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Interactions between Adolescent Fathers and Health Care Professionals during Pregnancy, Labor and Early Postpartum

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Abstract

Objective—This study examined interactions between adolescent fathers and health care professionals (HCPs) from the perspectives of the families of the adolescent fathers during pregnancy and early post partum.

Design—Data were from the prenatal and 1-month data points of a larger longitudinal qualitative case study design examining paternal involvement. A purposive sample of 25 sets of unmarried, low-income African American adolescent fathers, adolescent mothers and at least one of each of their parents were individually interviewed at 1, 6, 12, 18 and 24 months after birth using a semi-structured interview guide. Data were analyzed using content analysis methods.

Setting—Approximately 90% were interviewed in their homes.

Participants—Annual household incomes were between \$0 – \$28K (M = \$14,661). The 111 participants included 25 sets of adolescent parents, 50 grandmothers and 11 grandfathers. Approximately 75% of the adolescent fathers were 17 and 19 years of age.

Results—Supportive (information, emotional and material support), distancing and neutralizing interactions between HCPs and adolescent fathers were identified.

Conclusions—Although most interactions were perceived as supportive, distancing and neutralizing interactions could potentially have negative long-term effects for these vulnerable families and contribute to disparities in health care. Nurses may be important resources for these new fathers.

Keywords

African American families; adolescent fathers; adolescent parents; adolescent pregnancy

By 1960, 88% of births in the United States took place within hospitals rather than at home (Leavitt, 2003). As women giving birth moved into hospitals fathers moved into hospital waiting rooms to await news of the birth. Husbands were gradually permitted to stay with their wives during labor during the 1960s and 1970s (Draper, 1997; Latimore, 1999; Leavitt, 2003; Odent, 1999). It was not until the 1980s that at least 80% of United States fathers, regardless of marital status, were permitted to stay with the mothers during labor and birth (Palkovitz, 1987).

Most recently fathers have been permitted, and even encouraged, to attend prenatal visits with the mothers of their children. The fathers' increased presence during prenatal care and during the birth process contact is often associated with increased contact with health care professionals (HCPs). The increased numbers of contact between HCPs and unmarried, low-

income African American adolescent fathers can be viewed as opportunities to support these young fathers who face special challenges as they transition to their new paternal roles because of their socioeconomic status, unmarried status and developmental stage (Dallas & Chen, 1998; Dallas & Chen, 1999; Dallas, Wilson & Salgado, 2000; Dallas, 2004).

Research on all fathers has recently increased yet remains sparse for African American fathers and even more meager on African American adolescent fathers (Waller, 2002). The incidence of adolescent fatherhood has not been well established with the exception of two landmark studies on the age of the fathers of babies born to adolescent mothers utilizing review of birth certificates. Researchers in the first study used a nationally-representative sample and estimated that approximately two percent of all babies born in the United States each year are fathered by adolescent males (Males & Chew, 1996). Researchers in the second study reported that the incidence of adolescent fatherhood is higher for babies born to adolescent mothers, in comparison to adult mothers, and that 18% to 35% of the babies born to adolescent mothers are fathered by males younger than 20 years of age (Landry & Forrest 1995). They noted also that the father's age is often omitted from birth certificates of babies born to adolescent mothers. Researchers in that same study reported that the partners of African American adolescent mothers were more likely than the partners of either Caucasian or Latina adolescent mothers to be closer in age to the adolescent mothers (Landry & Forrest).

Low-income African American adolescent fathers and HCPs have few opportunities to learn what behavior to expect from each other prior to their contacts during pregnancy. Uninsured children are more likely to lack a usual source of care, to delay care and to have unmet medical needs in comparison to children with insurance (Hoffman, Schwartz & Tolbert, 2008). Despite recent increases in state-funded health insurance for low-income children, African American adolescents continue to have limited access to health care services due to lower Medicaid income eligibility levels for older children in some states (Kaiser Commission on Medicaid and the Uninsured, 2009). In comparison to their female counterparts, older adolescent and young adult males are much more likely to report lack of contact with a health professional [35.1% vs. 12.8%] (Callahan & Cooper, 2005). This trend is likely to continue into adulthood since men tend to have less contact with health professionals than women. Men utilize acute rather than primary health services and receive fewer health maintenance visits in comparison to women (Bertakis, Azari, Helms, Callahan & Robbins, 2000; Dean & Downey, 1998; Murphy & Hepworth, 1995).

