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The Use of Mindfulness-Based Approaches for Suicidal Patients

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Mindfulness-based approaches are becoming more widely used for individuals at risk of suicidal behavior: in the treatment of borderline personality disorder (in Dialectical Behavior Therapy), and as a way to reduce relapse in recurrent major depression (in Mindfulness-based Cognitive Therapy). This article describes and examines the commonalities and differences in the use of mindfulness in these two treatments. The reasons for considering the use of mindfulness-based approaches with suicidal individuals more widely are considered and potential risks outlined. The article closes with case examples to illustrate the use of mindfulness in the treatment of suicidal thoughts and behaviors.

Keywords mindfulness, suicidal behavior, behavior therapy, cognitive therapy

Recent developments in the structured psychotherapies can be considered to have occurred in three phases. The first phase took place in the 1960s, and consisted of the systematic application of behavioral learning theory to emotional disorders, initially specific fears and phobias and later agoraphobia and social phobias (Eysenck & Martin, 1987). The second phase was a shift towards cognitive models. In particular, A.T. Beck' s Cognitive Therapy brought together a number of behavioral and cognitive techniques with the joint aim of focusing on the way a person's thoughts, images and interpretation of events contribute to the onset and maintenance of the emotional and behavioral disturbances (Beck, Rush, Shaw et al., 1979; Williams, 1992). Originally applied to depression, the approach is now used with a wide range of different problems including Post Traumatic Stress Disorder, eating disorders, hypochondriasis, panic disorder, obsessive-compulsive disorders, social phobias, general anxiety and suicidal behavior (see Hawton, Salkovskis, Kirk et al., 1989).

The third, and most recent, phase is still in the early stages of development. The new treatments that are now being developed retain the structure associated with the earlier behavioral and cognitive phases, and the emphasis on evaluation of treatment efficacy, but incorporate elements, such as dialectical philosophy, mindfulness, acceptance, relationship, and spirituality (Borkovec, 2002; Roemer & Orsillo, 2002). One feature of these 'third phase' therapies is their willingness to learn from Eastern approaches to mind and body. In particular, many teach mindfulness meditation as a central aspect of the approach. The addition of such elements represents an important shift, taking

behavioral and cognitive therapy to a qualitatively different phase of development (Hayes, 2002; Hayes & Wilson, 2003).

The aim of this article is to describe mindfulness meditation as it is taught in two of these 'third wave' therapies: Dialectical Behavior Therapy (DBT; Linehan, 1993a) and Mindfulness-based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002). Both have been used for specific sub-groups of patients that are vulnerable to suicidal behavior. DBT was developed to treat chronically suicidal patients who meet criteria for a diagnosis of borderline personality disorder. MBCT, although not designed specifically to target suicide risk, was developed to reduce the risk of relapse in chronically recurrent major depression, one of the highest risk groups for suicide. To date, it is not clear what role mindfulness training may have outside the specific clinical groups for which DBT and MBCT were designed. In this article we consider first, what mindfulness is; second, the way it is used in these two treatment settings, and; third whether we can learn what role mindfulness approaches may play in reducing risk of suicidal behavior more generally.

What is Mindfulness?

Thich Nhat Hanh (1991) uses the term mindfulness "to refer to keeping one's consciousness alive to the present reality" and, in keeping with the more experiential Eastern tradition, illustrates this further through the use of examples and teaching stories. Take, for example, a common activity such as washing the dishes. If, while washing dishes, we think only of what we have to do next, rushing through them to get them out of the way, then we are not aware of what we are doing as we are doing it. While doing the next activity, the same applies: our minds continue to be elsewhere. "Thus we are sucked away into the future—and we are incapable of actually living one minute of life" (Thich Nhat Hanh, 1991, p. 5). The danger of such an "automatic pilot" mode is that old habits of thoughts, emotions, and body sensations may be triggered, and escalate, without a person being aware of it until it has become difficult to deal with skillfully.

By contrast, mindfulness training aims to teach people a new way of paying attention: on purpose, moment by moment, and without judgment (Kabat-Zinn, 1990). It teaches us to deal more skillfully with what happens, rather than getting caught up in wishing that things were different from how they are right now. This involves a different mode from the one in which we normally operate; in which achievement of goals dominate (e.g., "finish the dishes"). Instead, a different mode is sampled, in which the first response to problems (whether problems in the world or problems with emotion regulation) is to pause, to mindfully focus on each present moment, in order to see clearly what is going on. When this is done, we become more aware of how often our immediate, affect-based reactions tend to increase rather than decrease problems.

