ACT Randomized Controlled Trials 1986 through Present

Before publication of the 1999 book on ACT (N = 2)

1986 (1)


1989 (1)

2. Zettle, R. D., & Rains, J. C. (1989). Group cognitive and contextual therapies in treatment of depression. Journal of Clinical Psychology, 45, 438-445. Small (N = 31) RCT. Shows that ACT is as effective as two variants of cognitive therapy for depression (a full package of CT vs. one without distancing) when presented in a group format, and that it works by a different process. A full intent to treat reanalysis and mediation analysis using modern statistical methods was published in Zettle, R. D., Rains, J. C., & Hayes, S. C. (2011). Do Acceptance and Commitment Therapy and Cognitive Therapy for depression work via the same process: A reanalysis of Zettle and Rains, 1989. Behavior Modification, 35, 265-283. The reanalysis, without the odd partial cognitive therapy group that was included for theoretical reasons of importance in the early days of ACT, shows that ACT did better than CT on the BDI at follow up and that the results were mediated by post scores on cognitive fusion but not level of depressogenic thoughts or general dysfunctional attitudes.

2000 – 2004 (N = 7)

2000 (1)

3. Bond, F. W. & Bunce, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. Journal of Occupational Health Psychology, 5, 156-163. RCT (N = 90). Shows that ACT is more effective than a previously empirically supported behavioral approach to reducing worksite stress and anxiety, and that both are better than a wait list control. Those in the ACT condition then actively modified the work environment even though that was not targeted directly in the intervention. Process analyses fit the model.

2002 (1)

trial. *Journal of Consulting and Clinical Psychology, 70* (5), 1129-1139. RCT (N = 80) showing that a three-hour ACT intervention reduces rehospitalization by about 50% over a 4 month follow-up as compared to treatment as usual with seriously mentally ill inpatients. Process of change fit the model but would be very much unexpected outside the model. A one year follow up is being written up (still significantly different at one year)

2003 (1)


2004 (4)


7. Gifford, E. V., Kohlenberg, B. S., Hayes, S. C., Antonuccio, D. O., Piasecki, M. M., Rasmussen-Hall, M. L., & Palm, K. M. (2004). Acceptance theory-based treatment for smoking cessation: An initial trial of Acceptance and Commitment Therapy. *Behavior Therapy, 35*, 689-705. RCT (N = 76) comparing ACT to nicotine replacement therapy (NRT) as a method of smoking cessation. Quit rates were similar at post but at a one-year follow-up the two groups differed significantly. The ACT group had maintained their gains (35% quit rates) while the NRT quit rates had fallen (<10%). Mediational analyses shows that ACT works through acceptance and response flexibility.

8. Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., Masuda, A., Pistorello, J., Rye, A. K., Berry, K. & Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*, 821-835. RCT (N = 93) that found that a one day ACT workshop produces greater decreases in stigmatization of clients by therapists and greater decreases in therapist burnout than an educational control and (or some comparisons) than multicultural training. Mediational analyses fit the model.

methadone maintained opiate addicts. *Behavior Therapy*, 35, 667-688. A large randomized controlled trial was conducted with polysubstance abusing opiate addicted individuals maintained on methadone. Participants (n=114) were randomly assigned to stay on methadone maintenance (n=38), or to add ACT (n=42), or Intensive Twelve Step Facilitation (ITSF; n=44) components. There were no differences immediately post-treatment. At the six-month follow-up participants in the ACT condition demonstrated a greater decrease in objectively measured (through monitored urinalysis) opiate use than those in the methadone maintenance condition (ITSF did not have this effect). Both the ACT and ITSF groups had lower levels of objectively measured total drug use than did methadone maintenance alone.

2005 – 2009 (N = 19)

2006 (4)


2007 (6)

14. Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D. & Geller, P. A. (2007). A randomized controlled effectiveness trial of Acceptance and Commitment Therapy and Cognitive Therapy for anxiety and depression. *Behavior Modification, 31*(6), 772-799. 101 heterogeneous outpatients reporting moderate to severe levels of anxiety or depression were randomly assigned either to traditional CT or to ACT. 23 very junior therapists were used. Participants receiving CT and ACT evidenced large and equivalent improvements in depression, anxiety, functioning difficulties, quality of life, life satisfaction and clinician-rated functioning. “Observing” and “describing” one’s experiences mediated outcomes for those in the CT group relative to those in the ACT group, whereas “experiential avoidance,” “acting with awareness” and “acceptance” mediated outcomes for those in the ACT group. A recent two year follow up from this study found an unusual fall off in the ACT group in year two so that should be watched closely – it could be a real effect or could be related to the therapists or other factors. It is unclear because other large and very well-done studies (e.g., see RCT #54) have not found this. Forman, E. M., Shaw, J. A., Goetter, E. M., Herbert, J. D., & Park, J. A. (2012) Long-term follow-up of a randomized controlled trial comparing Acceptance and Commitment Therapy and standard Cognitive Behavior Therapy for anxiety and depression. *Behavior Therapy, 43*, 801-811.

