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Working With the Suicidal Client Who Also Abuses Substances

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Abstract

Substance use disorders and suicidal thoughts and behaviors commonly co-occur in adolescent and adult psychiatric populations and are often functionally interrelated. Although the evidence base for treatment of this population is sparse, integrated cognitive behavioral treatment (CBT) protocols, or those that rely heavily on CBT techniques, hold promise. In this paper, we provide an overview of the evidence-based literature for interventions that target suicidal behavior and substance use disorders with adults and adolescents. We then discuss the manner in which these behaviors may be functionally interrelated and offer a conceptual framework (S-O-R-C) to guide case conceptualization and treatment planning for clients with co-occurring suicidality and substance use disorders. Next, we provide a case example of a client with suicidal behavior and an alcohol use disorder and demonstrate how to apply an integrated CBT treatment protocol to this case. This case example is followed by a more general discussion about the potential advantages of integrated CBT protocols for suicidality and substance use disorders, guidelines for prioritizing treatment targets and skill selection for each individual client, and other important treatment considerations. We conclude with recommendations for future research in this area.

Suicidal behavior and substance use disorders (SUD) represent significant public health problems among adolescents and adults. Moreover, they tend to co-occur at relatively high rates in psychiatric populations, which increases risk for mortality. Reviews of the adolescent suicide literature suggest that up to 50% of adolescents who engage in suicidal behavior have a SUD. Further, SUDs have been associated with a 6- to 8.5-fold increase in risk of completed suicide and 3- to 4-fold increase in risk of attempted suicide (Esposito-

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Smythers & Spirito, 2004). Rates of co-occurring suicidal behavior and SUDs are even higher among adults. Up to 68% of adults who engage in suicidal behavior have an SUD, and the presence of an SUD has been associated with more than a 5-fold increase in risk of death by suicide and attempted suicide (Brown et al., 2005; Nock et al., 2009; Schneider, 2009; Yoshima, Kiyohara, & Miyashita, 2008). Moreover, the relation between suicidality and SUDs appears to strengthen as each problem increases in severity (Esposito-Smythers & Spirito; Goldston, 2004). Given the high rates of co-occurrence of these problems and associated morbidity, it is important to know how to treat clients who present with both suicidality and SUDs.

Overview of Evidence-Based Intervention Literature for Integrated Treatment

The psychosocial approach that has received the most empirical investigation and support in treating suicidal behavior (see Esposito-Smythers, Weismoore, Zimmerman & Spirito, in press; Rudd, 2000 for reviews) and SUDs (see Waldron & Turner, 2008; Denis, Lavie, Fatseas & Auriacombe, 2008, for reviews) among adolescents and adults is cognitive behavioral therapy (CBT) or interventions that heavily incorporate cognitive behavioral techniques (e.g., dialectical behavior therapy; DBT). Few randomized controlled trials have examined the efficacy of interventions that address both SUDs and suicidality. Within the adult literature, only DBT has been subject to such empirical investigation. DBT is based on the premise that clients should be taught the skills to deal with an emotional crisis, not be removed from it. DBT incorporates cognitive behavioral strategies, validation strategies (therapeutic warmth, empathy), and as needed, phone consultation to address high-risk behaviors (Linehan, 1993). It includes 12 months of individual therapy, group therapy, and phone consultation. Linehan and colleagues have published three treatment studies that examine the efficacy of DBT in addressing both suicidality and SUD in adults with borderline personality disorder (BPD). In their first study, Linehan et al. (1999) compared DBT to treatment as usual in the community (TAU) in a sample of 28 women with co-occurring SUDs and BPD. Though both conditions were associated with comparable reductions in suicide attempts and nonsuicidal self-injury, DBT was more efficacious in increasing days of abstinence over the course of treatment and at 16-month follow-up.

In a second study (Linehan et al., 2002), DBT was compared to Comprehensive Validation Therapy with 12-step program participation (CVT + 12S) for 23 women with co-occurring heroin dependence and BPD. CVT is a manualized intervention that includes all of the acceptance-based strategies employed in DBT and case management when requested, but not the cognitive and behavioral techniques of DBT. Participants in both conditions also received opiate agonist therapy. No differences were found across conditions on rates of self-harm or positive urinalyses. Both groups also showed comparable declines in opiate use through the first 8 months, but only those in DBT maintained their gains through the 16-month follow-up.

In a third study, Harned, Murray, Comtois, and Linehan (2008) reanalyzed data from a prior study (Linehan et al., 2006) that compared DBT to treatment by community-based nonbehavioral psychotherapy experts (CBTE) in 101 adults with BPD, to examine rates of change in co-occurring Axis I disorders. Those who received DBT, in comparison to CBTE, reported higher rates of full remission and more drug and alcohol abstinent days. Further, in the parent study, DBT relative to CBTE, was associated with fewer suicide attempts (Linehan et al., 2006).

