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Youth–Adult Connectedness:

A Key Protective Factor for Adolescent Health

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Abstract

Over the past 30 years, prevention science in the adolescent health field has moved from interventions focused on preventing single problem behaviors to efforts employing a dual approach, addressing risk factors that predict problems while simultaneously nurturing protective factors and promoting positive development. Through an examination of previous research and empirical case examples with vulnerable youth, this article considers the hypothesis that adolescents' sense of connectedness to caring adults acts as a protective factor against a range of risk behaviors. Multivariate analyses with existing data examined indicators of youth–adult connectedness among two groups at high risk for poor health outcomes: (1) mentor–youth relationship quality in a urban, ethnically diverse sample of students in a school-based mentoring program (2014 survey, N=239); and (2) parent–youth connectedness in a statewide sample of high school students who reported homelessness in the past year (2013 survey, N=3,627). For youth in the mentoring program, a high-quality youth–mentor relationship was significantly associated with positive social, academic, and health-related behaviors. Among students who experienced homelessness, all measures of parent connectedness were significantly associated with lower sexual risk levels. Collectively, findings from these analyses and previously published studies by this research group provide evidence that strong, positive relationships with parents and other caring adults protect adolescents from a range of poor health-related outcomes and promote positive development. Youth–adult connectedness appears to be foundational for adolescent health and well-being. Program, practice, and policy decisions should consider what strengthens or hinders caring, connected youth–adult relationships.

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Introduction

In a single generation, the field of adolescent health has experienced a profound shift in both inquiry and emphasis—moving from questions focused almost exclusively on risk to seeking an understanding of what promotes well-being and protects against harm in both vulnerable groups and general populations of young people.[1] Inherent in this shift is a perspective that views young people as resources to be developed, not problems to be solved."[2] This perspective is infused throughout the applied research at the University of Minnesota's Prevention Research Center (MN-PRC). MN-PRC research is guided by a framework that incorporates a strengths- and resilience-based orientation—the Healthy Youth Development (HYD) paradigm.

HYD is defined as "the events, opportunities and experiences that promote competence, confidence and caring in young people."[3] This paradigm increasingly guides youth-focused programs and research, both domestically and internationally.[4] HYD frames an expanding body of evidence in fields including developmental neuroscience, developmental psychology, prevention science, and social psychology that human connections are particularly salient during the adolescent years.[5,6] The concept of connectedness is an integral building block of HYD and core to the research of MN-PRC, both in the development of community-partnered interventions and analyses of large state and national data sets. In applied research guided by HYD, connectedness is conceptualized to include perceived caring, quality of and satisfaction with relationships, and a sense of belonging. Introduced into the adolescent health research literature in the late 1980s and early 1990s,[7–9] the positive effects of connectedness to pro-social adults— within family, school, or community—is a persistent finding in MN-PRC research and in studies with youth worldwide. Appendix Table 1 contains youth–adult connectedness studies conducted by researchers affiliated with MN-PRC from its inception in 1996. These studies illuminate the protective effects of connectedness. Both quantitative and qualitative research conducted by MNPRC has replicated these findings with groups of young people from diverse racial, ethnic, economic, and geographic backgrounds, and across a wide array of health-related outcomes.

Two original analyses conducted by MN-PRC researchers are presented below, explicating the protective effects of youth–adult connectedness for well-being among vulnerable youth. Connectedness is highlighted with an eye toward opportunities for prevention efforts through mentoring programs (Case Example 1) and among homeless youth (Case Example 2).

Case Example 1: Mentor–Mentee Relationship Quality and Youth Health-Related Outcomes

Benefits of mentoring for youth depend on the quality and duration of mentor–mentee relationships.[10] Although school-based mentoring is growing in popularity, best practices in this mode are still being defined, because matches are often shorter and constrained by school structure when compared with out-of-school mentoring programs. The Big Brothers Big Sisters– Greater Twin Cities school-based mentoring program was evaluated in 2014, with survey data from 239 mentors (69% female; mean age, 27 [range, 15–74] years; 77%

white). Demographic information on their 239 youth mentees (66% female; mean age, 10 [range, 6–16] years) was provided by Big Brothers Big Sisters. Mentees were racially/ethnically diverse (47% African American, 14% Hispanic, 15% white, 24% multiple/other); most were from low-income families (84% qualified for free/reduced price school lunch). Mentoring relationships varied in length (mean, 17 months; range, 1–60 months); almost all pairs (97%) were matched by gender. Multivariable regression analyses tested associations between relationship quality (6-item scale [α=0.73] assessing closeness, communication, and connectedness) and mentees' health-related behaviors, as reported by mentors.

