Review Article

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Child Sexual Abuse and Suicide: Essentials for the Forensic Nurse

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ABSTRACT

Sexual abuse can result in significant negative sequelae for victims. One particularly harmful consequence is suicidal ideation, which can lead to suicide attempts and even death. It is essential to screen children and adolescents for suicidal ideation when providing medical forensic care after disclosure of acute or nonacute sexual abuse/assault. Forensic nurses must feel confident in their abilities to assess suicide risk and provide appropriate intervention and referrals. A thorough understanding of the relationship between sexual abuse and suicidal ideation and behaviors can assist the forensic nurse in the development of practice behaviors to better identify, intervene, and prevent suicidal ideation and behaviors among youth experiencing sexual abuse.

KEY WORDS:

Forensic nurse; sexual abuse; suicide

Sexual abuse is a pediatric healthcare problem of epidemic proportions with over 61,000 American children experiencing sexual abuse in 2019 (U.S. Department of Health & Human Services, 2021). However, this number represents a mere fraction of actual victims. Retrospective studies of adults have shown that approximately one in five victims never disclose their victimization (Tener & Murphy, 2015). Sexual abuse can result in significant negative sequelae for victims (Hailes et al., 2020). One particularly harmful consequence is suicidal ideation, which can lead to suicide attempts and even death (Bakken & Gunter, 2012; O'Connor et al., 2013). The past decade has seen a significant increase in rates of suicide, with the largest rise occurring among 10- to 14-year-old female adolescents (Curtin et al., 2016). Suicide was the second leading cause of death among individuals 10–14 years and 15–19 years old in 2019 (Centers for Disease Control and Prevention, 2021). Forensic nurses play a crucial role in the medical forensic care of child and adolescent victims of sexual abuse and may be the first person with whom they share their abuse experiences (Adams & Hulton, 2016). A thorough understanding of the relationship between sexual abuse and suicidal ideation and behaviors can assist the forensic nurse in the development of practice behaviors to better identify, intervene, and prevent suicidal ideation and behaviors among youth experiencing sexual abuse.

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Sexual Abuse and Suicide

Numerous studies in adults (Campos et al., 2013; Kealy et al., 2017; You et al., 2012) and adolescents (Evans et al., 2004; Hadland et al., 2015) have shown an association between childhood sexual victimization and suicidal thoughts and behaviors. Younger child victims are also vulnerable. Children who have experienced sexual abuse often experience subsequent difficulties in relationships with nonabusive family members, and many develop trauma symptoms that closely mimic attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD; Hailes et al., 2020). Sheftall et al. (2016) noted that problems with family relationships and a diagnosis of ADHD/ADD in young children aged 5–11 years are strongly correlated with death by suicide. Studies also suggest that the relationship between child sexual abuse and suicidal ideation/behaviors extends beyond childhood and adolescence into middle age and older adulthood (Stansfeld et al., 2017; Talbot et al., 2004).

Suicidal ideation is defined as thoughts of harming or killing oneself, whereas suicidal behavior refers to self-inflicted destructive acts committed with the intent to cause one's own death (Perez-Gonzalez & Pereda, 2015). Suicidal ideation and behaviors differ from self-injurious behaviors, which involve actions carried out to cause bodily harm to oneself, but not death (Bridge et al., 2006). Victims of sexual abuse have up to 2 times greater risk to endorse suicidal ideation than nonvictims, and suicidal behaviors occur more than 3 times more often in sexual abuse victims than nonvictims (Perez-Gonzalez & Pereda, 2015). Understanding the mechanisms underlying the association between the two phenomena can better equip the forensic nurse to develop practice interventions to minimize the risk of suicidal ideation and behaviors in children and adolescents who have experienced sexual abuse (Sekowski et al., 2020). Refer to Box 1.

