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Crime Victims' Institute
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Victimization and Mental Health in Adolescence

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Adolescence is a time of great change and growth physically, emotionally, psychologically, and socially. While early scholarship was not specific about ages when describing the adolescent phase (Erikson, 1950, 1968), adolescence is now commonly considered to span from ages 10 to 19 (Richter, 2006). In terms of school grades, 10-year-olds are typically in grades 4 or 5, while 19-year-olds have graduated high school and are transitioning into the workforce or higher education. There are subcategories of adolescence (early, middle, and late), each characterized by unique experiences and needs (Barrett, 1996).

During adolescence, youth go through puberty, the timing of which can affect adjustment problems through an intersection of biological, emotional, physical, physiological, and social processes and where gender differences begin to emerge (Crosnoe & Johnson, 2011). For instance, girls begin to develop depression at a higher rate than boys in adolescence, a finding that persists for decades (Hankin et al., 2007). Adolescents tend to become hastier in decision-making and engage in more risky behavior, which can be explained by changes in brain development that encourage sensation and emotional pleasure-seeking (Steinberg, 2017).

Adolescent Victimization

The National Crime Victimization Survey (NCVS) surveys households, including adolescents, about their victimization experiences. In its 2022 report, the NCVS indicates that 27.4% of violent victimization victims were between the ages of 12 and 17—equivalent to 443,990 individuals (Thompson & Tapp, 2023). These numbers represent a significant increase from 2021 estimates, which found that 193,960 youth aged 12-17 were violently victimized.

Adolescents are prone to experiencing criminal victimization in the school context. In 2021, adolescents aged 12-18 experienced 170,600 victimizations at school and 384,300 away from school (National Center for Education Statistics [NCES], 2023). These victimizations may be criminal but also may include experiences such as being picked on, being pushed or shoved, or being the target of rumors. A unique form of victimization that is particularly present in adolescence is bullying victimization, which is categorized by repeated experiences of harm by a person in a position of higher power (Olweus, 1991). A 2019 survey found that 22% of adolescents aged 12-18 reported bullying victimization, which was more prevalent among females, mixed-race students, and younger students (NCES, 2022). Among a sample of high schoolers, the Youth Risk Behavior Surveillance System (YRBSS) 2021 report indicates that 15% of students were bullied at school and 15.9% were bullied electronically—a trend of decreasing rates since it began tracking bullying in 2009 and 2011, respectively (Centers for Disease Control and Prevention [CDC], n.d.).

The YRBSS data allows for state-level specific analyses. In Texas, 2021 statistics show that 13.8% of high schoolers had experienced bullying victimization, and 2019 statistics show that 11.9% of high schoolers had experienced cyberbullying victimization. Significantly higher rates of Texas high schoolers (8.5%) relative to the national average (6.6%) were threatened or injured with a weapon on school grounds in 2019. Texas high schoolers also reported higher rates of being physically forced to have sexual intercourse than the national average (10.3% and 7.3%, respectively; 2019). Additionally, in 2019, 5.4% of Texas high schoolers experienced sexual dating

violence, and in 2021, 12.8% experienced physical dating violence (CDC, n.d.).

Adolescent Mental Health

Public health agencies and associations, such as the U.S. Department of Health and Human Services (2023) and the American Psychological Association (2023), have noted that adolescent mental health is an issue of significant concern. There are many mental health concerns and disorders that may affect adolescents. However, internalizing and externalizing symptoms are concerns that are commonly discussed and studied in relation to victimization. Thus, the discussion of adolescent mental health herein follows this practice and focuses on such symptoms. While internalizing and externalizing are not diagnosable disorders, they incorporate a variety of disordered thought and behavioral patterns. Figure 1 provides an internalizing and externalizing symptomology categorization scheme. This report discusses defining characteristics, yet varying examples of internalizing and externalizing symptoms, and also describes related prevalence rates in the state of Texas.

