ADDRESSING THE DYNAMICS OF PATERNAL INVOLVEMENT IN PRENATAL CARE: CHALLENGES & RECOMMENDATIONS

by

Sharon Marilyn McCarthy

B.S., Virginia Commonwealth University, 1998

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This thesis was presented

by

Sharon Marilyn McCarthy

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and approved by

Dissertation Advisor:
Kenneth Jaros, PhD
Associate Chair for Departmental Administration
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

James Butler, MEd, DrPH
Assistant Professor
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Sara Goodkind, PhD
Assistant Professor
School of Social Work
University of Pittsburgh

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There is a gap between the growing presence of fathers in the lives of their children and their inclusion within the prenatal process. The healthcare system fails to acknowledge fathers by not addressing their needs, issues or concerns programmatically or within the clinical setting. This topic is of public health relevance because a father's contribution to the health of his child may optimize the child's over all health and well-being. The presence of fathers during labor and delivery is common place in today's society, however little is known about their birthing expectations and needs. Furthermore, the literature on this topic is sparse.

Maternal child health is the phrase used for the study of women and children, interestingly, paternal child health is invisible, and the phrase is non-existent. This research study seeks to address this gap by looking at programs that engage fathers in order to make recommendations in the prenatal health care sector. Interviews were conducted with fathers to assess their experiences throughout the prenatal process.

The mother-baby dyad has a historical context, but as the dynamics of our society has changed, the healthcare system cannot afford to remain stagnant. The dyad must evolve to include fathers' in-order to provide the services and information they need to parent their children as well as support mothers in the process.

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PREFACE

I begin this acknowledgment section by thanking God for you are my strength and my joy. When I think of your grace and goodness towards me, I am humbled. Father with you all things are possible. I thank you for protecting, guiding, encouraging and molding me through this journey. I express my gratitude Father, for there is none like you.

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1.0 INTRODUCTION

Men play a key role in maternal child health. Nearly two decades ago, pioneering research described fathers as the "forgotten contributors to child development" (Lamb, 1975 and 1977; Kotelchuck, 1976). There have been a plethora of research and evaluation studies since that time, documenting the importance of male involvement with regards to their influence on the outcomes of pregnancy, child health, maternal well-being, and development. Men's prenatal behaviors are defined as activities with their partners during pregnancy and activities with the child during and around the time of birth (Tinkew, Ryan, Carrrano & Kristin, 2007). Empirical work on the link between male prenatal behaviors and postbirth father behaviors is sparse, inconclusive and narrowly defines men's prenatal behaviors (Abma & Mott, 1994).

However, fathers are increasingly being recognized for their unique and irreplaceable contributions to the health and well-being of children beginning in infancy (Horn, 1998, Cochran, 1997). In early childhood, father involvement is associated with better cognitive and social development (Yogman, Kindlon & Earls, 1995). Furthermore, father support and involvement from the month following birth is connected with a range of positive outcomes in babies and toddlers, from better language development to higher IQ's (Goldman, 2005; Gottfried et al., 1988). Fathers often form an independent attachment with their infants that promote their security (Horns, 1998).

During school age, paternal involvement has been found to influence social maturity, pro-social behavior, the ability to exhibit empathy, and personality variables such as healthy self esteem (NFI; Father Facts, 2008). In addition, fathers are now understood to play a substantial role in a child's adjustment to school and their academic achievement (Amato & Gilbreth, 1999; Nord, 1996). In adolescence, strong and positive father-child relationships protect against adolescent's risk behavior and distress (Goldman, 2005). Paternal involvement has also been linked to better emotional connectivity during adolescence (Goldman, 2005; Frustenberg, 1995; Harris and Frustenberg, 1998).

Unfortunately a father's influence, experience, and inclusion in the prenatal process have been overlooked as part of an important component in pregnancy. As stated previously, there is not a substantial amount of literature addressing this issue. Less is known about healthcare provider inclusion of male partners in the prenatal process. Over the past 20 years, cultural expectations for fathers and their participation in the care of children have shifted (Tiedje, & Darling, 2003). Fathers are taking a more active role in their children's lives and health care. (Tiedje & Darling, 2003).

Research has shown that fathers have different, but equally important contributions to a child's growth and development with respect to emotional health and cognitive development (Marsiglio et al., 2000; Puuett 2000). A sparse body of literature suggests that healthcare provider inclusion of fathers is invisible in the healthcare settings (Garfield, 2001). Healthcare providers may not be overtly hostile to fathers, but often marginalize and ignore them (Tiedje & Darling, 2003).

There is a gap between the growing presence of father's in the lives of their children and the acknowledgment by the healthcare system. The perceptions of a father's role in the prenatal

process and delivery in the past, was one in which there was no interaction. For example, fathers were not present in the delivery room. The fathers were informed by a nurse or doctor once the baby was born. The lack of interaction between the medical staff and fathers has a historical context. Given past interactions with medical personnel, some fathers have noted that they have not been specifically acknowledged throughout the prenatal visits and they felt that they were not a part of the process. Tiedje and Darling (2003) expressed that they observed student providers and experienced practitioners, ignore fathers during child health and prenatal care visits, although much of the exclusion was nonverbal an unintentional.

Historically, questions are posed directly to the mother during prenatal visits. The premise behind the interaction is that the mother is the patient, she is carrying the baby in her womb; therefore she is aware of her symptoms, state of mind, and well being during the pregnancy. The question remains whether a concerted effort has been made by health care professionals to engage the fob in conversations to recognize his interests concern or excitement about his child.

Rosich-Medina and Shetty (2007) found that the fact that men lack the physical changes that accompany pregnancy could place them at a disadvantage and therefore they could benefit from emotional support from health professionals to help them acknowledge and understand the transition they are undergoing towards fatherhood. The actions by healthcare professionals may discourage paternal involvement and alienate fathers who may feel a sense of exclusion from the process. The question is no longer whether to include fathers but “how” to go about doing so.

The purpose of this thesis is to examine fathers’ engagement in the prenatal process, assess the interactions between fathers and healthcare providers, and review father engagement programs in order to make health care providers more aware and intentional in their interactions

with fathers. Best practice guidelines and recommendations will be provided to further the scope and direction of this issue, in order to develop future research initiatives and design clinical protocols, in an effort to develop more sound practices of inclusion during the prenatal process.

2.0 BACKGROUND: UNDERSTANDING FATHERS AND PRENATAL INTERACTIONS

2.1 FATHERS IN PRENATAL CARE

The prenatal period is a key moment for intervention: a time to treat and care for not only the mother, but for the father as well (first nine, 2007). Historically, fathers have been a rather invisible group in the study of child development and family processes, with their influence rarely considered and their voices scarcely heard (Coley, 2001). As mentioned previously, literature on father prenatal involvement is minimal. However, studies have revealed that father involvement leads to better pregnancy outcomes. When fathers assume an active parental role, they can have a positive influence on all aspects of their children's development (Lamb, 2004). Through accessibility and support to mothers, fathers have been shown to help mothers adjust better during pregnancy, have more positive birth outcomes and increase joy and affection towards infants (Parke, 1995; Teitler, 2001). This information assists in legitimizing the fact that fathers are important to maternal and child health.

Some hospitals around the nation have taken the initiative to provide prenatal questionnaires to mothers to indicate whether they think the father will be involved in the pregnancy, and to ascertain how the father feels about the pregnancy. These questionnaires

attempt to allow clinical social workers and medical staff the opportunity to tentatively gauge the dynamics of the mother-father relationship before a woman meets with the medical staff. Teitler (2001) notes that partner support is associated with positive maternal health behaviors during pregnancy, including early prenatal care and decreased smoking and drug use.

The prenatal questionnaires are not provided to the fathers; therefore the answers provided by the mothers may be biased, based on the mother's perception of her relationship with the father. Studies have attempted to move from accessing information on fathers solely from mother report to more commonly using child, father, or observational reports to tap fathers' behaviors and emotional connection with their children (Coley, 2001; Teitler, 2001).

The lack of inclusion by healthcare providers often inadvertently reinforces a set of expectations of fathers that is dismally low (Tiedje, Darling 2003, 1999). James May, Director of the National Fathers Network, observed that health care professionals typically ask mothers 90 percent of the questions regarding a child's care, even though both parents in the examination room (fathersnetwork.org). The reality is that fathers are typically peripheral to the basic care of children (Weissbourd, 1999).

Recent changes in demographics in the United States have had a major impact on family roles, in particular father's involvement in the care of their young children. . Today, approximately 1 in 20 (5%) children are raised by fathers without a mother (Fields & Casper 2001). In 2006, there were 12.9 million one parent families-1.4 million single mothers; 2.5 million single fathers. Shared custody arrangements between parents of divorce or separation are more common (Tiedje & Darling, 2003). According to Manning, Stewart & Smock, 2001, approximately 24% of fathers have three or more groups of children in their lives: biological children living with them, children of former mates living away, an stepchildren living with them

or elsewhere. The Council of Family Health, 1997 reports that in a survey of 251 men with children ages 12 years and under, 35% of fathers had missed 1 day of work to care for a sick child in the past year; 81% stated that they were very likely to administer medication to their children and 69% had taken children to a doctor's office. The data shows that fathers are taking a more active role in their children's lives and consequently healthcare providers need to be more aware of attentive to fathers in providing quality healthcare (Tiedje & Darling, 2003).

