The third wave of CBT

ACT, MBCT, CFT and metacognitive therapy: what they are, where Steven Hayes fits in, what the evidence shows and why the word "wave" is disputed

DRAFT this text has not yet been approved by the author and may change.

18 chapters ~53 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **The third wave changes your relationship to thoughts, not their content.** The second, cognitive wave asked: "Is this thought true?" The third asks: "What is this thought doing to you, and does it help you live the way you care about?" Its tools are acceptance, defusion from thoughts, mindfulness, values, self-compassion and work on metacognition, meaning thinking about your own thinking.
- **Steven Hayes put the term "third wave" into circulation in 2004.** Hayes created ACT, Acceptance and Commitment Therapy. By his own account, the road to it began with the panic disorder he developed in the late 1970s.
- **The evidence varies a lot from one approach to another.** MBCT reliably lowers the risk of depression coming back in people with recurrent episodes. ACT helps with many problems, but the data show it is comparable to classic CBT, not better. CFT and metacognitive therapy look promising, but there are few trials, or most come from the method's own developers.
- **The third wave grew out of an awkward finding.** In a 1996 trial, behavioural activation alone helped with depression as much as full cognitive therapy, and changed negative thinking just as much. Thoughts changed without anyone working on thoughts.
- **Mindfulness is not relaxation, and meditation is not harmless.** In 8-week mindfulness programmes, 6% of participants had impaired functioning lasting more than a month. Metacognitive therapy itself grew out of a case where relaxation triggered panic attacks.
- **Acceptance is not resignation.** ACT asks you to accept inner experiences (anxiety, sadness, unwanted thoughts), not bad circumstances, and to do it for the sake of action: the second half of the name is "commitment".
- **The debate about "waves" has no honest winner.** Critics called it "old hat" rather than a new wave. In 2017 Hayes and his main opponent, Stefan Hofmann, wrote together that the wave metaphor had been misleading, and proposed a future without therapy "brands": process-based therapy.

Timeline: the third wave over 45 years

From Hayes's first panic attack to clinical guidelines. Details and sources are in the chapters below.

1978 — 29-year-old Steven Hayes has his first panic attack at a department meeting
THIRD WAVE

1981 — Hayes writes the first manual for "comprehensive distancing", the future ACT
THIRD WAVE

1982 — Kabat-Zinn publishes results of a mindfulness meditation programme for chronic pain patients
THIRD WAVE

1985 — First full presentation of relational frame theory (RFT)
THIRD WAVE

1990 — Wells describes a patient whose panic was triggered by relaxation; attention training begins
THIRD WAVE

1990–1991 — Hayes's approach gets the name ACT
THIRD WAVE

1993 — Linehan publishes the DBT manual
THIRD WAVE

1996 — Jacobson's component analysis: behavioural activation alone is no worse than full cognitive therapy
EVIDENCE

1999 — Hayes, Strosahl and Wilson's book on ACT
THIRD WAVE

2000 — First randomised trial of MBCT
EVIDENCE

2004 — Hayes's paper on the "third wave"
THIRD WAVE

2006 — TIME: "The third wave of therapy", and accusations of a "cult"
THIRD WAVE

2008 — Öst's meta-analysis and Hofmann and Asmundson's "New wave or old hat?"
EVIDENCE

2009 Gilbert describes compassion-focused therapy (CFT)
THIRD WAVE

2014 Öst's updated meta-analysis: ACT's effect is smaller than it looked
EVIDENCE

2015 The PREVENT trial: MBCT versus maintenance antidepressants
EVIDENCE

2016 Individual patient data meta-analysis: MBCT lowers the risk of depressive relapse
EVIDENCE

2017 Hayes and Hofmann together: the "wave" metaphor was misleading
THIRD WAVE

2020 Review of 20 ACT meta-analyses; trial of metacognitive therapy versus CBT; review of meditation adverse events
EVIDENCE

2021 Britton and colleagues: adverse effects in 8-week mindfulness programmes
EVIDENCE

2022 The UK's NICE depression guideline includes MBCT-type mindfulness programmes
EVIDENCE

Dates follow the sources in the chapters below. The split into lines is a convenience: the very idea of a "third wave" is disputed, and a whole chapter is devoted to that.

How to read these notes: evidence labels

Every claim carries a label that tells you how solid it is.

The label comes first in brackets, followed by the source. **Proven by research** means randomised trials (participants are assigned to groups by chance and compared) or meta-analyses (studies that pool many trials). **Clinical consensus** means clinical guidelines, such as the UK's NICE. **The author's own account** is what Hayes or a method's founder says; it has not been independently checked. **Interpretation** is a reading of the facts, or a point still under debate. **Documented fact** covers dates, publications and institutions. **Not verified** means we could not open the primary source. Where sources disagree, both versions are given. Many figures about therapies come from abstracts (short summaries) of papers; where that is the case, the source says so.

Important This is education, not therapy or diagnosis. Techniques are described as they are used in therapy, not as a replacement for it. These notes mention panic attacks, severe reactions to meditation and thoughts of self-harm. If you need support now, see If you need help now.

Before the third wave, and why something new was needed

The first two waves changed behaviour and the content of thoughts. A surprising result in 1996 raised the question: what actually makes cognitive therapy work?

Two waves in a minute

The history of CBT (cognitive behavioural therapy) is often told as three waves; the first two are covered in detail in Episode 1.

The first, behavioural wave (1950s–1960s). Its question: what does the person do? Fears and habits are learned, so they can be unlearned. Afraid of lifts? You start riding them, step by step.

The second, cognitive wave (from the 1960s–1970s). Its question: is this thought true? Aaron Beck and Albert Ellis showed that feelings depend heavily on how a person interprets an event. The thought "I'll suffocate in the lift" can be tested like a hypothesis: what is the evidence for and against?

The third wave (from the 1990s). Its question: what is this thought doing to you? The thought "I'll suffocate" may stay, but it no longer decides whether you step into the lift. This is how Hayes and Hofmann themselves describe it: the emphasis moved from the content of thoughts and emotions to the person's relationship with them (authors' interpretation; Hayes & Hofmann, 2017).

