Suicidality Following Sexual Abuse Among Children Aged 10 to 17 Years

Daisy Sornabala, BS,[1] Bridget Duffy, MPH,[2] Saroj Bista, PhD, MPH, BPharm,[2] Fiona O'Malley, MA,[2] Gary A. Smith, MD, DrPH,[2,3] Kristin G. Crichton, DO,[3,4,a] Nichole L. Michaels, PhD[2,3,a]

abstract

OBJECTIVE: Survivors of child sexual abuse often experience trauma-related sequelae, including increased risk for psychiatric disorders. The objectives of this study are to (1) epidemiologically describe youth evaluated at a child advocacy center for concerns of child sexual abuse and compare the characteristics of those who did and did not experience subsequent suicidality and (2) explore associations between the presentation of suicidality and the victim-alleged perpetrator relationship.

METHODS: Electronic health records of children aged 10 to 17 years who were evaluated for child sexual abuse at a medically based child advocacy center in the Midwestern United States between January 1, 2018, and December 31, 2022, were retrospectively reviewed to identify suicidality within 90 days following assessment. Demographic, medical, mental health, and alleged perpetrator relationship data were descriptively analyzed.

RESULTS: Among 1391 youth medically assessed for child sexual abuse, 11.1% of youth reported suicidality within 90 days. Of those youth, 21.9% attempted suicide within that time period. When the relationship between the adolescent and alleged perpetrator was known, a significantly greater percentage of suicide attempts occurred among youth whose perpetrator was a nonrelative, rather than a relative (3.2% vs 1.4%, respectively; $P = .03$).

CONCLUSIONS: This study supports the need for suicidality screening for youth both at the time of child sexual abuse evaluation and in the weeks and months following disclosure. Prompt, trauma-informed mental health care is critical for preventing further harm, especially for high-risk youth, including individuals with current depressive symptoms, those with prior suicidal ideation, and those who identify as sexual and gender diverse.

[1]*Meharry Medical College School of Medicine, Nashville, Tennessee;* [2]*Center for Injury Research and Policy, The Abigail Wexner Research Institute at Nationwide Children's Hospital, Columbus, Ohio;* [3]*Department of Pediatrics, The Ohio State University College of Medicine, Columbus, Ohio; and* [4]*Center for Family Safety and Healing at Nationwide Children's Hospital, Columbus, Ohio*

[a]*Contributed equally as co-senior authors.*

Address correspondence to: Nichole Michaels, PhD, Center for Injury Research and Policy, The Abigail Wexner Research Institute at Nationwide Children's Hospital, 575 Children's Crossroads, Columbus, OH 43215. nichole.michaels@nationwidechildrens.org

Ms Sornabala conducted medical record review and coded cases, interpreted data, drafted the initial manuscript, and critically reviewed and revised the manuscript. Ms Duffy drafted the initial manuscript, interpreted data, and critically reviewed and revised the manuscript. Dr Bista conducted data analysis and critically reviewed and revised the manuscript. Dr Smith critically reviewed and revised the manuscript. Ms O'Malley conducted medical record review and coded cases, interpreted data, and critically reviewed and revised the manuscript. (Continued)

WHAT'S KNOWN ON THIS SUBJECT: Child survivors of any kind of physical, emotional, or sexual abuse are at increased risk of experiencing negative physical and psychological health effects, including suicidality.

WHAT THIS STUDY ADDS: Among 1391 youth aged 10 to 17 years who were assessed for child sexual abuse, 11.1% experienced suicidality within 90 days following their disclosure. Of those, 21.9% attempted suicide during that time.

To cite: Sornabala D, Duffy B, Bista S, et al. Suicidality Following Sexual Abuse Among Children Aged 10 to 17 Years. *Pediatrics.* 2026;158(1):e2025073356

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

INTRODUCTION

Child sexual abuse (CSA) remains a serious public health problem in the United States.[1] Experiencing CSA is an adverse childhood experience and contributes to negative implications for health throughout life.[2–5] CSA is defined as any sexual activity involving a child that the child does not understand, is not developmentally ready for, and/or cannot consent to and encompasses a spectrum of behaviors, including penetration, touching, and noncontact sexual acts.[6,7] Barriers to abuse disclosure are common among CSA survivors and contribute to substantial underreporting.[8–11] Risk factors for CSA include being female or sexual and gender diverse (SGD), having a neurodevelopmental disorder, and previous experience of sexual abuse.[12–16]

Experiencing CSA impacts multiple facets of life, including physical health, mental health, and economic stability.[17–21] Research shows strong associations between CSA and profound, long-lasting negative effects on mental health in both childhood and adulthood.[20,22,23] The relationship between the perpetrator and survivor has been theorized to influence mental health outcomes following CSA, with some studies suggesting that being related to the perpetrator increases the risk of negative mental health outcomes.[24,25] However, other research indicates worse mental health outcomes for CSA survivors when the abuse was perpetrated by a noncaregiver, rather than a caregiver.[26]

Suicidality is the risk of suicide, assessed by suicidal ideation or intent.[26] Survivors of CSA are known to be at increased risk for negative psychiatric sequelae, including suicidality.[27–30] CSA survivors may delay, not disclose, or not seek help for their abuse for a variety of reasons, including fear or shame.[31] Even when youth do receive timely medical care for CSA, behavioral health resources that may help identify and address future suicidality, such as trauma-informed counseling, can be difficult to access.[32] Identifying youth who are at greatest risk for suicidality following CSA is imperative for improving long-term outcomes for this population and can better inform clinician decision-making.

