Natural Mentoring Relationships and Adolescent Health: Evidence From a National Study

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Recently, mentoring of youth has received a great deal of attention in terms of both public awareness and government initiatives. Mentoring relationships may foster positive development and health among young people through several mechanisms, including the provision of social support, role modeling, opportunities to develop new skills, and advocacy. Nonparent adults who function as mentors may serve as crucial educators and support figures, promoting learning and competence, providing exposure to positive social norms, increasing a sense of efficacy and mattering, and helping youth realize their full potential. Formal mentoring programs currently are very popular; the National Mentoring Database, for example, lists more than 4500 organizations that support mentoring activities.

A recent meta-analysis found evidence of a significant but small overall positive effect of mentoring programs on the emotional, behavioral, and educational functioning of participating youth (Cohen d = .14). Other recent reviews of the literature have reached similar conclusions. Many youth, however, experience natural mentoring relationships outside of formal programs with persons such as extended family members, neighbors, teachers, and coaches. In a recent survey of a nationally representative sample of adults, these types of naturally occurring ties accounted for approximately two-thirds (69%) of all reported mentoring relationships with youth. Several considerations indicate a significant potential for natural mentoring relationships to promote positive outcomes.

These relationships, for example, typically occur within a young person's existing social network. Consequently, they may have beneficial linkages to other relationships in the youth's network and may be maintained over a significant portion of the youth's development. Many natural mentors, furthermore, have important roles in contexts and activities that are salient in the lives of youth (e.g., school, athletics). This may increase these mentors' accessibility and value as sources of support, and encourage the young person's bonding with larger groups and institutions in ways that promote favorable health outcomes.

Existing investigations suggest positive benefits of natural mentoring relationships on a range of health-related outcomes for youth. To date, however, such studies have been limited to relatively small and potentially nonrepresentative samples. Investigations also have focused primarily on younger adolescents. Older adolescents undergoing the transition to adulthood face unique challenges, including those relating to identity development and increased independence in negotiating demands in educational, work, and interpersonal domains, any of which, if not handled successfully, may impact negatively on health-related outcomes. Supportive mentoring relationships with nonparent adults during this period thus have the potential to make a key contribution to promoting outcomes important to public health goals and objectives.

The impact of natural mentors on youth experiencing individual or environmental risk factors is a further concern that has received little systematic evaluation. Research on formal mentoring programs suggests that the benefits of mentoring may vary depending on whether youth can be considered vulnerable because of individual or environmental risk. It is important, however, to investigate whether interactions with risk status also are evident for youth experiencing natural mentoring relationships.

We had 2 major goals with the present study. First, we sought to investigate the impact of natural (or informal) mentoring relationships on health-related outcomes among older adolescents and young adults.

Methods. We examined outcomes from Wave III of the National Longitudinal Study of Adolescent Health as a function of whether or not respondents reported a mentoring relationship. Logistic regression was used with control for demographic variables, previous level of functioning, and individual and environmental risk.

Results. Respondents who reported a mentoring relationship were more likely to exhibit favorable outcomes relating to education/work (completing high school, college attendance, working ≥10 hours a week), reduced problem behavior (gang membership, hurting others in physical fights, risk taking), psychological well-being (heightened self-esteem, life satisfaction), and health (physical activity level, birth control use). However, effects of exposure to individual and environmental risk factors generally were larger in magnitude than protective effects associated with mentoring.

Conclusions. These findings suggest a broad and multifaceted impact of mentoring relationships on adolescent health. However, mentoring relationships alone are not enough to meet the needs of at-risk youths and therefore should be incorporated into more comprehensive interventions. (Am J Public Health. 2005; 95:518-524. doi:10.2105/AJPH.2003.031476)
METHODS

We drew data for the present research from the Wave I and III public-use data sets of the National Longitudinal Study of Adolescent Health (Add Health). The Wave III public-use data set contains 4882 respondents selected randomly from the larger restricted-use sample (n = 15 197). Add Health was based on a stratified random sample representing high schools across the United States. Youth from a representative sample along with several special samples comprised the clusters, resulting in a sample with unequal probability of selection probability, procedures have been developed to ensure that unbiased parameters are obtained. Analyses in the present study were limited to respondents who gave valid responses to the mentoring item and had data for all covariates (see Measures section). Analyses were further limited to respondents for whom sampling weights were available (n = 3187). However, corrections for design effects and unequal selection probability do not address potential bias attributable to other sources, specifically (1) sample attrition from Wave I to Wave III and (2) exclusion of participants with missing data on study measures.

