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BARRY UNIVERSITY

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by

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Dedication

This thesis is dedicated to:

My husband, my son, my mother, and grandmother.

Thank you to my husband and soul mate, Nekoro. I've heard it said, "Your soul mate is not someone who comes into your life peacefully. It is who comes to make you question things, who changes your reality, someone that marks a before and after in your life. It is not the human being everyone has idealized, but an ordinary person, who manages to revolutionize your world in a second." You have transformed my world from our very first encounter in junior high school, and you continue to do so today. Your support, encouragement, and patience have been indispensible in my journey. Thank you to my baby boy, Nassir, whose smiles, giggles, hugs, kisses, and infinite declarations of, "I love you Mama" kept me motivated. Reach for the stars Baby. A special thank you to my mother, Patricia. Mommy: where would I be without you? Thank you for always trusting and believing in me. From as far back as I can remember you allowed me the freedom and autonomy to make my own decisions and learn from my own mistakes. Thank you for the sacrifices you have made in order to see me succeed. Your strength and love have carried me through. And finally, a very special thanks to my grandmother, Mary. You laid eyes on me and said, "I have to take that child back with me to the States," and you did. I love you so much for the opportunities that you have afforded me, and for the knowledge and wisdom that only my Mum could provide. I am forever grateful to all of you.

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Abstract

Adolescence is a delicate developmental period with substantial emotional, social and psychological growth. This period, with its daily challenges and adversities, has the propensity to become overwhelming. Research suggests that natural or nonparental mentors help to ease the consequences associated with these difficulties, through their support and guidance (Klasen et al., 2015; Tolan et al., 2014). The purpose of this research was to examine the influence of nonparental mentors on adolescent self-efficacy, self-esteem, and resiliency. The adolescent participants included 79 middle school students (62% female and 38% male) of Haitian descent. It was hypothesized that nonparental mentors would be correlated with self-efficacy, self-esteem, and resilience and nonparental mentors would predict self-efficacy, self-esteem, and resiliency in adolescents. Participants completed a series of self-report questionnaires online. Findings revealed a positive correlation between perceived social support and self-esteem ($r = .26$, $n = 71$, $p < .05$), and a positive correlation between perceived social support and resilience ($r = .47$, $n = 74$, $p < .01$). Enacted social support was positively correlated with resilience ($r = .43$, $n = 75$, $p < .01$). Stepwise multiple regressions were conducted to determine if social support would predict self-efficacy, self-esteem, and resiliency. Both perceived and enacted social support significantly predict resilience in adolescents ($R^2 = .33$, F (2, 69) = 17.01, $p < .001$). Results of this study support the notion that nonparental mentors play an important role in the lives of young people, specifically concerning resilience.

What Is The Effect Of Nonparental Mentors On Adolescents?

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Nonparental mentors are important adults who significantly influence adolescents, and on whom adolescents can rely for support. They are also referred to as "natural mentors" and may be an indispensable component in the lives of adolescents (Hurd & Zimmerman, 2010a). Natural mentors may be extended family members, teachers, employers, church representatives, neighbors, coaches, or older friends. Research suggests that natural mentors play an important role in the healthy development of adolescents (Hirsch, Deutsch, & DuBois, 2011; Schwartz, Chan, Rhodes, & Scales, 2013). Nonparental mentors are likely to have an effect on the lives and psychological development of adolescents through their ongoing support and guidance. Research has examined these roles and relationships and the effects of mentors on adolescent development. This research is important because it provides knowledge and information to assist in the understanding of at-risk youth. Nonparental mentors have a tendency to be beneficial in the lives of young people with regards to providing support and motivation, influencing academic and overall achievement, and fostering positive coping skills.

Adolescence represents a sensitive, vulnerable developmental period in which much emotional, social and psychological growth occurs. Adolescence is the time for the establishment of positive health and health routines (Curtis, Waters, & Brindis, 2011). The everyday challenges and obstacles adolescents face, ranging from uncomplicated to demanding, foster positive growth and development. In addition, adolescents are susceptible to even slight changes taking place in their environment (Komro, Flay, & Biglan, 2011). At-risk youth may face additional challenges during adolescence. These at-risk adolescents are more likely to engage in problem behaviors like alcohol and

substance use (Myers, 2013). Risks include disease restrictions, diminished functional ability, psychosocial stressors, low socioeconomic status (SES), limited social support, low caregiver education, and poor family functioning (Karlson et al., 2012). Some factors that may place adolescents at risk include involvement with the child welfare system, having teen mothers, and/or living in poverty (Brownell et al., 2010). Although all of these risk factors play a role in shaping adolescents' lives, poverty is a central risk factor for mental, emotional, and behavioral disorders, developmental challenges, and physical health problems (Komro et al., 2011). If interventions or preventative strategies are not utilized, the adversities of at-risk adolescents may further complicate their adult lives.

Research on poverty shows that health and well-being deteriorate with the decline of socioeconomic status, regardless of age (Wadsworth, Raviv, Santiago & Etter, 2011). Many economically disadvantaged adolescents fall victim to these negative effects, leading them to a destructive path. Some adolescents, however, demonstrate resilience, with the support of natural adult mentors. The purpose of the study is to examine the role of nonparental mentors on adolescent self-efficacy, self-esteem, and resiliency. The following section will consist of a review of the current literature relating to adolescent adversity. It begins by drawing attention to risk and protective factors of adolescents. A review of resilience theory and its four models of resilience will follow this section. Next, the social support theory is highlighted. The resiliency model of family stress, adjustment and adaptation, in addition to its domains of family functioning, are addressed. Finally, the role of mentors and their quality of relationships with adolescents

will be discussed. A study will be proposed which consists of the purpose, hypotheses, method, results, and discussion sections.

Risk and Protective Factors of Adolescents

Adolescence is a delicate transitional phase in human development marked by a myriad of changes. The conventional vicissitudes and challenges faced by adolescents during this time period can prove overwhelming. There are additional factors that also emerge during this time. These elements are referred to as risk and protective factors. The complex interactions involving these factors add to the mental health and development of adolescents. Risk factors are events, conditions, or experiences that increase the likelihood that a problem will be formed, maintained, or exacerbated. Protective factors are buffers against risk factors, and may directly influence the likelihood that a problem will increase (Myers, 2013). Nylander, Seidel, & Tindberg (2014) described protective factors as conditions that improve people's resistance to risk factors and disorders. Protective factors counterbalance the impact of risks, in addition to fostering healthy development.

Researchers understand the importance of studying psychosocial risk and protective factors of the developing adolescent as it relates to mental health. Adolescence is a critical time for the emergence of psychological disorders like depression and anxiety. Studies show that mental health problems in young people are common, possess the propensity for early onset, usually at age 13, and are among the major public health challenges of our times (Kessler et al., 2012). Research has demonstrated risk factors and the function that they serve in effecting adolescent behavior (Klasen et al., 2015). It is important to investigate these factors pertaining to psychological development in order to

find the best solutions to successfully counteract them while promoting resilience. It is also necessary to understand the manner in which risk factors interact with protective factors. Generally, decreasing risk factors and increasing protective factors can promote resiliency among youth (Maguire, 2013). Researchers are increasingly investigating protective factors, as they contribute to maintaining and rebuilding mental health despite risks (Klasen et al., 2015). Risk and protective factors interact on several different levels. This interaction, taken together with the diversity of each individual, makes it difficult to develop tailored prevention and intervention programs. However, possessing the knowledge of biological, personal, familial and social determinants of risk and protective factors assists in making it possible (Klasen et al., 2015).

Researchers have identified several potential risk factors that influence adolescent mental health and development. Parental mental health disorders are a well-established and well-known indicator of child psychopathology. It leads to the increased likelihood of depression, phobias, panic disorders and substance misuse during adolescence (Klasen et al., 2015). Researchers investigated the long-term impact of risk and protective factors on symptoms of depression in children and adolescents. Specifically, they studied the risk factor of parental psychopathology and its interactions with three protective factors. These are self-efficacy, family climate, and social support (Klasen et al., 2015). Results indicated that all three protective factors were associated with less initial depressive symptoms. Moreover, increases in these factors were associated with the development of less depressive symptoms over time. These findings illustrate the importance of self-efficacy, the functional family, and perceived social support in young people predisposed to depression and experiencing depressive symptoms.