The objectives of this study are to (1) epidemiologically describe youth evaluated at a medically based child advocacy center (CAC) for concerns of CSA and compare the demographic and circumstance characteristics of those who did and did not experience suicidality within 3 months of their CAC assessment and (2) explore associations between the presentation of suicidality and the victim-alleged perpetrator relationship. Findings from this study can help guide suicide prevention efforts, support standardization of trauma-informed care for CSA survivors, and inform future research.

METHODS

A retrospective medical record review was conducted using the electronic health record (EHR) system at a medically based CAC within a large, Midwestern children's hospital in the United States. CAC patients are primarily referred by child protective services but can also be referred by law enforcement, primary care physicians, or self-referrals; ours is the only CAC within our large urban county and we see all patients referred by partner agencies. Medical record review was completed by 2 study authors and the senior authors. The EHR was queried to identify youth aged 10 to 17 years who received care at the CAC between January 1, 2018, and December 31, 2022, for any of the following reasons: alleged physical or sexual abuse; concern for sexual abuse, including human trafficking; or problematic sexualized behaviors. Youth were excluded from the study if any of the following conditions were met: they did not have a forensic interview at the CAC; there were no disclosures or indications of CSA; they were only assessed at the CAC for a follow-up evaluation; or they did not reside in the county where the hospital is located or one of the 6 adjacent counties. If a youth was evaluated at the CAC for concerns of CSA on more than 1 occasion during the study period, only data from their first visit were included.

Using the EHR, the CAC evaluation, physical examination, and forensic interview notes were reviewed, including suicide risk screening results gathered at the time of the CAC assessment. Per our CAC's standard protocols, suicide risk screening was completed by a health care provider (ie, physician, advanced practice nurse) for all patients older than 11 years and for patients aged 10 or 11 years if the caregiver expressed concerns regarding the youth's dysphoric mood, suicidal ideation, or self-harm. Screenings occurred after the forensic interview, during the medical evaluation performed as part of every CAC assessment. Patients who screened positive for active suicidality were immediately transferred to our emergency department in coordination with our institutional behavioral health team. If the patient disclosed a history of suicidal ideation without active suicidality, CAC social workers met with the patient and caregiver(s) to ensure a safety plan was in place and provide urgent referrals for counseling, either within the institution or external, based on their preference. Mental health referrals are typically made for all patients who are seen at the CAC and disclose CSA, unless they already have counseling services in place.

Data from this suicide risk screening were used to identify whether the adolescent was currently experiencing depressive symptoms or suicidal ideation and if they had a prior history of suicidal ideation or attempted suicide. The study authors then reviewed each adolescent's health care encounters across the institution during the 90 days following their CAC evaluation to identify any reports of suicidality. In this study, suicidality was indicated if the youth presented with concerns for suicidal ideation or suicide attempt(s) within the 90 days following their CAC assessment, or if the child died by suicide during this time period. (Due to privacy concerns, the small number of deaths by

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

suicide identified in this study are not reported separately but are included with suicide attempts.) The EHR gathers data from a spectrum of health care encounters, including visits to emergency departments, pediatric or adolescent primary care, and behavioral health care within the institutional system, as well as affiliated school-based, home-based, and in-clinic counseling encounters. Assessment or treatment of suicidality outside of these venues could not be identified.

Data from CAC evaluations were used to identify the child's relationship to the alleged perpetrator of CSA. The relationship between the alleged perpetrator and the child was coded as either "relative" or "nonrelative" based on a review of information gathered by the social worker facilitating the forensic interview. Relatives were defined as individuals connected to the child through blood, marriage (including ex/former family members through marriage), or adoption. All other relationships were categorized as nonrelative.

Demographic data, including the adolescent's age, sex, race, ethnicity, and SGD status, were retrieved from the EHR. Race and ethnicity, which represent social constructs, were classified using the categories available in the EHR. Due to small counts, multiple racial groups were combined into "Other," including American Indian or Alaska Native and Native Hawaiian or other Pacific Islander. Youth were categorized as SGD if EHR documents reviewed for the study included documentation indicating they were either not cisgender or not heterosexual. This information was routinely collected for all patients and confirmed at each visit.