Regardless of these dynamics, fathers have voiced that they have been excluded in some way in the prenatal process. Healthcare providers have admitted to being unaware of their father-excluding behavior. The Dad Deficit is a research study that was conducted in the United Kingdom. It involved health professionals, mothers and fathers over the whole period before, during and after a birth. Highlights from their research revealed that 86% of fathers now attend the birth of their child. The report also shows that many fathers still feel excluded at the birth and can be literally be shut out when visiting time is over (fatherhood institute, 2008). They also found that maternity services aimed at dads are discretionary and not systematically engaging with them (fatherhood institute, 2008).

Weissbourd (1999) proposes that the major question for providers is how we create father-friendly healthcare more often, for more providers and more parents? The question is no longer whether the father should be included but how does the health care arena go about doing so in an intentional and natural way (Tiedje & Darling, 2003). The characteristics of effective interventions with fathers are still in the developmental phases and mostly confined to parent family education programs. The wide variety of parent education programs in health care, child care and other community settings still tend to be geared to mothers' not fathers'- needs and concerns (Weisbourd, 1999). Current time and budget constraints in health care delivery system

make implementation of father friendly health care challenging. For instance, some hospitals may not want to spend their budget to design and offer specialized pamphlets for fathers or spend money on social workers to address father needs. However, the primary prevention aspects of inclusion in healthcare are financially sound in the long run (Tiedje & Darling 2003).

2.2 CURRENT DYNAMICS OF PATERNAL INVOLVEMENT

There has been a dramatic increase in interest among researchers regarding paternal involvement. Questions concerning the amount, type and impact of fathers' involvement with their children and families are rising, as changing social norms and demographic patterns have altered societal views of paternal responsibility (Coley & Morris 2002). Although, these issues are intriguing, researchers struggle in their attempt to study father involvement with the current available data and methods.

According to Coley and Morris (2002) the lack of information stems from three primary causes: simplistic measurement regarding father involvement, father's nonparticipation in research studies of child development and family functioning, and concerns about the validity of mothers' reports of fathers. However, findings suggest that prenatal programs that encourage fathers to actively participate in the pregnancy and the fathers' presence during the prenatal process may be beneficial to later child well-being (Bronte-Tinkew, Ryan, Carrano & Moore, 2007). Clinicians should acknowledge the powerful influence mothers have on the father-child relationship and recognize the need to work with mothers to help them support fathers' involvement (Tiedje & Darling, 2003).

The most consistent findings concerning children's involvement and children's outcomes in low income, minority, and unmarried parent families focus on children's cognitive and educational attainment (Coley, 2001). These studies controlled for family socioeconomic status, considered children at various developmental stages, used a wide variety of measures and a broad definition of fathers. A consistent finding across this research is that more involvement by fathers correlates with better cognitive and school functioning by children (Coley, 2001).

Paternal beliefs about fathering and parenting responsibilities, forged by familial, moral, religious, and cultural influences, may also play an important role in determining father behaviors (Coley 2001). However, there has been relatively little written explaining how paternal involvement leads to better childhood outcomes. The theories available in the literature on paternal prenatal involvement are sparse and rarely addressed.

2.2.1 Theoretical Background

Several factors affect a fathers influence and involvement in the prenatal process at multiple levels, ultimately impacting both the mother and the child. There has been no concrete theoretical framework to address this issue. Theories have been taken from numerous disciplines to create and guide work with fathers in paternal influence and involvement. However, the social ecological model considers the complex interplay between, individual, relationship, community and societal factors (CDC, 2007). The model contains four levels, which intertwine with each other to create a framework for the theory. In essence, it mirrors the multiple factors that influence fathers. For this reason, the model is used in this thesis to foster an infrastructure for prenatal inclusion.

The Social-Ecological Model was developed to help practitioners better understand and learn how to create effective prevention programs. The model supports a comprehensive public health approach that not only addresses individual risk and protective factors, but also the norms, beliefs and social and economic systems that create conditions (wcas, n.d; Jewkes, Sen, Garcia-Moreno, 2002). It was built to show that in order to effect behavior change, programs need to address the target audience at multiple levels.

The individual level identifies biological and personal history factors (CDC, n.d). Some of these factors are age, education, income, substance use, history of abuse, or impulsive and other antisocial behavior. The relationship level includes factors that increase risk because of relationship with peers, intimate partners and family members. The community level explores the settings, such as schools, workplaces and neighborhoods, in which social relationships occur (CDC, n.d). The societal level examines broad societal factors (CDC, n.d). These factors include social and cultural norms, health, economic, educational and social policies that help maintain economic or social inequalities between groups in society.

Figure 1. CDC Social Ecological Model

2.2.2 Biological Factors in Paternal Behavior

Men may define the period during pregnancy, as a time of transition, as they seek to define their identity and sense of self (Barclay, Donovan & Genovese, 1996; Jordan 1990). Fathers with a strong commitment to parenting and an attitude that they have a responsibility to parent are more likely to be more involved fathers. Moreover, in a study of adolescent fathers, disinterest in childrearing was consistently found to predict a lack of involvement (Rhein, Schwarz, Pint-Martin, Zhao & Morgan, 1997).

Men experience pregnancy differently than women. Grappling with the reality of pregnancy and the child is central to the father's experience. The reality of the child's birth serves as the stimulus for taking on the identity of a father (Jordan, 1990). Many men may face the notion of creating new ways of being fathers as they may strive to be different from their own fathers in behavior and skills that they have observed.

During pregnancy women go through hormonal changes. Researchers have noted that fathers also undergo hormonal changes during their mates' pregnancy and childbirth. Storey et al., (2000) found that men experience significant prenatal, perinatal and postnatal changes in three hormones-- prolactin, cortisol and testosterone. According to Jordan (1990), the essence of the experience of expectant and new fatherhood is working for relevance, which has both intra and interpersonal aspects. Working for relevance is the process of consisting of three sub-processses: grappling with the reality of the pregnancy and child, struggling for recognition as a parent from a mate, co-workers, friends, family, baby and society, and understanding the role-making of involved fatherhood (Jordan, 1990).

In relation to prenatal health care services, fathers need to be included as clients in the provision of health care. The transition to acknowledging fathers as clients, means letting go of

the comfort, confidence and frameworks that have developed for working with mother-baby dyads (Bridges, 1991). For fathers to be considered as prenatal clients means forming a new paradigm of the prenatal client that includes the father, that is the mother-baby-father triad, will need to be incorporated in the health care system.

2.2.3 Paternal Involvement in Pregnancy Outcomes

To date, little is known about whether and how father involvement affects birth outcomes (Padilla and Reichman, 2001). Few studies have focused on the dynamics of paternal involvement in pregnancy and pregnancy outcomes. However, two crucial studies examine whether greater paternal involvement is likely to have a negative or positive effect on the mother and child. *In Low Birthweight: Do Unwed Fathers Help?* Padilla and Reichman (2001) examined the affects of birth outcomes during pregnancy based on the parents' relationship status and financial support provided by the baby's father. They sought to find out whether these factors influence the likelihood of delivering a low birthweight baby. The importance of birthweight is that is has long been considered an indicator of a child's health, longevity and well-being. They also examine the extent of racial and ethnic disparities in birth outcomes.

Padilla and Reichman compared birth outcomes of Mexican Americans to non-Hispanic blacks and non Hispanic whites. The researchers incorporated socioeconomic status, health characteristics and health behaviors within their study. They expected that mothers from a higher socioeconomic status would be healthier and thus have better birth outcomes. They measured community support, family support and mothers' attitudes and values. They hypothesized that religious beliefs, social support systems and traditional attitudes about

marriage would partially explain the better birth outcomes of Mexican Americans compared to African Americans.

They took into consideration the effects of father involvement on birth outcomes of unmarried mothers. They were interested in determining whether unmarried mothers who lived with or received financial assistance from the fathers would have more favorable birth outcomes, than those who did not have that support. Their findings show that mothers who were romantically involved and lived with the father had a higher birthweight compared to those who did not reside with the father. Among unmarried couples the father's financial contribution was found to be linked to lower rates of low birthweight. The researchers note that racial difference in birth outcomes within the populations studied did not vary in the level of father involvement.

Teitler (2001) warns against making inferences based on the results that married couples who reside together will have better pregnancy outcomes. He states that it may be incorrect to conclude that father involvement affects low birthweight. He points out that other factors may be involved, such as the father's desire to have a child.

