



The Effectiveness of Acceptance and Commitment Therapy (ACT) in a Group Setting on Social Competence, Academic Motivation, and the Improvement of High-Risk Behaviors in Male Students

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ABSTRACT

The present study aimed to examine the effectiveness of group-based Acceptance and Commitment Therapy (ACT) on social competence, academic motivation, and reduction of high-risk behaviors in first-grade secondary school male students. The research employed a quasi-experimental pretest–posttest follow-up design with a control group. The statistical population comprised all first-grade secondary school male students (7th, 8th, and 9th grades) in Mashhad during the academic year 2025–2026. Using multi-stage cluster sampling, a sample of 30 participants was selected and then randomly assigned to experimental and control groups (15 participants per group). The Social Competence Questionnaire, the Academic Motivation Questionnaire, and the Iranian Adolescent Risk-Taking Scale were administered to assess the study variables in the sample. The group-based ACT intervention was delivered to the experimental group over eight 90-minute sessions, while the control group received no training. Data were analyzed using multivariate analysis of covariance (MANCOVA) and paired-samples t-test in SPSS-22. The findings indicated that posttest means differed significantly between the experimental and control groups ($P < .05$). The results demonstrated that group-based ACT significantly increased social competence and academic motivation while reducing high-risk behaviors. Furthermore, the two-month follow-up results demonstrated desirable stability of the treatment effects across all three variables. Therefore, it is recommended that ACT-based programs be considered as an effective approach within school counseling and education as well.

Keywords: Acceptance and Commitment Therapy (ACT), social competence, academic motivation, high-risk behaviors, male students

Introduction

In the era of globalization and rapid social transformations, educational systems face numerous challenges in fostering healthy, well-adjusted, and successful students. One of these challenges is the emergence of high-risk behaviors during adolescence, which can jeopardize the physical and psychological health of both the individual and society [1,2]. Adolescence, as a sensitive and fateful developmental period, is accompanied by rapid physical, psychological, and social changes, and significant behavioral patterns that influence an individual's life are formed during this period [3]. High-risk behaviors in adolescence refer to

actions associated with a minimal probability of undesirable consequences, and according to the dual systems model, the increase in these behaviors during adolescence stems from an imbalance between the socio-emotional system (reward-seeking) and the cognitive control system (self-regulation) [1].

This imbalance reaches its peak during adolescence because the reward-seeking system matures earlier than the cognitive control system, propelling the adolescent toward risky behaviors [2]. Alongside these challenges, two other critical components, social competence and academic motivation, play a determining role in adolescents' academic success and social adjustment.



Social competence is defined as the ability to achieve social goals in an effective and contextually appropriate manner and encompasses cognitive, behavioral, emotional, and motivational skills [4,5]. This construct, within the framework of the "multilevel prism model," comprises three interconnected levels: the global level, characterized by effectiveness in social interactions; the index level, reflecting an individual's performance in achieving self-oriented and other-oriented social goals across various contexts; and the skill level, encompassing specific social, emotional, and cognitive abilities that support social interactions [4]. Deficits in social competence lead to behaviors such as delinquency, maladjustment, and academic failure [6], as well as substance abuse and addiction [7]. Research has demonstrated that empathy deficits constitute a risk factor and predictor of impulsive and disruptive behaviors, and childhood disruptive behavior disorders often develop into antisocial personality disorder in adulthood [8].

On the other hand, academic motivation refers to the set of beliefs, values, and goals that guide an individual's goal-directed behavior in learning situations and, based on situated expectancy-value theory (SEVT), comprises three main components: "competence beliefs" (Can I do this?), "task value" (Do I want to do this? including intrinsic value, attainment value, and utility value), and "cost" (psychological, effort, and opportunity costs) [9]. Academic motivation is influenced not only by individual factors but also strongly by the classroom context and teacher-student interactions [10]. Students with high levels of academic motivation consistently strive for success, anticipate it, and when they experience failure, they persist in their efforts until they succeed [11]. In contrast, students with low motivation not only show less diligence in completing academic tasks but also have a higher probability of dropping out and experiencing academic decline [12].

