

**Moving Away From Deficits: Promoting Prosocial and Positive Late Childhood and Early Adolescent Competencies to Reduce Adolescent Health Risk Behaviors (Editorial)**

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Published

2020

Journal Title

Journal of Adolescent Health

Version

Accepted Manuscript (AM)

DOI

[10.1016/j.jadohealth.2020.08.014](https://doi.org/10.1016/j.jadohealth.2020.08.014)

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## Moving away from deficits: promoting prosocial and positive late childhood and early adolescent competencies to reduce adolescent health risk behaviors

Understanding the connection between childhood and early adolescent experiences and later adult outcomes is the cornerstone to prevention and intervention science (1-2). We know that what happens in childhood and adolescence has an important effect on the kinds of adults that people will become. This is incredibly important as the cumulative effects of negative outcomes as the result of early experiences are still being explored. Early substance use in adolescence, for example, can have long term educational (3), economic (4-5), criminal (6), and health (5) outcomes. To date, the primary focus of these connections has traditionally been around how to prevent adverse early childhood experiences in order to mitigate adult outcomes (1-2) but in their recent article in *Journal of Adolescent Health*, Rougeaux and colleagues (7) flip the script and point us towards the importance of promoting positive late childhood and early adolescent aptitudes, in this case mental health competence, to reduce adolescent health risk behaviors.

Using the UK Millennium Cohort Study, Rougeaux et al. (7) have identified ways in which mental health competence (MHC) in late childhood and early adolescence (at age 11) can reduce problem behavior in mid-adolescence (age 14). In these data, MHC was operationalized as consisting of both prosocial behaviors, such as sharing, and learning behaviors, such as seeing a task through to the end. Youth with lower levels of MHC were more likely to have engaged in a host of adolescent health risk behaviors, especially substance use. Of particular interest is the fact that the largest associations were evident for the relationship between low MHC and increased risk for binge drinking and trying cigarettes, two adolescent health risk behaviors that have serious implications for adult well-being, both in terms of the health and behavioral outcomes identified above.

To that end, however, MHC did not predict linear increases in all risk behaviors at all levels. In some cases, 14 year olds with High-Moderate MHC were more likely to take part in health-risk behaviors than were their peers with only Moderate MHC. For example, those with High-Moderate MHC were more likely to report ever smoking, using e-cigarettes, or trying other illegal drugs (7). This lends a cautious reminder to researchers that not all risky adolescent behaviors are *always* risky for all youth, and measurement that focuses on *ever* doing something will potentially overinflate associations between behaviors and outcomes. Some risk taking behavior indicates normal adolescent development, such as breaking minor rules with peers in order to create stronger friendship bonds, and may not be indicative of a long-term path of negative consequences (8). Indeed, aging out of most risk behaviors is the norm, not the exception (9-10). But even seemingly contradictory findings point to the importance of promoting childhood and adolescent competencies, as the long-term benefits of high MHC will go beyond decisions about short term health-risk behaviors and help adolescents form into well-rounded competent adults on a variety of fronts.

The focus on this underexplored middle childhood and early adolescent competency opens up the conversation for ways in which prevention programs can better equip youth with important individual level resiliencies and competencies. Walking away from the *deficit model* of our understanding of childhood experiences gives way to create a dialogue about leveraging child and adolescent strengths (11) as a way to improve these long-term life outcomes. It also lends support to recent initiatives to expand and improve universal competency programs for children and adolescents, such as the movement towards

implementing social-emotional learning programs in schools (12). Schools are uniquely situated to promote health competencies in order to prevent a wide range of health risk behaviors (13), whether it be social-emotional learning or other types of competency-based programs, and the Rougeaux et al. (7) research offers more evidence of importance for long term well-being.

Moving forward, there are many directions research and policy should continue to explore. One particularly important aspect of a competency approach needs to focus on the role of the community in promoting child and adolescent well-being. We know that communities play a vital role in youth development and it stands to reason that these same effects would stand for mental health competencies (2, 14). There is no debate that policies that improve social and economic well-being in communities improve youth experiences. The connection between community level experiences and MHC should be explored further, especially to help create culturally meaningful ways to continue to promote MHC and other prosocial behaviors. These effects will not be homogenous and research on more diverse populations will continue to improve our understanding.

We must also continue to examine the long-term effect of the connections between mental health competencies and adolescent behaviors. Given the low rate of many of the riskiest of behaviors identified in the Rougeaux et. al. study (7), it will be important to target children and adolescents engaged in the riskiest of behaviors to better explore what constellations of risk *and* protective factors are mediating their behavior. Even in low MHC children, adolescent risk taking behaviors were very rare, pointing to the need for more targeted intervention to identify and help those in the highest risk categories. While longitudinal data like the UK Millennium study offer rich opportunities to look at behavior over time, it may not be the best way to understand how to effectively target the most vulnerable populations for intervention. Beyond diverse locations and diverse populations, there is also the need for diverse methodologies. Qualitative and mixed methodologies will give us greater insight into how these competencies play out in the real day to day lives of children and adolescents, which will better shape both our prevention programs and our future research efforts.

To that end, we must call for more discussion about the fact that not all risk is created equal. We may see the adolescent who is smoking in the bathroom as engaging in unnecessary risks but what about the student-athlete who leaves their comfort zone to try out for the school play? Or the student who organizes a climate change protest? In many ways, taking risks is not only normative, but positive; parents and teachers encourage certain types of risk taking in order to promote success. Yet positive risk-taking behaviors have been underexplored in children and adolescents, although research does show that many youth who engage in socially acceptable behaviors, like extracurricular activities, are also likely to report substance use and participation in delinquency (15). The fact that adolescents with comparatively high levels of MHC still report higher involvement in certain risk-taking behaviors in the Rougeaux et al study (7) points to the importance of a more well-rounded understanding of the role that risk-taking behaviors in children and adolescent play in promoting adult outcomes.

Rougeaux et al. (7) offer important insight into how we can leverage – and support – child and adolescent strengths in new and meaningful ways to reduce adolescent health-risk behaviors. And increasing MHC will undoubtedly have the kinds of positive trickle forward effects that are the goals of all prevention and intervention programs, improving not only adolescent experiences but adult outcomes as well.

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