Wave	What changes	Key question	Example
1st, behavioural	Behaviour: exposure, reinforcement	What does the person do?	Gradually riding the lift
2nd, cognitive	The content of thoughts: testing, reappraisal	Is this thought true?	"What's the evidence I'll suffocate?"
3rd	Relationship to thoughts and feelings	What is the thought doing to you, and does it help you live as you care about?	"I'm having the thought that I'll suffocate" — and stepping in

The table is our simplification, based on Hayes & Hofmann (2017); dates are approximate.

An awkward result: thoughts changed without working on thoughts

In 1996 psychologist Neil Jacobson and colleagues took cognitive therapy for depression apart. They randomly assigned 150 outpatients with major depression to three groups **documented fact; Jacobson et al., 1996**:

1. **Behavioural activation** only: getting back to activities that bring pleasure and meaning, and working on avoidance.
2. Activation plus work on **automatic thoughts**, the quick judgements that pop up on their own ("I can't do anything").
3. Beck's **full cognitive therapy**, including work on core beliefs.

The full therapy did no better than either stripped-down version, either at the end of treatment or six months later. And activation alone changed negative thinking as much as the full therapy did **proven by research; Jacobson et al., 1996**.

In plain terms: people whose thoughts were barely discussed still ended up thinking differently. So what exactly is doing the work in cognitive therapy? Hayes later described the third wave as growing out of "anomalies" like this in the data, together with philosophical shifts **the author's own account; Hayes, 2004**. Behavioural activation is covered in Episodes 6 and 7.

Meditation enters medicine

Meanwhile, contemplative practices were finding their way into medicine. In 1982 Jon Kabat-Zinn published results of a 10-week programme based on mindfulness meditation for 51 chronic pain patients who had not improved with usual care: 65% had their pain reduced by at least a third. The study was uncontrolled, with no comparison group, so the result was preliminary documented fact; Kabat-Zinn, 1982. That programme later became MBSR, mindfulness-based stress reduction, and then fed into MBCT.

> Myth vs fact **Myth:** the third wave is Buddhist therapy. **Fact:** ACT's roots are in Skinnerian behaviour analysis documented fact; Zettle, 2005. Meditation practices came into MBCT through Kabat-Zinn's programme, and in CFT they are one of several sources alongside evolutionary psychology and attachment theory the author's own account; Gilbert, 2009.

Chapter sources: Jacobson et al., 1996 · Hayes, 2004 · Hayes & Hofmann, 2017 · Kabat-Zinn, 1982 · Zettle, 2005 · Gilbert, 2009

Steven Hayes: the psychologist who couldn't speak

The founder of ACT and author of the "third wave" label went through panic disorder himself. This is his own account, not evidence for the method.

Steven Hayes was born in 1948 documented fact; Wikipedia. He trained in clinical psychology at West Virginia University (PhD, 1977), worked at the University of North Carolina at Greensboro and, from 1986, at the University of Nevada, Reno, where he is now a professor emeritus in the behaviour analysis programme documented fact; Hayes, CV; University of Nevada, Reno. By training and school he is a behaviour analyst, a first-wave man.

The department meeting, 1978

According to TIME, in 1978 Hayes, then a 29-year-old assistant professor, tried to speak at a department meeting and couldn't: his mouth "could only open and close wordlessly, as though it were a broken toy" documented fact, journalist's image; Cloud, TIME, 2006. It was his first panic attack.

A panic attack is a sudden surge of intense fear with physical symptoms: a racing heart, breathlessness, trembling, a sense that you are dying or going mad. When attacks keep coming and a person starts living in fear of the next one, it is called panic disorder (more in Episode 8).

From there, by his account, he did what nearly everyone does: he ran from anxiety, fought it and hid from it, sat next to the door, took tranquillisers. The attacks became more frequent and spread to more of his life: work, travel, restaurants, lifts, phone calls the author's own account; Hayes, TEDx, 2016. According to TIME, by 1980 he could lecture only with great difficulty documented fact; Cloud, 2006. In a 2019 interview he summed up the lesson: the more he tried to escape his anxiety, the stronger it grew the author's own account; Clarke, The Star, 2019.

The night on the carpet

Hayes told his best-known story on the TEDx stage in 2016. At around two in the morning he was lying on a brown and gold shag carpet, convinced he was dying of a heart attack: pressure in his chest, pain in his arm, a pounding heart. Part of his mind demanded that he call an ambulance. Instead he imagined a doctor at the hospital telling him: you're having a panic attack. Then he spoke to his fear and made himself a promise: "Never again. I will not run from me" the author's own account; Hayes, TEDx, 2016. How to keep that promise, and how to teach it to others, he says he did not yet know; that came later, through years of work the author's own account; Hayes, TEDx, 2016.

The year of that night is not given in open sources, so we don't name it. He says that by then he had been spiralling into panic disorder for two to three years the author's own account; Hayes, TEDx, 2016.

Important Chest pain, a racing heart and a numb arm can come with a panic attack and with heart disease. If you are not sure what is happening, the right step is to see a doctor or call emergency services. Hayes's story does not mean such symptoms can go unchecked.

In a 2019 interview Hayes said: "It was one of the great blessings in my life that I developed a panic disorder" **the author's own account; Clarke, The Star, 2019**. He is not claiming that panic is good. In his telling, it was what pushed him to look for another way.

An important caveat: one person's vivid story, told decades later, is not evidence that a method works. It is a story about where the method came from. The evidence follows in later chapters, and it is more complicated.

What he means to the field

- Co-founder of ACT with Kirk Strosahl and Kelly Wilson; their book came out in 1999 **documented fact; Zettle, 2005**.
- Co-author of relational frame theory (RFT) **documented fact; Hayes, Barnes-Holmes & Roche, 2001**.
- Author of the "third wave" framing **documented fact; Hayes, 2004**.
- One of the founders of contextual behavioural science and of the Association for Contextual Behavioral Science (ACBS) **documented fact; Hayes, CV**.
- In 1992 the Institute for Scientific Information (ISI) ranked him the 30th highest-impact psychologist in the world for 1986–1990 **documented fact; Hayes, CV; Wikipedia**.

The 2022 episode

In 2022 past presidents of the Association for Behavioral and Cognitive Therapies (ABCT) apologised for the field's past support of "conversion therapy" for homosexuality, and Hayes signed the statement. According to Inside Higher Ed, his own involvement was limited to a single case from his internship, written up in a 1983 publication. He said the work fit the treatment standards of the time, but publicly called the case morally wrong and asked the journal's editor whether the paper could be retracted **documented fact; Flaherty, Inside Higher Ed, 2022**.

