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THE EVOLUTION OF COGNITIVE AND BEHAVIOURAL THERAPIES ACROSS THREE GENERATIONS – A STATE OF THE ART

ЕВОЛЮЦІЯ КОГНІТИВНО-ПОВЕДІНКОВИХ ТЕРАПІЙ У ТРЬОХ ПОКОЛІННЯХ – СУЧАСНИЙ СТАН ДОСЛІДЖЕННЯ

This work provides a comprehensive analysis of the evolution of cognitive and behavioural therapies across three generations, highlighting their theoretical foundations, methodological innovations, and clinical implications. The first generation, rooted in the behavioural paradigm, prioritised symptom reduction through observable change, but its limitations in addressing cognition and language stimulated the emergence of the second generation. This stage placed dysfunctional thoughts, beliefs, and cognitive processes at the centre of clinical intervention, consolidating the foundations of cognitive-behavioural therapy (CBT). The third generation, often referred to as the "third wave," represents both continuity and innovation, as it integrates mindfulness, acceptance, and values-based action into established behavioural and cognitive frameworks. Interventions such as Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness-Based Stress Reduction (MBSR), and Mindfulness-Based Cognitive Therapy (MBCT) exemplify this shift by promoting psychological flexibility, enhancing resilience, and addressing complex psychopathologies.

The practical relevance of this analysis lies in demonstrating that modern cognitive and behavioural therapies are not limited to symptom management but serve as evidence-based approaches for improving overall functioning, preventing relapse, and supporting long-term well-being. Their methodological innovations are increasingly integrated into clinical practice, medical psychology, and professional training, making them central to multidisciplinary approaches in mental health care. By outlining the historical trajectory and contemporary applications, the study provides clinicians, researchers, and educators with a structured overview of how CBT and third-wave interventions contribute to sustainable psychological health and adaptive coping in diverse populations. In addition, the article emphasises the need for continued empirical evaluation of these interventions across cultural and clinical contexts to ensure their broad applicability. It also highlights the growing importance of integrating digital technologies and remote delivery formats, which expand access to evidence-based therapies and respond to emerging societal challenges.

Key words: Cognitive-Behavioural Therapy, Behavioural Paradigm, Third-Wave Therapies, Mindfulness-Based Interventions, Psychological Flexibility.

Ця робота містить всебічний аналіз еволюції когнітивних та поведінкових терапій протягом трьох поколінь, висвітлюючи їх теоретичні основи, методологічні інновації та клінічні наслідки. Перше покоління, засноване на поведінковій парадигмі, надавало пріоритет зменшенню симптомів через спостережувані зміни, але його обмеження у вирішенні когнітивних та мовних проблем стимулювали появу другого покоління. На цьому етапі в центрі клінічного втручання опинилися дисфункціональні думки, переконання та когнітивні процеси, що закріпило основи когнітивно-поведінкової терапії (КПТ). Третє покоління, яке часто називають «третьою хвилею», представляє як спадкоємність, так і інновації, оскільки інтегрує усвідомленість, прийняття та дії, засновані на цінностях, у встановлені поведінкові та когнітивні рамки. Такі втручання, як діалектична поведінкова терапія (ДПТ), терапія прийняття та зобов'язання (ТАЗ), зниження стресу на основі усвідомленості (МБСР) та когнітивна терапія на основі усвідомленості (МКТ), ілюструють цю зміну, сприяючи психологічній гнучкості, підвищенню стійкості та вирішенню складних психопатологій.

Практична значущість цього аналізу полягає в тому, що він демонструє, що сучасні когнітивні та поведінкові терапії не обмежуються лікуванням симптомів, а слугують науково обґрунтованими підходами для поліпшення загального функціонування, запобігання рецидивам та підтримки довгострокового благополуччя. Їхні методологічні інновації все частіше інтегруються в клінічну практику, медичну психологію та професійну підготовку, що робить їх центральними в мультидисциплінарних підходах до охорони психічного здоров'я. Окреслюючи історичну траєкторію та сучасні застосування, дослідження надає клініцистам, дослідникам та освітянам структурований огляд того, як КПТ та інтервенції третьої хвилі сприяють стійкому психологічному здоров'ю та адаптивному подоланню труднощів у різних групах населення. Крім того, стаття підкреслює необхідність постійної емпіричної оцінки цих інтервенцій у різних культурних та клінічних контекстах для забезпечення їх широкої застосовності. Вона також підкреслює зростаючу важливість інтеграції цифрових технологій та форматів дистанційного надання послуг, які розширюють доступ до науково

Ключові слова: когнітивно-поведінкова терапія, поведінкова парадигма, терапії «третьої хвилі», інтервенції на основі усвідомленості, психологічна гнучкість.

