Exploring Culture Care of Homeless Children

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Mary B. Knutson

Abstract

Homelessness has a dramatic impact on health and healthcare needs of those involved. This extensive review of literature supports the need for coping strategies and preventive health care. The purpose of this phenomenological transcultural research project was to discover and describe the lived experience of homeless children as perceived by the parents. Parents of four children were interviewed at the homeless shelter of a Midwestern city. Leininger's Culture Care Theory was the theoretical framework applied. Themes of autonomy, attitude, coping, and resources were found. Results support recommendations for the homeless shelter and implications for health professionals to develop culturally congruent care. This researcher hopes to prevent some developmental and health problems by increasing adaptive resourcefulness and social connectedness of homeless children.

Approval of Project

This project was accepted for credit towards the MSN degree.

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Exploring Culture Care of Homeless Indigent Children

Introduction

Homelessness is an ever-increasing, complex social problem that has dramatic impact on the health and healthcare needs of those involved. Children are especially affected, as they proceed through their crucial developmental stages in such a vulnerable situation as homelessness. According to White, Hummel, and Hoot Martin (2002), the dominant characteristic of the homeless is the absence of permanent housing. The homeless often need to find inventive and creative ways to meet daily food, clothing, health, and shelter needs. The needs become even more complex when children are involved.

This phenomenological research project focused on culture care meanings, expressions, lived experiences and practices of homeless children and their families as perceived by parents. Using this knowledge to better understand homeless children from a cultural perspective, it may be possible to prevent some serious developmental and health problems through culturally congruent care.

According to Vissing (1996), homelessness is devastating to a child. It is not a singular event or merely the lack of housing (except in "immediate" homelessness caused by fires, tornados or floods). Homelessness is a process in which personal chaos occurs slowly to the whole family. Chaos is the spiral of losing job, money, support networks, material possessions, and self esteem. The chaos and catastrophe of homelessness affects the body, emotion, mind, and structure of the family members. To date, little is known about the adaptive resourcefulness, including cultural patterns and care needs, of homeless children.

Ethnohistory

This research project was conducted in a homeless shelter in a mid-sized city in the Midwest. The region includes another adjoining city and other small towns and rural areas. This area is seen as a progressive, friendly and civic-minded community. There are innovative community programs and two hospital systems, two universities, and a technical college.

The local homeless shelter has been in existence since the 1970's. The March 2000 census showed there were 1,700 people living in shelters in Wisconsin, and it was likely there were many more homeless people than were counted (Hollnagel, 2002). The National Coalition for the Homeless (1999) reported that homeless counts may miss significant numbers of people who are literally homeless but "hidden", such as those who stay in vehicles, campgrounds or makeshift housing, as well as those living in doubled-up situations. It is likely that although homeless indigent children do not have a home of their own, most of them are not living on the street. If they are not living within the homeless shelter, they may be in transitional housing arranged by local agencies such as shelters for abused women and children, YMCA, or staying with other family, friends or relatives.

Hollnagel (2002) reported that the homeless situation is critical, with more and more people needing services, including families with one or more children. The homeless shelters have been consistently filled to capacity, and many people have been turned away due to lack of space. Hollnagel cited reasons for the rise in homelessness as lack of affordable housing, low wages, reduction in services and government assistance programs, lack of affordable health care, domestic violence, and problems with drug and alcohol addictions. Local agencies have been trying to add funding and programs for homeless people.

Research on the lived experiences of the local homeless people using Transcultural Nursing theory was of interest to this researcher. This project focused on homeless children because fewer studies exist in the literature than studies of homeless adults. Realizing the enormity and complexity of doing a qualitative study on many age groups, this project examined lived experiences of homeless children 13 years of age or younger, as perceived by their parents.

Review of Literature

History of homelessness

According to Portner (1996), Fr. Edward J. Flanagan was a pioneer in the history of homelessness who established Omaha's Boys Town child-care home in 1917. He saw destitute men who had been abandoned as youths. He wrote, "I know my work was not with these shells

of men, but with the embryo men—the homeless waifs who had nowhere to turn, no one to guide them" (Portner, p. 35). The eight to eighteen year olds who arrived at Boys Town in the first half of the century were primarily homeless and destitute. In 1979, girls were admitted to Boys Town as well (Portner, 1996).

Of the children at Boys and Girls Town in 1996, only 2 percent were orphans according to Portner (1996). More than half were sexually abused. Eighty percent were emotionally or physically neglected and many abused drugs or alcohol. One in four had attempted suicide. Besides giving kids a reason to be good, Flanagan believed in vocational and religious training. His simple principles of discipline have been tailored to fit the modern classroom. Since 1984, Boys and Girls Town has started satellite campuses in 14 states and the District of Columbia. Research programs continue in Boys Town, conducted in the spirit of Flanagan's European research on homeless children that began in 1948 (T. J. Lynch, personal communication, July 26, 2002).

Another organization influencing the lives of homeless children is called In His Arms Ministry. In 2001, it was active in 43 states and 19 countries. Its purpose has been to motivate, train and equip individuals and organizations to demonstrate and teach a lifestyle consistent with biblical principles to homeless and at-risk kids (Burr Turnbull & Martz George, 2002).

Current trends

In recent years, there has been a large increase in the number of homeless Americans, although the estimates vary widely with point-in-time estimates and projected rates (National Coalition for the Homeless, 1999). Families composed predominantly of single mothers and young children are the most rapidly growing segment of the homeless population. It has been estimated that they account for one third of the more than 2.5 million homeless persons nationwide (Bassauk, 1990; Davis, 1996; Reimer, Van Cleve, & Galbraith, 1995; Thrasher & Mowbray, 1995). One study in Massachusetts found single women headed more than 90% of the families that were homeless (Bass, Brennan, Mehta, & Kodzis, 1990). According to Davis, many homeless women were teenage mothers without social supports, family networks,

education, and employment, or women and children who left their homes due to sexual abuse or wife battering. In a California study by Reimer et al. (1995), at least 50% of the homeless people were nonwhite. In one of the counties studied, the average age of the homeless individual was 23.3 years, and children made up 36% to 43% of the total homeless population.

White, Hummel, and Hoot Martin (2002) reported that a large number of homeless persons reported excessive use of alcohol, drugs, and tobacco, but Davis (1996) cited estimates that only 20% to 40% of the homeless were alcoholic and 20% to 30% were mentally ill. Ehrmin (2002) studied a sample of African American women who revealed anger and emotional pain associated with negative life experiences, attempting to numb the emotional pain with alcohol or drugs. Negative consequences to homeless children may be magnified by substance abuse or mental illness of the parents. Bassuk (as cited in Burr Turnbull & Martz George, 2002) stated, "Research now is revealing something that we didn't know in 1992 but felt in our hearts to be true: Homeless children are destined to repeat the destructive cycle of homelessness" (p. 6). In spite of the many limitations and barriers, creative and effective ways to help homeless children must be found.

Transitions in homelessness

The lives of homeless families may be characterized as very unstable, with multiple transitions occurring. Meleis and Trangenstein (1994) performed an extensive literature review and described five types of transitions that are significant for nursing: (a) individual developmental transitions, such as child development, adolescence, becoming aware of sexual identity, or going into midlife; (b) family developmental transitions, such as mother-daughter relationship, parenthood, and childbearing family; (c) situational transitions, including relocation, work or education changes, divorce, widowhood, role changes or family caregiving; (d) health/illness transitions, such as hospital discharge, recovering from illness, or diagnosis of chronic illness; and (e) organizational transitions, such as changes in leadership, implementation of new policies or practices, implementation of a new curriculum, changes in nursing as a profession, and changes in communities.

