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 mentoring relationships on a wide range of outcomes in several domains (i.e., education/work, problem behavior, psychological well-being, physical health). Second, we sought to examine whether the impact of natural mentoring relationships varies with exposure to either individual or environmental risk factors.

**Objectives.** We used nationally representative data to examine 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).\textsuperscript{24–25} 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.\textsuperscript{26–28} Youth from a representative sample along with several special samples completed Wave I in-home interviews in 1995 (n=20 780) and Wave III interviews in 2001/2002 (n=15 197). In-home interviews were administered using a computer-assisted personal interview, with an audio computer-assisted self-interview for sensitive questionnaire content such as substance abuse and sexual behavior. Data collection for Add Health was based on a cluster sample with unequal probability sampling of the clusters, resulting in a sample in which observations are not independent and are not equally distributed.\textsuperscript{25} To correct for design effects and unequal selection probability, procedures have been developed to ensure that unbiased parameters are obtained.\textsuperscript{27,28} 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.\textsuperscript{7}

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.\textsuperscript{29} 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 cutoffpoint 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, and 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 reported having been treated for their sexual encounters during the previous year. The control for the 3 sexual health outcomes was whether respondents reported having been sexually active at Wave I.

Analysis

Logistic regression analyses were conducted to examine whether reporting a mentoring relationship predicted each outcome when controlling for demographic characteristics, individual and environmental risk, and indices of Wave I functioning (when available). Interactions also were tested between mentoring and risk (i.e., mentor × environmental risk, mentor × individual risk, and mentor × environmental risk × individual risk) to investigate whether having a mentoring relationship varied as a predictor of outcomes in association with either or both types of risk. Only significant interaction results are reported. Sampling weights and study design effects were incorporated in the calculation of logistic regression estimates using the GENMOD procedure of SAS (SAS Institute Inc, Cary, NC).26

Population attributable risk (PAR) values were calculated for mentoring and individual and environmental risk in analyses where mentoring was a significant predictor.30 These values enabled us to examine the relative potential influence of each predictor on outcomes and were computed based on estimates of relative risk that were adjusted for all covariates.31

As noted, certain outcome measures (e.g., self-esteem) were measured on a continuous scale, but were dichotomized for purposes of the present investigation. This allowed for consistency with other outcomes that already were dichotomous in nature (e.g., having completed high school), thereby facilitating interpretation of the relative impact of mentoring as a predictor of different outcomes. Supplementary analyses using multiple regression investigated whether findings differed when relevant measures were maintained in their original continuous form. Findings were highly similar to those obtained in primary study analyses, such that having a mentor was 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

Table 1—Mentoring as Predictor of Educational and Work Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mentoring OR (95% CI)</th>
<th>PARa</th>
<th>Individual Risk OR (95% CI)</th>
<th>PARb</th>
<th>Environmental Risk OR (95% CI)</th>
<th>PAR</th>
<th>Wave I Controlc OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed high schoold</td>
<td>1.53** (1.11, 2.13)</td>
<td>0.11</td>
<td>0.32*** (0.22, 0.47)</td>
<td>0.46</td>
<td>0.60*** (0.45, 0.81)</td>
<td>0.19</td>
<td>2.66*** (2.19, 3.32)</td>
</tr>
<tr>
<td>Attend collegee</td>
<td>1.65** (1.28, 2.11)</td>
<td>0.07</td>
<td>0.70*** (0.58, 0.83)</td>
<td>0.09</td>
<td>0.58** (0.47, 0.72)</td>
<td>0.12</td>
<td>3.31*** (2.82, 3.90)</td>
</tr>
<tr>
<td>Work 10 or more hours per weekf</td>
<td>1.38** (1.12, 1.72)</td>
<td>0.08</td>
<td>0.50*** (0.39, 0.65)</td>
<td>0.26</td>
<td>0.80 (0.62, 1.02)</td>
<td>0.08</td>
<td>...</td>
</tr>
</tbody>
</table>

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

a Wave I control for completed high school is average grade. There is no corresponding Wave I control variable for working 10 or more hours per week.

b For calculation of PAR values, these outcomes were expressed in negative terms (e.g., not completed high school).

c For enable comparison across predictors, PAR values for mentoring were computed with the mentoring predictor recoded so that a score of 1 represented not reporting a mentoring relationship.

d Analysis limited to respondents not currently enrolled in postsecondary education.