greater psychological flexibility with regard to diabetes related thoughts and feelings.

16. Lappalainen, R., Lehtonen, T., Skarp, E., Taubert, E., Ojanen, M., & Hayes, S. C. (2007). The impact of CBT and ACT models using psychology trainee therapists: A preliminary controlled effectiveness trial. *Behavior Modification, 31*, 488-511. Randomized controlled study in which 14 student therapists treat one client each from an ACT model or a traditional CBT model for 6-8 sessions following a 2 session functional analysis. Participants with any normal outpatient problem were included, mostly anxiety and depression. At post and at the 6 month follow up ACT clients are more improved on the SCL-90 and several other measures. Greater acceptance for ACT patients; great self-confidence for CBT patients. Both correlated with outcomes, but when partial correlations are calculated, only acceptance still relates to outcome.


2008 (5)

epilepsy diagnosis with drug-refractory seizures were randomized to ACT or yoga (12 hours of Rx both individual and group) and followed for 1 year. ACT reduced seizures more than yoga but both improved quality of life (ACT more on the WHOQOL-BREF; yoga more on the SWLS).


2009 (4)


27. Tapper, K., Shaw, C., Ilsley, J., Hill, A. J., Bond, F. W., & Moore, L. (2009). Exploratory randomised controlled trial of a mindfulness-based weight loss intervention for women. *Appetite, 52*, 396–404. RCT (N = 62) with dieting obese women randomly assigned to 4 2-hr ACT sessions or to wait list; at 6 mo. better exercise (p , .05), and for those applying the workshop, better weight loss as reflected by BMI differences (0.96 relative to controls, equivalent to 2.32 kg, p < 0.5).

28. Wicksell, R. K., Melin, L., Lekander, M., & Olsson, G. L. (2009). Evaluating the effectiveness of exposure and acceptance strategies to improve functioning and quality of life in longstanding pediatric pain - A randomized controlled trial. *Pain, 141*, 248-257. Small RCT (n = 32) comparing a brief ACT intervention (10 individual sessions) to multidisciplinary treatment plus amitriptyline (MDT) for chronic pediatric pain. Treatment continued in the MDT condition during the 3.5 and 6.5 month follow-up, which complicated comparisons at follow-up assessments due to more sessions for MDT, but results showed substantial and sustained improvements for the ACT group. When follow-up assessments were included, ACT performed significantly better than MDT on perceived functional ability in relation to pain, pain intensity and pain related discomfort (intent-to-treat analyses). At post-treatment, before the dose differences happened, significant differences in favor of the ACT condition were also seen in fear of re/injury or kinesiophobia, pain interference and in quality of life.

*Five year period from 2010 – 2014, N = 79*

2010 (8)

training, and waitlist on worksite stress (N = 107). ACT and SIT equally effective; ACT mediated by psychological flexibility, SIT not successfully mediated by cognitive change.

30. Flaxman, P. E., & Bond, F. W. (2010). Worksite stress management training: Moderated effects and clinical significance. *Journal of Occupational Health Psychology, 15*, 347-358. RCT (N = 311) of ACT vs. wait list. ACT worksite intervention found to be particularly effective for workers with above average levels of psychological distress. Following ACT, 69% of initially distressed workers improved to a clinically significant degree.


35. Smout, M., Longo, M., Harrison, S., Minniti, R., Wickes, W., & White, J. (2010). Psychosocial treatment for methamphetamine use disorders: a preliminary randomized controlled trial of cognitive behavior therapy and acceptance and commitment therapy. *Substance Abuse, 31*(2), 98-107. RCT (N = 104) showing that ACT is no more effect than CBT in retaining or treatment methamphetamine users.

36. Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-
Stevens, H. & Woidneck, M. R. (2010) A randomized clinical trial of Acceptance and Commitment Therapy vs. Progressive Relaxation Training for obsessive compulsive disorder. *Journal of Consulting and Clinical Psychology, 78*, 705-716. RCT (N = 79) of ACT for OCD vs relaxation. Good outcomes (including in depression). Mediation results coming in a separate study (AAQ worked as mediator; processes of change even at session 5 worked but outcomes were not different until later.

2011 (11)


38. Brinkborg, H., Michanek, J., Hesser, H., & Berglund, G. (2011). Acceptance and commitment therapy for the treatment of stress among social workers: A randomized controlled trial. *Behaviour Research and Therapy, 49*, 389-398. RCT examining ACT for stress and burnout in social workers (n = 106) ACT significantly decreased stress and burnout, and increased general mental health compared to a waiting list control among the 2/3 who were stressed at baseline. Among participants with high stress, a substantial proportion (42%) reached criteria for clinically significant change.


relaxation using a combination of an initial face to face session, a 7 week self-help manual with weekly therapist telephone support, and a concluding face-to-face session. 6 and 12 mo follow up. Better outcomes for ACT in level of function, pain intensity, acceptance, and marginal life satisfaction. Depression and anxiety improved but no diff between conditions.


2012 (14)

48. Fledderus, M., Bohlmeijer, E.T., Pieterse, M. E., & Schreurs, K. M. (2012) Acceptance and commitment therapy as guided self-help for psychological distress and positive mental health: a randomized controlled trial. Psychological Medicine, 42, 485-495. doi: 10.1017/S0033291711001206 RCT (N = 376) of an early intervention study for mild to moderate depression using ACT self-help with or without heavy email support. Reductions in depression, anxiety, fatigue, experiential avoidance and improvements in positive mental health and mindfulness; sustained at follow up. An important post hoc analysis found that participants showed a significant increase in flourishing as well (from 5% at pre to 28% after intervention) that was maintained at follow up: Bohlmeijer, E. T., Lamers, S. M. A., & Fledderus, M. (2015). Flourishing in people with depressive symptomatology increases with Acceptance and Commitment Therapy. Post-hoc analyses of a randomized controlled trial. Behaviour Research and Therapy, 65, 101–106. doi:10.1016/j.brat.2014.12.014


RCT (N = 73) showing that ACT helps with body dissatisfaction and disordered eating attitudes.


54. Arch, J. J., Eifert, G. H., Davies, C., Vilardaga, J., Rose, R. D., & Craske, M. G. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology, 80*, 750-765. doi:10.1037/a0028310 RCT (N = 128; 52% female; 33% minority) of 12 sessions of ACT v. tradition CBT for heterogeneous anxiety disorders; both including behavioral exposure. Broadly similar outcomes through 12 mo F-up but in blind clinical interviews ACT participants improve more in clinical severity from post to follow up than CBT (it is a very large effect: \(d = 1.33\)). Among completers their end-state clinical severity ratings were much better (\(d = 1.03\)). Better improvement for ACT in psychological flexibility (medium effect for completers: \(d = .59\)) for ACT; better quality of life at follow up (small effect: \(d = .43\)) for CBT. A separate moderation study found better outcomes for ACT those who also have depression (Wolitzky-Taylor, K. B., Arch, J. J., Rosenfield, D., & Craske, M. G. (2012). Moderators and non-specific predictors of treatment outcome for anxiety disorders: A comparison of cognitive behavioral therapy to acceptance and commitment therapy. *Journal of Consulting and Clinical Psychology, 80*, 786-799. doi:10.1037/a0029418) and another study found that treatment is mediated by cognitive defusion (Arch, J. J., Wolitzky-Taylor, K. B., Eifert, G. H., & Craske, M. G. (2012). Longitudinal treatment mediation of traditional cognitive


56. Jeffcoat, T. & Hayes, S. C. (2012). A randomized trial of ACT therapy on the mental health of K-12 teachers and staff. *Behaviour Research and Therapy, 50*, 571-579. ACT RCT with K – 12 school personnel (N = 236; 91% female; 30 - 60 years old) in a wellness program compared to wait list. Three-fourths were above clinical cutoffs in general mental health, depression, anxiety, or stress. Participants read the book for two months, completed exercises and quizzes, and after post assessment were followed for 10 weeks; wait list participants were then also given the book with two months to complete it. Overall, participants showed significant improvement in psychological health. Significant preventive effects for depression and anxiety were observed along with significant ameliorative effects for those in the clinical ranges of depression, anxiety and stress. Follow up general mental health, depression, and anxiety outcomes were related to the manner in which participants used the workbook and to post levels of psychological flexibility.