Relationship quality was positively related to youth social skills ($p<0.01$) and school competence ($p<0.01$) (Table 1). Relationship quality was negatively related to mentees' bullying involvement ($p<0.05$) and school tardiness/absence ($p<0.05$). Although limited to mentor reports, findings consistently indicate that relationship quality is related to better youth well-being.

Case Example 2: Parental Connectedness and Sexual Health Among Homeless Youth

Homeless youth are at increased risk of poor health outcomes, yet little research has examined protective factors among this population. Current research is limited by convenience samples of families and youth from shelters and service agencies. The role of parental connectedness in sexual health behaviors among youth reporting homelessness was examined using data from a 2013 statewide, school-based survey of ninth and 11th graders in Minnesota. Overall, 5% of students reported being homeless in the past year ($n=3,627$, 45% female, 59% non-Hispanic white). Multivariable logistic regression analyses, stratified by sex, assessed associations between indicators of parental connectedness (perceived parent caring, communication with parents) and sexual health measures.

Almost half of homeless adolescents (44%) reported ever having sex. Of these, 58% used a condom at last sexual encounter and 20% had either been pregnant (girls) or had gotten someone pregnant (boys). All measures of parent connectedness were associated with less risky sexual behaviors in multivariable models ($p<0.05$), with slightly different patterns for girls and boys (Table 2). For example, although both girls and boys who perceived greater parental caring had lower odds of ever having sex or experiencing a pregnancy, parental caring was associated with increased odds of using a condom at last sexual encounter only among girls. Additionally, communication with either parent was associated with reduced odds of ever having sex, though among girls, only maternal communication increased odds of condom use.

Discussion

These case examples highlight the importance of youth–adult connectedness among young people traditionally considered as "at risk." Example 1 confirms the protective effects of connections between pre-teens, young teens, and their mentors within a school-based setting. Example 2 provides evidence that adolescent–parent relationships characterized by

caring and open communication are important for youth sexual health, even within particularly challenging circumstances like homelessness.

These case examples are cross-sectional and limited to in-school youth. However, together with studies included in Appendix Table 1, findings provide evidence that strong, positive relationships with parents, family members, teachers, school staff, and other caring adults can protect adolescents from a range of poor health outcomes and promote positive development. Research conducted by MN-PRC has operationalized youth–adult connectedness as a multidimensional construct including closeness, caring, and belonging. Further research is needed to examine the relative salience of specific dimensions of connectedness in protecting youth from various poor health outcomes,[11] and whether salient dimensions vary with development and across social and cultural contexts.

Youth–adult connectedness appears to be foundational for adolescent health and well-being and an active ingredient of effective interventions serving vulnerable youth. Thus, it is critical that program, practice, and policy decisions in public health, education, health, and social service settings consider what strengthens or hinders connected youth–adult relationships.[12] For example, as public health services weigh the merits of available programs, a focal question could be: “Does this program help to strengthen caring relationships between youth and adults?”

This body of research informs the next generation of preventive intervention studies at Minnesota’s PRC. Current MN-PRC research rigorously tests youth outcomes associated with interventions in which prosocial youth–adult connectedness is a key objective. For example, the effectiveness of a professional development program for middle school teachers that emphasizes student–teacher connectedness and student engagement to improve young teens’ health, educational, and developmental outcomes is being evaluated (BJ McMorris, University of Minnesota, unpublished observations, 2016). Personalized interventions are being developed that are tailored to the presence or absence of supportive pro-social adults in adolescents’ lives.[13] The aim of this research is to advance knowledge of approaches to bolster caring, mutually responsive youth–adult relationships in ways that promote the health and healthy development of young people.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Impact of Mentoring Relationship Quality on Youth Behaviors

	Social skills[b]		**Bullying involvement**[c]		**School competence**[d]		**Tardy/ absent**[e]	
Indicator of mentor-mentee relationship quality	**β**	**(SE)**	**β**	**(SE)**	**β**	**(SE)**	**β**	**(SE)**
Relationship quality[a]	**0.41** **	(0.09)	**−0.18** *	(0.09)		(0.09)	-	(0.14)
					0.34 **		**0.19** *	
R^2	0.22		0.13		0.20		0.11	

Notes:

Boldface indicates statistical significance (*p< 0.05; **p< 0.01).

