CHAPTER 1

Introduction

It is one of the most difficult and painful conversations that takes place between a person seeking help for his or her psychological difficulties and the therapist, counselor, or teacher to whom he or she has come to see. For when questions about their life history have been asked, about their family and work, about what brings them here, about signs and symptoms of the depression, hopelessness, and mental pain that can accompany any physical or psychological problem, there needs to be a question about suicide: "Have things ever got to the point that you've considered ending it all; that life just wasn't worth living anymore; that even suicide would be better than carrying on like this?" He or she may have told no one, and yet feel a huge burden of guilt about harboring such thoughts.

There are many different ways of asking, but eventually the issue has to be addressed, especially if the person is or has been clinically depressed. Half of those who become depressed will have recurrent thoughts of death or suicide, but while any psychological problem increases the risk of suicide—anxiety or panic, bipolar disorder, posttraumatic stress disorder (PTSD), schizophrenia—it is the sense of depression and helplessness that comes with these problems that exacerbates the risk that someone may take his or her own life. Depression and hopelessness form the "final common pathway" for suicidal feelings and behavior, and it is suicidal depression and hopelessness that this book is about.

The approach to those at risk of suicide described in this book arose from a larger quest to help those suffering from depression in

general. Depression is consistently ranked in the top four disorders in terms of global disease burden and has been described as a significant global challenge for the 21st century (Collins et al., 2011). Twenty percent of the population will be seriously depressed at some point in their lives—over a billion people across the globe—and it blights the lives of people whether they live in high-, middle-, or low-income countries (World Health Organization, 2008). Wherever it strikes, depression erodes the well-being and quality of life of sufferers and their families and profoundly impairs people's ability to function in their day-to-day personal, social, and working lives. But it is a hidden scar—few people talk about it as openly as they would about other causes of disability.

In 1993, Zindel Segal, John Teasdale and Mark Williams set out to find a way of understanding the factors that increase risk of depression and then how that risk might be reduced. Originally they had intended to base their preventative approach on cognitive therapy, but their own personal experience and new scientific findings about what processes underlie the maintenance of high risk in depression convinced them that there was more to be discovered than was contained in their existing cognitive theories and therapies. Learning from Marsha Linehan's use of mindfulness (a key feature of her dialectical behavior therapy for people with a diagnosis of borderline personality disorder), and Jon Kabat-Zinn's pioneering work at UMass Medical Center on mindfulness-based stress reduction (MBSR), they proposed a psychological model to explain why mindfulness training, with its emphasis on changing *modes* of mind, might be helpful for people who repeatedly get stuck in recurrent and toxic patterns of mind.

But what is "mindfulness"? The word "mindfulness" is a translation of an ancient Pali word, originally meaning memory or nonforgetfulness. In the Buddhist writings it came to mean "lucid awareness" (Bodhi, 2011). In its more common usage in recent clinical literature, it has come to mean the awareness that emerges as a by-product of cultivating three related skills: (1) intentionally paying attention to moment-by-moment events as they unfold in the internal and external world; (2) noticing habitual reactions to such events, often characterized by aversion or attachment (commonly resulting in rumination and avoidance); and (3) cultivating the ability to respond to events, and to reactions to them, with an attitude of open curiosity and compassion. Mindfulness is traditionally cultivated by meditation in which

people learn to pay attention in each moment with full intentionality and with friendly interest. When people practice such meditation for any length of time, a number of qualities of their experience change. People say they feel more aware or awake, feel calmer and are more able to see clearly and gain freedom from their own emotional patterns and habits, free to be more compassionate to themselves and to others. The early research trials conducted by Kabat-Zinn and his colleagues had shown that this approach could be highly effective for patients who suffered long-term physical health conditions that had been destroying the quality of their lives (Kabat-Zinn, 2013).

Segal, Williams, and Teasdale recognized that mindfulness training might be the key to preventing depression. The research trial they carried out at the University of Cambridge (England), the University of Toronto (Canada), and Bangor University (Wales) showed that for those who had suffered three or more previous episodes of depression, mindfulness-based cognitive therapy (MBCT) reduced the rates of relapse by between 40 and 50% (Teasdale et al., 2000).

At that time, they were cautiously optimistic that mindfulness could pay a role in the reduction of risk of depression, but believed that such an approach might be of interest to a minority of clinicians. In 2002, they published a book that told the story of their research, their false starts and reversals, and what they eventually discovered. To their surprise, the book, *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002), was widely read and became highly influential. It transformed the whole landscape of clinical practice, changing both the way people understood depression and how best to prevent it, and then went on to have a wide impact on the field of evidence-based approaches to other serious psychological conditions.