Meleis and Trangenstein (1994) further described indicators of successful transitions: (a) emotional well-being, (b) mastery, and (c) well-being of relationships. Additional indicators using nursing's unique focus on health included (a) quality of life, (b) adaptation, (c) functional ability, (d) self-actualization, (e) expanding consciousness, (f) personal transformation, and (g) purposeful and mobilized energy.

The Zuluaga-Raysmith (Z-R model) is based on Maslow's theory. The Z-R model proposed that every human being has 10 basic human needs. If the needs are satisfactorily met, the entity will function autonomously in the community and be able to move to a higher level of wellness. The ten basic needs as described by Zuluaga (2000) were: (a) physical health, including the ability to perform activities of daily living as desired; (b) mental, emotional, social, and spiritual health; (c) income, which must be perceived to be sufficient to meet essential needs for food, clothing, shelter, and essential medical costs; (d) accommodation (shelter), including satisfactory housing arrangements as perceived by the individual; (e) protection and security; (f) knowledge, including access and availability of schools, adult education, health information, and libraries; (g) mobility, which may be physical limitations or barriers in the community; (h) communication, including language barriers, hearing or vision impairment, speech impediments, or lack of access to telephone or media; (i) self-development, which may include availability and access to hobby, craft, or other leisure activities; and (j) need to make a contribution, including a sense of benefiting others.

Homeless people have significant barriers to meeting basic human needs (Zuluaga, 2000). When so much time is spent searching for food and a place to sleep, meeting even the most basic necessities of life can be a struggle. Many homeless families postpone preventative health care and delay seeking medical care, until illness occurs, because of perceived barriers (Reimer et al., 1995). Homeless children may have even less access to clinic services because of being required to attend school and meet the rules of the shelter, which dictates when they should come and go (DeForge, Zehnder, Minick, & Carmon, 2001).

When seeking health care, lack of health insurance would be a deterrent. A permanent address may be necessary in some areas for state and federal benefits, as well as for mail delivery. Many homeless families move frequently from place to place. There are also other barriers for health professionals (Hunter, Getty, Kemsley, & Skelly, 1991) such as inability to follow through with healthcare services, lack of funds, lack of a safe place for discharge, and lack of motivation for self-care. According to Jezewski (1995), the essence of what nurses do to facilitate care for homeless people is "staying connected" by linking them with health care providers and systems, decreasing stigmatization, cultural barriers, and communication breakdowns.

Impact of homelessness on children

Burg (1994) studied the interrelationship between health and poverty, finding that lack of preventive health care resulted in serious consequences for homeless children such as incomplete immunizations, lack of physical and dental checkups, etc. Other health consequences of transitory sheltered living were malnutrition, asthma, infection, and possible high-lead exposure. Children suffered greatly from developmental delays in language skills, cognitive ability, and motor skills. Preschool homeless children showed as many behavioral problems such as sleeping difficulties, withdrawal, or aggression as did emotionally-disturbed children (Burg).

Lack of preventative health care and the situation of living in a homeless shelter may contribute to additional health risks for homeless children. Roth and Fox (1990) found that the shelter environment often posed a risk to health through crowded conditions, poor sanitation, and nutritionally inadequate food. There was increased risk for infectious diseases such as upper respiratory infections, hepatitis and tuberculosis. Although parents of homeless children were more likely to report that their children were in fair or poor health compared to low-income children living at home, they were less likely to obtain timely and continuous health care than other children. Roth and Fox also found that of children under age 15, who presented for treatment more than once, homeless children suffered from chronic physical disorders (including

cardiac disease, anemia, peripheral vascular disorders and neurological disorders) at twice the rate (16%) of children in the general ambulatory care population.

According to Wood, Burciaga Valdez, and Hayashi (1990), homeless children are at high risk for health and behavior problems due to many factors, including being poor, experiencing family problems such as parental loss, violence, and drug use, loss of friends and familiar neighborhood surroundings, school disruptions, exposure to many strangers, and threatening situations on the streets and in the shelters. The stress of homelessness on the child and family increases the child's risk for physical and mental health impairment during the episode of homelessness and beyond.

A study by Bassauk (1990) found that school-aged homeless children scored worse in the Children's Depression Inventory, Children's Manifest Anxiety Scale, and the Child Behavior Checklist than poor children with homes, but the difference on the Anxiety Scale approached statistical significance ($p = .06$). Rescoria, Parker, and Stolley (1991) found that school-aged low- income children did not differ significantly from homeless children on most measures. However, preschool homeless children exhibited slower development than their peers who had homes, and significantly fewer of the homeless children were enrolled in early childhood programs.

Wagner, Menke, and Ciccone (1995) studied rural homeless families. They interviewed parents to obtain data for the Child Behavior Checklist and the Symptoms Check List-90 Revised (SCL-90R) to assess mental health status, and did a Denver Developmental Screening test. Scores consistent with developmental lags were found in 52% of the children, and 15% had scores that indicated possible behavioral problems. However, this study did not compare their findings to low-income children with homes, and the accuracy of the findings were questioned because of high reported use of illegal drugs, alcohol, and cigarettes among the mothers.

Cohen (1993) researched sustained uncertainty as a source of psychosocial stress in illness. Although her research was focused on children with chronic, life-threatening illness, there is similarity in that their beliefs, values, expectations, relationships, and daily routines have been

dramatically changed. The child's reconstituted world had been defined by new priorities and unique norms that often create a sense of social distance from others who have not had similar experiences.

Adaptation and coping in homelessness

Torquati and Gamble (2001) examined social resources and psychosocial adaptation of children in a housing crisis. The impact of the stressors were inversely associated with positive parenting and school adaptation, and positively correlated with a child's negative affect. Mothers were the main social network members, and almost half of the children did not identify any friends in their social network. Results suggested that social resources provide unique opportunities for the development of competence for children.

In a small study of school-aged children living in a homeless shelter, DeForge et al. (2001) found that children were fearful of the ridicule they might receive by peers learning they lived in a shelter. Their research encouraged nurse educators to collaborate with schools to reduce the stigma associated with homelessness. Because violence was another common theme in the interviews, programs for reducing violence and teaching conflict resolution skills were suggested. Many of the children reported seeking approval from educators. Adding positive, supportive relationships with nurses, social workers, and other professionals can bring hope and increase self-esteem among homeless children.

Huang and Menke (2001) examined the coping behaviors of school-aged homeless children staying in shelters and found expression of stress similar to the themes by DeForge et al. (2001). The coping responses used to manage the stress were mainly social support, cognitive avoidance and behavioral distraction. These were similar to coping patterns of children with homes, but the research suggested that children could deal more effectively with stressors if additional coping behaviors were learned.

Heusel (1990) studied the child's perceptions of homelessness and encouraged further research of homeless children to assess for factors that may enable the school age child to remain relatively "untouched" by their experience of homelessness. She found that school was a very

important constant in their lives. Although the children were asked about their health during the interview, those aspects of Heusel's study were not developed into themes or summarized. Heusel's Homeless Children Interview Schedule was adapted by this researcher, for development of potential interview questions for parents of homeless children (Appendix A).

In this literature review, important information was gathered from the various studies of homeless children, but most of the studies were quantitative research. Of the few qualitative research studies on homeless children, none were Transcultural Nursing research. Transcultural studies of related issues, including one focusing on homeless adults, were found. Utilizing a research process consistent with Transcultural Nursing (Leininger, 2002), this researcher explored differences and similarities in the lived experience of homeless children.