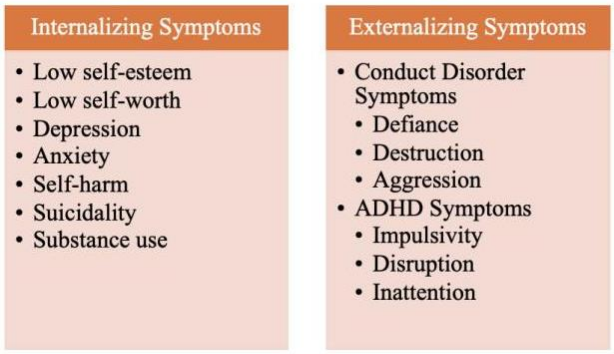

Figure 1: Internalizing and Externalizing Symptomology

Internalizing behaviors are generally defined as "actions that are overcontrolled in nature and directed inward, including withdrawn, depressive, anxious, and avoidance responses" (Cook et al., 2010, p. 67). More specifically, several disorders are considered internalizing in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), including separation anxiety, major depressive disorder, posttraumatic stress disorder, and generalized anxiety disorder (American Psychiatric Association, 2013). However, there may be internalizing disorders that are significant to an adolescent's life and may not meet such stringent diagnostic criteria. Alternative classification systems are used to measure internalizing problems through scales of anxiety, depression, social withdrawal, and somatic complaints (Gresham & Kern, 2004). Additionally, while substance use is not a characteristic of internalizing behavior specifically, substance use disorders are comorbid with internalizing disorders, meaning they often occur simultaneously within the same person (O'Neil et al., 2011).

On the other hand, externalizing behaviors are defined as being "undercontrolled in nature and characterized by a host of defiant, aggressive, disruptive, and noncompliant responses" (Cook et al., 2010, p. 67). Generally, externalizing behavior is most commonly identified by symptoms of both conduct disorder and attention-deficit hyperactivity disorder (ADHD) (Furlong et al., 2004). Conduct disorder symptoms include a persistent pattern of the violation of individuals' rights and social norms, aggression and physical cruelty, destruction of property, and deceitfulness (American Psychiatric Association, 2013). While aggression is part of the symptomology of conduct disorder, and thus externalizing behavior, it is also a behavior that may emerge more situationally in childhood or adolescence and be modeled in peer, family, and school settings (Furlong et al., 2004). ADHD symptoms overlap with depressive and anxiety disorders but include more externalizing symptoms such as impulsivity and inattention (American Psychiatric Association, 2013).

The YRBSS data (CDC, n.d.) reports rates of poor mental health amongst Texas high schoolers, drawing upon indicators of internalizing and externalizing symptoms. In 2021, 44.6% of Texas high schoolers felt sad or hopeless almost every day for two or more weeks in a row in the past year, and 31.3% reported that their mental health was most of the time or always not good. Further, 21.7% of Texas high schoolers had seriously considered attempting suicide in the past year, while 19.8% planned how they would attempt suicide and 12.3% actually attempted suicide. In 2019, statistics show that in the past 30 days, 13.2% of Texas high schoolers engaged in binge drinking, and 16.2% were using marijuana. Alternative forms of drug use among Texas high schoolers include taking prescription pain medicine without a prescription or differently than prescribed (16.1%), ecstasy (4.5%), cocaine (3.4%), methamphetamines (1.7%), and heroin (1.4%). In 2021, 2.3% of Texas high school students carried a

weapon on school property, and 5% carried a gun for purposes other than hunting or sport, a rate higher than the U.S. average (3.5%). Additionally, 20.8% of Texas high schoolers reported fighting in the past year, and in 2019, 8.0% had fought on school property.

Bidirectional Relationship Between Mental Health and Victimization

Much attention has been devoted to understanding the antecedents and outcomes associated with adolescent victimization. Some have noted personal factors, such as poor mental health, that are predictive of victimization (Hodges & Perry, 1999). However, research also suggests that while internalizing and externalizing may be related to youth being singled out for victimization, these mental health issues are also exacerbated by victimization experiences (Hodges & Perry, 1999). The relationship thus appears bidirectional in nature, such that while poor mental health predicts victimization, victimization predicts poor mental health (Drazdowski et al., 2021). This pattern is shown in Figure 2.