Chapter sources: Cloud, TIME, 2006 · Hayes, TEDx, 2016 · Clarke, The Star, 2019 · Hayes, CV · University of Nevada, Reno · Zettle, 2005 · Flaherty, Inside Higher Ed, 2022 · Wikipedia: Steven C. Hayes

Why a thought can't be deleted: relational frame theory

Hayes spent about fifteen years building a theory of language. Its practical upshot: connections in the mind can be added to, but not erased.

Hayes kept asking: why do words affect us so strongly? Why does the thought "I'll fail" raise your pulse when nothing has failed? His answer was **relational frame theory** (RFT), a behavioural theory of language and thinking. Hayes and Brownstein gave the first full presentation of it in 1985; the theory was developed over roughly fifteen years, came out as a book in 2001 and became the theoretical basis of ACT **documented fact; Zettle, 2005; Hayes, Barnes-Holmes & Roche, 2001**.

The idea in plain words

People can link things through relations that are not in the things themselves (the theory's authors' account; ACBS, RFT Basics):

- **Two-way links.** If you are taught that "gato" means cat, you work out by yourself that cat means "gato". Nobody taught you the reverse.
- **Combined links.** If A is bigger than B and B is bigger than C, you work out that A is bigger than C and C is smaller than A.

- **Transfer of properties.** Through these links, a word starts to "carry" properties of what it stands for.

An everyday example (our example). A student has had several gruelling exams. Now, on a Sunday evening, the word "exam" in the group chat is enough to raise anxiety, even though the exam is a week away and nothing is happening right now. The anxiety arrived through a word.

The practical upshot: no delete button

On this logic, a learned link cannot be erased; you can only add new ones. Hayes puts it this way: "there is no delete button in the human nervous system" **the author's own account; Clarke, The Star, 2019**. If a thought cannot be deleted, maybe there is no need to fight it. Maybe what should change is not the thought itself but the power it has over what you do. That is how a theory of language turned into a therapy.

According to Hayes, RFT explains why two processes are so common and so harmful **the author's own account; Hayes, 2004**:

- **Cognitive fusion**: a thought is taken as reality and runs your behaviour. "I'm a failure" sounds like a fact, so the CV never gets sent.
- **Experiential avoidance**: trying to suppress, change or dodge unpleasant thoughts, feelings and sensations. For example, not opening letters from the bank to avoid feeling anxious.

What is debated about RFT

Behaviour analysts argue about whether a new theory is needed beyond Skinner's work on verbal behaviour, how testable it is, and whether it explains the data or only describes them (interpretation; Gross & Fox, 2009, a review of the debate that we could not open — not verified).

Chapter sources: Zettle, 2005 · ACBS, RFT Basics · Hayes, 2004 · Clarke, The Star, 2019 · Hayes, Barnes-Holmes & Roche, 2001 · Gross & Fox, 2009

ACT: psychological flexibility and the six processes

ACT doesn't teach you to get rid of unpleasant thoughts. It teaches you to stop spending your life at war with them and spend it on what matters.

From distancing to ACT

Hayes wrote the first manual for his approach in 1981, when it was called "comprehensive distancing". In his 1984 dissertation, Hayes's first graduate student Robert Zettle compared distancing with cognitive therapy for outpatient depression and found it did at least as well; it was a small study **documented fact; Zettle, 2005**. Around 1990–1991 the approach was renamed: "distancing" had dissociative connotations, and the authors wanted to set the method clearly apart from cognitive therapy **documented fact; Zettle, 2005**. That is how the name **Acceptance and Commitment Therapy, ACT**, came about. The first full book appeared in 1999.

> Myth vs fact **Myth:** ACT appeared in 1999 as a trendy novelty. **Fact:** 1999 is when the first book came out; work on the approach had been going on since the late 1970s, and the first manual dates from 1981 **documented fact; Zettle, 2005**.

Psychological flexibility

The core concept of ACT is **psychological flexibility**: the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends (method authors' account; ACBS, The six core processes of ACT). Its opposite is psychological inflexibility, where behaviour is run by

thoughts, feelings and the urge to avoid them. For example, someone who has turned down meeting friends for years so as not to feel nervous.

The six processes (the hexaflex)

Flexibility is broken down into six processes, drawn as a hexagon known as the **hexaflex**. Definitions follow ACBS (method authors' account; ACBS, The six core processes of ACT); the examples are ours.

Process	What it is	Everyday example
Acceptance	Letting inner experiences be, without fighting or avoiding them	Before a talk you feel anxious; you notice your hands shaking and walk on stage anyway, without wasting energy on "calm down right now"
Defusion	Changing your relationship to a thought rather than the thought itself, so it has less power over behaviour	Instead of "I'm worthless": "I'm having the thought that I'm worthless"
Contact with the present moment	Noticing what is happening now, inside and around you, without judging	At dinner, noticing the taste of the food and your child's voice instead of rehearsing tomorrow's meeting
Self as context	Experiencing yourself as the one who notices experiences, not as the experiences	"I am the one noticing the anxiety, not the anxiety itself"
Values	Chosen qualities of action; a direction, not a goal you can tick off	"Being attentive to the people I love" is a value; "calling Mum on Sunday" is a goal
Committed action	Ever larger steps in the chosen direction	Fifteen phone-free minutes with your child each evening, even when tired

The six processes are often grouped into three pairs: **open** (acceptance and defusion), **aware** (present moment and self as context) and **active** (values and committed action) (interpretation; after the title of Hayes et al., 2011, "Open, aware, and active").

How defusion differs from working with thoughts in CBT

In classic CBT the thought is tested: "What is the evidence that I'm worthless?" and a more accurate wording is sought (Episode 5). ACT doesn't debate whether the thought is true. The thought may stay, but you stop following its "orders". These are two different tools, not a right one and a wrong one: the CBT approach works well when a thought can be checked against facts; defusion helps when arguing with a thought turns into endless rumination.

Myth vs fact **Myth:** acceptance means resignation: putting up with things and doing nothing. **Fact:** in ACT you accept inner experiences — thoughts, feelings, sensations — and you do it in order to act on your values; the second half of the therapy's name is "commitment" (method authors' account; ACBS). ACT does not ask anyone to accept dangerous or unjust circumstances, such as abuse.