Conceptual Framework

Culture Care Diversity and Universality

Leininger's Theory of Culture Care Diversity and Universality allows researchers to discover holistic aspects for human care in diverse cultures or subcultures. Clearly, the discovery of new insights about life situations related to keeping people well or relieving human suffering, illness or other unfavorable conditions has been an important goal to nurses and other health care professionals. Many factors influencing care and its meanings, health and well-being of people are discovered using Leininger's Culture Care Theory. Transcultural research advances the discipline of nursing and improves the quality of health care to cultures (Leininger, 2002). This researcher believes that a broad assessment made possible by Leininger's Sunrise Model, will obtain important information about homeless children and their families.

Sunrise Model

In conceptualizing the theory, the Leininger's Sunrise Model (Leininger, 2002) was developed to guide nurses, like a visual and cognitive map or enabler (Appendix B). Using this model, health professionals are able to "tease out" the multiple factors or components that need to be systematically studied with the Culture Care Theory. The model shows potential influencers that might explain care phenomena related to historical, cultural, environmental,

worldview, social structure, and other factors. Gender, race, age, class, historical and other features relate to social structure factors such as religion, kinship, politics, and economics. The Sunrise Model includes other potential influences on care expressions, patterns and practices, and holistic health or illness, including education, language, technology, and physical environment.

Nursing Modes of Action

Leininger's Sunrise Model has been used to focus on individuals, families, groups, communities or institutions, assessing both folk (emic), and then professional (etic) care. After finding care meanings, expressions and practices, the three nursing modes of action or decision are used: (a) culture care preservation/maintenance, (b) culture care accommodation/negotiation, and (c) culture care repatterning/restructuring. Culturally competent care is developed using this process (Leininger, 2002). Nursing interventions can be made that "fit" with cultures, to improve cooperation and to increase satisfaction with the care received.

Summary

Culturally congruent care of homeless children is possible when health professionals understand more about their subculture. In a transcultural nursing study of sheltered homeless adults by White et al. (2002), it was clear that homelessness can be best understood from the emic (insider) or folk point of view, with etic (outsider) or professional view added for contextual information about life experiences and health. Although that study did not focus on children, it was a good example of the depth of data that can be obtained using the Culture Care Theory with qualitative research methods. The lived experience, including culture care meanings, expressions, and practices of children who lived in the homeless shelter of the Midwestern city were studied, in order to promote and provide culturally competent care.

Research Questions

Three research questions were developed to guide this research project:

1. What are the meanings of health care to homeless children as perceived by parents, and how do they want to receive care?

2. What social structure factors (religion, kinship, environment, etc.) influence health care practices of homeless children?
3. What are some of the ways homeless children express themselves with respect to their care needs and what access to health care services do homeless children have?

Assumptive Premises

Phenomenology is a research method and philosophical framework developed around the following beliefs: (a) human meaning can be found in day-to-day experiences of the person; and (b) each person has his or her own unique perspective, yet people do share some common meanings. With these tenets in mind, phenomenology was chosen for this project.

Additional assumptive premises guiding this research project were adapted from Leininger's (2002) Culture Care Theory, including: (a) Culturally congruent nursing care of the homeless can only occur when its values, expressions, and patterns are known and used in meaningful ways, and (b) every human culture has folk care knowledge and practices and usually professional care knowledge and practices, which vary transculturally and individually.

This research may be helpful as the University's faculty and nursing students strive to increase accessibility of health care to homeless people through a nurse-managed clinic that provides nursing assessment and health intervention, case management, health teaching and screening. The nurse-managed clinic at the homeless shelter forms collaborative partnerships in the community and also gives student nurses a chance to observe and work with homeless people in the community setting as part of their nursing education. This project may increase awareness of the lived experience of homeless children for nurses who work in the nurse-managed clinic. In addition, using the information gathered by this project may promote culturally congruent nursing in similar settings at other locations. The information obtained may also help evaluate the availability, use, and effectiveness of health care services for homeless children.

Providing health services at the homeless shelter decreases barriers to preventative health care and health promotion. According to White et al. (2002), making shelters "one stop

shopping" centers providing immediate access to a variety of services can make health care more accessible to this subculture. This research project will help to characterize the homeless subculture and describe the lived experience of children who stay in the shelter.

This project will increase the body of knowledge available to nurses and health professionals about homeless children as perceived by parents, including their values, beliefs and practices, how they want to receive care, and what health care services are available to homeless children. As healthcare providers gain an understanding of the lifeways (ways of life) and practices of the homeless, as well as their strengths and limitations, it will help them provide culturally congruent care. Improving the situation of homeless children and their families may help them to meet their basic human needs.

Method

Theoretical Framework

The Theory of Culture Care Diversity and Universality was chosen as the theoretical framework for this study. Through discovery of meanings and expressions of care, knowledge can be used to design care "to fit with" lived experiences of cultures and subcultures. According to Leininger (2002), the nursing profession has a moral and ethical responsibility to discover, know, and use culturally based caring modalities as one of our unique and distinct contributions to humanity. The theory is designed to facilitate care for clients in a manner congruent with the client's beliefs and values and to improve health and well-being (Leininger).

The Sunrise Model (Leininger, 2002) was used as a conceptual, holistic research guide for the researcher during gathering and synthesis of data, in order to maintain a consistent theoretical framework for this research. According to Leininger (2002), qualitative methods are extremely valuable to discover embedded and hidden values. This researcher used phenomenological research methods to discover and examine unique aspects and meanings of care to homeless children. Transcultural nursing research can result in worldwide, comparative, culture care knowledge for practice.

Permission to do the project was obtained from the university, and the administration of the homeless shelter in a midwestern city. The research project to be conducted at the homeless shelter was approved by university faculty and Institutional Review Board. A convenience sample of participants, consisting of parents who met the following criteria, were recruited by the social worker of the homeless shelter:

1. Living in the homeless shelter for at least 2 weeks.
2. Adult mother or father of a child 13 years old or less, who remained in the custody of the parent.
3. Willing to participate in the research interview.

Data Collection

Interviews were scheduled through the homeless shelter's social worker. The researcher obtained informed and voluntary consent from four participants. Because children were considered a vulnerable group, this researcher chose to interview the parents rather than the children. Perceptions of the parents were used to explore the lived experiences, patterns, expressions, health, and care needs of their children. Each participant was given a $5.00 gift certificate from a grocery store, to compensate them for their time.

To begin, the researcher did a pilot, audio-taped interview in a private room at the homeless shelter. Field notes were taken as needed. Because the demographic information (regarding age, sex, marital status, ethnicity of themselves and their children, the circumstances of homelessness, etc.) was not provided ahead of time, the demographic information was completed with the parent after the interview. Following the pilot interview, the questions (Appendix A) were evaluated by the researcher, and revised for clarity and effectiveness in getting the intended information. A question about spirituality was added to the revised interview guide (Appendix C) and the first participant was interviewed a second time for the added question. Interviews with the remaining three participants followed.

Broad, open-ended questions were used to "draw out" rich descriptions, although more focused questions were used as needed to guide the interview. The research interviews were

approximately 45 minutes in length. No questions were directed toward the child as part of this research. Although one child was present during one of the interviews due to unavailability of childcare, the interview was focused on the parents and their responses. Valuable non-verbal data was collected by participant observation of the parents and recorded in field notes. Confidentiality was rigorously maintained by ensuring privacy with the interviews, and keeping the identity of the participants separated from the data.