Figure 2: The Bidirectional Relationship Between Poor Mental Health and Victimization

There is evidence that the reciprocal nature of this relationship is not necessarily stable and may vary in strength across developmental periods (Sweeting et al., 2006). For example, Sweeting and colleagues (2006) report that at age 13, there was a bidirectional relationship between victimization and depression, although the stronger path linked victimization to depression. However, by age 15, there was only evidence of a causal path linking depression and victimization (Sweeting et al., 2006). Overall, the evidence of a reciprocal relationship between victimization and mental health, even if variable across developmental periods, is important to understand when considering the experiences of victimized adolescents and those with poor mental health.

The Link Between Mental Health and Victimization

Adolescents may experience a variety of victimizations, including peer and bullying victimization. As described earlier, bullying is characterized by repeated acts, over time, perpetrated by someone in a position of power (Olweus, 1991). Peer victimization refers to victimization by those in the same age group, which may be physical or verbal, but in some way does not meet the definition of bullying. The connection between internalizing and externalizing problems and future victimization has been well documented as several studies have related poor symptomologies in both domains to peer and bullying victimization and even child maltreatment victimization. Table 1 summarizes five such studies, including their samples, the type of mental health problems investigated, and the type of victimization outcomes.

Table 1: Literature on Mental Health and Victimization

Authors	Year	Sample	Mental Health Predictors	Victimization Outcomes
Hodges, Malone & Perry	1997	Youth in grades 3-7 (N=229)	General internalizing and externalizing symptoms	Peer victimization
Hodges & Perry	1999	Youth ages 11 and 12 (N=173)	Internalizing – anxiety, withdrawal, depression	Peer victimization
Goldbaum, Craig, Pepler & Connolly	2003	Students in grades 5-7 (N=1,241)	Internalizing	Bully victimization
Turner, Finkelhor & Omrod	2010	Youth ages 2 – 17 (N=1,467)	General internalizing and externalizing symptoms	Child maltreatment, sexual and peer victimization
Brendgen, Girar, Vitaro, Dionne & Boivin	2016	Students in grades 4-9 (N=767)	Internalizing and externalizing – aggression	Peer victimization

Mediators

The link between poor mental health and victimization can be explained through target congruence. This theoretical concept, originally developed by Finkelhor and Asdigian (1996), suggests that there may be sets of factors that make an individual more prone to being victimized. Target congruence acts as a mediating influence that explains the connection between poor mental health and victimization. This relationship is illustrated in Figure 3.

Figure 3: Mediating Effects on Poor Mental Health and Victimization Link

Some factors reduce a person's ability to defend themselves, making them vulnerable; other factors make targets gratifiable to victimize, as the offender gains something from victimizing them; and still others antagonize offenders and instigate victimization (Finkelhor & Asdigian, 1996). Of most interest to this area of study is the idea of target vulnerability and target antagonism, both of which may be related to poor mental health. Specifically, internalizing problems may make a person more vulnerable and less able to defend themselves against an offender (Zavala & Whitney, 2019). Alternatively, impulsivity and aggression, both symptoms of externalizing problems, may generate negative reactions from potential offenders, making them more likely targets of victimization (Kulig et al., 2017).

Moderators

The idea of moderation suggests that there are factors that change the relationship between the predictor variable (poor mental health) and the outcome variable (victimization). In this context, moderators of interest addressed in the literature are the influence of peer groups (Hodges et al., 1997; Kljakovic & Hunt, 2016) and developmental stage (Brendgen et al., 2016). Such moderating effects are depicted in Figure 4.

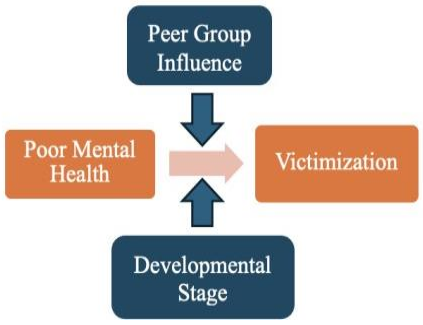

Figure 4: Moderating Effects on Poor Mental Health and Victimization Link

Peer Group Influence. The first moderating influences are peer groups. Peers may serve to moderate the relationship between poor mental health and victimization in several ways, such as offering protection against aggressors and bullies (Hodges et al., 1999). In one study, researchers find that the more friends an adolescent has, the less effect their poor mental health (i.e., internalizing or externalizing problems) has on their victimization risk (Hodges et al., 1997). Friends may generate fear of retaliation among would-be bullies, and they may also limit the time an adolescent spends alone; these processes, in turn, offer protection and lessen vulnerability (Hodges et al., 1997). However, if one's friends are deemed weak, then the risk of victimization increases (Hodges et al., 1997). In contrast to having many friends, peer rejection may reflect a "social outcast" status that puts adolescents at higher risk for victimization and also serves to exacerbate the effects of poor mental health on victimization (Kljakovic & Hunt, 2016).