The type and quality of interactions between health professionals and pregnant or parenting adolescents may affect how they view the accessibility of the health care system for themselves and for their children. The purpose of this article is to examine the interactions between adolescent fathers and HCPs from the perspectives of 25 families of unmarried, low-income African American adolescent fathers during the periods of pregnancy, labor, birth, and the immediately postpartum.

Background

Despite viewing themselves as patient advocates, nurses primarily act as agents of the hospital. Nurses provide essential information about hospital rules and policies to families, what behavior is expected and permitted (Reed, 2005). In addition to being the largest group of HCPs, nurses are often physically present in most environments in which pregnant and parenting adolescents receive health care. Thus, nurses often become the single most important link between pregnant and parenting families and the clinical agency. Nurses also evaluate the laboring mother's need for medical intervention and assume responsibility for administering pain relief and, at minimum, providing information about the imminence of

birth (Reed). Although health services are delivered directly to mothers during the birthing process, fathers who are present during this meaningful time will inevitably see and interact directly with nurses.

There are significant racial, socioeconomic and educational differences between low-income, African American adolescent fathers and HCPs that might contribute to differences in how these two groups view the fatherhood role. Health professionals are overwhelmingly Caucasian. Only 2.6% of physicians, 3.4% of psychologists, and less than 5% of dentists are of African American ethnicity (Smedley, Butler & Bristow, 2004). The average registered nurse is a white female [88.4 %], who is 46.8 years of age and has completed at least an associate degree [42.2%] (Bureau of Health Professions, 2004). Historically, Caucasians associate family with *affinity*, in which the relationship of a natal couple has been validated by the state and share a residence apart from other family members (Sudakarsa, 1980, 1988). Some nurses have expressed concern about their ability to provide culturally competent care for pregnant or parenting African American adolescents due to these differences (Cassata & Dallas, 2005). Tiedje & Darling-Fisher (2003) suggested reasons why some nurses may be uncomfortable working with any type of father, regardless of his age. Their reasons include: attitudes or beliefs about fathers shaped by nurses' families of origin; the lack of models for father inclusion in their personal lives; the overwhelmingly female presence in nursing; the lack of content about the significance of fathers and the absence of models in professional nursing education that demonstrate how to include fathers.

Characteristics of African American adolescent fathers look very different than those of nurses. The risks of becoming a father during adolescence are greatest for African Americans males who live in poverty, are academically at risk and who have siblings or parents who became parents during adolescence (Lerman, 1993; Marsiglio, 1987; Rivara, Sweeney & Henderson, 1985). Despite limited social support and financial resources, adolescent parents depend upon their families of origin as their primary sources of assistance with parenting tasks (Dallas et al., 1999; Dallas et al., 2004; Burton, 2001; Coley & Chase-Lansdale, 1998).

Finally, families of West Africa, the place where most slaves were taken, associate family with *consanguinity*, in which the relationship of a natal couple is secondary to their ties the relationships of their families of origin (Sudakarsa, 1980, 1988). African American adolescent fathers often reside in their home of their families of origin and live apart from their children and the mothers of their children. HCPs, and others more familiar with families in which father involvement is equated with marriage or residence, may be troubled by what seems to be the father's lack of involvement (Stack, 1974; Sudakarsa, 1988). They may ignore or fail to fully include these fathers whom they view as being uninvolved with their children. In addition to sometimes being ignored, the paternal roles of African American fathers are often minimized because their roles look different from the mainstream father roles (Conner & White, 2006).

