

The Psychological and Physical Well-Being of Involved, Low-Income Fathers

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Author Note

Kamp Dush is grateful for support for this research from the National Institute of Child Health and Human Development (NICHD) (1K01HD056238). This paper and its contents are solely the responsibility of the authors and do not necessarily represent the official views of NICHD. The Fragile Families study was funded by a grant from NICHD (#R01HD36916) and a consortium of private foundations and other government agencies. Persons interested in obtaining Fragile Families data should see <http://www.fragilefamilies.princeton.edu/data.asp> for further information.

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Shifting social standards for fathers have given rise to more engaged, active fathers. Although declines in father-child contact often occur after relationship dissolution, many fathers continue to spend time with their children despite significant challenges (Tach, Mincy, & Edin, 2010). There is evidence that involved fathers not only provide psychological benefits for children (e.g., Flouri & Buchanan, 2003; Perlmann & Gleason, 1993), but father involvement may also increase the psychological and physical health of fathers themselves (Eggebeen & Knoester, 2001). This paper builds upon previous efforts to examine the role of father involvement with regard to the psychological and physical health of fathers in a nationally representative sample of children born to low-income, unmarried mothers. Because low-income men may be particularly at risk for adverse psychological and physical health outcomes (Areias, Kuma, Barros, & Figueiredo, 1996; Roy, 1981), increases in these health statuses attributed to father involvement may encourage fathers to either continue to remain or become more involved in their children's lives.

Theory

Role theory posits that certain expectations exist for the behavior of individuals who occupy specific roles (Biddle, 1982). Normative behaviors for gender roles or cultural roles are generally agreed upon by members of a society; thus internal and external expectations are inherently bound within the occupation of a social role (Popitz, 1972). Most people occupy more than a single role in society; therefore certain roles may have greater saliency to the well-being of the individual. Expectations about role performance are internalized, and failing to meet culturally and personally defined role standards may influence the psychological and physical health of the individual (Simon, 1995).

Social norms regarding fatherhood have shifted; fathers are encouraged to become involved in their children's lives, and a multitude of positive benefits for children have been linked to father involvement (e.g., Amato, 1994; McBride, Schoppe-Sullivan & Ho, 2005). Men who occupy the parental role but who do not meet social or personal standards regarding appropriate fathering behaviors may be most susceptible to psychological distress and physical health decline. Edin and Kafalas (2005) found that low-income, unmarried mothers place a high premium on motherhood; fathers in similar socioeconomic circumstances may place a high premium on fatherhood as well. Thus, failing to live up to internal and external expectations for fatherhood may result in declines in psychological and physical health.

There are indications that men's family roles are especially important to their psychological functioning. For instance, Lein et al. (1974) posited that men in industrialized societies experience emotional and personal gratification through the interactions occurring within the family. In a qualitative study of urban, non-resident, African American fathers, Nelson, Edin, and Clampet-Lundquist (1999) found that fatherhood played an integral role in fathers' perceptions of self. Additionally, these fathers recognized parenthood as life-changing, and many decreased their participation in illegal or personally harmful behaviors. Indeed, Pleck (1985) found that husband's experiences within their family roles were more important to their psychological functioning than their experiences within work roles. Finally, Barnett, Marshall, and Pleck (1992) found that parental-role quality, rather than parental status, was a moderator in the relationship between men's job-role quality and psychological distress. Therefore, it may especially important to expand on previous measurements of non-resident father involvement (i.e. frequency of father-child contact), in an effort to adequately compare the potential psychological and physical health benefits of father involvement for all types of fathers.

Research Questions

Does father involvement contribute to the psychological and physical health of low-income men regardless of resident status? Are these contributions contingent upon the father's romantic involvement with the mother? Does the new partner status of either parent eliminate this association?

Fatherhood and Associated Health Benefits

Fathers undoubtedly provide their children with multiple benefits, and children who have involved fathers tend to experience more positive outcomes than children whose fathers are uninvolved or absent (Sigle-Rushton & McLanahan, 2004). While some efforts have been made to explore reciprocity in the father-child relationship (e.g., Crouter & Booth, 2003), much remains to be investigated with regard to father involvement and its role in strengthening the psychological and physical health of fathers.

