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# Mindfulness-Based Cognitive Therapy for Prevention of Recurrence of Suicidal Behavior



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Once suicidal thoughts have emerged as a feature of depression they are likely to be reactivated as part of a suicidal mode of mind whenever sad mood reappears. This article reviews the methods and the usefulness of mindfulness-based cognitive therapy (MBCT) as a treatment for the prevention of the reactivation of the suicidal mode. MBCT integrates mindfulness meditation practices and cognitive therapy techniques. It teaches participants to develop moment-by-moment awareness, approaching ongoing experience with an attitude of nonjudgment and acceptance. Participants are increasingly able to see their thoughts as mental events rather than facts (metacognitive awareness). A case example illustrates how mindfulness skills develop with MBCT and how they relate to the cognitive processes that fuel suicidal crises. An ongoing controlled trial will provide further evidence, but pilot work suggests that MBCT is a promising intervention for those who have experienced suicidal ideation in the past. © 2005 Wiley Periodicals, Inc. *J Clin Psychol: In Session*

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Treatment of suicidal behavior presents a challenging problem. Many forms of therapy have been developed and evaluated, but results to date are extremely mixed. Intensive therapies, such as Dialectical Behavior Therapy (DBT; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) and cognitive therapy (Berk, Henriques, Warman, Brown, & Beck, 2004), have reduced rates of repetition of deliberate self-harm. However, other studies reveal disappointing results (e.g., Tyrer et al., 2003). There is a need for other treatment approaches, in particular those that fall somewhere between minimalist and intensive

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interventions and hence are applicable to a broad range of suicidal people. In this article, we examine the clinical methods and potential usefulness of mindfulness based cognitive therapy (MBCT) in preventing recurrent suicidal ideation and behavior.

MBCT is an example of a “third wave” of cognitive-behavioral psychotherapies, which emphasize acceptance as well as change (Hayes, Follette, & Linehan, 2004). The origins of mindfulness meditation lie in a Buddhist tradition dating back more than 2,500 years (Kabat-Zinn, 1990). More recently, its practice spread to the West and it has been adapted to treat patients who have a wide variety of disorders, including chronic pain (Kabat-Zinn, 1990), depression (Segal, Williams, & Teasdale, 2002), and cancer (Carlson, Speca, Patel, & Goodey, 2003). Baer (2003) provides a review of its use in clinical practice.

MBCT was developed by Zindel Segal, Mark Williams, and John Teasdale in the interest of discovering a cost-effective treatment approach that would significantly reduce relapse and recurrence of depression (Segal et al., 2002). Based on Mindfulness Based Stress Reduction as developed at the University of Massachusetts Medical Center (Kabat-Zinn, 1990), the program consists of eight weekly class-based sessions with up to 12 participants. Each class is 2 hours in length, with one all-day practice between the sixth and seventh classes. Participation requires a high degree of commitment: participants are expected to practice meditation between classes for up to an hour a day, 6 days per week, using tapes or compact disks (CDs).

MBCT combines key elements of cognitive therapy with training in mindfulness meditation. *Mindfulness* has been described as “a particular way of paying attention: on purpose, moment-by-moment, and without judgement” (Kabat-Zinn, 1994). Participants in MBCT develop and hone their awareness through a range of both formal and informal meditative practices (see Table 1). Formal practices involve set periods of mindfulness meditation such as sitting and focusing attention on the breath, a body scan, mindful walking and stretching, and yoga. Informal practice encourages mindfulness in everyday life, for example, by deliberately focusing awareness on experience during everyday activities for short periods (breathing spaces). Early sessions concentrate mainly on learning to focus attention on specific aspects of experience such as the breath or body sensations. Later, participants learn to extend mindfulness to a broader range of internal and external experiences including thoughts and emotions, especially as they are experienced in the body. Participants are encouraged to take responsibility for their own practice, and the course is intended to provide them with a range of possible routes to mindfulness from which they can later select those they find most helpful and are best able to incorporate regularly into daily life.