Demographic characteristics are described using frequencies, percentages, means, and SDs. χ^2 tests, Fisher exact tests, and Wilcoxon-Mann-Whitney tests were used, as appropriate, to compare proportions and means of characteristics between groups, with P values of less than .05 indicating statistical significance. All analyses were performed using SAS 9.4 (SAS Institute Inc., Cary, NC). This study was approved by the Institutional Review Board at the authors' institution.

RESULTS

A total of 1391 youth met our inclusion criteria and were included in the study. The majority of adolescents were female (89.1%, Table 1). More than one-half were white (53.6%) and one-third were Black or African American (33.6%). Most were not Hispanic or Latino (88.8%), and 12.5% were identified as SGD.

Responses to suicide risk screening questions that were administered to youth during their CAC evaluations were analyzed and compared with regard to reported suicidality within the 90-day follow-up period (Table 2). There were statistically significant differences in responses to suicide risk screening questions related to current depressive symptoms, current suicidal ideation, history of suicidal ideation, history of suicide attempt(s), and reported suicidality within 90 days. A significantly greater percentage of adolescents who reported current depressive symptoms or suicidal ideation at the time of CAC evaluation reported suicidality within 90 days, compared with those who did not report depressive symptoms or suicidal ideation (16.3% vs 4.7%; $P < .001$ and 29.6% vs 10.4%; $P < .001$, respectively). Similarly, a significantly greater percentage of youth who reported a history of suicidal ideation or at least 1 prior suicide attempt at CAC evaluation reported suicidality within 90 days, compared with those who did not report a history of suicidal ideation or attempted suicide (17.1% vs 2.6%; $P < .001$ and 25.1% vs 7.4%; $P < .001$, respectively).

Table 3 presents adolescents' responses to suicidality risk screening questions administered during CAC evaluation, stratified by whether the alleged perpetrator of CSA was a relative or nonrelative. Among 1351 youth for whom the relationship between the adolescent and the alleged perpetrator of CSA could be identified, 51.7% of incidents involved a relative. There were not any statistically significant differences in the percentage of youth who reported current depressive symptoms, current suicidal ideation, or prior history of suicidal ideation or suicide attempt(s) between adolescents whose alleged perpetrator was a nonrelative vs a relative. There was also not a significant difference in the percentage of youth who reported suicidality in the 90 days following their CAC evaluation based on whether the alleged perpetrator was a nonrelative or relative (11.8% (77/652) vs 10.6% (74/699), respectively; $P = .48$). However, among youth whose relationship with their alleged perpetrator was known, a significantly greater proportion of suicide attempts occurred among youth whose alleged perpetrator was a nonrelative rather than a relative (3.2% (21/652) vs 1.4% (10/699), respectively; $P = .03$).

DISCUSSION

This study epidemiologically describes 1391 youth aged 10 to 17 years who were evaluated for CSA at a CAC within a Midwestern children's hospital over a 5-year period. The majority of adolescents in this study were female, consistent with prior research demonstrating that CSA is more frequently reported among female individuals than among male individuals in the United States.[33]

In the current study, 11.1% of youth evaluated at the CAC presented with suicidality concerns within 90 days. Although there were not any significant differences with regard to age, sex, race, or ethnicity, 19.0% of CAC evaluations involving SGD youth were followed by treatment for suicidality within 90 days, compared with 10.0% of assessments involving non-SGD youth. This is consistent with prior research demonstrating that SGD youth are at

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

TABLE 1. Demographic Characteristics of Youth Completing Child Sexual Abuse Assessments, Aged 10 to 17 Years, 2018–2022

Characteristics	Number (%)[a]			*P* Value
		Suicidality Within 90 d:		
	Total	Absent	Present	
Total youth	N = 1391	N = 1236	N = 155	
Age in years, mean ± SD	14.7 ± 1.5	14.7 ± 1.6	14.7 ± 1.5	.92
Sex				.19
Female	1240 (89.1)	1097 (88.8)	143 (92.3)	
Male	151 (10.9)	139 (11.3)	12 (7.7)	
Race				.45
White	687 (53.6)	604 (53.3)	83 (56.5)	
Black or African American	430 (33.6)	386 (34.0)	44 (29.9)	
Multiple races	141 (11.0)	125 (11.0)	16 (10.9)	
Asian	14 (1.1)	12 (1.1)	2 (1.4)	
Other[b]	6 (0.5)	4 (0.4)	2 (1.4)	
Refuse to answer	3 (0.2)	3 (0.3)	0 (0.0)	
Missing/unknown[c] (n = 110)				
Ethnicity				.12
Not Hispanic or Latino	1232 (88.8)	1092 (88.6)	140 (90.3)	
Hispanic or Latino	149 (10.7)	136 (11.0)	13 (8.4)	
Other[d]	6 (0.4)	4 (0.3)	2 (1.3)	
Missing/unknown[c] (n = 4)				
SGD[e]				<.001
Yes	174 (12.5)	141 (11.4)	33 (21.3)	
No	1217 (87.5)	1095 (88.6)	122 (78.7)	
Primary reason for visit[f]				.67
Alleged sexual abuse	1332 (95.8)	1180 (95.5)	152 (98.1)	
Alleged physical abuse	22 (1.6)	21 (1.7)	1 (0.7)	
Sexualized behaviors	15 (1.1)	15 (1.2)	0 (0.0)	
Concern for sexual abuse	13 (0.9)	12 (1.0)	1 (0.7)	
Other[g]	9 (0.7)	8 (0.7)	1 (0.7)	