In recent decades, third-wave therapeutic approaches in psychology, including Acceptance and Commitment Therapy (ACT), have emerged as promising strategies for improving psychological functioning and reducing problematic behaviors. ACT is a psychological intervention grounded in modern behavioral psychology that incorporates Relational Frame Theory (RFT) and utilizes processes of mindfulness, acceptance, and commitment to behavior change to foster psychological flexibility [13]. Unlike traditional approaches that seek to change the content of unpleasant thoughts and emotions, ACT emphasizes altering the individual's relationship with these internal experiences [14]. The primary goal of this therapy is to enhance psychological flexibility through six core processes: acceptance, cognitive defusion, self-as-context, contact with the present moment, values, and committed action [15]. Indeed, ACT is founded on the principle that attempts to control and eliminate unpleasant thoughts and

emotions are not only ineffective but paradoxically intensify them [14]. From a neurocognitive perspective, ACT increases prefrontal cortex activity (responsible for executive function control), thereby strengthening self-regulation and behavioral inhibition [16].

Numerous studies have demonstrated the effectiveness of ACT on variables related to mental health and academic performance. For instance, Biranvand et al showed that ACT was more effective than mindfulness-based therapy in reducing high-risk behaviors and enhancing positive life orientation in adolescents [17]. Kharaghani et al found that ACT had a significant effect on feelings of inferiority and academic enthusiasm among midwifery students [18]. Mali & Akbari Dehghi demonstrated that ACT significantly increased academic motivation (with an effect size of 30%) and improved emotion regulation strategies in adolescents [19]. Zarei et al also confirmed the effectiveness of ACT on self-efficacy beliefs and academic vitality in students [20]. Ahmadi Bani et al in their study, group ACT had a significant effect on improving social skills, academic performance, and particularly enhancing emotion regulation ability in adolescents [15]. Safari-Pour et al showed that ACT improved social adaptive functioning and reduced unproductive academic behaviors in female students [21]. Alizadeh and Rouhani also reported a 56% reduction in high-risk behaviors (except alcohol consumption) among students participating in their study [22]. Yekani-Zad et al demonstrated the effect of ACT on reducing social anxiety and increasing social competence in male students [23]. Gol-Pira et al also confirmed the effectiveness of ACT on reducing high-risk behaviors in female students. In international studies [24]. Asal et al showed that ACT significantly increased academic motivation, academic adjustment, and psychological flexibility in students [25]. Ishizu et al in Japan found that an ACT-based educational program was effective in clarifying values and commitment, self-esteem, and self-determination orientation in adolescents [26]. Demir and Kabakçı also demonstrated in their review study that working with values in ACT can help adolescents meet their developmental needs [27]. Bernal-Manrique et al also confirmed the effectiveness of ACT focused on negative rumination in improving interpersonal skills in adolescents with social adjustment problems [28]. Despite the growing evidence regarding the impact of ACT in education, three fundamental research gaps are observed in the existing literature: 1. Most previous studies have focused on formal educational settings and student populations, whereas first-grade secondary school students, due to the sensitive period of adolescence and the specific pressures of this stage, require unique interventions. 2. The effect of group-based ACT on all three variables of social competence, academic motivation, and high-risk behaviors simultaneously has not been investigated in any study in Iran. 3.

The role of sensitive developmental periods (such as adolescence) in the responsiveness to ACT-based interventions has been neglected. Ultimately, this research can provide scientific evidence regarding the role of acceptance and commitment skills in enhancing social competence and academic motivation and reducing high-risk behaviors, helping educational decision-makers and school counselors adopt more appropriate methods and techniques to improve the quality of education and students' mental health. This study aimed to fill these gaps by investigating the effectiveness of group-based ACT on social competence, academic motivation, and reduction of high-risk behaviors in first-grade secondary school male students.