What it looks like in therapy

Work typically goes like this (interpretation; a composite of the ACT model, protocol details not checked against manuals): therapist and client look at what the person has already tried in order to get rid of unpleasant experiences, and what it has cost; they notice that the strategy "first I'll get rid of the anxiety, then I'll start living" isn't working; they practise defusion and acceptance; they clarify values across areas of life and plan concrete steps. A typical trap is

using acceptance as a clever way to get rid of anxiety after all ("I'll accept it and it will go away"); by the model's logic, that is just more struggle (interpretation).

In the evidence-based treatments registry of the American Psychological Association's clinical psychology division (Division 12), the ACT protocol for chronic pain runs about 8 sessions **documented fact; Society of Clinical Psychology**. The WHO distributes an illustrated ACT-based self-help guide, "Doing What Matters in Times of Stress" **documented fact; WHO**.

CBT and ACT for chronic pain

Pain is called chronic when it lasts more than three months **clinical consensus; NICE NG193, 2021, via PharmaFile**. Psychological therapy doesn't "remove" the pain here, and it doesn't imply the pain is "all in the head". Its job is to make pain run less of your life: less suffering and restriction, more of your usual activities.

What the data show. A 2020 Cochrane review pooled 75 randomised trials (9,401 participants) in adults with chronic pain other than headache **proven by research; Williams et al., 2020**:

CBT compared with	Pain	Disability	Distress
Treatment as usual	−0.22 — small effect	−0.32	−0.34
Active control	−0.09 — very small	−0.12	−0.09

Against treatment as usual, effects were largely maintained at 6–12 months; against active controls they were not. Only 5 ACT trials were included (443 people), with very low certainty: the authors can't say with confidence whether ACT helps more than the comparison **proven by research; Williams et al., 2020**. In 2014, Öst rated ACT as "probably efficacious" for chronic pain **proven by research; Öst, 2014**.

The UK's NICE guidelines (2021) for chronic primary pain — pain that no other condition adequately accounts for — list CBT and ACT among the options, alongside exercise programmes and acupuncture; among medicines, certain antidepressants can be considered for new patients. NICE advises against starting paracetamol, anti-inflammatories, benzodiazepines or opioids: there is little or no benefit for quality of life, pain or distress, and there is a risk of harm **clinical consensus; NICE NG193, 2021, via NHS Medicines Resources and PharmaFile**. People already taking these medicines shouldn't stop them on their own: that is decided with a doctor.

Realistic expectations (interpretation; based on Williams et al., 2020): after CBT the pain itself usually eases only a little; distress and day-to-day disability change a little more. A good outcome is not "zero pain" but a life in which pain takes up less room. The cause of the pain and its medical treatment are for a doctor to determine.

Cult or science?

In 2006 TIME ran a piece titled "The third wave of therapy". By then, according to the magazine, roughly 12,000 students and professionals had been trained in ACT. The same article carried sharp criticism: psychologist Michael Spiegler called some of what surrounded Hayes "cultlike", Robert Leahy said Hayes's language theory sounded less like a science than a frame of reference for a new religion, and his workshops were compared with the faddish est seminars of the 1970s **documented fact; Cloud, TIME, 2006**. Hayes replied on the association's website: "It is not a cult. There is no forced agreement" **the author's own account; ACBS, 2006**.

One detail that speaks for openness: there is no ACT certification. ACBS says plainly that there is no ACT certification process, and explains that it chose not to create one because it could produce a hierarchical, closed process; membership dues can be paid on a values-based basis **documented fact; ACBS, ACT certification; ACBS, cost of training**. The other side (interpretation): a charismatic founder, a distinctive vocabulary and emotionally intense trainings really can breed uncritical enthusiasm. And the absence of certification means the label "ACT therapist" guarantees nothing by itself: check a practitioner's core qualification and training.

Chapter sources: Zettle, 2005 · ACBS, The six core processes of ACT · Hayes et al., 2006 · Hayes et al., 2011 · Society of Clinical Psychology: ACT for chronic pain · Williams et al., 2020 · NICE NG193, 2021 · Öst, 2014 · WHO, Doing What Matters · Cloud, TIME, 2006 · ACBS: Steve's reactions to the Time article · ACBS: ACT certification · ACBS: cost of training

MBCT: why depression comes back

MBCT has the strongest data in the third wave — for one specific job: keeping depression from returning in people who are already better.

The idea

While Hayes was coming from behaviour analysis, John Teasdale, Zindel Segal and Mark Williams reached a similar place from another direction. Their question was practical: why does depression come back so often?

Their answer (method authors' account; Teasdale et al., 2000): in someone who has been depressed, even a small dip in mood can reactivate a familiar style of thinking — "something's wrong with me", "here it goes again". That pulls them into **rumination**, going over the same thoughts again and again, and from there into a new episode.

An everyday example (our example). A woman who had severe depression two years ago sleeps badly for two nights. In the morning she is tired, and straight away: "It's starting again, I won't cope this time." An hour later she is going through every past failure. A thought set off by tiredness is dragging her mood down.

What MBCT does

MBCT (mindfulness-based cognitive therapy) combines ideas from Beck's cognitive therapy for depression with elements of Kabat-Zinn's programme **documented fact; Teasdale et al., 2000**. Its key ideas (method authors' account; Teasdale et al., 2000):

- **Decentring**: seeing thoughts as events in the mind rather than truths about yourself. "This is a thought about failure, not a failure."
- **Stepping out of autopilot**: noticing when the mind is running on habit, like a driver who gets home and can't remember the route.
- **Early recognition**: spotting the first signs of a dip so the spiral can be stopped in time.

In the first trial the programme looked like this **documented fact; Teasdale et al., 2000**: an individual introductory session, then 8 weekly group sessions of 2 hours with up to 12 people, daily home practice, and 4 follow-up sessions in the months after.

What the research shows

- **First trial (2000).** 145 people who had recovered from recurrent depression. In those with three or more previous episodes (77% of participants), MBCT significantly reduced the risk of relapse over 60 weeks: 37% versus 66% with usual care among those who completed the programme; 40% versus 66% when all allocated participants were counted **proven by research; Teasdale et al., 2000**. In people with two episodes, MBCT did not reduce relapse; in that subgroup relapse was even higher with MBCT, 56% versus 31%, but the difference was not statistically significant **proven by research; Teasdale et al., 2000**.
- **Replication (2004)** in people with three or more episodes: 36% versus 78% **proven by research; Ma & Teasdale, 2004, from the abstract**.
- **Pooled analysis (2016).** Data from 1,258 patients in 9 trials: MBCT lowered the risk of relapse over 60 weeks compared with no MBCT (hazard ratio 0.69, roughly a third lower risk) and compared with active treatments (0.79). The number of previous episodes no longer made a difference to the effect **proven by research; Kuyken et al., 2016**.