Abbreviation: SGD, sexual and gender diverse.
[a] Column percentage may not sum to 100.0% due to rounding error.
[b] Includes American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.
[c] Unknown and missing values were omitted from the denominator when calculating percentages.
[d] Indicated as "other" in electronic health record without further specification.
[e] If youth was identified as not cisgender or not heterosexual in electronic health record, SGD status was coded as yes.
[f] Primary reason for visit to the child advocacy center during which the child sexual abuse assessment occurred.
[g] Includes anatomic medical concern, human trafficking concern, and neglect.

increased risk for sexual abuse victimization and mental health issues, such as depression and suicidal ideation.[34–36] One possible explanation for this difference is that SGD youth may have had greater prior engagement with or access to mental health services than non-SGD youth, potentially increasing their likelihood of accessing care after CSA disclosure.[37] To promote the health and well-being of SGD youth, it is critical to ensure the mental health services accessed by SGD youth are welcoming and affirming of diverse identities.[38,39]

Findings of the current study underscore the importance of suicide risk screening during CSA assessments and the urgent need to ensure these youth are linked to appropriate mental health services. Statistically significant associations were identified between reported current depressive symptoms, current suicidal ideation, or a history of suicidal ideation or attempted suicide at the time of CAC evaluation and suicidality within 90 days. Youth who experience CSA are more likely to develop mental health disorders[22] but may face barriers to accessing high-quality timely treatment. A review by Herbert of 49 studies from Australia and the United States that examined therapy referrals and engagement following CSA disclosure found that among youth who received a therapy referral, only 61% ultimately accessed

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

TABLE 2. Responses to Suicide Risk Screening Questions Administered During Child Sexual Abuse Assessments, Stratified by Suicidality Within 90 Days, Ages 10 to 17 Years, 2018–2022

Characteristics[a]	Number (%)			*P* Value
		Suicidality Within 90 d:		
	Total[b]	Absent[c]	Present[c]	
Total youth	N = 1391	N = 1236	N = 155	
Current depressive symptoms				<.001
Yes	775 (55.8)	649 (83.7)	126 (16.3)	
No	613 (44.2)	584 (95.3)	29 (4.7)	
Missing/unknown[d] (n = 3)				
Current suicidal ideation				<.001
Yes	54 (3.9)	38 (70.4)	16 (29.6)	
No	1334 (96.1)	1195 (89.6)	139 (10.4)	
Missing/unknown[d] (n = 3)				
Any suicidal ideation history				<.001
Yes	820 (59.1)	680 (82.9)	140 (17.1)	
No	568 (40.9)	553 (97.4)	15 (2.6)	
Missing/unknown[d] (n = 3)				
Any suicide attempt history				<.001
Yes	295 (21.3)	221 (74.9)	74 (25.1)	
No	1093 (78.8)	1012 (92.6)	81 (7.4)	
Missing/unknown[d] (n = 3)				
Suicide attempt within 90 d				<.001
Yes	34 (2.4)	0 (0.0)	34 (100.0)	
No	1357 (97.6)	1236 (91.1)	121 (8.9)	

[a] Suicidality screening questions administered at child advocacy center assessment.
[b] Column percentage may not sum to 100.0% due to rounding error.
[c] Row percentage may not sum to 100.0% due to rounding error.
[d] Missing/unknown values were omitted from the denominator when calculating percentages.

services.[40] For youth who did not receive a therapy referral, outcomes were even more concerning, with only one-third engaging in services.[40] A case series by Zaydlin et al shed light on the consequences of delayed mental health care and diagnosis following CSA disclosure, documenting worsened trauma and mood symptoms in 3 CSA survivors following disclosure.[41] Due to limited resources for trauma-informed mental health care for adolescents and challenges related to coordination of care,[41] it can be difficult for youth survivors of CSA to receive adequate follow-up care after abuse disclosure. Even when youth are referred for services, many encounter barriers to initiating and engaging in care, underscoring the need for ongoing support.