Method

This study is applied in terms of purpose and quasi-experimental in terms of method, employing a pretest-posttest follow-up design with a control group. In this design, there were two groups: a control group and an experimental group. Participants were randomly assigned to either the experimental or control group. The group-based ACT intervention (Hayes et al., 2012) was delivered to the experimental group over eight 90-minute sessions (one session per week). The control group was placed on a waiting list and received no training until the completion of the experimental group's treatment. Finally, a posttest was administered to both groups after the treatment sessions, and a two-month follow-up was conducted.

The statistical population comprised all first-grade secondary school male students (7th, 8th, and 9th grades) in Mashhad during the academic year 2025–2026. The sample size was determined using multi-stage cluster sampling. Initially, 100 students were selected for screening high-risk behaviors. Then, based on inclusion criteria (scoring above the cutoff point on the Iranian Adolescent Risk-Taking Scale), the primary sample of students with a high tendency toward high-risk behaviors was identified. Finally, a final sample of 30 participants was randomly selected and divided into two groups of 15 (experimental and control). Inclusion criteria were: 1. Scoring above the cutoff point on the Iranian Adolescent Risk-Taking Scale (IARS); 2. Being a first-grade secondary school male student; 3. Providing informed consent to participate in treatment sessions; 4. Not receiving concurrent psychological interventions. Exclusion criteria were: 1. Missing more than two sessions of the total training sessions; 2. Diagnosis of major psychiatric disorders; 3. Use of psychiatric medications; 4. Withdrawal of informed consent to continue participation in the study. Three standard questionnaires were used for data collection:

a. Social Competence Questionnaire (SCQ): This questionnaire was developed by Felner (2002) to assess social competence. It contains 47 items and encompasses four dimensions: behavioral skills,

cognitive skills, emotional skills, and motivational orientations. Items are scored on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree). The total score is obtained by summing the item scores; therefore, the range of scores is between 47 and 329, with higher scores indicating greater social competence. Felner confirmed the validity of the instrument through factor analysis and reported its reliability using Cronbach's alpha as .88 and test-retest reliability with a one-month interval as .89 [29]. In Iran, the construct validity of the scale was examined through the correlation of the total scale with subscales, which was significant at the 99% level. Factor analysis was also conducted, yielding a KMO value of .83. Afrouz et al reported the reliability of the instrument using Cronbach's alpha as .86. The reliability of the scale in the present study was obtained as .77 using Cronbach's alpha [30].

b. Academic Motivation Questionnaire: This questionnaire was developed by Harter to assess academic motivation [31]. The scale contains 33 items scored on a 5-point Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = most of the time, 5 = almost always). However, this scoring method is reversed for items 3, 4, 5, 9, 10, 15, 16, 17, 21, 27, and 31. The total score is obtained by summing the item scores; therefore, the range of scores is between 33 and 165. Scores between 33 and 66 indicate weak academic motivation; scores between 66 and 99 indicate moderate academic motivation; and scores above 99 indicate very good academic motivation. Harter reported the validity coefficient using the Richardson formula 20 ranging from .54 to .84, and test-retest reliability over a 9-month period ranging from .48 to .63, and over a 5-month period ranging from .58 to .76 in another sample [31]. In Iran, the reliability of this questionnaire was calculated as .92 using Cronbach's alpha [32].

c. Iranian Adolescent Risk-Taking Scale (IARS): This scale was developed by Zadeh Mohammadi et al and contains 38 items rated on a Likert scale (strongly agree = 5 to strongly disagree = 1) [33]. The questionnaire comprises 7 subscales: dangerous driving, violence, smoking, substance abuse, alcohol consumption, sexual behavior and relationships, and attraction to the opposite sex. Zadeh Mohammadi et al examined the validity of this scale using internal consistency via Cronbach's alpha and its construct validity using exploratory factor analysis and principal component analysis. The KMO value was .949, indicating a highly satisfactory level, and Bartlett's test of sphericity was statistically significant. Furthermore, the reliability of the total scale and its subscales was at a satisfactory and appropriate level, with Cronbach's alpha for the total scale, alcohol consumption, substance abuse, smoking, violence, dangerous driving, sexual behavior and relationships, and attraction to the opposite sex reported as .931, .938, .809, .856, .907, .906, and .907, respectively [33].