Fatherhood (i.e. occupation of the parental role) has been linked to a variety of positive social benefits. Cowan and Cowan (1992) showed that fatherhood increased relationship stability among married couples; marriage has also been positively linked to increases in men's psychological and physical health (Waite, 1995). Eggebeen and Knoester (2001) found that, compared to men who were not fathers, fathers tended to have better psychological health and stronger social connections. Further, they showed that father involvement itself was linked to decreased symptoms of depression, particularly among fathers who were co-resident with their children. Although this study provided an important contribution to our knowledge of father involvement and its impact on men's health, the father involvement measure fell short in capturing the experiences of low-income and non-resident fathers. This study seeks to reconcile

this measurement issue by utilizing the same measurement for father involvement regardless of resident status.

Low Income Fathers and Health Risks

Low income fathers experience a variety of stressors that may contribute to declines in psychological and physical well-being. Challenges such as unemployment, lack of access to reliable transportation, and limited access to housing have been linked to increases in depressive symptoms among low-income fathers (Anderson, Kohler, & Letiecq, 2005). Depressed fathers may withdraw from activities with their children (Roggman, Boyce, Cook, & Cook (2002) and, among non-resident fathers, depressive symptoms may jeopardize the maintenance of father-child contact if conflict with the mother should arise as a result. Findings indicate that non-resident fathers are typically less involved with their children (Tach et al., 2010), and depression may further limit the benefits associated with non-resident father involvement.

While depression is an important aspect of psychological health, depressive symptoms may manifest themselves differently in men and women. For instance, Cochran and Rabinowitz (2000) found that men were more likely than women to exhibit reckless behaviors when dealing with depression, thus alcohol and drug abuse may be better indicators of depression for men. Economic hardship is linked to increases in alcohol abuse (e.g., Van Oers, Bongers, Van de Goor, & Garretsen, 1999) and illicit drug use among men (e.g., Compton, Thomas, Stinson, & Grant 2007), and the abuse of drugs and alcohol reduces positive parenting behaviors (Hamer 2001; Magura & Laudet, 1996; McMahon & Rounsaville, 2002). Therefore, we consider the abuse of alcohol and use of illicit drugs an indicator of poor psychological health for fathers.

Method

Sample

Data from the Fragile Families and Child Wellbeing Study, a longitudinal study designed to assess the characteristics of unmarried parents, their relationships, and the impact of these factors on children, were used to examine the association between father involvement and psychological and physical health outcomes for fathers. The full study sample consisted of 3,712 children born to unmarried parents and a comparison group of 1,186 children born to married parents; the weighted sample was representative of births in US cities with populations greater than 200,000 (McLanahan et al., 2001). Births from parents in seventy-five hospitals located within twenty cities were recorded. Interviews were conducted with mothers and fathers (when available) separately following the birth (Carlson, McLanahan, & Brooks-Gunn, 2008). Approximately 85% of eligible mothers and 76% of eligible fathers completed the interviews at baseline (Reichman, Teitler, Garfinkel, & McLanahan, 2001). Follow-up interviews were conducted at one, three, and five years post-partum. Researchers asked parents detailed questions about their relationships, living arrangements, fertility histories, support, involvement, etc.

Dependent Variables

Depression. A continuous measure of father's depressive symptoms at years one, three, and five, was created from the Composite International Diagnostic Interview – Short Form (CITI-SF; Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998; Walters, Kessler, Nelson, & Mroczek, 2002). Scoring of the CITI-SF follows the *Diagnostic and Statistical Manual of Disorders, Fourth Edition* diagnostic criteria for a major depressive episode and generalized anxiety disorder (American Psychiatric Association, 1994). First, fathers were asked whether they had 1) feelings of depression or 2) an inability to enjoy things that give them pleasure in the

past year for at least two weeks. If they endorsed either, they were asked more specific questions about whether or not they had other symptoms during that time including: feeling tired, change in weight, trouble sleeping, difficulties concentrating, feelings of worthlessness, and thoughts about death. Fathers who reported that they felt depressed, had loss of interest, and reported each of the other six symptoms during a two-week period received a value of 1 on this variable. The depressive symptoms score was created by summing the values of all 8 items, with an alpha of .95 at year one and .94 at years three and five.

