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Acceptance and Commitment Therapy (ACT): a quick guide

Terapia de Aceitação e Compromisso (ACT): um guia rápido

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Abstract: Acceptance and Commitment Therapy (ACT) is an empirically supported treatment and a process-based approach to psychological suffering and the promotion of human prosperity. This paper presents a quick guide to ACT, aiming at students and professionals who are first reading about it. Readers will learn the first steps to understanding ACT, the Psychological Flexibility model, the current state of evidence for ACT, and some thoughts on the future of this approach.

Keywords: acceptance and commitment therapy, ACT, psychological flexibility, introduction.

Resumo: Terapia de Aceitação e Compromisso (ACT) é um tratamento empiricamente sustentado e uma abordagem baseada em processos que endereça tanto o sofrimento psicológico quanto a promoção da prosperidade humana. Este artigo apresenta um guia rápido sobre a ACT, destinado especialmente a estudantes e profissionais que estão lendo sobre o tema pela primeira vez. O leitor encontrará os primeiros passos para entender o que é a ACT, o modelo de flexibilidade psicológica, o estado atual das evidências e algumas palavras sobre o futuro dessa abordagem.

Palavras-chave: terapia de aceitação e compromisso, ACT, flexibilidade psicológica, introdução.

What is Acceptance and Commitment Therapy (ACT)?

Acceptance and Commitment Therapy (or sometimes called "Acceptance and Commitment Training when used in a non-clinical context, "ACT" in either case, pronounced as a single word; Hayes et al., 1999; Hayes, Strosahl et al., 2012; for a recent book-length treatment of the topic, see Twohig et al., 2023) is an intervention strategy that is empirically supported (e.g., Gloster et al., 2020) and is based on a process-based approach to psychological suffering and the promotion of human prosperity (e.g., Ong, Ciarrochi et al., 2024). The overall knowledge development strategy in which ACT work is done is a modern facet of behavior analysis known as Contextual Behavioral Science (CBS; Hayes, Barnes-Holmes et al., 2012). ACT is only one of the applied branches of CBS. It has gained more prominence so far, although there are other widely distinguished applications (e.g., Dixon et al., 2017; Ming et al., 2024; see Zettle et al., 2016 for a book-length treatment of the topic).

The way in which ACT explains the goals and direction of psychotherapeutic intervention is based on a philosophy of science called Functional Contextualism (e.g., Biglan & Hayes, 1996, 2006; Gifford & Hayes, 1999; Hayes, 1993; Hayes, Barnes-Holmes et al., 2012), which understands psychological actions as an *act-in-context* determined by historical and situational variables that interact functionally. Many of the key processes that generate and modulate suffering or prosperity are related to human language and cognition (e.g., Harte et al., 2023; Kovac & Perez, 2022; Wilson et al., 2001). ACT understands such interaction based on a contemporary behavioral account, Relational Frame Theory (RFT), which suggests that events can have their functions radically transformed through symbolic (relational) processes (Hayes et al., 2001; Hayes, Law et al., 2021; see also Harte & Barnes-Holmes, 2023; for Portuguese readings, see Perez et al., 2013, 2022). The central claim of RFT (see Hayes, Law et al., 2021 for a brief review) is that relating is an operant (behavior), and when brought in part under the control of arbitrary social cues it forms the basis of human language and cognition. From a clinical point of view, for example, though such "arbitrarily applicable relational responses" we can learn to fear events that we have never experienced directly (e.g., the fear of death; to fear flying for the first time; see Dougher et al., 2007 for relevant experimental data on this topic) or establish suicidal behavior to cope with extreme emotional pain (Hayes, 1992). ACT argues that these difficult verbal processes can be addressed in a skill set known as "Psychological Flexibility" (Hayes et al., 2006; Hayes, Strosahl et al., 2012), defined as "*the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends*" (Hayes et al., 2006, p. 7).