A nearly identical longitudinal study involving youth from immigrant backgrounds yielded similar results. Nguyen, Rawana, and Flora (2011) investigated the predictive effects of risk and protective factors on depressive symptoms. They hypothesized that developmental risk factors like family dysfunction, parental rejection, and problematic parent–child conflict resolution would be related to higher levels of initial depressive symptoms. They hypothesized that the impact of these factors would be associated with sharper increases in depressive symptoms or less sharp declines in symptoms throughout adolescence. Regarding protective factors, researchers hypothesized that self-esteem, optimism, positive peer relationships, and parent–child cohesion would be associated with lower levels of depressive symptoms at onset. They also expected these protective factors to be associated with less steep increases in depressive symptoms or steeper declines in depressive symptoms across adolescence into adulthood. Researchers found that higher levels of self-esteem, optimism, positive peer relationships and maternal cohesion were associated with lower initial levels of depressive symptoms. Paternal cohesion, family dysfunction, and problematic paternal conflict resolution were not significantly correlated with youth symptoms of depression. Conversely, low levels of maternal conflict resolution were associated with an increase in depressive symptoms. Although researchers hypothesized that risk and protective factors would have an effect throughout adolescence into adulthood, results were not significant. Protective factors like self-esteem, optimism, positive peer relationships, and mother–child cohesion were all shown to safeguard against symptoms of depression at onset.

Similarly, Olives et al. (2013) studied the effects of the same risk factor, parental mental health, in addition to life events, and home life. They investigated the impact on adolescents' mental health as it related to behavioral conduct, emotions, and hyperactivity scores. Mediators included social support and financial support. The results confirmed that parental mental health is one of the primary risk factors related to influencing young people. Positive home life was considered a protective factor, and according to the participants surveyed, it possessed the most influence on adolescents' mental health. Concerning the mediators, the study showed that youth benefit from both social and financial support. These results demonstrate the importance of home life as it relates to family cohesion, parents' availability, and support in the prevention of mental health problems in adolescents.

Additional psychosocial risk factors include friends, school, and unstructured leisure activities, according to Myklestad, Røysamb, and Tambs (2012**)**. However, they also refer to social support as it relates to friends, family, and school as the most important protective factors of healthy adolescent development. These researchers investigated potential adolescent and parental psychosocial risk and protective factors for predicting psychological distress among adolescents. They examined whether adolescents' psychosocial variables would operate as a mediator between parental variables and adolescents' psychological distress. They also explored gender differences in the effects of risk and protective factors on adolescent psychological distress. Results indicated that psychosocial variables like academic achievement and being bullied at school were strong and consistent predictors of psychological distress among adolescents. The strongest protective factors for psychological distress consisted of social support

from friends and spending time with friends during leisure time. Concerning parental variables like alcohol abuse and separation or divorce, the findings showed them to have a significant direct effect on adolescent psychological distress prior to adjusting for adolescent psychosocial variables. This reduction in adolescent psychological distress shows that their psychosocial variables mediate the effects of their parents. Concerning gender differences, females were more susceptible than males to several psychosocial risk factors, in terms of psychological distress. Some of these risk factors consist of living alone, father's alcohol use/abuse, having seen their parents being drunk, academic achievement in school, conduct problems in school, dissatisfaction in school, being with friends during leisure time, smoking daily, and frequently consuming excessive amounts of alcohol. For males, structured leisure activity was the only predictor that was more important for psychological distress when compared to the females. Results indicate how important it is to implement interventions at the school level. These interventions could assist youth with regards to academics and the prevention of bullying. Some of the interventions should also be varied related to gender discrepancies of risk factors.

Myers (2013) executed a study to identify risk and protective factors associated with alcohol and substance abuse among African American adolescents in a rural community. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2006, as cited by Myers, 2013) found that although these young people are exposed to risk factors at a higher rate than their Caucasian counterparts, they consume alcohol and employ illegal drugs at a lower rate. However, by young adulthood, African Americans have surpassed Caucasians in alcohol and drug consumption (Myers, 2013). The author of this study ascertained a number of possible risk and protective factors

associated with substance use. Risk factors included being 16 years of age or older, being raised by non-family members, spending time after school with friends, having friends and family who use substances, and having plans to enroll in the military following high school. The protective factors included being raised in a home with parents or other family members, spending time after school with parents, having parents who discuss the dangers of substance use and their disapproval of it, participating in extra-curricular church-related activities, and having plans to enroll in college or technical school following high school. The findings also suggest a correlation between using drugs and alcohol and having friends who consume these substances. It appears that peer influence, parental support, and open communications are considerable protective components in the life of an adolescent.

Social disorganization is another psychosocial risk factor. Social disorganization refers to poverty, economic and residential instability, family disruption, and violence (Nasim, Fernander, Townsend, Corona, & Belgrave, 2011). These researchers investigated the relationship between community disorganization and substance use among rural African American adolescents. Their objective was to understand how specific individual and community level factors interact to increase or decrease one's tendency to engage in substance use. Another goal was to identify protective factors to prevent substance use. They posited that community disorganization would significantly predict substance use among the adolescents. They further predicted that traditional, cultural attitudes and behaviors would moderate the relationship between community disorganization and substance use. Findings demonstrated a significant association between community disorganization and substance use. However, traditional religious

beliefs and practices were associated with both promotive and protective-stabilizing effects. More specifically, these religious beliefs were associated with decreases in substance use in addition to maintaining adolescents' low susceptibility to substance use despite worsening conditions. Traditional family practices also moderated the effects of community disorganization, presenting a protective, but reactive effect. Adolescents who reported highly traditional family practices were more susceptible to substance use as community disorganization worsened. Researchers related this to the notion that traditional African American families are characterized by interdependence and collectivism, which extends to the neighborhood. When the community lacks resources and support, it makes it difficult for the adolescent and family to thrive. This is a clear indication that risk and protective factors occur on multiple levels. As a result, it is necessary to implement strategies to increase protective factors not only in the individual and familial context, but at the community level as well.

Further research shows that adolescents who are socially connected and involved in organized activities are more likely to experience subsequent adult well-being for six to ten years into young adulthood (Mahoney & Vest, 2012). This suggests that organized activities serve as a protective factor. Mahoney and Vest (2012) examined whether the amount of time spent in structured activities during adolescence related to positive or negative adjustment during young adulthood. They addressed four major questions. They assessed whether the positive outcomes associated with activity intensity during adolescence would continue into adulthood, whether or not family income and age would moderate this relationship, whether or not the over-scheduling hypothesis (OSH) depended on the adolescents' age, and whether linear relationships between activity

intensity and adjustment in young adulthood would provide an adequate test of the OSH. Activity intensity was assessed in terms of weekly hours spent partaking in activities. OSH refers to the notion that too much participation in activities leads to poor developmental outcomes. Results indicated that participation in organized activities predicted positive adjustment into adulthood. Organized activities were unrelated to several indicators of negative adjustment through adulthood. Findings showed that the more time youth spent engaging in structured activities, the more their positive adjustment increased. This relationship was maintained despite family income and age. Regarding the OSH, results did not show a significant relationship between activity intensity and any of the outcomes at young adulthood. Structured activities during adolescence were consistently linked to positive adjustment.

Overall, research has established that individual, familial, and social dynamics all converge to generate both risk and protective factors. Risk factors include parental psychopathology, parental rejection, and problematic parent–child conflict resolution. Family dysfunction including alcohol abuse, separation or divorce, and being raised by non-family members constitutes a risk factor. Having friends and family who use substances, participation in unstructured leisure activities, and having plans to enroll in the military after high school are risk factors. Social disorganization related to poverty, economic and residential instability, and violence are also risk factors for adolescents. Conversely, protective factors consist of high self-efficacy, self-esteem, and optimism. Positive family climate and home life including parent–child cohesion, being raised in a home with parents or other family members, and spending time after school with parents, all serve as protective factors. Having parents who discuss the dangers of substance use

and their disapproval of it is also an important factor. Maintaining traditional religious beliefs and practices, participating in extra-curricular church-related activities and other structured activities, and having plans to enroll in college or technical school after high school are also protective factors. Positive peer relationships and social support related to friends, family, and school are also important protective factors. All of these risk and protective factors need to be considered in the development of adolescent prevention and intervention plans.