Box 1: Mechanisms Underlying Child Sexual Abuse and Suicide

Overwhelming feelings
Shame
Guilt
Betrayal
Depression
Stigmatization
Impulsivity
Trust impairment
Stress and stress response
Emotional affect dysregulation
Self-capacity disturbance
Emotional security
Neurobiology
Hypothalamic–pituitary–adrenal axis
Elevated neural activity salient portions of the brain
Disengagement
Emotional reactivity

Adapted from Girard et al. (2021), Miller et al. (2017), and Radmanovic (2020).

Mechanisms Linking Sexual Abuse and Suicide

Overwhelming Feelings

All forms of child maltreatment, physical abuse, sexual abuse, emotional abuse, and neglect have been found to be significantly associated with suicidal ideation (King & Merchant, 2008; Miller et al., 2013). Yet, sexual abuse may well be a unique contributor to suicidal ideation in adolescents (Yoon et al., 2018). Child sexual abuse is a distinctive form of trauma exposure often accompanied by feelings of shame, guilt, and betrayal (Yoon et al., 2018; You et al., 2012), and these feelings may be exacerbated when the perpetrator is a parent or other close adult (Kealy et al., 2017). When the child experiences sexual abuse by a significant adult, they may feel trapped in a relationship with their perpetrator, leading to feelings of helplessness (Ferenczi, 1955). Self-critical emotions such as shame and guilt develop. Shame is often associated with feelings of worthlessness, inferiority, and powerlessness (Sekowski et al., 2020) and is often focused on one's body and sexuality (Aakvaag et al., 2016; Dyer et al., 2015). Victims with shame-related feelings show an increased proclivity for suicidal ideation and behaviors (You et al., 2012). Guilt is accompanied by feelings of remorse, regret, worries about hurting others, and responsibility for the sexual abuse. Shame and guilt can easily become heavy, pervasive emotions, which can lead to depression. Guilt in reference to suicidal behaviors becomes more important when guilt is coupled with depression. These feelings also lead to a sense of stigmatization and contribute to the fact that many cases of child sexual abuse remain undisclosed for a lifetime or are only disclosed often weeks, months, or years after victimization (Yoon et al., 2018). Thus, the feelings invoked after experiencing sexual abuse may affect victims more profoundly or in different ways than victims of other forms of child abuse.

Depression, Impulsivity, and Stress

Decades of research into adult and adolescent suicidal ideation and behavior has revealed that it is very difficult to identify overall risk factors predictive of suicidal behaviors (Miller et al., 2017). However, an earlier meta-analysis (Franklin et al., 2017) revealed internalizing psychopathology (such as depression), externalizing psychopathology (impulsivity or aggression), demographic characteristics (age, gender), and social factors (such as a history of child maltreatment or other traumatic or stressful life events) as relatively consistent risk factors for suicidal ideation and behaviors. Patients who have experienced sexual abuse may face a variety of negative mental health outcomes, including depression, internalizing behaviors, and externalizing behaviors (Felitti et al., 1998; Hornor, 2017). Many studies suggest that depressive symptoms may indeed be a strong predictor of suicidal ideation in adolescent girls; higher rates of suicidal ideation have been found in girls with more severe depressive symptoms (Avenevoli et al., 2015; DeCou & Lynch, 2019). Sexual abuse can alter the victim's processing of self and the world affecting their thoughts, feelings, and behaviors (Radmanovic, 2020). In addition, sexual abuse can disrupt the victim's ability to trust; it disrupts the feeling that the world is a safe place, and the individual's ability to trust others is impaired (Radmanovic, 2020). The sexual abuse victim's ability to cope with even everyday stress can become severely compromised. Anger management difficulties may develop, and

impulsivity can become heightened, increasing engagement in high-risk behaviors. Depression coupled with impulsivity and coping difficulties contribute to increased suicide risk (Radmanovic, 2020).