Although this study also explored associations between the presentation of suicidality and the victim-alleged perpetrator relationship, we identified few differences in suicidality when comparing youth who were abused by a relative vs a nonrelative. One exception was that among youth whose relationship with their alleged perpetrator was known, a significantly greater proportion of suicide attempts occurred among adolescents who were not related to their perpetrator. The reasons for this difference are unknown. However, one potential explanation may be related to the types of interventions that are implemented after disclosure. If an adolescent identifies the alleged perpetrator as a relative living in their home, child protective services may immediately intervene with a safety plan designed to eliminate the youth's exposure to that individual. However, if the alleged perpetrator is a nonrelative, identifying the individual and implementing a safety plan may be more difficult and prolonged, negatively impacting the adolescent's mental health. This reasoning highlights an area for future investigations to better explore the involvement of child protective services in CSA cases and subsequent mental health outcomes. An additional factor that we were not able to account for was the initiation or outcome of any criminal legal system response to the CSA. Law enforcement investigations and court proceedings may impact the mental health of survivors and should be considered as a topic for future research.

Clinical Recommendations

The etiology of suicidality is multifactorial, and although not every aspect is fully understood, assessments for CSA by

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

TABLE 3. Responses to Suicide Risk Screening Questions Administered During Child Sexual Abuse Assessments, Stratified by Alleged Perpetrator Relationship, Ages 10 to 17 Years, 2018–2022

Characteristics[a]	Number (%)			*P* Value
		Alleged Perpetrator		
	Total[b]	Relative[c]	Nonrelative[c]	
Total youth	n=1351	n=699	n=652	
Current depressive symptoms				.82
Yes	751 (55.7)	391 (52.1)	360 (47.9)	
No	597 (44.3)	307 (51.4)	290 (48.6)	
Missing/unknown[d] (n = 3)				
Current suicidal ideation				.90
Yes	53 (3.9)	27 (50.9)	26 (49.1)	
No	1295 (96.1)	671 (51.8)	624 (48.2)	
Missing/unknown[d] (n = 3)				
Any suicidal ideation history				.42
Yes	800 (59.4)	407 (50.9)	393 (49.1)	
No	548 (40.7)	291 (53.1)	257 (46.9)	
Missing/unknown[d] (n = 3)				
Any suicide attempt history				.42
Yes	284 (21.1)	141 (49.7)	143 (50.4)	
No	1064 (78.9)	557 (52.4)	507 (47.7)	
Missing/unknown[d] (n = 3)				
Suicidality within 90 d				.48
Yes	151 (11.2)	74 (49.0)	77 (51.0)	
No	1200 (88.8)	625 (52.1)	575 (47.9)	
Suicide attempt within 90 d				.03
Yes	31 (2.3)	10 (32.3)	21 (67.7)	
No	1320 (97.7)	689 (52.2)	631 (47.8)	

Note: For 40 youth, alleged perpetrator relationship was missing/unknown.
[a] Suicidality screening questions administered at child advocacy center assessment.
[b] Column percentage may not sum to 100.0% due to rounding error.
[c] Row percentage may not sum to 100.0% due to rounding error.
[d] Missing/unknown values were omitted from the denominator when calculating percentages.

trained clinicians should be occurring with every encounter, especially for high-risk youth, including those being seen in a CAC. These assessments should include screenings for symptoms of depression, past or present suicidal ideation, and history of suicide attempts or self-harm. Based on this evaluation, proper referrals should be made for trauma-informed counseling and other appropriate mental health care. Ideally, follow-up should occur to ensure that youth are successfully linked with these services in a timely manner. Beyond referrals, embedding mental health care services directly within CACs could facilitate immediate counseling, safety planning, and lethal means assessment for this high-risk population. Integrating these services may improve continuity of care and reduce the risk of disengagement.

Recognizing that CSA disclosure can be a crisis involving the whole family, caregivers may need support to ensure their children receive proper mental health care. Family connectedness has been shown to reduce the risk of suicide behaviors among youth with a history of CSA, and engaging the youth's family and caregivers in follow-up care has been demonstrated to improve trauma-related symptoms.[29,42] One evidence-based treatment that can be initiated with families following CSA disclosure is the Child and Family Traumatic Stress Intervention, a brief intervention designed to be implemented during the acute phase of trauma response or after a recent disclosure of abuse.[42–44] This intervention is associated with significant reductions in child-reported posttraumatic stress scores.[45]

Multidisciplinary team members working in CACs must be aware of the risk of suicidality following CSA disclosure and should counsel caregivers on how to take necessary safety precautions within their homes and when and how to seek care for urgent mental health concerns. According to guidelines from the American Academy of Child and Adolescent Psychiatry, caregivers of youth who are

