

An Intervention Based on Acceptance and Commitment Therapy for People Experiencing Work- or Career-Related Difficulties: A Randomized Controlled Trial

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This randomized controlled trial assessed the effectiveness of a group intervention based on acceptance and commitment therapy designed for people facing work- or career-related difficulties (e.g., job loss, burnout). Participants were recruited with the assistance of community organizations providing career counseling services, and they were randomly assigned to either an intervention group ($n = 82$) or a waitlist group ($n = 82$). They completed questionnaires aimed at measuring process (i.e., psychological flexibility and inflexibility) and outcome variables (i.e., psychological well-being, psychological distress, meaning in life, and career engagement) on three occasions (baseline, postintervention, and follow-up). Participants took part in seven 2.5-hr sessions offered online during a 7-week period. Results of mixed-effects models on intention-to-treat data showed that the intervention led to an increase in psychological flexibility ($d = .64$), well-being ($d = .32$), and meaning in life ($d = .42$) and a decrease in psychological inflexibility ($d = -.51$) and distress ($d = -.36$). These effects were maintained at follow-up (17 weeks later), moderated by participants' initial levels of distress and precarity (for some outcomes). Indirect effect analyses showed that changes in psychological flexibility/inflexibility statistically accounted for these effects. The intervention had no significant effect on career engagement. Overall, this trial suggests that the intervention helped promote well-being and flourishing among people struggling with work- or career-related difficulties.

Public Significance Statement

This study found that an online group program based on acceptance and commitment therapy significantly improved participants' well-being, sense of meaning, and psychological flexibility while reducing distress—benefits that lasted for several months. The findings suggest that such interventions can effectively support people coping with job loss, burnout, or other career challenges.

Keywords: acceptance and commitment therapy, psychological well-being, psychological distress, psychological flexibility

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People encounter various challenges throughout their careers (i.e., job loss, career transition, career indecision; Sullivan & Al Ariss, 2019), which can lead to experiencing psychological distress symptoms (Milot-Lapointe et al., 2016). For example, evidence indicates

that unemployed individuals are at a higher risk of developing stress, anxiety, and depression symptoms (Picchio & Ubaldi, 2023), while those facing work–life conflicts are more likely to report poor mental health (Kim & Cho, 2020). Research has also shown that career

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Maryse Damecour played a lead role in investigation, project administration, visualization, and writing—original draft, a supporting role in formal analysis, and an equal role in conceptualization, data curation, and methodology. Marina M. Doucerain played a lead role in data curation, formal analysis, and visualization, a supporting role in funding acquisition and investigation, and an equal role in conceptualization, methodology, and writing—review and editing. Lise Lachance played an equal role in conceptualization, funding acquisition, methodology, validation, and writing—review and editing. Simon Grégoire played a lead role in funding acquisition, resources, supervision, and writing—review and editing, a supporting role in data curation and formal analysis, and an equal role in conceptualization, investigation, methodology, project administration, and validation.

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indecision is closely related to anxiety and depression (Bian, 2021). This is why researchers have long insisted on the importance of designing career interventions that address the interwoven nature of work and mental health, interventions that not only assist individuals in navigating career challenges but also promote well-being and flourishing (Tang et al., 2021; Valach & Young, 2017). In this study, we evaluated a novel group intervention based on acceptance and commitment therapy (ACT; Hayes et al., 2012) to support people experiencing work- or career-related difficulties (e.g., job loss, career indecision, burnout). In the following sections, we briefly review the literature on the application of ACT in the workplace and then introduce three avenues for further research advancing research in this field.

ACT in the Workplace

ACT is a process-based approach to therapy (Ong et al., 2024) rooted in the pragmatic philosophy of functional contextualism (Gifford & Hayes, 1999) that does not specifically target symptom reduction but rather encourages participants to develop a more adaptable and functional repertoire of behaviors and engage in values-based actions. The overall aim of ACT is to increase psychological flexibility (PF; i.e., the ability to be present and attentive to one's immediate experiences and to act according to one's values, even when confronted with difficult thoughts, emotions, or sensations) and reduce psychological inflexibility (PIF; i.e., any attempts to control uncomfortable internal experiences; Hayes et al., 2013; Ong et al., 2024). To do so, ACT targets six flexibility processes (acceptance, cognitive defusion, present-moment awareness, self-as-context, values, and committed action) and six inflexibility processes (experiential avoidance, cognitive fusion, lack of contact with the present moment, self-as-content, lack of contact with values, and inaction; Hayes et al., 2012).