Ethical Considerations: This study was conducted with approval from the Ethics Committee of Islamic Azad University, Torbat-e Jam Branch, under ethics code IR.IAU.TJ.REC.1404.099, and with full adherence to ethical principles, including obtaining informed consent from parents and students, ensuring confidentiality of information, the right to withdraw from the study, and non-disclosure of participants' identities.

Following the acquisition of necessary permissions, including the university ethics committee approval and two-stage informed consent (parents and participants), the researcher visited the schools during the specified time frame and, after providing explanations to the administrators, initiated the sampling and research

implementation process. Questionnaires were administered before the intervention (pretest), after the training course (posttest), and two months later (follow-up). The ACT protocol, detailed in Table 1, was implemented by the researcher for the experimental group in 90-minute sessions. After data collection, data were analyzed using descriptive statistics (mean and standard deviation) and inferential statistics (multivariate analysis of covariance and paired-samples t-test) to examine the effect of the ACT intervention on students' social competence, academic motivation, and high-risk behaviors.

Table 1: Details of ACT Sessions Based on the Hayes et al. (2012) Protocol

Session	Session Title	Educational Objectives	Specific Activities
1	Introduction to Therapy	Familiarity with ACT principles and values	Examining thoughts and feelings; providing a general explanation of the therapy and its goals; beginning therapy with attention to individuals' values
2	Psychological Acceptance and Experiential Avoidance	Psychological acceptance of mental experiences	Explaining the ineffectiveness of controlling mental experiences using metaphors of "tug-of-war" and "unwanted guest"
3	Creative Hopelessness	Explaining the concept of "creative hopelessness"	Explaining the ACT principle that "control is the problem, not the solution"; reviewing previous unsuccessful attempts to control internal experiences
4	Testing Control of Thoughts and Emotions	Experiencing the actual control of thoughts and emotions	Using metaphors of "falling in love" and "chocolate cake" to demonstrate the ineffectiveness of direct control attempts over internal experiences
5	Acceptance and Distinguishing Pain from Suffering	Explaining the relationship with internal events	Introducing the acceptance component and using personal life examples; "hungry tiger" metaphor; explaining the difference between pain and emotional suffering
6	Cognitive Defusion and Mindfulness	Introducing cognitive defusion and mindfulness	Using metaphors and experiential exercises (e.g., "leaves on a stream" and "word repetition"); teaching relaxation exercises
7	Self-as-Context and Values Clarification	Identifying personal values	Mindfulness exercise; helping individuals identify their core personal values; explaining the formation of self-concept using "chessboard" and "passengers on the bus" metaphors
8	Committed Action and Summary	Commitment to action and summarizing learnings	Teaching the "commitment to action" component; identifying value-consistent behavioral plans and establishing commitment to act on them; providing a summary of therapy sessions

Results

Following data collection and analysis, in the descriptive section, the frequency distribution of age groups in the control and experimental groups indicated a relative balance in the age composition of the samples. Before addressing the research hypothesis, the results of the Shapiro-Wilk test for examining the normality of the distribution of research variables are reported. Table 2 presents the descriptive indices and Shapiro-Wilk test results for the research variables.

If the probability value of the Shapiro-Wilk test exceeds .05, there is no reason to reject the null hypothesis (normality). Consequently, the distribution of the variables of social competence, academic motivation, and high-risk behaviors in both groups and at both time points is normal at the five percent error level.

Table 2: Descriptive Indices and Shapiro-Wilk Test for Research Variables

Variable	Time	Control (Test Statistic)	Control (Probability Value)	Experimental (Test Statistic)	Experimental (Probability Value)
Social Competence	Pretest	-	-	-	-
	Posttest	.954	.587	.962	.713
Academic Motivation	Pretest	-	-	-	-
	Posttest	.947	.492	.958	.648
High-Risk Behaviors	Pretest	-	-	-	-
	Posttest	.951	.531	.965	.782

Another prerequisite for conducting this analysis is testing the homogeneity of the variance-covariance matrix of the variables, which is performed using Box's M test, the results of which are presented in Table 3.