Integrated interventions for co-occurring suicidality and SUDs among adolescents are less well studied. Only one randomized controlled trial has been completed in this area. In a

study conducted by Esposito-Smythers, Spirito, Hunt, Kahler, and Monti (2010), an integrated CBT protocol (I-CBT) was compared to enhanced treatment-as-usual in the community (E-TAU) in a randomized clinical trial with 40 adolescents with co-occurring suicidality and SUDs (alcohol and/or cannabis use disorder). I-CBT included a 6-month acute, 3-month continuation, and 3-month maintenance treatment phase. Individual, parent training, and family sessions were provided. Two therapists were assigned to each case, one who worked with the adolescent and one who worked with the parents. Participants in both conditions were also offered medication management for free as needed with the same child psychiatrist, as well as case management. I-CBT relative to E-TAU was associated with fewer suicide attempts, psychiatric hospitalizations, emergency department visits, heavy drinking days, and days of cannabis use, relative to E-TAU over the course of the 18 months posttreatment enrollment follow-up. Both groups showed comparable reductions in suicidal ideation and number of drinking days.

As is evident, there exists preliminary evidence that CBT and/or interventions that heavily integrate CBT techniques are efficacious in reducing both suicidal behavior and substance use among adolescent and adults with these co-occurring problems. The remainder of this paper will discuss how to integrate treatment of suicidality and SUDs in the context of a CBT protocol. First, we provide a conceptual framework to help guide the selection of treatment targets. Next, we provide a case example and demonstrate how to apply an integrated I-CBT protocol (Esposito-Smythers et al., 2010) to this case. We conclude with a brief discussion of the material presented and future directions.

Conceptual Framework: S-O-R-C (Stimulus-Organism-Response-Consequences) Model

Suicidal behavior and SUDs appear to be functionally interrelated, though the nature of this relationship may vary across individuals (Bagge & Sher, 2008). For example, for some individuals, SUD and suicidality may be temporally related. The acute effects of intoxication may heighten psychological distress, increase aggressiveness (toward self and others), enhance suicide-specific SUD expectancies (e.g., “alcohol will give me the courage to make a suicide attempt”), and inhibit the generation and implementation of adaptive coping strategies. Among individuals contemplating suicide, these events may be sufficient to propel suicidal thoughts into action (Hufford, 2001). SUDs and suicidality may also have a more distal relationship. For example, SUDs may lead to substance-related social, academic, and/or legal problems, which in turn may cause and/or worsen co-occurring psychiatric symptoms, and eventually lead to the development of suicidal thoughts or behavior (Hufford). These are two of many potential ways that suicidality and SUDs may be functionally interrelated. A first step in developing a treatment plan for a client with co-occurring suicidality and SUDs is to obtain an understanding of the client’s suicide and substance-related behaviors, and their relationship in the context of environmental antecedents, risk and protective factors, and consequences. This can be done through the use of a rigorous functional analysis of both behaviors.

As suggested by Curry, Wells, Lochman, Craighead, and Nagy (2003), the S-O-R-C (stimulus-organism-response-consequences) model (Goldfried & Sprafkin, 1976), provides a useful method for developing a functional analysis. Events that occur prior to, trigger, or set the occasion for suicidal and/or substance use behaviors are referred to as the “S” (for discriminative stimuli) in the S-O-R-C model. Factors that are unique to the individual but increase risk or serve as protective factors (i.e., which moderate risk) of the behaviors occurring in the presence of the discriminative stimuli are referred to as “O” (for organismic variables). For example, deficient problem-solving skills may increase the likelihood of suicidal behaviors in the presence of certain triggers or precipitants. The “R” in this model

refers to the behavioral responses of interest (i.e., substance use and/or suicidal behavior). Finally, the "C" in this model refers to the environmental consequences that occur after the behavior(s) of interest occurs, which may serve to reinforce or have punishing effects (i.e., increasing or decreasing, respectively, the likelihood for suicidal and substance use behaviors in similar contexts). For example, being hospitalized for a suicide attempt may decrease the likelihood of acute substance intoxication and suicidality in the future. Below we apply the S-O-R-C model to a case example, provide a case conceptualization, and a present a corresponding cognitive-behavioral treatment plan.

Case Example

Jane is a 16-year-old Caucasian female who was hospitalized on an adolescent psychiatric inpatient unit for a suicide attempt. The results of a diagnostic interview suggested that she met DSM-IV criteria for major depressive disorder (with irritable mood), oppositional defiant disorder, and alcohol abuse. She had been depressed for approximately 1 year and this was her first suicide attempt. Jane started drinking when she was 13 years old and met criteria for both oppositional defiant disorder and alcohol abuse by age 14. On average, she reported binge drinking (five or more drinks in one sitting) every Friday and Saturday night with friends. Jane would also drink at home alone at least once a week. Jane had not received mental health services prior to her hospitalization.

Jane's parents divorced when she was 7 years old. Her biological mother remarried when she was 10 and her biological father remarried when she was 13. Jane lived with her biological mother and stepfather. She also visited her biological father and stepmother at least once a month. Jane also had a biological sister who was 20 years old and lived on her own.