Risky Behaviors and Clinical Depression. Following Meadows (2009), we examined a composite score of the father's psychological health assessed from three dichotomously coded variables: clinical depression, drug abuse, and alcohol abuse. Following Filippone and Knab (2005), fathers met the criteria for clinical depression when they reported all 8 depression symptoms (see depression description above) at a high frequency (lasting at least "about half the day" and "almost every day") for two weeks for those symptoms that included a frequency assessment.

A father's illicit drug use was measured at years one, three, and five, and corresponded to the father's reports of the use of at least one illicit drug (sedatives, tranquilizers, amphetamines, analgesics, inhalants, marijuana, cocaine, LSD/hallucinogens, or heroin) in the past month, without a prescription, in larger amounts than prescribed, or for longer than prescribed. Alcohol abuse was defined as the consumption of at least five alcoholic drinks in one sitting at least once in the previous month at the one-year time point, and four or more alcoholic drinks in one sitting at least once in the previous month at years three and five.

Self-Rated Physical Health. At interview years one, three, and five, self-rated physical health was measured using the father's rating of their overall physical health, ranging from 1=

excellent to 5 = *poor*. Items were reverse coded to reflect higher numerical values when better physical health was reported.

Independent Variables

Father Involvement. At each wave, father involvement was measured from an 8-item scale based on the father's reports of participation in engagement and routine childcare activities. Engagement questions such as, "How often do you play inside with toys such as blocks or legos with the child?" and, "How often do you hug or show physical affection to the child?" were included. Questions regarding routine childcare included, "How many days a week do you usually put (child) to bed?" and "How many days a week do you usually assist (child) with eating?" (year three). Response options were 0 = *never*, 1 = *1 day per week*, 2 = *2 days per week*, 3 = *3 days per week*, 4 = *4 days per week*, 5 = *5 days per week*, 6 = *6 days per week*, and 7 = *7 days per week*. Responses to each question were averaged to produce the father involvement variable. At each wave, fathers who reported no father-child contact within the previous 30 days were given a zero on each value of the father involvement scale. Cronbach's alphas of .88, .89, and .87, correspond to measurement at years one, three, and five.

Controls

Father's New Partner Status. A dichotomous indicator of the father's romantic involvement with a new partner was created from fathers responses to the following question: "Are you currently involved in a romantic relationship with someone other than (mother)?" where 0 = *no new partner*, and 1 = *new partner*. Fathers who indicated that they were involved in a romantic relationship with the mother of the focal child were ineligible to answer the new partner question and were given a value of 0 on this indicator.

Mother's New Partner Status. A dichotomous indicator of the mother's new partner status was created from mother's responses to the following question: "Are you currently involved in a romantic relationship with someone other than (father)?" where 0 = *no new partner*, and 1 = *new partner*. Mothers who indicated that they were involved in a romantic relationship with the father of the focal child were ineligible to answer the new partner question and were given a value of 0 on this indicator.

Romantic Relationship Status. A dichotomous indicator of the father's romantic involvement with the mother of the focal child was created from fathers' responses to the following question: "What is your relationship with (mother) now?" Response options included 1 = *married*, 2 = *romantically involved*, 3 = *separated/divorced*, 4 = *just friends*, and 5 = *not in any kind of relationship*. Options 1 and 2 were combined and coded as 1 = *romantic relationship*, and options 3 through 5 were combined and coded as 0 = *no romantic relationship*.