Table 3: Box's M Test Results for Homogeneity of Variance of Research Variables at Posttest Between Control and Experimental Groups

Box's M Statistic	Fisher's F Statistic	First Degree of Freedom	Second Degree of Freedom	Probability Value
3.882	1.220	3	259920	.301

The probability value obtained by Box's M test exceeds .05, and there is no reason to reject the assumption of homogeneity of the variance-covariance matrix of these variables at posttest between the control and experimental groups; therefore, the assumption of homogeneity of the variance-covariance matrix for ANCOVA is also met.

The final assumption of ANCOVA is the homogeneity of regression slopes. For this purpose, the significance of the interaction effect between the group variable and the research variables in Table 4 indicates that the interaction effects are not significant, and thus the assumption of homogeneity of regression slopes is met.

Table 4: Results of Testing the Assumption of Homogeneity of Regression Slopes

Independent Variable	Dependent Variable	Sum of Squares	df	Mean Square	F	sig
Group Social Competence-Pretest	Social Competence-Posttest	.881	1	.881	1.119	.298
	Academic Motivation-Posttest	.050	1	.050	.077	.783
Group Academic Motivation-Pretest	Social Competence-Posttest	.464	1	.464	.589	.448
	Academic Motivation-Posttest	.484	1	.484	.747	.394

Table 5 examines the between-group effects of pretest and group (independent variables) on all dependent variables at posttest.

In Table 5, the pretest rows examine the significance of the effect of each variable's baseline, and the group row compares the variables between the control and experimental groups at posttest. The last column shows the effect size, indicating the magnitude of the sample size's influence on the obtained results. Furthermore, the probability value for the group row for both variables at posttest is less than .05, indicating a significant difference between the posttest means of the control and experimental groups at the five percent error level. In other words, with 95% confidence, it can be claimed that group-based ACT has a significant effect on enhancing social competence and academic motivation and reducing high-risk behaviors, confirming the research hypothesis. Additionally, paired-samples t-test results comparing the mean scores of the experimental group at posttest and two-month follow-up showed that the differences between posttest and follow-up means

for all three variables—social competence ($p = .083$), academic motivation ($p = .076$), and high-risk behaviors ($p = .095$)—were not significant at the .05 level. Therefore, the treatment effects demonstrated desirable stability at the two-month follow-up.

Table 5: Between-Group Effects in MANCOVA for Examining the Effect of Group-Based ACT on Enhancing Social Competence and Academic Motivation and Reducing High-Risk Behaviors

Independent Variable	Sum of Squares	df	Mean Square	F	sig	Eta
Social Competence-Pretest	22.439	1	22.439	28.647	.000	.443
Academic Motivation-Pretest	.036	1	.036	.057	.813	.002
Group	.019	1	.019	.025	.876	.001
Error	4.333	1	4.333	6.913	.013	.161
	13.042	1	13.042	16.650	.000	.316
	7.944	1	7.944	12.676	.001	.260
	28.198	36	.783			
	22.562	36	.627			

In Table 5, the pretest rows examine the significance of the effect of each variable's baseline, and the group row compares the variables between the control and experimental groups at posttest. The last column shows the effect size, indicating the magnitude of the sample size's influence on the obtained results. Furthermore, the probability value for the group row for both variables at posttest is less than .05, indicating a significant difference between the posttest means of the control and experimental groups at the five percent error level. In other words, with 95% confidence, it can be claimed that group-based ACT has a significant effect on enhancing social competence and academic motivation and reducing high-risk behaviors, confirming the research hypothesis. Additionally, paired-samples t-test results comparing the mean scores of the experimental group at posttest and two-month follow-up showed that the differences between posttest and follow-up means for all three variables—social competence ($p = .083$), academic motivation ($p = .076$), and high-risk behaviors ($p = .095$)—were not significant at the .05 level. Therefore, the treatment effects demonstrated desirable stability at the two-month follow-up.