The study by Miller et al. (2017) examined the relationship between depression, stress, and abuse exposure; specifically physical and sexual abuse; and risk for suicidal ideation and behaviors in female adolescents between the ages of 12 and 16 years. Higher levels of depression and stress were associated with suicidal ideation but not suicidal behavior in adolescent girls both with and without a history of abuse. This and other studies suggest depression and stress alone are not sufficient to stimulate suicidal behavior among youth with suicidal ideation (Miller et al., 2017; Nock et al., 2010). However, when an impulse control component is coupled with depression or stress, the risk for suicidal behavior is heightened. Sexual abuse victims tend to exhibit elevated impulsivity when compared with peers (Radmanovic, 2020). Miller et al. (2017) also examined the influence of individual fluctuations of depression and stress upon suicidal ideation and behavior; differences emerged between adolescents with and without a history of abuse. Adolescent girls with a history of abuse who experienced individual higher fluctuations in depression and stress were associated with both increased suicidal ideation and behavior regardless of their baseline mean levels of depression and stress.

Neurobiology and Emotional Regulation and Self-Capacities

Neurobiology offers an explanation for this elevated suicide risk (Miller et al., 2017). Sexual and physical abuse results in blunted hypothalamic–pituitary–adrenal axis responses to stressors (Elzinga et al., 2008), and both emotional reactivity and emotional regulation abilities are altered. Children who have been abused respond to stress (negative stimuli) with elevated neural activity to salient areas of the brain such as the amygdala (responsible for autonomic responses for fear and survival) and require greater activation of brain regions responsible for emotion regulation to decrease emotional reactions (El-Khoury et al., 2020; McLaughlin et al., 2015). Thus, adolescent girls with abuse histories are biologically primed for poor outcomes, including suicidal ideation and behavior.

Interpersonal traumas in childhood, such as sexual abuse, can also interrupt development, yielding disturbances in self-capacities (Girard et al., 2021). Self-capacities refer to an individual's ability to maintain a sense of personal identity and self-awareness across various experiences, tolerate and control strong negative emotions without avoidance (affect or emotional regulation), and develop and maintain meaningful healthy relationships without dysfunctional behavior or preoccupation with rejection or avoidance (Bigras et al., 2015). Affect dysregulation has been associated with experiencing sexual abuse; victims have difficulty in identifying their emotions, differentiating and expressing them appropriately, and adjusting and regulating them adequately (Cook et al., 2005; Dvir et al., 2014; Gong et al., 2020). The child may be unable to cope with negative emotions associated with the sexual abuse, which leads them to resort to drastic, maladaptive affect regulation strategies, such as affect avoidance, as they avoid emotions and feelings (Girard et al., 2021). Affect dysregulation has been linked with a number of mental health symptoms and disorders, including depression and suicidality (Bekh-Bradley et al., 2011). It is further thought that affect dysregulation may result from overwhelming negative emotions, such as those present in depression, that are linked to the trauma of sexual abuse and intensify the development of multiple mental health problems including suicidality (Girard et al., 2021). Girard et al. (2021) found affect dysregulation to be an explanatory mechanism in the association between depression and suicidal ideation in adolescent sexual abuse victims. The child develops a negative world view and may perceive people as unsafe and harmful (Jackson et al., 2017; Keil & Price, 2009). The sexual abuse victim faced with a lack of healthy affect regulation strategies, no understanding of their feelings, or suppression of their emotions (affect avoidance) may begin to think of suicide as a way to cope with their emotional burden (Girard et al., 2021).

