Fatherhood in Adolescence

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Pediatrics in Review 2008;29;364
DOI: 10.1542/pir.29-10-364

In Brief

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Author Disclosure

Drs Hollman, Alderman, and Adam have disclosed no financial relationships relevant to this In Brief. This commentary does not contain a discussion of an unapproved/investigative use of a commercial product/device.

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The challenges of teen pregnancy and motherhood long have been considered in depth, but attention to adolescent fathers has been far less conspicuous. The relative lack of attention given to adolescent fathers by health-care practitioners, social workers, government agencies, and researchers furthers the (sometimes incorrect) idea that the fathers often are absent. Although many adolescent mother-baby programs are available, few include provisions for adolescent fathers. In recent years, efforts have increased to acknowledge teen fathers in clinical practice and in the research forum, but much still needs to be addressed.

Numerous studies have characterized adolescent fathers as being older than the mothers of their children. Several studies have found that fathers of the children of adolescent mothers are an average 2 to 3 years older than the mothers. However, in a large California study of adolescent mothers younger than age 15 years, the age difference was nearly 9 years. The actual number of adolescent fathers is difficult to ascertain because the age of the father is not always on the birth certificates of children born to adolescent mothers.

Several factors are correlated with becoming a father during adolescence, particularly low income and poor academic achievement, which also are predictive of adolescent motherhood. Some studies have found an association between emotional difficulties and early fatherhood. A history of criminal behavior correlates with adolescent fatherhood, with adolescent fathers more likely being serious delinquents. Given the financial hardship parenthood can present, unlawful behavior in these teens often persists into fatherhood. Finally, male children of adolescent mothers are more likely to become adolescent fathers.

Contrary to stereotype, most adolescent fathers desire involvement in the care of their children. They feel an obligation to the child, and some report wishing to do a better job at parenting than their own fathers did. In general, they do not consider fatherhood to be disruptive, detrimental, or troublesome. Similarly to adolescent mothers, their knowledge and expectations of parenthood are lacking compared with those of nonadolescent parents. As with adolescent mothers, young fathers may have self-serving reasons for wanting to be a parent. Among these is the visible accomplishment of parenthood, which can boost pride and self-esteem. A child also can help the adolescent achieve status, be a sign of fertility, and bolster a sense of masculinity. Both adolescent mothers and fathers see a child as an individual on whom to bestow love and who will return love.

Adolescent fathers want to be involved in decision-making during the pregnancy. If the partner, or the partner's family, is unwilling to allow the father to assist in making decisions, the teen father can feel alienated and withdraw. Once the child is born, role confusion may ensue, which can strain the relationship between the child's father and mother. Denying the father decision-making involvement may serve as an escape route for the young man, facilitating retreat into noninvolvement. Conversely, adolescent fathers who are involved with decision-making early in the pregnancy tend to maintain involvement after the birth of the child.

Adolescent fathers, like adolescent mothers, need a support system that most often is provided by the father's own family. Adolescent fathers usually cite their own mothers as their most significant role models. Peers and friends also provide support that is appreciated as beneficial. Community resources can be a helpful complement to the young father's support system, but adolescent fathers have far less

access to social services than do their maternal counterparts.

Foremost among the multiple stresses an adolescent father experiences is the feeling of personal obligation to support his new child financially. The expectations of the baby's mother and other family members are likely to compound the pressure, and the young father may find himself forced to hold a job for the first time. As a result, adolescent fathers tend to enter the workforce early in life, and education, even if it can continue, becomes more difficult or even burdensome. Many fathers drop out of school, weakening their earning potential later in life. Often lacking in maturity, many teen fathers are not ready to meet the emotional demands of fatherhood. With their personal freedom restricted, they may feel isolated from peers who are not fathers. Many fathers live separately from the mothers and children, and the effort and expense of visiting can be seen as an additional burden. Finally, the relationship with the mother and her family can be a source of stress.

Adolescent fathers usually have established relationships with the mothers of their children at the time of pregnancy. Contrary to common belief, most fathers perceive the relationship as serious, not casual. Teen mothers expect their partners to participate actively in parenting tasks. Although adolescent fathers express the wish to be available, they most often cite financial support as their key responsibility. The mother's own parents can be a barrier to the father's involvement. If the maternal grandparents perceive the relationship to be based on commitment rather than on sexual conquest, they are more accepting, and it is easier for the father to be involved with caring for the child. However, the maternal grandparents may characterize the father as being immature or unpredictable and, therefore, be less likely to accept him as a caretaker of the child. In most cases, the maternal grandparents have expectations that the father will support the family financially, regardless of their acceptance of him.