The practice of mindfulness stems from a long philosophical tradition routed in Eastern practice, although, similar practices can be found in other religious traditions, for example, the Christian contemplative tradition. In recent times clinicians have considered the application of these practices to patients with a wide range of difficulties, from chronic pain to borderline personality disorder. This article will review two therapies utilizing this approach in the field of mental health, Dialectical Behavior Therapy and Mindfulness-Based Cognitive Therapy. Both of these approaches have a growing evidence base for their efficacy, discussion of which is beyond the focus of this article DBT: (Bohus, Haaf, Simms et al., 2003; Bohus, Haaf, Stiglmayr, 2000; Koerner & Dimeff, 2000; Koons, Robins, Tweed et al.,

2001; Linehan, Armstrong, Suarez et al., 1991; Linehan, Dimeff, Reynolds et al., 2002; Linehan, Schmidt, Dimeff et al., 1999; Rathus & Miller, 2002; Verheul, Van Den Bosch, Koeter et al., 2003; MBCT: Ma & Teasdale, in press; Teasdale, Segal, Williams et al., 2000; Mindfulness: Baer, 2003).

Mindfulness in Dialectical Behavior Therapy

Dialectical Behavior Therapy (Linehan, 1993a,b) aims to remediate the problems of patients who are chronically suicidal, who engage in a wide range of parasuicidal behaviors, and who meet criteria for borderline personality disorder (show impulsive self-damaging behavior, unstable and intense inter-personal relationships, inappropriate and intense anger, problems with the experience of self (they often have crises of self-identity), extremely unstable emotions, chronic feelings of emptiness or boredom, and intolerance of being alone). Parasuicidal behaviors are present in 69–80% of individuals who meet criteria for borderline personality disorder (Clarkin, Widiger, Frances et al., 1983; Cowdry, Pickar, & Davies, 1985; Gunderson, 1984). Moreover, the rates of suicide in individuals who meet criteria for borderline personality disorder are between 5 and 10% and double when only those with a history of parasuicidal behavior are considered (Frances, Fyer & Clarkin, 1986).

In attempting to develop an effective treatment for these individuals, Linehan began with the application of standard behavior therapy. This proved to be ineffective for a number of reasons (Linehan, 1993a). One key reason, she suggested, was the exclusive focus on change, as evidenced by cognitive-behavioral approaches, which often invalidate the client's beliefs about herself. In the presence of invalidation (which occurs whenever the environment fails to verify the client's experience or beliefs about herself in the moment), the client's arousal level increases. This leads to a sense of being more out of control and consequently a failure to process any new information (Swann, 1997). In the absence of validation, or self-verification, the client cannot learn new skills and psychotherapy becomes ineffective. To overcome the difficulties arising as a result of this focus on change, Linehan searched for an approach that focused on acceptance.

The tradition that she turned to was that of Zen philosophy. In contrast to the cognitive-behavioral approach that focuses on the application of rationality and logic, Zen has a more experiential focus that emphasises intuition and paradox. There are a number of ways in which the application of Zen principles is present in the treatment (see Linehan, 1993a; Linehan, 1997). We focus in this article, however, on one aspect of the use of acceptance, namely the use of mindfulness.

DBT utilizes a *capability* & *motivational deficit model* to understand the difficulties experienced by suicidal, borderline patients. Within this frame a key component of the treatment is directed at enhancing client capability. This most commonly occurs in the form of a skills training group. It is in this context that mindfulness first appears, as one of four skills modules (emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness), each directed at overcoming some of the core deficits experienced by borderline patients (Linehan, 1993b). While all four modules are considered important, mindfulness is a theme running through all three of the others and so is reviewed briefly between each of them.