As suggested by Dixon et al. (2023), "*ACT does not assume that human struggles are symptoms of a hidden 'disease' lurking somewhere in the soul, mind, or hidden in the synapses between brain cells. Rather, those who implement ACT attempt to alter the function of psychological distress so that it can be used as a tool to guide effective action, and then put these same skills to the broader task of building a life worth living.*" (p. 40). Within the Psychological Flexibility model, psychopathologies can be understood as patterns of rigid behaviors in affect, cognition, attention, sense of self, motivation or overt behavior, and the most modern version, addressed later in this paper, their social and biophysiological extensions (Ong, Ciarrochi et al., 2024). For example, experiential avoidance efforts may reside either inside (e.g., avoiding thoughts, feelings, sensations, memories, etc.) or outside our skin (e.g., avoiding getting on an airplane, speaking in public, facing a difficult conversation, etc.) (Hayes et al., 1996; Levin et al., 2014; see also Boavista & Perez, 2025). Such restriction of one's behavioral repertoire is termed *Psychological Inflexibility* (Figure 1, right side) in the ACT model (Hayes et al., 2006; Hayes, Strosahl et al., 2012) and can be verified in six psychological dimensions. These dimensions guide the clinician's vision for how the client interacts not only with the direct conditions that produce suffering, but also with their own behavior (e.g., including "private events"): (1) *experiential avoidance* — to use strategies to escape, avoid, or neutralize part of one's experience (e.g., acting impulsively as a way to deal with boredom); (2) *fusion* — to respond to the content

of one's own thought in a literal manner (e.g., a client with OCD who responds to intrusive thoughts as if they were imperative truths, so as to foster the unwarranted domination of relational framing over other sources of behavioral regulation); (3) *attachment to the conceptualized self* — to respond rigidly to the content of the narrative about oneself (e.g., "I am a failure, thus it's not worth even trying..."); (4) *inflexible attention to the present moment* — to attend to thoughts focused on the past or future or to orient towards immediate discomfort, in ways that restricts flexible, fluid, involuntary attention to present events; (5) *lack of clarity of values* — being unable to describe and orient toward chosen qualities of being and doing that are important for oneself and for a meaningful life (e.g., when someone is oriented only towards what is important for others); (6) *Inaction, Impulsivity, and Avoidant Persistence*.

Psychological Flexibility is an alternative to these various forms of behavioral rigidity. ACT offers tools that allow generating variation, expanding the client's repertoire in situations associated with suffering (for a therapeutic skills training manual, see Luoma et al. 2017). According to the ACT model, summarized in the *Hexaflex* (Figure 1, left side), six change processes can guide clinical intervention. That is, they point to repertoires that need to be developed to have psychological health, vitality, and a meaningful life as an outcome. In ACT language these would include (1) *acceptance* — to be open to one's own experience, even when it is challenging, giving up control when it is ineffective or unnecessary; (2) *defusion* — to interact with one's own thoughts in a functional way, without literally attaching to the content described therein; (3) *self-as-context / healthy perspective taking* — to note the different aspects of one's experience in perspective, as an observer, beyond the judgments and evaluations; (4) *awareness of the present moment and attentional flexibility* — to learn a flexible attention, able to fluctuate with curiosity among different aspects of the here-and-now; (5) *values* — to choose qualities of action that bring meaning to one's own behaviors: for example, being "kind", "brave", "loving"; (6) *committed action* — performing actions and building habits that are connected to one's chosen values.