Emotional Security and Family Attachment Style

Canton-Cortes and colleagues (2020) examined the effects of familial attachment style and emotional security upon suicidal ideation among sexual abuse victims. Suicidal ideation was associated with older age at the onset of sexual abuse, increased longevity of abuse, and polyvictimization (experiencing sexual abuse as well as another form of child abuse; Canton-Cortes et al., 2020). Anxious attachment style, a type of insecure attachment style based on a fear of abandonment and feelings of insecurity related to being underappreciated, was found to be associated with increased suicidal ideation (Canton-Cortes et al., 2020; Lutz-Zois et al., 2011). Emotional security can be defined as the sense of safety, stability, and well-being that develops from positive, stable family relationships even in the presence of common stressors such as interparental conflict and is linked to fewer emotional difficulties in children (Forman & Davies, 2005). Emotional security becomes thwarted when children are exposed to stressful or frightening events within the family and the caregiver's comforting response to the child is nonexistent or inadequate. Children then develop strategies like disengagement to attempt to preserve feelings of emotional security. Disengagement is the tendency to minimize the importance of the family and to emotionally detach oneself from it. Disengagement was found to be associated with suicidal ideation at the time of crisis.

Resiliency

Resiliency in children and adolescents is composed of three components: sense of mastery (optimism, self-efficacy, and

adaptation), sense of relatedness (trust, support, comfort, and tolerance), and emotional reactivity (sensitivity, recovery time, and impairment because of emotional arousal; Prince-Embury, 2008). Mastery and relatedness are protective components of resiliency, and emotional reactivity is threatening to resiliency. Sexual abuse is a trauma exposure that can lead to trauma-related distress and suicidal ideation and behaviors (Perez-Fuentes et al., 2013). Resiliency in trauma-exposed individuals has been proven to lessen suicide risk (Nrugham et al., 2010). DeCou and Lynch (2019) suggest that, in adolescents with both depression and a history of sexual abuse, emotional reactivity may be directly implicated in the association between depression and suicidal ideation. Furthermore, there appears to be a robust relationship between higher depression symptoms and suicidal ideation in adolescents with and without a history of sexual abuse. It is thought that high levels of depression acuity obscure the protective resiliency factors of mastery and relatedness in adolescents with and without a history of sexual abuse. However, emotional reactivity appears to heighten suicide risk only in adolescents who have experienced sexual abuse.

Implications for Forensic Nursing Practice

Screening

Child and adolescent victims of both acute and historical sexual abuse are vulnerable to a significantly increased risk of suicidal ideation and behaviors regardless of when the abuse occurred. Because of the increasing prevalence of suicidal ideation, especially among children and adolescents, the Joint Commission (2019) added a "National Patient Safety Goal (NPSG) 15.01.01 Reduce the Risk for Suicide," which states the need for healthcare providers to "screen all patients for suicidal ideation who are being treated or evaluated for behavioral health concerns as their primary presenting problem using a validated screening tool." The American Academy of Pediatrics states that medical care of children presenting with a concern of sexual abuse should include an assessment for mental health problems and, if any are identified, appropriate emergency mental health services should be sought (Jenny et al., 2013). In addition, adolescents who have experienced acute sexual assault should also be screened for suicidal ideation (Crawford-Jakubiak et al., 2017). Of note, the U.S. Department of Justice in national protocols guiding the medical forensic examinations of adults and adolescents experiencing sexual assault (U.S. Department of Justice, 2013) and medical forensic examinations of children experiencing sexual abuse (U.S. Department of Justice, 2016) recommends suicidal ideation screening.

Cochran (2019) used an evidence-based screening tool to assess suicidality after acute sexual assault/abuse in a sample of patients aged 13 years and older. Two thirds (67%) of victims screened medium to high risk for suicidality. Barriers to suicide risk screening in the healthcare setting have been identified and include lack of provider knowledge regarding suicide risk, provider discomfort with screening and follow-up procedures, time constraints, and perceived parental disapproval (Horowitz et al., 2014). It is imperative that forensic nurses overcome these barriers to feel comfortable and competent utilizing evidence-based techniques to assess and intervene for suicidal ideation and behaviors in child and adolescent sexual abuse/assault patients (Gilmore et al., 2020).