Cognitive therapy techniques involved in MBCT include education about the symptoms of depression, the role of negative thoughts, and how rumination, avoidance, suppression, and struggling with unhelpful cognitions and emotions can perpetuate distress rather than resolve it. Participants learn to tune in to small experiences and aspects of their surroundings that would usually pass unnoticed and to work toward increasing the presence of nourishing activities in their daily life (activities that lift mood and increase energy). Thus an important aim of MBCT is to improve positive well-being, not simply to reduce negative emotions. Finally, participants learn to identify patterns of emotional response and negative thinking that act as warning signals for potential relapse and help one another to develop crisis plans, incorporating actions to take in the event of future depression, hopelessness, and suicidal ideation.

Although cognitive therapy components are important, MBCT differs from cognitive therapy in at least three ways. First, it emphasizes acceptance rather than change strategies. Second, MBCT offers no training in changing the *content* of thinking, but rather an emphasis on seeing thoughts as thoughts rather than as reflections of reality

Table 1  
*Description of Mindfulness-Based Cognitive Therapy Practices*

Mindfulness-Based Cognitive Therapy Practices	What Can Be Learned?
Mindful eating (raisin exercise) Focusing attention solely on the experience of eating	Recognizing mindful awareness versus automatic pilot Mindfulness able to reveal and transform experience
Mindfulness of everyday activities Focusing attention on an activity often done without awareness (for example, brushing teeth)	Learning how all pervasive mind wandering is
Body Scan Paying attention to different parts of the body in turn	Using direct experiential knowledge Practicing deliberately engaging and disengaging attention Relating skillfully to mind wandering Repeated practice of noticing, acknowledging, and returning to the body Allowing conditions to be as they are Using the breath as a vehicle Noticing and relating differently to mental states such as aversion
Mindfulness of breathing Using the breath as a focus of attention	Anchoring yourself within the moment Settling so that it is possible to gather and concentrate the mind
3-Minute breathing space Using mindfulness of breathing for short periods at set times and when required	Dealing skillfully with mind wandering Learning to be gentle with yourself
Mindfulness of pleasant/unpleasant activities Using daily activities as a focus of attention	Identifying the different thoughts, feelings, and body sensations that are generated automatically as a result of pleasant and unpleasant experiences
Mindfulness of body Using the body as a focus of attention	Being mindful of sensations arising in the body whether pleasant or unpleasant
Mindful stretching/yoga/walking Focusing attention on the body as it performs different actions	Noticing aversion to sensations as it arises Learning acceptance
Mindfulness of sounds, thoughts, and feelings Using thoughts and feelings as a focus of attention	Learning a different way to relate to thoughts and feelings (decentering) Learning to relate to thoughts and feelings in the same way that it is possible to relate to sounds Learning to see recurring patterns in thoughts and feelings

(metacognitive awareness). Third, patients are taught to notice the effects of negative mind states on the body and to explore body sensations directly, rather than ruminating about or suppressing the mind state.

Two controlled clinical trials have now demonstrated that MBCT can reduce the likelihood of relapse by about 40% to 50% in *people who have suffered three or more previous episodes of depression* (Ma & Teasdale, 2004; Teasdale et al., 2000). This result is broadly comparable to the prophylactic effect of standard cognitive therapy for depression.

But what evidence suggests that MBCT may be suited to the treatment of people who have a history of suicidal ideation or behavior? Suicidal behavior, like major depression, is episodic and mainly occurs in the context of depressed mood. Indeed the population

attributable ratio (PAR) for depression in suicidal behavior is 80% (Beautrais et al, 1996). Therefore, if we were able to eliminate depression, there would be an 80% reduction in suicidal behavior. Thus, in reducing relapse rates in patients who have three or more episodes of depression, MBCT may indirectly benefit individuals with recurrent suicidal ideation and behavior. Might mindfulness also be directly relevant for suicidal people?

Mindfulness techniques have been incorporated in other therapies designed to target suicidal ideation and behavior, for example, DBT (Linehan et al., 1991). DBT was developed for the treatment of those borderline personality disorder patients who engage in repeated self harm. Trials of DBT show significant reductions in repetition of self-harming behavior (Linehan et al., 1991; Verheul et al., 2003). However, in addition to mindfulness, DBT incorporates a number of other components, and the treatment is intensive and prolonged. Our aim now is to build on the insights of Linehan and colleagues to examine mindfulness (in the form of MBCT) as a primary intervention for suicidal ideation and behavior.

