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THE INTERNATIONAL CENTRE
RESEARCHING CHILD SEXUAL EXPLOITATION, VIOLENCE AND TRAFFICKING

Concepts and frameworks for thinking about adolescent mental health and wellbeing and how these relate to adolescent sexual abuse: A briefing on the literature

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Key messages

- Mental health, wellbeing and resilience are not neutral terms. They are defined and understood in different ways.
- We need to understand the ways in which these terms are used by young people so that conversations can begin from a point of mutual understanding and be appropriately pitched.
- The evidence suggests that it is inappropriate to assume that conceptual frameworks developed for adults or younger children can be applied to adolescents. Age appropriate frameworks, informed by young people's understandings, are urgently needed.
- Young people's perspectives on mental health, wellbeing and resilience are largely absent from the literature, particularly in relation to sexual abuse.
- Our participatory research will contribute to a much-needed exploration of their perspectives on mental health and wellbeing concepts in relation to adolescent sexual abuse.

1. Background

1.1 *Learning from the Experts* is a participatory research study being undertaken by the University of Bedfordshire, with the support of the Association of Young People's Health. The research, funded by the National Society for the Prevention of Cruelty to Children (NSPCC) and the Economic and Social Research Council (ESRC), explores the mental health and wellbeing needs of those who experience sexual abuse in adolescence. You can read more about the research **here.**

1.2 The research began with a narrative literature review. This briefing summarises the findings on concepts and frameworks of mental health, wellbeing, resilience and recovery and how these relate to, or are understood by, young people who have experienced sexual abuse in adolescence.[1] Two associated briefings, on 1) the impacts of adolescent sexual abuse and 2) identifying, assessing and supporting young people following sexual abuse in adolescence, are published alongside this. A detailed methodology is published **here** for interested readers.

2. Introduction

[1] The term 'adolescent sexual abuse' specifically refers to sexual abuse experienced during adolescence.

2.1 This briefing addresses the first literature review question (as set out in the methodology briefing): *How are the concepts of mental health, wellbeing and resilience defined and theorised in relation to adolescent sexual abuse?*

2.2 The ways in which people conceptualise terms such as 'mental health/illness' and 'wellbeing' are recognised to shape their help-seeking behaviours. In fact, attitudinal barriers to help-seeking and stigma are suggested to be stronger than structural barriers such as location or cost of support (Georgakakou-Koutsonikou and Williams, 2017). It is critical for our research, then, to understand the ways in which young people who have experienced sexual abuse in adolescence conceptualise mental health, wellbeing and associated terminology in order to develop a young person-centred approach to improving responses to adolescent sexual abuse.

2.3 Despite the fact that mental health, wellbeing and resilience are pervasive terms that are frequently used in policy, research and practice, there is little consensus on how these terms should be conceptualised.

3. Brief overview of methodology and summary of relevant papers

3.1 As detailed in the separate methodology briefing, we searched the literature for the concepts of 'mental health', 'wellbeing', 'resilience' and 'recovery',[2] as they intersect with literature on adolescent sexual abuse. No literature was found that specifically considers how these concepts are understood by young people who have experienced adolescent sexual abuse. In order to provide reference points for the research, our review therefore draws on (a) literature on the issues in relation to adolescents who have experienced child sexual abuse (CSA)[3] at any age, or at age undefined and (b) broader literature on adolescence within the

[2] Although not in the original research question, literature on 'recovery' was additionally considered, given its prominence in both the mental health and sexual abuse fields. While originating within the mental health arena, it has extended as a key approach to practice in relation to the process of overcoming sexual abuse experiences although, as explored later, its application is quite distinct.

[3] Department for Education 2018 definition of CSA: Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

mental health field, where explicit consideration is given to the conceptualisation of these terms for adolescents.

3.2 Fifteen papers were included in this part of the review, all of which focused specifically on conceptualisations of mental health (as opposed to, for example, experiences of mental health which fell outside of the scope of this question). Table 1 below presents a breakdown of these papers according to their concept relevance.

Table 1: Papers included in the concepts and framework review

Mental Health	• Three papers consider the ways in which adolescents conceptualise mental health or mental illness, but these are not specific to young people who have experienced sexual abuse (Georgakakou-Koutsonikou and Williams, 2017; Johansson, Brunnberg and Eriksson, 2007; Lovett, Tamkin and Fletcher, 2010).
Recovery	• Two papers examine adult 'recovery' models in relation to young people but these are not specific to young people who have experienced sexual abuse (John et al., 2014; Simmonds et al., 2014).
Resilience	• Six papers consider resilience in relation to young people who have experienced sexual abuse (Edmond et al., 2006; DuMont, Spatz Widom and Czaja, 2007; Williams and Nelson-Gardel, 2012; Domhardt et al., 2015; Flett and Wekerle, 2015; Horn, Charney and Feder, 2016). We do not know how relevant these are to young people who experience abuse in adolescence. The remaining two (Newman, 2002; Wexler et al., 2009) address resilience in adolescence more generally.
Wellbeing	• Two papers consider conceptualisations of wellbeing in relation to adolescence, but neither relate to young people who had experienced sexual abuse (The Children's Society 2017; McLeod and Wright, 2016)