57. Mo'tamedi, H., Rezaiemaram, P., & Tavallaie, A. (2012). The effectiveness of a group-based acceptance and commitment additive therapy on rehabilitation of female outpatients with chronic headache: Preliminary findings reducing 3 dimensions of headache impact. *Headache: The Journal of Head and Face Pain, 52*, 1106-1119. Doi: 10.1111/j.1526-4610.2012.02192.x Small RCT (N = 30) with 8 group sessions of ACT plus medical TAU vs. TAU alone for outpatients patients in Iran with chronic tension headaches (63%) or and chronic migraines without aura (37%). Significant reduction in disability, affective reaction, and distress (large to very large effect sizes) but not in sensory aspect of pain. Follow up not reported.


2013 (23)

62. Bethay, S., Wilson, K. G., Schnetzer, L., Nassar, S. (2013). A controlled pilot evaluation of Acceptance and Commitment Training for intellectual disability staff. Mindfulness, 4, 113-121. Small RCT (N=34) of ACT + ABA training vs. ABA training for intellectual disability staff. Better outcomes w/ ACT for those with high distress at pre. Small (n = 34) RCT of 3 3-hour group trainings. Participants were randomly assigned to receive either 9 hours of Applied Behavior Analysis training or 9 hours of ACT plus Applied Behavior Analysis. Between group differences were observed only for participants who reported that they had been consistently applying the techniques they had learned. In addition,
ACT group participants with higher levels of psychological distress at pretest showed decreased psychological distress from pretest to follow-up when compared to their control group counterparts.


65. Luoma, J. B. & Vilardaga, J. P. (2013). Improving therapist psychological flexibility while training Acceptance and Commitment Therapy: A pilot study. *Cognitive Behaviour Therapy, 42*, 1–8, Doi: 10.1080/16506073.2012.701662 Small RCT (N = 20) of therapists receiving an ACT workshop, half of whom also received six 30-min ACT-based phone consultation sessions after the workshop. Both groups improved on ACT knowledge, burnout, and sense of personal accomplishment but those in the consultation condition reported higher psychological flexibility at the 3-month follow-up.


ACT and behavioral activation versus wait list; 3 month follow up. Large effect on depression.

68. Fledderus, M., Bohlmeijer, E. T., Fox, J. P., Schreurs, K. M. G., & Spinhoven, P. (2013). The role of psychological flexibility in a self-help Acceptance and Commitment Therapy intervention for psychological distress in a randomized controlled trial. *Behaviour Research and Therapy, 51*, 142-151. DOI: 10.1016/j.brat.2012.11.007 Participants with mild to moderate depression randomized to ACT self-help with e-mail support (n=250), or to a waiting list control group (n=126). Effects of the intervention on psychological distress stronger for participants with higher levels of psychological flexibility. Improved psychological flexibility mediated the effects of the ACT intervention.


National Cancer Institute’s Smokefree.gov website. Participants spent significantly longer on the ACT site and were more satisfied with it; quit rates at 3 month follow up were more than double on the ACT site than the NCI site (23% vs. 10%). Smoking cessation was mediated by increases in total acceptance of physical, cognitive, and emotional cues to smoke (80% of the effect).


74. Zhao, W., Zhou, Y., Liu, X., & Ran, L. (2013). Effectiveness of acceptance and commitment therapy on depression. Chinese Journal Of Clinical Psychology, 21(1), 153-157. Small RCT (N = 27) comparing ACT and CBT groups in 27 college students with severe depression and intense rumination. At 9 week F-up more reduction in depression and rumination in the ACT group; only depression significantly decreased in CBT group.

75. Steiner, J. L., Bogusch, L., & Bigatti, S. M., (2013). Values-based action in fibromyalgia: Results from a randomized pilot of acceptance and commitment therapy. Health Psychology Research, 1 (3), e34 - e34. Small RCT (N = 28) of ACT vs education for fibromyalgia examining the impact on values. Improvement in both groups in some areas. ACT but not education participants demonstrated significant, maintained improvements in success in intimate relationships.


health and behavioral outcomes in survivors of colorectal cancer: A randomized controlled trial. *Journal of Clinical Oncology, 31*, 2313-2321. Large RCT (N = 410) with colorectal cancer survivors assigned to usual care or to 11 ACT-based telephone health coaching sessions over 6 months focusing for physical activity, weight management, dietary habits, alcohol, and smoking. Significant differences at 1 year follow up for physical activity, body mass, and fat intake; vegetable intake better at 6 month. Alcohol and smoking not significantly different.