Although originally developed for clinical purposes, ACT has also been used in the workplace with people experiencing work- or career-related difficulties such as burnout (Prudenzi et al., 2021, 2022; Reeve et al., 2018; Rudaz et al., 2017; Towey-Swift et al., 2023; Unruh et al., 2022). Evidence suggests that ACT-based interventions are effective in reducing psychological distress symptoms among workers, especially those who report high levels of distress at baseline (Reeve et al., 2018). Prudenzi et al. (2021) published a meta-analysis based on 10 randomized controlled trials (RCTs) involving health care professionals. They found that ACT outperformed pooled control conditions with a small effect size for general distress at postintervention and for work-related distress at follow-up. In their meta-analysis of 17 RCTs, Unruh et al. (2022) showed that ACT was more effective than passive and active control conditions regarding psychological distress and well-being at posttreatment and stress and well-being at follow-up.

Other studies have led to mixed results. For instance, in a systematic review and narrative synthesis of RCTs, Towey-Swift et al. (2023) found that 11 of 14 ACT-based interventions had a statistically significant positive impact on burnout compared with both waitlist and active controls. However, Reeve et al. (2018) found no pool effect in favor of ACT in their meta-analysis compared with control conditions on emotional exhaustion (one dimension of burnout).

These inconsistent results are not necessarily surprising as research in the workplace is still in its early stage, but they do suggest that more studies are needed to determine whether ACT can effectively help people experiencing a mix of work and mental health issues (Prudenzi

et al., 2021; Towey-Swift et al., 2023). Below, we discuss three avenues for advancing research in this field: (a) integrating ACT into a broader career framework, (b) testing its efficacy using theoretically relevant process and outcome variables, and (c) targeting a more diverse working population.

Integrating ACT Into a Broader Career Framework

We have argued elsewhere (Piot et al., 2024) that ACT would benefit from being integrated into a broader career development framework such as the contextual action theory (CAT; Domene et al., 2015) when used with people presenting a combination of career and mental health issues. CAT is not "defined by its sharp borders but by its integrative stance" (Young et al., 2015, p. 316). It is a broad framework that can incorporate various approaches rather than being a standalone counseling or therapeutic approach. Moreover, ACT and CAT have a lot in common: (a) They are both rooted in contextualism (Pepper, 1942) and view individuals as whole persons interacting within complex systems; (b) they underline the role of intentional, goal-oriented actions in shaping life paths; and (c) they aim to address any problematic actions in the client's life and design more life-enhancing endeavors (Valach & Young, 2017). But ACT and CAT also differ in certain ways. For instance, while ACT originates from clinical psychology and is aimed at increasing PF, CAT is grounded in career counseling and development and focuses on the construction of careers through actions and social context. While ACT employs mindfulness or cognitive defusion experiential exercises, CAT utilizes a narrative and constructivist approach, encouraging participants to story their career processes and envisage future possibilities. When applied in combination, ACT and CAT offer a comprehensive framework that not only addresses the dynamic interaction between psychological and action-oriented processes but also accounts for the social, cultural, and relational contexts in which these processes are embedded.

Using Relevant Processes and Outcomes of Change

Ong et al. (2023) presented a compelling argument for conducting RCTs using change processes and outcome variables that are theoretically pertinent to ACT. As PF is the primary target and hypothesized mechanism of change in ACT, the authors maintain that measuring this construct is crucial. They believe that PIF should be measured as well because evidence suggests that PF and PIF are likely distinct constructs, rather than two ends of a shared spectrum (Cherry et al., 2021; Rolffs et al., 2018). Unfortunately, PIF is seldom considered in studies, while results regarding PF have been inconsistent (Reeve et al., 2018). For example, Prudenzi et al. (2021) noted that in some studies conducted in work settings, PF did not significantly improve at postintervention or at follow-up, contrary to expectations.

Regarding outcomes, many have argued that since ACT does not specifically target symptom reduction or the elimination of maladaptive behaviors, researchers should prioritize positive indicators of mental health that are more in line with ACT therapeutic goals (e.g., well-being, flourishing, quality of life, work engagement, or meaning and purpose; Ong et al., 2023). However, these outcome indicators have not been popular in organizational studies. Of the 17 RCTs examined in Unruh et al.'s (2022) meta-analysis, only three included measures of well-being. Although the authors found that participants undergoing an ACT intervention showed an increase in well-being

compared to those in the control condition, they also noted that these effects were minor and based on small samples. Other studies conducted with workers found mixed results or no effect of ACT on psychological well-being (McConachie et al., 2014; Wersebe et al., 2018).