Table shows results from multivariable regression models controlling for: youth age, youth sex, youth race (white, black, other), free/reduced lunch status, two parent household (vs. not), mentor age, mentor race (white vs. other) and length of match.

[a]Relationship quality scale; 6 items; alpha=0.73; example item: *I feel close to my Little [mentee];* response options: 1 *Strongly disagree* to 5 *Strongly agree*.

[b]Social skills scale; 3 items; alpha=0.71; example item: *My Little [mentee] is hard to get along with;* response options; 1 *Not at all true* to 5 *Very true* (reverse-coded).

[c]Bullying involvement; 2 items; r=0.35; example item: *My Little [mentee] picked on or bullied others at school or in his/her neighborhood;* response options; 1 *Never* to 5 *Very often*.

[d]School competence scale; 4 items; alpha=0.74; example item: *My Little [mentee] worked hard at school;* response options: 1 *Never* to 5 *Very often*.

[e]Tardy/absent measure; 1 item; *My Little [mentee] is late to school or skips school;* response options; 1 *Not at all true* to 5 *Very true*.

β, beta coefficient

Table 2

Odds of Sexual Behaviors and Pregnancy History Among Homeless Adolescents,[a] Stratified by Sex

	Ever had sex[b]		Condom use with last sex[c,d]		Pregnancy history[c,e]	
Indicator of parental connectedness	**OR**	**(95% CI)**	**OR**	**(95% CI)**	**OR**	**(95% CI)**
Females						
Perception of parent caring[f]						
Low (ref)	--		--		--	
High	**0.53**	**(0.41–0.68)** ***	**1.70**	**(1.16–2.47)** **	**0.48**	**(0.27–0.85)** **
Can talk with mother[g]						
No (ref)	--		--		--	
Yes	**0.78**	**(0.61–0.99)** *	**1.69**	**(1.21–2.35)** **	1.41	(0.88–2.25)
Can talk with father[g]						
No (ref)	--		--		--	
Yes	**0.58**	**(0.45–0.74)** ***	1.13	(0.80–1.60)	1.14	(0.71–1.85)
Males						
Perception of parent caring[f]						
Low (ref)	--		--		--	
High	**0.52**	**(0.42–0.65)** ***	1.10	(0.79–1.52)	**0.38**	**(0.24–0.59)** ***
Can talk with mother[g]						
No (ref)	--		--		--	
Yes	**0.57**	**(0.46–0.72)** **	1.14	(0.84–1.55)	0.81	(0.56–1.67)
Can talk with father[g]						
No (ref)	--		--		--	
Yes	**0.73**	**(0.59–0.90)** **	1.27	(0.93–1.73)	0.78	(0.54–1.13)

Notes:

Boldface indicates statistical significance (*p<0.05; **p<0.01; ***p<0.001).

Table shows results from multivariable logistic regression models controlling for: race/ethnicity, grade in school, urbanicity (living in Twin Cities metro area vs. not), SES (receipt of free/reduced price lunch vs. not), sexual orientation (gay or lesbian/bisexual/questioning vs. straight) and whether a parent or other adult family member was present during homelessness.

[a]Homelessness categorized based on adolescents' response to the question *During the past 12 months, have you stayed in a shelter, somewhere not intended as a place to live, or someone else's home because they had no other place to stay?* 1=yes (with parent/adult family member, or unaccompanied), 0=no.

[b]Report of ever having sexual intercourse; 1=yes, 0=no.

[c]Among adolescents who reported ever having had sex.

[d]Used a condom with last sex; 1=yes, 0=no.

[e]Number of times adolescent had *been pregnant or gotten someone pregnant*; 1=ever (1, 2 or more times), 0=never (0 times).

[f]Adolescents' perception of how much parents care about them; 1=high (very much), 0=low (not at all, a little, some, quite a bit).

[g]Can talk with mother/father about problems they are having; 1=yes (some or most of the time), 0=no (not very often, not at all, mother/father not around).

ref, referent category

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