Resilience Theory

Adversity or risks refer to negative life circumstances associated with adjustment difficulties (Myers, 2013). Resilience is considered a multidimensional process. The resilience process refers to positive adjustment among young people who have been exposed to one or more risk factors (Fergus & Zimmerman, 2005; Hurd & Zimmerman, 2010a). It is important to note that resilience cannot exist without the presence of risks and promotive factors (Fergus & Zimmerman, 2005). There are several models of resilience. This includes compensatory, protective factor, the challenge model, and attachment theory. The resiliency models posit relationships and processes, and concurrent analytical strategies for testing them (Zimmerman, 2013). Resilience theory focuses on healthy adolescent development, instead of the negative aspects associated with risk exposure alone. It takes a strengths-based approach in understanding youth development and formulating intervention strategies (Fergus & Zimmerman, 2005; Zimmerman & Brenner, 2010). The theory explains the interaction between risk factors and compensatory or protective promotive factors (Hurd & Zimmerman, 2010a).

Promotive factors are positive contextual, social, and individual variables that operate in opposition to risk factors. They help youth overcome negative effects of risk exposure (Fergus & Zimmerman, 2005; Zimmerman & Brenner, 2010). There are two main promotive factors that help adolescents reduce or avoid the effects of environmental risks. These are assets and resources. Assets are internal attributes that adolescents rely on during times of adversity. These attributes include positive coping skills, competence, self-esteem, and self-efficacy. In contrast, resources refer to positive factors that are external and varied based on the individual's environment. Resources may consist of positive adult mentors, parental support, extracurricular activities and a wide array of constructive social establishments (Fergus & Zimmerman, 2005). When adolescents exhibit social competence and age-appropriate developmental functioning in the face of adversity, it is referred to as positive adaptation (Klasen et al., 2015). These patterns of positive adaptation are known as resilience.

Models of Resilience

There are several models of resilience. The three prominent models explain how promotive factors reduce or eliminate the negative effects associated with adolescent risks. The models are the compensatory or additive model, protective factor or interaction model, and challenge model. The remaining, less familiar model of resilience is referred to as attachment theory. The compensatory or additive model explains the way an asset or resource directly alleviates a risk factor (Zimmerman, 2013). It posits that risk and protective factors have additive effects on maladjustment. When the protective factors outweigh the risk factors, it results in resilience (Hatala, 2011). For example, an adolescent living in poverty is considered at-risk for numerous psychological

effects and/or problem behaviors. However, having parental support or a positive adult mentor can counteract the effects of these risks, serving as a buffer between the risk and the adolescent (Hurd & Zimmerman, 2010a).

The protective factor model, otherwise known as the interaction model, explains the way in which promotive factors moderate the effects of a risk on negative outcomes. This model is similar to the compensatory model in that high levels of parental support and/or a nonparental mentor may reduce the effects of risks on the adolescent. Competence may also reduce these risks. The protective factor model posits that protective factors only emerge during high-stress situations, while remaining inactive during daily low-stress situations (Hatala, 2011). There are two different approaches in which the protective model can affect outcomes. The approaches are the risk-protective model and protective-protective model (Zimmerman, 2013). The risk-protective model posits that a protective factor such as a nonparental mentor moderates or reduces the effects of the risk. However, when that protective factor is absent, the connection between the risk and negative outcome increases. Regarding the protective-protective model, the protective factor enhances the effects of one's assets or resources. Just as in the risk-protective model, when the protective agent is missing, the correlation between risk and negative outcome grows stronger.

The challenge model of resilience stands apart from those aforementioned. In the challenge model, introduced by Rutter (1987), the risk and promotive factors are the same and are categorized according to the level of intensity and the outcome. In this model, the level of adversity should be moderate to allow the adolescent to develop the necessary assets to handle the challenge. Otherwise, they must learn to utilize their

available resources to address it. If the challenge is too undemanding, the necessary skills will not have the opportunity to develop. If the adversity is excessive, the adolescent will be inundated and have difficulty recovering, ultimately being overcome by negative effects associated with the risks. Ideally, when adolescents are repeatedly subjected to low-level risks, they develop the necessary promotive factors to overcome high levels of adversity (Fergus & Zimmerman, 2005).

The attachment theory of resilience, developed by Bowlby and Ainsworth, postulates that resilience is associated with internal personality traits, resulting from early developmental attachment styles. The attachment style, whether secure or insecure, predicts a child's ability to be resilient. Individuals who possess a secure attachment style are more likely to demonstrate resiliency when faced with adversity than those with an insecure attachment style (Hatala, 2011).

Limitations

Although the resilience theory appears thorough, there are limitations and criticisms. First, researchers lack uniform terminology concerning resilience phrases and definitions (Greene, 2014; Smith-Osborne & Bolton, 2013). Some researchers describe resilience as a cluster of personality traits while others refer to it as a process leading to positive adjustment (Greene, 2010; Hurd & Zimmerman, 2010a). The lack of a single, operational definition delays the progression of research in the field. It is necessary for researchers to establish the appropriate constructs using a homogenous set of words and definitions. A further limitation to resilience theory is that the overall concept of resilience is not fixed and definitive. Resilience constructs vary from one individual to the next and from one situation to the next. For instance, an adolescent may demonstrate

resiliency in the face of one type of adversity, but be defenseless concerning another circumstance. Moreover, provided the same risk factor, adolescents may utilize different assets or resources in order to overcome the negative associations with the situation (Myers, 2013; Myklestad et al., 2012).

Another limitation to resiliency research is the lack of explanations as to why a specific reaction occurred (Fergus & Zimmerman, 2005). When adolescents are confronted with adversities, they utilize a combination of assets and/or resources to cope or manage them. However, there needs to be a further explanation when the outcome is successful. In this way, it may be applied to future situations of a similar caliber. For instance, when a specific resource is successful in counteracting the effects of a specific risk, the reason for that particular outcome needs to be examined. Although resilience theory has a few limitations, it is helpful with regards to understanding and generalizing the process and outcome of resilience. It also leads to further research on social support theory. Social support theory focuses on relationships with others.

Social Support Theory

Social support, which is defined as having someone who listens and gives support outside the family, such as friends, peers, teachers, or other caregivers, has demonstrated a protective effect on mental health in various cross-sectional studies **(**Klasen et al., 2015; Myklestad et al., 2012). The nature of support may be informational, physical, emotional (showing empathy or love), instrumental (providing financial support), and appraisal (information promoting self-evaluation) (Kim, Connolly & Tamim, 2014). Social support theory is similar to resilience theory with regards to the promotive factor of having an adult mentor or important person to depend on during times of adversity. The

effect of support on mental health, regardless of the presence or the extent of stressors, is referred to as direct effect (Bae, 2015). Social support, whether from parents, positive peers or positive adult mentors, serves as a buffer between detrimental life circumstances and their negative effects.

Hurd and Zimmerman (2010a) conducted a longitudinal study to investigate the effects of natural mentors on African-American high school seniors. They hypothesized that youth with natural mentors would have greater declines in depressive symptoms, sexual risk behavior, and substance use. Findings indicated that having a natural mentor was associated with less depressive symptoms and sexual risk behavior. Having a mentor did not have a significant effect on substance use. Another study examined the influence of violence exposure and social support on depression (Eisman et al., 2015). They sampled urban adolescents during the course of high school. Researchers found that being exposed to violence and conflict in the family were both associated with increased symptoms of depression. However, among these same adolescents exposed to violence, those with high mother support were less likely to suffer from symptoms of depression and poor health than adolescents receiving lower levels of support from their mothers. Social support is instrumental for at-risk youth.

