wage:
Was this a Summer Youth Program Job?	☐ Yes ☐ No
Did you work as many hours as you desired?	☐ Yes ☐ No

Job 3	
Where did you work?	
Start Date:	End Date:
How many hours per week?	Hourly Wage:
Was this a Summer Youth Program Job?	☐ Yes ☐ No
Did you work as many hours as you desired?	☐ Yes ☐ No

(YDACH) ID Number: ______________________________ Date: ____________________
Interviewer: ____ Pseudo:__________________

PARENTING (FATHERHOOD) INFORMATION

Please list your children (biological and non-biological):

Name of Child	Date of Birth	Child's mother's name	Is this your biological child?	Have you signed the Birth Certificate/Gone to Court to establish paternity?	Does this child have your last name?	Have you established custody of this child?
1			Yes No	Yes No	Yes No	Yes No
2			Yes No	Yes No	Yes No	Yes No
3			Yes No	Yes No	Yes No	Yes No
4			Yes No	Yes No	Yes No	Yes No
5			Yes No	Yes No	Yes No	Yes No
6			Yes No	Yes No	Yes No	Yes No
7			Yes No	Yes No	Yes No	Yes No
8			Yes No	Yes No	Yes No	Yes No
9			Yes No	Yes No	Yes No	Yes No
10			Yes No	Yes No	Yes No	Yes No

(YDACH) ID Number: ______________________________	Date: ____________________
Interviewer: ______________________________________	Pseudo:__________________

MEDICAL INFORMATION

Instructions: *How often have you experienced each of the following issues in the past **TWO WEEKS**? For each statement, put an "X" in the box beneath the answer that best describes how you have been feeling*

	(0) Not at All	(1) Several Days a week	(2) More than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed?	☐	☐	☐	☐
9. Being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
10. Thoughts that you would be better off dead, or hurting yourself in some way?	☐	☐	☐	☐
11. Have you experienced physical pain, discomfort, or other health issues?	☐	☐	☐	☐
12. Do you have difficulty controlling your anger?	☐	☐	☐	☐
13. How often do you find yourself worrying?	☐	☐	☐	☐
14. Do you get into heated arguments with your partner or the mother of your baby?	☐	☐	☐	☐

(YDACH) ID Number: ______________________________ Date: ____________________
Interviewer: _______________________________________ Pseudo:__________________

Instructions: *Read each item and place a check in the box opposite the reply which comes closest to how you have been feeling in the* ***past week****. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.*

15. I feel tense or 'wound up':
    - ☐ Most of the time
    - ☐ A lot of the time
    - ☐ From time to time, occasionally
    - ☐ Not at all
16. I still enjoy the things I used to enjoy:
    - ☐ Definitely as much
    - ☐ Not quiet so much
    - ☐ Only a little
    - ☐ Hardly at all
17. I get a sort of frightened feeling as if something awful is about to happen:
    - ☐ Very definitely and quiet badly
    - ☐ Yes, but not too badly
    - ☐ A little, but it doesn't worry me
    - ☐ Not at all
18. I can laugh and see the funny side of things:
    - ☐ As much as I always could
    - ☐ Not quite so much now
    - ☐ Definitely not so much now
    - ☐ Not at all
19. Worrying thoughts go through my mind:
    - ☐ A qreat deal of the time
    - ☐ A lot of the time
    - ☐ From time to time but not too often
    - ☐ Only occasionally
20. I feel cheerful:
    - ☐ Not at all
    - ☐ Not often
    - ☐ Sometimes
    - ☐ Mors of the time
21. I can sit at ease and feel relaxed:
    - ☐ Definitely
    - ☐ Usually
    - ☐ Not often
    - ☐ Not at all

(YDACH) ID Number: ______________________________ Date: ____________________
Interviewer: ______________________________________ Pseudo:__________________

22. I feel as if I am slowed down:
    - ☐ Nearly all the time
    - ☐ Very often
    - ☐ Sometimes
    - ☐ Not at all

23. I get a sort of frightened feeling like 'butterflies' in the stomach:
    - ☐ Not at all
    - ☐ Occasionally
    - ☐ Quite often
    - ☐ Very often