Jane had a family history of substance abuse. Jane's biological father reportedly abused alcohol as a young adult. Jane's sister used alcohol heavily as a teenager and currently as a young adult. Though Jane's biological mother and stepfather did not drink regularly, they enjoyed drinking heavily at social events, and on occasion would return home highly intoxicated.

With regard to family relationships, Jane had a highly conflictual relationship with her biological mother and idolized her biological father. Jane blamed her biological mother for her parents' divorce, noting that she was too rigid, controlling, and unforgiving of her biological father's minor faults. Jane's biological mother was also the disciplinarian in their home. Jane despised rules and structure and would get into intense arguments with her biological mother when she attempted to set rules or discipline Jane. In contrast, Jane loved her biological father whom she described as "easygoing, cool, and fun." Jane's biological father did not discipline Jane and would attempt to intervene on her behalf, on occasion, when her biological mother implemented consequences for her misbehavior. Jane wanted to live with her biological father but his work schedule prevented him from being home enough to parent her. Jane's father would also cancel planned visits with Jane due to conflicts with his work schedule, which hurt Jane. Jane liked both of her stepparents but was not close to either of them. Jane was very close to her biological sister and turned to her regularly for support and advice around family issues. She talked with her on the phone on at least a weekly basis and would occasionally visit with her. Jane's biological sister did not get along with their biological mother, either. She would side with Jane during their conversations and tutor Jane on how to get away with drinking and other devious behaviors without being caught.

Jane was a very social teenager and had a strong peer support network. The majority of her peers drank heavily at parties. Jane reported that she developed a reputation as the "heaviest drinker" among her peers and that she was proud of this identity. She did not spend any time with peers who did not drink.

Academically, Jane was failing two of her five classes. She never completed her homework and would frequently get in trouble at school for being disrespectful to her teachers. Jane developed a reputation among her teachers as a teenager with a "bad attitude." Jane's peers also reinforced her disruptive behavior at school.

Jane was intoxicated at the time of her suicide attempt. She had a fight with her biological mother and then left her home without her permission. Jane split a bottle of rum with a friend and when she got home took a handful of her stepfather's thyroid medication. Her biological mother found her passed out in her bedroom. Unable to wake her, Jane's biological mother called an ambulance. At the hospital, it was determined that Jane had very high levels of blood alcohol and thyroid medication. She was medically treated and then admitted to a psychiatric inpatient unit for treatment.

Case Conceptualization

Consistent with the S-O-R-C model, there were a number of triggers (i.e., Stimuli) and risk and protective factors (i.e., Organismic variables) for Jane's substance use and suicide attempt, as well as environmental consequences (i.e., Consequences) that served to reinforce or punish these behaviors (i.e., Responses). One of the primary triggers for Jane's suicidal behavior and drinking was family conflict. Family conflict is common trigger for both suicidal behavior and substance abuse among adolescents and adults (Hufford, 2001; Simons-Morton et al., 1999; Wagner, Silverman, & Martin, 2003; Windle & Davies, 1999). Jane had a highly conflictual relationship with her mother and would reportedly use alcohol to "numb out" and cope with anger toward her mother. Jane also made a suicide attempt after a fight with her mother. Another trigger for her suicidal behavior and her drinking were feelings of abandonment by her father. Jane would also drink to forget about the hurt she experienced when her father cancelled visits and missed important events. Feelings of abandonment also played a role in her depression and suicidal thinking. Similar to family-related stressors, Jane's academic failure also served as a trigger for her drinking and suicidal thoughts.

Jane's alcohol use was both temporally and distally related to her suicidal behavior. Jane was highly intoxicated at the time of her suicide attempt and she reported that she rarely experienced suicidal thoughts when she was sober. Distally, Jane's alcohol use fueled family conflict, worsened her mood, and contributed to her academic failure, all risk factors for suicidal behavior. These interrelated factors resulted in a cumulative increase in stress, which grew worse over the course of time, and contributed to her decision to attempt suicide.

In Jane's case, there were also a number of other "organismic" variables, or variables that moderated her risk of suicidal behavior and alcohol use, in the presence of the aforementioned triggers. One risk factor was her lack of education around the negative effects of alcohol. Jane was unaware of the dangers associated with binge drinking and the manner in which alcohol affects her mood and body. Related was the fact that Jane had clear positive alcohol expectancies (e.g., belief that alcohol is associated with positive arousal, tension reduction, etc.), which have been shown to contribute to the initiation, quantity, and frequency of alcohol use, as well as the maintenance of social networks that are supportive of use (Aas, Leigh, Anderssen, & Jakobsen, 1998; Homish & Leonard, 2008). Jane's attitudes toward drinking stemmed, in part, from those held by her sister and peer group. For

example, Jane's sister praised Jane for her drinking and encouraged her to be "smarter" about her drinking so that she did not get caught. Jane also experienced peer pressure from a deviant social support system. Jane's peers provided her with alcohol and drank with her. Involvement with peers who drink and/or use substances has been shown to negatively influence drinking patterns and substance use among adolescents and adults (Brook, Whiteman, Cohen, Shapiro, & Balka, 1995; Homish & Leonard).