The Resiliency Model of Family Stress, Adjustment and Adaptation

The Resiliency Model of Family Stress, Adjustment and Adaptation is a conceptual framework developed by McCubbin and McCubbin (1996). It is an extension of both the Family Stress Model and the Resilience Theory (Brown, Howcroft, & Muthen, 2010). The Resiliency Model of Family Stress, Adjustment and Adaptation is unique in that it takes the family perspective and experience into account, as opposed to

the sole viewpoint of the adolescent. It examines the ways in which family strains modify the family system, and each individual member (Shin, Choi, Kim, & Kim, 2010). Consistent with resilience theory, this model focuses on the healthy aspects of psychological and physical development rather than the negativity of adverse life situations. Furthermore, family resilience emphasizes the strengths and limitations of the family unit and their role as a resource to support and benefit each member. The Resiliency Model of Family Stress, Adjustment and Adaptation incorporates trials and tribulations into the family's history (Brown et al., 2010).

Domains of Family Functioning

When a family is faced with adverse conditions, such as life-threatening or life-changing sickness, the death of a loved one, or other unanticipated circumstances, certain functions need to be in place in order for its members to effectively recover. These are called the four major domains of family functioning (Greeff & Wentworth, 2009). These domains include interpersonal relationships and development, well-being and spirituality, community relationships and nature, and structure and function. In addition, these four domains operate on the basis of five fundamental assumptions. The first of these essential assumptions is that a family faces hardships as a natural and predictable part of life. Second, families develop assets such as basic competencies and abilities meant to promote growth and development among its members. Third, these competencies and abilities are unique to the family and designed to protect them from any unexpected or abnormal stressors and strains. The competencies and abilities help the family recover from crises or major changes. Fourth, families draw from and contribute to the network of relationships and resources in their community, including ethnicity and cultural

heritage, especially during a crisis. The fifth assumption is that families faced with a crisis that demands changes in the family functioning work to restore order, harmony, and balance within their unit (Greeff, & Wentworth, 2009). Once the aforementioned domains of family functioning and five fundamental assumptions are in place, the family is prepared to enter the adjustment and adaptation phase of the Resiliency Model of Family Stress, Adjustment and Adaptation.

Adjustment and Adaptation

There are two related processes that a family may undergo during times of a crisis. Depending on the family's reaction, they risk becoming trapped in the cycle, which is considered maladjustment or maladaptation. However, if they utilize their assets and resources to their benefit, they can adapt successfully, restoring the family's harmony, balance, and structure. Adjustment requires protective factors that influence the family's ability and efforts to maintain normal functioning during a crisis. Adaptation however, concerns the family's ability to recover and adapt in these times of turmoil. Adaptation focuses on the family's recovery factors (Brown et al., 2010). The outcome of the crisis or adverse situation ranges from positive (bonadjustment) to negative (maladjustment). If the family negatively adjusts to the given circumstance, they reenter the crisis phase, in which they are forced into new patterns of functioning and an imbalance. If they positively adjust, they complete the cycle and reestablish balance and harmony within the family structure (Greeff, & Wentworth, 2009).

Mentors

Traditionally, mentors have been associated with official, structured mentoring programs, such as the Big Brothers Big Sisters program. However, mentoring relationships are capable of developing in a variety of informal ways with nonparental adults, providing much-needed support, guidance and encouragement to youth (Hurd & Zimmerman, 2010a). Natural mentors are nonparental adults who play an important role in the adolescent's life. They are usually within their social network of extended family, neighbors and older friends (Hurd & Zimmerman, 2010a). However, these high-quality relationships between youth and caring adults may also commence in community settings, establishing the foundation for deeper youth involvement and skill development (Hirsch et al., 2011; Schwartz et al., 2013). Relationships with nonparental adults may be a key resource for youth. These relationships help protect youth from negative outcomes associated with adversity (Hurd & Zimmerman, 2010a). Generally, natural mentors are more effective than formal mentors or volunteers, because of their frequent and prolonged contact, energy, and understanding of the youth. Additionally, since natural mentors are already involved in the adolescent's social circle, they possess a better knowledge of the more personal, family, and cultural issues (Hurd & Zimmerman, 2010a).

At-risk youth seem to benefit a great deal from the supportive role of a nonparental mentor. These mentors serve as buffers against depression, anxiety, stress, and other psychological symptoms. Hurd and Zimmerman (2010b) examined African American mothers beginning in their senior year of high school and extending over the course of five years. They hypothesized that adolescent mothers with natural mentors

would demonstrate greater decreases in depressive symptoms and anxiety over time. They further hypothesized that the adolescent mothers with natural mentors would show a weaker relationship between stress and mental health problems over time. Results indicated that adolescent mothers reported fewer symptoms of depression, anxiety, and problem behaviors when they had the social support of a natural mentor, compared to those without mentors. The results remained consistent over the five-year time period.

Studies involving mentors have found significant effects of decreasing externalizing and internalizing behavior problems (Tolan, Henry, Schoeny, Lovegrove, & Nichols, 2014). Moreover, there is an increase in positive outcomes as well as a decrease in negative behaviors (Whitney, Hendricker, & Offutt, 2011). Whitney et al. (2011) examined the presence and quality of a natural mentor, the type of mentor, and the quality of mentor in the lives of adolescents. The findings indicated a significant relationship between high-quality mentoring and increased self-esteem, lower incidences of alcohol problems, and fewer symptoms of depression, compared to low-quality mentors. Results also indicated that adolescents with adult mentors showed fewer symptoms of depression and fewer alcohol problems when compared to youth with peer mentors. These findings suggest that high-quality, adult mentors have a positive, long-lasting effect on youth.

The presence of natural mentors has also been linked to positive attitudes concerning school and long-term educational attainment. Researchers explored whether relationships with natural mentors would influence the attitudes of academically at-risk African American adolescents through adolescents' racial identity beliefs (Hurd, Sánchez, Zimmerman, & Caldwell, 2012). They hypothesized that natural mentors

would foster adaptive racial identity beliefs by helping adolescents view their race as an important part of their identity, helping them feel positive about themselves and other members of their race, and helping them raise their awareness of barriers resulting from racial bias. They predicted that the mentors would contribute to an adaptive set of racial identity beliefs, which would promote positive academic outcomes among the adolescents. They further hypothesized that the presence of the mentor would be associated with adolescents' beliefs concerning the importance of school for future success and long-term educational attainment through their racial identity beliefs. Lastly, researchers postulated that adolescents who reported higher levels of racial centrality would have stronger relations between private and public regard and their beliefs in school being important for future success and long-term educational attainment.

Racial centrality is the extent to which they define themselves in relation to race (Sellers, Smith, Shelton, Rowley, & Chavous, 1998). Private regard includes positive or negative perceptions of one's racial group and the membership in that group, whereas public regard refers to one's perception of how society perceives the racial group. Researchers found that having a natural mentor predicted higher levels of racial centrality, private, and public regard. Additionally, adolescents with mentors were found to have stronger beliefs in the importance of school for future success through their private regard. Stronger beliefs about the importance of school for future success predicted higher levels of academic attainment five years later. Researchers speculated this was the case because of the possibility that mentors play the role of social mirrors, otherwise referred to as the looking-glass self, a term coined by Cooley (1902). The looking-glass self describes the process of the mentors' opinions and perceptions of the

adolescent being incorporated into the adolescent's self-perception and identity (Hurd et al., 2012; Schwartz et al., 2013). This study demonstrated positive effects concerning academically at-risk African American adolescents. Relationships with their natural mentors promoted improved long-term educational attainment.

Schwartz et al. (2013) conducted a study to investigate contextual factors like adolescent involvement in activities and general community attitudes toward them, which may be associated with natural mentoring relationships. They also explored the mediating role that the mentoring relationships could possibly play in explaining associations between the contextual factors and youth outcomes. Researchers hypothesized that greater involvement in youth activities and more positive perceptions of community attitudes toward youth would be associated with an increased likelihood of a mentor and higher quality relationships. They further postulated that positive youth outcomes would be associated with higher quality mentoring relationships. Finally, they posited that the presence of a mentor and the quality of that relationship would partially mediate the relationship between the aforementioned contextual factors and youth outcomes. Findings suggested that adolescent involvement in structured activities and increased perceptions of being valued by the community were associated with an increased likelihood of having a mentor. Furthermore, while the increased perceptions of being valued by the community were associated with higher quality mentoring relationships, participation in structured activities was not associated with the mentoring quality. The quality of these mentoring relationships did mediate the association between the community's attitudes toward adolescents and the adolescents' school engagement, mastery, prosocial values, and purpose. The mentor significantly mediated the

association between activity involvement and perceptions of community attitudes toward youth and youth outcomes for prosocial values. Results of studies like these suggest that communities need to focus on creating structured activities for youth, in addition to fostering positive attitudes toward them. Building communities that are conducive to natural mentoring relationships may result in more enduring relationships and greater numbers of youth connected with mentors.