The relationship between adolescent parents often declines with time. The immaturity of either parent may weaken the relationship as early as during the pregnancy or soon after the birth of the child. Failure of the father to achieve ongoing intimacy with the mother correlates negatively with paternal involvement. The father may feel that the reason for the relationship failing is the mother's reluctance to allow his involvement with the child. Regardless, the combined pressures of adolescence and of parenting are difficult to overcome. Studies have shown variable results, with one reporting that 50% of teenage fathers live with their children, at least for a short period of time, and another that 60% of adolescent mothers consider the fathers of the children to be their boyfriends at the children's first birthdays. A study of African American teenage mothers shows that 20% of them still have contact with the father of the child at the child's fifth birthday.

Limited studies have shown that paternal involvement by adolescent fathers is beneficial to the child, but may depend more on the quality of the relationship between the baby's parents. The presence of a father in the home of a teenage mother and child has been associated with a modest advantage in terms of school achievement, employment, and emotional well-being as well as a decrease in criminal behavior and teen parenthood. The true benefit has been to those children who reported a close paternal relationship, and those children had a substantial advantage in outcomes.

The risk of child abuse by adolescent fathers and mothers when compared with that of nonadolescent parents is higher, likely related to unrealistic expectations about the child. Adolescent parents of both sexes lack knowledge of normal childhood development and may mistake the child's age-appropriate behavior for deliberate misbehavior, leading to inappropriate discipline. In most cases, the involvement of the adolescent father is beneficial. Although more research is needed, it appears that a positive mother/father relationship in the home is beneficial to the child, while a turbulent relationship brings additional stress and may be detrimental.

Adolescent fatherhood is a challenge that has been garnering increased attention recently but needs to be addressed further. Many adolescent fathers desire relationships with their children and wish to be involved in decision-making and child-rearing. In most successful cases, these fathers are supported by their own families and benefit from a good relationship with the mother and her family. Education often is lacking for the adolescent father. Although young mothers have many resources available to help prepare them for motherhood, fathers often are forgotten. Parenting classes may be helpful. Involving the adolescent father in parenting education and anticipatory guidance if he is interested is an opportunity too often missed. The adolescent father should not be forgotten by social workers, who can counsel fathers, help them to recognize their value to the child and mother, and answer many of their questions. Social workers, in particular, may be able to intervene positively by helping fathers achieve educational goals, obtain employment, and become aware of programs available to them. Increased attention to the adolescent father as an individual benefits not only the father himself, but ultimately the mother and their child.

Comment: Henry Lewis Gates, Jr, among other prominent scholars, has argued that the absence of actively involved fathers contributes significantly to the disparities we see in education, opportunities, and income for so many African American children. Ethnicity and race aside, we should be doing all we can to encourage and support adolescent fathers in meeting their responsibilities and experiencing, for their own sakes, the rewards of fatherhood.

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In Brief

Safety on Bicycles, Skateboards, Scooters, and Skates

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Author Disclosure

Drs Okun and Adam have disclosed no financial relationships relevant to this In Brief. This commentary does not contain a discussion of an unapproved investigative use of a commercial product/device.

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Pediatricians should counsel families on ways their children can avoid injury on bikes, scooters, skateboards, and skates. Although some recommendations are based more on common sense than on evidence, the protective effects of helmet use for bicycle riders are uncontested. Each year in the United States, approximately 500,000 people of all ages are treated in emergency departments (EDs) for injuries related to bicycle riding. About 6% of these visits, 30,000 per year, lead to hospitalization, and close to 1,000 of the injuries are fatal. Facial injury, bony fractures, blunt abdominal trauma, abrasions, and lacerations account for most of the injuries. Although head injuries are involved in only one third of these ED visits, they lead to two thirds of hospital admissions and cause three quarters of the deaths related to biking. Children younger than age 15 years are disproportionately affected, accounting for three quarters of ED visits for bicycle-related head injuries and up to one half of the deaths.