Two additional risk factors for Jane included a lack of and/or failure to employ effective coping and affect regulation skills when faced with stressors such as family conflict, feelings of disappointment by her father, and academic failure. Both poor coping (Galaif, Sussman, Newcomb, & Locke, 2007; Wright, Beck, Newman, & Liese, 1993) and affect regulation (Brook et al., 1995; Esposito, Spirito, Boergers & Donaldson, 2003; Gonzalez, Bradizza & Collins, 2009) skills have been associated with suicidal behavior and alcohol/substance abuse among adolescents and adults. Jane used alcohol and suicidal behavior as a means to control negative emotions (Colder & Stice, 1998; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997) resulting from family and academic stressors.

Another significant risk factor for Jane was the presence of unipolar depression and associated cognitive distortions. Specifically, it was clear that Jane experienced cognitive errors (i.e., catastrophizing, personalization, selective abstraction, and overgeneralization) around her family circumstances and academic situation, as well as hopelessness around any positive change in her future. Cognitive errors as well as hopelessness have been linked to suicidality (Brent, Kolko, Allan, & Brown, 1990; Brown, Beck, Steer, & Grisham, 2000; Goldston et al., 2001). Unfortunately, she also lacked a prosocial support system to help counter negative thinking. Those people whom she turned to for advice, such as her older sister, peers, and occasionally her biological father, reinforced the belief that her biological mother was "crazy" and their relationship was hopeless. Jane's sister and peers recommended that she just drink to forget about her concerns. Jane also lacked prosocial activities. Her time outside of school was spent with her friends drinking, which left her with no positive success experiences or future goals.

Two additional risk factors included poor family communication and a lack of effective parental monitoring or discipline within Jane's family. When conflict erupted, Jane and her mother lacked the ability to talk through their problems, which increased Jane's likelihood of suicidal behavior and drinking. Indeed, poor family communication skills are common in families of adolescents and adults who engage in suicidal behavior and abuse alcohol or substances (Hufford, 2001; Simons-Morton et al., 1999; Wagner et al., 2003; Windle & Davies, 1999). There was also poor communication between Jane's biological mother and father. Jane's biological father would take Jane's word for events that occurred in their home, side with Jane, and discredit his ex-wife's attempts at discipline. Related, Jane's biological mother and father lacked effective parental monitoring and discipline methods. Neither of them knew how to effectively monitor for alcohol use. Moreover, Jane's biological mother tended to overcompensate for Jane when she disobeyed whereas Jane's biological father refused to provide any discipline. Indeed, poor parental monitoring and ineffective discipline have been associated with adolescent alcohol and substance use (Mulhall, Stone, & Stone, 1996; Patton, 1995).

As is evident, there were a number of factors that increased Jane's risk for suicidal and drinking behaviors. However, she did have a few very strong protective factors that could be used to facilitate therapeutic change in the behavioral responses of interest, including both suicidal behavior and drinking. These included the fact that she was intelligent, willing to attend treatment, was able to build a therapeutic alliance with her therapist, her biological

mother and father loved her, and her biological mother and father were invested in her treatment.

Consistent with the S-O-R-C model, there were also a number of environmental consequences that occurred after Jane's suicidal and drinking behaviors that served to reinforce or have punishing effects. Jane's suicide attempt was partially reinforced by a temporary decrease in conflict with her biological mother and greater attention from her biological father. In contrast, Jane expressed concern over the potential stigma associated with her suicidal behavior and inpatient hospitalization, which decreased the likelihood of a future attempt. With regard to her drinking, Jane received a great deal of reinforcement for this behavior from her sister, who praised her for deviant behavior, and her peers, who referred to her as "the life of the party." Alcohol also temporarily decreased her affective arousal, which she found reinforcing. However, Jane's alcohol use also led to negative consequences, including greater conflict with her mother, more academic failure, low moods, and poor judgment as evidenced by periodic sexually promiscuous behavior and her suicide attempt.

Application of Cognitive-Behavioral Treatment Protocol

As is evident through the application of the S-O-R-C model, Jane entered treatment with a number of triggers, risk factors, and reinforcing environmental consequences for her suicidal and drinking behaviors. These included problems within her family, academic, and peer systems. Therefore, an effective treatment approach would need to be comprehensive, flexibly administered, and of adequate duration to address her complex case presentation. The I-CBT protocol developed by Esposito-Smythers et al. (2010) was designed precisely for this type of case. Through this protocol, adolescents and their parents are taught coping, cognitive restructuring, affect regulation, communication, and parenting skills that are needed to remediate skill deficits underlying both suicidality and SUDs in adolescents. It includes a menu of individual adolescent, parent training, and family CBT skill building modules, which can be selected, implemented, and practiced based on the needs of each individual client (see Table 1 for treatment menu). In addition, a motivational interview is provided at the start of treatment to enhance treatment engagement, and case management is provided as needed to resolve academic and other systems-related issues that contribute to suicidality and SUDs. Moreover, the use of a two-therapist model, one assigned as the adolescent therapist and one as the parent training/ family therapist, helps to remediate problems within the family system in a timelier manner while maintaining a therapeutic alliance with both adolescents and parents. This is particularly important given that treatment dropout rates are high for clients who report suicidal behavior (Spirito, Stanton, Donaldson, & Boergers, 2002) and SUDs (Crits-Christoph & Siqueland, 1996).