Quality of Mentoring Relationship

Emotional closeness and amount of time spent together determine the quality of a mentoring relationship. Studies have shown that higher quality mentoring is associated with higher self-esteem, fewer alcohol problems, and fewer symptoms of depression when compared to lower quality mentoring (Whitney et al., 2011). One study explored how the Big Brothers Big Sisters school-based mentoring program affected students' academic attitudes, self-esteem, misconduct, grades, and prosocial behavior (Chan et al., 2013). They hypothesized that the effects of high-quality relationships on positive youth outcomes would be mediated through their positive influence on parental relationships. They also hypothesized that these effects would be mediated through their positive influence on teacher–student relationships. Results indicated that higher quality relationships between mentors and adolescents were associated with positive student outcomes and improvements in students' relationships with their parents and teachers. These improvements, in turn, were associated with school-related psychological and behavioral outcomes. Youths receiving high quality mentoring displayed improved academic attitudes, self-esteem, and prosocial behavior.

The frequency of contact is another factor strongly correlated with closeness and duration of the mentor relationship. Both are significant predictive factors of positive effects. Research in mentoring has demonstrated the importance of intensive, individual one-to-one relationships with caring adults (Hirsch et al., 2011; Hurd et al., 2012). Perceived support, the idea that support would be available if needed, is also important. Some of the ways in which adolescents may perceive support from mentors include everyday emotional support, emotional support in response to problems, instrumental support, social companionship and informative support (Drogendijk, van der Velden, Gersons, & Kleber, 2011). When adolescents experience a greater connection in their mentoring relationships, they tend to have higher social skills and psychological well-being compared to adolescents experiencing less of a connection to a mentor (Hurd, Varner, & Rowley, 2013). There is extensive research to support the notion that quality is the key to a successful mentoring relationship (Chan et al., 2013; Whitney et al., 2011).

Limitations

Although the presence of a mentor appears beneficial, there are a few important limitations. First, volunteer mentors tend to be less effective than natural mentors. This is because of the limited interaction time between the mentors and mentees, and the short-term life of their relationship (Hurd et al., 2013). Additionally, formal mentors, like those assigned by the Big Brothers Big Sisters program, do not offer youth the opportunity to select their mentor. This reduces the possibility of establishing a natural connection (Hurd et al., 2012). Volunteer mentoring may actually have a negative impact on some youth if the mentoring is infrequent and/or of short duration (McQuillin, Smith, & Strait, 2011). These researchers evaluated the effectiveness of a middle school

mentoring program lasting one semester. The program was designed to assist youth in their transition to middle school. They postulated that mentoring services provided once a week for eight weeks would produce meaningful effects concerning grades and behavior, and connectedness to school and teachers. Researchers found school-based mentoring failed to produce any significant benefits with regards to school connectedness, teacher connectedness, or school referrals. In contrast, there was a statistically significant negative effect on reading scores. This suggests that adolescents need to be involved in the mentor/mentee relationship for extended periods of time, with frequent contact in order to establish greater involvement and closeness. Consequently, mentor relationships need to be carried out in such a way that it benefits the adolescent, as opposed to fostering further disadvantages.

Rationale

Adolescence is a sensitive developmental period with substantial emotional, social and psychological growth. As difficult as it is to navigate, at-risk adolescents have added impediments, which complicate their circumstances even further. Many studies have suggested that natural mentors help to ease the consequences associated with adversity (Klasen et al., 2015; Tolan et al., 2014). This is important because, with a mentor, at-risk adolescents are more likely to demonstrate resiliency and less likely to resort to negative behaviors. The purpose of the proposed research is to examine the role of natural mentors in the lives of adolescents, in addition to the quality of support received. The study will examine whether or not social support predicts self-efficacy, self-esteem, and resiliency in at-risk youth.

Hypotheses

Hypothesis One:

Null Hypothesis (H_0): Perceived social support, as determined by the Quality of Relationships Inventory, will not be correlated with self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Alternative Hypothesis (H_1): Perceived social support, as determined by the Quality of Relationships Inventory, will be correlated with self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Hypothesis Two:

Null Hypothesis (H_0): Perceived social support, as determined by the Quality of Relationships Inventory, will not predict self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Alternative Hypothesis (H_1): Perceived social support, as determined by the Quality of Relationships Inventory, will predict self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Hypothesis Three:

Null Hypothesis (H_0): Enacted social support, as determined by the Inventory of Socially Supportive Behaviors, will not be correlated with self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Alternative Hypothesis (H_1): Enacted social support, as determined by the Inventory of Socially Supportive Behaviors, will be correlated with self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Hypothesis Four:

Null Hypothesis (H_0): Enacted social support, as determined by the Inventory of Socially Supportive Behaviors, will not predict self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Alternative Hypothesis (H_1): Enacted social support, as determined by the Inventory of Socially Supportive Behaviors, will predict self-efficacy, self-esteem, and resilience in adolescents, as assessed by the General Self-Efficacy scale, the Rosenberg Self-Esteem Scale, and the Child and Youth Resilience Measure.

Method

Participants

This study's sample consisted of 79 middle school students from the South Florida region. Sixty-two percent of the participants identified as female. Participants included 49 females and 30 males, ranging in age from 10 to 14. The average age was

12. All participants were of Haitian descent. Because the participants were minors, the study was described to the parents and adolescents. Parents provided consent and adolescents provided assent prior to completing online surveys.

Procedure

The adolescents were participants from the Haitian Empowerment and Literacy Project (H.E.L.P.). H.E.L.P. is a summer arts-based literacy program for Haitian adolescents that takes place on the campus of a private Catholic University in South Florida. The objective of H.E.L.P. is to empower Haitian adolescents through improvements in literacy and the development of social skills. Participants completed a series of self-report questionnaires online through psychsurveys.org. They were provided instructions to read each statement carefully and respond with their best answer. Participants were informed that there were no right or wrong answer choices. Following the completion of the survey, they were provided with free time to play on the computer.

Measures

Perceived social support. The Quality of Relationships Inventory (QRI) measures perceived support with regards to specific relationships (Pierce, Sarason, Sarason, Solky-Butzel, & Nagle, 1997; Lakey, Adams, Neely, Rhodes, Lutz, & Sielky, 2002). This is a 25-item support scale. Items are divided into three subscales. The subscales are support, conflict, and depth. Participants were asked to use the measure to describe a relationship with someone they consider a mentor. Questions on the measure include, “To what extent can you turn to this person for advice about problems?” and “To what extent can you count on this person to listen to you when you are very angry at someone else?” Items were rated on a four-point scale ranging from *not at all* (1) to *very*

much (4). The internal consistency for this scale is .84. See Appendix A for QRI.

Enacted social support. The Inventory of Socially Supportive Behaviors (ISSB) Short form measures enacted supportive behaviors within the past month (Barrera & Baca, 1990). Participants were asked, "During the past four weeks, how often did other people do these activities for you, to you, or with you?" The question was followed by 19 statements. Statements on the survey consisted of, "Gave you some information on how to do something" and "Helped you understand why you didn't do something well." Items were rated on a five-point scale ranging from *not at all* (1) to *about every day* (5). The internal consistency for the short form of the ISSB is .84. See Appendix B for ISSB.

General Self-Efficacy. The General Self-Efficacy scale (GSE) was developed by Schwarzer and Jerusalem (1995). It measures perceived self-efficacy, a personality trait characterized by belief in personal competence and the ability to manage stress (Tahmassian & Jalali Moghadam, 2011). This is a 10-item inventory with statements like, "I can always manage to solve difficult problems if I try hard enough" and "If someone opposes me, I can find the means and ways to get what I want." Items were rated on a four-point scale ranging from *not at all true* (1) to *exactly true* (4). This scale demonstrates high internal consistency ranging from .76 to .90. See Appendix C for GSE.