Introduction. Cognitive and behavioural therapies have undergone a gradual transformation from narrowly defined behavioural interventions toward broader, integrative models of psychological care. While the early behavioural approaches provided a scientifically rigorous foundation, their limitations in addressing the intricacies of human thought and language prompted a shift toward cognitively oriented strategies that positioned dysfunctional beliefs and schemas as central therapeutic targets [1; 17]. More recently, the so-called third wave has broadened the scope of therapy by embedding mindfulness, acceptance, and values-based practices into established behavioural and cognitive frameworks. This stage reflects a paradigmatic shift away from symptom eradication alone toward cultivating resilience, psychological flexibility, and long-term well-being [2; 8]. The significance of this trajectory lies in demonstrating that clinical effectiveness cannot be reduced to technical change but must also include context, meaning, and the dynamic interplay of cognition and behaviour.

A similar emphasis on cognition emerges within organisational and managerial research, where the concept of cognitive style is recognised as a determinant of adaptive capacity and decision-making effectiveness. Investigations in the tourism and hospitality sector have shown that the cognitive characteristics of managers not only shape their companies' dynamic capabilities but also moderate the relationship between organisational culture and strategic performance [12]. Earlier studies stressed that cognitive style should be understood as a pattern of awareness, interpretation, and dissemination of information that affects both staff productivity and consumer satisfaction [11]. These insights highlight the broader relevance of cognitive paradigms: just as in psychotherapy, where therapeutic change increasingly relies on understanding how individuals process experience, in management the capacity to align cognitive patterns with environmental demands becomes a decisive factor of sustainability. The intersection of clinical and organisational perspectives thus illustrates the central role of cognition in shaping adaptation and growth across diverse human systems.

This study intends to conduct a theoretical examination of the evolution of cognitive and behavioural therapies and to contrast their interpretation within the frameworks of behavioural, cognitive, and third-wave paradigms. Objectives: (1) to perform a theoretical examination of the conceptual foundations and methodological innovations of cognitive and behavioural therapies; and (2) to investigate their development through the lenses of behavioural, cognitive, and third-wave psychological traditions.

Presentation of the main material

A Critical Appraisal of the First Generation within the Behavioural Paradigm

The first generation of the behavioural perspective emerged as a scientifically grounded endeavor, primarily oriented towards the development of rigorously tested and methodologically robust technological applications. These interventions were firmly anchored in empirically validated principles of learning and behavioural science. In line with its epistemological stance, this paradigm categorically rejected poorly specified or vaguely delineated procedures, as well as clinically oriented theories that lacked systematic empirical substantiation [17].

Within this framework, behavioural therapy was articulated as a direct, parsimonious, rational, and empirically anchored mode of intervention. Its central orientation resided in the immediate alleviation of symptomatic expressions, with clinical objectives predominantly restricted to first-order change [2].

However, this inaugural generation soon demonstrated a critical incapacity to adequately account for the intricacies of human language and cognition. Such limitations highlighted the pressing necessity of therapeutic models capable of addressing thoughts and emotions in a more explicit, systematic, and theoretically coherent manner, thereby positioning these dimensions at the very core of clinical intervention. It was within this epistemic shift that the emergence of cognitive methodologies marked the advent of what has since been designated as the 'second wave' of behavioural and cognitive therapies [1].

The Ascendancy of the Second Wave in Cognitive-Behavioural Approaches

The second wave asserted itself through an amplified capacity to engage with cognition, positioning it at the very core of both theoretical elaboration and clinical intervention. Cognition was no longer treated as a peripheral construct but rather as a domain of unequivocal clinical salience, to be examined and modified directly. Within this framework, systematic attention was directed towards the identification of thoughts, beliefs, and cognitive distortions, typically operationalised through structured psychometric instruments and clinically oriented interviews designed with specificity for distinct clinical populations. In this respect, the second wave can be conceptualised as the establishment of direct methodological strategies explicitly devised to remediate cognitive dysfunctions [1].