Fathers in Western society are usually expected to act as primary financial providers for their children and the mothers of their children. However, the percentage of African Americans in poverty [25%] is twice that of the total US population [12%] (McKinnon & Bennett, 2005). Regardless of their age African American fathers who live in poverty face challenges providing for their families and may be more willing to assume a nurturing role due to their limited ability to assist with finances (Hammer, 2001). Racial disparities in the juvenile justice system also affect the ability of African American adolescent fathers to assume provider roles. *Building Blocks for Youth* initiative conducts research on the disparate impact of the justice system on youth of color and reported that African American youth were disproportionately arrested in 26 of 29 arrest categories in 2004 (Po-Yamagata &

Jones, 2007). Even when they were referred for the same type of offenses African American youth were more likely than Caucasian youth to be formally charged in juvenile court. A history of incarceration can reduce the wages of ex-inmates by 10–20 percent and the lifetime rate of wage growth by 30 % (Western, 2002; Western, Kling, & Weiman, 2001).

African American adolescent fathers face additional significant challenges in meeting expectations of the traditional fatherhood role. More than half of the 5.6 million African American boys in the United States live in fatherless homes and fewer than half graduate from high school within four years (Fletcher, 2006). African American adolescents [5.7%] are more likely than Caucasians [3.7%] to drop out of high school; coming from a low-income family quadruples the odds of dropping out (Laird, DeBell & Chapman, 2006).

Finally, poverty may affect differences in developmental stages for some African American adolescents. Children who grow up in poverty and racism may experience an accelerated developmental trajectory that encourages adolescents to assume adult roles and responsibilities earlier than adolescents who grow up in more economically stable environments (Burton, 1990; Geronimus, 1987, 1996, 2003).

Despite these significant challenges, and in contrast to stereotypes concerning the lack of participation of unmarried, low-income African American adolescent fathers, many of these young fathers provide significant social support to the adolescent mothers and successfully remain involved with their children both emotionally and financially (Chen, Tellen, & Chen, 1995; Coley et al., 1998; Dallas, 1995; Lerman, 1993). Unmarried African American adolescent fathers are more likely than either Caucasian or Latino unmarried adolescent fathers to remain involved with their children throughout their children's lives (Coley et al.; Danziger & Radin, 1990; Florsheim, et al., 2003; Lerman). Despite living separately and being unmarried, both non-residential and cohabitating fathers perform essential fatherhood functions for their children including fulfilling or contributing to the provider role (Amato & Gilbreth, 1999; Knoester, Petts & Eggebeen, 2007).

Some adolescent fathers also remain in romantic relationships with the mothers of their babies. While scarce, literature on romantic relationships between adolescent parents illustrates that adolescent fathers express feelings of both love and concern for their partners (Westney, Cole & Munford, 1986). African American males who become fathers during adolescence need at least as much support as do the mothers of their children. Nurses can be an important resource for these vulnerable new fathers.

Methods

The data from this study were taken from a larger study examining paternal involvement of unmarried, low-income African American adolescent fathers from the perspectives of the kinship system (Dallas, Norr, Dancy, Kavanaugh, & Cassata, 2005a; Dallas, Norr, Dancy, Kavanaugh & Cassata, 2005b). Each of the 25 kinship systems was composed of the adolescent father, his parents or parent surrogate, the adolescent mother and her parents or parent surrogate. The purpose of the larger study was to examine the evolution of the paternal role over time for unmarried, low-income, African American adolescent fathers from the multiple perspectives of his kinship system (*hereafter referred to as family members*).

Sample

A purposive sample was recruited from a larger Midwestern metropolitan area via radio ads and flyers. Inclusion criteria were that this be the first pregnancy carried to term for both unmarried adolescent parents, that both adolescent parents reported wanting the father to be

involved after the birth of the baby and that both adolescent parents identified at least one parent or parent surrogate who participated in the study (Dallas et al., 2005a). The parents and parent surrogates of the adolescent father and mother are hereafter referred to as grandparents.