Self-Esteem. The 10-item Rosenberg Self-Esteem Scale (RSES) measures global self-worth by assessing positive and negative feelings about the self (Rosenberg, 1965). Statements on the measure include, "On the whole, I am satisfied with myself" and "At times I feel like I am no good at all." Items were rated on a four-point scale from strongly agree to strongly disagree, with high scores indicating higher self-esteem. There

are five reverse-scored items on this scale. This scale demonstrates high internal consistency ranging from .77 to .88. See Appendix D for RSES.

Resilience. The Child and Youth Resilience Measure (CYRM) is a measure of the resources (individual, relational, communal and cultural) available to individuals that may reinforce their resilience. It was developed under Ungar and Liebenberg (2011) as part of the International Resilience Project (IRP). The CYRM-28 consists of three subscales: individual capacities and resources, relationships with primary caregivers and contextual factors that facilitate a sense of belonging. Statements on the measure include, "I have people I look up to" and "Getting an education is important to me." This is a 28-item inventory with items rated on a five-point scale. Responses ranged from *not at all* (1) to *a lot* (4). This scale demonstrates high internal consistency ranging from .65 to .91. See Appendix E for CYRM.

Results

This section will describe and summarize the statistical analyses utilized to examine the research questions and hypotheses set forth in the previous sections. It will begin by addressing any differences in the data related to demographic variables. Next, the internal consistency will be provided for each inventory, in addition to the subscales within each inventory. The relationship between each scale and subscale will be analyzed. Finally, the predictive relationship between social support and the outcome variables, self-efficacy, self-esteem, and resilience will be reported.

Demographics

This study includes 79 adolescents. Sixty-two percent of the adolescents ($N = 49$) were females and 38% ($N = 30$) were males. Participants ranged in age from 10 to 14, with an average age of 12. The means for perceived and enacted social support were $M = 67.4$ and 61.4, $SD = 10.78$, 14.76, respectively. The means for self-efficacy, self-esteem and resilience were $M = 30.3$, 34.1, and 115.9, $SD = 5.01$, 4.04, and 15.68, respectively. To determine whether gender influenced the results, independent samples t-tests were computed for each dependent variable. Means, standard deviations, and t-test statistics are displayed in Table 1. The findings revealed that there were no statistically significant differences between these observed variables. There was not a significant difference in the self-efficacy scores for male ($M = 31.0$, $SD = 5.66$) and female ($M = 29.8$, $SD = 4.58$) conditions; $t(75) = .99$, $p = .325$. There was not a significant difference in the self-esteem scores for male ($M = 35.0$, $SD = 3.88$) and female ($M = 33.5$, $SD = 4.07$) conditions; $t(72) = 1.53$, $p = .131$. There was not a significant difference in the resiliency scores for male ($M = 117.5$, $SD = 16.37$) and female ($M = 114.9$, $SD = 15.31$) conditions; $t(75) = .71$, $p = .479$. These results suggest that gender does not have an effect on self-efficacy, self-esteem, or resilience.

Scale Reliability

Estimates of internal consistency were obtained for all of the inventories. The alpha coefficient for the QRI was .84, the ISSB was .89, the GSE was .82, the RSES was .69, and the CYRM was .92. The estimates of the internal consistency of the subscales for the QRI and CYRM were also examined. The QRI support subscale and depth subscale had an internal consistency of .78. The CYRM individual subscale, relationship

with caregiver subscale, and contextual factors subscale had an internal consistency of .86. These reliability estimates suggest that the measures have high levels of internal consistency in the Haitian-American sample.

Correlations

Hypothesis One

Pearson product-moment correlation coefficients were computed to assess the relationships between perceived social support and self-efficacy, self-esteem, and resilience. Means, standard deviations, and correlations for these variables are displayed in Table 2. It was hypothesized that the QRI would correlate significantly with the GSE, the RSES, and the CYRM. The QRI, which measures perceived social support, and the RSES, which measures self-esteem, were positively correlated, $r = .26$, $n = 71$, $p < .05$. These variables share about 7% variability. The QRI and the CYRM, which measures resilience, were positively correlated, $r = .47$, $n = 74$, $p < .01$. In addition, these variables share about 22% variability.

The QRI and CYRM each contain three subscales. Pearson product-moment correlation coefficients were computed to assess the relationships between the perceived social support subscales, self-efficacy, self-esteem, and the resiliency subscales. Means, standard deviations, and correlations for these variables are displayed in Table 2. The QRI total is positively correlated with its support subscale, $r = .68$, $n = 76$, $p < .01$, conflict subscale, $r = .72$, $n = 76$, $p < .01$, and depth subscale, $r = .66$, $n = 76$, $p < .01$. The QRI support subscale and depth subscale are also positively correlated, $r = .64$, $n = 76$, $p < .01$. The QRI support subscale is positively correlated with the GSE, which measures self-efficacy, $r = .29$, $n = 74$, $p < .05$. The QRI support scale is also positively

correlated with the RSES, which measures self-esteem, $r = .47$, $n = 71$, $p < .01$. The QRI total is positively correlated with all of the CYRM subscales. It is positively correlated with the individual subscale, $r = .45$, $n = 74$, $p < .01$, the relationship with caregiver subscale, $r = .30$, $n = 74$, $p < .01$, and the contextual subscale, $r = .48$, $n = 74$, $p < .01$. The CYRM total was positively correlated with the QRI support subscale, $r = .62$, $n = 74$, $p < .01$ and QRI depth subscale, $r = .37$, $n = 74$, $p < .01$. The QRI support subscale was positively correlated with the CYRM individual subscale, $r = .61$, $n = 74$, $p < .01$, relationship with caregiver subscale, $r = .42$, $n = 74$, $p < .01$, and contextual subscale $r = .59$, $n = 74$, $p < .01$. The QRI depth subscale is also positively correlated with the CYRM individual subscale, $r = .34$, $n = 74$, $p < .01$, relationship with caregiver subscale, $r = .23$, $n = 74$, $p < .05$ and the contextual subscale $r = .40$, $n = 74$, $p < .01$.

Hypothesis Three

Pearson product-moment correlation coefficients were computed to assess the relationships between enacted social support and self-efficacy, self-esteem, and resiliency. Correlation coefficients were also computed to assess the relationships between enacted support and the three CYRM subscales. Means, standard deviations, and correlations for all variables are displayed in Table 3. It was hypothesized that the ISSB would correlate significantly with the GSE, the RSES, and the CYRM. The ISSB, which measures enacted social support, and the CYRM were positively correlated, $r = .43$, $n = 75$, $p < .01$. These variables share about 18% variability. The ISSB total and the CYRM individual subscale were positively correlated, $r = .47$, $n = 75$, $p < .01$. The ISSB total was also positively correlated with the CYRM relationship with caregiver subscale, $r = .28$, $n = 75$, $p < .05$ and the contextual factor subscale $r = .36$, $n = 75$, $p < .01$.

Regressions

Hypotheses Two and Four

Hypotheses two and four posited that perceived social support and enacted social support, provided by a nonparental mentor, would predict self-efficacy, self-esteem, and resiliency. Stepwise multiple regressions were executed using each criterion variable. The results are presented in Tables 5, 6, and 7. Perceived social support, measured by the QRI, was the predictor variable in step 1. Enacted social support, measured by the ISSB, was the predictor variable in step 2. Perceived social support and enacted social support do not significantly predict self-efficacy. Step 1 of the regression indicated that perceived support was not a significant predictor of self-efficacy ($R^2 = .05$, F (2, 69) = 1.92, $p = .155$). The addition of enacted support in step 2 did not add to self-efficacy. Perceived social support and enacted social support do not significantly predict self-esteem either. Step 1 of the regression indicated that perceived support was not a significant predictor of self-esteem ($R^2 = .07$ F (2, 67) = 2.44, $p = .095$). Enacted social support in step two did not add to self-esteem. Perceived social support and enacted social support significantly predict resilience in adolescents ($R^2 = .33$, F (2, 69) = 17.01, $p < .001$). This result indicates that there is less than 1% chance that an F-ratio this large would happen if the null hypothesis were true. Perceived social support seems to be the best predictor of resiliency. This variable has a larger beta-value when compared to enacted social support. The standardized beta = .412, $p < .001$. The hypotheses were partially supported.