Notwithstanding its innovations, the second wave preserved a strong emphasis on first-order change, predominantly through techniques aimed at restructuring maladaptive beliefs and correcting errors in information processing. This orientation facilitated its assimilation into the wider behavioural movement, ultimately crystallising in the emergence of what came to be designated as cognitive-behavioural therapies (CBT) [2].

A Dialogue Between the First and Second Generations

Cognitive-behavioural therapists progressively broadened the repertoire of clinical targets to encompass irrational cognitions, maladaptive cognitive schemas, and distortions in information-processing styles, thereby extending the conceptual horizon of direct change. Concurrently, they developed novel techniques specifically tailored to address these domains, which in turn contributed to the refinement of both the theoretical architecture and the clinical praxis of cognitive-behavioural intervention [15].

Within the framework of the second generation of behavioural therapy, undesirable cognitions were to

be systematically identified, weakened, and ultimately eliminated through processes of detection, correction, empirical testing, and cognitive disputation, mirroring, at a higher level of abstraction, the manner in which the first generation had sought to supplant anxiety with relaxation [16].

However, the appearance of empirical anomalies within the traditional cognitive-behavioural model, most notably the recurrent observation that clinical improvement in CBT frequently precedes the full implementation of prescribed therapeutic targets, signalled the limitations of this framework and catalysed a further stage in its evolution.

Concurrently, constructivist and postmodern perspectives began to erode the mechanistic assumptions that had long underpinned certain domains of behavioural science. In their place, increasingly pragmatic and contextually situated assumptions came to acquire greater epistemic legitimacy and clinical relevance, marking a decisive shift in the trajectory of the field [17].

The Emergence of the Third Generation in Behavioural and Cognitive Traditions

It has become increasingly defensible to refer to a third generation of CBT, insofar as a constellation of emerging therapeutic approaches, united by shared assumptions concerning psychological phenomena and the mechanisms of therapeutic change, are evolving in parallel within both the behavioural and cognitive strands of the CBT tradition [2].

These developments have unfolded in a manner that is simultaneously organic and theoretically coherent. Exposure-based interventions, for example, have been reconceptualised to privilege internal events, with functional properties of experience accorded primacy over their form, frequency, or situational contingencies. In parallel, attentional and metacognitive perspectives have assumed growing prominence, marking a decisive reorientation of therapeutic focus. Increasing recognition has also been directed towards the clinical utility of mindfulness and the acceptance of change in the treatment of complex cases, an orientation that fundamentally challenges the presumed universality of first-order change. Furthermore, the therapeutic significance of cultivating present-moment awareness has emerged as a defining feature of this evolving paradigm [7].

The third wave, while remaining anchored in the empirical principles that underpinned the original behavioural and cognitive traditions, distinguishes itself through a heightened sensitivity to the contextual and functional dimensions of psychological phenomena, rather than their surface form alone. It foregrounds contextual and experiential strategies of transformation, while simultaneously incorporating direct and didactic methods. The focus is no longer directed primarily towards the eradication of narrowly defined symptomatology, but rather towards the cultivation of a broad, flexible, and adaptive repertoire of responses [7; 8].

Equally, it underscores the salience of therapeutic material not only for the patient but also for the therapist, thereby reinforcing the inherently intersubjective nature of the therapeutic enterprise [18].

In this respect, the third generation represents both continuity and departure: it preserves its roots within the cognitive-behavioural tradition yet moves decisively beyond an exclusive preoccupation with first-order change. By adopting contextualist assumptions and integrating experiential and indirect modes of intervention alongside established direct techniques, it considerably broadens the scope and deepens the transformative potential of contemporary therapeutic practice [2].

On the behavioural side, as exposure-based treatments began to engage increasingly with internal events, it became evident that their functional properties, rather than their form or frequency, constituted the aspect of greatest clinical significance. Moreover, the outcomes consistently achieved with Dialectical Behaviour Therapy have provided compelling empirical support for the therapeutic value of mindfulness and acceptance in the treatment of complex psychopathologies [3].

Within the cognitive tradition, parallel shifts have been observed. The incorporation of mindfulness and acceptance represents a radical extension of cognitive therapy, insofar as these approaches explicitly challenge the presumed universality of first-order change strategies. Attentional and metacognitive perspectives have further demonstrated that it is the function of problematic cognitions, rather than their mere form, that constitutes the most clinically relevant dimension. Accordingly, greater emphasis has been placed on cultivating present-moment awareness, with the empirical successes of mindfulness-based interventions further consolidating this reorientation of therapeutic focus [4; 5; 6].