Bronte-Tinkew et al. (2007) conclude that men with higher scores on the prenatal behavior index are more likely to exhibit positive postbirth engagement in five domains: cognitively, stimulating activities, physical care, warmth, nurturing activities, and caregiving activities. In contrast, men who did not want the pregnancy are less likely to exhibit warmth following birth. These findings provide evidence that positive pregnancy intentions, especially prenatal behaviors are related to positive father engagement for resident dads (Tinkew et al, 2007).

Julian Teitler, (2001) in *Father Involvement, Maternal Health Behavior and Birth Outcomes* examines whether the level and effects of father involvement influences child's birth

weight and mother's health behavior during pregnancy. Teitler found that father involvement effects are strongest for prenatal care and weakest for low birth weight. Fathers may influence the mother to obtain prenatal care, but his influence may not be as strong when it comes to changing health behavior. Stopping the use of alcohol, smoking and drugs are much harder to change and take greater effort.

Teitler's comparison of married and unmarried mothers and paternal involvement found that the most consistent and positive effect in the mother's health behavior and baby's birth weight was with married couples. Marriage correlates with the likelihood for a baby to be born with a normal birth weight. Marriage also has a positive influence on prenatal care; however it has a negative association with drug and alcohol usage. Unmarried, cohabiting fathers' involvement has no effect on birth weight but has a positive influence on early prenatal care and over-all mothers' health behavior. The father's involvement also decreases the use of alcohol and drugs. For non-cohabiting relationships, there are no positive or negative effects with the father on health behavior. Interestingly, birth rates are worse for this group than for mothers who are no longer in a relationship with the father. Teitler (2001) states that perhaps mothers who are no longer in relationship have higher levels of social support from their family. Overall the results indicate that the more involved the parents are the better the outcome. The results are very consisted with the notion that father involvement benefits the mother (Teitler 2001).

2.2.4 Fathers and the Health Care System

It is important to promote fathering through preparation, in order to address and resolve issues prior to the baby's birth. An involved father can be the primary support person for his partner during pregnancy, and mitigate adverse health and social outcomes in his children's lives

(Hoghughi, 1998; McBride & Darragh, 1995.) In essence, father's could be more supportive in the process, if they were aware of what was going on during the prenatal process, feel comfortable communicating with the medical staff and felt acknowledged and included by health care professionals. According to Hall (1992), a man's potential to become an involved, nurturing father is influenced by prior learning experiences, developmental readiness, and means of support. Although men and women become parents at the same time, they do not become parents in the same way (Watson et al., 1995).

Levels of paternal involvement are likely to be the highest at or around the time of the child's birth (Teitler, 2001). This would be an optimal period of time for health care professionals to engage fathers, involve them in the decision making and acknowledge his presence and position in the birth of his child. Greater involvement of fathers is unlikely to be an effective way of improving children's birth outcomes unless it is accompanied by effective prenatal care (Teitler, 2001). Care that helps mothers adopt or maintain health behaviors.

Health professionals, especially physicians, nurses and social workers need to engage fathers while providing health information about their child in a way that meets the needs of fathers. Nurses, in particular, should be aware that the promotion of father involvement can be beneficial for pregnant women and their babies. Findings by Gage and Kirk (2002) show that there is a need to engage fathers in the prenatal care of the mother and infant. Fathers, also, have unique needs as they prepare to become parents. Teitler (2001) concludes from his research that fathers influence mothers health behaviors, therefore this might translate into positive birth outcomes if the prenatal care mothers receive is effective. Prenatal programs and care have to be comprehensive and inclusive of the mother and father's needs during this time.

James May, Director of the National Fathers Network, produced a video on African-American men in the health care systems. He observed that even when both parents were in the room, health care professionals rarely gave father's eye contact. May, expresses that mothers were seen as the designated experts. When fathers came to an appointment by themselves with their child, professionals tended to ask, "Where's your wife?" These interactions provide a message that fathers aren't capable of seeing to their children's needs or know enough about their child's health to adequately speak for them in a health care setting. Granted, the actions of the health professional may not have been intentional nor done to make the man feel incomparable, but it sheds light on the way in which the health care systems views fathers in some capacities. Health care professionals may not be aware of their actions; however this provides more of a reason to bring this issue to the forefront of health care. Some fathers have voiced that they deem healthcare professionals as a credible and reliable source of information, therefore healthcare professionals can send a very different and powerful message to fathers they are important in the process.

May states that the notion that not only bearing but raising children is fundamentally a female responsibility is encoded in our most basic health care symbols (Weissbourd, 1999). Felton Earls, a family and community researcher at the Harvard School of Public Health, points out, we still have departments of maternal and child health, not departments of paternal and child health (Weissbourd, 1999). The Father in maternal child health is non-existent. It takes both an egg and a sperm to create a child, one is not able to reproduce without the other; therefore we cannot exclude a portion of the equation when it comes to health care either. Both units are just as important in the life of a child. Mothers have taken care of their children throughout history with or without a help mate, recognizing father's does not diminish the important roles mother's

play. Moreover, it helps to elevate all the responsibility that is placed on the mother's shoulders and provide a child with two persons to rely on throughout their life.

The lack of programs offered to fathers through the health care system that focus predominately on their needs and concerns during the prenatal process are minimal. Many programs were originally developed with the mother in mind and then revised to include or focus on fathers. What we understand most about parenting has been developed based on theory and research developed on mothers. Weisbourd (1999) stresses the importance for fathers to routinely see themselves as caregivers for their children, managing alongside mothers their children's daily lives, without fanfare. If children benefit from fathers involvement and engagement in aspects of their lives, then that needs to be reflected in the institutions that help raise children and support families (Weisbourd, 1999). The challenge is making inclusion of fathers an intentional component of healthcare (Tiedje & Darling, 2003).

3.0 METHODOLOGY

The data represented in this study are collected from 3 data sources: literature reviews, key informants, and in-depth qualitative interviews. This method was used to gain robust insight into the paternal prenatal process from various sources. Due to the sparse literature on paternal involvement in prenatal care, I gathered information by conducting and analyzing literature reviews on several father involvement programs. I utilized experienced social workers as key informants. The social workers I consulted with had over 10 years of experience in the OB-GYN unit; therefore they had candid insight into the prenatal process and paternal involvement. Additionally, I conducted in-depth qualitative interviews with fathers who had been involved in the prenatal process of their children.

Approaching qualitative research utilizing my social work skill set was invaluable in the process of collecting data from the men. In social work the importance of gaining entry is crucial to the dialogue in the client patient dynamic. I began the qualitative interview process gradually and then built up to more complex questions to foster an open forum. The practice skills I learned in social work helped me facilitate a more open-ended approach and allowed the research participants to reveal what they wished in a manner that they wished to produce candid stories and accounts in which I could then derive productive meaning. The essence of qualitative research is flexibility, in social work you are taught to probe when appropriate and gauge whether a structured, unstructured or semi-structured interview would be more appropriate. The

flexible nature of qualitative interview allowed me to add subsequent questions and delve into statements and learn more about the context from the father's perspective. The skills taught in social work helped create structure in an effort to avoid being overly controlling of the conversation or guiding the interview towards a certain view point.

Three men were interviewed. Each father in the sample had a different relationship dynamic with the mother of his child. For instance, one father was married, another father considered the mother of child his girlfriend, while another considered the mother of his child as a friend or an acquaintance. Institutional review board (IRB) approval was obtained for exempt status through the University of Pittsburgh.

3.1 FATHER INVOLVEMENT PROGRAMS

In June, 1995, the Clinton Administration launched a government wide initiative to strengthen the role of fathers in families. Recognizing men's important role in their children's development, the U.S Department of Health and Human Services' Head Start Bureau began a fatherhood initiative in the mid 1990's to actively engage fathers in their children's Head Start program and to facilitate health interaction with their children (Child Welfare League of America, n.d). Head Start is a national program that promotes school readiness by enhancing social and cognitive development of children through education, health, nutrition and social activities. The Father Involvement initiatives have increased over the past several years, in an effort to foster positive relationships in the lives of their children. Increased father involvement with infants and young children has resulted in a demand for effective programs for fathers

wanting to learn more about parenting during the child's early years (Magill-Evan, Harrison, Benzies, Gierl and Kimak 2007).

Although the benefits of father involvement on child development have been well documented and multiple theoretical models for father engagement exist, there are relatively few evidence based practice models for guiding public health programs (Navaie-Walsier, Jones, Spriggs, Ensler, & Lincoln, n.d). Moreover, few evidence-based models guide programs on how to successfully engage fathers as active participants in their children's lives (Navaie-Waliser, Jones, Spriggs, Ensler, Lincoln, 2007). Compared to mother initiatives, father involvement interventions and research are lacking. Historically, the research has been focused on the mother, primarily because the mother was seen as the immediate caregiver for the child. As previously mentioned, programs for fathers are frequently based on classes originally designed for mothers (Doherty, Erickson, & La Rossa, 2006). However, there have been father involvement interventions that have been successful in engaging male investment, responsibility and relationship with their children. Healthy Start Pittsburgh, PA reports that for a program to be successful it must be holistic in approach, community-based and culturally sensitive, multi-disciplinary, collaborative across systems, prevention-principled and outcomes-oriented.