2014 (23)

85. Katterman, S. N., Goldstein, S. P., Butryn, M. L., Forman, E. M., & Lowe, M. R. (2014). Efficacy of an acceptance-based behavioral intervention for weight gain prevention in young adult women. *Journal of Contextual Behavioral Science, 3*, 45-50. [http://dx.doi.org/10.1016/j.jcbs.2013.10.003](http://dx.doi.org/10.1016/j.jcbs.2013.10.003) RCT (N = 58) of ACT and behavioral methods (8 group sessions) vs assessment only in preventing weight gain in female college students with a BMI 23-32 kg/m². ACT group lost 2.24 kg (−0.74 kg/m²) over one year; control group gained 1.07 kg and 0.34 kg/m² over the year.


87. McConachie, D. A. J., McKenzie, K., Morris, P. G., & Walley, R. M. (2014). Acceptance and mindfulness-based stress management for support staff caring for individuals with intellectual disabilities. *Research in Developmental Disabilities, 35*, 1216-1227. doi: [10.1016/j.ridd.2014.03.005](http://dx.doi.org/10.1016/j.ridd.2014.03.005) RCT (N = 120) comparing ACT-based workshop (n = 66) and wait list (n = 54); pre-, post and 6 week follow-up) for DD support staff. Greater reductions in distress in Rx group esp. among those distressed at baseline.

condition in drug abuse treatment with incarcerated women, found that at posttreatment, CBT was more effective than ACT in reducing anxiety sensitivity; however, at follow-up, ACT was more effective than CBT in improving mental health and in reducing objectively verified drug use (abstinence rates in a 6 month follow-up of 44% vs. 27% for ACT and CBT, respectively; a wait list control had a rate of 18%). It is a bit confusing but some of these same data were reported in 2013 (Villagrá-Lanza, P. & González-Menéndez, A., Acceptance and Commitment Therapy for drug abuse in incarcerated women. Psicothema, 25, 307-312). Since the larger report in 2014 contains everything in the 2013 report and then some, the earlier citation should be ignored. The long term (18 month) follow up data from the larger report are shown in González-Menéndez, A., Fernández, P., Rodríguez, F., & Villagrá, P. (2014) Long-term outcomes of Acceptance and Commitment Therapy in drug-dependent female inmates: A randomized controlled trial. International Journal of Clinical Health Psychology, 14, 18-27, and continued to show the same differences.

   RCT with middle managers comparing an ACT-based smartphone treatment (n = 36) or to a waitlist (n = 37) over a 6 week period. Small to moderate advantages for the ACT app (between group d 0.41 to 0.50) in stress and general health.


patients. *Journal of Clinical Psychology, 5*, 55-64. Small RCT (N = 24) comparing ACT (using a protocol similar to Gregg et al. protocol: see study # 15 above) versus a wait list on self-reported self-management of Type 2 diabetes. Pre-post only. Large impact on self-management (pre $\bar{x}$ = 10.58 behaviors to post $\bar{x}$ = 27.91 for the ACT condition, versus $\bar{x}$ =11.67 to $\bar{x}$ =13.5 behaviors for the TAU group -- 66% of the post treatment self-management behavior was explained by treatment group. No measure of actual blood glucose control.


96. Clarke, S., Kinston, J., James, K., Bolderston, H. & Remington, B. (2014). Acceptance and commitment therapy group for treatment-resistant participants: A randomised controlled trial. *Journal of Contextual Behavioral Science, 3*, 179-188. Doi: DOI: 10.1016/j.jcbs.2014.04.005 RCT (N = 61) comparing groups based ACT vs CBT for participants with various diagnoses who had failed to respond to previous psychosocial intervention. Both groups reduced symptoms after intervention but improvements were more sustained in ACT at a 6-month follow-up. ACT processes were predictive of response to ACT.