The third generation demonstrates a distinct preference for strategies that are not primarily mediated through language, privileging an orientation towards processes rather than the explicit content of cognition. It situates the body as a central locus of therapeutic attention, foregrounds the immediacy of present-moment experience, and engages directly with the emotional domain [19]. Crucially, it does not marginalise broader dimensions of quality of life, nor does it neglect existential concerns, which often constitute a core dimension of the suffering and aspirations of those who turn to psychotherapy [2].

The Concept of Mindfulness

Mindfulness may be defined as the practice of attending in a particular way: intentionally, in the present moment, and without judgement. Mindfulness may also be understood as the cultivation of a metaperspective on one's mental life, wherein the individual sustains continuous awareness of the flow of thoughts, emotions, bodily sensations, and impulses, while recognising them precisely as mental events rather than as objective realities or imperatives for behaviour. In this sense, mindfulness fosters an observing mode of consciousness: a reflective awareness that monitors the operations of the mind without becoming entangled in them [8; 9].

Mindfulness-Based Interventions

Dialectical Behaviour Therapy (DBT), developed by Marsha Linehan, wasoriginally formulated for the treatment of **borderline personality disorder** (BPD). It was originally developed as an outpatient, year-long

treatment for individuals with borderline personality disorder (BPD).

The standard DBT program integrates weekly individual psychotherapy with group-based skills training, structured across four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The notion of dialectical encapsulates the central therapeutic principle of balancing, integrating, and synthesizing opposites, framing treatment as a dynamic tension between the acceptance of present realities and the commitment to change [10]. DBT has since become the gold-standard intervention for borderline personality disorder (BPD), but its application has extended to individuals presenting with chronic impulsivity and pervasive emotion dysregulation. A robust body of empirical research supports its effectiveness, particularly in reducing self-injurious behaviors and suicide attempts, lowering treatment dropout rates, and decreasing psychiatric hospitalizations [10].

Clinically, individuals with BPD often experience themselves as powerless, vulnerable, and fundamentally unacceptable. Conversely, they may be perceived by others as hostile, manipulative, or even abusive. At its core, BPD is marked by profound instability in relationships and attachment, frequently rooted in adverse childhood experiences such as physical and sexual abuse or emotional neglect. These developmental adversities contribute to the emergence of dichotomous, or "black-and-white," thinking patterns, wherein experiences and relationships are interpreted in rigid, polarized terms.

Within Schema Therapy, this pattern is captured by the construct of hypervigilance, an early maladaptive schema defined by persistent and exaggerated attentional focus on cues of threat, rejection, or abandonment [20]. Hypervigilance reflects a chronic expectation of harm and a state of continuous emotional and cognitive alertness, even in the absence of objective danger. Among individuals with BPD, such schemas often stem from histories of abuse and neglect, undermining the development of a stable sense of safety and attachment. As a result, patients frequently monitor the reactions of others, interpreting even subtle shifts in affect or behavior as signs of rejection. This heightened sensitivity fuels the interpersonal instability that characterizes BPD, in which others are alternately idealized and devalued. Hypervigilance also reinforces dichotomous thinking, with ambiguous cues interpreted in extreme terms such as "he is going to leave me" or "she hates me" [14].

The clinical consequences of hypervigilance are profound. Patients often live in a near-constant state of anxiety and internal tension, and impulsive behaviors frequently arise as attempts to manage perceived threats. In more severe presentations, self-injurious behaviors may emerge as maladaptive strategies for regulating the overwhelming emotional arousal generated by chronic vigilance [14].

DBT conceptualizes such patterns as arising from a model of dysfunctional behavior that combines motivational deficits with impaired coping skills. Individuals with BPD typically lack core interpersonal abilities as well as skills for self-regulation and distress tolerance [10]. For treatment to be effective, two critical factors must be addressed: the enhancement of motivation for change and the development of new behavioral skills. Yet, for emotionally vulnerable patients, interventions narrowly focused on change may be experienced as invalidating, leading to withdrawal, mistrust, and premature dropout. Moreover, when therapy prioritizes motivation for altering severely maladaptive behaviors, the acquisition of new coping skills can become difficult, if not impossible.