All sessions delivered in the I-CBT protocol follow the same structure, which includes an assessment of suicidality and alcohol/drug use over the prior week, an assessment of psychotropic medication adherence (if applicable), setting an agenda, review of homework, skill introduction and practice, work on agenda item(s), homework assignment, and a brief child and parent "check-in." Below we review the skills that were selected and implemented from the I-CBT treatment menu to address Jane's personal triggers, risk factors, and reinforcing environmental consequences for her suicidal and drinking behaviors.

Session 1—The focus of the first session with both Jane and her family was rapport building to increase engagement, identification and resolution of obstacles to attending treatment to increase compliance, an overview of the I-CBT protocol, psychoeducation on the association between suicidality and alcohol use, identification of treatment goals, and safety planning with both Jane and her family. Jane spent time in the individual portion of

the first session developing a safety plan with her therapist that included coping strategies to use in the event that suicidal thoughts were to re-emerge, and a list of reasons for living to help counter suicidal thoughts. She agreed to continue working on her list of reasons for living between sessions. Jane's family members in attendance (biological mother and father and her step-father) were provided with instruction in how to keep their homes safe until a suicidal crisis passes (i.e., remove or lock up guns, razors, medications, alcohol, etc.) and how to access immediate help for Jane in the event that she experiences future suicidal thoughts or behavior.

Session 2—The second session selected for Jane was a problem-solving session. The purpose of this session was to help Jane identify her triggers for her suicidal behavior and teach her a problem-solving method that could be used to generate and evaluate alternative options to suicidal behavior and alcohol use. Jane and her therapist selected conflict with her mother as the "problem" to be solved, given that it was her most powerful trigger for both her suicide attempt and alcohol use. Indeed, Jane had experienced thoughts of suicide between Session 1 and 2, after having an intense argument with her mother and then drinking alcohol that she snuck from her home. However, Jane was able to refrain from binge drinking and remind herself of her reasons for living in this situation. In session, Jane was able to identify adaptive alternative options to employ if faced with this trigger in the future and added them to the safety plan that she developed in the first session.

In the concurrent parent training session, the parent therapist administered a motivational interview developed to enhance treatment engagement and parental compliance with treatment recommendations. Jane's parents were given a feedback report, based on a comprehensive intake assessment, which included a summary of Jane's psychiatric diagnoses, severity of her psychiatric symptoms, and current coping and affect regulation skills. This report also included scores on parent rated measures of parental monitoring, family conflict and dysfunction, parental alcohol use, and parental distress/psychiatric symptoms. Parental reactions to this information were elicited and time was spent discussing what could happen to Jane and her family if they did not receive an adequate course of treatment. Based on this feedback, Jane's parents worked with the therapist to select family goals for treatment. Next, they were presented with a treatment menu that included all of the skill-based sessions from the I-CBT protocol, and discussed what sessions would be most helpful for their family. The last portion of the session was spent problem-solving through obstacles to meeting their family goals as well as eliciting and supporting self-efficacy statements in an effort to empower Jane's parents.

Session 3—Given that Jane's alcohol use was both temporally and distally related to her suicidal thoughts and behavior, and she did not want to change her drinking habits despite acknowledging that her suicidal thinking primarily emerged when drinking, the third session selected for Jane was a motivational interview for alcohol use. This session followed the same format as a standard motivational interview (see Miller & Rollnick, 2002) and was designed to challenge her positive alcohol expectancies, provide psychoeducation, and improve her motivation to abstain from drinking. First, Jane created a list of the pros and cons of her drinking. Then she was provided with a feedback report that compared her rates of alcohol use to national adolescent norms, listed her highest and average blood alcohol levels and their implications, and included information on the relation between her alcohol use and emotional and behavioral problems. Her reaction to this information was elicited throughout. She was then asked to spend time envisioning her future, and generated a list of things that could happen if she made a change in her drinking or chose not to make a change. The subsequent portion of session was spent generating alcohol-related goals for treatment, choosing from a menu of strategies to help reduce/abstain from drinking (e.g.,

alternatives to drinking), identifying and problem-solving through obstacles to her goals, and eliciting and supporting self-efficacy statements for change.

Concurrently, Jane's parents met separately with their therapist to learn parental monitoring skills around alcohol use. Specifically, they were taught how to identify signs and symptoms of alcohol use, when and how to monitor for alcohol use, how to best approach Jane if intoxicated, a technique for monitoring her whereabouts, and the importance of getting to know her peers and their parents. Time was also spent brainstorming potential rewards and consequences for abstinence, eliciting and discussing concerns about parental monitoring, and offering support for their efforts.