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

exhibiting suicidality should lock up weapons, medications, vehicle keys, toxic chemicals, and ropes (and similar long cords) and monitor online activity related to self-harm or suicide.[46] Caregivers should be prompted to involve mental health providers as soon as possible if a child or adolescent displays warning signs of suicidality, including frequent or pervasive sadness; changes in eating or sleeping patterns; withdrawal from family, friends, or regular activities; frequent complaints of physical symptoms often related to emotions (eg, abdominal pain); problems at school; preoccupation with death; drug or alcohol use; violent or rebellious behavior or running away; neglect of personal appearance; marked personality change; loss of interest in pleasurable activities; and statements such as "I wish I was dead."[47]

Limitations

Although this study has many strengths, there are also limitations to consider. We cannot demonstrate that cases of suicidality reported in this study were a direct result of CSA. Also, data were collected from 1 CAC in the United States with robust mental health resources and thus may not be representative of the general US population or all CACs. Additionally, if an adolescent presented with concerns for suicidality within the 90-day time period to a health care provider not accessible via our hospital's EHR, that encounter was not included in the study. Similarly, patients experiencing suicidality who did not seek health care were also not included. Thus, suicidality and suicide attempts may be underrepresented. It is also possible that some cases of nonsuicidal self-injury were inadvertently coded as suicidality based on information recorded in the EHR. Cases in which youth presented with suicidality outside of the 90-day window following CAC evaluation were excluded from this study. Furthermore, although we were able to use the EHR to determine whether patients had a known history of suicidal ideation or attempted suicide, we were not able to obtain a complete and detailed accounting of each patient's mental health encounters before and after CAC evaluation. Such data could provide valuable context for understanding whether the experiences of suicidality occurred in isolation or if there were observable patterns of behavior that could guide future intervention development.

CONCLUSIONS

Youth survivors of abuse are at increased risk of experiencing negative health outcomes, including suicidality. This study highlights immediate mental health risks following CSA evaluation and identifies subgroups—including youth with current depressive symptoms, those with prior suicidal ideation, or those who identify as SGD—as particularly vulnerable. Prompt, trauma-informed mental health care in the weeks and months following CSA disclosure is critical. Given the prevalence of underreporting of both CSA and suicidality, youth may go without needed support. Expanding access to affirming, culturally responsive mental health services is essential to preventing further harm. Future research should explore additional strategies to identify and address mental health needs of youth survivors of CSA.

ABBREVIATIONS

CAC: child advocacy center
CSA: child sexual abuse
EHR: electronic health record
SGD: sexual and gender diverse

Dr Crichton conceptualized and designed the study and critically reviewed and revised the manuscript. Dr Michaels conceptualized and designed the study and critically reviewed and revised the manuscript. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

CONFLICT OF INTEREST DISCLOSURES: The authors have no conflicts of interest relevant to this article to disclose.

FUNDING: Ms Sornabala's work on this study was supported by the National Student Injury Research Training Program of the Center for Injury Research and Policy at Nationwide Children's Hospital, funded by the Child Injury Prevention Alliance (CIPA).

Accepted for Publication Date: April 1, 2026

https://doi.org/10.1542/peds.2025-073356

Copyright © 2026 by the American Academy of Pediatrics

REFERENCES

1. Centers for Disease Control and Prevention. About child sexual abuse. Published 2024. Accessed February 6, 2025. https://www.cdc.gov/child-abuse-neglect/about/about-child-sexual-abuse.html
2. Daníelsdóttir HB, Aspelund T, Shen Q, et al. Adverse childhood experiences and adult mental health outcomes. *JAMA Psychiatry*. 2024;81(6):586–594. PubMed doi: 10.1001/jamapsychiatry.2024.0039

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

3. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci.* 2006;256(3):174–186. PubMed doi: 10.1007/s00406-005-0624-4

4. Bellis MA, Hughes K, Leckenby N, Hardcastle KA, Perkins C, Lowey H. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. *J Public Health (Oxf).* 2015;37(3):445–454. PubMed doi: 10.1093/pubmed/fdu065

5. Sachs-Ericsson NJ, Rushing NC, Stanley IH, Sheffler J. In my end is my beginning: developmental trajectories of adverse childhood experiences to late-life suicide. *Aging Ment Health.* 2016;20(2):139–165. PubMed doi: 10.1080/13607863.2015.1063107

6. Kempe CH. Sexual abuse, another hidden pediatric problem: the 1977 C. Anderson Aldrich lecture. *Pediatrics.* 1978;62(3):382–389. PubMed doi: 10.1542/peds.62.3.382

7. Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics.* 2005;116(2):506–512. PubMed doi: 10.1542/peds.2005-1336

8. Collin-Vézina D, De La Sablonnière-Griffin M, Palmer AM, Milne L. A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse Negl.* 2015;43:123–134. PubMed doi: 10.1016/j.chiabu.2015.03.010

9. Alaggia R, Collin-Vézina D, Lateef R. Facilitators and barriers to child sexual abuse (CSA) disclosures: a research update (2000–2016). *Trauma Violence Abuse.* 2019;20(2):260–283. PubMed doi: 10.1177/1524838017697312