So the question "who exactly is it for?" is still open: the first trial found an effect only with three or more episodes, while the large pooled analysis did not confirm that difference sources disagree; Teasdale et al., 2000; Kuyken et al., 2016.

MBCT and antidepressants

In the PREVENT trial (2015), 424 people with three or more episodes of depression who were taking antidepressants were split into two groups: MBCT with support to taper off medication, or staying on medication. Relapse: 44% and 47%, not a significant difference proven by research; Kuyken et al., 2015, from the NIHR summary. MBCT was neither worse nor better than medication.

> Myth vs fact **Myth:** MBCT replaces antidepressants. **Fact:** in PREVENT, MBCT with gradual tapering did about as well as staying on medication, not better (Kuyken et al., 2015). It is a reason to discuss options with a doctor, not a reason to stop taking tablets. Medication should only be stopped together with a doctor.

The UK's NICE guideline on depression (2022) lists group mindfulness programmes designed specifically for depression (such as MBCT) among treatment options, and for people at higher risk of relapse who don't want to continue antidepressants after recovery it suggests considering group CBT or MBCT clinical consensus; NICE, 2022, official "Preventing relapse" summary. The current guideline has no strict "three episodes or more" rule: among the factors for higher risk NICE lists recurrent episodes without giving a number clinical consensus; NICE, 2022, same summary. NICE also advises that groups be led preferably by two practitioners, at least one with specialist training clinical consensus; NICE, 2022.

The key limitation: MBCT was designed for people **in remission**, when the acute episode is over, as relapse prevention documented fact; Teasdale et al., 2000. It is not a treatment for acute severe depression. Depression treatment is covered in Episode 7.

Chapter sources: Teasdale et al., 2000 · Ma & Teasdale, 2004 · Kuyken et al., 2016 · Kuyken et al., 2015 · NICE, 2022

Mindfulness is not relaxation, and meditation is not harmless

The point of mindfulness is to notice, not to calm down. And for some people meditation brings severe reactions.

Many people think of mindfulness as a relaxation technique: close your eyes, breathe, feel calmer. MBCT's aim is different: to notice that you are on autopilot and to see a thought as a thought (method authors' account; Teasdale et al., 2000). Relaxation may happen, or it may not.

> Myth vs fact **Myth:** mindfulness is a way to relax. **Fact:** the aim is attention and a different relationship to experience (Teasdale et al., 2000). Metacognitive therapy grew out of a case where relaxation itself triggered panic attacks (Wells, 1990), and for some people meditation increases anxiety (Farias et al., 2020).

What we know about adverse effects

- **Britton et al. (2021).** 96 participants in three versions of 8-week mindfulness programmes. 58% reported at least one meditation-related adverse effect; for 37% these effects interfered with functioning; for 6%, impaired functioning lasted more than a month. When people were simply asked "were there any problems?", the rate was understated by roughly 70% proven by research; Britton et al., 2021, from the Brown University press release. The same source notes that fewer than 1% of nearly 7,000 meditation studies measured adverse effects at all.
- **Farias et al. (2020).** A review of 83 studies with 6,703 people. Adverse events affected 8.3% of practitioners on average: 3.7% in experimental studies and 33.2% in observational ones. The most common were anxiety,

depression and unusual cognitive experiences; severe reactions also occurred, including in people with no psychiatric history **proven by research; Farias et al., 2020**.

The gap between 3.7% and 33.2% shows how much the answer depends on how, and about what, people are asked.

What follows from this

This doesn't make meditation a harmful practice, but it is a powerful tool rather than neutral "relaxation" (interpretation). In good programmes the leader asks specifically about difficulties, and participants always have the right to open their eyes, stop, or shift attention to the sounds around them. If practice makes you feel worse, that's not you doing it "wrong": stop and tell the person leading it. In acute psychosis, severe depression, recent trauma or dissociation (feeling cut off from yourself or from reality), intensive meditation without a specialist is not appropriate (interpretation).

Chapter sources: Teasdale et al., 2000 · Wells, 1990 · Britton et al., 2021 · Farias et al., 2020

CFT: when the logic is there but the relief isn't

Compassion-focused therapy grew out of an observation: people with strong shame can find a sensible thought but feel no relief from it.

The observation

British psychologist Paul Gilbert describes a picture therapists know well: people high in shame and self-criticism learn to come up with "alternative thoughts" and can explain why they are not really failures, yet feel no better **the author's own account; Gilbert, 2009**. As one client he quotes put it, they understand the logic of the alternative thinking but it doesn't really help them feel much better. Behind this there are often histories of bullying, neglect or a lack of warmth **the author's own account; Gilbert, 2009**.

Three emotion regulation systems

Gilbert explains this in evolutionary terms **the author's own account; Gilbert, 2009**:

System	What it does	What it feels like
Threat and protection	Detecting danger and defending; "better safe than sorry"	Anxiety, anger, disgust
Drive	Seeking resources, achieving goals	Energy, excitement, pleasure
Soothing and safeness	Calm and connection with others; linked in evolution to attachment	Contentment, a sense of "I'm safe"

Normally the soothing system balances the other two. In people with high shame, on Gilbert's model, threat dominates and soothing is hard to reach. **Self-criticism**, on this logic, is the threat system turned on oneself **the author's own account; Gilbert, 2009**. Gilbert links the systems to particular brain chemistry as a hypothesis; it is not a proven mechanism of the therapy (interpretation).

An everyday example (our example). Someone is late for a meeting and spends half the day berating themselves: "Typical, you're hopeless." They can list reasons why being late is not a disaster, but the inner voice sounds like an attack, and they don't feel any calmer.

What happens in CFT

CFT (compassion-focused therapy) was set out by Gilbert in a 2009 review documented fact; Gilbert, 2009. Its core is **compassionate mind training**: building care for one's own wellbeing, sensitivity to pain, the ability to tolerate distress, and non-judgement — through attention, reasoning, imagery and behaviour the author's own account; Gilbert, 2009. In therapy people work, for example, with the image of a compassionate other or of themselves in a compassionate role, and learn to tell criticism that attacks from care that wants them to be better.