In addition to well-being, two other outcomes are theoretically consistent with the use of ACT with workers: meaning in life and career engagement. According to Steger et al. (2006), “meaning in life” refers to the sense made of and significance felt regarding the nature of one’s being and existence. Though meaning in life has not been studied extensively within the ACT literature, there are reasons to believe that it might help workers perceive their life as more significant and purposeful. In fact, as it encourages participants to clarify their personal and professional values and commit to goals and actions that are coherent with such values, we would expect ACT to have a positive influence on meaning in life. Moreover, by cultivating acceptance of adverse emotions and thoughts, ACT may reduce experiential avoidance and facilitate engagement in meaningful activities rather than disengagement or withdrawal.

Career engagement is the degree to which a person is proactively developing his or her career, as expressed by diverse behaviors such as career planning, career self-exploration, networking, or searching for a new job or training opportunities (Hirschi et al., 2014). Research suggests that career engagement is significantly related to job satisfaction (Hirschi et al., 2014). Moreover, as workers are expected to deal with increasingly unpredictable and dynamic work environments (Wiernik & Kostal, 2019), many authors argue that they must be self-directed, flexible, and committed to their career development. As workers taking part in ACT usually spend a fair amount of time reflecting on what is important for them at work, setting professional goals according to these values, and taking concrete actions to attain such goals, we would expect these processes to have a positive and significant impact on their career engagement. One could also argue that as people become more psychologically flexible, they may be more willing to contact with undesirable thoughts and emotions while continuing to act in a manner congruent with their chosen goals and values. In other words, they may be proactive in the management of their career despite the uncomfortable thoughts, emotions, or sensations they experience. Although they align with ACT goals, meaning in life and career engagement have not yet received significant attention.

The Need for a More Diverse Working Population

To date, ACT interventions have been provided to a relatively homogeneous working population. Flaxman et al. (2023) pointed out that participants working in public sector organizations are overrepresented in workplace ACT intervention research. Unruh et al. (2022) noted that most studies on ACT “focused on typical white-collar jobs or social and health care workers, thereby excluding workers with heavy manual labor, people in the service industry, tradespeople, people providing care work, or employees working from home” (p. 122). People holding precarious jobs or atypical and nonstandard work arrangements (e.g., involuntary part-time or temporary work) were also mostly excluded from these studies. Precarious employment is understood as a multidimensional phenomenon, characterized by employment insecurity, inadequate income, and limited rights and social protection (Irvine & Rose, 2024). It is often contrasted with the

“Standard Employment Relationship,” defined as full-time, stable, and socially protected work with a single employer (Bosch, 2004). Within this framework, precarious employment encompasses a range of nonstandard contractual arrangements, including temporary agency work, casual positions, gig or platform labor, freelancing, and self-employment. The fact that very few ACT studies have been conducted with precarious workers is unfortunate as their prevalence is on the rise, in part due to organizational restructuring, eroding social safety nets, digitalization, and automation (Campbell & Price, 2016). In Canada, more than half of workers now have unwanted atypical and non-standard conditions (Ivanova & Strauss, 2023), especially women, ethnic minority workers, and those aged 25–34 (Bhattacharya & Ray, 2021; Ivanova & Strauss, 2023). Precarious workers also experience more financial insecurity (as they often have low-income jobs or limited access to benefits such as health insurance), uncertainty (as they depend on their employer for continuous work and survival), and vulnerability (as they often lack workplace protections, rights, and social security benefits; Allan et al., 2021). Moreover, they rarely have access to mental health training programs, despite the fact that precarious work is increasingly recognized as a major detriment to health (Macmillan & Shanahan, 2021), and job insecurity is positively related to symptoms of anxiety, depression, and emotional exhaustion (Llosa-Fernández et al., 2018). Because ACT-based interventions have predominantly been provided to full-time, permanent, and stable employees (Hofer et al., 2018), efforts should be made to extend these interventions to individuals in precarious jobs or atypical work arrangements.

The Present Study

The goal of this RCT was to assess the effectiveness of a group intervention based on ACT designed for people experiencing work- or career-related challenges using process (i.e., PF and PIF) and outcome variables (i.e., psychological well-being, psychological distress, meaning in life, career engagement). We selected a switching-replication design to balance methodological rigor with equitable access to the intervention for participants experiencing significant work- and career-related difficulties. This design allowed all participants to eventually receive the intervention while preserving random assignment during the initial comparison phase. At the same time, this design introduces asymmetry in the temporal alignment of intervention phases across groups, which limits the extent to which temporally ordered mediation processes can be examined across the full sample.