Sessions 4 and 5—The next two sessions were spent creating a behavioral home contract to address Jane's alcohol use and academic failure, both of which incited significant family conflict and associated depressogenic and suicidal thinking. In family sessions, Jane and her parents discussed house rules around alcohol use (i.e., abstinence) and academic work (e.g., attending all classes, when homework must be completed), and together selected rewards and consequences for compliance. The focus on rewards (both verbal acknowledgment of the therapeutic steps that Jane was taking, as well as privileges and tangible rewards) was especially important, given Jane's depression, hopelessness about her situation, as well as the fact that communication and interactions within her family were colored by anger and blame and centered on the difficulties that Jane caused for the family.

Session 6—As is common when behavioral contracts are first implemented in the home, Jane failed to follow the rules, received punishment, and arrived at this session very angry. As a result, the session was spent teaching and practicing a cognitive restructuring method used to help dispute irrational thoughts. The trigger selected was "rules at home." Jane was able to identify irrational thoughts associated with her anger (e.g., "The rules are stupid," "My mom is trying to ruin my life," "My dad would never do this to me"), and with therapist guidance, challenge these with more rationale and helpful coping thoughts (e.g., "I won't be a teenager forever," "My mom is not trying to hurt me," "My dad agreed on the contract in session"). Time was also spent helping Jane re-focus her thoughts on the rewards associated with the behavioral contract.

The concurrent parent training session was spent working on helping Jane's parents identify irrational parenting beliefs (e.g., Jane should always know the right thing to do and make the right decision, Jane is misbehaving on purpose to hurt and anger us, Jane is never going to change, and Jane is going to end up hospitalized again or dead) and challenge them with more rational thoughts (e.g., "All teenagers make mistakes," "Jane is not intentionally trying to hurt us but has a problem and needs our help," "Change takes time"), using the same cognitive restructuring method that Jane learned in her session. This session helped Jane's parents decrease their anger toward Jane, foster realistic perceptions of her behavior, and improve their parenting skills.

Sessions 7 and 8—Building on work conducted in the prior session, these sessions were spent teaching Jane effective affect regulation skills to decrease the likelihood that she would engage in a suicide attempt or binge drink to cope with heightened negative affect. Jane learned deep breathing and progressive muscle relaxation. She was also taught how to recognize physiological arousal and employ adaptive affect regulation techniques (e.g., relaxation, self-soothing activities, and taking space) in response to stressors such as family conflict.

The sessions with Jane's parents were spent teaching them basic parenting skills and affect regulation skills around parenting. Specifically, Jane's parents were provided with

psychoeducation on adolescent development, taught how and when to set limits, and how to respond to Jane when she disagrees with them, loses her temper, or disobeys. They were also provided with strategies to help maintain their composure in these situations (e.g., deep breathing, taking space, positive self-talk, etc.) and generate options around parenting-related decisions using the same problem-solving method that Jane learned in her first session.

Session 9—Between Sessions 8 and 9, Jane received a report card with failing grades. Jane started to re-experience suicidal thoughts as her depressogenic thinking patterns emerged and she anticipated her parents' anger. She was able to calm herself down using techniques introduced in the last session. She also called her therapist, one of the options in her safety plan, to problem-solve the situation. Jane and her parents arrived at session angry and frustrated because Jane continued to test the limits around the behavioral contract. Jane's parents were also displeased with her lack of progress on her academic work. Jane's session with her individual therapist was spent discussing her safety plan and praising her for using the safety plan when feeling suicidal. They also used the problem-solving and cognitive restructuring methods that she learned previously to generate options for getting her work done, and to dispute thoughts that were impeding her academic progress and precipitating her suicidality (e.g., "This is impossible," "I might as well drop out, I am a complete failure," "My parents will never get off my case"). Becoming increasingly agitated with Jane's slow pace, Jane's parents worked with their therapist to practice their affect regulation skills around parenting. Time was also spent generating options around how to modify the behavioral contract to make it more reinforcing around academic related issues. At the end of the session, Jane and her parents met together to discuss Jane's plan for improving her academic situation. Changes in the behavioral contract were also negotiated and agreed upon by Jane and her parents.

Session 10—Jane reported feeling better at this session, with no suicidal thoughts, and was thinking more positively about the possibility of improving her academic progress. In preparation for needed family work around communication, Jane worked with her individual therapist to learn and practice assertiveness communication skills. Jane primarily used an aggressive communication style with her biological mother, which resulted in family conflict. Concurrently, Jane's parents learned how to recognize and attend to Jane's positive behaviors, which they practiced over the following week. This skill set the stage for more positive feelings and interactions between Jane and her parents.