Data Analysis

Leininger's (2002) Phases of Analysis for Qualitative Data were used to analyze the data. The first phase involved collecting, describing and documenting raw data with both a field journal and tape recorder. Besides writing down non-verbal observations, any personal biases or feelings that could influence the research were documented in field notes (for credibility to ensure the truth of the findings). In the second phase, the researcher transcribed the interviews verbatim, coded and classified the perceived meaning of the data in the margins of the typed interviews (for identification and categorization of descriptors and components). After finding fourteen similar meanings the codes were determined, such as: (a) loss of autonomy, (b) big change/disruption, (c) changed developmental experience, etc. The process of consolidating data into patterns, themes, and major themes is shown in Appendix D. Both the researcher and the doctoral prepared faculty advisor participated in coding the typewritten interviews similarly, demonstrating confirmability (to explain the processes of decision-making in determining codes, patterns and subsequent themes). The third phase included scrutinizing the data to discover patterns and contextual analysis (with documentation of meaning-in-context, recurrent patterning). A form developed by the researcher was used to organize the supportive data from the four interviews in columns on each page. The data was marked with a "P" if it referred to something the parent said about herself. The researcher found that the codes could be further condensed by finding similarities in meaning and they were consolidated into five broader meanings such as (a) adapting to change and limited autonomy, (b) increased stress and changed attitudes, etc. (Appendix D). In the fourth phase, major themes, research findings, theoretical

formulations and recommendations were synthesized and interpreted. The researcher consolidated the meanings into four major themes: (a) autonomy, (b) attitudes, (c) coping, and (d) resources.

Saturation was not obtained due to the small sample size, but information obtained was similar in the four interviews. Transferability is uncertain, although the findings could be applied in similar situations. Because the participants were highly mobile, themes were not confirmed after the interviews. The findings provided an opportunity to understand the lived experience and ultimately help improve the health of children living in homeless shelters.

Results

Participants

The sample consisted of four participants, all women ranging in age from 23 to 39 years old, with three of the four being age 24 or younger. Of the sample, one participant was single and three of the women were married. However, only one of the participants had a husband living with her. The husband of one of the married women was in prison, and she spoke of herself as a single mother. One of the participants was separated and planned to divorce when she had enough money to pay for it.

Description of Children

Three of the participants had one child, and one of them had two children. The children consisted of three boys and two girls, who ranged in age from two years old to nine years old. The average age of the children was five years old. There was variety in age, gender and race of the children described in this research project.

Sample Characteristics

The Midwestern city's homeless shelter had many ethnic groups represented, but only a few people at the shelter had children with them. The sample in this research project consisted of one African American woman, and three Caucasian women. Two of the participants had been evicted from their house or apartment. One participant said their lease ran out and the other one was not able to afford rent for her own apartment, but had to leave a "stressful" situation while

living with her fiancé. The length of time participants had been at the shelter ranged from one week to 3 months. Two of the participants had stayed with family for part of the time they were homeless. Only one of the participants reported having been homeless previously.

Themes Identified

The research findings involved holistic health needs and dimensions of self and family relationships affected by homelessness and by living in the shelter. As in Leininger's Sunrise Model (Appendix B), factors that affected those relationships were also considered, such as worldview, philosophy, religion (and spirituality), kinship, social structure, language, political, legal, educational, economic, technological, ethnohistorical and environmental context of culture. The four themes identified in this research project were (a) autonomy, (b) attitudes, (c) coping, and (d) resources.

Autonomy. Because the children no longer had their own home or access to many of their own belongings and they were confined to the spaces and the rules of congregate living, autonomy was greatly affected by staying in the shelter. Findings reflected limited freedom in activities and play, lack of flexibility in mealtimes, food choices, bedtime, and bathroom use. Mothers were not able to follow the routines they had established at home for their children. One mother described her concern:

> They don't have their independence like they would have in their own house. They don't have the freedom they had… to run and explore and do normal children things like playing pots and pans or exploring new territory. They have a playroom and a play yard, but you can only do so much with that.

Others voiced concerns about a lack of activities at the shelter for the older children, as well as a limited selection of books, although one mother said that they do change the selection of books periodically. One participant said she was told that she shouldn't check anything out of the public library while staying at the shelter.

Rules of the shelter include not spanking or slapping children, and that parents must supervise their children at all times, regardless of their ages. The mother of a nine-year-old boy explained:

> I can't let him run around in here. I can't let him play, like he used to play with his friends basketball. He likes to go to the gym and play basketball, but I have to go with him. He's not used to that.

All four participants noticed a change in attitude of their children that included being temperamental with increased acting out, and increased moodiness. This will be discussed further in the next theme, but it is mentioned here due to its impact on the need for discipline. A concern of two of the mothers was the inability to effectively discipline their children at the shelter. One of the participants explained:

> Here you put them in time out, and because there's so many people, they get the attention if they scream and cry. So that's what she [my child] would use as an attention-getter. So the discipline would be completely pointless for her.

Some other difficulties were voiced relating to living with so many other people: (a) limited use of the refrigerator, (b) lack of enough hot water for daily baths, (d) frequent room changes, and (d) not being allowed to open the windows. The congregate living arrangement for many of the women and children is described by one of the participants:

> It's a one-room that has the beds and bathroom and shower. Then there is a common lounge where everybody can sit and watch TV. There is a playroom where the kids can go to watch TV, or a playground they can go out to [play in].

One mother explained that because of living with other women, her husband was not allowed to sleep in the same room with her and her daughter. That caused her daughter to be angry. One other participant said that her daughter had "a lot of anxiety" when her grandmother had to be moved to a separate room, but she was able to move back with them the next night. One of the mothers said that when the shelter filled up on the weekends, family members would sometimes have to change rooms.

There was a congregate dining room, where everyone who lived in the shelter gathered for meals. The participants said the meals were balanced, but they were described as high in salt and fat, with some vegetables, but not a lot of fruit or fruit juices. The kitchen staff was willing to serve smaller portions to children, and sometimes allowed the parent to save a sleeping child's meal until later so it could be reheated when the child awakened. But the child's food choices and preferences were an issue for three of the four participants. Many of them purchased food outside of the shelter and were able to keep some of it in the refrigerator or in the room to feed their children additional foods they liked. One participant said, "I have to trick him, here, when we have lunch. You know the sandwiches they made? I act like I made them, you know, or else he will not eat them." And, when asked if she could cook sometimes, she responded, "I don't think so. I never asked." One participant explained that her child is a picky eater and if she doesn't eat at mealtime, "I can't force her to eat, but you really wish you could because you know they're gonna want it later anyway." The findings reflected that all the participants had difficulty with the loss of autonomy for themselves and their children. This loss of autonomy could hinder successful transitions, psychosocial, and emotional health.

Attitudes. The second theme that emerged in analysis of the data was attitudes. With such disruption of normal routines and discipline, attitudes of the children were noticeably influenced. All four participants reported a change in their child's attitude while in the homeless shelter. Two of the children were described as very moody and temperamental, acting out more, and tending to get "stir crazy" when feeling "cooped up". Their mother also described them as being confused, clingy and easily upset.