Statistical Models

We use fixed-effects regression, also known as a difference model (Allison, 1990) or a change-score model (Johnson, 2005). To begin, separate cross-sectional models predicting depressive symptoms at years 1 and 3 can be written (in the interest of space, we use 1 and 3 to illustrate the example):

$$(0) \quad \text{Depress}_{i1} = \alpha_1 + \beta_1 \text{FatherInvolvement}_{i1} + \beta_2 M_i + \beta_3 U_i + \varepsilon_{i1}$$

$$(0) \quad \text{Depress}_{i3} = \alpha_3 + \beta_1 \text{FatherInvolvement}_{i3} + \beta_2 M_i + \beta_3 U_i + \varepsilon_{i3}$$

where α is the constant at each year, β s are regression parameters at each year, and ε is the error term at each year. M represents a vector of measured time-invariant potential causal variables and U represents a vector of unmeasured time-invariant potential causal variables. To derive the

difference model, the cross-sectional equation at year 1 is subtracted from the cross-sectional equation at year 3 as follows.

$$(0) \quad (Depress_{i3} - Depress_{i1}) = (\alpha_3 - \alpha_1) + (\beta_1 FatherInvolvement_{i1} - \beta_1 FatherInvolvement_{i3}) \\ + (\beta_2 M_i - \beta_2 M_i) + (\beta_3 U_i - \beta_3 U_i) + (\varepsilon_{i3} - \varepsilon_{i1})$$

which reduces to:

(0)

$$(Depress_{i3} - Depress_{i1}) = (\alpha_3 - \alpha_1) + (\beta_1 FatherInvolvement_{i1} - \beta_1 FatherInvolvement_{i3}) + (\varepsilon_{i3} - \varepsilon_{i1})$$

Here, M and U are differenced out of the equation because M_i equals M_i at each phase, and U_i equal U_i at each phase because the variables in each are time invariant. In difference models, measured time-varying control variables can be entered into the equation as well. For non-experimental studies, Allison (1994) argued that given the potential of unmeasured third-variable bias, difference models are “nearly always preferable for estimating the effects of events” (p. 181) and indeed, using family data from the National Survey of Families and Households, Johnson (2005) illustrated that LDV models produce biased estimates as compared to difference models.

Results

Sample Characteristics. On average, fathers were in their late 20s, the majority identified as African American, and around one-third had obtained a high school education (see Table 1). Fathers reported few depression symptoms and low rates of alcohol abuse, illicit drug use, and clinical depression. On average, fathers in the sample reported high levels of self-rated physical health.

Depression. Increases in father involvement were significantly associated with decreases in depressive symptoms. This association remained significant after controlling for the father’s

new partner, mother's new partner, and romantic relationship status. A one point increase in father involvement was associated with a 0.03 point decrease in depressive symptoms. Fathers' romantic relationship status (i.e. romantically involved with the mother of the focal child) was significantly associated with a decrease depressive symptoms; that is, fathers who were romantically involved with the mother of the focal child decreased in depressive symptoms over time.

Risky Behaviors and Clinical Depression. Father involvement was marginally associated with decreases in risky behaviors and clinical depression among fathers; this association was robust to the inclusion of controls. A one point increase in father involvement was marginally associated with a 0.01 point decrease in reports of risky behaviors and clinical depression. Fathers who were romantically involved with the mother of the focal child decreased in alcohol abuse, illicit drug use, and clinical depression over time.

Self-Rated Physical Health. Father involvement significantly increased self-rated physical health and this association remained significant after the inclusion of controls. A one point increase in father involvement was associated with a 0.03 point increase in self-rated physical health. Fathers who were romantically involved with the mother of the focal child was reported better self-rated physical health over time.

Discussion

Expectations for fathers have changed in recent decades and today's fathers are more involved with their children than ever before (Bianchi, Robinson, & Milkie, 2006). Further, fathers are encouraged to remain involved in their children's lives even after the dissolution of romantic relationships. Government programs such as child support have placed expectations of financial support for children on fathers, while at the same time, social norms regarding involved

fathering have placed expectations of support in the form of quality time with children on fathers as well. Thus, men who occupy the role of father may experience stress if they are unable to meet externalized and internalized standards for fatherhood. This stress may manifest itself in the form of decreased psychological and physical health. In contrast, fathers who are able to meet expectations for fatherhood, specifically in the form of time spent with children, may experience psychological and physical health benefits.