Mindfulness and Suicidality

But there were gnawing questions being asked again and again: Can mindfulness be used for the most vulnerable people, that is, for those who have a history of severe adversity? What if people get *more* upset because mindfulness has made them more aware of their difficulties? What if they have a risk for suicide? Wouldn't it be unethical to encourage people to do a practice that might end up with them becoming

more aware of suicidal thoughts and feelings? Williams had long been concerned about those people who become so depressed that they consider suicide as their only option. His colleagues and coworkers in the International Association for Suicide Prevention had shown that across the globe each year, around one million people commit suicide. Suicide claims more lives than war. There was an urgent need to help, but few clues about how best to do so.

In January 2003 Williams moved from Bangor University to the University of Oxford to begin a 10-year research program as a Wellcome Trust Principal Research Fellow, setting up a team that would be able to investigate whether the psychological processes underlying mindfulness, that enable it to help prevent recurrence in depression, could also apply to those who suffered depression so severely that they became suicidal. Oxford was the center of choice since this is where Keith Hawton had been working for many years at the forefront of research into suicide and suicidal behavior. Here was an opportunity to deepen our understanding of the particular vulnerabilities of people who had suffered so much throughout their lives that they were persistently thinking of ending it all. Could mindfulness help them? Ultimately, the team would have to carry out a research trial to see whether and for whom mindfulness might be helpful. But before that, there was a lot of work to be done to clarify exactly what made some people suicidal. Only if they could understand the factors that trigger and maintain suicidal thinking and behavior could they begin to see what might help.

This book is the story of what they discovered, and about the impact these new understandings had on their approach to MBCT. It would affect their view of how to train new therapists in MBCT, and how to assess competence in teaching it. But most importantly, the research would show them how best to offer MBCT to those suffering not only from suicidal depression but also from other difficulties that have chronic histories and persistent symptoms.

Overview of This Book

We have divided the chapters in this book into four parts. In Part I, we cover the research and theoretical background. Chapter 2 describes the "cry of pain" model of suicidality, and how hopelessness and despair

can be switched on very suddenly under certain circumstances—when a person feels defeated and believes deeply that he or she has no escape route. Chapter 3 goes into more detail about what we found when we tested these theories in the laboratory. We see the science behind suicide risk—examining the difficulty that some people have in bringing to mind positive images of the future and then the way people differ, one from another, in how reactive they are to small changes in mood. Reactivity not only encompasses negative themes but also rumination and avoidance. More specifically, in those at risk of suicide, reactivity includes graphic images of suicide that, while being intrusive and disturbing for some sufferers, are comforting for a few. Finally we see how subtle changes in the way people recall their personal past (autobiographical memory) affects their reactivity to the present.

If we hope that the mindfulness approach will be taken seriously by those who are most vulnerable, we have to explain to them why mindfulness training might be appropriate for them to try. Chapter 4 offers a framework a clinician can use for answering the patient's question "Will it work for me . . . and how can it help?"

Part II moves from the laboratory and into the clinic, describing the practical application of the Part I research. Chapter 5 examines how we can best assess suicidal vulnerability in order to ensure that we know as much as we can about the risks, and do not do harm. In Chapter 6, we tell the story of how a pilot clinical trial to test our ideas revealed important factors about who drops out before the end of a MBCT course, and describe how we elaborated the preclass interview so as to enhance engagement in the program. We take the learning from this into Chapters 7–14, in which we describe, session by session, the specific changes we made to the original MBCT for depression protocol, and how our participants experienced these changes. These chapters go into detail about the way MBCT can be offered to those in whom strong suicidal thoughts and actions can be easily activated. If it is true that transformation can come only by our "turning toward difficulties," how can this be done in a way that provides a place of genuine safety for participants in the class?

Chapter 15 summarizes the MBCT program by "listening" to the dialogues that take place in the class between teacher and a single participant. It is out of this dialogue following each meditation (often called "inquiry") that much or most learning takes place.