3.1.1 Early Head Start Program

Early head start promotes healthy prenatal outcomes; it enhances the development of infant and toddlers to promote healthy family functioning. The program serves children and their families from birth to age three. Through its Father Studies Work Group HHS's Early Head Start Research and Evaluation Project was amongst the first to investigate the role low income fathers play in the lives of their children and toddlers. Parent involvement has long been one of the

cornerstones of Head Start, and fathers are encouraged to participate in all aspects of the program (Father Involvement, 1998). Almost all Early Head Start Programs invite fathers to participate. Most make efforts to interact with fathers who accompany mothers (Child Welfare League of America, n.d).

Nationally Early Head Start has embarked on implementing a number of adjustments to become more father friendly. For instance, they have incorporated the use of multiple recruitment methods to engage fathers. Head Start (2004), outlines their procedures in the following way, they train staff to work with fathers, and provide a toolbox of activities to implement in challenging situations that may arise. Father involvement coordinators are hired to take ownership of initiatives to engage fathers. Early Head Start Programs also collect enrollment information on fathers, by providing space on their applications to include the father's information. Regardless of whether the father is involved with the mother, the father can still be contacted about activities he can participate in with his child and be addressed by placing their name on mailed material. They also use multiple recruitment methods to engage fathers—noting that different cultural groups may respond to certain outreach methods over others, and incorporating knowledge about activities and methods to which specific father respond to improve father involvement. The program offers activities at convenient times and locations to accommodate fathers' schedules. Moreover, they educate fathers on the importance of their role in their children's lives.

Efforts to promote father involvement increase father participation (Kaye, 2007). Early head start programs that incorporate fatherhood involvement strategies have significantly greater father participation—77% participate in programs with fatherhood initiatives, compared with

27% in standard programs (Head Start Bureau, 2004). The program is successful because they make an effort to acknowledge the father and his role in his child's life.

The Father Studies Work Group found the biggest barrier to involving fathers in programming is fathers' work schedules, followed by fathers not living with mothers and children. Another barrier was the lack of male staff to whom fathers could relate and disagreements between father and mothers (Child Welfare League of America, nd.). Gate keeping by mothers was found to be one of the factors that impede programs from achieving father involvement. Inappropriate program design and delivery is also mentioned as one factor impeding father involvement. According to Head Start Bureau, barriers stem from program design and philosophy, including concern that increasing funding for providing services to men will drain limited fiscal resources (Child Welfare League of America, n.d). Research reveals that due to a lack and confidence among staff, understanding how to best work with fathers, an attitude of ambivalence can be a factor impeding Head Start and state-funded pre-kindergarten programs from achieving father involvement (Head Start Bureau, 2004).

The strengths of Early Head Start are that the program strives to develop and implement innovative practices to increase father involvement. They have made strides to incorporate fathers within their day to day programming. The program acknowledges that all fathers are not the same; therefore they adapt the program by using various recruitment methods. They have also taken steps to provide tool kits as guides when confronting difficult issues, this helps to speak to the fact that implementation may not be easy but there are some steps to deal with the situation. Hiring males as father coordinators reinforces the fact that they are willing to seek out staff to sustain and run the project.

3.1.1.1 Early Head Start: Visiting Nurse Services of New York

Based on its experience serving fathers and families in a New York City Early Head Start program, Visiting Nurse Services of New York (VNSNY) has developed a practice model for father engagement (Child Welfare League of America, n.d). The Father First Initiative in Far Rockaway, New York is implementing this model; it also offers counseling, house visitation, education and skill training, employment assistance and linkages to Early Head Start and other community-based activities (Child Welfare League of America, n.d).

The evidence-based practice model for father engagement consists of six progressive action steps. This model at its core relies on past theories and is based on eight years of cumulative practice based evidence from Father's First Initiative. Researchers, Navaie-Waliser et al., (n.d) states that, the first step emphasizes a culture of inclusion. For this step to be successful, EHS must (1) have clarity about what is meant by father involvement, a father may not necessarily be the biological father, it may be step father or an important male figure (b) receive training with regards to technique that are effective in interacting and building relationships with fathers, (c) perform a self-assessment to uncover personal beliefs, experiences and value placement regarding father involvement. There also needs to be a physical environment that welcomes fathers. For instance a display of father pictures with children in an open forum and print materials that are father focused (Navaie-Walise, et al., nd).

Step 2 involves various strategies for making initial contact with fathers, including community outreach (active or passive), home-based outreach, obtaining referrals from mothers, accepting self-referrals or receiving referrals from other sources. Step 3 focuses on relationship building based on the concept of generative fathering, defined as fathering that meets the needs of children by working to create and maintain ongoing supportive and ethical relationships

between a father and a child (Navaie-Walise, et al., nd). Building relationships between EHS staff and fathers involved collaboration (providing relevant and timely information and consistency of contact); Patience (building trust and allowing the process to be driven by fathers); reflection (staff must remain non-judgmental and have varying levels of acceptance of fathers' lifestyles and behaviors) (Navaie-Walise, et. al, nd).

Step 4 involves making assessments to support fathers' underlying reasons for wanting to become engaged in their children's lives by helping them express their motivations (emotional, tangible and/or social) and needs (intrinsic and extrinsic). Step 5 requires that EHS staff assist fathers with prioritizing incremental actions steps to increase participation in their children's lives (Navaie-Walise, et. al, nd). Step 6 outlines diverse home-based, center-based or community based activities for engaging fathers with their children, the child's mother, the EHS program and its staff and the community (Navaie-Waliser et. al, nd).

The six steps mentioned above are as follows:

- Create a culture of inclusion with father friendly environments;
- Provide both passive and active outreach;
- Build relationship through collaboration, patience and, reflection;
- Assess needs and motivations to cultivate fathers' "buy-in"
- Prioritize goals from easier to harder; and
- Provide diverse opportunities for engagement at many levels—individual, family, program and community

The success of this program is due to the fact that it engages men as early as possible. The program is community centered so it has a connection to the men they serve. The initiative is a strengths based-approach that focuses on collaborating with participating father and

developing a culture of inclusion. David Jones, Director of Family Support Services VNSNY, expresses

"There are many losses for the male during pregnancy, and the gains are difficult to realize, especially in the first to half of the pregnancy while the baby is still not real to him (Jones, 2007)." The Father's First program attempts to tackle the losses by offering a comprehensive program that deals with the whole man and different aspects in his life. The goal is to help men bond with and nurture their child. The program has the potential to be replicated at other EHS program or be adapted in part for other father involvement initiatives.

3.1.2 Steps Toward Effective, Enjoyable Parenting (STEEP)

An intervention carried out to enhance the quality of father-child interaction, utilized a randomized experimental design of 165 couples to evaluate an 8 session program. The intervention focused on first time parents in their second trimester of pregnancy and ending at five months post partum. The intervention outcomes were assessed with time diaries, coded observations of parents' child play and self reports. The results of the intervention showed positive effects on fathers' skills in interacting with their babies and their involvement (Doherty, Erickson & LaRossa, 2006). Researchers concluded that a brief intervention during the transition to parenthood can improve fathering.

The eight session intervention included an initial individual home visit and subsequent group sessions in the clinic. The curriculum was developed by using elements of STEEP (Steps Toward Effective, Enjoyable Parenting Program and previous successful intervention studies with fathers. The curriculum consisted of mini lectures, group discussion, videotapes, and demonstration of skills, role playing, and use of new parent role models. The rationale for doing most of the

intervention in groups was to foster an environment where group members could learn from one another and be encouraged by each other, in addition to making the intervention more cost effective.

The educational content and process of the intervention was to enhance fathers' knowledge, skills and commitment to the fatherhood role; to increase mothers' support and expectation for the fathers' involvement' foster co-parental teamwork in the couple; and to have the couple deal more constructively with contextual factors (Doherty, Erickson & LaRossa, 2006). The sessions were conducted by licensed parent educators. Male-female instructors were used in order to give fathers and mothers a same gender teacher with whom they could relate.

The researchers finding suggest that brief couple-oriented group interventions that is and delivered by community-based parent educators can impact the transition to fatherhood, particularly in men's skills with their infants in time involvement during work days. The strengths of this strategy are that it was couple driven. Each individual in the couple could hold one another accountable to attend sessions and learn the material being taught about transition into parenthood. The couples were also receiving the same material at once, so that they could discuss information further at a later date. The intervention used instructors who were both male and female to give a gender based perspective. This helps to provide an open forum for questions that are gender specific. An additional strength is that the intervention used multiple activities within the curriculum so that each session wasn't mundane. The father had the opportunity to put his learning into practice through role playing and demonstrations.