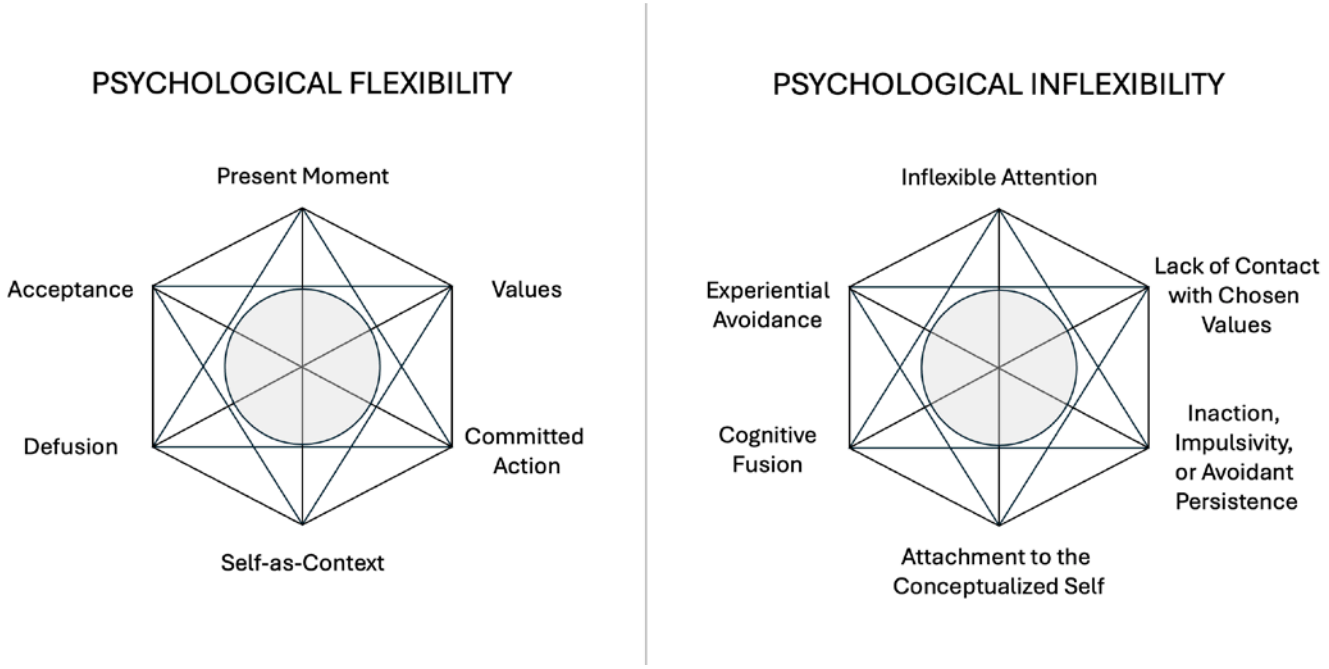

Figure 1. Hexaflex depicting the six ACT processes of Psychological Flexibility (left) and Psychological Inflexibility (right).

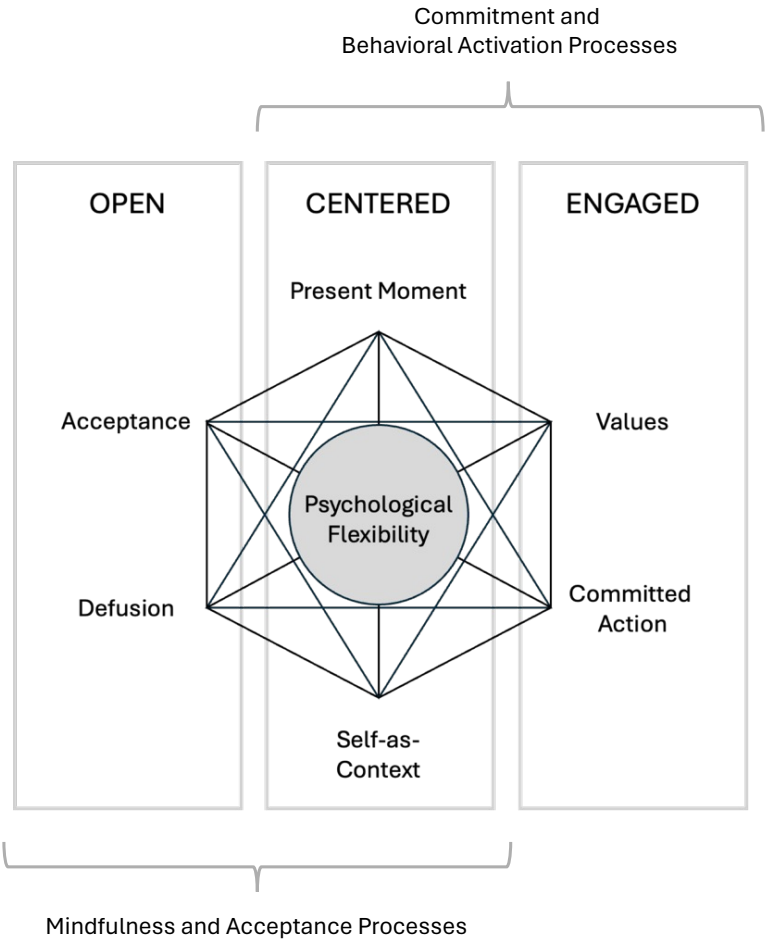

Figure 2. Hexaflex depicting the six ACT processes of Psychological Flexibility, organized into: (a) three pillars: open, aware, and engaged; and (b) two sides: mindfulness and acceptance processes, and commitment and behavioral activation processes.