An important subtlety: CFT is not the advice "be kinder to yourself". For people with strong shame, warmth towards themselves can bring up anxiety or tears; CFT treats this as an expected part of the work, not a failure the author's own account; Gilbert, 2009. That is why, with a history of trauma, such exercises are done with a trained professional.

Myth vs fact **Myth:** self-compassion is self-pity and weakness. **Fact:** in CFT compassion includes being willing to look at pain and bear it; people with high shame find it hard and can even find it frightening the author's own account; Gilbert, 2009.

What we know about the evidence

- An early 2015 review: 14 studies, only 3 of them randomised. Conclusion: promising for mood disorders, especially with high self-criticism, but larger high-quality trials are needed proven by research; Leaviss & Uttley, 2015.
- A 2023 meta-analysis: 15 randomised and pilot studies from 2013–2022. CFT raised self-compassion and self-reassurance more than control conditions; the effect on depression was small (0.24–0.25). Quality was unclear in 7 of the 15 studies, about 75% of participants were women, and long-term effects have not been studied proven by research; Millard et al., 2023.

The honest summary: promising, but there is not much data yet (interpretation).

Chapter sources: Gilbert, 2009 · Leaviss & Uttley, 2015 · Millard et al., 2023

Metacognitive therapy: it's not the thoughts, it's what you do with them

Adrian Wells proposed looking not at the content of anxious thoughts but at how people respond to them, and at their beliefs about their own thinking.

The 1990 case

In 1990 British psychologist Adrian Wells described a patient with panic disorder whose panic attacks were triggered by relaxation. Training her to direct attention outwards stopped the attacks, while autogenic training (a relaxation technique) made them more frequent documented fact; Wells, 1990, a single case. This case gave rise to the **Attention Training Technique** (ATT): exercises in flexibly directing and switching attention between sounds.

The model

Metacognitive therapy (MCT) rests on Wells and Matthews's model of how the mind regulates itself documented fact; secondary source, MDWiki. Everyone has anxious "what if" thoughts. The problem, for Wells, is what happens next. He called that pattern of responses the **cognitive attentional syndrome** (CAS) (method author's account; secondary source):

1. Prolonged worry and rumination.
2. Threat monitoring, with attention locked onto danger.
3. Coping strategies that backfire: suppressing thoughts, avoidance, constant reassurance-seeking.

The syndrome is kept going by **metacognitive beliefs**, beliefs about one's own thinking. Positive ones: "if I worry, I'll be better prepared". Negative ones: "my thoughts are uncontrollable and dangerous, I'll go mad" (method author's account; secondary source; wordings are illustrative).

An everyday example (our example). After a conversation with their manager, someone spends the whole evening replaying every sentence, believing this will "help work out what went wrong". No answer comes, but the anxiety grows. CBT would ask: "Is it true that your manager is unhappy with you?" Metacognitive therapy asks: "What does all this replaying give you, and is it true that it can't be stopped?"

What happens in therapy

MCT doesn't argue with the content of a thought. Therapy teaches **detached mindfulness** — noticing a thought without either arguing with it or acting on it (Wells distinguishes this from meditation); postponing worry to a set time; and testing in practice the belief that "worry is uncontrollable" (method author's account; secondary source). We did not check individual exercises against the manuals **not verified**.

> Myth vs fact **Myth:** worrying helps you prepare. **Fact:** in the MCT model this is exactly one of the beliefs that keeps prolonged worry going (method author's account; secondary source). Preparing means doing things; endless replaying is no substitute.

What we know about the evidence

- **A 2014 meta-analysis:** 16 studies, 9 of them controlled, 384 people with anxiety or depression in total. Very large effects: against waitlist g = 1.81, against CBT g = 0.97. The authors themselves urge caution: small samples and few active control groups **proven by research; Normann et al., 2014**. g is a standardised difference between groups; 0.2 is considered small and 0.8 large.
- **A 2020 trial:** 174 adults with major depression at a single clinic in Denmark. Recovery at the end of treatment was 74% with MCT versus 52% with CBT, and at 6 months 74% versus 56%; MCT took 5.5 sessions on average, CBT 6.7 **proven by research; Callesen et al., 2020**.

Why these figures need caution (interpretation, partly the authors' own account): the 2020 trial had only two therapists, one of whom treated about 69% of patients; the therapists were more experienced in CBT than in MCT; and a co-author was Wells himself, who developed the method and directs an institute that trains people in it — the authors themselves name possible allegiance effects (Callesen et al., 2020). Most MCT research comes from groups linked to its founder. Independent replications are needed. For now, "new therapy beats CBT" is a press-release headline, not a scientific consensus.

Chapter sources: Wells, 1990 · MDWiki: Adrian Wells · Wikipedia: Metacognitive therapy · Normann et al., 2014 · Callesen et al., 2020 · University of Manchester, 2020

DBT, FAP and behavioural activation: who else counts as third wave

Who belongs to the third-wave "family" depends on who is drawing up the list.

- **DBT** (dialectical behaviour therapy, Marsha Linehan, 1993) combines acceptance and change: skills in mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. It is counted as third wave because acceptance and mindfulness are central to it (interpretation; Öst, 2008; ACBS). Linehan herself put "cognitive-behavioral" in the title of her book **documented fact; Linehan, 1993**. More in Episode 11.
- **FAP** (functional analytic psychotherapy, Kohlenberg and Tsai, 1991): the main place where change happens is the relationship with the therapist itself. If someone avoids closeness, it will show up in the session, and that is where

something different can be tried (method authors' account; Kanter et al., 2017). There is not yet enough evidence for specific disorders proven by research; Kanter et al., 2017.

- **Behavioural activation**: getting back to meaningful activities and working on avoidance; its success in 1996 was one of the triggers for the third wave proven by research; Jacobson et al., 1996. More in Episodes 6 and 7.

The boundaries are contested (interpretation). Wells traces metacognitive therapy to the cognitive psychology of attention, not to behaviour analysis; Gilbert describes CFT as an integrative approach drawing on evolutionary psychology, attachment theory and neuroscience. What they share with ACT is the task — working on the relationship to thoughts — not a common origin. Whether schema therapy belongs to the third wave is something sources disagree on; it is covered in Episode 12.