24. I have lost interest in my appearance:
    - ☐ Definitely
    - ☐ I don't take so much care as I should
    - ☐ I may not take quiet as much care
    - ☐ I take just as much care as ever

25. I feel restless as if I have to be on the move:
    - ☐ Very much indeed
    - ☐ Quite a lot
    - ☐ Not very much
    - ☐ Not at all

26. I look forward with enjoyment to things:
    - ☐ As much as ever I did
    - ☐ Rather less than I used to
    - ☐ Definitely less than I used to
    - ☐ Hardly at all

27. I get sudden feelings of panic
    - ☐ Very often indeed
    - ☐ Quite often
    - ☐ Not very often
    - ☐ Not at all

28. I can enjoy a good book or radio or TV program
    - ☐ Often
    - ☐ Sometimes
    - ☐ Not often
    - ☐ Very seldom

(YDACH) ID Number: ______________________	Date: ______________
Interviewer: ______________________	Pseudo: ______________

Instructions: *Below are five statements that you may agree or disagree with. Please indicate your agreement with each item by placing a check in the column that corresponds to how much you agree/disagree with the statement. Please be open and honest in your responding.*

	Strongly agree	Agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Disagree	Strongly disagree
29. In most ways my life is close to my ideal.	☐	☐	☐	☐	☐	☐	☐
30. The conditions of my life are excellent.	☐	☐	☐	☐	☐	☐	☐
31. I am satisfied with my life.	☐	☐	☐	☐	☐	☐	☐
32. So far I have gotten the important things I want in life.	☐	☐	☐	☐	☐	☐	☐
33. If I could live my life over, I would change almost nothing.	☐	☐	☐	☐	☐	☐	☐

Instructions: *Please select "yes" or "no" for the following questions*

34. In the ***past year,*** have you felt depressed or sad most days, even if you felt okay sometimes?	□ Yes	□ No
35. Has there been a time in the ***past month*** when you have had serious thoughts about ending your life or hurting your self?	□ Yes	□ No
36. Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt?	□ Yes	□ No
37. Do you have a stable place to live?	□ Yes	□ No
38. Do you have enough food for yourself and your children?	□ Yes	□ No
39. Do you receive cash assistance to help pay your bills?	□ Yes	□ No
40. Do you have concerns about custody of your child?	□ Yes	□ No
41. Do you have concerns about visitation of your child?	□ Yes	□ No
42. Do you have health insurance?	□ Yes	□ No

YDACH General Questionnaire—December 2, 2013

(YDACH) ID Number: ______________________________ Date: ____________________
Interviewer: ____ Pseudo: __________________

43. What is the name of your doctor? _____________________________________

a. When was the last time you saw your doctor? ______________________________

b. What was the reason for your last visit to the doctor? (Check all that apply)

☐ Check-up/Physical
☐ I was sick
☐ An emergency
☐ Other___________________

SERVICES REQUESTED:

Which of the following services would be helpful to you? (Check all that apply)

☐ Job Readiness Training	☐ Financial management	☐ Domestic Violence Assistance
☐ Job placement Assistance	☐ Couples Counseling	☐ Obtain identification
☐ Transportation Assistance	☐ Individual Counseling	☐ Legal Assistance
☐ Food/Clothing Assistance	☐ Substance Abuse Treatment	☐ Health Insurance
☐ Community Service Hours	☐ Parenting Skills	☐ GED/Educational Attainment
☐ Anger Management	☐ Single Parenting	☐ Other ________________________

APPENDIX G

Interview Protocol

Young Dad's and Children's Health Study

Thank you for agreeing to meet with me. I am interested in learning more about how young dads think about and are involved in caring for their children's health needs. I also hope to learn more about how things around them—their communities, relationships with the mothers of their children and other family members, and personal health histories—impact how they approach dealing with their children's health. There are no "right" or "wrong" answers to any of the questions that I'll ask—I just want to learn more about your real experiences as a father. If you have any questions as we go forward, please let me know and I would be more than happy to answer them. Please also let me know if there are any questions that make you uncomfortable or that you would rather not answer.

I. Warm-Up & General Background

Let's start with some general background information.