3.1.3 Young Dads Parenting Program

Mazza (2002) highlights the fact that adolescent fathers are frequently neglected both as potential resources to their children as well as clients with their own unmet needs. Mazza's (2002) study explored the needs of urban African-American adolescent fathers and how to best meet their needs so they can experience personal success and become consistent and nurturing fathers. In a parenting program focused on young African-American adolescent dads, sixty males were randomly assigned to two groups to study intervention strategies. The focus was to help these adolescents develop better and more consistent relationship with their young children (Mazza, 2002). The impact of individualized social work intervention with African American adolescent fathers was measured. It was presumed that male social workers would be better able to establish an effective therapeutic relation and provide a positive role model for parenting (Mazza, 2002).

Thirty fathers were randomly assigned to each group, either experimental or a control group. An interview was conducted with each father to measure their perception of themselves, of their children, children's mother, support systems, ideas of fatherhood and their goals for the future (Mazza, 2002). The experimental group received weekly individual counseling, biweekly group counseling, educational/vocational referrals and placements, medical care and referral, and parenting skills training. The specific intervention for these young men was tailored around goals they had set for themselves. The control group received the weekly group parenting skill training and was invited to participate in hospital or child welfare agency case planning.

Results of the study indicated that programs for young fathers that focused only on teaching parenting skills were ineffective (Mazza, 2002). Significant statistical changes were noted

between the control and experiment group especially as it related to current relationship with child and predicting the equality of the future relationship with the child. In six months, after the subjects were administered the interview schedule for the second time, the experimental group rated the quality of their current relationship with their children at 77%, “excellent” or “good” compared to 50% of the control group. When asked to predict the closeness quality and consistency of their relationship with their children in the future, 63% of the experimental group projected that their future relationship with their children will be “excellent”, compared to only 27% of the control group (Mazza, 2002).

Mazza (2002) states that fathers continue to receive fewer services. The cost to implement comprehensive individualized service to young African-American fathers may be expensive. However, in terms of adding to community participation and lessening the social burden of caring for indigent children as well as building families and holding them together the benefits are to both individual and society’s favor (Mazza, 2002).

The strengths of this intervention are the comprehensive individualized service. The needs of the father are determined and the social worker assists in addressing these needs. The male role model to guide these young men is invaluable, they are able to engage in a relationship with the social worker and build trust. Another key strength of the intervention was that it looked at the whole young man not just the fact he was a father and was in need of parenting skills, but it explored his feelings, strengths, concerns and fears regarding himself and his ability to parent.

3.1.4 Hit the Ground Crawling: A Peer Mentoring Scheme for New Dads

The Fatherhood Institute is a fatherhood think-tank based in the United Kingdom. It strives to collate and publish international research on fathers to disseminate different approaches to

engaging with fathers. It helps shape the government's family policy and influence the public's debate on fathers to ensure a father-inclusive approach. It also trains family services to be more inclusive. It is the UK's leading provider of training and consultancy on father inclusive practice. Part of the Institutes vision is for a society that gives all children a strong and positive relationship with their father and any father figures (Fatherhood Institute, n.d).

Hit the Ground Crawling was developed to enable high quality services to support positive father child relationships. It was originally adapted from a highly successful US model. The program involves small groups of expectant fathers with two or three fathers who have recently had babies, (mentor father) with those babies present. A trained facilitator is present in the group. There is no specific curriculum or list of things provided to "tell the expectant fathers". The approach instead is for the expectant fathers to discuss their thoughts and concerns with other fathers and have the chance to see practical baby care by fathers.

The advantages of this program are that it provides a forum for fathers. It demonstrates that fathers are capable of taking care of their children. It fosters companionship amongst the men that bring a sense of normalcy to their situation. It offers comfort to the fathers that they are not going through this alone. It provides an avenue to discuss their feelings and emotions and ask for advice and information on how to cope. It promotes peer to peer learning and discovery as well as fosters father roles and responsibility.

3.1.5 Review of Programs

In sum, several intervention programs have been developed to address father involvement. More programs have been designed to prevent teen pregnancy and discourage father absent families which have demonstrated some success. Programs that have been successful in father

engagement demonstrate that comprehensive services are advantageous. While there has not yet been a systematic effort to get father involved prenatally, there are programs and agencies nationwide that have taken up the cause (first nine, 2007). Their approaches include the intentional engagement of fathers in prenatal clinic visits; fatherhood preparation classes focusing on infant care and fathers' roles as care (first nine, 2007). Though paternal support efforts hold promise rigorous research design and evaluation information are needed.

3.2 WHAT FATHERS ARE SAYING

The catalyst for this paper was based on a set of interviews conducted with a sample of men who recently engaged in the prenatal process. The original premise of the study was to find out more about fathers' engagement in the prenatal process. The focus remained the same throughout the study, but broadened to encompass fathers' engagement during delivery and directly after the birth of their child. I chose this subject because of my experiences as a Social Work Intern at the Magee Womens Hospital in Pittsburgh, Pennsylvania. I worked in the out-patient OB-GYN unit. I was intrigued by the interactions or lack there of, between the medical staff and the father of the baby. Although some fathers attended prenatal visits, I noticed that in some cases, they were not specifically acknowledged throughout the visit. I contemplated whether the fathers felt a part

of the whole experience. Researchers have noted that fathers who accompany the mothers on prenatal visits were more likely to engage in father-child activities later. Their presence at the birth of their children also was positively associated with later father-child activities.

Each woman's situation was different. Furthermore, each father was different in terms of his investment in the relationship and the pregnancy. Some women were accompanied by the father of the babies, who were supportive. Several women attended each visit alone. Some women explained that the father of the baby was supportive, but they were no longer together. Others stated that they were estranged from the relationship and the father of the baby was not involved in any capacity. I witnessed that the relationship between the mother and father affected whole birthing experience.

Through my various experiences in the clinic, I contemplated whether the fathers felt they had a voice in the experience? Did they feel comfortable voicing their opinions or concerns to the physicians? Did they feel as if they were in the forefront or background of the process? Did they view the prenatal process as solely women's journey? I set out to gain a better understanding of the father's experiences and perceptions through this research study.

3.2.1 Respondents

Three men were interviewed. The first respondent will be referred to as Miles. This is the first pregnancy for both Miles and his girlfriend. His daughter is 9 months old. He attended some of the visits, approximately 8 to 10. He could not recall the total number of prenatal visits the mother of his child attended. During the pregnancy, Miles resided in Pittsburgh, while his girlfriend lived in Ohio. The second respondent will be referred to as Peyton. This is Peyton's second pregnancy; his first daughter was with another woman. Peyton does not consider the

mother of his child his girlfriend. He would refer to her as a friend. This was her first pregnancy. Peyton's daughter is 2 years old. He attended few of the visits. Both Peyton and his daughter's mother reside in Pittsburgh. The third respondent will be referred to as Kevin. This is Kevin's third pregnancy. He attended most of the visits. His first two kids were with another woman. Kevin is married. This is his wife's first pregnancy. His son is 8 months old. Both Kevin and his wife reside in Maryland.

3.2.2 Access Issues

Initially, I had planned to interview fathers in the OB-GYN clinic setting. After much contemplation, I realized that for the purpose of this study, the clinic would not be conducive. The clinic could get extremely busy and there was a high demand for the limited amount of space. The plan was to conduct a 45 minute to an hour interview with each respondent. As mentioned, this was not feasible due to the demand for examination rooms and office space throughout the day.

My initial thought process was to approach couples in the waiting room to explain my research project and ask whether the father would be willing to be interviewed. The waiting room is an open space, with patients in close proximity to one another. I questioned whether ethically it would be appropriate to approach individuals in such an open forum. I also would be making the assumption that the gentleman with the woman was the father, which could be incorrect. I also contemplated whether my conversation with the couple for initial screening would infringe on their privacy. They may not intend on keeping the baby. They mother and

father may have decided to give the baby up for adoption or abort, which may make my approach an uncomfortable one for the mother and father.

The mother and father most likely would not want to be separated to conduct an interview especially while waiting to see the doctor. They could be called in to the examination room at any time during their wait. If I were to conduct an interview during this time period, I would be interrupted during the course of the interview. This would have hindered the flow of the conversation as I would have to pick it up at a later date. Furthermore, there would be no compensation offered for their time, thus decreasing an incentive to speak with me.

Ultimately interviews were conducted with fathers out of the OB-GYN setting for the above mentioned reasons. I thought it would be beneficial to interview fathers who have recently gone through the process up until two year ago, so that they could reflect on their experiences. The data would be enriched, by the father's ability to recall the birthing process from the beginning to the birth of their child.