Discussion

The objective of this study was to explore the predictive effects of support from nonparental mentors on self-efficacy, self-esteem, and resilience among Haitian American adolescents. The following section will address the implications of the statistical analyses presented in the results section. It begins by examining the results of the hypotheses and relating it to previous research and theory. A discussion of the implications of this research and suggestions for practice and future prevention research will follow. Finally, the limitations of the study will be addressed.

This study of Haitian-American students ages 10-14, supports that adolescents who perceive their nonparental mentor as highly supportive are more resilient than adolescents who view their mentors as less supportive. Specifically, both perceived social support and enacted social support predicted resiliency in these young people. Adolescents with high scores on the support and depth subscales related to perceived support were more likely to demonstrate resilience than youth with low scores. Social support from a nonparental mentor did not appear to predict self-efficacy or self-esteem in these adolescents. However, the results indicated that as youth experienced increased levels of support related to the QRI subscale, their self-efficacy and self-esteem increased as well.

The results indicated a significant relationship between self-efficacy and self-esteem. As self-efficacy increased, self-esteem increased as well. Self-efficacy and resilience were positively correlated. As self-efficacy increased, so did resilience. There was a significant relationship between self-esteem and resiliency. As self-esteem increased, resiliency increased as well. Self-efficacy and the individual subscale and

contextual subscale of the resilience inventory were positively correlated. As self-efficacy increased, so did the individual and contextual subscale scores. Self-esteem was positively correlated with the resilience subscales: individual, relationship with caregiver, and contextual. As self-esteem increased, so did each subscale.

The present findings have theoretical implications for understanding how promotive factors interact to foster resilience (Zimmerman & Brenner, 2010). Regarding social support predicting resiliency, findings were consistent with earlier studies stating that having an adult mentor may counteract the effects of risks, leading to increased resilience (Hurd & Zimmerman, 2010a). Concerning self-efficacy and self-esteem, both factors are important elements of resilience. These internal attributes were also examined in relation to social support from nonparental mentors. The results related to self-esteem are inconsistent with previous research, which stated that high-quality mentoring relationships predict self-esteem (Whitney et al., 2011). Finally, although social support did not significantly predict self-efficacy, the support subscale of the QRI showed a positive correlation with self-efficacy. As levels of perceived support increased, self-efficacy increased as well.

An important contribution of this study that extends the previous literature is that it examined social support in relation to self-efficacy, self-esteem, and resiliency. Previous studies have explored social support as it relates to depression, anxiety and problem behaviors, and long-term educational attainment (Klasen et al., 2015; Hurd and Zimmerman 2010b; Hurd et al., 2012). This study extends the research through its focus on a specific cultural group, Haitian American youth. Furthermore, the findings of this study, along with previous research, have significant implications regarding high-quality

mentoring and adolescents. The results of this study indicate the importance of perceived and enacted social support in the lives of young people. Quality social support has a direct effect on resiliency. Nonparental mentors are in a position to foster positive development in the youth that they interact with. It is important that they take this role seriously. It is imperative that those in the position to be nonparental mentors dedicate the necessary time and energy to foster these lasting effects, especially with regards to at-risk youth. Social support appears to serve as a vital preventative measure and intervention component for adolescents.

Although measures were taken to ensure a strong study, there were still several limitations. All of the inventories relied solely on adolescent self-report. With self-report measures, it is uncertain how honest the participants' respond. Social desirability may affect responses to certain questions. Future research should utilize varied assessment methods. A further limitation is the cross-sectional design of the study. Although the cross-sectional design is beneficial because participants are observed without manipulating their environment, it does not necessarily provide cause-and-effect relationships. The researcher is unaware of occurrences prior to, and following the particular observation. Future studies may consider longitudinal studies. A final limitation of the study was the low number of participants. Perhaps a larger sample size would have yielded additional significant results.

Results of this study support the notion that nonparental mentors play an important position in the lives of young people. It is important to incorporate their high-quality social support into the community. The support serves as both a preventative measure and an intervention strategy with regards to at-risk youth. This study provides

empirical support for the idea that social support leads to increased resiliency in adolescents. Further, it serves as a catalyst, opening the doors for future researchers to extend investigations to additional cultural groups.

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Appendix: A

Quality of Relationships (QRI)

Please use the scale to describe your relationship with someone you consider a mentor.

A. Not at all
B. A little
C. Quite a bit
D. Very much

1. To what extent could you turn to this person for advice about problems?
2. How often do you need to work hard to avoid conflict with this person?
3. To what extent can you count on this person for help with a problem?
4. How upset does this person sometimes make you feel?
5. To what extent can you count on this person to give you honest feedback, even if you might not want to hear it?
6. How much does this person make you feel guilty?
7. How much do you have to "give in" in this relationship?
8. To what extent can you count on this person to help you if a family member very close to you died?
9. How much does this person want you to change?
10. How positive role does this person play in your life?
11. How significant is this relationship in your life?
12. How close will your relationship be with this person in 10 years?
13. How much would you miss this person if the two of you could not see or talk with each other for a month?
14. How critical of you is this person?
15. If you wanted to go out and do something this evening, how confident are you that this person would be willing to do something with you?
16. How responsible do you feel for this person's well-being?
17. How much do you depend on this person?
18. To what extent can you count on this person to listen to you when you are very angry at someone else?
19. How much would you like this person to change?
20. How angry does this person make you feel?
21. How much do you argue with this person?
22. To what extent can you really count on this person to distract you from your worries when you feel under stress?
23. How often does this person make you feel angry?
24. How often does this person try to control or influence your life?
25. How much more do you give then you get from this relationship?

QRI SCORING INSTRUCTIONS

Support Scale Items: 1, 3, 5, 8, 15, 18, 22
Conflict Scale Items: 2, 4, 6, 7, 9, 14, 19, 20, 21, 23, 24, 25
Depth Scale Items: 10, 11, 12, 13, 16, 17

Scoring:
Not at all = 1
A little = 2
Quite a bit = 3
Very much = 4

Sum scores for each scale separately and divide score total by the number of items in the scale.

Appendix: B

Inventory of Socially Supportive Behaviors (ISSB)
Short form

INSTRUCTIONS
We are interested in learning about some of the ways that you feel people have helped you or tried to make life more pleasant for you over the *past four weeks.* Below you will find a list of activities that other people might have done for you, to you, or with you in recent weeks. Please read each item carefully and indicate how often these activities happened to you during the *past four weeks.*

Use the following scale to make your ratings:

A. Not at all
B. Once or twice
C. About once a week
D. Several times a week
E. About every day

Please read each item carefully and select the rating that you think is the most accurate

During the past four weeks, how often did other people do these activities for you, to you, or with you:

1. Gave you some information on how to do something.
2. Helped you understand why you didn't do something well.
3. Suggested some action you should take.
4. Gave you feedback on how you were doing without saying it was good or bad.
5. Made it clear what was expected of you.
6. Told you what he/she did in a situation that was similar to yours.
7. Told you that he/she feels close to you.
8. Let you know that he/she will always be around if you need help.
9. Told you that you are OK just the way you are.
10. Expressed interest and concern in your well-being.
11. Comforted you by showing you some physical affection.
12. Told you that he/she would keep the things you talk about private.
13. Agreed that what you wanted to do was the right thing.
14. Did some activity together to help you get your mind off things.
15. Gave or loaned you over $25.
16. Provided you with a place to stay.
17. Loaned you or gave you something (a physical object) that you needed.
18. Pitched in to help you do something that needed to get done.
19. Went with you to someone who could take action

Scoring
The 5-point ratings of each item are summed to form a total frequency score.