Sessions 11 and 12—Jane did not report suicidal thoughts during the weeks of these two sessions, and expressed confidence in her ability to follow her safety plan. These sessions were spent learning and practicing family communication skills. Specifically, Jane and her family were taught the general principles of good communication and reflective listening skills. These were modeled by the therapists and then role-played and practiced by Jane and her parents in session. By learning how to effectively communicate with one another, the goal was that Jane and her family would be less likely to experience the type of heightened conflict and negative affect that served as the trigger for Jane's suicidal episode.

Sessions 13+—The first 12 sessions were primarily spent teaching Jane and her family skills to help maintain safety; eliminate common triggers for her suicidal and drinking behaviors (with a focus on family conflict given that it was her strongest trigger for both); remediate common cognitive distortions and skill deficits (i.e., coping skills, affect regulation skills, communication) that increased her risk for these behaviors; and address environmental consequences that reinforced these behaviors. By the end of this sequence of sessions, Jane reported an absence of suicidal thoughts but was not abstinent from alcohol.

The subsequent sessions were spent practicing and reinforcing skills in response to Jane's periodic violations of the home contract (e.g., Jane drinking with her friends) as well as learning new skills to address other triggers for Jane's alcohol use. Continued work around alcohol use was particularly important given that alcohol served as both a temporal and distal risk factor for her suicidal behavior. Jane's suicidal thinking primarily emerged while intoxicated and family conflict related to her drinking was a trigger for depressive and suicidal thinking. Therefore, continued alcohol use placed her at risk for the reemergence of suicidality.

Given that peer pressure from Jane's friends around alcohol use was a strong trigger for Jane, she and her therapist worked on skills to help her identify and build relationships with prosocial peers (i.e., building social support networks module); identify healthy alternatives to drinking (i.e., increasing healthy pleasant events module); address peer pressure to use (i.e., alcohol/drug refusal skills module); manage urges to drink (i.e., coping with cravings module); cope with unanticipated situations that might trigger urges to drink (i.e., planning for emergencies module); and restructure thoughts that fostered ambivalence around changing her drinking behavior (e.g., "Life will be boring," "I will have nothing to do with my friends"). Moreover, given that Jane's older sister continued to encourage Jane to drink and break house rules, Jane's sister was invited to some family communication sessions. Jane's sister processed her longstanding anger toward her parents. The manner in which Jane's sister negatively influenced Jane's progress in treatment was also addressed.

Time in the latter sessions was also spent fostering more positive family interactions (i.e., increasing positive family interactions module) as well as family communication around the real reasons for Jane's parents' divorce, what Jane thought about her biological father's lack of active involvement in her life, and the importance of working together as a family despite living in separate homes. These family communication sessions helped restructure Jane's cognitive distortions around her parent's divorce (i.e., that her mother was to blame) and her biological father's distant behavior (i.e., that he did not love her), which decreased hostile and depressive thinking patterns, and provided her with hope about her family situation and relationships. These family sessions also helped to improve cooperation and decrease conflict among family members. This infusion of hope and improvement in family cooperation helped decrease Jane's risk for future suicidal behavior.

Sessions concluded with a review of all of the skills learned and accomplishments made over the course of treatment (i.e., treatment progress and skill review module) as well as a discussion of ways to prevent relapse of both suicidal behavior and old drinking patterns (i.e., relapse prevention module). By the end of treatment, Jane and her mother were getting along much better. Jane also significantly curtailed her drinking, reported no suicidal thoughts or depressive symptoms, was more compliant with house rules, caught up on her academic work, passed all of her classes, and obtained a job. She also began to take better care of her health and acknowledged that having an identity as a "drinking girl" was not something to be valued. Rather, she was working toward developing a new identity and prosocial goals for her future.

Discussion

A substantial percentage of suicidal clients present with co-occurring SUDs as well as other psychiatric disorders. Jane's case presentation highlights the complexities of treating this type of client. In Jane's case, there were multiple triggers, risk factors, and reinforcing environmental consequences for her suicidal and drinking behaviors that required attention. However, despite this complex presentation, Jane and her family showed significant progress over the course of treatment through the use of a few motivational interviewing

sessions to foster treatment engagement and flexibly administered CBT sessions to remediate cognitive distortions and skill deficits. Also of note is that this integrated CBT protocol effectively addressed other co-occurring conditions, including Jane's depression and oppositional behavior. This is not surprising given that many of the cognitive distortions and skill deficits that underlie suicidal behavior and SUDs are also common to other types of mental health problems. Therefore, when clients learn core CBT skills to address cognitive distortions and behavioral skill deficits (e.g., problem-solving, cognitive restructuring, affect regulation, communication skills) for suicidal behavior and SUDs, the effects of these techniques may generalize, with relatively little modification, across other mental health problems. Moreover, because training in CBT is becoming more widely available, it also may be the therapy approach that practitioners can most readily access and be trained in most efficiently and effectively.