The "What" and "How" Skills of Mindfulness in DBT

Within the *mindfulness* module clients are taught three "what" skills of mindfulness

and three "how" skills. The "what" skills are those skills to practice in order to become more mindful. These are *observe* (focusing on what is present in the current moment and noticing it), *describe* (using words to describe that which is observed), and *participate* (becoming one with the experience of the current moment). *Observing* involves learning to see clearly what is arising in each moment, both in the external world (sights, sounds, touch) and in the "internal world" (thoughts, emotions, and bodily sensations). *Describing* involves using language to put into words what is experienced. It has the advantage of "articulating" an experience as accurately as possible, but also has the danger that it introduces constructs and interpretations that may obscure seeing reality as it is. For example, following an exercise in which participants in class had been asked to observe sound, one participant, when asked for feedback, reported "I heard the sound of table tennis being played next door" (the session was taking place in a leisure centre). Another reported, "I heard the sound of the weights in the weight room next door." Note that neither of these, strictly speaking, were describing precisely what they had observed. Rather, they were interpretations of observed sounds (a rhythmic clunking/tapping sound). In this case, one of the interpretations was in fact correct (the weights room *was* next door). The fact that it was correct, however, does not make the statement an observation or a description. A more mindful description would be "when I heard the rhythmic clunking sound, the thought that the weights room was next door came into my mind."

The assumption of the mindfulness approach is that many of life's difficulties come from making too fast a link between "raw" observation of empirical reality and automatic interpretations or assumptions about it. One of the goals in learning this skill is to increase awareness of this tendency, and then to notice how, in unpleasant contexts, it can lead to increased distress. Naturally this is often easier to do initially in a calmer frame of mind.

Participating is the third "what" skill. It involves becoming "at one" with the present moment. Such "at one-ness" can best be illustrated by the common experience of becoming engrossed in an activity so that time seems to pass quickly—playing a sport, listening to music, watching a film. On these occasions it is likely that we have been fully "participating" in the activity. The goal for clients and therapists here is to facilitate full participation in the current moment. Clients often have this experience when they engage in self-harm or other problematic behaviors. In such circumstances, the task is to help clients switch what they are participating in, to activities that are more effective in the longer term.

In addition to the "what" skills, there are three skills that apply to "how" to be mindful. The first is to *practice non-judgmentally;* to let go of thoughts that some behaviors, thoughts, emotions, situations are good or bad and to simply describe or experience these events as they are. Judgments, in this context, refer particularly to value judgments (whether a situation or thought is considered to be "good" or "bad"). The task here is to notice value judgments and to let them go. The second is to *practice "one-mindfully"*. Essentially, this means to do one task at a time (and if you notice your mind wandering to other thoughts or tasks to escort it gently back to the focus of the moment). The third "how" skill is to be effective. In other words *focus on doing what works*, acting as skillfully as possible in this situation, rather than wishing that the situation were other than it is.

Presenting these skills to clients can be a challenge and often the novice therapist will back off from this task for fear that clients will find the task too abstract, too challenging or too spiritual. All of these

are, of course, judgements or interpretations by the therapist and as such, they become opportunities for therapists to practise the skills themselves. Just as in teaching any skill, however, the client needs to be presented with a coherent rationale and to be motivated to apply the new skill. One way that this can be done is by asking a question (of both clients and therapists): how much time is spent mentally in the past or in the future? To what extent does spending time in the past and future reduce or enhance distress? For those with traumatic pasts and apparently hopeless futures this is a major problem. By becoming more mindful, more present in the current moment, the experience is of an increasing sense that attentional processes need not be on automatic pilot all the time. As clients often feel at the mercy of their automatic, reactive attentional processes they may be very motivated to learn any skill that will assist with this process. It is important to emphasize two things here, for clients and therapists. First, learning this skill is not easy (though it may sound simple). Second, mindfulness is not designed to make a person feel better or more relaxed. Rather it is designed to help a person remain in the present moment and, from that perspective, deal with whatever is arising in the present moment as effectively as possible.

Practical Issues

Given the client group for which DBT is designed there are some practical issues around how to introduce clients to the skill. The main general principle is initially to keep the practice relatively concrete and relatively short so, for example, focusing on making a cup of tea mindfully, washing up a plate mindfully. This involves, throughout the practice, noticing where the mind wanders and gently escorting it back to the focus of the practice. Having begun on such tasks the client can then experiment with being mindful of thoughts and emotions or of practicing awareness of the breath. Key to the effective implementation of mindfulness, however, is weaving the practice into daily life so it is always there as a possible approach, among others, with which to prevent problems occurring or to address problems that the client commonly experiences. This is primarily achieved, in DBT, through the mode of individual therapy where the therapist focuses on helping the client become more aware of when they are becoming unmindful, and then cueing and rehearsing the skill with them in session. This may involve helping the client simply notice when they have moved to focusing on the future or when they have moved to judgements about self or others.