It is therefore crucial to acknowledge that motivational needs cannot be fully met within a treatment framework that adheres to a rigid, skills-focused agenda. The application of newly learned coping strategies is particularly challenging for individuals in acute crisis. When these difficulties are compounded by environmental contingencies that reinforce dysfunctional behaviors, the generalization of adaptive skills beyond the therapy setting becomes exceedingly difficult, and in some cases, virtually unattainable [10].

The implementation of DBT involves several coordinated components. Individual outpatient psychotherapy constitutes the central element, complemented by skills training, which may be delivered by different therapists and typically conducted in small groups ranging from two to eight participants. In addition, telephone consultation is available to provide real-time support in the generalization of skills to daily life. The treatment model also requires regular clinical supervision meetings for therapists, ensuring adherence and consistency in delivery. Finally, DBT is often integrated with adjunctive interventions, including pharmacological treatment, day hospital programs, and other supportive services [14].

Acceptance and Commitment Therapy (ACT) is a scientifically grounded psychotherapeutic approach that belongs to the "third wave" of cognitive-behavioral therapies (CBT). Its theoretical foundation lies in Relational Frame Theory (RFT), a comprehensive research program that examines the mechanisms by which human cognition and language shape behavior. From the perspective of RFT, many of the strategies humans employ to resolve psychological problems can paradoxically function as traps, amplifying distress and perpetuating suffering. Within the ACT framework, psychological suffering is conceptualized as emerging from the interaction between human language, cognition, and behavioral regulation. Rather than seeking to eliminate or suppress unpleasant experiences, ACT calls for a fundamental shift in perspective, encouraging individuals to alter the way they relate to their internal events.

Through its core methods, ACT provides innovative strategies for approaching psychological difficulties, focusing on acceptance, mindfulness, and values-based action. In doing so, it seeks not merely to reduce symptoms but to substantially modify the processes underlying psychological problems, thereby diminishing their impact and promoting greater psychological flexibility in daily life [8].

At its core, ACT does not seek to eliminate painful or difficult thoughts and feelings but rather to transform the individual's relationship with them. It demon-

strates that powerful alternatives are available, including acceptance, mindfulness, cognitive defusion (or deliteralization), values clarification, and committed action. Through these processes, ACT fosters psychological flexibility, enabling individuals to pursue meaningful lives even in the presence of suffering [10]. ACT posits that psychological inflexibility emerges from experiential avoidance, cognitive entanglement, attachment to a conceptualized self, loss of contact with the present moment, and the consequent failure to take behavioral steps that are consistent with core values.

Mindfulness-Based Stress Reduction (MBSR), was developed by Jon Kabat-Zinn at the University of Massachusetts Medical School, and represents the seminal programme through which mindfulness entered mainstream medical and psychological practice.

MBSR was designed as a group-based, transdiagnostic intervention for heterogeneous populations presenting with a wide spectrum of physical and psychological difficulties, including chronic pain, stress-related conditions, and comorbid mental health problems. Crucially, the programme was not tailored to a specific diagnosis but sought instead to provide a broadly applicable framework for reducing stress, enhancing resilience, and fostering overall well-being [8].

The programme is delivered over eight weeks and consists of weekly sessions lasting approximately two to three hours. A hallmark feature is the all-day intensive practice session conducted in the sixth week. Equally central is the expectation of daily home practice: participants are asked to engage in mindfulness exercises for around 45 minutes per day, six days per week, thereby consolidating skills between sessions.

Within the group context, three core practices are taught: the body scan, sitting meditation, and mindful movement. These experiential practices are supplemented with structured discussions and psychoeducational components aimed at strengthening participants' capacity to manage stress and respond more adaptively to life's demands [10].

The overarching objective of MBSR is the systematic cultivation of presence across both internal and external domains of experience, as well as their interrelationship. Internal experience includes bodily sensations, cognitions, and emotions, while external experience encompasses interpersonal interactions, actions in the world, and situational contexts. Through sustained awareness of these domains, MBSR fosters an integrated mode of presence that enhances clarity, resilience, and psychological flexibility [8].

Mindfulness-Based Cognitive Therapy (MBCT) was developed as a clinical adaptation that integrates traditional cognitive therapy with the structure and practices of Mindfulness-Based Stress Reduction (MBSR). While preserving the meditative foundation of MBSR, MBCT was specifically designed as a relapse-prevention program for individuals with recurrent depression, particularly those in remission who have experienced three or more prior episodes. Evidence from landmark randomized controlled trials provides strong empirical support for its efficacy. Compared with treatment as usual, MBCT has been shown to significantly reduce the risk of depressive relapse in patients with a history of multiple episodes of major depression [13].