One five year old was described by her mother as being unstable, confused, bossy, nosy, and rude. Another child who never had separation anxiety before became very clingy and upset when they moved to the shelter. According to her mother, "If I go out to take the trash out she has to come with me because she is afraid I will leave and not come back." Her mother also described some other behavior changes:

> When people argue- sometimes even just the raised voices- like when people are over-excited talking and having a good time, she starts chewing her nails and just exhibiting nervous behavior. When people move in and out of the rooms and stuff, she'll act out more. She'll be more aggressive…throw temper tantrums.

The mother of the nine year old said he was impatient, unhappy, and ashamed to have his friends come to the shelter. "He don't know why or how we took this 'big fall' to be in the shelter." When she tried to explain it to him, he didn't want to listen to her. All the participants said their child didn't understand being homeless, and didn't know what to expect. To avoid feeling ashamed, one mother told her child they were at "Hotel Sally". One participant said she didn't want to explain everything to her children because she didn't want them to worry. It seemed to be a very difficult and emotional time for the parents as well as the children. One of the mothers wept during the interview. One participant said that when she cried or was upset, her children would give her a hug.

Some of the mothers shared that their children don't know how to act with strangers, especially with those people who are irritable, or who don't like or understand kids. Some of the children were scared of things, for example, some of the "big, hairy, scary, dirty old men" in the dining room; and, one child was afraid of the darkness in the room where she slept. Parents reported that their children miss their homes, possessions, toys and friends, and they worried about separation from their new friends when they leave the shelter.

Coping. The third theme identified in the project was coping. Additional worries and losses due to congregate living influenced the need for coping. Participants had worries in addition to the financial and housing issues. Some of the mothers said they were afraid of: (a) germs, molds and allergies; (b) bad memories; (c) decreased learning skills; (d) custody battles; and (e) influences of others. One mother worried because she perceived some of the people at the homeless shelter as bad examples for her children.

Participants described the children's coping in various ways: (a) trying to get their way, (b) wanting to cuddle or hug, (c) wanting to be left alone, (d) playing or choosing recreational

activities, and (e) reading the Bible and praying. A pregnant mother who had lost her infant son three years ago, said, "She [my daughter] knows about death and dying. Her little brother went away. I think she kind of knows what to handle because she's handled quite a bit for a little girl." She explained that she and her husband had not been to church since he [their infant son] died, but added, "My husband has actually discussed finding a church to go to. But right now… we're just not comfortable entering a church temporarily."

One of the participants who must work on Sundays is not able to attend church, even though they went to church regularly before they were homeless. Because her son goes to the Boys and Girls Club while she is working, he is not able to attend church. A participant who attends church regularly at the shelter said, "It's got me through this hard time." All the parents reported that their children participated in prayers at mealtime.

All of the participants said that their children enjoyed day care or school, and the young children were all happy with the shelter's fun playroom, toys, books, and the outdoor playground. One of the mothers said her daughter's social skills had increased because of playing with other children at the shelter. Some of the mothers voiced appreciation to the homeless shelter for providing a bed, shower, food and clothing. Among some other positive statements about the shelter, one parent shared that when staying at her brother's house, her child wanted to come back to the shelter to be with her friends. Some positive findings reflected increased activity and socialization at the homeless shelter, which helped the children cope.

In spite of some positive aspects, all participants said their children were wishing for a home. The children's other wishes shared by the mothers were; (a) wanting a pet, (b) wanting freedom, (c) wanting their mom's cooking, (d) wanting their own belongings, for example their own bed, toys, and dolls, (d) wanting to live with their grandma or dad again, and (e) wanting to become a doctor. The findings reflected that the mothers did not expect their children to reach their dreams as long as they were homeless. The participants were disappointed by the homelessness they and their children had to cope with. The participants were all looking for ways to improve their situation and were making efforts to move out of the shelter to a home.

Resources. The final theme identified in this research project was resources. Along with the influences of family and friends, school and recreation, there were important financial and healthcare resources, such as programs for helping low-income and homeless people. All of the participants had health insurance coverage for their medical care and were attending regularly scheduled doctor appointments. Participants said they received reminders when they need to schedule routine appointments. Medical Assistance, Healthy Start and Head Start were listed as some of their resources to fund health care. All children were said to be up-to-date on their immunizations. All except one child had been to routine dental check-ups, and two of them also had ongoing appointments for dental work. Participants said they had no problem keeping their health insurance coverage even though they no longer had a permanent address.

All of the mothers said their children were healthy, except for a few colds. One participant said, "Her [my daughter's] activity level has really skyrocketed, but her diet has gone downhill." Some of the children had been to their doctor's office or the urgent care clinic for allergies, unusual pigmentation of skin, ear infections, and colds. Two of the mothers had been to the Emergency Room when ill, but all participants said their children had not been treated there.

All of the participants mentioned buying juice, milk, and other foods to supplement the food at the homeless shelter. One mother said, "I'm glad because I get food stamps now that I can take to the store and get her watermelon or strawberries or whatever." One of the mothers reported giving her child a daily vitamin. One takes her child out to eat, and one does some cooking at her brother's house. Participants reported that they use the bus for transportation, or take walks. One of the participants mentioned that her family had gone camping together. Some of the participants brought their children to local parks to play. Findings reflected that the parents and children enjoyed outings and recreation away from the shelter.

After completion of the interviews, the researcher sought further information from the social worker of the homeless shelter regarding the availability of technology resources such as telephone and computers. The social worker explained that a few of the residents in the homeless shelter have cell phones. They couldn't keep the same phone number otherwise, because of their

mobility. There was a phone at the shelter for local calls, and another phone that could be accessed for long distance calls if permission was obtained. There was not a computer in the homeless shelter for resident use, but there were computers available in the library about two blocks away, and computers for job searching at the employment services office a few blocks away. The social worker had requested funding for a computer to be purchased for residents' use, but it had not yet been approved.

Mail delivery was not available in the homeless shelter on weekends, however residents' mail could be picked up at the shelter's office on weekdays during regular business hours. The social worker was not sure how the medical appointment reminders were received. The nurse-managed clinic was mentioned by some of the participants, but they did not say how it was utilized for their children's healthcare.

The physical health of the children at the homeless shelter was good according to the participants, but there was an imbedded concern about the children's attitudes and coping. Although there were no complaints voiced by the mothers about the staff at the shelter, school, daycare, or the clinic, the findings reflect that they consider their children vulnerable, especially their emotional health. Leininger (2002) describes health as a state of well-being or restorative state that is culturally constituted, defined, valued, and practiced by individuals or groups that enables them to function in their daily lives. These participants and their children have found strengths to draw on to help maintain their health during these difficult transitions. They also have limitations and unique needs based on the subculture of homelessness.

Discussion

Using Leininger's Sunrise Model (Leininger, 2002) to probe for care meanings, the kinship and social factors were assessed very readily with an abundance of "rich" data obtained. The cultural beliefs and lifeways were embedded in the data, and came through in the patterns and themes. The values of autonomy, discipline, family togetherness and stability, protective behavior, and activities for health promotion were evident. Assessment of political, legal, and economic factors pointed out some barriers to the individuals, families and communities.

However, a helpful network of resources, programs and services was available to them for legal issues, health care, job programs, housing, and financial assistance at the local, county, state, and federal levels.

The researcher used the identified data and themes to formulate ways to improve the lived experience of children at this homeless shelter. By using the Transcultural Care Decisions and Actions process as the culmination of Leininger's Sunrise Model, culturally congruent care is possible.