It was hypothesized that the intervention would help increase PF, psychological well-being, meaning in life, and career engagement and reduce PIF and psychological distress (Hypotheses 1 and 2). It was further expected that changes in PF and PIF would statistically account for part of the association between the intervention and changes in outcome variables (i.e., indirect effects through process variables), consistent with ACT theory (Hypothesis 3). To explore whether the intervention’s benefits depended on participants’ vulnerability, we also investigated the potential moderating role of baseline distress, work status, and income in changes in process and outcome variables. Given the exploratory nature of this last aspect, we formed no specific hypotheses regarding these effects.

Method

Participants

This study included 164 participants with an average age of 42 ($SD = 9.16$). Most identified as women (81.1%), 14.1% identified as men, and 4.8% felt they did not fit in those categories or did not answer the question. About a third identified as Canadians (37.8%), 25% reported having an ethnic or cultural identity other than Canadian, and 37.5% of the data regarding this question were missing or uninterpretable (e.g., participants who identified as White). Participants held graduate (43.3%), undergraduate (32.9%), postgraduate (7.3%), college (7.3%), professional (5.5%), or high school (3.7%) diplomas. Just over half were permanent workers (51.2%). The others were either working in a temporary position (14.0%), unemployed (13.5%), self-employed (14%), or on sick leave (7.3%). Among those who were employed or self-employed, most worked in the education (22.6%), community (14.9%), arts and culture (13.7%), services (12.5%), and health care (10.7%) sectors.

To be eligible for this study, participants had to report experiencing a difficult work or career situation, be more than 18 years old, speak and read French, live in the province of Québec (Canada), and own a personal computer with an internet connection at home. Participants were excluded if they reported having a severe mental or physical illness.

Participants were recruited through community organizations offering employment and career counseling services in the Montreal region (e.g., Young Women's Christian Association). We partnered with these organizations because their clients were more prone to holding precarious jobs or atypical work arrangements (e.g., artists, immigrants). When they felt their clients might be interested in this study, employees working in those organizations would briefly introduce the intervention described below and invite participants to consult the website, which contained various information regarding its aim, nature, and format. It was presented as a group intervention "designed for people who felt they were in a difficult and vulnerable situation in their career" and wanted "to take time to reflect on their personal and professional values." The intervention was also publicized on social media platforms such as LinkedIn and Facebook.

Some participants enrolled in the intervention because they were in the process of major career transitions and were seeking guidance on how to navigate these transitions (36.3%). Others were experiencing burnout symptoms (23.2%) or dissatisfaction at work due to factors such as lack of purpose or toxic colleague relationships (23.6%). Some needed support to make important career decisions (12.1%) or

find jobs (4.8%). Participants provided written informed consent before attending the intervention at no cost. They received \$25 for completing their questionnaires.

Research Design and Procedure

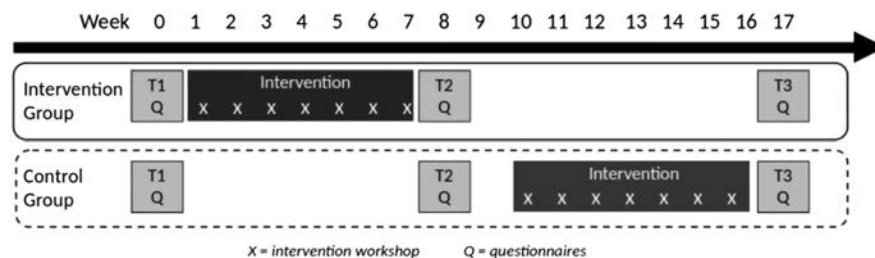
A parallel RCT was conducted using three times of measurement and a switching-replication design, illustrated in Figure 1. Participants in the intervention group attended sessions during a 7-week period and were asked to do exercises at home between sessions. In the control group, participants were placed on a waiting list for 7 weeks before being offered the intervention. In both groups, participants were invited to complete questionnaires at baseline, Week 8, and Week 17.

Data were collected between September 2021 and April 2023 during four consecutive trimesters. The intervention was offered to four cohorts of participants. Recruitment began 8 weeks before each trimester with support from partner organizations. People wishing to know more about the intervention registered on the project's website, completed an online screening questionnaire, and were then contacted by phone by the first author of this article. The aim of the call and questionnaire was to verify participants' eligibility and inform them about the study and the intervention. Those wishing to enroll were then randomly assigned to one of the two groups on a first-come, first-served basis using a blocked randomization list. Participants could not change their group once assigned. To improve the blinding integrity of the trial, a random sequence was generated by an independent researcher. Participants and trainers remained unaware of the study design, hypothesis, and control groups.