A central theoretical contribution of MBCT lies in its emphasis on the distinction between two modes of mind: the "**doing mode**" and the "**being mode**" [19]. The mind cannot simultaneously inhabit both modes, as each requires the exclusive engagement of overlapping cognitive resources. The **doing mode** is activated when the mind registers a discrepancy between the present reality and an imagined or desired state. Cognitive activity in this mode is therefore oriented toward closing the perceived gap, typically through evaluative and problem-solving strategies.

In contrast, the **being mode** reflects a state of awareness characterized by the absence of goal pursuit, in which experience is approached openly and non-judgmentally rather than evaluated against normative standards. This distinction is fundamental to MBCT, as cultivating the being mode enables individuals vulnerable to depression to disengage from ruminative cycles of evaluation that perpetuate relapse. By fostering present-moment awareness without striving for immediate change, MBCT interrupts maladaptive monitoring processes and reduces vulnerability to depressive recurrence.

The **doing mode**, while adaptive in problem-solving contexts, becomes maladaptive when applied to internal experiences such as thoughts, feelings, or mood states. Once discrepancies are detected between "how things are" and "how they ought to be," two consequences typically follow: (1) the automatic elicitation of negative affect and (2) the activation of habitual thought patterns designed to reduce the perceived discrepancy.

When no immediate corrective action is available, this cycle intensifies, leading individuals to experience emotions as compelling realities rather than transient mental events. Patients often become caught in repetitive analysis of past and future scenarios, thereby neglecting direct contact with the present moment. These cycles of evaluative processing and goal-driven analysis are central to depressive rumination, a cognitive style strongly linked with increased risk of relapse.

MBCT directly targets this vulnerability by training a shift from the doing mode to the being mode. In the being mode, thoughts and emotions are observed as passing events in the mind rather than as accurate reflections of reality requiring immediate resolution. Experience is approached with openness, curiosity, and non-judgment, thereby weakening the escalation of ruminative cycles and promoting a more adaptive relationship with internal states [13; 19]. This shift provides a protective cognitive stance, reducing relapse risk in those with recurrent depression.

It is also important to note that dysfunctional routines persist because individuals often remain entrenched in a cognitive style marked by:

(1) operating on "automatic pilot";

(2) a persistent drive to eliminate negative affect, often tied to the overarching pursuit of happiness;

(3) continual monitoring and comparison of current and desired mental states; and

(4) reliance on verbal, problem-solving strategies as the primary means of coping. These dynamics illustrate the limits of the doing mode when applied to internal experiences, underscoring the importance of cultivating the being mode through mindfulness practice.

Although more difficult to define conceptually, the being mode is best understood experientially. It may be considered the counterpart of the doing mode, emerging when one is not striving toward specific goals nor seeking or anticipating reinforcement. Two defining features account for this shift: (1) the absence of constant monitoring or evaluation of "what must I do to achieve my goals," and (2) an orientation toward acceptance and allowing, without pressure for immediate change.

The being mode is thus characterized by a direct, immediate, and intimate engagement with present-moment experience. In this mode, thoughts are related to as ephemeral events of the mind, arising, entering awareness, and naturally passing away.

Mindfulness-Based Cognitive Therapy (MBCT) Interventions

Mindfulness-Based Cognitive Therapy (MBCT) interventions generally begin with an individual **pre-program meeting** of approximately one hour. This session, conducted by the instructor with each potential participant, fulfills several critical functions. It serves to introduce the structure and content of the program, while simultaneously assessing the individual's suitability for this form of training. For participants, it provides an opportunity to develop a clear understanding of the program's rationale and methods, as well as to consider how it may address their specific needs. Equally important, this meeting underscores the centrality of daily home practice, thereby fostering an early commitment to the consistent engagement that is integral to MBCT. From the instructor's perspective, the pre-program session also provides a space to evaluate the participant's potential to benefit from the intervention and to identify psychological and contextual factors that may contribute to the onset and maintenance of depressive difficulties [8].

Following this preparatory stage, the MBCT program is delivered across **eight weekly group sessions**, each lasting approximately two hours. The first and final sessions are typically extended by an additional 30 minutes to allow for group processes of initiation and closure. Each session incorporates at least one guided formal meditation practice, structured group discussion, and experiential inquiry in which participants share and reflect on their mindfulness practice both within the sessions and at home. These experiential components are complemented by didactic teaching and psychoeducational content, designed to deepen participants' understanding of the cognitive and affective mechanisms underlying relapse and recovery [8].