Modes of Decision Making

Broad, holistic assessment of the subculture of homeless children enabled this researcher to find the meanings of care, which were different than the health care meanings, patterns and lifeways that were expected. According to Leininger (2002), listening to how care is linked with kinship, religion, economics, politics, cultural values and beliefs, and other general factors is essential to discover meanings and practices about care. The next step in the Leininger's Sunrise Model (Appendix B) was to focus on the three theoretical modes of culture-care actions and decisions that might be appropriate, congruent, satisfying, safe, and beneficial to the people being studied. The researcher explored culture care to homeless children using the three modes of decision-making: (a) culture care preservation/maintenance, (b) culture care accommodation/negotiation, and (c) culture care repatterning/restructuring (Leininger). Thus, the three modes of decision-making and action were used to find practical ways of improving culturally congruent care to homeless children.

Culture Care Preservation or Maintenance. The participants of this study demonstrated several appropriate and creative care practices to be preserved and maintained, including those related to generic/folk care activities for their health outcomes. Nurses should not " do for" homeless people, but instead preserve their decision-making strategies and cultural lifeways to use their own resources to care for self and others (White, Hummel, & Hoot Martin, 2002).

Parents were actively seeking developmental experiences, discipline, better nutrition, education, healthcare and social support for their children. Some of the ways they sought

developmental experiences included going to the YMCA, taking walks, going to parks, visiting relatives and playing with friends. Although some of the parents were having difficulty with discipline, they tried to utilize the "time out" method of discipline as suggested by the shelter, but did not find it to be effective. Two of the participants expressed that it could be more successful if there was a more private place available to them. All participants were seeking better nutrition and giving attention to food preferences of their children. All participants had enrolled their children in day care or school to increase developmental experiences, education, and social support for their children. These appropriate care practices should be preserved and maintained for culturally congruent care.

Culture Care Accommodation or Negotiation. Some suggestions based on participant interviews could modify the shelter's regulations to better accommodate the care needs and developmental needs of the homeless children. They were: (a) allowing children and parents to use books, videos, audiotapes, preschool learning packets, etc. from the public library; (b) having additional healthy snacks and fruit juice available for children at the shelter when requested by the parents; allowing some modifications to the meals to allow for preferences of children; allowing use of more refrigerator space and a cooking area; (c) having books, toys, and activities for older children as well as younger ones, including books about homelessness to increase understanding of the concept and decrease feelings of shame; (d) having education and resources available for parents to effectively discipline their children, and discussing options for more private areas for time-outs; and (e) providing a videotape of church services for those unable to attend, or allowing them to the use of a VCR to record the televised church services.

As health or behavior problems come up, the shelter staff or nurse-managed clinic staff could provide culturally congruent care by negotiating with the homeless families for creative solutions, appropriate follow-up, and improved communication in the hope of obtaining more favorable outcomes. According to Leininger (2002), culture care negotiation/accommodation refers to those assistive, supportive, facilitative, or enabling creative professional actions and

decisions that help people of a designated culture (or subculture) to adapt to or to negotiate with others for meaningful, beneficial, and congruent health outcomes.

Culture Care Repatterning or Restructuring. Through creative professional actions and decisions, it is possible to help clients reorder, change, or modify their lifeways for new, different, and beneficial health care outcomes using culture care repatterning or restructuring. The nurse-managed clinic provided care services such as health education and screening that could repattern folk and professional care to benefit the health of the homeless. By listening carefully to homeless people, and incorporating what they are willing and able to do for themselves, culturally congruent care would be possible. For example, providing private telephone areas for confidential conversation, and internet connection and e-mail for accessibility to information about community services would be appropriate restructuring. Jezewski (1995) explained that staying connected is essential to decreasing stigmatization, cultural barriers, and communication breakdowns.

The mission of providing safe shelter for the community may make it more difficult to also meet the needs of individual families. However, repatterning may help give parents resources to help themselves and their children. The most effective and satisfying way to help the children cope may be the simplest, as the children would indirectly benefit when the needs of the parents are met. By increasing the sense of autonomy, finding creative solutions, promoting supportive relationships, increasing spirituality, and connection to resources, the transitions to and from the homeless shelter would probably be less upsetting to the whole family. Repatterning to allow family members (including husbands and wives) to stay together whenever possible, would be a big step toward promoting strong family relationships, and increasing feelings of security for the children.

This phenomenological research project described the lived experience of children in a Midwestern homeless shelter. The impact of homelessness on culture care and health needs was explored. Although the physical health of the children was very good, and they were receiving professional health care services appropriately, the findings indicated that some psychosocial,

emotional, and developmental health needs of the homeless children were not being met. This is valuable information for health professionals. The lived experience of homeless children, patterns, expressions and meanings of care were discovered by using the Theory of Culture care Diversity and Universality.

Theoretical Framework

As Culture Care Diversity refers to cultural differences in care beliefs, meanings, patterns, values, symbols and lifeways within and between cultures and human beings, Culture Care Universality refers to commonalities or similarities of the above, reflecting care as a universal humanity. Using Leininger's Theory of Culture Care Diversity and Universality (Leininger, 2002) fit with this research project well because the findings reflected that the participants and their children are very similar to those who are not homeless. The differences exist with the situation of homelessness, which then becomes their subculture.

There are multiple factors affecting the cycle of homelessness. For example, educational factors are very important to break the cycle of homelessness, for both the child and the parent. School and day care appear to be positive activities, providing structure and security for the children who are away from their parents. Both education and technology factors can prepare parents for gainful employment or improve ability to access health education, and may be very important to children's success with school work. Religious factors are important because of their power to strengthen family bonds and improve the child's sense of connectedness and security.

Meanings of Care

Resources impacted both etic (folk) practices of developmental and nutritional caring for their children and etic (professional) care. In this limited sample, health care services, as well as other community programs and services were used effectively. Some ways to decrease negative consequences and risks to homeless children were identified in the literature review and some suggestions were made for providing culturally congruent care at the homeless shelter.

Other aspects of caring, as in Father Flanagan's work with homeless children, were emphasizing discipline, education and religion (Portner, 1996). In this research project, discipline of the children was expected, but some parents perceived it as difficult to enforce in that environment due to the influences of others. The homeless shelter promoted spirituality and prayer, but some of the families did not attend church, so a positive impact on coping may not have been realized.

The indicators of successful transitions such as emotional well-being, mastery and healthy relationships described by Meleis and Trangenstein (1994) were supported. It is of interest that children in a homeless shelter are probably going through four out of the five transitions, or all five when illness occurs. The ten basic human needs as described by Zuluaga (2000) are all highly relevant to children's healthy development through crucial developmental stages. If feelings of uncertainty, vulnerability, shame, lack of trust and lack of control persist, serious health or behavior problems may develop.

The homeless families in this limited study were in temporary, short-term situations, and had regularly scheduled appointments for preventative health care, immunizations, and appropriate dental care. Previous research in the review of literature found that homeless people postponed preventative care (Reimer, Van Cleve, & Galbraith, 1995), had less access to care (DeForge, Zehnder, Minick, & Carmon. 2001) and had additional barriers to getting health benefits and care (Hunter, Getty, Kemsley, & Skelly, 1991). It is possible that if the participants had not had health insurance, quality health care providers, and the appointment reminders that were generated by the clinic, health care would not have been utilized as well. The participants in the homeless shelter in the Midwestern city also had the unique resource of a nurse-managed clinic for health education, screening and health promotion. The researcher hopes that this transitory stay in the homeless shelter will have little (if any) long-term impact on the children. However, the longer they remain homeless, the more impact it will likely have on them and their families.