98. Bricker, J. Bush, T., Zbikowski, S. M., Mercer, L. D., & Heffner, J. L. (2014). Pilot randomized trial of telephone-delivered Acceptance and Commitment Therapy (ACT) versus Cognitive Behavioral Therapy (CBT) for smoking cessation. *Nicotine and Tobacco Research, 16* (11), 1446-54. doi: 10.1093/ntr/ntu102 Medium sized RCT (N = 121) comparing uninsured South Carolina State Quitline callers who were adult smokers (at least 10 cigarettes/day) wanting to quit within the next 30 days. Randomized to 5 sessions of either ACT or CBT telephone counseling. Intent-to-treat 30-day point prevalence abstinence at six months post
randomization: 31% in ACT vs. 22% in CBT (OR=1.5, 95% CI=0.7-3.4). Among participants depressed at baseline (n = 47), the quit rates were 33% in ACT vs. 13% in CBT (OR=1.2, 95% CI=1.0-1.6). Among participants scoring low on acceptance of cravings at baseline (n = 57), the quit rates were 37% in ACT vs. 10% in CBT (OR=5.3, 95% CI=1.3-22.0). The latter two finding are marginally significant and significant.


Double-blind RCT (N = 196) comparing smartphone-delivered ACT for smoking cessation application (SmartQuit) with the National Cancer Institute’s application for smoking cessation (QuitGuide). More use of ACT app. Quit rates of 13% in SmartQuit vs. 8% in QuitGuide (OR = 2.7; 95% CI = 0.8-10.3). A sub-analysis with depressed smokers showed better outcomes with ACT and lower depressive symptoms (Jones, H. A., Heffner, J. L., Mercer, L., Wyszynski, C. M., Vilardaga, R., & Bricker, J. B. (2015). Web-based acceptance and commitment therapy smoking cessation treatment for smokers with depressive symptoms. *Journal of Dual Diagnosis*, 11(1), 56-62. doi: 10.1080/15504263.2014.992588.


RCT (N = xx) comparing face to face with internet based ACT for outpatients experiencing mild or worse depression. 6 weekly therapy sessions versus 6 weeks of access to an ACT-based Internet program. Pre-treatment to 18-month follow-up within-group effect sizes for all symptom measures in the iACT treatment group (1.59-2.08), were similar or larger than for the face-to-face ACT group (1.12-1.37).


RCT (N = 59) with parents of children with acquired brain injury randomly assigned either to treatment as usual or Stepping Stones Triple P: Positive Parenting Program (SSTP) plus Acceptance and Commitment Therapy (ACT) workshop. Better outcomes in treatment condition in number and intensity of child behaviour problems, child emotional symptoms, and parenting laxness and overreactivity. Most improvements were maintained at 6 months.

RCT (N = 87) for social phobia comparing 12 week program of CBT or ACT, and a wait-list; follow up for a year. Both interventions better than wait list. Some unexpected moderation (Lower self-reported psychological flexibility at baseline was associated with greater improvement in CBT at one year). A meditational analysis has already been published: Niles, A. N., Burklund, L. J., Arch, J. J., Lieberman, M. D., Saxbe, D. & Craske M. G. (2014). Cognitive mediators of treatment for social anxiety disorder: Comparing acceptance and commitment therapy and cognitive-behavioral therapy. *Behavior Therapy, 45*, 664-677. doi:10.1016/j.beth.2014.04.006. RCT comparing CBT and ACT for social anxiety disorder. Rapid decreases in experiential avoidance as measured by the AAQ mediated posttreatment social anxiety symptoms and anhedonic depression in ACT, but not in CBT.


RCT with fibromyalgia patients (N = 156) assigned to a group-based form of ACT, recommended pharmacological treatment (RPT; pregabalin + duloxetine), or wait list (WL). Better functional outcomes and secondary outcomes for ACT at post and maintained at 6 months with medium effect sizes in most cases. Pain acceptance only mediated the relationship between study condition and health-related quality of life.


Small RCT (N = 24) randomly assigning in patients with schizophrenia to 10–12 45 min twice-weekly sessions of ACT in addition to TAU or TAU. 4 mo follow up. ACT group had lower internalized stigma at post and follow up.


Small RCT (N = 30) comparing 8 sessions of ACT and a wait list with women experiencing chronic headache and migraines. 8 Week pre-post, no follow up. Large and significant improvement on the General Health Questionnaire (post score $d = 1.43$, $CI = .63, 2.23$) and all of its subscales (physical symptoms, anxiety and insomnia, social dysfunction, depression; all large effect sizes).
Small (N = 28) RCT comparing 6 weeks of ACT-based skills training to a wait list for high-functioning students with autism spectrum disorder (aged 13–21 years) in a special school setting. 2 mo f-up. Better outcomes on stress, hyperactivity, emotional distress and prosocial behaviour.