The forensic nurse must also fully understand the implications of a positive screen for suicidal ideation. Health screening can be defined as the presumptive identification of unrecognized conditions via the application of tests, examinations, or other procedures that can be performed rapidly to identify those individuals likely to have a condition versus those who probably do not, and for whom prompt intervention can improve outcomes (Milliman et al., 2021). Therefore, a positive suicidal ideation screen is not diagnostic of imminent suicidal intent; rather, it indicates further evaluation is needed (Milliman et al., 2021). Every individual who expresses suicidal ideation will not go on to attempt or complete suicide (Crosby et al., 2011), an important consideration when assessing suicide risk (Silverman & Berman, 2014). According to an international study (Nock et al., 2008), lifetime prevalence of suicidal ideation is approximately 9% and one third (34%) of these individuals have had a plan of how they would commit suicide. Nearly three fourths (72%) of individuals with a suicide plan will actually attempt suicide.

Forensic nurses often initially feel uncomfortable asking children and adolescents questions about suicide; however, research indicates that over 90% of youth are comfortable with non-mental-health clinicians asking them about suicidal ideation in the healthcare setting (Ballard et al., 2017; Ross et al., 2016). Addressing the concerns of forensic nurses and providing adequate training is crucial to successful screening for suicidal ideation and behaviors in children and adolescents after sexual abuse/assault. Screening for suicidal risk requires careful planning and a detailed protocol. The crucial first step when designing a protocol for screening for suicide risk among child and adolescent victims of sexual abuse/assault is choosing the appropriate screening tool. The use of an evidence-based validated tool with high sensitivity and specificity is key (Cochran, 2019).

Depression screening tools are often used to screen for suicide risk. However, the use of a validated, evidence-based depression screening tool to also screen for suicidal ideation may be inadequate; the tool may lack the sensitivity and specificity to detect suicidal ideation (Kemper et al., 2021; Lanzillo et al., 2019). Examples of tools that are highly reliable and valid for depression screening in children and adolescents, although not specific enough to screen for suicidality, include Children's Depression Inventory (Kovacs, 1985),

Center for Epidemiologic Studies Depression (Radloff, 1991), and Patient Health Questionnaire-9 (Richardson et al., 2010).

There are no suicide risk screening tools available for use in children less than 8 years old. Children as young as 5 years old have died by suicide (Sheftall et al., 2016). It is important that forensic nurses explore potential suicide risk with both the caregiver and the young child. They should assess for risk factors including sexual abuse, difficulties in family relationships, and a diagnosis of ADD or ADHD (Sheftall et al., 2016). In addition, they should ask the child a few screening questions. However, given that communication skills are still developing in this age group, know that a negative answer does not rule out the possibility of suicidal ideation. Have you ever wanted to die or not wake up in the morning? Have you ever thought about hurting or killing yourself? Have you ever hurt yourself? Forensic nurses must have an open discussion with the caregiver regarding any previous self-injurious behaviors or statements made by the child. Does the caregiver have any concerns that the child will harm themselves? If assessment raises any concerns for potential suicide risk, the young child needs an immediate suicide risk assessment completed by a mental health clinician. The child should be supervised by healthcare personnel, and any potentially dangerous items should be removed from the environment.

Suicide risk screening tools do exist for children aged 8 years and older. Refer to Box 2 for evidence-based suicide risk screening tools for children and adolescents. Registered nurses can administer suicide risk screening tools. The Columbia Suicide Severity Rating Scale (C-SSRS)-screen version is the shorter version of the full C-SSRS. The screen version consists of five items designed to measure suicidal ideation over recent months and classify risk level as low, moderate, or high (The Columbia Lighthouse Project, n. d.). Although the full C-SSRS risk assessment has been fully validated for use in children and adolescents, the screen version has not. A positive screen using the C-SSRS-screen version indicates that a full risk assessment is indicated.