Even though the homeless children were quite healthy in this research project, developmental delays and behavioral problem such as sleeping difficulties, withdrawal, and aggression as described by Burg (1994) may still result. It seems logical that increased stress, grief and loss increases the child's risk for physical and mental health impairment, as was found by Wood, Burciaga Valdez, and Hayashi (1990). However, increasing supportive relationships and resources by having homeless children enrolled in day care or school may help minimize risk of developmental delays and behavior problems, There are also risks such as sustained uncertainty and psychosocial adaptation of children in a housing crisis. Homeless children need to learn effective coping behaviors by positive parenting and school adaptation (Cohen, 1993; Huang & Menke, 2001; Torquati & Gamble, 2001).

Interventions like obtaining night-lights when requested, having developmentally appropriate activities to do at the shelter, and having some private time with their parents are things that can be done to ease the transition for homeless children. Expectations to prevent or intervene in behavior or attitude problems resulting from ineffective coping should not be for school or day care alone. There is a burden of responsibility for the well-being of the children on both the homeless shelter, its staff, and the school. The parents, who have primary responsibility, may not be able to advocate for their child fully if they are in a psychosocial crisis themselves. Care for homeless children involves much more than the physical health of the children.

Research of Care Meanings

A broader meaning of care was discovered in this research. When written as "health care" in the proposal, it was intended to focus more on professional health care. However, as the research questions were answered, it was apparent that most of the professional health care needs had been met by either the physician or by the nurse-managed clinic at the homeless shelter. The focus then became more on the emic (folk) care, which was found using Leininger's Sunrise Model for a holistic assessment. The research questions could then be answered based on the findings.

What are the meanings of health care to homeless children (as perceived by parents), and how do they want to receive care? By promoting autonomy and increasing developmental experiences, children will be better able to continue their developmental transitions. By helping the children to understand homelessness, they may be better able to cope with the situation they find themselves in, thus improving their attitudes and making discipline more effective. By maximizing resources of homeless families, children can have the difficult transitions of homelessness eased.

What social structure factors (religion, kinship, environment, etc.) influence health care practices of homeless children? All of the factors in Leininger's Sunrise Model (Appendix B) influence "care practices", which directly or indirectly affect health of children. The factors that seem to effect care practices the most are the kinship and social factors, beliefs, and education. The environmental context influences their care expressions, patterns and practices. The parents and children will develop either a positive or negative worldview as they see their barriers and resources. This has an impact on the children's perception of themselves and their health.

What are some of the ways homeless children express themselves with respect to their care needs, and what access to health care services do the homeless children have? Homeless children express themselves by behavior and attitude changes. All of the parents in this study noticed a definite change in the attitude of their children. The "acting out" may be a call for help when they are not able to effectively cope with the situation. It takes psychosocial support, astute listening and sensitive responding to provide culturally competent care to homeless children and their families.

Access to health care services was good, but there was no mention of any of the families utilizing counseling services other than speaking with the homeless shelter's social worker or the nurses and nursing students at the nurse-managed clinic. Professional counselors may be available at the school for children with behavior problems or psychosocial issues, if an evaluation or referral is needed for psychosocial concerns.

Limitations of the Research Project

The rich description of this qualitative, phenomenological research project was impressive. However, since it was limited to only four interviews, this research could not be generalized. The deep meaning of this interesting "snapshot" of the lived experience of the homeless children may be transferable in similar situations, but it would have been more valuable if more interviews had been done until saturation occurred. Additionally, the confirmability could have been improved by asking participants to look at the patterns and themes that were developed, to determine if that is what they actually meant. The mobility of the participants did not allow for that. However, results were confirmed by comparing the transcripts and field notes by more than one researcher. The ethnicity of the convenience sample was similar to what would be expected in the population of this city and the surrounding area. If there had been a larger sample, more ethnic groups may have been represented.

One of the participants had been at the shelter only one week at the time of the interview, although a criterion for participation in this study was staying in the shelter at least two weeks. The demographic questions were asked following the interviews. The researcher determined that the participant that had been there only one week had valuable information to share. All four participants were included in this research project, realizing that the number of interviews would not have been enough to draw meaningful conclusions if there were only three participants

This beginning researcher who was inexperienced in semi-structured research interviews, found that some questions and comments during the interview could be interpreted as "leading" the participant to an expected answer. However, the rich detail of the supporting data makes it very likely that the results were reliable and valid. With more time spent in the interviews, more thorough assessment of the factors in Leininger's Sunrise Model (Leininger, 2002) and the environmental context of the shelter would have been possible. However, it was encouraged that the interviews be kept to less than one hour.

When participants gave comments following the interviews, one participant suggested that more information about the parents' lived experience would have been valuable to this study,

rather than questions focusing on children's lived experiences. That participant had mentioned leaving her home because of a "stressful" situation with her fiancé, but since the parent was not the focus of the interview, the researcher did not discuss the situation in detail. If the study would be repeated, the researcher suggests asking additional questions about technology and communication, health beliefs, emic (folk) practices and counseling used to maintain health, and difficult (potentially abusive) situations at home if the participant brings up the subject.

Prior to conducting the research project, this researcher's assumptions about homeless parents and children were quickly negated. The families seemed consistent with those of neighbors or even peers who would be at risk of a similar temporary situation if they lost their job. The researcher chose to not use the word indigent to describe the homeless children, as had been used when originally writing the proposal and research questions.

Future Study

Some questions raised by this research project that might be considered in a future study are: If the length of stay in the homeless shelter increased, would the findings be different? What differences exist for married versus single parent families? In addition, longitudinal research would be helpful to determine what changes occur when homeless children return to their own homes. Replicating this study in various parts of the country, including both urban and rural areas would also be very worthwhile to determine similarities and differences in the lived experience of homeless children, their attitudes, ways of coping, changes in autonomy and developmental experiences, and resources available to them in those other settings. Further study of homeless children for promoting and providing culturally competent care may decrease the negative effects of homelessness on children.

Implications for Nurses

Nurses can help by promoting autonomy of parents and children whenever possible by giving choices, realizing that they have less autonomy in their life at the shelter. Communication can be maintained by phone, e-mail (if available) or mail to keep the family "connected" to the health care system and to facilitate preventative health care appointments. Referrals for

community services and programs should be coordinated with the social worker at the shelter, making transitions as smooth as possible, especially when illness is involved. The level of stress, anxiety and depression may be high, making effective health education more difficult and more necessary. Written information and phone numbers of contact people are important, so follow-through on the plan of care would be possible with the help of family and staff of the shelter, school or day care.

Transcultural nursing knowledge and research can be used to expand the knowledge base of nurses. Health professionals should realize that culturally congruent care increases satisfaction, increases effectiveness of interventions, and increases compliance. Listening to clients share their care knowledge, beliefs, preferences and practices, then using the three modes of decision-making for culture care, allows nurses to create new care practices. It isn't true that "only professionals know best", and co-participation is valued by most cultures (Leininger, 2002).

Conclusion

An extensive review of literature was synthesized to illustrate the complex, and difficult issues of homeless children and to examine resources for effective coping. This transcultural research project focused on culture care meanings and practices of children in a homeless shelter, as perceived by their parents. The information will be used to better understand the health care needs of children in the homeless shelter, and there is reason for optimism. Findings suggested several possible interventions that would be helpful for families in the homeless shelter, and some practical implications for nurses and other health care professionals. Findings will be used for providing culturally congruent care to homeless children, with the goals of increasing adaptive resourcefulness and social connectedness, with potential to break the destructive cycle of homelessness.