Developmental Period. The idea that the developmental period moderates the influence of mental health and victimization was proposed by Boivin and colleagues (2010). Supporting literature shows that the factors that make a bully victim "attractive" to offenders may differ as youth transition from primary to secondary school (Brendgen et al., 2016). Victimization that occurred in primary school, but did not continue into secondary school, was related to aggression but not internalizing behavior. However, victimization that began in primary school and continued into secondary school was associated with higher levels of internalizing but not externalizing behaviors (Brendgen et al., 2016). These patterns may reflect changes in normative behavioral expectations, whereby aggressive behaviors become increasingly tolerable through adolescence, whereas internalizing behaviors are increasingly associated with vulnerability (Boivin et al., 2010).

The Link Between Victimization and Mental Health

Adolescence is a period marked by the heightened importance of peer groups, social relationships, and popularity. Thus, when adolescents experience negative events—especially those perpetrated against them by their peers and resulting in a potential social stigma—the damage can be severe, damaging, and long-lasting. Mental health outcomes associated with victimization can be internalizing in nature, given the emotional harm involved. However, externalizing outcomes, such as aggressive retaliation against the offender, can also occur (Bettencourt & Farrell, 2012). Between the two outcomes, internalizing reactions are typically of greater interest in research literature, especially the outcomes of substance use, suicidality, and self-harm. Table 2 summarizes a few studies that track the influence of various victimization experiences on mental health outcomes.

Table 2: Literature on Victimization and Mental Health

Authors	Year	Sample	Type of Victimization	Mental Health Outcomes
Esbensen & Carson	2009	Youth aged 10 -15 (N=2,353)	Bullying victimization	Internalizing – low self-esteem, low self-efficacy
Hay & Meldrum	2010	Students in grades 6-12 (N=426)	Cyber and offline bullying victimization	Internalizing – self-harm and suicidal ideation
Biebl, DiLalla, Davis, Lynch & Shinn	2011	Youth aged 5-12/20 (N=70)	Physical and relational victimization	Internalizing and externalizing
Glassner & Cho	2018	Youth aged 12-17 (N=2,423)	Bullying victimization	Internalizing – emotional health and substance use
Turner, Exum, Brame & Holt	2013	Students in grades 6-12 (N=1,874)	Bullying victimization	Internalizing – depression and suicidal ideation

Mediators

The mechanism that explains the relationship between victimization experiences and poor mental health is the concept of negative emotionality. While this concept may appear similar to poor mental health, the difference is that negative emotionality is a shorter-term state of poor emotional regulation, which can lead to coping through internalizing or externalizing symptomology. In essence, when an adolescent is victimized, they may be unable to process or control their emotions or physiological stress response, which can create negative mental health experiences. This relationship is illustrated in Figure 5.

Figure 5: Mediating Effect on Victimization and Poor Mental Health

When youth are exposed to traumatic and negative life events such as victimization, they may experience diminished mood or negative emotionality. Considered a direct effect of victimization, negative emotionality provides a pathway that connects victimization and internalizing outcomes such as substance use (Glassner & Cho, 2018). Negative emotionality may take several forms, such as unpleasant physiological response, cognitive distortion, and difficult emotion processing. For example, following victimization, youth may experience biological stress response systems that operate beyond their control and which, in turn, are linked to longer-term anxiety disorders (Heim et al., 2000). Stress responses affect every youth differently, and this connection may explain why some youth develop more severe mental health outcomes (Arseneault et al., 2010).

Additionally, experiences of trauma at an early age may cause youth to distort the way they interpret their environment, such that they blame themselves for their victimization (Arsenault et al., 2010). Taken together, these variations in the immediate reactions to victimization may explain why some youth carry on into engaging in internalizing behaviors. These behaviors may even be prolonged and continue into adulthood (Glassner & Cho, 2018).