We show that father involvement, regardless of resident status, is a significant predictor of the psychological and physical well-being. Fathers who participated in engagement and routine childcare activities experienced psychological benefits in the form of decreased depressive symptoms and clinical depression. Additionally, involved fathers abused alcohol and illicit drugs less often. Most importantly, the results remained consistent even after controlling for romantic involvement and both mother's and father's new partner status. These results expand upon previous findings that father involvement is beneficial for the psychological health of fathers (Eggebeen & Knoester, 2001); however we show that these benefits are not contingent upon the resident status of the father.

The importance of these findings are twofold. First, these findings suggest that children also provide benefits to fathers when fathers are involved in their lives, supporting the notion of reciprocity within the parent-child relationship (e.g., Crouter & Booth, 2003). Furthermore, because these results were obtained within a sample of low-income fathers, these findings suggest that father involvement may be beneficial for even the most vulnerable fathers in the population. Low-income fathers face a variety of stressors that may adversely impact their psychological and physical health, such as a lack of economic resources due to low wage jobs and unemployment, inadequate or unstable housing situations, and social marginalization. These

circumstances may increase a father's risk for experiencing one or more adverse psychological and physical health symptoms (Compton et al., 2007; Van Oers et al., 1999). Depressive symptoms and the abuse of alcohol or use of illicit drugs further increases the disadvantages that low-income fathers face.

Second, we show that these health benefits are not limited to fathers who are co-resident with their children. This is important because previous findings suggested that psychological health benefits were limited to fathers who resided with their children (Eggebeen & Knoester, 2001). The fact that father involvement may have health benefits for fathers regardless of their living situation suggests that increasing father involvement among non-resident fathers may serve other functions as well. For instance, fathers who are less depressed and who abstain from the abuse of alcohol and illicit drugs may be better equipped to participate in activities such as work that would have positive impacts on their economic, living, and personal situations. Additionally, fathers who are able to maintain good psychological and physical health may be better role models for children and may be able to provide a much needed sense of stability to children who are most at risk for experiencing multiple family transitions (Bumpass & Lu, 2000). Most importantly, processes of selection that may be at play in determining which fathers maintain resident status with children (or maintain romantic relationships with their mothers), are insufficient in determining which fathers receive benefits from their own involvement with their children.

Finally, these results have social implications as well. Social policies that support low-income mothers provide less, and sometimes no support to low-income fathers. Temporary Assistance for Needy Families (TANF) provides aid to low-income mothers and children living within the same household, whereas fathers who no longer co-reside with mothers (but who may

be economically disadvantaged themselves) may not qualify for assistance (Department of Health and Human Services, 1999). Therefore, the health benefits that fathers may receive by actively participating in the lives of their children may serve to decrease health disparities between low-income men and men who have access to adequate healthcare resources. Further, decreasing depression, alcohol abuse, and illicit drug use in this population may decrease the cost of healthcare in the long-term. Alcohol abuse, illicit drug use, and depression are linked to a variety of adverse health trajectories (e.g. Beekman, Deeg, Braam, Smit, & van Tilburg, 1997; Rehm, Room, Graham, Monteiro, Gmel, & Sempos, 2003; Strang et al., 1998), thus men who do not engage in alcohol and drug abuse and who do not suffer from depression may place less financial burden on the healthcare system over time.

This study is not without limitations. First, the direction of causation cannot be determined; it may be that fathers with better psychological and physical health are more involved, whereas fathers with adverse health conditions are less involved with their children. However, we utilize stringent statistical tests that take into account all within-person time-invariant characteristics. Second, the measurement of father involvement utilized in this study, although more stringent than previous measures, fails to take into account the quality of the father-child relationships. Recent calls for a reconceptualized measurement of father involvement stress the importance of considering the quality of the father-child relationship rather than simply measuring father involvement in terms of quantity (Pleck, 2010).