The core of the Psychological Flexibility model was summarized by Hayes et al. (2004, pp. 12-13) using a question that practically can orient clients and therapists to relevant behavioral changing processes in therapy: "Given a distinction between you as a conscious human being and the psychological content that is being struggled with (self-as-context), are you willing to experience that content fully and without needless defense (acceptance), as it is and not as what it says it is (defusion), and do what takes you in the direction (committed action) of your chosen values (values) at this time and in this situation (contact with the present moment)?"

Another strategy to help professionals target the process of change in an ACT-consistent manner is organizing the original *Hexaflex* vertices in three pillars (Figure 2): (1) OPEN, (2) AWARE, (3) ENGAGED. Each pillar represents a response pattern, some of which have already been explored in treatment components studies (e.g., Hayes et al., 2011; Levin et al., 2020; Villatte et al., 2016). OPEN is a middle-level term (as any term within the *Hexaflex*; for a broader discussion, see Barnes-Holmes et al., 2016; Vilardaga et al., 2009) that describes a quality of curiously responding to our own behavior, including all kinds of experiences regardless of how they are evaluated (e.g., good, bad, nasty, frightening, etc.), incorporating both acceptance and defusion processes. AWARE (or centered) describes taking perspective as an observer of the here-and-now as it unfolds in our experiences, mixing self-as-context and present moment processes. ENGAGED (or active) refers to behaving in accordance with a meaningful life, or life directions that are freely chosen as relevant and essential for oneself, that is, the processes of clari-

fying values and committed action. Another possibility is to organize the *Hexaflex* into two sides or large groupings (Figure 2): one referring to mindfulness and acceptance processes (acceptance, defusion, present moment, and self-as-context) and another to commitment and behavioral activation processes (present moment, self-as-context, values, and committed action). From a functional perspective, all these different organizations within the Psychological Flexibility model are considered functionally dependent on the therapist, researcher, or trainer's agenda. They are not real things in the world (for a broader discussion, see Hayes et al., 1988; Hughes, 2018; Wilson, 2016). They are words to orient the practitioner to broad behavior classes that will comprise case formulation and guide the intervention.

Studies suggest that Psychological Inflexibility is a transdiagnostic process linked to many psychological disorders (e.g., Levin et al., 2014), and is negatively correlated with well-being (e.g., Ong, Barthel et al., 2024). Conversely, Psychological Flexibility is a relevant target of psychological interventions, reducing psychological distress (Macri & Rogge, 2024), and positively impacting treatment outcomes (Gloster et al., 2020; Hayes et al., 2022; Rutschmann et al., 2024). In addition, Psychological Flexibility is a key process to improve quality of life and symptoms in multiple chronic health conditions (e.g., Kashdan, 2010; Konstantinou et al., 2023; McCracken, 2024; Zhang et al., 2018) and also to guide preventive strategies in different domains (Biglan et al., 2008). Hayes et al. (2022) reviewed about 54,633 psychological intervention studies and selected 1,353 texts to identify process measures that reliably mediated treatment outcomes. Among 1,050 mediational findings across 624 studies, they found 72 measures that have successfully mediated intervention outcomes and were replicated between studies. Among the identified measures, 55% of the known mediators were part of the classic psychological flexibility concept and were functionally important pathways of change in psychological interventions aimed at mental health. If a more expansive definition of these processes were adopted (see below), virtually all known mediators of change can be accommodated by the Psychological Flexibility model.

The State of Evidence for ACT

ACT has been widely recognized by several leading institutions, including the World Health Organization and the US Centers for Disease Control (see other institutions at https://contextualscience.org/state_of_the_act_evidence), as an evidence-based approach to treating a variety of physical and mental health conditions. Currently (August 2025), there are 1,418 randomized clinical trials (RCTs) involving ACT, as well as 611 meta-analyses registered on the Association for Contextual Behavioral Science's website.