10. Brattfjell ML, Flåm AM. "They were the ones that saw me and listened." From child sexual abuse to disclosure: Adults' recalls of the process towards final disclosure. *Child Abuse Negl.* 2019;89:225–236. PubMed doi: 10.1016/j.chiabu.2018.11.022

11. McElvaney R. Disclosure of child sexual abuse: delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Rev.* 2015;24(3):159–169. doi: 10.1002/car.2280

12. Sedlak A, Mettenburg J, Basena M, et al. *Fourth national incidence study of child abuse and neglect (NIS–4): report to congress.* U.S. Department of Health and Human Services, Administration for Children and Families; 2010.

13. Papalia N, Mann E, Ogloff JRP. Child sexual abuse and risk of revictimization: impact of child demographics, sexual abuse characteristics, and psychiatric disorders. *Child Maltreat.* 2021;26(1):74–86. PubMed doi: 10.1177/1077559520932665

14. Ohlsson Gotby V, Lichtenstein P, Långström N, Pettersson E. Childhood neurodevelopmental disorders and risk of coercive sexual victimization in childhood and adolescence - a population-based prospective twin study. *J Child Psychol Psychiatry.* 2018;59(9):957–965. PubMed doi: 10.1111/jcpp.12884

15. Friedman MS, Marshal MP, Guadamuz TE, et al. A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health.* 2011;101(8):1481–1494. PubMed doi: 10.2105/AJPH.2009.190009

16. Thoma BC, Rezeppa TL, Choukas-Bradley S, Salk RH, Marshal MP. Disparities in childhood abuse between transgender and cisgender adolescents. *Pediatrics.* 2021;148(2):e2020016907. PubMed doi: 10.1542/peds.2020-016907

17. Guiney H, Caspi A, Ambler A, et al. Childhood sexual abuse and pervasive problems across multiple life domains: findings from a five-decade study. *Dev Psychopathol.* 2024;36(1):219–235. PubMed doi: 10.1017/S0954579422001146

18. Hailes HP, Yu R, Danese A, Fazel S. Long-term outcomes of childhood sexual abuse: an umbrella review. *Lancet Psychiatry.* 2019;6(10):830–839. PubMed doi: 10.1016/S2215-0366(19)30286-X

19. Afifi TO, MacMillan HL, Boyle M, Taillieu T, Cheung K, Sareen J. Child abuse and mental disorders in Canada. *CMAJ.* 2014;186(9):E324–E332. PubMed doi: 10.1503/cmaj.131792

20. Coles J, Lee A, Taft A, Mazza D, Loxton D. Childhood sexual abuse and its association with adult physical and mental health: results from a national cohort of young Australian women. *J Interpers Violence.* 2015;30(11):1929–1944. PubMed doi: 10.1177/0886260514555270

21. Dinwiddie S, Heath AC, Dunne MP, et al. Early sexual abuse and lifetime psychopathology: a co-twin-control study. *Psychol Med.* 2000;30(1):41–52. PubMed doi: 10.1017/S0033291799001373

22. Spataro J, Mullen PE, Burgess PM, Wells DL, Moss SA. Impact of child sexual abuse on mental health: prospective study in males and females. *Br J Psychiatry.* 2004;184(5):416–421. PubMed doi: 10.1192/bjp.184.5.416

23. Easton SD, Kong J. Mental health indicators fifty years later: a population-based study of men with histories of child sexual abuse. *Child Abuse Negl.* 2017;63:273–283. PubMed doi: 10.1016/j.chiabu.2016.09.011

24. Yüce M, Karabekiroğlu K, Yildirim Z, et al. The psychiatric consequences of child and adolescent sexual abuse. *Noro Psikiyatri Ars.* 2015;52(4):393–399. PubMed doi: 10.5152/npa.2015.7472

25. Cantón-Cortés D, Cantón J. Coping with child sexual abuse among college students and post-traumatic stress disorder: the role of continuity of abuse and relationship with the perpetrator. *Child Abuse Negl.* 2010;34(7):496–506. PubMed doi: 10.1016/j.chiabu.2009.11.004

26. APA Dictionary of Psychology. Accessed November 6, 2024. https://dictionary.apa.org/

27. Pérez-Fuentes G, Olfson M, Villegas L, Morcillo C, Wang S, Blanco C. Prevalence and correlates of child sexual abuse: a national study. *Compr Psychiatry.* 2013;54(1):16–27. PubMed doi: 10.1016/j.comppsych.2012.05.010

28. Lopez-Castroman J, Melhem N, Birmaher B, et al. Early childhood sexual abuse increases suicidal intent. *World Psychiatry.* 2013;12(2):149–154. PubMed doi: 10.1002/wps.20039