Part III moves into considering the crucial role of the teacher. In Chapter 16, we turn to the controversial question of how we assess the quality of teaching in mindfulness-based interventions. For any evidence-based therapy, it is important to know that what is taught week by week is faithful to the intentions of the approach—that the teaching covers the curriculum, and is taught at a certain level of competence. These issues are not confined to research trial contexts. If we want to disseminate mindfulness teaching to trainees, we need to have a clear understanding of the skills and processes we are conveying as a framework for training and supervision. So the question arises: How can we consistently and reliably assess competence and adherence (the "integrity" of the teaching)? The answer to this question is not simple, because the process of teaching and learning within any mindfulness-based intervention is subtle, and in a large part arises implicitly through the process rather than by covering an explicit curriculum. So assessment of teaching has also to address the "hidden curriculum," that is, how teachers embody the learning in their own way of being. This chapter considers the issues of mindfulness-based teaching integrity, what it is, how it develops over time, and how it can be assessed. Chapter 17 approaches teaching from a different and complementary angle, focusing on the experience of the teacher "from the inside." How can teachers best remain true to the curriculum and intentions of the approach when working with the most vulnerable patients? In particular, the chapter explores the challenges of teaching a manualized, protocol-based program, and the need to balance adherence to the particular, defined curriculum of MBCT, on the one hand, with flexibility and responsiveness to participants, on the other.

Finally, we move to Part IV. In Chapter 18, we summarize the previous chapters, and reveal what we found when we tested MBCT in a large randomized controlled trial—and what the results show us about how to treat the most vulnerable patients, including the best approach to dealing skillfully with reactions of extreme suicidal despair. We place our findings in the context of trials of MBCT that have been published more recently and that inform our view of how to move forward with this evidence-based approach. In sum, by the end of the book, we shall have identified the practical implications for mindfulness teachers, in terms of how they can assess would-be participants' suitability for MBCT, and how to shape its planning and delivery,

remaining faithful to the protocol without undue rigidity or fear, as well as drawing out the implications for teachers for sustaining their own practice and continuing their own training.

How to Use This Book

No single book on mindfulness stands alone. Each one work contributes its own piece to a long-standing and worldwide body of knowledge, understanding, and practice. This book is no exception: it is intended to complement the standard MBCT manual of Segal, Williams, and Teasdale (2013) both in terms of describing its adaptation for highly vulnerable patients, and also in providing additional information on recent general developments that are relevant from a broader perspective, such as the definition and assessment of teacher competency. The book is not a "manual," and we would caution against any teacher or therapist imagining that mindfulness alone will "cure" suicidal thoughts and behavior. Segal and colleagues are very clear about knowing the limits of our competence when any of us are working with trauma and serious mental distress, and we endorse their advice about the training required to work in this field (Segal et al., 2013, pp. 420–421).

The book follows an inherent logic, and it would be best to read it in the sequence presented. In this way, the modifications to the MBCT program and its delivery become understandable from a background of research findings, and the advice on how to implement the program week by week is informed by our best current knowledge. We often recommend that teachers reread the relevant chapter in the book before teaching a particular session, not only in order to remind themselves of the structure of the session, but also to reacquaint themselves with its broader theme and the characteristic responses that may recur. Being prepared in terms of the "hidden curriculum" may be particularly important when working with highly vulnerable patients, so we have laid out key issues in Part II (Chapters 7–14), session by session. To support the implementation of the MBCT program, we have made available audio recordings of practice exercises from the second edition of *Mindfulness-Based Cognitive Therapy for Depression* (Segal et al., 2013), which can be streamed directly from the Web or downloaded

in MP3 format. Participants find the recordings helpful, especially when they are getting started in practicing mindfulness. Teachers can access these tracks at *www.guilford.com/williams6-materials*. Finally, in the later chapters focusing on the experience of the teacher, we intend to convey a sense of what is important psychologically in helping teachers to respond with understanding, compassion, and care to suicidality and despair in MBCT and in other settings.

We hope the book will serve as a helpful resource not only for those teaching MBCT to highly vulnerable patients but also for those who might not be involved in teaching mindfulness in a mental health setting but nonetheless find that they, or those who come to them for help, struggle with suicidality, and despair.

Suicide is a tragedy that affects many of us, families, friends and colleagues of those who have taken their lives, leaving behind feelings of shame, anger, loneliness, and sorrow. As therapists, clinicians, counselors, or mindfulness teachers, we need to deepen and extend our understanding of the field in general and our vulnerable clients or participants in particular. We dedicate this book to all those whose lives have been touched by such a tragedy. May it bring fresh perspectives, courage, and wisdom for those working with people at risk of suicide.