1. How old are you?
2. Tell me about the neighborhood where you live now. How would you describe it? What is it like?
    a. Neighbors
    b. Peers
    c. Safety
    d. Jobs
    e. Resources (i.e., doctors' offices, hospitals, transportation).
3. Who do you live with now?
    a. How long have you lived there?
    b. What other places do you stay?
    c. If you needed a place to stay, where might you go?
    d. Where does your child(ren) live? Do they stay with you? How often?

II. Transition to Parenthood and Relationship with Mother(s) of Child/children

I'd like to spend some time learning about what it was like when you became a father and your relationship with the mother(s) of your child/children.

1. Tell me a bit about your child/children. What are their names? Ages?
2. Thinking back to when you found out that you would become a father, how old were you?
    a. How did you find out that you were going to be father?
    b. What went through your mind when you found out? How did you react?
    c. Did you think you were ready to become a dad? How so?

3. After you learned that you were going to be a father, how did you prepare yourself to become a father? What things did you do to get ready?
    a. From where you stand as a dad with some experience now since <Child's Name> arrived, do you think you were ready? How so?
        i. What could have helped you become more ready? Are there things you could have done?
4. Tell me about your relationship with <Child's Name's> mother around the time when you learned that you would become a father.
    a. What's her name?
    b. How did you meet?
    c. How long had you known each other?
    d. Were you romantically involved? Talking? Casual Partners.
    e. How was your relationship during the pregnancy?
5. How has your relationship with <Mother of Child> changed since <Child's Name> was born?
    a. Ups and downs?
    b. Consistency?

< < < < REPEAT QUESTIONS II:2-II:6 FOR EACH CHILD > > > >

III. PERCEPTIONS CHILDREN'S HEALTH

I'd like to hear about your thoughts about your child's health and experiences caring for his/her health since they were born.

1. Let's go back to when <child's mother> was pregnant. How did you think about your child's health? What did you do?
2. Now, think back to when <Child's Name> was born. Were you in the delivery room?
    a. What was it like when he/she was born?
    b. Was he/she healthy?
3. How has <Child's Name>'s health been since he/she was born?
4. (IF BOY) Did you and <Child's mother> have him circumcised? How did you decide this?
2. Does he/she have any long-term health issues (i.e., asthma, colic, virus, disabilities)?
    a. When did you learn that <Child's Name> had this?
    b. How could you tell? How could mom tell that something was wrong?
    c. What was it like learning that <Child's Name> had this?
        i. Who told you?
        ii. What went through your mind when he/she told you?
        iii. How did it change your ideas about what it meant to be a father?
        iv. How has living with <The Condition> changed the things you do as a dad?
    d. Does <Child's Name> require any special medical care?
        i. If so, what needs to be done?

ii. How do you work caring for <Child's Name> into your day?

1. How is his/her health now?

IV. HEALTH CAREGIVING EXPERIENCES

Now let's talk about some of your specific experiences caring for your children's health. We'll start by talking about what it was like when <child's name> was born and move towards the present.

3. Parents sometimes divide up caregiving responsibilities and that can be true for caring for children's health. Are there certain things that you usually do for your child's health and other things that mom usually does?
    a. How did you and <Mother of Child> come to that arrangement?
4. If I were to ask the mother of your child about your involvement in caring for the health needs of your child, what might she say?
5. On the day to day, how do you care for your child's health needs? What things do you do?
6. Kids go to a lot of doctors' visits, especially when they're young. Have you gone to their visits?
    a. What's the name of your child's doctor?
    b. What's it like for a father to go to the doctor's office with his kid when the kid is sick?
    c. Do you take <Child's Name> to the doctor with <Mother of Child>?
        i. Have you ever come to a visit without the mother? Why? Why not?
    d. How do doctors treat you?
    e. How do doctors speak to you?
        i. Do they address you?
        ii. Is it understandable?
    f. In general, dads are often less likely to come to their children's doctors' visits. Why do you think that is?
7. What illnesses has <Child's Name> been diagnosed with?
    a. When did you learn that <Child's Name> had this?
    b. How could you tell? How could mom tell that something was wrong?
8. Tell me about the last time <Child's Name> was sick.
    a. What was going on with him/her?
    b. How could you tell that he/she was not feeling well?
    c. How did you and mom communicate about the illness?
    d. What did you do?
    e. How did your child's illness impact what you did those days?
9. Have you had to take <Child's Name> to the emergency room?
    a. What was going on?
    b. How did you know that <Child's Name> needed to go to the emergency room?
    c. How did you and mom communicate about taking <Child's Name> to the doctor?