Measures

Mentoring. Respondents having a mentoring relationship were identified with the following Wave III item: "Other than your parents or step-parents, has an adult made an important positive difference in your life at any time since you were 14 years old?" Several additional items asked about features of the relationship, including the mentor’s role (e.g., sibling, teacher) and the relationship’s duration. Respondents who identified a younger sibling (i.e., "younger brother" or "younger sister"), "spouse or partner," or "friend" as a mentor were excluded from the present study. These choices were excluded because it was possible that the individuals nominated in the various categories would not be older than the respondent, which is a commonly accepted part of most definitions of a mentor. Covariates. Covariates included demographic characteristics and indicators of individual and environmental risk. Demographic characteristics assessed were gender, age, and race/ethnicity. The sample for the present study comprised 1470 (46.1%) males and 1717 (53.9%) females. Respondents ranged in age from 18 to 26 years at Wave III (mean = 21.4; SD = 1.6). Race/ethnicity was coded using the following categories: White (n = 2148; 67.4%), Hispanic (n = 356; 11.2%), African American (n = 763; 23.9%), Native American (n = 126; 3.9%), Asian American (n = 126; 3.9%), and Other (n = 200; 6.3%). Individual risk was coded as present if the respondent reported 1 or more of the following at Wave I: counseling or substance abuse treatment in the past year, suspension from school, failing a grade, or a physical disability. A total of 1408 respondents (44.2%) met criteria for individual risk.

Environmental risk was coded as present if respondents reported 2 or more of the following at Wave I: parent receiving public assistance, not living in a 2-parent family, no parent with a high school diploma, no parent working full time, having 3 or more siblings living at home, not feeling safe in the neighborhood (assessed by a single yes/no item), and relatively low levels of peer, family, or school connectedness (for each type of connectedness, a score below the sample median for the average of relevant survey items). A total of 1262 respondents (39.6%) met criteria for environmental risk.

Outcomes. Outcomes were assessed using Wave III measures, with corresponding Wave I indices utilized when available to control for initial levels of functioning. Education and work outcomes included completion of high school, college attendance, and working 10 or more hours per week (all coded as yes/no). The Wave I control for the 2 education outcomes was average grade across 4 course areas (math, language arts, science, social studies). The work-related outcome had no Wave I control.

Problem behavior outcomes included binge drinking in the previous 12 months (yes/no), drug use within the previous month (yes/no), smoking within the previous month (yes/no), belonging to a gang (yes/no), injuring another person in a fight in the previous year (yes/no), and a tendency toward risk-taking (above or below the median on a scale comprising 5 items). Wave I control variables included frequency of binge drinking in the previous year, frequency of drug use in the past month, having tried smoking, frequency of delinquent behavior (aggregate of items assessing violent and nonviolent delinquency), and frequency of injuring another person in a fight during the previous year, respectively. No Wave I control was included for risk-taking.

Psychological well-being outcomes included self-esteem, life satisfaction, depressive symptoms, and suicidal ideation. Self-esteem, depressive symptoms, and suicidal ideation were measured at both Wave I and Wave III. Life satisfaction had no corresponding Wave I control. Self-esteem was measured as the average of 4 items representing global feelings of self-worth. Life satisfaction was measured using a 5-point scale from very dissatisfied to very satisfied. Depressive symptoms were measured using the average of 9 items from the Center for Epidemiologic Studies Depression Scale. Suicidal ideation was assessed as the presence (yes/no) of suicidal thoughts in the previous year. Wave III self-esteem and life satisfaction scores were dichotomized as high or low (i.e., above or below the sample median). Depressive symptoms were dichotomized as high or low based on a cutpoint corresponding to an average rating of 1 on the 3-point response scale for these items.

Physical health outcomes included perceived general health, physical activity level, diagnosis of a sexually transmitted disease (STD), and regular use of birth control and condoms. Perceived general health was rated at both Wave I and Wave III on a 5-point scale from poor to excellent. Physical activity level at both Wave I and Wave III was assessed as the mean of responses to multiple
items indicating the frequency of participation in physical activities during the previous week. Wave III scores for general health and physical activity level were dichotomized using a median split. STD diagnosis reflected whether respondents indicated at Wave III that they or their partners had used birth control or condoms most or all of their sexual encounters during the previous week. Having a mentoring relationship varied as a significant predictor of the same outcomes, and the same interactions reached or approached significance. However, when using a continuous measure of depressive symptoms, follow-up analysis of the mentor × individual risk × environmental risk interaction failed to reveal having a mentor as a significant predictor of this outcome for any risk subgroup. **RESULTS**

Characteristics of Mentoring Relationships

Approximately three-quarters of the sample (n=2323; 72.9%) reported having had a mentor. Mentoring relationships ranged in duration from 1 to 26 years (mean=9.1; SD=7.1). More than 40% of mentors were family members (older brother=8.0%; older sister=8.0%; grandmother=8.7%; grandfather=4.0%; aunt=7.8%; uncle=5.6%). Approximately one-quarter (26.0%) of mentors were teachers or guidance counselors. Other mentors included coaches (5.6%); religious leaders such as ministers, priests, and rabbis (5.1%); employers (4.1%); coworkers (4.4%); neighbors (1.3%); friends’ parents (4.8%); doctors or therapists (0.5%); and others (5.9%).