While mindfulness appears most clearly in the treatment as a skill to be taught and practiced by patients, mindfulness is also more than this. Mindfulness used solely as a set of skills can easily become a method of attempting to "fix" things. The idea is rather that clients learn to live a mindful life so that the practice of mindfulness supports the use of other skills and strategies in a more effective approach to their difficulties. This approach permeates the treatment and requires that therapists bring an experience of mindfulness to their practice of therapy.

The willingness of therapists to learn to use mindfulness in their own lives is important in a number of ways. First, mindfulness is an experiential practice and the teaching is more by embodying mindfulness than by didactic instruction about it. It is in their own struggle with the practice of being more present, non-judgmentally, in the moment that the therapist can teach and model to clients.

Second, it is emotionally demanding working with very distressed clients who are also at high levels of risk. It requires the therapist to think clearly under conditions of high emotional arousal. Under such circumstances, therapists themselves

can become unmindful; thinking about past or future moments or becoming judgemental about themselves or the client. It is here that the practice of mindfulness can help the therapist. The task is for the therapist first to notice any emotions or thoughts as they arise, then to return to the present moment, focusing on what would be the most effective strategy, in this moment, not some future moment, to help the client.

Note, however, the important caveat that although there have been several trials of DBT (see later) there has not yet been a study that evaluates the mindfulness component alone for the treatment of chronically or intermittently suicidal individuals. One of the issues is what such a treatment would look like. One possibility is adapting a program such as that developed by Kabat-Zinn and colleagues. It is to this possibility that we now turn.

Mindfulness-based Cognitive Therapy

Kabat-Zinn developed a Mindfulness-based approach to stress reduction at the University of Massachusetts Medical Center in Worcester, Massachussetts (Kabat-Zinn, 1990, 1994; Kabat-Zinn, Lipworth, Burney et al., 1986; Kabat-Zinn, Massion, Kristeller et al., 1992). His eight-week, two and a half hour a week program had been originally developed to deal with people with chronic physical pain, but then expanded to take referrals from many physicians whose patients' stress was significantly exacerbating a wide range of physical and psychological conditions. A number of open and randomized trials have shown that the approach can achieve as much change as the best structured psychotherapies (Baer, 2003), but at much reduced cost, since the mindfulness training is class-based.

The skills of mindfulness are taught by an instructor who has a daily mindfulness meditation practice. For the participants, it involves cultivating the skills with daily home-based meditation practice. This practice involves learning to focus attention on a single object (such as the breath, or parts of the body). Later, the same quality of non-judgmental awareness is used to attend to anything that arises in moment-to-moment experience. In this way, participants become aware of the way their mind is often on "automatic pilot," reacting relatively "mindlessly" to events, how the mind attempts to avoid some outcomes or become attached to others, and reacts catastrophically when things go wrong.

Recent research has explored how Kabat-Zinn's approach might be applied to relapse prevention for major depression (Ma & Teasdale, in press; Segal, Williams, Teasdale, et al., 1996; Segal, Williams and Teasdale, 2002; Teasdale, 1999; Teasdale, Segal & Williams, 1995; Teasdale, Segal, Williams et al., 2000; Williams, Teasdale, Segal et al., 2000). Mindfulness-based cognitive therapy (MBCT) embeds cognitive techniques into Kabat-Zinn's mindfulness approach. After an individual preliminary interview, the patients attend 8 two-hour classes. The goal of MBCT is (a) to increase patients' awareness of present, moment-to-moment, experience, and (b) to encourage patients to become aware of how they are relating to their experience. Practice is given in how to notice the tendency to judge moment by moment experience on whether it is liked or disliked. Such judgment gives rise to attachment to some experiences (setting up disappointment when the experience fades) and aversion to others (setting up attempts to avoid the experience and frustration when avoidance fails).

Patients receive extensive practice in learning to bring their attention back to the present, using a focus on the breath as an "anchor," whenever they notice that attention has been diverted to streams of thoughts, worries, or general lack of awareness. Being aware of where the attention is

being "pulled off," patients learn to take a wider perspective on their experience. Homework is given each week, up to one hour per day, for carrying out at least 6 days a week. These are mostly audio-tapes of mindfulness practice as well as generalization practice (see Table 1). Preliminary evidence for the efficacy of MBCT in reducing depressive relapse is encouraging (Ma & Teasdale, in press; Teasdale, Segal, Williams et al., 2000).