29. Eisenberg ME, Ackard DM, Resnick MD. Protective factors and suicide risk in adolescents with a history of sexual abuse. *J Pediatr.* 2007;151(5):482–487. PubMed doi: 10.1016/j.jpeds.2007.04.033

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch

30. Ng QX, Yong BZJ, Ho CYX, Lim DY, Yeo WS. Early life sexual abuse is associated with increased suicide attempts: an update meta-analysis. *J Psychiatr Res*. 2018;99:129–141. PubMed doi: 10.1016/j.jpsychires.2018.02.001

31. Smith DW, Letourneau EJ, Saunders BE, Kilpatrick DG, Resnick HS, Best CL. Delay in disclosure of childhood rape: results from a national survey. *Child Abuse Negl*. 2000;24(2):273–287. PubMed doi: 10.1016/S0145-2134(99)00130-1

32. Hoffmann JA, Alegría M, Alvarez K, et al. Disparities in pediatric mental and behavioral health conditions. *Pediatrics*. 2022;150(4):e2022058227. PubMed doi: 10.1542/peds.2022-058227

33. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *J Adolesc Health*. 2014;55(3):329–333. PubMed doi: 10.1016/j.jadohealth.2013.12.026

34. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Childhood gender nonconformity: a risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics*. 2012;129(3):410–417. PubMed doi: 10.1542/peds.2011-1804

35. Craig SL, Austin A, Levenson J, Leung VWY, Eaton AD, D'Souza SA. Frequencies and patterns of adverse childhood events in LGBTQ+ youth. *Child Abuse Negl*. 2020;107:104623. PubMed doi: 10.1016/j.chiabu.2020.104623

36. Kingsbury M, Hammond NG, Johnstone F, Colman I. Suicidality among sexual minority and transgender adolescents: a nationally representative population-based study of youth in Canada. *CMAJ*. 2022;194(22):E767–E774. PubMed doi: 10.1503/cmaj.212054

37. Duffy B, Nurre OM, Bista S, O'Malley F, Michaels NL. Characteristics of fatalities among sexual- and gender-diverse youth in the United States: 2015–2020. *Pediatrics*. 2024;154(Suppl 3):e2024067043P. PubMed doi: 10.1542/peds.2024-067043P

38. Rafferty J, Yogman M, Baum R, et al; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4):e20182162. PubMed doi: 10.1542/peds.2018-2162

39. Levine DA, Braverman PK, Adelman WP, et al; Committee On Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 2013;132(1):198–203. PubMed doi: 10.1542/peds.2013-1282

40. Herbert J. *Rates of therapy use following a disclosure of child sexual abuse*. Australian Institute of Family Studies; 2021.

41. Zaydlin M, Pérez-Laras L, Laras L. The role of psychiatry in the management of sexual assault: a case series. *Cureus*. 2021;13(3):e13644. PubMed doi: 10.7759/cureus.13644

42. Berkowitz SJ, Stover CS, Marans SR. The Child and Family Traumatic Stress Intervention: secondary prevention for youth at risk of developing PTSD. *J Child Psychol Psychiatry*. 2011;52(6):676–685. PubMed doi: 10.1111/j.1469-7610.2010.02321.x

43. Hahn H, Putnam K, Epstein C, Marans S, Putnam F. Child and family traumatic stress intervention (CFTSI) reduces parental posttraumatic stress symptoms: a multi-site meta-analysis (MSMA). *Child Abuse Negl*. 2019;92:106–115. PubMed doi: 10.1016/j.chiabu.2019.03.010

44. Epstein C, Hahn H, Berkowitz S, Marans S. The child and family traumatic stress intervention. In: Landolt MA, Cloitre M, Schnyder U, eds. *Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents*. Springer International Publishing; 2017:145–166.

45. Stover CS, Hahn H, Maciejewski KR, Epstein C, Marans S. The child and family traumatic stress intervention: factors associated with symptom reduction for children receiving treatment. *Child Abuse Negl*. 2022;134:105886. PubMed doi: 10.1016/j.chiabu.2022.105886

46. American Academy of Child & Adolescent Psychiatry. Suicide safety: precautions at home. Published 2020. Accessed November 10, 2024. https://www.aacap.org/AACAP/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/suicide-safety-130.aspx

47. American Academy of Child & Adolescent Psychiatry. Suicide resource center. Published 2024. Accessed June 20, 2025. https://www.aacap.org/AACAP/Families_Youth/Resource_Centers/Suicide_Resource_Center/AACAP/Families_and_Youth/Resource_Centers/Suicide_Resource_Center/Home.aspx?hkey=fc34217e-4ad1-4bfc-92b2-fd4f2ab78421

Downloaded from http://publications.aap.org/pediatrics/article-pdf/158/1/e2025073356/1939245/pediatrics.2025073356.pdf
by UT Rio Grande Valley, Stanley Fisch