3.2.3 Sample Procedure

The study sample was small. However, the study findings were consistent with studies with a larger sample. The men were selected with knowledge that they had recently had a child. The men were included in the sample, if the birth of their child occurred within a 2 year period.

Initially, I had planned on utilizing a snowball sample. I did not utilize it because I was able to identify men who had recently delivered their children, within the specified time period. The advantage to this strategy was that the men were somewhat familiar with me, so they felt comfortable being candid about their experiences. Another advantage to this strategy was that I was able to include different relationship dynamics in terms of the relationships they had with

the mother of their children. One father was married, another father considered the mother of child his girlfriend, while another considered his baby's mother as a friend or an acquaintance. A disadvantage to this strategy was that the men were not culturally diverse; each father was African-American, although one father hailed from Sierra Leone, West Africa.

3.2.4 Data Collection

Prior to each of the three interviews, the respondent was provided an informed consent form, summarizing the study's intent, its potential risks, and given the option to stop the interview at any time, if they felt uncomfortable or did not want to proceed. Respondents were informed that they would be audio taped; they had the option to decline. No identifiable markers would be attached with the interview to preserve anonymity and confidentiality. This study presented no foreseeable risk. Respondents were made aware that summaries would be gathered and shared within a report in fulfillment with coursework. The interviews consisted of open-ended, in-depth qualitative questions designed to elicit personal experience. The questions were reviewed by a professor of social work, who was conducting and facilitating the qualitative research course and an IRB representative from the University of Pittsburgh. Notes were taken during each interview.

The interview process took place where the father was most comfortable discussing the subject matter. Each father provided his permission to record the interview. Interviews were conducted face to face; one was conducted over the phone. Strengths to interviewing the fathers in person were the capability to gauge their body language and facial expressions. This enabled me to assess the conversation, whether to probe further, or whether to change subject matters. I was able to observe their body postures and determine whether the specific topic was crucial to

his experience by his inflections in his voice and expressions. A limitation to the phone conversation was that I had to determine whether times of silence was a time to probe, or whether he was contemplating the question because I was unable to see him. Letting the men choose where they felt most comfortable interviewing helped to add to their comfort level to expressing themselves.

The strengths of having a tape recorder were having the ability to listen to the interview more closely at a later date. The tape recorder captures the interview in real time, so the accuracy is of the highest level. The limitation is that some fathers may feel uncomfortable with the recording and knowing that their conversation is documented. This may hinder them from being fully honest on the subject matter.

I utilized an interview guide with all interviews, to ensure that I addressed all the questions to be discussed. However, natural diversion was welcome, as it could provide insight and add to the information I was gathering. The interviews were conducted in a conversational manner, appropriate to qualitative data gathering. Emphasis was placed on the respondent's experiences and perceptions of the prenatal process. The strength of this data collection was that I could analyze questions later on and compare responses between the respondents. The limitation is that the conversation may not flow as well because the father may be anticipating the next question.

3.3 FINDINGS

Several themes emerged from the study data which described the personal needs, issues, and support needs of each father during the prenatal process. These findings were consistent with studies conducted with a larger sample size. A consistent topic arose from the men's account of their prenatal experience the feeling of exclusion, as one author stated in the literature review "the invisible or forgotten parent." At some point throughout the process each father mentioned this notion of exclusion. In describing their experiences, the men spoke about their interactions with medical staff, their concerns, feelings of inclusion and exclusion, advice, concerns, whether or not the birthing process was solely a woman's experience, program offerings, issues that hinder fathers and their perceptions.

I arrived at themes by analyzing my original question and brainstorming subsequent questions that would help reinforce my original focus. While I was doing this process I became cognizant of core topics that would help further my understanding of the research problem. While transcribing the interviews, I identified themes that were present throughout my interviews with the fathers. I also utilized my qualitative research classmates to help me decipher which themes stood out to them, while reviewing my interviews. As I listened to my tape recordings over and over again, issues that I had not identified at first became more apparent insight and therefore became a theme.

I arrived at my understanding of the data by comparing statements made by all three men to gain clearer insight. I reflected on my experiences as a social work intern in a clinical setting to analyze the statements that were made. I also conferred with my social work supervisors at Magee Womens Hospital to gain their understanding of circumstances and prompt me to look at

several scenarios that may affect the engagement of fathers' in the prenatal process. This paper will only address a few of these themes.

3.3.1 Exclusion

Each of the fathers mentioned a scenario during the pregnancy, where they felt excluded or like bystanders to the process. The fathers experienced exclusion in different ways. Miles felt as though the medical staff excluded him because he was not married to the mother of his child. He felt included in the whole process, until after the delivery of the baby. This depicts the power that the medical staff has over the father's experience of child birth.

However, Peyton's feelings of exclusion were based on his relationship with the mother of his child. He describes being invited to prenatal visits. He felt that his experience was very different from the mother of his child's experience. He had to adjust to the pregnancy because he felt he had been tricked by her. Kevin's feelings of exclusion where based on his own thought process, where he simply stated that it wasn't about him, it was about her, referring to his wife. He articulates that there wasn't much for him to do. Feelings of exclusion can come from many different places and can be influenced by separate things. Miles expresses the dynamics of his relationship with his girlfriend and how he felt he was excluded:

> *This lady and myself were not married and so after the delivery I noticed there wasn't really recognition as I was before the delivery. And um so I think that was really like it shut some people out like, I have taken part in all this process leading to this moment and here is this baby, she is my baby and all that, but then the hospital staff didn't give you the recognition that you think you deserve as the father.*

I went on to ask Miles, how he felt left out or disregarded from the process.

> *Like umm on the day that she had to leave the hospital even though she was weak and she didn't have enough strength to carry the baby and I offered to carry the baby to the car, they wouldn't let me handle the baby. Yes they brought a wheel chair to carry her downstairs that was one aspect and what else?*

I probed further asking whether they gave him a reason why? Or did he feel as though he knew the reason why he felt disregarded.

> *No umm….The reason was because we weren't married and so technically, the baby was hers until I was proven to be the dad of the baby.*
>
> He went on to report that,
>
> *you couldn't even fill the birth certificate as the dad, and she has to do everything and sign it, and has to send it. So, as a dad if you want to establish fatherhood you have to do the DNA or the paternity test and then later your name will later be added to the child's certificate or else the birth certificate will say dad unknown at time of delivery even though you are there and all of that.*

Peyton's feelings of exclusion stemmed from something entirely different than the other men. He felt as though he was tricked into the pregnancy, so he had a lot of mixed emotions. He was adjusting to the pregnancy and coming to terms with the fact that he would share parenthood with someone he didn't anticipate having a baby with. One father expresses how he was invited to the prenatal visits:

> *I was invited to a few of the prenatal visit towards the end.*

It could have been planned on her end. I wouldn't have known. She said she couldn't have babies.

Peyton believed that if they had gone through a midwife they would have experienced more patience and caring and less of an assembly line process with regards to the delivery. I asked Peyton why he and the mother of his child didn't utilize a midwife. Again his feeling of exclusion was expressed when he stated:

I didn't have much control over the process. It was her body she was dictating the process the way she wanted to do it.

Kevin's feelings of exclusion were in regards to his engagement during the prenatal visits.

I wasn't too engaged I pretty much sat and listened.

The process being all about the woman there was not too much for me.

He then went on to say that, there was not much to do but be supportive of the woman.

One of the fathers explained how he asserted himself by making the doctor aware of his concerns regarding his girlfriends condition during the pregnancy, because he knew he wouldn't be asked directly by the doctor. Exclusion was also felt when fathers were asked to physically leave during physical examinations and when specific information was being discussed.

3.3.2 Focus on Mother

I explored the theme entitled "Focus on Mother". All the men at some point in the interview felt that the mother was the focus of the prenatal visit. The similarities of the responses from the fathers, made me conclude that the men unanimously felt that the women were the primary

focus. Whether they felt included in the process or not, they felt the process was geared towards her in every form and fashion. As one father explained:

> *Most of the questions were actually directed towards the pregnant lady.*
>
> *The doctors pretty much did not like just sit there telling the lady "Oh you should be going through this". Most of the time they were asking questions; she was the one going through the experiences and asking about any concerns any issues.*

In reference to the prenatal process,

Peyton's view on whether the focus was on the mother was articulated as follows:

> *Initially with the first child I thought it was all about the baby, but it was about the mother.*

Kevin made the following comments throughout the interview with regards to the prenatal process being focused on the mother.

> *"It's more of an experience for the woman"*
>
> *"This is a woman's time"*
>
> *"The mother sets the tone"*
>
> *"The process being all about the woman there was not too much for me."*

The men in the study commented on the advise they were given by family members and other fathers. The often spoke about how they were told it was a women's time and that she will be going through numerous emotional and physical changes and it would be the man's responsibility. None of the men discussed a forum where they could voice their concerns in an open manner and receive guidance and advice on how to move forward in their role as a father.