Key Themes and Assumptions of MBCT

There are four key themes in MBCT. First, that all of us are often on automatic pilot, our minds are often miles away, analyzing the past, planning the future (mixing trivial and important issues). Second, that this state of mindlessness is particularly vulnerable for those with depressive/suicidal tendencies, since events or thoughts can trigger old, unhelpful habits of thinking which

***TABLE 1.* Comparison of Main Features of DBT and MBCT**

DBT	MBCT
Developed for treatment of chronically suicidal patients with a diagnosis of BPD	Developed for prevention of relapse/ recurrence in patients with history of recurrent depression
Patients may be at imminent risk of suicidal behavior	Patients currently in remission
Combines class-based skills training (+homework) with individual psychotherapy	Class-based skills training only (+homework)
Originally one year contract in the research setting, with the option to renew, but now adapted for different settings (see text)	Program consists of eight weekly classes plus four follow-up classes over subsequent year
Extensive homework and practice (both acceptance and change based strategies)	Daily homework, predominantly mindfulness practice (tapes)
Strong focus on generalization, including (in some settings) contact with the therapist between sessions to apply skills to crises as they arise	Generalization through short structured meditation (three minute breathing space) as well as practicing carrying out routine activities mindfully
Progression in program is from less formal practice to a more extensive range of mindfulness practices. At no stage is a formal practice required although if clients wish to do this and it is effective for them it would not be discouraged.	Progression in program is from formal practice to their application in everyday life
Mindfulness is a key skill but is only one of many skills taught	Mindfulness is taught as the first step in choosing other ways to handle specific problems
Problematic behaviors are specifically targeted for change; each target is monitored closely each week; targets are hierarchically organized and problematic behaviors as they occur are compre hensively analyzed and solutions implemented	Focus of the therapy is the practice of mindfulness as an approach to whatever occurs, rather than selection of target behaviors
In DBT there is a balance between two styles; reciprocal and irreverent, with the therapist being active and directive as necessary if that is most effective for the client.	The style of MBCT is more invitational than directive. Use of the present participle in mindfulness instructions (e.g. 'bringing the focus of attention to x', rather than 'bring the focus of attention to x') emphasizes this.
Therapists may or may not have their own mindfulness practice	Instructors in MBCT have a current, daily mindfulness meditation practice.

tend to be self-perpetuating. Third, these habits often lead to worsening mood—a "landslide" effect. Fourth, there is an alternative: to be more aware, so we are able to give ourselves the possibility of freedom of choice about how to think and act (rather than being driven, by automatic pilot, down old established habits).

MBCT assumes there are features common to all emotional disturbance including suicidal tendencies: that what is damaging is a combination of nonawareness (so old habits can be initiated) plus judgment (the constant wish for things to be different) which gives rise to ruminative attempts to problem-solve. Extending this to suicidal ideation, we assume that much of the unendurable "psychic pain" experienced by suicidal people arises from their attempts to reduce, change, or fix their pain and from the thoughts that arise when such attempts fail. MBCT's focus on awareness and modification of these processes, not on changing contents, may be particularly appropriate for suicidal clients.

Unlike cognitive therapy, MBCT does not set out to conduct experiments to check out the truth of self-talk, but encourages the person to watch the thoughts as they come and go, to get curious about them, to see them arising and passing away, and to note what emotions and bodily sensations they give rise to. Taking awareness to thoughts, feelings and bodily sensations in this way, without judging them, or reacting to them, or trying to suppress them, or take instant action on the basis of them gives time for a different perspective to emerge, a perspective that might involve new information that had been previously swamped by the attempt to avoid or react to the thinking.

Why Adapt this Approach to Recurrent Depression for Individuals at Risk for Suicidal Behavior?

There are a number of reasons why mindfulness may be considered a useful approach to adapt to the treatment of suicidal individuals. Firstly, the link between suicidal behavior and depression would suggest the potential usefulness of exploring the application of MBCT for depression to suicidal patients. Secondly, mindfulness makes theoretical and conceptual sense as an intervention given what is understood about the processes that lead to suicidal thinking and behavior. Both of these will be explored in more detail.