The sample was composed of 25 unmarried adolescent fathers, 25 unmarried adolescent mothers, 50 maternal and paternal grandmothers and 11 maternal and paternal grandfathers. At enrollment approximately 75% of the fathers were 17 to 19 years-of age; their ages ranged from 14 to 19 years. All of adolescent mothers were younger than 19 years of age. The annual household incomes for these families ranged from \$0 to \$28,000 [Mean household income was \$14,661]. All of the subjects self-identified as being black or African American.

Data collection

Research team members performed individual semi-structured interviews with each family member when the adolescent mother was at least 28 weeks gestation and again when the baby of the adolescent parents was 1, 6, 12, 18 and 24 months of age. The 580 individual qualitative interviews were conducted by trained researchers; most [90%] interviews were performed in the subjects' homes (Dallas & Kavanaugh, in press). At each data point each subject was specifically asked about the amount and quality of any contact between the adolescent father and any member of the health care system, in addition to other questions. Interviewers then probed for details of any reported encounter. The responses to these questions about contact with members of the health care system for the prenatal and 1-month data points were analyzed for this article.

Family members in this longitudinal study often identified the HCP as "a nurse" even in cases when it was doubtful from the context of the story, whether the HCP was actually a nurse. Therefore the generic term, "HCP", is used to refer to the variety of health care professionals who came into contact with the adolescent father and their families in this article. This term includes nurses, nurses' aides, medical assistants, physicians, social workers, health educators and ultrasound technicians. When nurses were clearly identified by the respondent the term, "nurse", was used.

Data analysis

Data were analyzed for the prenatal and 1-month interviews using techniques for data reduction, data display, and conclusion drawing (Miles & Huberman, 1994). Data were reduced by reading and re-reading interview data relevant to the research topic. The researcher then assigned codes and developed definitions using an iterative process to refine and revise codes based on the data. The researcher randomly selected excerpts from the transcripts to enhance reliability of the findings. The excerpts were coded again using the codes and definitions developed by the researcher. This second coding was performed by a colleague who had acted as a co-investigator during the larger study. Differences between the two coders were resolved by refining definitions and discussion until an inter-rater reliability of 90% on the codebook was reached (Miles et al.). Using an audit trail to track changes in codes also enhanced the credibility and trustworthiness of findings (Patton, 2002). Coded data were displayed in matrices to facilitate pattern identification and conclusion drawing (Miles et al.).

Results

The categories of interactions between the unmarried, low-income African American adolescent fathers and HCPs during the pregnancy and early postpartum periods from the

perspectives of the families of the adolescent fathers were divided into three categories, supportive, distancing and neutralizing interactions. A description of each category follows.

Supportive interactions were the most commonly reported category and were defined as those interactions that supported the adolescent father in his new role by acknowledging him in the fatherhood role. These interactions were reported as being positive by family members and were most often identified as having been performed by nurse midwives and ultrasound technicians. There were three types of supportive interactions: those in which the HCP provided information, those in which the HCP provided emotional support and those in which the HCP provided material support. Each is defined and described in detail below.

Providing information

HCPs provided information to adolescent fathers when they shared knowledge about the physical processes of pregnancy or about the growing fetus, often by teaching. Descriptions of one-on-one teaching of specific skills to adolescent fathers were rare.

One adolescent father told a story of being present during an ultrasound of his baby. He reported feeling “amazed” at the ultrasound and told us that, “Seeing the baby [during the ultrasound] helped to make the baby real.” This young father was also permitted to ask “lots of questions” during the ultrasound that the HCP responded to in detail. Several HCPs “invited” adolescent fathers to come in during ultrasounds and responded to their questions. Other HCPs permitted the adolescent fathers to listen to the fetal heartbeat. Still another adolescent mother recalled how a nurse midwife made sure that the adolescent father was included during prenatal visits.

The midwife will ask him [adolescent father] to come into the exam room and will talk to us both together. She tells us about signs of labor, how to know if something’s wrong, and how to arrange transportation if the [adolescent father] is not there.