3.3 The literature review demonstrates that mental health, wellbeing and resilience frameworks that presuppose an understanding of young people's perceptions and needs or that have been developed for adults, younger children or children generally are being applied to young people without consideration of their age appropriateness or relevance for the adolescent age group (Georgakakou-Koutsonikou and Williams, 2017; Simmonds et al., 2014; John et al., 2014).

4. Conceptualisation of Mental Health and Mental Illness

4.1 Mental health and mental illness are complex, multidimensional concepts. The terms have been conceptualised in relation to psychological, environmental, relational, biological and genetic causes. Different conceptualisations of mental health and mental illness stress these causal factors to varying degrees. Distinctions have also been made between mental health and mental illness, with

the former recognised to have both negative and positive attributions and the latter associated with largely negative connotations.

4.2 Johansson, Brunnberg and Eriksson (2007), for instance, in a study of adolescents' perceptions of 'mental health', found it to be operationalised along a series of scales and dimensions, which include both negative and positive attributions. Groups of young people, aged 13 (n=18) and 16 (n=30) perceived mental health as an emotional experience that can be described as positive or negative – it is 'how you feel' and 'what you think' (Johansson, et al., 2007:187). Positive mental health, for these young people, often related to feelings of being happy, harmonious, being a good person, having good self-confidence, being liked, being loved by your parents and having people to talk to. Negative mental health, on the other hand, related to a feeling of being unhappy, lacking meaning and hope, having low self-confidence, not being liked, being lonely and being unhappy at home.

4.3 Lovett et al.'s (2010) study of mental illness with young people aged 10 to 18 found pervasive negative impressions of mental illness among their sample. Young people often conflated mental illness with learning disabilities and associated it with violence and unpredictability, resulting in a highly stigmatised view of mental illness. These two studies together demonstrate that 'mental health' and 'mental illness' are understood differently and are not neutral terms and therefore the way they are used by professionals is important when considering how to support young people to seek support.

Age and gender specific conceptualisations

4.4 A number of different studies confirm that young people, though capable of conceptualising mental health and mental illness, may find this more difficult than adults (Georgakakou-Koutsonikou and Williams, 2017; Johansson, et al., 2007; Lovett et al., 2010) Georgakakou-Koutsonikou and Williams (2017), for example, in comparing evidence about children and young people's perspectives on depression with those of adults, found that children and young people can struggle to articulate how they understand the concept.

4.5 The literature would suggest there are also key age and developmental differences among children and young people in terms of the way that they understand and conceptualise mental health and/or illness.

4.6 Johansson et al. (2007), for example, found that adolescents aged 16 were able to reflect on the concept of mental health in ways that adolescents aged 13 were not. They found that older adolescents related mental health mostly to themselves, whereas younger children described feelings in relation to other people such as friends and parents. Furthermore, 13 year olds in their sample associated mental health primarily with maternal and family environmental

contexts whereas 16 year olds were more likely to associate mental health with school, peers and socioeconomic circumstances.

4.7 Georgakakou-Koutsonikou and Williams (2017), in their review of the literature on children and young people's conceptualisations of depression, found that younger children (6-7 years) were more likely to perceive depression to be a physical illness, compared with older adolescents (15-17 years) who were more likely to perceive depression as being caused by upbringing and life events. Moreover, older adolescents (16 years) were more likely than younger adolescents (12-14 years) to believe that someone with depression needs help and to recommend professionals as a source of help. Despite this, older adolescents were less likely than younger adolescents to be positive about someone with depression and were significantly less likely to be accepting of males with depression.

4.8 There also appear to be important gender differences to consider. Georgakakou-Koutsounikou and Williams' (2017) review found that girls are more likely than boys to recognise depression, show more concern about someone who is depressed, suggest a longer time for recovery from depression, identify a need for help and offer help. Boys are more likely than girls to endorse dealing with depression alone and believe they would worsen things if they helped a peer. Girls tend to assign less responsibility and are more positive towards a depressed peer than boys while boys are more likely to socially distance themselves from a someone with depression. In Johansson et al.'s (2007) study of mental health, girls in general reported that not going to school, not eating, and having headaches and backaches are all signs of negative mental health. Boys, on the other hand, felt that bullying others, being quiet, mean, bitter or angry and being shy are all signs of negative mental health.

4.9 These findings on gender and age raise important implications for approaches to supporting young people around mental health. Gender considerations are crucial in considering ways to reduce stigma and shape service responses in diverse ways.