Small RCT (N = 40) of male socially anxious middle-school students (age 12 to 16) with learning disabilities randomized to 10 sessions of ACT or no treatment. Pre-post, no follow up. Good impact on social avoidance, distress, and general social anxiety.

**2015 (36 so far, counting in press)**

Minimally active adults (n = 59) were randomly assigned to received a 12 week pedometer-based walking program, or the same program plus an ACT DVD. Physical fitness and steps taker were higher in those receiving the ACT DVD.

Patients (N = 43) with panic disorder and/or agoraphobia (PD/A) who failed to respond to an average of 42.2 sessions of evidence-based treatment were switched to 8 sessions over 4 weeks of ACT done by novice therapists, either immediately (n = 33) or after a 4-week wait (n = 10). At post-treatment, patients who received ACT were more improved than wait list patients on the Panic and Agoraphobia Scale, and the Clinical Global Impression (d = 0.72 and 0.89, respectively). Improvement on the Mobility Inventory (d = 0.50) was nearly significant. Follow-up indicated stable and continued improvement. Dropout was low (9%).

Small RCT comparing ACT (N = 15) and a wait list (N = 15) with women dealing with breast cancer. Less anxiety in the ACT group.

RCT (N = 67) parents of children with CP randomly assigned to Stepping Stones Triple P (SSTP), SSTP plus ACT, or waitlist. SSTP with ACT was associated with decreased behavioral problems including hyperactivity as well as decreased parental overreactivity and verbosity (PS MD = 0.68, CI 0.17 to 1.20, P = .01). SSTP alone was associated with decreased behavioral problems but ACT delivered additive benefits.


RCT with persons suffering from chronic pain (N = 238) comparing internet-delivered, guided self-help based on ACT (n = 82), an internet-based pressive Writing (n = 79) or a wait list (n = 77); measure at baseline, posttreatment (3 months) and at a 3-month follow-up. Better outcomes for pain interference, esp. among those who adhered to the intervention; also superior improvement on depression, pain intensity, psychological inflexibility and pain catastrophizing (d: .28-.60). 28% of ACT-participants showed general clinically relevant improvement vs. 5% for the other groups.


Small RCT (N = 40) comparing a 6 hour ACT+education workshop versus TAU for individuals at risk of vascular disease with clinically significant anxiety or symptoms of depression. Measures at pre, 12 wk post, and 24 week f-up. Significant and large (d ~ 1.4) impact on anxiety and depression from ACT as compared to control.


Consulting and Clinical Psychology, 83, 199-212. doi:10.1037/a0037946 RCT (N = 101) comparing ACT and attention placebo in treatment of partner aggression in a clinical population. 12 week 2-hour groups; 3 and 6 mo follow up. Psychological and physical aggression decreased steadily in ACT but not control conditions – small effects at post, large at follow up. Follow up mediated by flexibility processes.

Small RCT (N = 30) of ACT for anxiety disorders in teenaged girls. 12 session of ACT vs. no treatment. Reduction in anxiety; related to changes in psychological flexibility.

RCT (N = 135) comparing ACT, CBT, and a control group on depression, anxiety, leisure, dysfunctional thoughts, and experiential avoidance. Similar to CBT effects on depression pre to post (and better than the control); fall off in ACT at follow-up. Better effects on anxiety than CBT at post and follow up. Significant changes in leisure and dysfunctional thoughts in both ACT and CBT, with changes in experiential avoidance only for ACT.

RCT (N = 30) w/ obese (Body Mass Index ≥ 30) women of ACT vs. Wait list. Significant diff in BMI at F-up (Pre BMI: ACT - 33.32 (2.37); Control - 33.59 (3.62). F Up BMI: ACT - 31.95 (2.07); Control - 34.24 (4.07).

In Press

119. Wang, S., Zhou, Y., Yu, S., Ran, L., Liu, X., & Chen, Y. (in press). Acceptance and Commitment Therapy and Cognitive–Behavioral Therapy as treatments for academic procrastination: a randomized controlled group session. Research on Social Work Practice. doi: 10.1177/1049731515577890 RCT (N = 60) comparing 8 group sessions of ACT or CBT to a wait list for highly procrastinating and highly neurotic undergraduates. 3-mo follow-up. On the two primary outcomes (procrastination and neuroticism) ACT improved more. In procrastination, both treatments improved identically pre to post but ACT improved from post to follow up while CBT maintained gains. In neuroticism,
only ACT participants showed gains. At process level, ACT participants showed more improvement in negative affect; CBT in time management.