10. **Surveillance**
    In addition to dealing times when a child is sick, some dads have described becoming vigilant—watching over—their children's health since they were born. Is that something you do? How do you do it?
    a. What do you look for?
    b. How do you know that something is wrong?
    c. Tell me how observing your child's health is part of your day? Part of your time with your child.
11. What do you do to help prevent your children from getting sick?

V. IDEAS ABOUT FATHERHOOD & CARING FOR CHILDREN'S HEALTH

I'd like to get a sense of your ideas about what it means to be a father as well as your perceptions of caring for your child/children's health.

1. Being a father is a lot and requires you to wear a lot of different hats and do a variety of things for your child. What are your ideas about what it means to be a father?
2. Being a young father can sometimes be stressful. In your experience, how stressful has fatherhood been for you?
    a. What are some of the major sources of stress for you as a father?
    b. How do you deal with these sources of stress? In other words, how do you cope with them?
3. When you think of what it means to be a father, does caring for children's health come to mind? How is caring for children's health part of being a father?
    a. Health, particularly children's health, is a big word and can have a lot of meanings. What is involved in caring for children's health?
    b. Some say that mothers end up caring for much of their children's health needs. Why do you think this happens?
        i. What do you think <Mother of Child> expects you to do to care for the health of your child?
        ii. How do you and the mother(s) of your child/children divide caring for the health needs of your child[ren]?
4. What do you expect yourself to be able to do to care for the health of your child?
    a. Are you able to do this?
    b. What helps you do this? What makes it difficult?

VI. HEALTH PROMOTION

Fathers often encourage healthy behaviors for their children various ways. I would like to take some time to talk what you think about and do to promote your children's health.

1. Health responsibility
    a. As a dad, you may "scan" your child to make sure he/she is okay. What things do you look for?

   b. Has there been a time when you noticed something was wrong with your child or thought that he/she might be sick? Who did you tell?
   c. Now that you're a dad, you may spend some time learning about children's health and how to care for them. Where do you learn about children's health?
      i. Family?
      ii. Books?
      iii. Videos/internet/TV?
      iv. Classes?
2. *Physical Activity—Some people think that being physically active is important for children's development.*
   a. What do you think? Is it important to make sure that your kids are active?
   b. How do you know if your child is physically active enough?
   c. What do you do to make sure that your kids are active?
      i. What helps them be active?
      ii. Do you participate with them?
3. *Daily Routines—Nutrition & Sleep*
   a. *Nutrition—I'd like to take some time to talk about how feeding your happens in your family.*
      i. Families sometimes have feeding rituals. How does feeding your child(ren) fit into your daily routine?
         1. Do he/she/they eat at the same time every day?
         2. Who makes food?
         3. Who feeds him/her/them?
         4. What kind of things do your kids eat when they are with you?
         5. What kind of things do they eat when they are with others?
         6. If you had your choice, what would you feed your kids?
   b. *Sleep—What about sleep?*
      i. How well does he/she sleep?
      ii. When did he/she go to sleep last night? When did he/she wake up?
      iii. When does he/she usually go to sleep and wake up?
   c. Is it important for children to be on a schedule or have consistent routines?
      i. Why/why not?
      ii. (IF YES) How do you make this happen?
      iii. (IF YES) What helps you keep your child on a schedule? What makes it challenging?
4. *Interpersonal relationships*
   a. When you think of promoting children's health, does helping them have positive relationships with those around them come to mind?
      i. If so, what do you do to help them develop these relationships? What about with you?

   b. I imagine that there are people that you would want your child to have close relationships with. Who are these people? How do you think these relationships will benefit your child?
5. Thinking over al the things you do to promote your child's health, what things help you do this? What makes it easier? What makes it challenging? What could make it easier?
6. So, we've spent some time talking about how you promote your child's health. When did you begin trying to make sure that your child would be healthy?
   a. What got you thinking that you thinking about caring for your child's health?
   b. Were there things you did when <Child's Mother's Name> was pregnant?
      i. What? (i.e., checking in with mom to see if the baby was okay, learning about pregnancy, learning about caring for children's health)?
      ii. How did she receive this?