Description of the Intervention

The intervention used in this study is an updated version of the Oreka intervention (Piot et al., 2024). It draws on the psychological (in)flexibility processes presented above and contains seven 2.5-hr sessions. Those were based on specific themes and intentions and contained group discussions, contemplative practices, psychoeducational strategies, and behavioral activation strategies (Mazzucchelli et al., 2010). They included a mix of classical ACT metaphors (e.g., the struggle switch metaphor; Harris, 2008) and experiential exercises such as the pen exercise (Stoddard & Afari, 2014) or the ACT matrix (Polk & Schoendorff, 2014). They also contained narrative exercises inspired by CAT (e.g., future autobiography exercises) designed to assist participants in gaining a deeper understanding of themselves;

Figure 1
Switching-Replication Design of the Study



Note. T = time.

identifying patterns, themes, or pivotal moments in their careers; and making sense of their past experiences, current situations, and future goals. Apart from the activities done during the sessions, participants were invited to complete exercises at home, such as the Bull's-Eye Values Survey (Lundgren et al., 2012). Unruh et al. (2022) showed that ACT-based interventions can be improved by assigning homework to expand and generalize learned strategies. For further details on the intervention, see Table 1.

The intervention was offered to groups of 8–12 participants. Group interventions not only provide a cost-effective alternative to individual interventions, but they have also been repeatedly shown to yield outcomes comparable to individual interventions across a range of psychological conditions (Burlingame et al., 2016). The intervention was facilitated by three practitioners: one doctoral student in clinical psychology and two career counselors holding a master's degree in career counseling. All were White Canadian women with an average age of 39 years old ($SD = 4.35$). Prior to joining this study, they had accumulated an average of 55 hr of training on ACT and 90 hr of training on group facilitation/counseling. Throughout the study, they were supervised by one of the authors (Simon Grégoire), a psychologist and researcher who worked with ACT for more than 15 years. Facilitators were paired to offer the intervention. The intended facilitation approach was experiential, dialogical, participant-driven, and interactive.

Because COVID-19 restrictions were still prevalent when launching this study in September 2021, the intervention was offered online using the Zoom videoconferencing platform. It was manualized so that facilitators could rely on a guidebook with information on how to introduce the exercises contained in each session and orient the group discussions. The facilitator manual was designed to ensure a consistent

delivery of the intervention across groups and to offer sufficient latitude and spontaneity to facilitators during the sessions. A manual containing all exercises was also provided to the participants 1 week before the intervention. Oreka's facilitator and participant manuals are available on the Open Science Framework website (Grégoire & Saules, 2025).

Measures

Process and outcome variables were assessed at all times of measurement, whereas sociodemographic information was gathered only at baseline. All scales described below were completed online using the LimeSurvey platform. Cronbach α s are presented in Table 2.

PF and PIF

PF and PIF were measured using the French version of the Multidimensional Psychological Flexibility Inventory Short Form (Grégoire et al., 2020). Items in this inventory are rated on a 6-point scale ranging from 1 (*never true*) to 6 (*always true*).

Responses to the 12 PF items (e.g., "In the last two weeks, I was attentive and aware of my emotions") and the 12 PIF items (e.g., "In the last two weeks, negative feelings often trapped me in inaction") were summed to create flexibility and inflexibility composite scores.

Psychological Well-Being

The Warwick–Edinburgh Mental Well-Being Scale (Tennant et al., 2007; Trousselard et al., 2016) is a 14-item scale that covers subjective well-being and psychological functioning. Participants rated their level of agreement with items (e.g., "I felt good about myself") based on the previous 2 weeks using a 5-point Likert scale

Table 1
Brief Description of the Intervention

Session	Theme and intention
1	• Create a safe, inclusive, respectful, and caring group environment • Encourage participants to introduce themselves and share their expectations regarding the intervention • Allow them to discuss the challenging work situation they are currently facing
2	• Introduce the goals of the intervention and some ground rules on how to interact with others • Encourage participants to explore the thoughts, emotions, and sensations associated with their situation • Validate and normalize participants' distress • Explain the ACT matrix
3	• Introduce present-moment awareness process through experiential exercises • Invite participants to explore how experiential avoidance and cognitive fusion show up in their experience • Normalize experiential avoidance, but also underline its illusory nature and counterproductive nature • Normalize cognitive fusion while highlighting the risks of believing all our thoughts
4	• Introduce acceptance and cognitive defusion through experiential exercises • Help participants clarify their values and share with the group what is important to them, both professionally and personally • Discuss the relationship between suffering and values in the ACT matrix • Distinguish between values and goals
5	• Invite participants to identify personal or professional projects that are consistent with their values • Ask them to choose one or two projects they would like to explore by the end of the intervention • Develop an action plan to realize these projects • Explain the importance of committed action in a career context
6	• Allow participants to discuss the projects they started to explore during the week, the actions they have taken, and the obstacles they have encountered • Help participants become aware of their experience when they are involved in committed actions • Invite them to complete their own ACT matrix and synthesize what they have learned so far
7	• Enable participants to reedit their professional story in such a way that it links the past with the future and is rich in meaning and commitment • Allow them to share their appreciation of the group and what they got out of the intervention

Note. ACT = acceptance and commitment therapy.