Appendix: C

The General Self-Efficacy Scale (GSE)

1	I can always manage to solve difficult problems if I try hard enough.
2	If someone opposes me, I can find the means and ways to get what I want.
3	It is easy for me to stick to my aims and accomplish my goals.
4	I am confident that I could deal efficiently with unexpected events.
5	Thanks to my resourcefulness, I know how to handle unforeseen situations.
6	I can solve most problems if I invest the necessary effort.
7	I can remain calm when facing difficulties because I can rely on my coping abilities.
8	When I am confronted with a problem, I can usually find several solutions.
9	If I am in trouble, I can usually think of a solution.
10	I can usually handle whatever comes my way.

Response Format/ Scoring:

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

Higher scores indicate higher levels of self-efficacy.

Appendix: D

Rosenberg's Self-Esteem Scale (RSES)

	STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.				
2.	I feel that I have a number of good qualities..				
3.	All in all, I am inclined to feel that I am a failure.				
4.	I am able to do things as well as most other people.				
5.	I feel I do not have much to be proud of.				
6.	I take a positive attitude toward myself.				
7.	On the whole, I am satisfied with myself.				
8.	I wish I could have more respect for myself.				
9.	I certainly feel useless at times.				
10.	At times I think I am no good at all.				

Scores are calculated as follows:

- *For items 1, 2, 4, 6,* and *7:*
  Strongly agree = 3
  Agree = 2
  Disagree = 1
  Strongly disagree = 0

- *For items 3, 5, 8, 9,* and *10* (which are reversed in valence):
  Strongly agree = 0
  Agree = 1
  Disagree = 2
  Strongly disagree = 3

The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

Appendix: E

The Child and Youth Resilience Measure

To what extent do the sentences below describe you? Circle one answer for each statement.

	Not at All	A Little	Some-what	Quite a Bit	A Lot
1. I have people I look up to	1	2	3	4	5
2. I cooperate with people around me					
3. Getting an education is important to me					
4. I know how to behave in different social situations					
5. My parent(s)/caregiver(s) watch me closely					
6. My parent(s)/caregiver(s) know a lot about me					
7. If I am hungry, there is enough to eat					
8. I try to finish what I start					
9. Spiritual beliefs are a source of strength for me					
10. I am proud of my ethnic background					
11. People think that I am fun to be with					
12. I talk to my family/caregiver(s) about how I feel					
13. I am able to solve problems without harming myself or others (for example by using drugs and/or being violent)					
14. I feel supported by my friends					
15. I know where to go in my community to get help					
16. I feel I belong at my school					
17. My family stands by me during difficult times					
18. My friends stand by me during difficult times					
19. I am treated fairly in my community					
20. I have opportunities to show others that I am becoming an adult and can act responsibly					
21. I am aware of my own strengths					
22. I participate in organized religious activities					
23. I think it is important to serve my community					
24. I feel safe when I am with my family/caregiver(s)					
25. I have opportunities to develop skills that will be useful later in life (like job skills and skills to care for others)					
26. I enjoy my family's/caregiver's cultural and family traditions					
27. I enjoy my community's traditions					

*Higher scores indicate higher levels of characteristics associated with resilience.

Appendix: F

Table 1

T-Test Analysis Summary

	Males		Females		
Measure	*M*	*SD*	*M*	*SD*	*t*
Self-Efficacy	31.0	5.66	29.8	4.58	.99
Self-Esteem	35.0	3.88	33.5	4.07	1.53
Resilience	117.5	16.37	114.9	15.31	.71

Table 2
Means, Standard Deviations, and Correlations for Perceived Social Support and Dependent Variables

Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9	10
1. QRI	67.38	10.78	-									
2. GSE	30.27	5.01	.14	-								
3. RSES	34.05	4.04	.26*	.47**	-							
4. CYRM	115.87	15.68	.47**	.33**	.60**	-						
5. QRI-S	20.89	4.43	.68**	.29*	.47**	.62**	-					
6. QRI-C	27.83	7.27	.72**	.04	-.01	.13	.05	-				
7. QRI-D	18.66	3.90	.66**	-.01	.19	.37**	.64**	.06	-			
8. CYRM-I	44.18	6.83	.45**	.32**	.59**	.92**	.61**	.12	.34**	-		
9. CYRM-R	29.12	4.76	.30**	.22	.46**	.83**	.42**	.42**	.23*	.64**	-	
10. CYRM-C	42.57	6.02	.48**	.33**	.53**	.91**	.59**	.14	.40**	.76**	.64**	-
N			76	77	74	77	76	76	76	77	77	77

Note. QRI = Quality of Relationships Inventory; GSE = General Self-Efficacy Scale; RSES = Rosenberg Self-Esteem Scale; CYRM = Child and Youth Resilience Measure; QRI-S = Support Subscale; QRI-C = Conflict Subscale; QRI-D = Depth Subscale; CYRM-I = Individual Subscale; CYRM-R = Relationship w/Caregiver Subscale; CYRM-C = Contextual Factors Subscale; N = sample size; ** $p < .01$. * $p < .05$

Table 3

Means, Standard Deviations, and Correlations for Enacted Social Support and Dependent Variables

Variables	*M*	*SD*	1	2	3	4	5	6	7
1. ISSB	61.43	14.76	-						
2. GSE	30.27	5.01	.21	-					
3. RSES	34.05	4.04	.12	.47**	-				
4. CYRM	115.87	15.68	.43**	.33**	.60**	-			
5. CYRM-I	44.18	6.83	.47**	.32**	.59**	.92**	-		
6. CYRM-R	29.12	4.76	.28*	.22	.46**	.83**	.64**	-	
7. CYRM-C	42.57	6.02	.36**	.33**	.53**	.91**	.76**	.64**	-
N			77	77	74	77	77	77	77

Note. ISSB = Inventory of Socially Supportive Behaviors; GSE = General Self-Efficacy Scale; RSES = Rosenberg Self-Esteem Scale; CYRM = Child and Youth Resilience Measure; CYRM-I = Individual Subscale; CYRM-R = Relationship w/Caregiver Subscale; CYRM-C = Contextual Factors Subscale; N = sample size; ** $p < .01$. * $p < .05$

Table 4

Means, Standard Deviations, and Correlations for Dependent Variables

Variables	*M*	*SD*	1	2	3	4	5	6
1. GSE	30.27	5.01	-					
2. RSES	34.05	4.04	.47**	-				
3. CYRM	115.87	15.68	.33**	.60**	-			
4. CYRM-I	44.18	6.83	.32**	.59**	.92**	-		
5. CYRM-R	29.12	4.76	.22	.46**	.83**	.64**	-	
6. CYRM-C	42.57	6.02	.33**	.53**	.91**	.76**	.64**	-
N			77	74	77	77	77	77

Note. GSE = General Self-Efficacy Scale; RSES = Rosenberg Self-Esteem Scale; CYRM = Child and Youth Resilience Measure; CYRM-I = Individual Subscale; CYRM-R = Relationship w/Caregiver Subscale; CYRM-C = Contextual Factors Subscale; N = sample size; ** $p < .01$. * $p < .05$

Table 5
Stepwise Regression Analyses
Predicting Self-Efficacy

Variable	*B*	*SE B*	β	*T*
Perceived Support (QRI)	.05	.06	.11	.91
Enacted Support (ISSB)	.06	.04	.18	1.54

Note. QRI = Quality of Relationships Inventory; ISSB = Inventory of Socially Supportive Behaviors. ** $p < .001$.

Table 6
Stepwise Regression Analyses Predicting Self-Esteem

Variable	*B*	*SE B*	β	*T*
Perceived Support (QRI)	.09	.05	.244	2.01
Enacted Support (ISSB)	.01	.03	.05	.41

Note. QRI = Quality of Relationships Inventory; ISSB = Inventory of Socially Supportive Behaviors. ** $p < .001$.

Table 7
Stepwise Regression Analyses Predicting Resilience

Variable	*B*	*SE B*	β	*T*
Perceived Support (QRI)	.57	.14	.41	4.09**
Enacted Support (ISSB)	.33	.10	.32	3.22**

Note. QRI = Quality of Relationships Inventory; ISSB = Inventory of Socially Supportive Behaviors. ** $p < .001$.