Logistic Regression Analyses

Education and work. Results of logistic regression analyses predicting education and work outcomes are presented in Table 1. Having a natural mentor was associated with a greater likelihood of having completed high school and attended college. The analysis for the work outcome was limited to participants not attending college at Wave III. Youth reporting a mentoring relationship were significantly more likely to be working 10 or more hours a week.

**Problem behavior.** Table 2 presents results for problem behavior outcomes. Mentoring was associated with a significantly decreased likelihood of being a gang member, hurting someone in a fight during the previous year, and risk taking. The mentor × environmental risk interaction was significant for hurting another person in a fight. Further examination indicated that the effect of mentoring for this outcome was nonsignificant for youth without environmental risk, but was significant for...
youth with environmental risk (odds ratio \(OR\) = 0.47; 95% confidence interval (CI) = 0.29, 0.76; \(P<.01\)).

**Psychological well-being.** Results for psychological well-being outcomes are shown in Table 3. Having a mentor was associated with a greater likelihood of reporting relatively high levels of self-esteem and life satisfaction. There was a significant mentor \(\times\) individual risk \(\times\) environmental risk interaction for depressive symptoms. Further examination indicated that the effect of having a mentor for this outcome was significant only for youth without individual or environmental risk (OR = 1.76; 95% CI = 1.07, 2.89; \(P<.05\)), with this finding in the unexpected direction of mentoring predicting relatively higher reported levels of depressive symptoms.

**Physical health.** Table 4 presents results for the physical health outcomes. Having a mentor was associated with a greater likelihood of reporting a relatively high level of physical activity as well as regular use of birth control. There was a significant mentor \(\times\) individual risk \(\times\) environmental risk interaction for physical activity level. Further examination revealed that the effect of having a mentor for this outcome was significant for youth without individual or environmental risk (OR = 1.61; 95% CI = 1.19, 2.19; \(P<.01\)) and for youth with both individual and environmental risk (OR = 1.50; 95% CI = 1.01, 2.22; \(P<.05\)), but was nonsignificant for youth with only individual or only environmental risk. Finally, the mentor \(\times\) environmental risk interaction was significant for STD diagnosis. However, further examination indicated that the effect of mentoring for this outcome was nonsignificant for youth both with and without environmental risk.

**DISCUSSION**

Several features of the current study are noteworthy. First, the study was based on a nationally representative sample of older adolescents and young adults (aged 18–26 years at follow-up) participating in the Add Health study. Second, natural mentoring relationships were investigated as predictors of outcomes during late adolescence and early adulthood, thus addressing their role in promoting health among older youth than have been included in most prior studies. Finally, data from an
The results of the current study are consistent with the view that mentoring relationships facilitate positive gains in the health and well-being of developing youth. Similar findings have been reported in previous research. Methodologically, however, those studies were not based on large, nationally representative samples and typically did not include statistical control for either risk factors or earlier levels of functioning.

Youth who reported a natural mentoring relationship were more likely to exhibit favorable outcomes in the areas of education/work (i.e., completing high school, college attendance, working 10 hours a week), problem behavior (i.e., reduced risk of gang membership and hurting others in physical fights and decreased risk taking), psychological well-being (i.e., heightened self-esteem and life satisfaction), and physical health (i.e., greater physical activity level, birth control use). Factors or earlier levels of functioning.

TABLE 4—Mentoring as Predictor of Physical Health Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mentoring OR (95% CI)</th>
<th>PAR*</th>
<th>Individual Risk OR (95% CI)</th>
<th>PAR</th>
<th>Environmental Risk OR (95% CI)</th>
<th>PAR</th>
<th>Wave I Control OR (5% Cl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health</td>
<td>0.98 (0.77, 1.25)</td>
<td></td>
<td>0.79* (0.65, 0.96)</td>
<td></td>
<td>0.79* (0.64, 0.98)</td>
<td></td>
<td>2.15*** (1.90, 2.45)</td>
</tr>
<tr>
<td>Physical activity level^d</td>
<td>1.42*** (1.16, 1.74)</td>
<td>0.05</td>
<td>0.96 (0.81, 1.13)</td>
<td>0.01</td>
<td>0.73** (0.60, 0.89)</td>
<td>0.07</td>
<td>1.59*** (1.39, 1.82)</td>
</tr>
<tr>
<td>STD diagnosis</td>
<td>1.07 (0.71, 1.53)</td>
<td></td>
<td>1.19 (0.82, 1.71)</td>
<td></td>
<td>1.10 (0.76, 1.58)</td>
<td></td>
<td>2.57*** (1.78, 3.72)</td>
</tr>
<tr>
<td>Birth control use^d</td>
<td>1.40** (1.12, 1.76)</td>
<td>0.07</td>
<td>0.66** (0.53, 0.81)</td>
<td>0.14</td>
<td>0.82 (0.64, 1.04)</td>
<td>0.06</td>
<td>0.78* (0.63, 0.96)</td>
</tr>
<tr>
<td>Condom use^d</td>
<td>1.23 (0.96, 1.56)</td>
<td></td>
<td>0.86 (0.71, 1.04)</td>
<td></td>
<td>0.77* (0.61, 0.98)</td>
<td></td>
<td>0.74* (0.59, 0.92)</td>
</tr>
</tbody>
</table>