*P<.05; **P<.01; ***P<.001.

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%).
There was a significant mentor–individual risk × environmental risk interaction for depressive symptoms. Further examination indicated that the effect of having a mentor for this outcome was significant only for youth both with and without 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 × 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

### TABLE 3—Mentoring as Predictor of Psychological Well-Being Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mentoring OR (95% CI)</th>
<th>PARa</th>
<th>Individual Risk OR (95% CI)</th>
<th>PARa</th>
<th>Environmental Risk OR (95% CI)</th>
<th>PARa</th>
<th>Wave I Controlb OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem†</td>
<td>1.23* (1.01, 1.50)</td>
<td>0.03</td>
<td>0.86 (0.72, 1.02)</td>
<td>0.04</td>
<td>0.91 (0.76, 1.10)</td>
<td>0.02</td>
<td>2.25*** (1.93, 2.63)</td>
</tr>
<tr>
<td>Life satisfaction†</td>
<td>1.31* (1.05, 1.64)</td>
<td>0.04</td>
<td>0.63** (0.48, 0.83)</td>
<td>0.15</td>
<td>0.50*** (0.40, 0.63)</td>
<td>0.24</td>
<td>...</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>1.17 (0.87, 1.56)</td>
<td>...</td>
<td>1.63** (1.29, 2.06)</td>
<td>...</td>
<td>1.48* (1.17, 1.88)</td>
<td>...</td>
<td>3.92*** (2.98, 5.14)</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>1.08 (0.73, 1.59)</td>
<td>...</td>
<td>1.05 (0.75, 1.47)</td>
<td>...</td>
<td>1.59** (1.14, 2.21)</td>
<td>...</td>
<td>5.53*** (1.64, 5.14)</td>
</tr>
</tbody>
</table>

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

† Wave I control for self-esteem is self-esteem scale score; for depressive symptoms, the control is average frequency of depressive symptoms; for suicidal ideation, the control is experience of suicidal ideation in the previous year (yes/no). There is no corresponding Wave I control variable for life satisfaction.

b 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 recoded so that a score of 1 represented not reporting a mentoring relationship.

‡ For calculation of PAR values, these outcomes were expressed in negative terms (e.g., low self-esteem).
The mentoring relationships reported by par-
search.12,15,17,18,20,23 Methodologically, however,
findings have been reported in previous re-
and well-being of developing youth. Similar
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earlier time point in the Add Health study
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ability outcomes in the areas of education/work
ally representative samples and typically did
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that underlying beneficial mentoring relation-
service youth who were not experiencing ei-
risk alone, compared to when they were
and environmental risk, or environmental
whether respondent reported having had sexual intercourse at a time point prior to Wave I.

### TABLE 4—Mentoring as Predictor of Physical Health Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mentoring</th>
<th>Individual Risk</th>
<th>Environmental Risk</th>
<th>Wave I Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health</td>
<td>0.98 (0.77, 1.25)</td>
<td>0.79* (0.65, 0.96)</td>
<td>0.79* (0.64, 0.98)</td>
<td>2.15*** (1.90, 2.45)</td>
</tr>
<tr>
<td>Physical activity level</td>
<td>1.42*** (1.16, 1.74)</td>
<td>0.96 (0.81, 1.13)</td>
<td>0.73** (0.60, 0.89)</td>
<td>1.59*** (1.39, 1.82)</td>
</tr>
<tr>
<td>STD diagnosis</td>
<td>1.07 (0.71, 1.63)</td>
<td>1.19 (0.82, 1.71)</td>
<td>1.10 (0.76, 1.58)</td>
<td>2.57*** (1.78, 3.72)</td>
</tr>
<tr>
<td>Birth control use</td>
<td>1.40** (1.12, 1.76)</td>
<td>0.66*** (0.53, 0.81)</td>
<td>0.82 (0.64, 1.04)</td>
<td>0.78* (0.63, 0.96)</td>
</tr>
<tr>
<td>Condom use</td>
<td>1.23 (0.96, 1.56)</td>
<td>0.86 (0.71, 1.04)</td>
<td>0.77* (0.61, 0.98)</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.