HCPs also provided information about fetal growth and newborns by giving literature to adolescent fathers. In one special case, after a fetal cardiac anomaly was identified, the physician drew pictures of the anomaly and provided special genetic information to both adolescent parents. Less frequently, HCPs gave specific fatherhood advice to adolescent parents. HCPs provided advice “about being a father” and “things to do to become a father.” One nurse told an adolescent mother who had just given birth to, “make sure that the father gets to know the baby.” This nurse’s advice made the young mother “increase [her] efforts to have the father get to know the baby.”

Research on the fatherhood behaviors of adolescent fathers is scarce and there is very little published research on which factors actually predict long-term involvement of African American adolescent fathers with their children, particularly since most live apart from their children (Coley et al., 1998; Lerman, 1993). Though still limited, more is known about factors that predict long-term involvement of adult fathers who do not share a residence with their children, non-residential fathers. In the absence of research on adolescent fathers factors that contribute to long-term involvement with adult fathers that might also influence adolescent fathers are proposed. As such, HCPs who promote the relationship between the adolescent parents may contribute to the adolescent father’s continuing involvement with his child, as was true for adult fathers, and may contribute to better preventive health care for the children of adolescent parents.

Positive and consistent father involvement has a positive influence on child well-being and can significantly influence the cognitive development of their children (King, Harris, & Heard, 2004; King & Sobolewski, 2006; Paquette, 2004). A higher level of involvement

with their children was associated with the mothers' support of adult fathers (DeLuccie, 1996) and a romantic or supportive relationship between the natal couple consistently predicted continued involvement for unmarried, non-residential adult fathers (Cutrona, Hessling, Bacon & Russell, 1998; Gager, McLanahan & Gleib, 1998; Johnson, 2001). One study of adolescent mothers reported that the partners of adolescent mothers who maintained relationships with their children's fathers were more likely than those who did not to practice better preventive health care for their children (Kelly, 1995).

Emotional support

HCPs provided emotional support when they praised or encouraged the behaviors of adolescent fathers that were connected to the fathers' support of adolescent mothers during pregnancy or the fathers' participation in their children's early health visits. An adolescent father recalled the time when "a nurse praised me for attending prenatal visits, which made me feel good." Several family members told stories of how some HCPS praised the adolescent fathers for attending prenatal visits, the births of their children and their children's well-child visits and how good it made these young fathers feel about themselves.

The nurse [said] that most men wouldn't be here. She told me that most men really aren't here, even if it was a visit in the emergency room, or they'll make, but they are late. You're here on time. So that made me feel like a strong person and I'm going to be here. Even if she just has a checkup appointment, I'm there. So, it's pretty much morning, night, whenever [her appointment] is, I'm there.

Material support

HCPs provided material support when they contributed to the care of the baby either directly or indirectly. HCPs contributed material support directly when they gave the adolescent parents objects for the baby, such as diapers or formula. HCPs contributed material support indirectly when they gave employment information to the adolescent father. In a very few instances HCPs, usually nurses, provided material support to adolescent fathers by providing baby clothes and diapers and helping them find jobs. An adolescent father told of the time that a nurse "brought clothes and Pampers, which saved me some money." Another adolescent father described how a nurse tried to help him find employment.

She [nurse] gave me this paper for a job fair because she knew I didn't really have a job and I thought that was nice. She was trying to help me get a job and she helped me understand the father's role. She talked to me while she [adolescent mother] was like in the doctor's office. That was a nurse.