BOX 2: Suicide Screening and Risk Assessment Tools

Screening Tools	Strengths	Limits
Columbia Suicide Severity Rating Scale (C-SSRS)-screen version	Focused directly on spectrum suicidal behaviors; designed to measure severity of suicidal ideation and behavior; longer risk assessment validated in children and adolescents	No published validation date specific to C-SSRS-screen version for use in children and adolescents
The Ask Suicide-Screening Questions (ASQ)	Developed for use in children and adolescents aged 8 years and above; studied in pediatric populations; online toolkit facilitates implementation	Specificity; research testing only in emergency department settings
Risk Assessment Tools	Strengths	Limits
C-SSRS-Risk Assessment tool (full assessment)	Extensively validated in adolescents and adults; predicts short-term suicidal behavior in high-risk adolescents; does not require a mental health specialist or an advanced practice provider	Challenges classifying intent and imminence; unclear implementation
ASQ-Brief Suicide Safety Assessment (BSSA)	Further triage suicide risk if screen positive ASQ; developed from literature and suicide experts; recommend administration by advanced practice provider	No published research on BSSA
Suicide Assessment Five-Step Evaluation and Triage	Comprehensive suicide risk in adolescents and adults; pocket card and suicide safe mobile app; designed for administration by mental health clinician	Based on practice parameters; no published studies on reliability and validity

Sources: The Columbia Lighthouse Project, n.d.; National Institute of Mental Health [NIMH], 2020; Suicide Prevention Resource Center, 2009

The Ask Suicide-Screening Questions (ASQ) offers an evidence-based, valid, and reliable method to screen for suicidal ideation. The ASQ has been tested in the psychiatric setting with 98% sensitivity and 66% specificity and in a general pediatric emergency department population with 97% sensitivity and 88% specificity (Newton et al., 2017). High sensitivity is crucial to identifying individuals at risk for suicide with few missed cases (Milliman et al., 2021). In addition, the ASQ has a high negative predictive value of 99.7%,

indicating the probability that a child or adolescent who screened negative for suicide is indeed not at risk for suicide (Horwitz et al., 2001). The ASQ is a brief four-item screen available in 13 languages and valid for use in children between the ages of 8 and 21 years. An online toolkit for use is available via the NIMH (2020). The ASQ was developed for implementation by registered nurses (NIMH, 2020). A forensic nurse of any educational level can administer the ASQ screening tool. Ideally, caregiver and child are separated while the screening tool is administered. The ASQ takes only a few minutes to administer and consists of four yes/no questions. If a child answers yes to any of the four initial questions, then a fifth question is triggered to gauge suicidal acuity (Brahmbhatt et al., 2019). A positive answer to Question 5 indicates that the patient is at an imminent suicide risk and requires the initiation of safety precautions (constant direct observation by staff, removal of potentially dangerous items, etc.) and an urgent full mental health evaluation by a skilled mental health clinician. Answering yes to any of the four screening questions is considered a positive screen, and further risk assessment is then indicated (see Figure 1).

Suicide Risk Assessment

The C-SSRS-screen version and the ASQ are screening tools designed to identify individuals at a potential risk for suicide. A positive screen should trigger a more comprehensive suicide risk assessment. Suicide risk assessments are most oftentimes completed by a mental health specialist such as an advanced practice mental health nurse, social worker, psychologist, or psychiatrist and are conducted to confirm suspected suicide risk, assess imminent danger of suicide, and decide upon the treatment interventions (Cwik et al., 2020). See Box 2 for suicide risk assessment tools.

The C-SSRS (www.cssrs.columbia.edu) or the suicide assessment five-step evaluation and triage (https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432) can be used for conducting the suicide risk assessment. The ASQ toolkit also contains a tool that can be utilized to complete the suicide risk assessment—the ASQ-Brief Suicide Safety Assessment (BSSA; www.nimh.nih.gov/ASQ; see Figure 2). The BSSA evaluation can be completed in approximately 15 minutes and is designed to be performed by providers, such as mental health clinicians, physicians, nurse practitioners, or physician assistants, who have received appropriate training in completing suicide risk assessment (Brahmbhatt et al., 2019; NIMH, 2020). The BSSA should be conducted without the caregiver in the room with the child.