Suicidal behavior and depression are closely linked. The Population Attributable Ratio (PAR) for depression in serious but nonfatal suicidal behavior (that proportion of suicidal behavior that would be removed if depression were taken out of the picture) is 80 percent (Beautrais, Joyce, Mulder et al., 1996). Given the increased risk of suicide associated with suicidal behavior in depression, particularly in those with a chronic course, effective prevention of relapse and recurrence in major depression is a central challenge in the overall management of suicide risk.

Furthermore, it has become increasingly clear that the management of depression needs to expand beyond merely dealing with the acute episode and to focus on the prevention of relapse and recurrence. Recent data suggest that depressed patients will experience an average of four lifetime major depressive episodes of 20 weeks duration each (Judd, 1997). This means that a major contribution to the risks associated with major depression (including suicidal behavior) is that, as well as being a condition with a high rate of incidence, it is also a condition characterized by relapse, recurrence and chronicity. Similarly, it is possible that once an episode of suicidal behavior has happened, further episodes may be more easily triggered, analogous to the "kindling" phenomena found to increase the risk of recurrent depression (van Heeringen, Hawton & Williams, 2000).

Most models of suicidal behavior identify a number of common features, a

consideration of which will illuminate the potential uses of mindfulness. The central component of most models is the presence of intense psychological pain often related to issues of loss, defeat, rejection or all three. In the context of high levels of affect following from such events there is an absence of perceived escape routes either initiated by the sufferer or indeed initiated by others, that is, an absence of social support. The presence of high levels of affect in the absence of the means of escape or rescue leads to a sense of helplessness and hopelessness and often to the sense of the situation being unbearable and intolerable; a context in which suicide may seem more viable as a solution (O'Connor, 2003; O'Connor & Sheehy, 2000; Williams & Pollock, 2001).

The experience of psychological pain itself and the capacity to generate and/or elicit help from others are all affected by a number of cognitive processes. Distressed individuals are more likely to experience attentional biases such that they are more sensitized to signals that indicate defeat or loss or other themes commensurate with their current distressed mood. The identification of such signals may lead to the automatic activation of or exacerbation of negative affect. Mindfulness may be useful here in interrupting the automaticity of this process; increasing the individual's awareness of this activation may decrease the impact of the activation itself.

One aspect of the activation of negative mood states, in particular in depression, that has been hypothesized to be relevant in suicidal processes is rumination, a style of thinking that that has a repetitive and recurrent self-focus in particular around symptoms, their causes and consequences. Rumination may be particularly important in the suicidal process in two ways. Firstly, rumination has been shown experimentally to be important in the maintenance of overgeneral memory (Watkins & Teasdale, 2001). Overgeneral memory, in which individuals demonstrate a repeated difficulty in recalling detailed aspects of their autobiographical memory, has been repeatedly shown to be a characteristic of individuals who have engaged in parasuicidal behavior and is linked to poor problem-solving in such individuals (Evans, Williams, O'Loughlin et al., 1992; Williams & Broadbent, 1986). Rumination may, therefore, decrease the likelihood that alternative routes for escape other than suicide will be identified. Secondly, rumination may also impact the willingness of the individual to solve his or her problems (Lyubomirsky, Tucker, Caldwell et al., 1999) and the available executive processing capacity to problem-solve (Watkins & Brown, 2002). Over time these internal ruminative processes may become more salient in the triggering of suicidal behavior than stressful events. This would be supported by the work of Joiner & Rudd (2000) demonstrating that suicidal behavior in multiple attempters is less associated with external stressful events that in first time attempters.

These ruminative processes may be impacted by mindfulness treatments in a number of ways. Firstly, an early emphasis in the MBSR and MBCT programs is the identification of the tendency that many people have to be on automatic pilot much of the time. Starting by identifying such automaticity is important. This tendency to be on automatic pilot renders people who are vulnerable to suicidal behavior particularly at risk, because they are not aware of the activation of negative thoughts and the catastrophic escalation of emotions by small changes in mood until it is too late.

Secondly, mindfulness focuses on ways in which people can learn to maintain the focus of their attention in the face of the tendency for the mind constantly to wander. This aspect of the approach is very important because of the need to teach patients a way to handle skillfully those times when their mind is ruminating on

negative themes. The aim is to notice, without judgment, where the attention is gone when the mind wanders, and make a deliberate decision about whether this is where you want the mind to be. It is a greater awareness that is taught, rather than the assumption that there are good and bad places for the mind to be.