Though the case presentation highlights the treatment of an adolescent with co-occurring suicidality and SUD, the same conceptual model and integrated treatment approach can be applied successfully with adults. However, with adults, treatment may require couples work with significant others or marital partners (Darke & Ross, 2002; Hufford, 2001) as opposed to parents. Regardless of age, there are typically a myriad of contextual factors associated with clients' suicidality and SUDs, as well as associated cognitions and behavioral patterns. Therefore, an important consideration is how to prioritize targets for treatment. Safety considerations always have first priority in treatment, although attention to issues around safety might also be intertwined with a discussion of motivation and motivational interviewing. For example, if the client is still experiencing suicidal thoughts, especially with a method of attempt envisioned, or participating in levels of substance abuse that are potentially life-endangering, there is always a focus on these issues first. There is a presumption that if the client cannot be kept safe, any other work is premature. The second priority in treatment is that of motivation. Because of high levels of attrition from treatment by clients with suicidality and SUDs, they have to feel motivated to participate in treatment, and have to experience some degree of control over the process. New coping skills are introduced after there is sufficient motivation to be a collaborative partner in the therapeutic process. This does not necessarily mean that clients have to agree to abstinence at the outset, but merely that they have sufficient motivation to discuss issues and participate in the cognitive behavioral treatment. As illustrated in the case presented above, the first three sessions with Jane and her parents included safety planning around suicidal behavior; problem-solving to teach Jane how to identify adaptive alternatives to suicidal behavior and drinking if faced with the same stressor that triggered her suicidal episode; and motivational interviewing to increase Jane's motivation to change her drinking behavior as well as Jane's parents' willingness to engage in her treatment.

In terms of cognitive and behavioral coping skills, the focus is first and foremost on those problem areas that are most strongly related to suicidal thoughts or behaviors and substance abuse, and their interrelationship, as identified in the functional analysis. Priority is generally given to coping skills that the client can use to reduce risk for both sets of outcomes (both substance abuse and suicidality). Priority is also given to new skills that, in the judgment of the therapist, are most likely to result in the most substantial or in the quickest change. In the case presented above, family conflict was most strongly associated with Jane's suicidal behavior and alcohol use. Therefore, priority was given to teaching Jane and her parents the skills needed to decrease conflict in their home and improve family relationships (i.e., behavioral contracting, cognitive restructuring, affect regulation, catching and rewarding positive behavior, and communication skills).

Lastly, part of the content of sessions is always developed collaboratively, so if the client has an issue that he or she would like to discuss, it is always included in the agenda for the

session. When this happens, the therapist tries to integrate discussion of emergent issues with new skills that are being learned, or reviews and applies skills that were previously introduced. As evident in the case example, when Jane and her parents arrived to session angry and frustrated over a recent conflict, the session was spent learning new skills, and/or practicing skills that were previously introduced, to work through the problem area.

Another important consideration, though not discussed in the case presentation above, is whether psychotropic medication may be helpful to the client. Many clients who present with co-occurring suicidality and SUDs also have other psychiatric disorders, and may benefit from concurrent medication management. Therefore, a medication evaluation may be warranted for many of these clients. Relatedly, as it has been well established that there is a strong familial transmission of both SUDs (Hopfer, Crowley, & Stallings, 2006) and suicidality (Brent & Melham, 2008), clinical referrals for family members may be warranted to the degree that their behavior affects the clients' suicidal behavior and substance use. The same is true for partners of clients, as substance use (Grant et al., 2007) and other psychiatric disorders (Low, Cui, & Merikangas, 2007) are also common among partners of individuals with SUDs and suicidality.

Though the treatment outcome literature on integrated interventions for co-occurring suicidality and SUDs is exceedingly small, both because of the complexities inherent in treating this population and poor adherence to treatment protocols, preliminary work in this area suggests that CBT, as well as protocols that rely heavily on CBT techniques such as DBT, offer a particularly promising treatment approach. To firmly establish the evidence base for an integrated CBT approach for co-occurring suicidality and SUDs, more data from randomized trials is needed. These trials will need to be large enough so that true tests of efficacy can be conducted. Multisite trials will need to be sponsored in the future in order to properly test these integrated approaches with different populations, such as adults versus adolescents and drug versus alcohol dependent clients.

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Table 1

Treatment Menu for I-CBT
Core Individual Skill Modules
Introduction to treatment/goal setting
Problem-solving
Cognitive restructuring
Increasing healthy pleasant events
Building healthy social support networks
Affect regulation: Recognizing and managing negative emotions
Affect regulation: Deep breathing/progressive muscle relaxation training
Communication: Assertiveness training
Skill Practice/Review
Supplementary Individual Affect Regulation Modules
Functional analysis of dangerous behavior
Guided imagery
Managing aggression Part I
Managing aggression Part II
Individual Substance Specific Modules
Motivational interview for alcohol/drug use
Coping with cravings
Alcohol/drug refusal skills
Planning for emergencies
Relapse prevention
Family Modules
Family problem-solving
Family communication
Increasing positive family interactions
Contingency management/behavioral contracting
Parent Training Modules
Motivational interview for treatment engagement
Parental monitoring
Parental cognitive restructuring
Parent emotion regulation
Parent problem-solving
Positive attending
Maintenance/Booster Sessions
Treatment progress and skill review
Relapse prevention