The BSSA evaluation assesses for the following: frequency of suicidal thoughts; past or current suicide plan; past suicidal behaviors; symptoms such as depression, anxiety, impulsivity, isolation, loss of interest/pleasure, sleep, and appetite, substance use, and irritability; and safety and support (NIMH, 2020). The BSSA evaluation classifies suicide risk as low, high, or imminent risk based on clinical assessment. Patients classified as low risk via BSSA do not require a full suicide safety assessment in the clinical setting (Brahmbhatt et al., 2019). Low-risk BSSA patients typically require referral to community mental health treatment, if not already linked; discussing basic safety information with the patient and caregiver (safe storage and removal of lethal means); providing crisis resources; and notification of the patient's primary care provider of the positive ASQ screen and low-risk BSSA. When the BSSA result is high-risk, a full suicide safety assessment by a trained mental health clinician is necessary before discharge to determine whether discharge home with an outpatient mental health care plan is

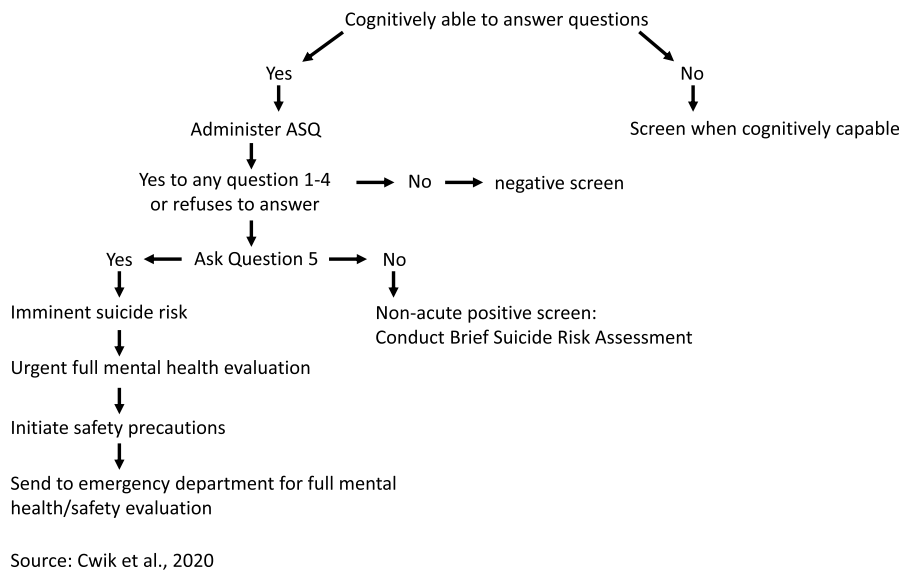

FIGURE 1. ASQ suicide risk screening pathway.

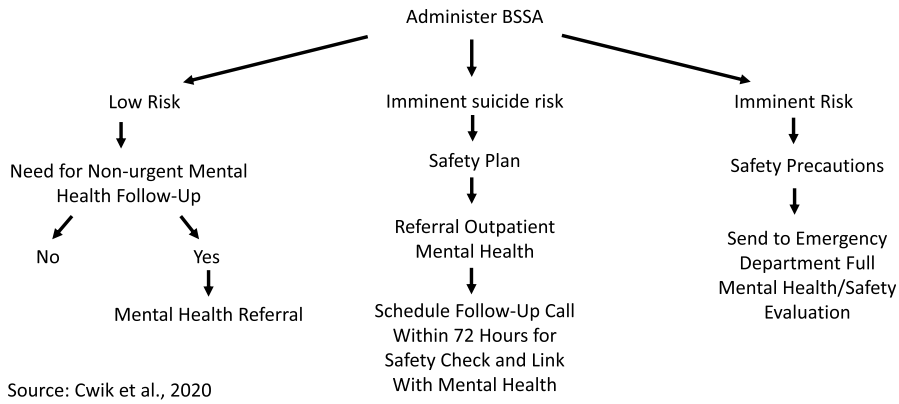

FIGURE 2. ASQ-Brief Suicide Safety Assessment (BSSA).