Gloster et al. (2020) reviewed 20 meta-analyses, which included 133 studies and more than 12,000 participants. ACT was effective for several conditions such as: anxiety, depression, substance abuse, chronic pain (for a caveat, see Williams et al., 2020; for updates, see Martinez-Calderon et al., 2024; McCracken, 2024) and transdiagnostic groups, presenting larger effect sizes when compared to inactive control groups (e.g., waiting list), TAU (treatment-as-usual) and most of the active treatments, except cognitive-behavioral therapy (CBT) – from which, in general, no statistically significant differences were found compared to ACT. Small to moderate effect sizes were also observed for other relevant outcomes, such as quality of life, well-being, functionality, and disability.

An overview of research on ACT was offered by Levin et al. (2024), who analyzed recent systematic reviews and meta-analyses involving ACT in multiple domains. Although the methodological rigor varied among studies, the authors suggested that there is plausible evidence for the efficacy of ACT for depression, anxiety, obsessive-compulsive disorders, psychosis, substance use disorders, chronic pain, obesity, stigma, stress, and burnout. The authors also reported studies in which ACT improved other relevant outcomes such as quality of life, symptoms, disease management, adherence to treatment, etc., for a wide range of chronic health conditions such as cancer, diabetes, overweight, stroke, heart disease, multiple sclerosis, epilepsy, asthma, arthritis, inflammatory bowel disease, cardiovascular, tinnitus, and HIV. It is also worth noting that ACT is a potential treatment for reducing the severity of insomnia and improving sleep pat-

terns, particularly when combined with behavioral components such as stimulus control and sleep restriction (Paulos-Guarnieri et al., 2022). ACT has also inspired treatment protocols in challenging research areas, such as in psychedelic-assisted therapy (Herbert et al., 2025; Watts & Luoma, 2020). There are areas of interest, however, in which ACT is yet to be well established, for instance, in treating bipolar disorders (BD) (Khafifi, Perez, El Rafihi-Ferreira et al., 2025). The efficacy of ACT as a stand-alone treatment for BD has now been tested in an RCT in Brazil (Khafif, Perez, Hamoui et al., 2025).

Hayes and King (2024) reviewed the first 1000 RCTs involving ACT between 1986 and 2022. They found ACT studies conducted across all continents for a variety of targeted outcomes, beyond psychiatric conditions, including general health, weight loss, exercise, workplace, intimacy, and academic, athletic, and social concerns. ACT studies also explored different populations, for instance, parents, caregivers, teachers, and therapists. They also found an impressive number of studies in lower- and middle-income countries (LMICs; N = 463; see also Sahdra, King et al., 2024), including large-scale ACT-based protocols with refugees (Acarturk et al., 2022).

The Future of Acceptance and Commitment Therapy

From Protocols to Processes

As ACT enters its fifth decade, it increasingly exemplifies a larger scientific shift: the movement away from syndromal protocols toward a focus on processes of change (e.g., Hayes, 2025; Hayes et al., 2019, Hayes, Hofmann, & Ciarrochi, 2020; Hayes & Hofmann, 2020; Hofmann & Hayes, 2018; Moskow et al., 2023). Instead of aligning interventions with the fluctuating categories of the DSM or ICD, ACT has, from the beginning, been rooted in the analysis of functional processes that underlie diverse forms of suffering and well-being (Ciarrochi, Hernández et al., 2024). The Psychological Flexibility model — open, aware, and actively engaged, extended to your body, relationships, and culture (see Figure 3) — has proven to be among the most robust sets of processes studied in intervention science (Hayes et al., 2022), producing positive outcomes across a vast range of human concerns (Hayes & King, 2024).

The process-based orientation ACT has been aided by the extended evolutionary meta-model (EEMM; Hayes, 2025; Hayes et al., 2022; Hayes, Hofmann, & Ciarrochi, 2020; Ong, Ciarrochi et al., 2024), which situates ACT within a broader biopsychosocial frame (Figure 3). By mapping ACT processes onto evolutionary principles of variation, selection, retention, and context (Hayes, Hofmann, & Wilson, 2020), ACT is able to incorporate new methods while remaining true to its functional contextualist core. In this sense, the future of ACT has little to do with the impact of a particular set of techniques and far more about learning how to apply principles of flexible, contextually sensitive change.

Expanding the Psychological Flexibility Model

The future of ACT requires a broader vision of flexibility. Emotional openness is not only about acceptance of distress but also non-attachment to positive emotions (Ong, Ciarrochi et al., 2024). Cognitive flexibility includes not just defusion but also adaptive reappraisal when it fosters variation and value-based selection (Ong, Ciarrochi et al., 2024). Social flexibility extends the focus from the individual to relationships, culture, and community (Hayes, Merwin et al., 2021).