As suicidality is common to many diagnoses, it may be legitimate to consider trans-diagnostic aspects of suicidal thinking and behavior that might be targeted in treatment. A range of cognitive-behavioral deficits have been identified in suicidal people. In particular, studies have focused on hopelessness and problem-solving difficulties as markers of vulnerability. However, although people who have made previous suicide attempts are at high risk of repetition, both hopelessness and problem solving improve rapidly in the days after a suicidal crisis, even in the absence of treatment (Schotte, Cools, & Payvar, 1990). This finding suggests that cognitive-behavioral risk factors may be latent between suicidal episodes. Similarly, the dysfunctional attitudes and negative patterns of thinking that are central to depressive thinking normalize as mood improves, and that normalization presents a paradox: Cognitive factors predict depression and suicidality, but they are inaccessible out of episode. How then can they be targeted in treatment? Let us look first at what we may learn from similar research in depression.

Latent risk factors for recurrent depression have been explained in terms of *cognitive reactivity*, the process by which small changes in mood reactivate cognitive patterns that were present during past episodes of depression but became hidden when mood returned to normal (Ingram, Miranda, & Segal, 1998). Research shows that the ease with which depressive thinking is triggered by a negative mood induction is related to risk of recurrence of depression (Segal, Gemar, & Williams, 1999). The pattern of thoughts, emotions, body states, and behaviors activated during depressive episodes together constitutes a whole *mode* of mind. We suggest that recovered suicidal patients, like people suffering recurrent depression, experience cognitive reactivity (Lau, Segal, & Williams, 2004). In these people the suicidal mode of mind is reactivated by relatively mild, normal deteriorations in mood. The person's mind rapidly becomes dominated by the type of suicidal cognitions described by Rudd, Joiner, and Rajab, (2001): "I am a burden to my family"; "I can never be forgiven for the mistakes I have made"; "Suicide is my only option to solve my problems"; and "When I get this upset, it is unbearable."

Recent evidence suggests that cognitive reactivity may indeed be present in suicidal patients. Williams, Barnhofer, Crane, and Beck (2005) compared previously depressed people, with and without a history of suicidal ideation when depressed, to a group of never-depressed control subjects. In normal mood, all three groups showed the same level of problem-solving performance. After a negative mood induction, however, the previously suicidal group showed a marked deterioration in problem-solving effectiveness, which was apparent neither in the nonsuicidal previously depressed people nor in the control subjects. This finding is important because it suggests that people who have been suicidal may retain a vulnerability to suicidality, which only becomes observable when mood is low.

The reactivity pattern seen in previously suicidal patients may reflect rapid, automatic activation of the suicidal mode of mind, which is not recognized until it is too late. If so, treatment addressing suicidal reactivity would target precisely those who are at higher risk of relapse (those in whom reactivity is more easily initiated).

How might MBCT achieve this? MBCT is carried out in a class format (rather than a therapy group) with an instructor, rather than a therapist. Through intensive training in meditative disciplines over eight weekly classes and through home practice, participants' awareness of internal experience (thoughts, feelings, and body sensations) is enhanced. This awareness facilitates a move from automatic to conscious processing and creates the space to make choices: "Ah! What's going on here? What is this? Do I recognize this? Is it an old tape playing? Do I need to engage with it? Can I just stay with it, notice what it does, and watch it as it passes and dissolves?" Thus participants *develop a different relationship* with the thoughts, feelings, and body sensations that would normally form a toxic spiral, deepening hopelessness and the sense of entrapment and opening the way to another suicidal crisis. This change may be particularly relevant for patients whose suicidal thinking quickly evaporates once a crisis is over. With such patients, traditional cognitive therapy can be difficult to carry out because, when the patient is well, access to unhelpful thinking that contributes to the buildup of the crisis is limited. MBCT is specifically designed for people in recovery, rather than in an acute state of crisis. The necessary practice in changing the relationship to subjective experience can proceed with *any* thoughts, feelings, or sensations that arise during the meditation practice, and not only negative thoughts or those most closely tied to suicidal behavior.