Note. OR= odds ratio; CI= confidence interval; PAR= population attributable risk; STD= sexually transmitted disease. All analyses include statistical control for demographic variables of gender, age, and race/ethnicity.

^Analysis limited to respondents who were sexually active during the year prior to the Wave III assessment.

*For calculation of PAR values, these outcomes were expressed in negative terms (e.g., low physical activity level).

**PAR values are included only for outcomes where mentoring is a significant predictor. To enable comparison across predictors, PAR values for mentoring were computed with the mentoring predictor recorded so that a score of 1 represented not reporting a mentoring relationship.

^Wave I control for general health is self-rated general health; for physical activity level, the control is average physical activity level; for STD diagnosis, birth control use, and condom use, control is whether respondent reported having had sexual intercourse at a time point prior to Wave I.

Individual Risk

Environmental Risk

Wave I Control

Our findings generally failed to reveal significant variation in the benefits of natural mentoring relationships as a function of individual or environmental risk. The interactions found, furthermore, were not consistent in pattern and may reflect chance findings owing to the large sample size and number of tests of significance. In comparison, formal mentoring programs have been found to have stronger effects when they served youth who were experiencing either both individual and environmental risk, or environmental risk alone, compared to when they were serving youth who were not experiencing ei-
The favorable overall effects on many outcomes that are evident for natural mentoring relationships do indicate a capacity for these ties to help offset negative effects of individual and environmental risk on the same outcomes. However, estimates of PAR associated with whether the respondent reported having a mentor were fairly small in absolute magnitude (3%-11%), and in most instances were less than those associated with individual or environmental risk. The benefits of having a mentor thus were not strong enough to fully compensate for the effects of risk.

Because there was conceptual overlap between certain indicators of risk status (e.g., failing a grade) and outcomes (e.g., completing high school), PAR estimates may have been inflated for individual and environmental risk. Overall, however, our findings are consistent with the view that it may be unrealistic to expect mentors alone to undo cumulative effects of multiple sources of risk. Research on resilience suggests that successful outcomes depend on a broad range of factors, including skills in communication and problem solving, quality of ties with primary caregivers, and access to relevant opportunities and resources within the community.

Relative to prior research, a greater proportion of youth in this sample reported having a natural mentor. Factors contributing to this difference may include the extended time frame that respondents were asked to consider as well as the wide range of familial and nonfamilial ties incorporated into the study’s operationalization of mentoring. Previous studies, for example, typically have not considered older siblings as potential natural mentors. Variations in these and other aspects of how natural mentoring relationships are defined may have implications for the associations observed between mentoring ties and outcomes, and should receive systematic investigation in future work.

Applied Implications and Directions for Future Research

The findings of the current study indicate that natural mentoring relationships contribute to the health and well-being of youth from a diverse range of backgrounds. Health promotion and prevention programs thus may benefit from the use of strategies to cultivate ties between youth and adults who have the potential to serve as effective natural mentors. The frequency with which extended family members and school personnel were nominated as mentors in the present sample suggests their promise as targets for intervention. Systematic comparison of outcomes associated with these and other categories of natural mentors should be undertaken in future research to clarify this issue.

For interventions to be optimally effective, specific relationship characteristics and processes (e.g., closeness of the relationship, longer duration) that promote positive health-related outcomes also need to be identified. Further research in these directions may expand the range of outcomes for which mentoring relationships are indicated to be beneficial. We will address this possibility in a follow-up investigation with the present data set.

It seems clear that, even under ideal circumstances, mentoring alone will not likely be sufficient to fully address the needs of at-risk youth. Taking all of these considerations into account, the cultivation of mentoring relationships within comprehensive, multifaceted interventions offers the greatest promise.

Programs and policies that utilize mentoring ties to enhance the delivery and implementation of strategies that target other well-established risk and protective factors is a promising direction that should be pursued.

Human Participant Protection

No protocol approval was needed for this study.

References


March 2005, Vol 95, No. 3 | American Journal of Public Health

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