Chapter sources: Linehan, 1993 · Öst, 2008 · Kanter et al., 2017 · Jacobson et al., 1996 · Gilbert, 2009 · Wikipedia: Metacognitive therapy

Is ACT better than CBT? What the data say

Short answer: no, it's comparable. The long answer is the story of a dispute in which neither side is neutral.

Öst: "not yet proven"

In 2008 Swedish researcher Lars-Göran Öst pooled the third-wave trials: 13 randomised trials each for ACT and DBT, one for CBASP (a method for chronic depression), two for integrative behavioural couple therapy and none for FAP. Third-wave studies were methodologically noticeably weaker than CBT studies, and the average effect of ACT and DBT was moderate. His conclusion: "none of the third wave therapies fulfilled the criteria for empirically supported treatments" proven by research; Öst, 2008.

In 2014 Öst repeated the analysis with 60 ACT trials (4,234 participants). The average effect was 0.42 (small), down from 0.68 in 2008, and study quality had not improved significantly. Compared with various forms of cognitive or behavioural therapy, ACT's effect was small and not significant (0.16). His conclusion: ACT "is not yet well-established for any disorder"; it is probably efficacious for chronic pain and tinnitus, and possibly efficacious for depression, psychotic symptoms, OCD, mixed anxiety, drug abuse and work stress proven by research; Öst, 2014.

Shrinking effects are common for young methods: the first studies are small and run by enthusiasts (interpretation). Öst himself notes that most ACT–CBT comparisons were published after his first review, and points out that studies with only one or two therapists may inflate effects, especially if the therapist is one of ACT's originators the author's own account; Öst, 2014.

The ACT side responds

In 2017 a group of researchers that included Hayes reported 91 factual or interpretive errors in Öst's review, affecting about 80% of the studies covered; by their account the errors consistently went against ACT, and independent raters did not reproduce his quality ratings (one side's interpretation; Atkins et al., 2017, from the abstract). Öst replied that the criticism was irrelevant or unfounded not verified; known only from a summary on ACBS slides. We found no independent check of the 91 errors.

What later reviews show

- **A-Tjak et al. (2015):** 39 randomised trials, 1,821 patients. ACT outperformed control conditions overall (g = 0.57): waitlist (0.82), treatment as usual (0.64) and psychological placebo (0.51). There was no significant difference from CBT proven by research; A-Tjak et al., 2015.
- **Gloster et al. (2020):** a review of 20 meta-analyses, 100 controlled effect sizes, 12,477 participants. ACT was efficacious for all conditions examined — anxiety, depression, substance use, pain and transdiagnostic groups; it

outperformed inactive controls, treatment as usual and most active interventions, with the exception of CBT proven by research; Gloster et al., 2020.

- As of October 2026, ACBS lists 1,577 randomised trials of ACT (the association's own count; ACBS, 2026). This is a tally by the method's supporters, with no quality assessment.

The honest conclusion: ACT is a good tool, comparable to classic CBT. Not a revolution that cancelled the past, and not an empty fad (interpretation; based on Öst, 2014; A-Tjak et al., 2015; Gloster et al., 2020).

Five approaches side by side

	ACT	MBCT	CFT	Metacognitive therapy	DBT
What counts as the problem	Fusion with thoughts, avoidance, inflexibility	Reactivated depressive thinking, rumination	Dominant threat system, shame, self-criticism	Prolonged worry and beliefs about thinking	Difficulty regulating emotions
What you do with a thought	Notice it, defuse, act on values	See it as an event in the mind	Respond with warmth, not only logic	Don't argue, postpone, don't engage	Observe, check the facts, use skills
Meditation	Short exercises	Central, daily practice	Imagery and breathing	Not meditation	Mindfulness skills
Roots	Behaviour analysis, RFT	Beck's cognitive therapy and Kabat-Zinn's programme	Evolutionary psychology, attachment	Cognitive psychology of attention	Behaviour therapy and Zen
Format	Flexible; about 8 sessions for chronic pain	Group, 8 sessions of 2 hours	Group or individual	Brief individual therapy	Individual plus skills group
Strength of evidence	Moderate, comparable to CBT	High for preventing depressive relapse	Limited, promising	Promising, small samples	High for BPD (Episode 11)

The table is our synthesis of the chapter sources (interpretation).

Chapter sources: Öst, 2008 · Öst, 2014 · Atkins et al., 2017 · A-Tjak et al., 2015 · Gloster et al., 2020 · ACBS: ACT randomized controlled trials · Teasdale et al., 2000 · Kuyken et al., 2016 · Millard et al., 2023 · Normann et al., 2014

The "waves" debate: new wave or old hat

The term "third wave" itself became a point of contention. Nine years later, the main opponents wrote a paper together.

How Hayes defined the third wave

In a 2004 paper in *Behavior Therapy*, Hayes called the new approaches the third wave of behavioural and cognitive therapy. The gist of his definition: these approaches look not only at the form of a thought or feeling but at its

function — what it does in a person's life — and so they work through experience and context, not only through explanation; they aim to build broad, flexible repertoires of behaviour rather than simply removing a narrowly defined problem (**the author's own account; Hayes, 2004, from the abstract and ACBS's quotation**). ACBS itself notes that there is no sharp boundary between the "waves" (the association's account; ACBS).

The critique: "old hat"

In 2008 Stefan Hofmann and Gordon Asmundson published a paper with a wry title: "Acceptance and mindfulness-based therapy: New wave or old hat?" Their argument: ACT and CBT differ in their philosophical foundations, but ACT techniques are fully compatible with CBT (authors' interpretation; Hofmann & Asmundson, 2008, from the abstract). In emotion regulation terms, CBT mostly teaches people to appraise a situation differently before an emotion takes hold, while ACT's acceptance strategies counter unhelpful responses, such as suppression, once a reaction has started. Hofmann and colleagues later wrote that the developers of DBT and metacognitive therapy themselves see their methods as extensions of CBT, and that the data show no "wave" outperforming the others (interpretation; Hofmann, Sawyer & Fang, 2010; more in Episode 1).

Hayes replied that comparing "ACT versus CBT" cannot really succeed while traditional CBT refers not to specific processes, principles or theories but to a "tribal tradition" (**the author's own account; Hayes, 2008, from the abstract**).