Although these limitations exist, numerous strengths of this study stand out. First, father's reports of involvement were utilized in an effort to reduce significant discrepancies that may be inherent in mother's reports of father involvement (Mikelson, 2008). Because the sample consisted of numerous non-resident fathers, mother's reports of father involvement may be

especially skewed. Therefore, our utilization of father's reports of involvement may reduce measurement bias. Second, we measured father involvement for both resident and non-resident fathers the same. Often, measurement of father involvement for non-resident fathers is restricted to the use of frequency of contact rather than in terms of specific activities (e.g. Tach et al., 2010), not only limiting comparisons between resident and non-resident fathers, but potentially influencing results. The design of the Fragile Families and Child Wellbeing Study allowed us to level the playing ground, so to speak, between co-resident and non-resident fathers. This is a significant strength of our study.

Overall, our findings show that involved fathering is linked to better psychological and physical health among low-income fathers. More importantly, these results are not contingent upon the resident status of the father. This finding underscores the importance of continuing to invest in programs that enable non-resident fathers to become involved in their children's lives. Further, reducing psychological and physical health problems among low-income fathers, especially those who are non-resident, may reduce barriers to much needed opportunities that have the potential to alleviate even more stress for disadvantaged fathers. Additionally, research should continue to investigate how certain aspects of father involvement may contribute to specific health outcomes and their trajectories.

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Table 1

Descriptive Statistics

	Range	M (SD)	% Missing
Independent Variable			
Father Involvement	0-7	3.75 (1.96)	0
Psychological and Physical Health Variables			
Depression	0-8	0.67 (1.85)	0
Risky Behaviors and Clinical Depression	0-3	0.45 (0.66)	0
Self-Rated Physical Health	1-5	3.91 (0.99)	0.05
Control Variables			
Romantic Relationship Status	0-1	0.71	0.30
Paternal New Partner	0-1	0.14	0.30
Maternal New Partner	0-1	0.14	0.30
Sample Characteristics			
Paternal Age	16-61	28.35 (7.15)	0.1
Maternal Age	15-43	25.84 (6.10)	0
Paternal Race	0-1		0
White		0.24	
Black		0.43	
Hispanic		0.24	
Other		0.09	
Maternal Race	0-1		0
White		0.27	
Black		0.44	
Hispanic		0.25	
Other		0.04	
Paternal Education	0-1		5.28
Less than High School		0.29	
High School		0.31	
Some College		0.26	
Maternal Education	0-1		0.09
Less than High School		0.30	
High School		0.29	
Some College		0.36	

Table 2

Depression

	N	n (groups)	b	se	t	F	r ² within	r ² overall
Father Involvement	9271	3916	-0.06	0.02	-4.19***	13.52***	0.010	0.034
Controls								
Father's New Partner			-0.12	0.09	-1.38			
Mother's New Partner			-0.06	0.01	1.88			
Romantic Relationship Status			-0.28	0.08	-3.32***			
Note: ⁺ p<0.10, *p<0.05, **p<0.01, ***p<0.001								

Table 3

Risky Behaviors and Clinical Depression

	N	n (groups)	b	se	t	F	r ² within	r ² overall
Father Involvement	9293	3924	-0.01	0.01	-1.80 ⁺	2.72*	0.002	0.014
Controls								
Father's New Partner			-0.01	0.03	-0.26			
Mother's New Partner			-0.02	0.03	-0.55			
Romantic Relationship Status			0.53	0.03	19.11***			
Note: ⁺ p<0.10, *p<0.05, **p<0.01, ***p<0.001								

Table 4

Self-Reported Physical Health

	N	n (groups)	b	se	t	F	r ² within	r ² overall
Father Involvement	9275	3916	0.03	0.01	3.99***	6.93***	0.005	0.008
Controls								
Father's New Partner			-0.01	0.04	-0.03			
Mother's New Partner			0.01	0.04	0.32			
Romantic Relationship Status			0.07	0.04	96.20 ⁺			
Note: ⁺ p<0.10, *p<0.05, **p<0.01, ***p<0.001								