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Interview Guide for Parents of Homeless Children

(Original Version)

1. Tell me what you think it is like for your child (children) to not have a regular or permanent place to live.
    a. What has changed for you and your children?
    b. How do you think that makes them feel?
2. How does living in the homeless shelter affected your child's relationships to others? (i.e. friends and classmates.)
    a. What do they share with you about living here?
    b. Tell me about your child's experiences at school.
    c. What do you think makes your child feel bad? Nervous? Afraid?
    d. How does your child cope when bothered or upset? What helps them?
    e. What things has your child shared with you that they wish for or dream of?
3. Tell me how your child's health care needs are met.
    a. When was their last Dr. visit? Was it for a routine check-up, or for an illness?
    b. Where are your children typically seen for their healthcare needs? (i.e. clinic, Emergency Room, or Urgent Care?)
    c. How often are your children seen by a doctor?
    d. What immunizations have they had? Are their immunizations up-to-date?
    e. When was your child's last visit to the dentist? Was it a routine visit, or for a problem? How often do they see a dentist?
4. What do you do to keep your family healthy? What does your child do to stay healthy? What would help your children be healthier?

Developed by Mary Knutson

April 15, 2003

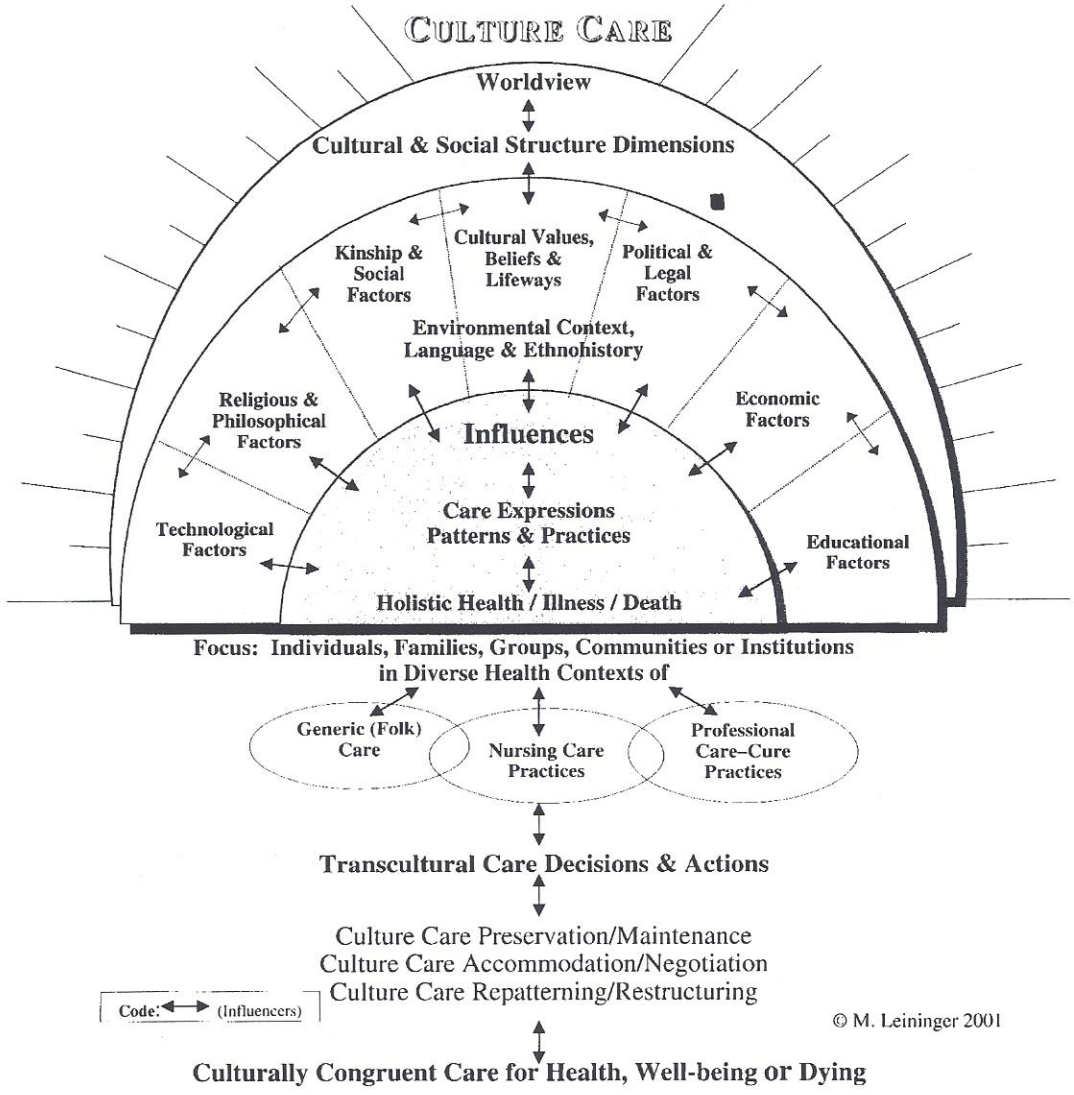

Figure 3.1
Leininger's Sunrise Model to depict the Theory of Cultural Care Diversity and Universality.

Leininger, M. (2002). The theory of culture care and the ethnonursing research method. In A. Seils & J. M. Morriss (Eds.), *Transcultural nursing: Concepts, theories, research and practice* (3rd ed., pp. 71-98). New York: McGraw-Hill.

Interview Guide for Parents of Homeless Children

(Revised Version)

5. Tell me what you think it is like for your child (children) to not have a regular or permanent place to live.
    a. What has changed for you and your children?
    b. How do you think that makes them feel?
6. How does living in the homeless shelter affected your child's relationships to others? (i.e. friends and classmates.)
    a. What do they share with you about living here?
    b. Tell me about your child's experiences at school.
    c. What do you think makes your child feel bad? Nervous? Afraid?
    d. How does your child cope when bothered or upset? What helps them?
    e. What things has your child shared with you that they wish for or dream of?
    f. Tell me what spiritual needs your children have and how they are met.
7. Tell me how your child's health care needs are met.
    a. When was their last Dr. visit? Was it for a routine check-up, or for an illness?
    b. Where are your children typically seen for their healthcare needs? (i.e. clinic, Emergency Room, or Urgent Care?)
    c. How often are your children seen by a doctor?
    d. What immunizations have they had? Are their immunizations up-to-date?
    e. When was your child's last visit to the dentist? Was it a routine visit, or for a problem? How often do they see a dentist?
8. What do you do to keep your family healthy? What does your child do to stay healthy? What would help your children be healthier?

Developed by Mary Knutson

August 8, 2003

Coding in Second Phase of Analysis (Leininger, 2002)

Loss of Autonomy

Big Change/Disruption

Changed Developmental Experiences

Separation of Family

Changed Attitude of Child

Lack of Understanding

Living with Strangers

Negative Emotions

Loss/Grief

Wishes

Coping

Spirituality

Positive Aspects

Health Needs/Health Resources

Patterns in Third Phase of Analysis (Leininger, 2002)

Adapting to Change and Limited Autonomy

Increased Stress and Changed Attitudes

Congregate Living with Changed Developmental Experiences

Coping and Protective Behaviors

Utilizing Resources for Health and Development

Themes Found in Fourth Phase of Analysis (Leininger, 2002)

Autonomy

Attitudes

Coping

Resources