Moderators

There is evidence that the relationship between victimization and mental health is moderated by gender, a pattern shown in Figure 6. Essentially, the pathway between victimization and poor mental health may be unique for boys and girls.

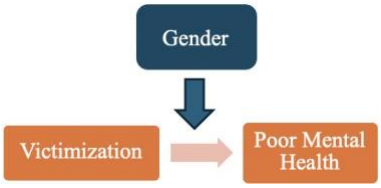

Figure 6: Moderating Effect on Victimization and Poor Mental Health Link

Gender differences begin to emerge in adolescence and may be exacerbated by victimization experiences as it is evident that girls, but not boys, who were chronically victimized had more emotional and physical problems than nonvictims (Biebl et al., 2011). Further, gender differences may emerge based on the type of victimization experienced by adolescents. Sexual assault is a gendered form of victimization, more often perpetrated by males against females (Rinehart et al., 2020), and girls experience worse internalizing problems than boys after experiencing sexual violence (Bentivegna & Patalay, 2022). Alternatively, other scholars suggest that both boys and girls react to victimization with different mental health symptomology (Hanish & Guerra, 2002). Specifically, they suggest that boys tend toward externalizing behaviors after their victimization (Rusby et al., 2005), while girls experience more internalizing outcomes (Paul & Cillessen, 2003).

Conclusion

Adolescence is fraught with emotional and physical change and development. Youth who exhibit poor mental health become at a higher risk for victimization. Exhibiting symptoms of internalizing or externalizing behaviors places adolescents as a target for victimization, whether it be bullying or peer

victimization (Turner et al., 2010). This pattern may be explained through a mediating factor of target congruence and moderated by factors such as peer group influence and developmental period. Meanwhile, youth who experience victimization are at higher risk of developing both internalizing and externalizing problems after their experience. This connection can be explained through the mediating process of negative emotionality and moderated by gender. Overall, the connection between mental health and victimization in adolescence is bidirectional, such that poor mental health puts adolescents at a higher risk of victimization, and victimization puts youth at a higher risk for poor mental health.

Policy Implications

Importantly, there are intervention strategies that can be targeted toward youth with poor mental health to improve their outcomes. Since youth spend so much time in schools, the staff may observe both victimization and mental health symptomologies. Thus, schools offer an intervention point where resources can be shared with students in need. For instance, in Texas schools, implementing mental health resources is optional, and implementation varies by district. The Texas Education Agency (TEA) provides school districts with a list of optional evidence-based practices in the Texas School Mental Health Resource Database, which includes aspects like mental health prevention and intervention and trauma-informed practices to be used to support students (TEA, 2023).

Regarding support for crime victims, the state of Texas has state-wide anti-bullying legislation, which defines bullying and cyberbullying and dictates that schools report bullying to parents and guardians, provide counseling for victims, and foster an environment of safety and connectedness (Texas Education Code Chapter 37, § 37.0832). Additionally, students who are the victims of a violent crime on school grounds are guaranteed the option to move schools based on the Elementary and Secondary Education Act (ESEA) § 8532. The ESEA was passed during the Johnson Administration in 1965 and later reauthorized by the Every Student Succeeds Act (ESSA) in 2015 during the Obama Administration.

Other intervention and resource options are available at the district level. Houston Independent School District (HISD) implemented a “Let’s Stay Connected” mental health hotline in 2020 that aimed to provide mental health support for not only students but also parents (HISD, 2020). Dallas Independent School District (DISD) offers an anonymous reporting system for concerns about threatening or bullying behavior, which is shared with school and law enforcement teams (DISD, n.d.).

In sum, the state of Texas has taken steps to support crime and bullying victims in schools. However, although the TEA makes information on mental health programs readily available, there are no state-wide requirements for such resources. Several of Texas’s largest school districts have integrated mental health and victim support resources into their schools. Given the bidirectional and reciprocal nature of mental health and victimization, support in one area is likely to support adolescents in the other. Thus, it is recommended that Texas schools continue to generate and promote student safety and mental health.

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