Table 2*Descriptive Statistics for Process and Outcome Variables*

Time	Variable	α	<i>M (SD)</i> in total sample	<i>M (SD)</i> in control group	<i>M (SD)</i> in intervention group
Time 1	Psychological flexibility (MPFI-FLEX)	.91	38.57 (10.53)	39.99 (11.58)	37.21 (9.28)
	Psychological inflexibility (MPFI-INFLEX)	.90	36.62 (9.61)	36.60 (9.65)	36.74 (9.62)
	Distress (DASS)	.91	23.07 (10.66)	22.76 (11.86)	23.36 (9.43)
	Well-being (WEMWBS)	.87	43.83 (6.98)	44.57 (7.68)	43.11 (6.19)
	Meaning in life (MLQ)	.76	19.93 (6.58)	20.43 (6.48)	19.44 (6.69)
	Career engagement (CE)	.88	23.62 (8.11)	23.73 (7.66)	23.52 (8.57)
Time 2	Psychological flexibility (MPFI-FLEX)	.84	42.76 (10.16)	40.91 (10.70)	44.90 (9.11)
	Psychological inflexibility (MPFI-INFLEX)	.94	32.02 (10.27)	34.22 (10.38)	29.49 (9.62)
	Distress (DASS)	.93	18.69 (11.18)	20.23 (12.41)	16.90 (9.33)
	Well-being (WEMWBS)	.88	46.58 (7.36)	46.21 (8.21)	47.00 (6.30)
	Meaning in life (MLQ)	.77	22.51 (6.10)	21.68 (6.02)	23.48 (6.09)
	Career engagement (CE)	.90	26.78 (8.23)	26.14 (7.77)	27.52 (8.73)
Time 3	Psychological flexibility (MPFI-FLEX)	.93	43.83 (10.91)	44.53 (11.33)	43.12 (10.51)
	Psychological inflexibility (MPFI-INFLEX)	.88	28.96 (9.36)	28.80 (9.23)	29.12 (9.56)
	Distress (DASS)	.91	16.25 (10.47)	15.86 (11.31)	16.64 (9.64)
	Well-being (WEMWBS)	.91	47.29 (7.62)	47.55 (8.32)	47.03 (6.91)
	Meaning in life (MLQ)	.88	23.42 (6.54)	23.93 (6.35)	22.92 (6.73)
	Career engagement (CE)	.92	27.01 (8.43)	28.52 (7.45)	25.52 (9.10)

Note. MPFI-FLEX = Multidimensional Psychological Flexibility Inventory–Psychological Flexibility; MPFI-INFLEX = Multidimensional Psychological Flexibility Inventory–Psychological Inflexibility; DASS = Depression Anxiety Stress Scales; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; MLQ = Meaning in Life Questionnaire; CE = Career Engagement Scale.

ranging from 1 (*none of the time*) to 5 (*all the time*). A higher score (obtained by adding all items) on the Warwick–Edinburgh Mental Well-Being Scale indicates greater well-being.

Meaning in Life

This outcome was measured using the “Presence of Meaning” subscale of the French version of the Meaning in Life Questionnaire (Steger et al., 2006). For this study, the word “life” was changed to “professional life,” and the instructions were modified so that participants were asked to respond based on their “experience in the last two weeks” rather than in general. This subscale contains five items and refers to the subjective experience of having meaning (e.g., “My professional life clearly has meaning”). Responses ranged from 1 (*totally false*) to 7 (*totally true*). They were summed to create a total score.

Career Engagement

The Career Engagement Scale (CE; Hirschi et al., 2014) was used to assess the extent to which participants engage in career behaviors to proactively develop their careers (e.g., “In the past two weeks, to what extent have you undertaken things to achieve your career goals?”). CE is a nine-item scale that loads on a single factor. Because this questionnaire was not available in French, it was translated using the back-translation methodology (Klotz et al., 2023). CE items are based on a Likert scale ranging from 1 (*almost never*) to 5 (*very often*) and were summed to create a total score.