Discussion and Conclusion

The findings indicated that posttest means differed significantly between the control and experimental groups ($P < .05$). In other words, with 95% confidence, it can be claimed that group-based ACT has a significant effect on enhancing social competence and academic motivation and reducing high-risk behaviors, thus confirming the research hypothesis. To examine this finding and compare it with previous research, the following section discusses and interprets the hypothesis. The results of studies by Biranvand et al [17], Kharaghani et al [18], Mali & Akbari Dehghi [19], Zarei et al [20], Ahmadi Bani et al [15], Safari-Pour et al [21], Alizadeh and Rouhani [22], Yekani-Zad et al [23], Gol-Pira et al [24], Asal et al [25], Ishizu et al [26], Demir and Kabakçı [27] and Bernal-Manrique et al [28] are consistent with the findings of the main hypothesis of the present study. To explain the obtained result, it can be stated that Acceptance and Commitment Therapy (ACT), as one of the third-wave cognitive-behavioral approaches, unlike traditional approaches.

Approaches that seek to change the content of unpleasant thoughts and emotions, emphasizes altering the individual's relationship with these internal experiences [13]. The primary goal of ACT is to create "psychological flexibility" through six core processes: acceptance, cognitive defusion, self-as-context, contact with the present moment, values, and committed action [15]. According to theoretical foundations, ACT is a psychological intervention based on modern behavioral psychology and Relational Frame Theory (RFT), utilizing processes of mindfulness, acceptance, and commitment to behavior change [13]. ACT is founded on the principle that attempts to control and eliminate unpleasant thoughts and emotions are not only ineffective but paradoxically intensify them [14].

Regarding the research variables, social competence is defined as the ability to achieve social goals in an effective and contextually appropriate manner and encompasses cognitive, behavioral, emotional, and motivational skills [4,29]. Academic motivation, based on situated expectancy-value theory, comprises competence beliefs, task value, and cost [9]. High-risk behaviors in adolescence, according to Steinberg's dual systems model, stem from an imbalance between the socio-emotional system (reward-seeking) and the cognitive control system (self-regulation) [1]. A review of the literature indicated that numerous domestic and international studies support the effectiveness of ACT on these variables.

From the perspective of therapeutic processes, acceptance and cognitive defusion help individuals view negative thoughts merely as words in the mind rather than objective reality, thereby reducing fear of negative evaluation and increasing willingness to engage in social interactions [13]. Furthermore, the self-as-context process teaches students to view themselves as separate from transient thoughts and emotions and to experience a stable sense of self, helping them be less influenced by mood fluctuations and momentary judgments in social interactions [34]. Values clarification also helps students understand what types of relationships, academic goals, and lifestyles are authentically important to them and then take concrete steps toward their realization through committed action [27]. Overall, theoretical foundations and research literature indicate that ACT, by reducing experiential avoidance and increasing acceptance, can provide a suitable foundation for improving social competence (through reducing fear of negative evaluation and increasing social interactions), enhancing academic motivation (through values clarification and reducing fusion with self-disabling thoughts), and reducing high-risk behaviors (through increasing tolerance of unpleasant emotions and choosing value-consistent behaviors).

Like all studies, this research has limitations. The implementation of this study in Mashhad limits the generalizability of results to other cities with cultural and economic diversity. Additionally, restricting the age range to 15–18 years and to male participants constitutes another limitation. Therefore, generalization to other groups should be made with caution. The sample size was small, and results were examined only in students from a few schools; generalization to larger populations should be made with caution. Furthermore, assessment instruments may not possess the necessary accuracy and reliability and may not fully capture more complex dimensions of mental health. Given the mentioned limitations, it is recommended that other researchers conduct similar studies on other groups and compare the results with those of the present study. It is also

suggested that samples be drawn from different cities to evaluate information from various regions. Future research should examine this method at higher educational levels and separately for girls and boys. Longitudinal studies are also recommended to examine changes in academic self-regulation and behavioral inhibition over time. Finally, school counselors are advised to utilize ACT-based training to improve social competence, academic motivation, and reduce high-risk behaviors based on the results of this study.

Conflict of Interest:

This research is extracted from a master's thesis.

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