5 Recovery

5.1 'Recovery' has emerged as a central concept in mental health provision (Simmonds et al., 2014). 'Social recovery', in the context of this briefing, explicitly relates to overcoming traumatic experiences associated with the stigma of a 'mental illness' label and poor experiences in the mental health system. This is in contrast to the use of the term to denote the process of overcoming sexual abuse experiences. Instead, social recovery in the mental health field promotes empowerment, control, positive identity development, social connectivity, hope, optimism and discovering meaning and purpose as key recovery-enhancing processes within the social recovery approach (John et al., 2014). The concept

relates to recovery *despite* mental health needs, and works with individuals to support the possibility of living *with* symptoms rather than focusing on their reduction or elimination (Simmonds et al., 2014; John et al., 2014).

5.2 John et al.'s (2014) study of recovery in young people treated in specialist mental health services identified a two-part process which characterised their recovery in relation to mental health needs: 1) a period of intense distress, lack of understanding and social withdrawal, followed by 2) a period of greater understanding, greater ability to take control and increase engagement with others. The study found a strong inverse correlation between total difficulties (as measured by anxiety and depression) and recovery; as difficulties reduced young people's sense of recovery increased, and a positive correlation was found between recovery and self-esteem.

5.3 Similarly, Simmonds et al. (2014), exploring the applicability of an adult recovery model for young people, identified a staged process of recovery in relation to anxiety and depression within a small sample of young people. Recovery for young people in their study included: 1) the loss of self, where their young participants reported losing their place in the world; 2) a re-negotiation of the self, where young participants 're-authored' their self-concept rather than regained a lost prior self; and 3) the anticipation of future self. It is this third stage that appears to differentiate young people's 'recovery' from that of adults. The authors report that young people focused on immediate goals (such as exams, or going to college) but were unable or unwilling to engage with longer term goals, compared to adults who demonstrated an ability to reflect on the long-term.

5.4 Simmonds et al. (2014) also hypothesised that where social recovery for adults requires the ability of an individual to integrate potentially opposing self-concepts (for instance, gaining meaning and purpose in the face of continued psychological and functional difficulty), for adolescents up to the age of 16, there can be great difficulty integrating contradictory self-concepts, which can cause confusion and distress. The applicability of this recovery model to young people who have experienced sexual abuse in adolescence cannot be assumed. The impacts of sexual abuse on cognitive and behavioural development may, for example, produce different ways of conceptualising the future than that experienced by young people without these experiences.

6 Resilience

6.1 There is a wide body of literature on resilience and young people, but only a small number of studies explicitly explored the conceptualisation of the issue. Limited evidence was also found in relation to resilience and young people who experienced CSA.

6.2 There is a lack of consensus on how resilience is defined and operationalised within the literature (Domhardt et al., 2015; DuMont, Spatz Widom and Czaja, 2007; Edmond et al., 2006; Horn, Charney and Feder 2016; Wexler, DiFluvio and Burke, 2009). Despite this, there does appear to be general agreement that resilience is not an individual trait, but a multi-dimensional construct determined by an individual's life circumstances, including supra-individual connections (families, communities, schools, for example) and positive adaptation (Domhardt et al., 2015). Resilience is concerned with the interplay of risk and protective factors in order to determine behavioural and mental health outcomes for children and adolescents (Edmond et al., 2006; Horn, et al., 2016).

6.3 There are a number of challenges associated with the conceptualisation and measurement of resilience. These problems underpin the variable rates of resilience observed across studies of child and adult survivors of CSA. These challenges include:

- Wide variation in operational definitions of resilience and what resilience looks like as an outcome (Domhardt, 2015). Some studies have used one criterion to measure resilience whereas others have used multiple criteria.
- Variations in the extent to which contextual factors are considered in relation to resilience. Examples of contextual factors include an individual's family, neighbourhood, school or work setting (DuMont, et al., 2007).
- A lack of clarity on the level of competence required to define 'positive adaptation' and whether this must be demonstrated in only one or in more than one domain of resilience (Domhardt et al. 2015).
- The 'fixed' meaning of resilience outcomes and whether resilience outcomes are the same for all young people. This is a particular issue for young people whose values diverge from those of the dominant society. Culture is often excluded from resilience research as a variable. Alongside this challenge, researchers have argued that risk and protective factors are not experienced in the same way by all young people (Wexler, et al., 2009).

6.4 It is important to interrogate the evidence on adolescent resilience and the ways in which protective factors and resilience outcomes are understood. Within the literature reviewed, a number of cases have been identified where young people are recorded as resilient because they are deemed to meet resilience outcome measures, such as getting along with others, following social norms and performing well at school, but are simultaneously experiencing a great deal of anxiety or depression internally. Luthar and Zelaro (2003) refer to this as "covert distress underlying manifest competence" (cited in Edmond et al., 2006: 539). Furthermore, there does not appear to be a clear relationship between behavioural competence (the way young people present and their academic achievements and functionality) and mental health and emotional need (Newman, 2002; Flett and Werkele, 2015).