3.3.3 Medical Staff Interaction

Two of the three fathers raised the same concern, with regards to how the medical staff interacted with them. Their reasons were different, but what is intriguing was the magnitude of the interaction, it left a strong impression on them and affected how they viewed their experience with the medical staff. All of the fathers, state that they were never posed a question by the medical staff, regarding the child or any issues they may have been concerned about. This is a failure by the staff; these men should have at least been asked whether they had any concerns or questions about the pregnancy. After all, these are their children too.

Miles had made it a point to do his research before attending the visits. He felt comfortable broaching question to the medical staff. He also felt that the medical staff acknowledged him as the FATHER throughout the process. When asked how often the medical staff asked him a question he stated never. As one father explains:

> *Miles: Like Umm…A couple of times, you know if I read something on the web and we went for the visit and that never came up between her and the doctor, I may usually broach concerns about that one thing.*
>
> *Sharon: Did the medical staff acknowledge you as the father of the baby?*
>
> *Miles: Yes, during the visits*
>
> *Sharon: They did...ok, how often did the medical staff pose a question to you during the visit?*
>
> *Miles: None, like I mean I would probably say 100% of the questions were directed to her.*

Payton felt comfortable with the prenatal visits. He thought the process was very similar to his first daughter's birth, so he felt knowledgeable. He felt that the Doctor's were insensitive and

could have provided more information about the process. In Payton's case, the medical staff never posed a question to him either. As one fathers described his perspective in the following manner:

> *They induced her on the 22nd. It wasn't natural. I think most doctors are insensitive, it's all about them. More information about the process would be helpful. The doctors know what they are trying to accomplish in every visit. They should draw it out for people. What types of things they're looking at and checking for, they should have an outline. First, second, third trimester and include child development, women's health wellness, put more info out there in layman's terms.*
>
> *The first time I was shocked the whole time. I didn't know nothing about no dr. giving an exam putting his whole hand inside a woman. But you know that was shocking.*

Kevin felt that the Medical staff did acknowledge him as the father. Although, he stated the medical staff never posed a question to him. He felt comfortable bringing up concerns to the staff and he did feel as though they understood his concerns as a father.

> *I guess at times the medical staff wasn't as informative. They were just saying she was okay. They provided no detail as to how the baby was doing at times.*

Fathers noted that it was a common scenario to often not be able to ask their own questions or broach their concerns. The fathers felt that the information the Doctors had to provide was valuable and had credibility, but their question or concerns were not of interest as much as the mothers of their children's questions. Two of the fathers felt that the mothers care could have been better or that alternate techniques could have been used during the pregnancy, but not one mentioned that to the medical staff taking care of the baby. This may be credited to their interactions with staff previously, where they felt that their concerns were not of importance.

3.3.4 Solely a Womens Experience

I found it intriguing that two of the three men stated that it was a woman's experience. One of the father's went on to talk about his feeling of being overwhelmed. I took this to mean that the mother had her experience, but so did the man. The experience may have been different in some ways, but in others ways it was mutual. One father states no, no, no this was not solely a woman's experience it depends on the dynamics of the relationship between the couple. This shows that the interaction between the couple impacts the birthing experience. As one father explains:

> *I personally was overwhelmed, you know with the experience seeing the sonogram and all that sort of thing was very overwhelming for me yes.*
>
> *No, no, no, it depends how much the guy is involved in the process. Is it a planned pregnancy, if it isn't, is he going to buy into the idea that they are going to have a child.*

Kevin articulates:

> *Yeah, there is not much to do but be supportive of the woman.*
>
> *This is a woman's time any woman that is pregnant this is her time. So…uhh you adjust and adapt to the environment that you're in with her, so if her moods change you adapt.*

The impression from the fathers was that their need for identity during this time was not addressed. The men expressed how their need for acknowledgement and information was non-existent, unless they made an effort to seek it out or voice it themselves. One of the fathers never addressed his need for support at all, he was consumed with the notion of what he had been told by a friend, that this was not a time for him at all this was a time for her, the mother.

3.3.5 Program Offerings

Whether a father will take part in a program is based on his personal preference. One father stated that he would not go to a program if it were offered because he feels he doesn't need it. Two of the fathers expressed they would attend if it were offered. They each had their preferences in term of how long it would be and what should be included within the program. One of the fathers describes his interest in programs in the following manner:

> *Miles: Yeah, yeah, I would have.*
>
> *Sharon: What would you have liked for it to entail?*
>
> *Miles: Any program that would enhance your knowledge your skill in handling pregnancy or even the child after that the baby would be very helpful.*
>
> *Peyton states:*
>
> *It depends on how long, how detailed and whether it included the whole process.*

They commented that generally they received their information from websites and books for expectant fathers as well as their own experiences from previous birth. However, they expressed that most of the information was targeted for the mother. One father stated that Lamaze classes he attended definitely were all about the women in the birthing process. The fathers were just an accessory.

4.0 DISCUSSION

The major message conveyed from the literature reviews and qualitative interviews is the need for father full acknowledgement of fathers as part of the prenatal process. The overarching theme was the "invisible" or "excluded" parent within the prenatal process. This was found in the men's accounts of their prenatal and birthing experiences. The lack of data available on father's inclusion in the prenatal process and the scarce amount of programs specifically focused on the father's issues and concerns is a major problem. The health care system has to rethink the way in which it interacts and perceives fathers within the clinical setting. Many men spoke of their invisible or excluded status in a covert or overt manner. I realized that the mother baby dyad is the norm and focal point of many clinical settings today, therefore it will take time and concerted effort to change this dynamic. The mother baby dyad must be revised to be inclusive of fathers.

It was evident from the data and materials reviewed for this research that fathers were not seen as a client in the prenatal process by health care professionals. Moreover, they were not readily seen as being in the forefront of the prenatal process, but rather in the peripheral. The perception of the birthing process through the father's eyes was rarely told and the father's voice was seldom heard. Often times, the fathers were forgotten or overshadowed by the needs of the mother. The fathers did not receive trainings or guidance about how to prepare for their newborn

and subsequently how to take care of the child once delivered. The fathers were not offered any type of assessment to monitor their physical and mental emotions during this period of transition.

Men discussed how they became fathers with many unknowns and the lack of support. Many utilized the internet or their partners to prepare for the births of their children. Most articulated that they viewed the physicians as a credible source of information, yet seldom reached out to them for their insight. This could be due to the lack of relationship building between the parties.

Men spoke about how they were not prepared for the intense emotion that they experienced during the birth of their children. The fathers in the study indicated that they would have benefited from preparation for their new role. The men spoke about expecting to be briefed during prenatal classes and hospital nurse visits, yet they left with unanswered questions or the perception that this was not the appropriate time for their questions to be addressed in that forum. The shift that needs to occur to involve fathers and acknowledge them as clients in the prenatal health, specifically nurses will take intentional and direct interaction. There will be a shift from the way in which things have always been done to the adaption of a new view of expectant father as being part of the support system. This will require revising practices that have been successful with just working with the mother to assimilate new ways of working with both partners.

4.1 APPLYING SOCIAL ECOLOGICAL MODEL TO RECOMMENDATIONS

Consistent with the social-ecological model, the experiences of fathers in this study are influenced by people, their relationships, community and society. All of these factors intertwine

with each other As a result, an intervention sought to increase father involvement and acknowledgement in prenatal care ought to address the multidimensional aspects of these issues. The purpose of this thesis is to provide recommendations to foster an infrastructure of inclusion of fathers throughout the prenatal process.

A comprehensive paternal inclusion program should include multiple and overlapping levels that include strategies that focus on the individual skills of the father, both intrapersonal and interpersonal, the community, organizations and policies. On an individual level the focus on changing an individual's knowledge, attitudes and behavior is through direct contact with that individual. The program will target the father's social, cognitive skills and behavior. The approach will include counseling, therapy and educational training sessions. A majority of these recommendations were adopted form the Fatherhood Institute summary of skills for midwives.

Programs will be developed to find out about the father's lifestyle and assess how it can be adapted in order to support his own and the baby's well-being. Consistent with the father's age, role, level and understanding a dialogue will take place addressing the father expectations and preferred ways of communicating his needs. Programs will be tailored to establish the level and knowledge of the father's role in the pregnancy, postnatal period and any misconceptions he may have. Sessions will focus on recognizing the fathers own feelings, beliefs and values that may affect the communication process with his partner. Discussions will focus on how to express concerns and seek advice and information. Tailored educational material, classes and groups specifically to men would be available and designed for the demographics served.

In the interpersonal relationship family level influences with peers, intimate partners and family play a role; it is a person's closest circle. Programs and strategies in this level will address interpersonal relationship through parenting training. As mentioned above tailored

parenting programs will be available specifically geared for fathers. The programs will encourage the father to work in partnership with the woman and key people, to develop a care plan. The plan will negotiate and agree on accounting for consent and wishes, abilities and needs during the pregnancy and afterwards (Fatherhood Institute, n.d). The couple will agree on roles and responsibilities of care of the baby. The parents will be encouraged to take an active part in the review process and identify areas of disagreement and attempt to resolve those issues, with those involved in the care of the baby in a way that respect different perspectives (Fatherhood Institute, n.d). The program will address fathers giving appropriate support to mothers. They will also include how to manage and participate effectively as a father in all aspects of care.