Psychological Distress

Psychological distress was measured using the general psychological distress factor of the Depression Anxiety and Stress Scales

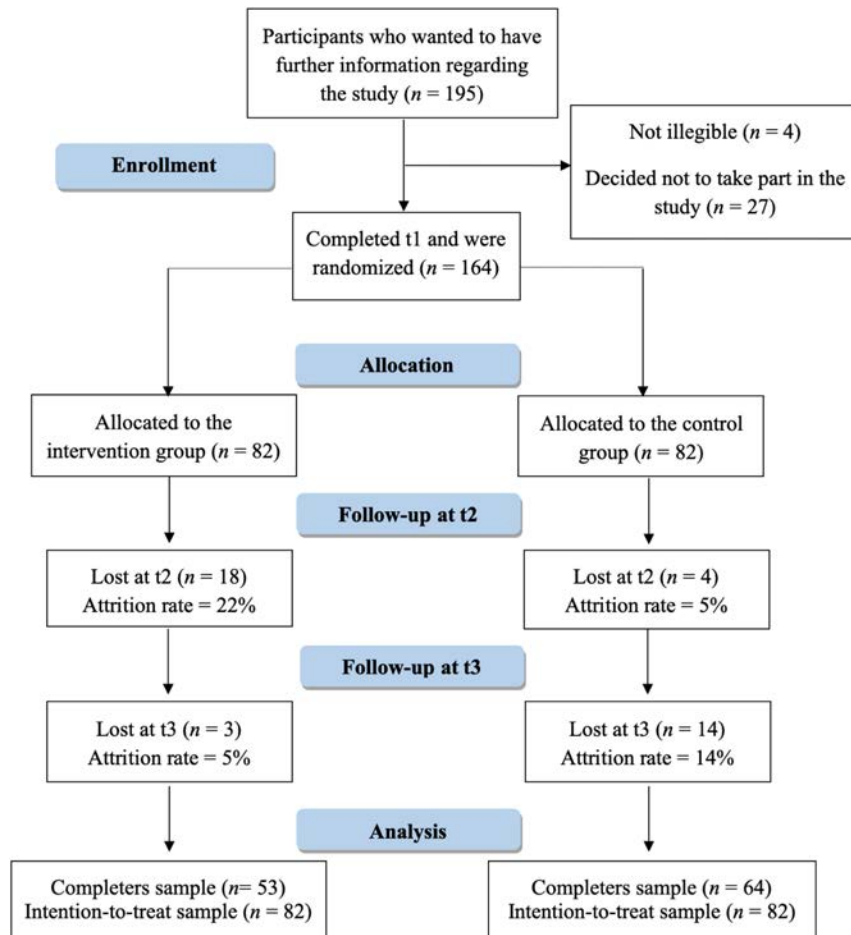
(Henry & Crawford, 2005; Ramasawmy et al., 2012). Items were rated on a 4-point Likert scale ranging from 0 (*did not apply to me at all*) to 3 (*applied to me very much or most of the time*) and summed to create a total score.

Attrition

A total of 195 people registered on the project website. Four were not eligible, and 27 decided not to enroll in the study. Among them, some felt that they no longer needed the intervention, and others never returned our calls. One hundred sixty-four people were randomly assigned to either the intervention group ($n = 82$) or the control group ($n = 82$). Twenty-two dropped out at Time 2 and 17 at Time 3. A total of 117 participants completed five sessions (71% of the whole intervention) and all three questionnaires and thus formed the completer sample. In this trial, the attrition rate was 23%, a number comparable to what has been noted in other ACT studies in the workplace (Unruh et al., 2022; see Figure 2 for more details).

Sample size determination was based on feasibility and past RCTs, especially given that power analyses are notoriously difficult for multilevel analyses (Matuschek et al., 2017), in part because of the complexities of random effects. We conducted post hoc power analyses based on Monte Carlo simulations. Power to detect hypothesized effects using multilevel analyses (Hypotheses 1 and 2) was excellent for flexibility, inflexibility, and meaning in life ($>.95$). It was moderate for distress (.69) and well-being (.71) and low for career engagement (.33). In terms of indirect effect analyses, power was excellent for the indirect effect through flexibility for distress, well-being, and career engagement ($>.99$) and moderate for meaning in life ($>.75$). Power was also excellent for the indirect effect through inflexibility for distress ($>.99$) and moderate to low for the other dependent variables (.57–.11 for career engagement). For all effects that had a power $<.80$, we provide power curves in the [Supplemental Materials](#). These curves show the

Figure 2
Flowchart of Study Inclusion/Exclusion Process



Note. t = time. See the online article for the color version of this figure.

probability of obtaining significant results for different sample sizes in the future if the effect sizes found here were indeed population effect sizes. They will be useful for sample size determination in future research.