safe or if acute psychiatric care is indicated. An imminent-risk BSSA result indicates that the patient has endorsed current, active thoughts of suicide requiring immediate attention to maintain patient safety while still in the emergency department or other facility providing sexual abuse/assault care. Appropriate safety precautions must be instituted immediately such as constant supervision of the patient and removal of potentially lethal objects from the patient's environment. Further mental health evaluation, including a full suicide evaluation by a trained mental health clinician, is indicated, and the patient may require inpatient psychiatric admission.

After completion of the BSSA interview, the provider conducting the interview meets with the patient and caregiver together to discuss a safety plan, determines an intervention plan (emergency mental health evaluation, nonemergency mental health follow-up, or no intervention), and provides crisis hotline numbers to patients and caregivers (Cwik et al., 2020). Any safety planning must include the caregiver and other appropriate family members, stressing their roles in supporting the patient in maintaining safety (Kennard et al., 2018).

Mental Health Resources

Children and adolescents who have experienced sexual abuse and who are also endorsing active thoughts of suicide must be provided with the resources to treat/alleviate their suicidal ideation before they can begin to heal from their trauma exposure. Therefore, forensic nurses must be knowledgeable regarding evidence-based suicide prevention mental health interventions available in the community. One such evidence-based intervention is Cognitive Behavioral Therapy-Suicide Prevention (CBT-SP), developed to address risk factors for youth suicide that are modifiable, such as depression, with an emphasis on the prevention of future suicidal behavior. Essential elements of CBT-SP include safety planning, developing a "hope kit" that contains objects or quotes that stimulate memories of wanting to live, analysis to explore circumstances that led to previous suicide attempts, determining crucial coping skills to develop to address similar circumstances in the future by identifying immediate suicide precipitants and long-term risk factors, developing identified coping skills (emotional regulation, mood monitoring, distress tolerance, etc.), and preventing relapse by revisiting the suicide attempt and reviewing the event through the frame of skills learned (Cwik et al., 2020). CBT-SP also includes family sessions as support, which is key to suicide prevention.

Another evidence-based mental health intervention designed to treat individuals at a high suicide risk is dialectical behavior therapy (DBT). DBT helps to prevent suicidal behaviors by focusing on the individual's reasons for living (Linehan & Wilks, 2015). DBT is based on behavioral and Zen principles and a philosophy on dialectics (Linehan & Wilks, 2015). The original DBT model has been adapted for use in adolescents and young adults aged 11–20 years and has been studied in this population with demonstrated efficacy (Mehlum et al., 2014). DBT for adolescents includes family members in skills training groups, family sessions, and specific adolescent–family dialectical dilemmas (McPherson et al., 2013). DBT for adolescents has efficacy in decreasing self-harm behaviors and suicidal ideation in adolescents (Mehlum et al., 2014).

Conclusions

It is essential to screen children and adolescents for suicidal ideation when providing medical forensic care after disclosure of sexual abuse/assault. Forensic nurses must feel confident in their abilities to assess suicide risk and provide appropriate interventions and referrals. Whereas many forensic nurses practice in clinical settings where mental health professionals are readily available for consultation, others may not. It is vital that forensic nurses be knowledgeable regarding local resources for patients requiring further mental health evaluation and psychiatric resources available for patients endorsing active suicidal ideation. Forensic nurses possess the knowledge and skills to enhance the care and safety

of victims of sexual abuse when they are most vulnerable, which must include assessing for suicide risk and providing evidence-based intervention.

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