These supportive interactions between adolescent fathers and HCPs may have long-lasting beneficial effects for both adolescent parents and for their children. During adult fathers' transition to parenthood, the individuals within his environment may promote or inhibit his transition by providing or withholding acknowledgment of his new role (Jordan, 1990). HCPs who acknowledged the adolescent father's role by including him in the care provided to the adolescent mother and to his child may have facilitated an adolescent father's transition to the fatherhood role as well. Living apart from the adolescent mother often means that adolescent fathers have less experience with the biological changes associated with fetal growth that make the developing baby a reality for the mothers of their babies. Since African American adolescent fathers often live apart from the mothers of their babies (Coley et al., 1998) HCPs' supportive interactions of may help to make the baby "real" for the young father, a detail that may also support his transition to his new role. As one adolescent father described,

It hadn't really occurred to me that we were having a baby until I first heard the heartbeat, and then I was like, it is really a baby. Then when I saw the ultrasound, then I really felt like a father. Really, really felt like a father!

Supportive interactions between adolescent fathers and HCPs may also have significant benefits for the children of these young parents, as was true for adult fathers. Adult fathers who felt supported and encouraged by health professionals continued to attend their children's well-child care as their children more frequently than fathers who did not feel support and encouragement (Ahmann, 2006; Moore & Ketelchuck, 2004).

Neutralizing interactions were the second most common category of interactions reported by families of unmarried, low-income African American adolescent fathers. These interactions were defined as those interactions that failed to acknowledge the adolescent father in his role as a father during times when he was trying to act as a father.

Attending prenatal visits with the adolescent mother was identified by family members as an important part of adolescent fathers' fatherhood role (Dallas, 1995). Since most prenatal visits are scheduled for the convenience of HCPs during weekday daytime hours, adolescent fathers experienced challenging scheduling conflicts with their school and work schedules (Dallas). Adolescent fathers who were able to overcome scheduling conflicts and attend prenatal visits were sometimes ignored by HCPs. An adolescent father described being in the examination room during prenatal visits and being ignored by HCPs on multiple occasions who "wouldn't talk to [him]." None of HCPs initiated conversations with him and he reported being "afraid to ask questions." One adolescent father described his interactions with HCPs during prenatal visits.

Interviewer: How did the doctors and nurses treat you as a father during prenatal visits?

Adolescent Father: They really weren't focusing on me.

Interviewer: Did they talk to you?

Adolescent Father: They asked me if I was the father and said congratulations. That's it.

Family members also told us how, during prenatal visits, all conversation was usually directed to the adolescent mother. The adolescent father stayed quiet and "just paid attention" hoping to learn. Other family members described how the adolescent father "attends doctor visits, but they don't really talk to him" or that he "goes to the office but does not talk to anyone." Adolescent fathers who attended prenatal visits were trying to act like fathers by meeting the expectations of the maternal and paternal families. Those HCPs who participated in neutralizing interactions made no attempt to acknowledge or support the adolescent father in his role or to facilitate his transition to fatherhood.

Adolescent Father: I went to the doctor with her one time when she fell on her stomach but that was it. They just said all she needed to do was rest and lay down but that was it.

Interviewer: During that one visit did you have any direction interaction with the doctor or the nurses or did they just talk to her or maybe her mother?

Adolescent Father: They just talked to her.

Even those adolescent fathers who were not ignored were not acknowledged as being fathers. Some HCPs provided neutral informational statements to adolescent fathers without any other acknowledgment of his role. Neutral informational statements included providing specific information regarding the sex of the baby during an ultrasound exam or correcting

the adolescent father's method of holding his baby after the birth without any further interaction.

The third and final category, *distancing interactions*, were the least frequently reported category of interactions. Distancing interactions were defined as those that either denigrated the adolescent father or actively negated his fatherhood role. The portrait of the sexually promiscuous black male simultaneously fathering multiple children continues to exist among some nurses (Cassata et al., 2005). The following scene took place between a nurse and the adolescent father who attended the birth of his child and was described by the adolescent mother.

An adolescent mother recalled that shortly after she gave birth, a nurse asked the adolescent father if he was happy about the birth of his baby. In response to the young father's enthusiastic response the nurse immediately queried, "How many babies does this make?" The adolescent mother later told us how the nurse's question had embarrassed the young couple by implying that the young man had fathered many children.