Fewer ED visits, approximately 125,000 per year, are made for injuries related to the use of scooters, skateboards, and skates. Most of these injuries involve fractures of the wrist, hand, or ankle and trauma to the face. One third of those injured on skateboards experience their trauma in the first week of skateboarding. These data on morbidity and mortality derive from hospital inpatient and ED records, which represent the severe end of the spectrum of injuries.

Helmets have been shown to provide as much as an 88% reduction in the risk of head and brain injury and a 65% reduction in injuries to the upper extremities and mid-face related to bicycle riding. For inline skaters, wearing wrist guards and elbow pads can reduce the risk of upper extremity injuries by 90%. Few data have been reported on the protective effects of safety gear for riders of scooters and skateboards. One study supports the belief that when cyclists wear bright or reflective clothing and limit riding in the dark, they are more likely to be noticed by drivers.

Pediatricians are urged to counsel children and families to use properly fitting, approved helmets for all of these activities and to wear these helmets low on the forehead for maximal protective effect. People on scooters, skateboards, and skates should wear knee and elbow pads. Skateboarders and skaters also should wear wrist guards. Novice skaters are encouraged to learn in rinks. For those on skateboards, specifically designed parks are favored over courses that have home-constructed ramps and jumps because they provide environments that are likely to be safer and better supervised. Children and adolescents should not ride scooters or skateboards in traffic. Skaters and skateboarders never should

hitch a ride on motor vehicles, a dangerous practice known as "skitching" or "truck-surfing."

The past 30 years of literature on office-based safety counseling by pediatricians has failed to demonstrate much impact on behavior outside of improvements in household safety and the use of infant car seats. The most important advances in bicycle safety have come from the increased use of helmets resulting from community-based advocacy and legislation. Public campaigns have employed widespread educational efforts and subsidies for helmets. These interventions have been most effective when they have been community-based and the helmets are provided free, rather than leaving users to buy low-cost helmets. The first major campaign in the United States was carried out in Seattle, Washington, between 1987 and 1992, leading to a rise in helmet use in the community from less than 6% to 40% and a reduction by two thirds in the rate of bicycle-related head injury among children ages 5 to 14 years belonging to one health maintenance organization. Helmet use rose from 8% to 19% from 1990 to 1992 in Montgomery County, Maryland, during a similar initiative.

Legislative interventions have had powerful effects in the United States and abroad. Two- to fivefold increases in observed helmet use by children have been documented in Austin, Texas; Jacksonville/Duval County, Florida; San Diego, California; a rural community in Georgia; and across the states of Oregon and California. In Victoria, Australia, helmet use by children rose from 6% to 36% over the course of a 7-year educational campaign between 1983 and 1990. One year after legislation was enacted there, helmet use by children doubled again, to 73%. Between 1990 and 1996 in Houston, Texas, helmet use rose from 4% to 67% after legislation was passed, and the rate of bicycle-related head injuries at one major medical center was cut in half. In four provinces in Canada, where mandatory bicycle helmet laws were enacted between 1994 and 1998, hospitalizations for bicycle-related head injury dropped by 45% compared with 27% in provinces having no such legislation. Bicycle-related traumatic brain injuries among minors fell by 18% in California, and associated fatalities were reduced by 30% in Oregon following statewide legislation.

Bicycle helmet laws are now in effect in 22 states and 129 counties and municipalities in the United States. To date, no credible evidence has documented that riders who wear helmets counteract the protection by riding faster or under more dangerous conditions. This concept of "risk homeostasis" has been the principal argument waged against campaigns and legislation in favor of helmet use. Other barriers to more widespread use of helmets and protective gear, particularly among children and adolescents, include a perceived low risk of personal injury, lack of comfort, poor ventilation, and concerns about appearance. These important obstacles need to be addressed creatively.

The "SAFE KIDS Campaign" of the National Highway Safety Traffic Administration offers sample legislative wording for those interested in advocating for mandatory use of bicycle helmets. Health professionals should realize that work to promote bicycle helmet use through community campaigns and legislative advocacy has the potential to do the greatest good.

Comment. Don't we, as a nation, ever learn? After all the years it took to get automobile seat belt legislation passed, why, with so much compelling data, do only 22 states have bicycle helmet laws in place today?

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