To illustrate how MBCT might work in real life, let us consider the case of Maria. Details of the case have been changed to preserve confidentiality.

### Case Illustration

#### *The Client*

Maria, aged 35, was living with her partner and daughter (age 7). Maria worked as a secretary. She wanted to do something more creative and independent but lacked confidence and had low self-esteem.

Maria regularly used drugs and alcohol. She did not normally take drugs in the home and attempted to control her drinking for the sake of her daughter but had had several drinking binges before the start of the MBCT course. She was feeling increasing frustration and hopelessness about changing her life and improving her stormy relationship with her partner. She reported recurrent crises during which her thoughts whirled around and around in her head. She felt that life was not worth living, she was a complete failure, there was no point going on, she was in a black hole, and she wanted to die. She had attempted suicide once, by overdose, 7 years ago.

Maria described a family environment devoid of love and affection. She began experiencing periodic downs during adolescence and started drinking alcohol, and later using drugs, to blot out painful thoughts and numb her feelings. She had managed periods of sustained abstinence in the past and said that she would like to stop taking drugs completely but would prefer to continue social drinking.

#### *Case Formulation*

If we had been doing cognitive therapy, treatment would have been guided by a shared formulation of the factors contributing to the development and maintenance of the client's

presenting problems (beliefs, assumptions, negative automatic thoughts, associated emotions and behavior, aspects of the interpersonal environment). Formulation is a dynamic process, which continues to evolve, through dialogue and observation, as treatment progresses and new information comes to light. It relies for accuracy and utility on trust and open communication between therapist and patient. Therapy sessions create a secure space in which these can safely develop.

In MBCT, opportunities to develop an elaborated individual formulation are largely lacking. In the initial precourse interview, the instructor aims primarily to identify problem areas for which MBCT might be helpful; the process usually results in a rough map of the territory. The interview typically elicits brief information about personal history, about the onset and development of problems, about current circumstances, symptoms, and state. In this process, exploratory questions may approximate to a cognitive case formulation, but the level of detail about elements, sequences, and connections is necessarily limited. Once classes begin, the focus of discussion is quite deliberately not on talking about problems, but on sharing and reflecting on participants' experiences of the meditation practices and other tasks. The atmosphere is one of a course or classroom, of shared learning and skills acquisition, and not of a therapy group.

Correspondingly, the nature of the relationship of instructor and participant is somewhat different from that of therapist and patient in cognitive therapy. The key difference is in the degree of personal contact once the initial interview is completed. Further one-to-one contact is not an integral part of the course, and the degree of communication varies widely according to participants' willingness to speak openly about their experiences in the classes. That said, the classic features of the psychotherapeutic relationship are firmly present (empathy, warmth, genuineness), and there is a sense of friendly, respectful collaboration, which is entirely consistent with the relationship at the heart of cognitive therapy. As one participant said, "You equalized it; it felt we were all in it together." This sense of common endeavor is fostered by instructors' having their own personal meditation practice, and thus having direct personal knowledge of the difficulties and the potential benefits.

A clearer sense of the cognitive and behavioral factors that have led to the development and persistence of problems may emerge from participants' comments and reflections in class. For example, a participant may mention being troubled by painful childhood memories or describe a habit of worrying, or his or her reactions to self-help assignments may make it clear that he or she is a perfectionist, or highly self-critical, or prone to expect the worst and engage in evasive action (safety behaviors). But such insights are by no means certain and indeed participants are not obliged to speak in classes.