1. 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.
2. 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 recoded so that a score of 1 represented not reporting a mentoring relationship.
3. For calculation of PAR values, these outcomes were expressed in negative terms (e.g., low physical activity level).
4. Analysis limited to respondents who were sexually active during the year prior to the Wave III assessment.

* P < .05; ** P < .01; *** P < .001.

earlier time point in the Add Health study
(approximately 6 years prior) were available
for most outcome measures, thus enabling
statistical control for the contribution of ear-
lier levels of functioning.

The results of the current study are consist-
tent with the view that mentoring relations-
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search.12,15,17,18,20,23 Methodologically, however,
those studies were not based on large, nation-
american 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 favor-
able outcomes in the areas of education/work
(i.e., completing high school, college attend-
dance, working ≥ 10 hours a week), problem
behavior (i.e., reduced risk of gang member-
ship and hurting others in physical fights and
decreased risk taking), psychological well-
being (i.e., heightened self-esteem and life sat-
isfaction), and physical health (i.e., greater
physical activity level, birth control use).

These findings suggest a broad and multifact-
eted impact of mentoring relationships on
adolescent health and well-being.

Longevity appears to be an important fac-
tor underlying beneficial mentoring relation-
ships.30,32–34 It is noteworthy, therefore, that
the mentoring relationships reported by par-
ticipants in the present study were often of
long duration (9.1 years on average). Long-
term ties provide opportunities for stronger
and more influential bonds to develop be-
tween mentors and youth.7 Furthermore,
the types of adults identified as mentors in
the current study often are important figures
in the day-to-day lives of youth—more than
40% of identified mentors were extended
family members, and approximately one-fourth
were teachers or guidance counselors.
Family and school are both primary
contexts for adolescent development. Men-
toring ties that are linked to these settings
thus may be especially well suited to pro-
moting positive outcomes.

However, mentoring relationships were not
indicated to have beneficial effects on all out-
comes examined in the current study. Favor-
able effects of mentoring were evident for all
but 2 of 9 positive outcomes (general health,
condom use), but were not apparent for 6 of
the 9 negative outcomes (binge drinking,
drug use, smoking, depressive symptoms, sui-
cidal ideation, STD diagnosis). In accordance
with this trend, Rhodes recently proposed a
model that specifically emphasizes the role
of mentoring in promoting positive developmen-
tal outcomes during adolescence such as
emotional well-being, social competence, and
academic achievement.7

There also are potential barriers to the ca-
capacity of mentors to decrease risk for various
negative youth outcomes. In the present re-
search, natural mentoring was not found to
be related to reduction in risk for any of the
types of substance use examined (binge
drinking, drug use, smoking). Evidence of
benefits for mentoring in this area has been
mixed in other research as well.12,35 Monitor-
ing by significant adults (e.g., parents) is an
important factor in preventing substance
use.36,37 Mentors, in comparison, are not
likely to be able to provide a high level of
monitoring if they have only periodic contact
with youth. In addition, mentors may inad-
vertently model behaviors such as alcohol
consumption or smoking.38 Finally, some
forms of substance use may be perceived as
normative by older adolescents and young
adults (e.g., binge drinking among college
students39) and may therefore be especially
difficult to deter through mentoring.

**Mentoring and At-Risk Youth**

Our findings generally failed to reveal
significant variation in the benefits of natural
mentoring relationships as a function of indi-
vidual or environmental risk. The interac-
tions 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 other 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.

About the Authors

David L. DuBois and Narda Silverthorn are with the Community Health Sciences Division, School of Public Health, University of Illinois at Chicago. Requests for reprints should be sent to David L. DuBois, PhD, Community Health Sciences Division, School of Public Health (MC 923), University of Illinois at Chicago, 1603 W Taylor St, Chicago, IL 60612-4324 (e-mail: dldubois@uic.edu).

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Contributors

D. L. DuBois conceptualized the study. N. Silverthorn conducted the analyses and wrote the first draft of the article. Both authors revised the article.

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Human Participant Protection

No protocol approval was needed for this study.

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