The twist: opponents become co-authors

In 2017 Hayes and Hofmann wrote a paper together for *World Psychiatry*. In their words, some readers took the wave metaphor to mean that earlier generations of work would be washed away, but that was neither the intent nor the result: waves "leave behind a changed shore" (the authors' own account; Hayes & Hofmann, 2017). Old and new methods mostly live side by side. Mindfulness methods, acceptance-based procedures, decentring and cognitive defusion, in their view, have become part of the wider CBT tradition (the authors' own account; Hayes & Hofmann, 2017).

> Myth vs fact **Myth:** the third wave replaced CBT. **Fact:** the term's own authors write that waves absorb earlier ones rather than wash them away (Hayes & Hofmann, 2017); critics see the new approaches as part of the CBT family (Hofmann & Asmundson, 2008). CBT remains one of the most researched methods (Episode 14).

What they propose instead of waves: process-based therapy

Hofmann and Hayes propose **process-based therapy** (PBT). The idea: choose an intervention not by diagnosis or therapy "brand", but by which process keeps the problem going for this particular person — avoidance, rumination, self-criticism — and which technique, from any school, has been shown to change that process (the authors' own account; Hofmann & Hayes, 2019). They predict fewer "named" therapies with fixed technique sets, and more research on mechanisms and individual models (the authors' own account; Hofmann & Hayes, 2019).

An example (our example). Two people have different diagnoses: one has depression, the other an anxiety disorder. But for both, the main engine of the problem is hours of rumination. In PBT terms, the work would target rumination first, and the technique might come from MCT, MBCT or behaviour therapy.

A critical view (interpretation): for now PBT is more a research programme than a ready-made method with its own evidence base. Individual models are hard to test on groups, and different schools often measure "processes" with questionnaires those same schools created.

Chapter sources: Hayes, 2004 · ACBS: What characterizes the third wave · Hofmann & Asmundson, 2008 · Hofmann, Sawyer & Fang, 2010 · Hayes, 2008 · Hayes & Hofmann, 2017 · Hofmann & Hayes, 2019

Myths about the third wave: a quick check

All the myths from these notes in one table.

Myth	What the sources say	Label
ACT is better than CBT	In major reviews ACT is comparable to CBT, not better	**Proven by research**
The third wave replaced CBT	The term's own authors write that the waves coexist	**Interpretation**
Acceptance means resignation	You accept inner experiences in order to act on values, not bad circumstances	Method authors' account
Mindfulness is relaxation	The aim is to notice thoughts and step out of autopilot	Method authors' account
Meditation is safe for everyone	6% of participants in 8-week programmes had impairment lasting over a month	**Proven by research**
MBCT replaces antidepressants	Comparable to maintenance medication in one trial; stopping medication only with a doctor	**Proven by research**
MBCT treats any depression	Designed for relapse prevention in remission	**Documented fact**
Self-compassion is self-pity	In CFT it means being willing to look at pain and bear it	**The author's own account**
Worry helps you prepare	In MCT this is a belief that keeps prolonged worry going	Method author's account
The third wave is Buddhist therapy	ACT grew out of behaviour analysis; Buddhist practices feature in MBCT and partly in CFT	**Documented fact**
ACT appeared in 1999	The first manual dates from 1981	**Documented fact**
An ACT therapist is certified	There is no ACT certification	**Documented fact**

Try this: "I'm having the thought that…"

A one-minute exercise from ACT. It is a first step in self-observation, not therapy.

Example **One minute, one thought.**

1. Recall one thought that sounded like a fact to you today. For example: "I won't cope."
2. Say it to yourself the way it sounds.
3. Now: "I'm having the thought that I won't cope."
4. And once more: "I notice that I'm having the thought that I won't cope."

5. Notice whether anything shifted, even slightly. The thought doesn't have to go away. Ask yourself: if I act on this thought, does it bring me closer to what matters to me? What one small step today would?

Steps 1–4 follow the description of defusion on the ACBS website (method authors' account; ACBS, The six core processes of ACT). The aim is not to prove the thought false or to get rid of it, but to loosen its grip on what you do.

One more question, taken from Hayes himself. In his TEDx talk he recalls hiding under his bed as a child while his parents fought, and draws from it the line: "we hurt where we care and we care where we hurt" the author's own account; Hayes, TEDx, 2016. From that, a question to sit with: where does it hurt most right now — and what value is that pain pointing to? (our question, inspired by that line).

Important **What not to do.** Don't use this exercise to argue with yourself or to "ban" thoughts. If anxious or depressive thoughts are getting in the way of your life, or you are thinking about harming yourself, don't carry on alone: talk to a psychotherapist or doctor, and in an emergency contact emergency services. See If you need help now.

Check yourself and what to remember

Check yourself

1. **How does the third wave's question differ from the second wave's?** The second asks whether a thought is true; the third asks what the thought does to the person and whether it helps them live the way they care about.
2. **What did Jacobson's component analysis (1996) show?** Behavioural activation alone helped with depression as much as full cognitive therapy and changed negative thinking just as much.
3. **Name ACT's six processes.** Acceptance, defusion, contact with the present moment, self as context, values, committed action.
4. **Who did MBCT help in the first trial, and what did the 2016 analysis change?** People with three or more episodes of depression (37% versus 66% relapse); in the 2016 pooled analysis the number of episodes no longer affected the result.
5. **What is the cognitive attentional syndrome?** Prolonged worry and rumination, threat monitoring, and coping strategies that backfire.
6. **What is the honest answer to "Is ACT better than CBT?"** No: in major reviews ACT is comparable to CBT.

What to remember

- The third wave changes your relationship to thoughts and feelings, not just their content.
- Steven Hayes coined the term in 2004; ACT grew from behaviour analysis and relational frame theory and, in Hayes's telling, from his own struggle with panic.
- The evidence is uneven: MBCT is reliable for preventing depressive relapse; ACT is comparable to CBT; CFT and metacognitive therapy are promising but thinly researched.
- Acceptance is not resignation, mindfulness is not relaxation, and meditation is not harmless.
- For chronic pain, CBT and ACT are in the NICE guidelines, but the effect on pain itself is small: the aim is less suffering and restriction, not "zero pain".
- The term's own authors admitted the wave metaphor was misleading; they see the future in working with processes rather than therapy brands.

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