120. Pots, W.T.M. , Fledderus, M., Meulenbeek, P.A.M., ten Klooster, P.M. , Schreurs, K.M.G. & Bohlmeijer, E.T. (in press). Acceptance and Commitment Therapy as a web-based intervention for depressive symptomatology: A randomised controlled trial. _British Journal of Psychiatry_. RCT (N = 236) finding that a guided web-based Acceptance and Commitment Therapy (ACT) intervention for adults with mild to moderate depression, was better pre to post than a credible expressive writing comparison (Cohen’s d = 0.36) and a wait list(Cohen’s d = 0.56). Effects were sustained at 6- and 12-month follow-up

121. Frögéli, E., Djordjevic, A., Rudman, A., Livheim, F., & Gustavsson, P. (in press). A randomized controlled pilot trial of acceptance and commitment training (ACT) for preventing stress-related ill health among future nurses _Anxiety, Stress, and Coping_. doi:10.1080/10615806.2015.1025765 RCT (N=113) comparing 6 2-hour group ACT sessions to reflection seminars to prevent the development of stress and burnout in nursing students. 3-mo f-up. Lower stress and burnout; better mindful awareness; lower experiential avoidance. Some support for the impact of process on outcome, esp, mindful awareness.

122. Azadeh, S. M., Kazemi-Zahrani, H., & Besharat, M. A. (in press; 2016 expected). Effectiveness of Acceptance and Commitment Therapy on interpersonal problems and psychological flexibility in female high school students with social anxiety disorder. _Global Journal of Health Science_, 8, DOI: 10.5539/gjhs.v8n3p131 Small RCT (N = 30) w/ female high school students w/ social anxiety disorder as determined by self-report and a clinical interview. 10 90-min ACT sessions vs. no rx. Better interpersonal, soc. anx., and psych flexibility outcomes

123. George, B. (2015). Efficacy of acceptance and mindful based relapse prevention program on emotion regulation difficulty among alcoholics in Kerala, India. _Journal of Alcohol and Drug Dependence_, 3(3): 250. Small RCT (N = 32) for alcohol dependent adults; randomly assigned to ACT or no treatment. The study focused almost exclusively on emotional regulation. Impact on alcohol consumption was claimed but seemingly not reported.

Medium sized matched control study (N = 52) comparing TAU to ACT + TAU with patients with Alcohol Use Disorder comorbid with either depression or bipolar disorder; group protocol; 3 and 6 mo F-up. Better cumulative abstinence, obsessive drinking, depression, and anxiety in ACT than in TAU. Most improvements sustained the 6-month follow-up period.

DOI: 10.1249/MSS.0000000000000536
RCT (N = 39) for exercise tolerance in women comparing ACT + listening to music vs listening to music. Increased exercise time w/ ACT and great post exercise enjoyment.

DOI: 10.1017/S1352465813000969
RCT (N = 57) comparing ACT and wait list on self-reported depression using inexperienced therapists. 6 mo F-up. Large to medium effect sizes on depression and psychological flexibility.

DOI: 10.1186/s12889-015-1604-x
RCT (N = 138) of physically inactive participants aged 30 to 50 years randomly allocated to feedback or ACT + feedback. 6 mo. F-up. No difference in physical activity change and more stability of exercise in non-depressed participants in ACT. Cognitions related to physical activity and exercise improved more in the ACT + FB group.

doi:10.1016/j.brat.2015.07.001
RCT (N = 59) comparing SSPPP + ACT to TAU. Significant small to medium improvements relative to the CAU group in parental confidence in managing behaviors, family adjustment, parent psychological distress, and number of disagreements between parents.

RCT (N = 39) of web-based ACT w/ minimal support vs wait list. 1 yr F-up. Significant and large relative benefits on depression; and medium effects on distress and ACT-related process measures.


RCT (N = 126) of ACT group therapy (9 3-hr sessions and 1 booster) vs Wait List. 10 mo. f-up. Large and significant improvement on illness worry (between group $d = .89$) at F-up; also improvement in emotional distress and health-related quality of life. Among the best outcomes yet reported w/ hypochondriacs.

DOI: 10.1111/pme.12885
RCT (N = 101) comparing ACT + SOC to a minimal support group. Significant relative improvement between groups in acceptance, pain related anxiety, compensation strategies, and pain interference in walking.

impacts on depressive symptoms and stress and changes in psychological flexibility.