By embedding ACT in the EEMM (Ong, Ciarrochi et al., 2024), flexibility processes now cover the full range of psychological dimensions—cognition, affect, attention, self, motivation, and behavior (see the six vertices of the *Hexaflex* in Figure 3)—while explicitly linking them to sociocultural and biophysiological levels and their contextual determinants. Figure 3 shows the fully expanded ACT model as of late 2025. This expansion allows ACT to engage with processes as varied as compassion, cooperation, physiological regulation, and cultural adaptation, all while retaining coherence within its scientific framework.

Idionomic Science and Personalized Care

Perhaps the most important methodological development shaping ACT's future is the rise of idionomic science (e.g., Hayes, 2025). Traditional group-based statistics assume ergodicity—the equivalence of between-person and within-person

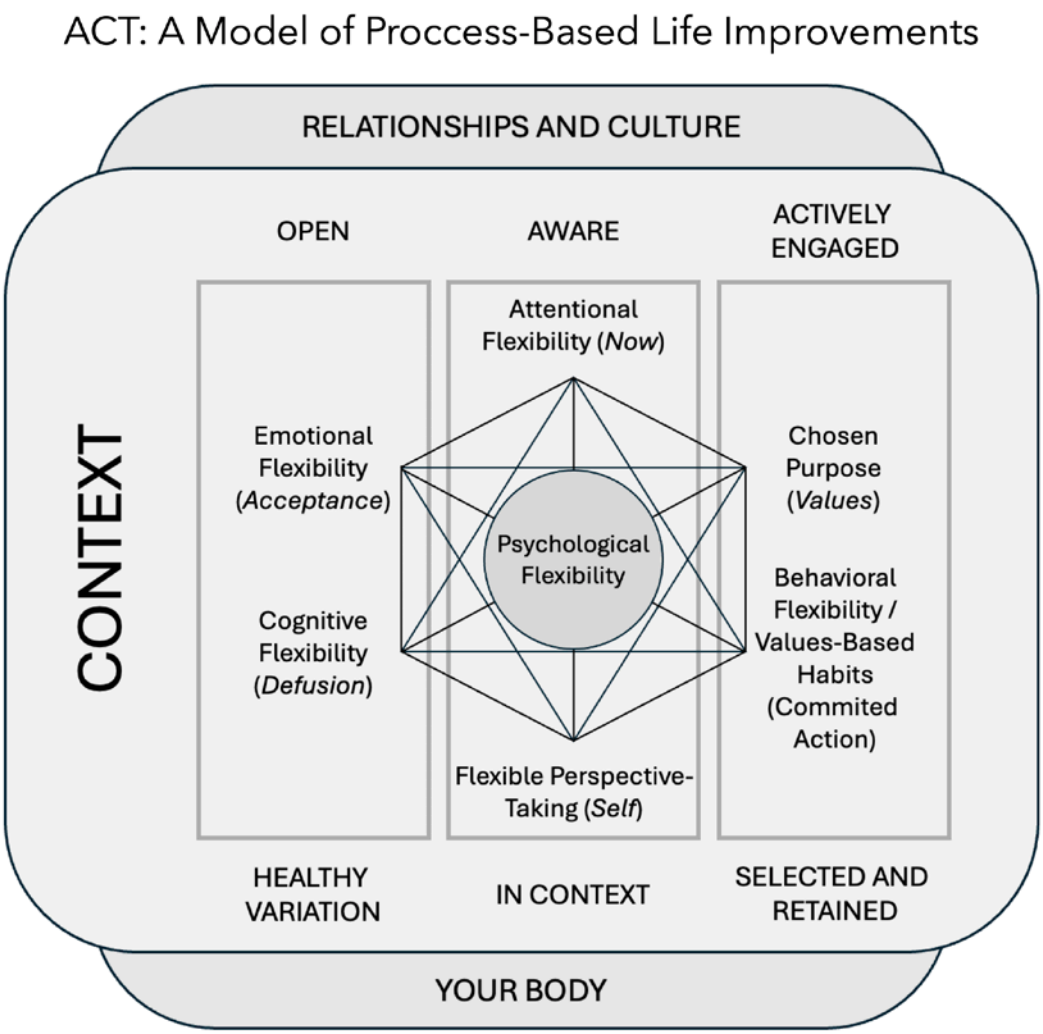

Figure 3. The ACT model as extended by the EEMM.

variation—but this assumption rarely holds in psychology (Hayes et al., 2023). As a result, nomothetic findings often fail to describe individual lives (e.g., Ciarrochi, Sahdra et al., 2024; Gloster et al., 2024; Sahdra, Ciarrochi et al., 2024, Sahdra et al., 2025).