6.5 Newman (2002) found, for example, that young people scoring high levels of adjustment on behavioural measures of competence (subsequently identified as 'resilient'), were experiencing depression and anxiety. In relation to young people affected by sexual abuse, Newman found surprisingly high levels of age-related competencies alongside observed high levels of anxiety or depression. Flett et al. (2015)'s research similarly identified young people affected by CSA as high functioning and able to cope in the achievement domain yet suffering from high levels of hidden anxiety and sadness. In these cases, it appears that "overcoming adversity" or "bouncing back" is an effective balance of factors, rather than an elimination of all negative consequences of early trauma (Newman, 2002). This suggests that there are still challenges in the way we measure and conceptualise resilience.

6.6 These studies also raise questions as to what is conceptualised as "positive" adaption and a resilience outcome for young people, particularly young people who have experienced sexual abuse. Newman (2002) and Flett and Werkele (2015) highlight that educational achievement, for example, may not necessarily be a 'positive' adaption in the way it was initially conceptualised to be. Hickle and Hallett's (2015) research on CSE highlights the potential of maladaption as a mechanism for survival and functionality, considering the ways in which maladaption may enable young people to take control of their situation.

7 Wellbeing

7.1 Mental health is better conceptualised in the literature than wellbeing. McLeod and Wright (2016) describe the contemporary understanding of wellbeing as a construct of 'good life', one that is often associated with both physical and mental health encompassing numerous indicators, from subjective experiences of happiness, mood and attitude to less subjective markers of economic prosperity. They argue that it is a concept that relates to resilience, self-esteem and welfare, yet, as we have found in this review, the literature on resilience has not adopted the term 'wellbeing', which means the connections between them remain poorly articulated.

7.2 While increasing attention is paid to young people's wellbeing generally, we found a limited number of papers that explored the concept of wellbeing in relation to young people and no studies which specifically examined wellbeing in relation to young people with experiences of sexual abuse in adolescence, nor experiences of sexual abuse more generally. It is unclear, therefore, how wellbeing is conceptualised or applied in relation to this group.

7.3 In the UK, the Children's Society (2017) has been carrying out a series of household surveys with young people aged 10 to 17 to explore their perspectives on wellbeing. Their most recent survey (their sixth to date) found that, overall, young people's wellbeing is at its lowest since 2010; that fear of crime is the most

common problem reported; and that nearly a fifth of young people report seven or more problems in their lives. Young people reporting more than seven problems were more likely to be unhappy than those reporting fewer than seven. Through their research, the Children's Society has identified ten aspects of life associated with wellbeing that emerge as most important for the young people who participated in the survey (see Table 2).

Table 2: Ten aspects of life that emerged as the most important for the young people

school	money/things	future	friends	home
appearance	choices	use of time	health	family

7.4 It remains unclear how experiences of CSA may intersect with these aspects, and whether young people with experiences of sexual abuse in adolescence would prioritise the same sorts of things as adolescents more generally when defining wellbeing.

8 Summary and conclusion

8.1 Our review found no literature about the ways in which young people with experiences of sexual abuse in adolescence conceptualise mental health and related concepts. Only a few studies published since 2007 include direct evidence from young people about what they think (Johansson et al., 2007; Lovett et al., 2010; Simmonds et al., 2014; John et al., 2014). Resilience is the only concept where we found evidence specifically in relation to sexual abuse, although the concept was applied *to young people* rather than explored *with young people*. Our key findings from the broader literature with potential implications for our research include the following:

- These concepts of mental health, wellbeing and resilience are not neutral. They are defined and understood by young people in different ways.
- Gender and age are important considerations within the conceptualisations of mental health and related concepts. These differences are likely to have important implications for the ways in which services engage with and support young people with experiences of sexual abuse in adolescence.
- Evidence suggests that differences between the needs and developmental trajectories of adults and young people indicate that adult frameworks of recovery are not necessarily appropriate for adolescents.
- Given the absence of substantial theoretical or empirical work with adolescents relating to the other concepts considered in this briefing, it is unclear how relevant frameworks developed for adults are to young people. It is therefore inappropriate to assume that conceptual frameworks developed

for adults or younger children can be applied to adolescents. This indicates the need for age appropriate frameworks.

- Although still limited, this evidence, together with evidence on resilience and adolescents more generally, raises important questions around the concept of resilience for this age group and the role of protective factors within this.
- Young people's perspectives are conspicuously absent in relation to resilience in comparison to mental health and recovery literature, with none of these papers exploring the concept of resilience in qualitative or participatory ways.

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