VII. Personal Health History

Oftentimes, our personal experiences from when we were younger—and even more recently—impact how we approach parenting our children. The next few questions will ask you about your health experiences as a child and how these may shape your perspectives of how you care for your children's health today.

1. Thinking back to when you were really young—elementary school or earlier—how would you describe your health?
   a. Who looked after your health?
      i. How did they do this?
   b. Do you remember going to doctors' visits?
      i. Did you have the same doctor for every visit? What was the name of your doctor?
      ii. How often did you go to the doctor? For what reasons (i.e., check-ups, acute illness, emergencies)
   c. Did you have any health issues? Asthma? Injuries?
      i. How much did these impact your life?
      ii. How did the people around you care for these health issues?
2. Let's move into middle school—when you were 11-14. How would you describe your health?
   a. Who looked after your health when you were in middle school?
      i. How did they do this?
   b. Do you remember going to doctors' visits?
      i. Where did you go for care?
      ii. Did you have the same doctor for every visit? What was the name of your doctor?
      iii. How often did you go to the doctor? For what reasons (i.e., check-ups, acute illness, emergencies)

    c. Did you have any health issues? Asthma? Injuries?
        i. How much did these impact your life?
        ii. How did the people around you care for these health issues?
3. What about high school—between 15-18. How was your health then?
    a. Who looked after your health when you were in middle school?
        i. How did they do this?
    b. Do you remember going to doctors' visits? (What about dentist appointments?)
        i. Where did you go for care?
        ii. Who made your appointments?
        iii. Did you have the same doctor for every visit? What was the name of your doctor?
        iv. How often did you go to the doctor? For what reasons (i.e., check-ups, acute illness, emergencies)
    c. Did you have any health issues? Asthma? Injuries?
        i. How much did these impact your life?
        ii. How did the people around you care for these health issues?
4. How has your health been since you've become an adult?
    a. Who looks after your health new?
        i. What things do they do (i.e., care during illness, making appointments, carrying insurance)?
    b. Do you currently have health insurance?
    c. Do you have a doctor?
        i. When's the last time you went to the doctor?
        ii. For what?
        iii. When's the last time you went to the doctor for a regular check up?
        iv. Young men often do not go to the doctor as much as they should. Why do you think this is?
            1. Has becoming a father changed the way you think about your own health?
    d. Do you currently have any health issues?
        i. How do these impact your daily life?
        ii. How do people around you help you care for these issues?
5. If you think about how your (mother/father/others) have cared for your health needs over the years, what have you learned about how to care for your child's health needs?
    a. What do you do the same? What do you do differently?
6. How have your personal experiences affected how you care for your children's health?
    a. Experiences with doctors
    b. Illnesses/getting sick
    c. Chronic issues
7. Are there things you now do as a father that you didn't do before you had a child? Are there things you now do?
    a. Risk behaviors (smoking, drinking, hanging out)

b. Physical's doctors' visits

VIII. Health Promotion and Modeling

I now have some questions about what you want your kids to know about health and the things you do to teach them.

1. What things do you want your kids to know about caring for their health? What do you think you will teach your children about health? How will you do this?
    a. Do you currently follow your own advice?
2. What health behaviors do you model for your child? What things do you do that you want your kids to do? Are there things that you do but wouldn't want your kids to do the same?
3. What things do you think you do well in relation to caring for your child's health?
4. What makes it hard to care for your child's health needs?
    a. How do you overcome these challenges?
5. What would help you care for your <Child's Name>'s health needs?

IX. Wrap-Up

We've come to the end of our interview. Do you have any questions? Are there any things you would like to add?

I am often curious about how dads use these gift cards. What are your plans for it?
Thank you for your time and sharing your experiences.

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