In the community level are influences that factor into a person's individual experience in this case it would be the health care system, specifically the prenatal care medical staff. Educational training and materials will be developed for nurses, doctors, midwives and other health care professional about the importance of including fathers during prenatal visit and how to go about implementing it (Tiedje & Fisher, 2003). Training will address how to practice active outreach. Health care providers should in always acknowledge a fathers presence and convey the message "We are glad you're her and we value your input (Tiedje & Fisher, 2003)." Medical staff should look carefully for father's strengths. Working with fathers not only involves imparting, information but acknowledging the father's strengths during a visit. The health care system can institutionalize father inclusion into written protocols (Tiedje & Fisher, 2003). Well child, prenatal and postpartum protocols documentation forms, assessments, guidelines, handouts and checklist must all include parent or father as well as mother language (Tiedje & Fisher, 2003). Address the man's adjustment to becoming a father. A rigorous evaluation program for standards and results will be implemented from the beginning to gauge

program successes and failures. Social workers can work with local community organizations to build a repository of information so that referrals can be made when appropriate.

The societal level influences involve collaborations with multiple partners to change laws and policies in order to foster father inclusion and research. Fatherhood programs will form a network to exchange information, disseminate guidelines and encourage that funding for evidence programs. The groups will band together to collaborate on father initiatives when possible.

4.1.1 Specific Strategies

Best practices with fathers in healthcare can build upon family education programs and then evolve to include more effective practices based on what works well with fathers. This can help facilitate a dialogue between fathers, researchers and practioners to improve upon "best practice guidelines". Healthy Start Pittsburgh states that men need what women need comprehensive teams and services.

May (2001) provides self-assessment questions to guide health care professionals with their interactions with fathers. I have adapted these questions into action steps. In a clinic setting, strategies and approaches for clinicians can begin simply by addressing the father, for example, "My name is Tiffany, I am a registered nurse. What is your name? How are you related to the child? Practioners and healthcare providers should make a conscious effort to be mindful of their body language. This can make a difference in the way in which fathers feel acknowledged. Practioners should position their bodies in relation to both the father and mother with open arms. Crossed arms may be perceived as closed off or not receptive. Health care professionals should be cognizant of who they make eye contact with frequently. When both the

mother and father are in the room, an effort should be made to look at both parents. As health professionals obtain and give information, they should routinely include fathers in the discussion or direct questions to the father as well. Healthcare professionals may in-turn need to examine their own biases and reflect on how their own experiences may influence their current beliefs and expectations about fathers (Tiedje & Darling, 2007). Health care providers should use this time to encourage health screenings and provide tailored education and information.

Steps that can be taken in regards to policy and legislation in a clinic setting can include institutionalizing father inclusion into written materials. For example, when a first time father is identified special tailored information should be provided to him, as well as, classes. An assessment should be given to fathers to gauge how he's transitioning to fatherhood and identify issues that he might be facing which can be addressed in the clinic. Social workers can provide depression screening and referrals. Language that states "parent" or "father" as well as mother verbiage, should be included in well-child, prenatal and postpartum protocols, documentation forms, assessments, guidelines, handout and checklists (Tiedje & Darling, 2007).

Father-friendly components that can be implemented in a local community program have to be multi-dimensional, offering programs that not only deal with the father and his child, but his own emotional are hiring male outreach coordinators and workers, providing mentoring opportunities, as well as activities to encourage male bonding with their children and other fathers in the community. Male coordinators can be an asset to recruit men and provide a male perspective in design and implementation as well as facilitation. Male coordinators can use unconventional methods to recruit fathers by posting information at barber shops, recreation centers, male bathrooms, sporting events, church functions. Targeted case management can be offered through the community interventions to work with fathers individually in their

surroundings. Targeted case managers and outreach coordinators can work to build a referral network for men, for instance information regarding family planning, local health providers, mental health and drug and alcohol treatment, additionally employment and training can all be offered. Mentoring programs can help fathers develop a relationship with each other to provide support to one another. It also enhances a father's network of influence when he is seeking guidance or advice and provides a forum for learning and discovery. The mentoring program can help one father give back to another in-turn helping to contribute to the father child relationship. This relationship can be crucial for first time fathers, as well as men who may have never had a father figure in their lives when they were growing up. These fathers may struggle with how and what it is to be a father. This relationship can strengthen interpersonal skills, commitment to his child and provide a sounding board when questions or concerns arise.

Providing activities with fathers and their children can also offer an opportunity for fathers to take outings with each other. This provides a group setting for fathers in similar situations to go out and each other and their kids, it provides a normalcy to their experience. It helps provide comfort that the father is not the only one going through the process. Community interventions can offer holistic programming which focuses on the whole man. According to Healthy Start Pittsburgh, holistic methods can help to increase empathy and understanding specific to gender roles and responsibilities. This method can be infused in father family nights where mother education forums can be held.

4.2 LIMITATIONS AND FUTURE STRATEGIES

While the findings from this small sample may not be genreralizable to fathers throughout the United States, the findings were comparable to findings with a larger sample size. To build on the results of this study, more interviews should be conducted in order to reach the saturation point necessary to draw conclusions. The fathers interviewed in this study were African-American, while one hailed from the continent of Africa. The findings can be more generalizable if fathers from different ethnic and social backgrounds are included in further studies. Recruitment efforts can be enhanced by utilizing different forums to engage fathers to participate in studies such as barbershops, sporting events and gyms to include fathers who may not be comfortable attending prenatal and health visits. Furthermore, male interviewers and recruiters may help to encourage men to join research studies and provide a point of contact that fathers may feel more comfortable relating to in the process.

5.0 IMPLICATIONS AND CONCLUSION

The findings from this study, as well as, further research have significant implications for public health professionals. When fathers are engaged in the prenatal experience they contribute to the overall health and well-being of their children (first nine, 2007). Father involvement in the prenatal process is a good way to get men engaged in the beginning in hopes that they will continue to stay involved through their child's life.

In order for a transition to occur in prenatal health care the father must be included and acknowledged in the provision of care. There are several barriers to prenatal father involvement, in-order for improvement to occur; the dynamics in the health care infrastructure will have to evolve. Taking steps to engage fathers during the prenatal period is not just a matter of responding to fathers' interests, but is even more significantly linked to the broader social interest in promoting child and family health and stability (first nine, 2007). Moreover, educating student nurses and physicians on engagement practices and inclusion should be instituted in curriculums. The first steps of acknowledgement can take place now, by speaking to the fathers and legitimizing his presence.

Interventions have mainly been defined by mother baby interactions, this is important. However, more effort must be taken to review father baby systems with further research and pilot programs to foster an inclusive system. Continuous, increased funding for father intervention programs and research will likely have a positive impact on the general well-being

of children. It is important to gauge the father's willingness to be involved and care for his child. Every father's situation is different. We cannot institute a one size fits all intervention. Medical staff may have to do more to find out how invested the father is in the process to engage him appropriately through teaching, programs and activity offerings. Physicians and nurses will have adjust to the structure of taking care of the whole family dynamic, the pregnant women and the baby so that a comprehensive care infrastructure will be in place.

Just as doctors and nurses chart their interactions with mothers; it would be beneficial for the interactions with the father to be charted as well, so the medical staff are made aware of his interest and involvement in the process. In a culture where we have come to strictly focus on woman in the prenatal process, we cannot overcompensate by strictly focusing on the man either; a balance must be in place to address both of their needs in the process. The importance of mothers and fathers working together should be stressed in the process, both are needed to make this endeavor successful. Health care systems can have an impact on health care promotion; these steps can revolutionize how fathers are perceived and move to a more inclusive experience for the baby, mother and father.

APPENDIX

QUALITATIVE INTERVIEW QUESTIONS

How would you describe your experience during the prenatal visit?

How engaged did you feel when you attended?

How often were questions posed to you, by the doctor, nurse or social worker during the visit?

How included did you feel in the prenatal process?

Tell me, do you feel the prenatal process is solely a women's journey?

What did you see as your role in the process?

What were your concerns during the prenatal visit?

How comfortable were you bringing up those concerns to the medical staff?

What did you consider yourself to be in the background or forefront of this experience?

How could the prenatal experience be improved?

What could be done or has been done to ensure that you are included in the prenatal process?

What types of prenatal programs would you attend if they were offered? What would the criteria entail?

Tell me, what would your ideal prenatal experience entail?

How did you prepare for birth?

What information was provided to your prior to the birth?

What emotions did you encounter going through this experience?

Would you like to add anything that we may not have addressed?

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