Finally, MBCT makes explicit what is already implicit in cognitive therapy: the importance of learning to treat thoughts as thoughts. In cognitive therapy, different strategies are woven together in the service of identifying negative themes, assumptions, thoughts and images, then evaluating the evidence for and against their validity. The aim is to reduce the degree of belief that the patient has in the thought or image. In this way, patients who have been through cognitive therapy are able better to see their thoughts as simply that, thoughts. This change in perspective with respect to thinking is an important part of what cognitive therapy does, but the cognitive model would predict that unless the degree of belief in the thought changes, then behavioral change will not be forthcoming, or will not last. MBCT suggests that learning to step out of automatic pilot and how to change perspective on thinking (seeing thoughts as thoughts) is fundamental.

In addition to these reasons, however, the nature of the mindfulness approach makes it a good prima facie case for investigating how, if offered to clients by itself, and in a class-based rather than therapy-based approach, it may affect suicidal ideation and behavior. The mindfulness approach emphasizes the importance of wholeness and well-being, rather than merely the treatment of psychopathology. This is important since by the time suicidal patients come for treatment, their worst symptoms may have abated, the crisis may have passed and their mood disturbance may have reduced (Schotte, Cools & Payvar, 1990).

Case Examples

Because MBCT has not yet been used systematically for suicidal patients, we take two examples from the use of mindfulness within a DBT approach. It is important to bear in mind in the following examples the focus is on the use of mindfulness. In both cases a variety of other problem-solving and dialectical strategies (Linehan, 1993a) were utilized in the overall management of the case.

Jane[1] presented with features of borderline personality disorder, a co-morbid eating disorder and parasuicidal behaviors. She was being treated in an in-patient DBT program. During one particular session, she indicated that she was considering making a further allegation of sexual abuse by a family member. During the therapy session she became distressed and indicated that her urges to suicide had increased. She identified a key thought that occurred whenever she considered making the disclosure: "to be rejected is unbearable, therefore I need to kill myself." Associated with this thought was the experience of hopelessness. Given the client's past experience of rejection after making allegations of childhood sexual abuse, reality testing of her cognition would not have been an effective strategy in this moment. Instead, the focus was to remain mindful of the present moment rather than some future moment. At this stage the final outcome of her family's response to the situation was unknown and therefore she was encouraged to focus exclusively on the current moment using a breathing exercise saying "just this" on the in-breath and "one-breath" on the out-breath. If, during

[1]Names and details of case examples have been changed to protect anonymity.

this exercise, thoughts of future rejection came to mind, Jane was encouraged to notice and label these thoughts as thoughts and to return to mindfulness of the breath. This approach to the management of problematic cognition is common in DBT. While standard challenging of dysfunctional cognitions may be applied as part of the treatment, it is more common, especially early in therapy, to focus on being mindful of thoughts and the impact of these on mood and behavior. In this regard the cognitive component of DBT is often more process rather than content focused.

For Jane, practicing this exercise in session produced a dramatic shift. She became noticeably calmer and expressed the view that by staying in the present moment rather than an unknown future moment she found the idea of her family's future reaction less overwhelming. This led in session to an increased capacity to work on solving the problem of how to handle the current situation. With practice Jane was able to utilize this mindfulness practice as one approach to tolerating escalating suicidal thoughts and affects, increasing her capacity to focus on more active problem-solving.

Andrea had a history of multiple overdoses and violent behavior towards her siblings. A common precipitant to both her aggression and her suicidal urges were arguments with a younger brother. The brother often used to taunt the patient telling her she was a psychopath. The patient would often then assault her brother and subsequently believe that this confirmed the accuracy of her brother's perceptions. This confirmation of her worst fear led to an increase in suicidal urges and on occasions to overdoses.

Two interventions in this sequence were helpful in interrupting this chain of events. Firstly, "challenging" Andrea's belief that she was a psychopath by reviewing the diagnostic criteria, discussing features of psychopathic behavior and assessing whether this was true of her. This was an effective in-session technique for decreasing the occurrence of this thought and the distress associated with it. Andrea found it useful too if this thought came to mind when she was feeling relatively calm. It was an ineffective strategy, however, when her brother was challenging her. What proved more useful here was to utilize the mindfulness skill of being non-judgmental. Teaching this skill enabled the patient to recognize the label "psychopath" as a judgment and to focus upon whether judgmental thoughts were more or less effective in helping her to act in ways that fulfilled her long-term goal of overcoming her problems. Becoming aware of both her own judgmental thoughts (and those of her brother) enabled her to successfully interrupt this chain of events that had frequently led to parasuicidal behavior in the past.