A distinctive feature of MBCT is the inclusion of an intensive **practice day, usually held in the sixth week**, during which participants engage in a full day of structured, guided mindfulness practices. This immersion provides an extended opportunity to cultivate sustained awareness and deepen experiential learning. The program concludes with a final session that emphasizes reflection on the overall experience and the articulation of strategies and goals for maintaining practice and well-being beyond the formal intervention [8].

Mindfulness Exercises

Within the MBCT framework, **four core practices** are systematically introduced during the weekly sessions and consolidated through daily home assignments. The first of these is the **Body Scan meditation**, typically performed while lying on the floor. During this practice, attention is deliberately and sequentially directed through different regions of the body, with the aim of fostering awareness of bodily sensations regardless of whether they are experienced as pleasant, unpleasant, or neutral. The Body Scan is considered a foundational practice within MBCT, as it cultivates an attitude of non-judgmental awareness toward moment-to-moment bodily experience [19].

The second practice is **Mindful Movement**, which is introduced as part of the home practice from the third week onwards. Here, participants are encouraged to sustain moment-to-moment awareness of the bodily sensations that accompany movement, while adopting an attitude of openness and acceptance. Rather than attempting to suppress or alter the arising of thoughts or feelings related to these sensations, participants are guided to allow such experiences to be present as they are. In this way, Mindful Movement extends the cultivation of mindfulness into dynamic activity, bridging formal meditation with everyday functioning [19].

The third practice is **Sitting Meditation**. Participants are invited to remain upright and alert while maintaining a relaxed posture, and to systematically direct attention to various domains of experience. A typical sequence begins with awareness of the breath, then expands to bodily sensations, followed by sounds, thoughts, and emotions. Ultimately, participants are encouraged to allow attention to move freely, resting with whichever experience is most salient in the present moment. The purpose of this practice is not to eliminate thoughts or emotions, but to cultivate a more skillful and decentered relationship with mental activity, thereby deepening insight into the workings of the mind [19].

The final formal practice is the **Three-Minute Breathing Space**, a brief meditation designed to integrate mindfulness into everyday life. This exercise unfolds in three stages: first, stepping out of automatic pilot by acknowledging the present-moment experience; second, gently directing attention to the sensations of breathing; and third, expanding awareness from the breath to encompass the whole body, using it as an anchor from which to open to the broader field of experience. The Three-Minute Breathing Space functions as a practical tool that participants can apply throughout the day to reconnect with mindful awareness [19].

In addition to these four formal practices, MBCT places strong emphasis on the cultivation of **informal mindfulness in daily life**. For example, by the third or fourth week, participants are asked to complete a **calendar exercise** in which they record both pleasant and unpleasant events in detail. The purpose of this task is to illuminate how the mind habitually categorizes

experiences and how thoughts and mood states shape such interpretations. Similarly, **deliberate attention to routine activities**, such as eating or walking, is encouraged from the first week of the program. These informal practices reinforce the integration of mindfulness into everyday contexts, supporting the generalization of skills beyond the structured meditation exercises [19].

Conclusion. The historical development of cognitive and behavioural therapies reflects an ongoing process of refinement, integration, and expansion in response to clinical challenges and empirical findings. The first generation, grounded in behavioural principles, provided a rigorous scientific basis for intervention but proved insufficient to capture the complexity of human cognition and emotion. The second generation addressed these limitations by incorporating cognitive processes, laying the foundation for modern CBT and establishing it as the gold standard for evidence-based psychotherapy. The emergence of the third wave represented not a rejection but an evolution, integrating acceptance, mindfulness, and contextual approaches that address deeper issues of meaning, values, and psychological flexibility. Approaches such as DBT, ACT, MBCT, and MBSR illustrate how contemporary therapies transcend symptom reduction to foster resilience, adaptive functioning, and sustainable well-being. This trajectory highlights the importance of viewing therapy not as a static set of techniques but as a dynamic field, continually shaped by scientific inquiry and clinical innovation. Ultimately, the evolution of cognitive and behavioural therapies underscores a central shift: from treating pathology toward promoting flourishing, positioning psychotherapy as both a corrective and a generative practice for human development.

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