Returning to Maria, during the preclass interview with the instructor a number of issues to which MBCT might be relevant were identified:

- The recurrent, automatic spiral of depression, hopelessness, and sense of failure, which tended to be well established before Maria was able to recognize its presence (MBCT might help her to become more aware of early warning signals)
- Suicidal thoughts, from which she was unable to distance herself (MBCT might help her experience them simply as thoughts, part of a passing mind state)
- A habit of self-criticism and self-judgment, which worsened when her mood was low (as opposed to the stance of allowing, self-acceptance, and compassion encouraged by MBCT)
- Flight to alcohol when she experienced painful thoughts and feelings (MBCT might help her to stand at a distance from them, recognizing them as fleeting events, so that avoidance and suppression are no longer necessary)

- Difficulty facing decisions she needed to make about her life (the meditation might create a space where she could make healthy decisions about how she would prefer things to be)

### *The Training*

Table 1 summarizes the practices used in MBCT (details of how to obtain the CDs and other materials used in MBCT in Oxford are available from the Oxford Cognitive Therapy Centre; [www.octc.co.uk](http://www.octc.co.uk)). Mindfulness training teaches a way of *being* rather than of *doing*, allowing participants to step back from automatic behaviors and habitual thought patterns. A common misconception early on is that *being mode* is incompatible with getting things done in everyday life. Rather, the invitation is to incorporate mindful awareness into daily activities, so that people learn to extend awareness and a more spacious perspective to *whatever* they are doing.

Developing the ability to move out of an automatic, *doing* processing style is a fundamental part of mindfulness teaching. Patients entering treatment are often unaware of how much time they spend “away” from the present moment with their mind elsewhere. When asked to bring awareness to eating a single raisin (see Table 1), Maria found that within seconds her mind took her back to eating dinner at school as a child. Demonstrating this tendency to be lost in thought is one of the first teachings of MBCT. Maria was surprised at how easily she had slipped, without noticing, away from direct sensory experience of the raisin.

Increasing ability to rest within the present moment requires training in concentration and sustained attention. Patients are taught to ground themselves in the moment as a starting point, for example, by paying attention to the movement of the breath or to body sensations. The body and the breath are constantly present, and the mind can return to them whenever awareness is lost. Participants in the classes discover that they cannot be fully aware of body sensations or the breath from moment to moment, if their mind has wandered off to another place or time.

The body scan practice is designed to increase patients’ ability repeatedly to engage, sustain, and then disengage attention. Participants move a focused spotlight of attention from one part of the body to another, as if they could “breathe in” to each location and explore sensations in depth *just as they are* before letting go and moving on. Participants are encouraged to approach whatever sensations arise with an attitude of kindness, open curiosity, and nonjudgment. When the mind wanders, they are invited simply to notice where it has gone and gently to shift attention back to the body.

During the first body scan, Maria experienced strong bodily sensations, which made it difficult for her to follow the instructions. In fact, she felt a strong desire to stop the practice altogether. However, because she was in a class with others, she managed to continue until the end, by which point the sensations had subsided to some degree. Noticing the ease with which body sensations are judged and labeled, as well as the tendency to avoid unpleasant sensations, is often an important aspect of the body scan. Labeling internal states as aversive or threatening, combined with a desire to escape, can contribute to the escalation of suicidal crises. By staying with the body scan, Maria had an opportunity to notice how her experience changed from moment to moment and to practice a different way of responding to intense, uncomfortable sensations.

Another common observation arising from meditation practice in class and at home is how frequently participants judge themselves and their performance and want conditions to be different from how they actually are. Developing nonjudgmental awareness of

thoughts, body sensations, and physical stimuli (sights, sounds) facilitates adoption of this same nonjudgmental attitude when responding to negative thoughts, for example, about the self. Training in awareness of thoughts occurs later in the program, during sitting meditations. Participants develop their ability to see thoughts as mental events that pass through the mind, rather than as facts or central parts of their identity. For example, one exercise involves imagining thoughts that arise during sitting meditation as passing images on a cinema screen or as leaves floating past on a river. When Maria used this technique, she was surprised to discover that sustained but decentered attention to the thoughts caused them to lose their ability to provoke an emotional reaction. She found that many thoughts disappeared altogether as she watched them come and go and was keen to experiment with this technique in other situations. Her attitude to her thoughts changed from fear and sadness to investigative curiosity.

Responding to negative thoughts about the self with kindness and acceptance allows participants to let go of maladaptive, ruminative thinking patterns. Maria found it particularly helpful to use awareness of the body as an alternative to becoming entangled in her thoughts. In the past, she had tried to analyze them or push them away, but now she was able to attend to them without getting sucked in.