Possible Dangers of Mindfulness-based Approaches

We need to be aware that there may be some dangers in applying this approach to suicidal patients more generally so practitioners should be cautious. Issues to be particularly aware of relate to the stage of treatment, the characteristics of the intervention and challenges within the practice of mindfulness itself. The first caution relates to the severity and complexity of the presenting problems of the patient, that is, the stage of treatment at which they are presenting. Stage 1 treatments (of which DBT is one; Linehan, 1999) focus on helping the patient with high levels of psychopathology and/or suicidality achieve stability and behavioral control. For such patients we would not recommend an approach solely based on mindfulness. What evidence base there is would support the use of problem-solving therapy for those who are depressed and suicidal and DBT for those with a diagnosis

of borderline personality disorder (Hawton, Arensman, Townsend et al., 1998).

With regard to the characteristics of the therapies themselves, both DBT and MBCT require persistence despite apparently little change for some people in the short term and both therapies start with "high demand" rather than build "behavioral momentum." This can be a challenge for both patients and therapists alike and it is important to orient to this aspect of the treatment and to get commitment to the treatment before beginning. This is perhaps especially the case with the client presenting with suicidality in the context of BPD and, as a consequence, in DBT warrants its own pre-treatment phase of therapy. During this phase the therapist establishes the goals that the client has for therapy and works explicitly with the client to link the goals of the treatment, namely the reduction of suicidal behaviors, to these goals. The key focus of this stage is working with clients to obtain commitment to give up suicidal behaviors while fully orienting clients (often experientially) to the structure, style and content of therapy and the level of commitment required from them in order to derive maximum benefit from the approach.

Within the practice of mindfulness itself there are a number of problems to be aware of. Firstly, for some clients increasing self-focus increases rumination, and makes contents overwhelming. This may be especially true if they see the approach as an aid to fixing/putting right, or as distraction (which then may not "work"). This problem can be addressed by orienting patients to the function of mindfulness and coaching in reasonable expectations. For patients who have a tendency to be overwhelmed by traumatic memories it may be that they require a more structured intervention utilizing both CBT and mindfulness-based components prior to entering, or alongside, a group-based mindfulness intervention or more concrete practices to begin.

Regardless of diagnosis, symptoms of negativity and hopelessness often undermine motivation to do the practice necessary to step out of negative cognitive patterns. Thoughts such as "I'm no good at this," "this just proves I'm a failure" and commonly "I can't do it" occur frequently during the practice. If this is persistently problematic, the patient may need additional coaching to assist them in noticing these thoughts as judgments and interpretations and being able to describe them as such and let them go. For some patients (and for some novice therapists) mindfulness practice can sometimes be seen as another method of suppressing or avoiding thoughts. If so, there is the danger that thoughts will return more strongly than before following practice, and that patients will not be exposed to the radically new perspective that "thoughts are thoughts." Given these warnings, we remind our colleagues that, at the moment, we are suggesting the use of MBCT for depressed and suicidal patients while they are relatively well, rather than while in episode or in crisis.

CONCLUDING REMARKS

A few years ago, we would not have contemplated that a mindfulness approach would be relevant to suicidal clients, but Marsha Linehan's pioneering work with the most severe borderline patients told a different story. It was her utilization of mindfulness with chronically suicidal patients that encouraged the exploration of what a relatively pure mindfulness approach might have to offer for relapse prevention in depression. We believe that such re-orientation is clearly relevant to suicidal patients more generally: for they often show failures in reality testing, difficulties in managing the experience of affect (anger, anxiety, sadness), and the thoughts and beliefs accompanying these emotions

(abandonment and hopelessness) and as a result have a tendency to act impulsively.

It may come as a tremendous relief to patients to discover that they do not have to fight their negative thoughts; that having such thoughts does not mean that they are stupid, worthless or going crazy. They are intrigued to discover that when they give up fighting with them or trying to suppress them, the thoughts may lose some of their power. If it is the case that such battles within the mind lie at the heart of the final common pathway for suicidal behavior, any approach that may help the person to deal skilfully when such battles are threatening to overwhelm them is worth exploring.

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