Another adolescent father was denied the opportunity to witness the birth of his child because he was unable to "prove" that he was the baby's father. This father had made special arrangements with his employer to leave work early when the time for the birth arrived. He arrived at the Labor and Delivery Unit only to be turned back by a nurse. The nurse told the young father that since he and the adolescent mother had different last names he would have to prove that he was the expectant father. Unable to produce proof, the young father was turned away and relegated to the waiting room.

Although these interactions may be consistent with the personal values of the HCP or with the institutional policy of the clinical agency, distancing interactions may prove to be shortsighted. They may inhibit the adolescent father's transition to his role and interfere with his relationship with the mother of his child.

Discussion

Most of the literature on adolescent pregnancy and parenting includes only adolescent mothers. This study addressed an important gap in that literature by focusing on unmarried, low-income, African American adolescent fathers and including the multigenerational perspectives of their partners and their parents.

One strength of the qualitative approach is its flexible design and inductive method that produce new information in understudied areas. Study subjects were selected based on their ability to provide rich information about their experiences and not randomly selected to represent the target population of adolescent fathers. The findings of this study should not, therefore, be generalized beyond the study sample. Nevertheless, this study contributed new information about how the interactions between adolescent fathers and HCPs may be viewed by members of these vulnerable families and the potential consequences of the different categories of interactions.

It is increasing likely that HCPs in all areas of health care will experience a greater presence of both adult and adolescent fathers as the nurturing roles of fathers continue to evolve. HCPs, already so accomplished at supporting mothers during this important time must also learn to provide equitable services for fathers. Those HCPs who treat adolescent fathers as peripheral to the parenting process risk alienating an already marginalized group from seeking future advice or education from HCPs, as well as antagonizing a primary source of support for adolescent mothers, such as fathers who provide support for mothers'

breastfeeding (Harner & McCarter-Spaulling, 2004). HCPs who fail to fully engage unmarried, low-income, African American adolescent fathers may miss important opportunities to support these vulnerable young fathers and their families which may have long term effects for both the adolescent parents and the well-being of their children.

Future research should examine the same types of interactions from the perspectives of HCPs to examine their feelings, beliefs and expectations regarding the fatherhood roles of adolescent fathers during this important time. Future research is needed to learn more about factors that motivate HCPs to interact in ways that support, neutralize or distance unmarried, low-income, African American adolescent fathers.

Implications for Nurses

The implications for nurses and for nursing practice are clear. This study demonstrated that nurses can potentially act as important resources for adolescent fathers and have long-term influences on the parenting behaviors of this vulnerable group. Nurses are the largest group of health professionals and are a continuing presence from pregnancy diagnosis through labor, from birth to early postpartum, up to and including well-child visits. As such, nurses have multiple opportunities to portray health professionals as important and accessible sources of health information as each new family is created.

Nurses who provide care to these young families should consider the significant racial, socioeconomic and educational differences between low-income, African American adolescent fathers and how those differences might affect the type of support needed. These vulnerable fathers needed more than just information to meet the challenges of fatherhood. Although informational support from HCPs was valued, these families also appreciated emotional support and material support that some HCPs provided to the adolescent fathers.

Finally, it may seem self-evident but it is important to remember during pregnancy, birth and early postpartum that fathers are parents, too. The medicalization of birth has unquestionably saved innumerable lives of both mothers and babies. Nevertheless, birth is also a social process and family members of the birthing mothers also need support during this time of transition. Fathers may not receive direct health care services during the prenatal and postpartum periods but they do influence their partners' behaviors during pregnancy and beyond and their children's early interactions with the health care system. Nurses who remember this and act on it know that the processes of pregnancy, birth and early postpartum are family matters.

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CALLOUTS

1. African American adolescent fathers face additional significant challenges in meeting expectations of the traditional fatherhood role.
2. African American males who become fathers during adolescence need at least as much support from health professionals as do the mothers of their children.
3. Nurses have the potential to act as important resources for adolescent fathers and to have long-term influence on their parenting behavior.