### *Outcome and Prognosis*

At session eight, all participants completed a questionnaire describing their reactions to MBCT (in addition to other questionnaires measuring different aspects of well-being). Maria wrote:

Before, when my daughter was difficult and had tantrums, I would get really angry and feel unable to manage her bad behavior. I would end up shouting at her, and only making matters worse. I felt really guilty. Recently though, when she's had a tantrum I've been more able to accept her behavior and not see it as a reflection of my capabilities as a mother. I have noticed my tendency to react in an angry way and the last time she had a tantrum I was able to step back from my feelings. I found that the feelings weren't so overwhelming and because I didn't make the situation worse we got back to normal more quickly.

These comments reflect a shift in Maria's tendency to react automatically to her daughter's behavior with anger and self-blame. This shift allows her to interrupt the downward spiral in her mood. She gave another example of this change, when she went to a local community meeting only to find it had been cancelled. Normally this event would have created an intense emotional reaction, but this time (after an initial, immediate wash of anger and despair) Maria was able to tune into how she was feeling and to avoid getting caught up in old patterns. At the end of the course Maria had reduced her intake of alcohol and drugs. She had become aware of how much time she spent on automatic pilot. She had learned to recognize when she wanted to take action on a problem, while being able to accept matters as they were in the present moment without becoming frustrated. This included being aware that there were aspects of herself that she would like to change, but without the harsh self-criticism that had previously been present. She now felt more able to take skillful action to solve her problems. Maria described the course as extremely important to her; indeed, she described it as "a life-changing experience."

Is it possible to quantify the kind of changes Maria reported—and are similar changes seen in other people? The Mindful Attention and Awareness scale (MAAS; Brown & Ryan, 2003) is a self-report questionnaire designed to measure a person's level of mindfulness. We cannot yet conclude that a change in MAAS scores is linked to changes in

suicidal reactivity (an exploratory trial in Oxford currently underway will explore this possibility), but the MAAS is a useful tool to test whether the increase in mindfulness seen in Maria (from a score of 35 to 56) can be generalized to other participants. Results from a pilot class suggest that this may be the case. Although the numbers are small ( $n = 16$ ), there was a statistically significant increase in participants' scores from the start of the course ( $M = 50.70$ ,  $SD = 12.14$ ) to the end of the course ( $M = 61.63$ ,  $SD = 9.39$ ,  $t = 5.87$ ,  $p < .01$ ).

These findings, together with Maria's comments and previous work on cognitive reactivity in depression, suggest that MBCT is a useful tool in the treatment of people who have experienced suicidality in the past, helping them to acquire skills that will enable them to respond more skillfully in times of impending crisis. Further work, including the current trial, will provide a more controlled means of assessing this hypothesis.

### Clinical Issues and Summary

Through experience with pilot courses, we have become aware of issues that may need particular attention with potentially suicidal patients and that should perhaps lead to shifts in emphasis in established MBCT. In particular:

- Increased emphasis on careful identification of relapse signatures and creation of action plans to short circuit the beginnings of suicidal crises.
- Given suicidal risk, the importance of ensuring that participants have a clear sense of whom they can contact in the event that they recognize that a crisis is building and they need help and support over and above the classes. MBCT instructors are *instructors*, not psychotherapists. MBCT is currently viewed as an approach to help people stay well, rather than an acute treatment.
- Increased emphasis is given to externally focused mindfulness practices, so that patients overwhelmed by intense affect and powerful negative thoughts during crises have an extended repertoire of grounding meditations that help them to focus on moment-by-moment awareness of the physical world around them.
- At first, we were concerned about the wisdom of explicitly introducing examples of suicidal cognitions into classes, for fear of "giving people ideas." In fact, the reaction was positive: a sense of recognition and shared experience that produced a real energy and engagement among participants. It seemed that "inviting the monsters in to tea" (as one participant put it) was a helpful and transformative thing to do. By doing so, we see the monsters more clearly and discover that they do not need to dominate our life and determine our actions to such a degree.

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