ACT is at the forefront of correcting this error by advancing idiographic, longitudinal, high-density methods that track processes of change within individuals over time (e.g., Hernández et al., 2025; Sanabria-Mazo et al., 2025; Sahdra, Ciarrochi et al., 2024; Sanford et al., 2022; Wooley et al., 2025). This "idionomic" approach links person-specific patterns to general principles only when they add predictive and functional value. Already, studies show that psychological flexibility processes interact in surprising, dynamic ways that would be invisible under normative statistics (Hernández et al., 2025).

In practice, this means that ACT will increasingly provide clinicians with real-time feedback about the networks of processes that matter most for the client in front of them. Rather than assuming that what worked for the average trial participant will work here, practitioners will be able to see directly which processes are shifting, which remain rigid, and how to best target interventions in a functional, individualized manner.

Treating the Whole Person

The future of ACT also entails a decisive move away from a disorder-centric framework (e.g., Hayes, 2025). Analyses of the first 1,000 ACT RCTs show that fewer than one-third focused on DSM-defined problems (Hayes & King, 2024). Instead, ACT research has emphasized medical conditions,

parenting, prejudice, occupational stress, stigma, and positive outcomes such as resilience, hope, and well-being. This breadth is not incidental—it reflects ACT's core commitment to treating the whole person rather than discrete diagnostic labels.

Such a focus allows ACT to respond to what people actually care about: living meaningful lives despite pain, illness, fear, or loss. It also places ACT at the center of a larger evolution in behavioral health toward personalized, process-based approaches that integrate mental, physical, and social dimensions.

A Global and Culturally Humble Approach

One of the most striking findings in ACT's research history is its global reach. Nearly half of all ACT RCTs have been conducted in non-indexed journals from lower- and middle-income countries (LMICs), often in local languages and addressing local priorities (Hayes & King, 2024). These studies extend ACT to contexts often overlooked in Western science—dialysis patients in Iran, refugees in Uganda, adolescents in South America, families in East Asia.

The uptake of ACT by the World Health Organization, including the deployment of ACT-based *Self-Help Plus* in war-torn and resource-constrained settings, illustrates how well the model adapts across cultures (Acarturk et al., 2022). Future progress will depend on deepening this cultural humility: co-developing interventions with local communities, adapting language and delivery to context, and avoiding the imposition of Western diagnostic frameworks that may not fit. ACT's emphasis on values and context makes it uniquely suited to such global dissemination.

Technology as a Tool for Flexibility

Finally, ACT's future will be inseparable from the thoughtful use of technology. Digital platforms, apps, wearables, and ecological momentary assessment allow for the dense, longitudinal data collection that idionomic science requires. These tools can deliver ACT kernels at scale, monitor processes in real time, and support practitioners in tailoring care to individuals.

However, technology must be used with care. The goal is not to replace the therapeutic relationship but to extend its reach, enhance personalization, and provide access to those who might otherwise go without. The most promising future for ACT is one in which technology supports flexibility—opening doors, not closing them.

Conclusion: Toward a Process-Based Future

ACT began with an ambitious goal: to create a unified, process-based model of human change as a natural extension of the functional and contextual wings of behavior analysis. More than 40 years and 1,400 RCTs later, that vision is no longer aspirational—it is increasingly the reality of evidence-based practice. The next era will see ACT deepen its process focus, expand its flexibility model, embrace idionomic methods, move beyond disorders, adapt globally, and harness technology wisely. This was a choice of the entire world ACT community (Hayes, Merwin, et al., 2021) and as a result its implementation is already widespread. If these directions are realized, ACT will not merely be one option among many. It will increasingly serve as a foundation for evidence-based psychological care itself: a science and practice of change that is flexible, humane, culturally sensitive, and more adequate to the challenges of the human condition.

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