Hypotheses and Analysis

The study hypotheses were operationalized as follows:

Hypothesis 1: There will be a significant between-group difference in process and outcome variables from Time 1 to Time 2, such that the intervention group will display a significant increase/decrease (i.e., treatment effect), whereas the control group will not (i.e., no waiting effect). This pattern translates into significant group differences at Time 2 (but not at Time 1).

Hypothesis 2: There will be a significant between-group difference in process and outcome variables from Time 2 to Time 3, such that the intervention group will not change (i.e., maintenance of treatment effect), whereas the control group will

display a significant increase/decrease (i.e., delayed treatment effect consistent with a switching replication design).

Hypothesis 3: Process variables at Time 2 will statistically account for the effect of group conditions at Time 1 (intervention vs. control) on outcome variables at Time 2, controlling for process variables at Time 1.

To test Hypotheses 1 and 2, we ran a set of mixed-effects models with all three measurement times. This approach considers the hierarchical nature of the data with timepoints nested within participants (Singer & Willett, 2003). The first block included age, gender, work status (permanent position or self-employed vs. temporary, unemployed, or on sick leave), cohort, and baseline values of the process and outcome variables as covariates. We then entered time (with Time 2 as the reference level), group condition (intervention vs. control), and its interactions with time. We centered baseline values and age around the grand mean for ease of interpretation and to address multicollinearity. We included random intercepts but not random slopes because time was modeled as contrasts between two timepoints. In separate steps, we explored the moderation by baseline

distress (Time 1), work status, and income, respectively, of Time 2 versus Time 1 changes in process and outcome variables in the subset of participants in the intervention group, with the same covariates.

We tested Hypothesis 3 with a set of path analysis indirect effect models. Standard errors of indirect effects were estimated with 10,000 bootstrap samples. All analyses were performed using R Version 4.2.1 (R Core Team, 2024) and packages lme4 (Bates et al., 2015), lavaan (Rosseel, 2012), jtools (Long, 2024b), interactions (Long, 2024a), and tidyverse (Wickham et al., 2019).

According to the Consolidated Standards of Reporting Trials recommendations (Moher et al., 2010), we ran all analyses according to the intention-to-treat (ITT) principles using the last-observation-carried-forward method (Twisk & de Vente, 2002) based on the conservative assumption that participants who did not complete Time 2 or Time 3 would not have experienced significant changes during the intervention. The analyses were also replicated with the completer sample. It has been argued that the use of both ITT and completer samples helps “bracket” the likely effects of an intervention under different conditions (Del Re et al., 2013). While the ITT sample allows to explore what happens to participants who are allocated to an intervention, the completer sample gives information on what happens to those who completed the intervention without any major deviations from the study protocol. Because of space considerations, only the models based on the ITT samples are reported below (those tested with the completer samples are presented in the [Supplemental Material](#)). Differences between samples are reported below.

Results

Table 2 displays descriptive statistics for the overall sample and within each condition. Table 3 presents correlations among the study variables.

Hypothesis 1

Table 4 shows the results of mixed-effect regressions modeling changes in process and outcome variables across all three assessments for the ITT sample. Figure 3 displays the interactions between condition and time. Interactions between condition and Time 2 versus Time 1 were statistically significant for PF, PIF, distress, well-being, and meaning in life, but not for career engagement. As expected, simple-slopes decomposition of these interactions showed no significant group differences in any variable at Time 1. At Time 2, participants in the intervention group reported significantly more PF ($b^* = 0.42$, $B = 4.56$, $SE = 1.04$, $p < .01$), less PIF ($b^* = -0.39$, $B = -4.01$, $SE = 1.01$, $p < .01$), less distress ($b^* = -0.26$, $B = -2.90$, $SE = 1.14$, $p = .01$), more well-being ($b^* = 0.24$, $B = 1.77$, $SE = 0.75$, $p = .02$), and more meaning in life ($b^* = 0.28$, $B = 1.83$, $SE = 0.60$, $p < .01$) than participants in the control group, also as expected. However, they did not differ for career engagement ($b^* = 0.08$, $B = 0.70$, $SE = 0.84$, $p = .40$). These results support Hypothesis 1. In terms of effect sizes, standardized group differences seem larger for the process variables PF and PIF (0.42 and 0.39) than for the outcome variables (from 0.24 to 0.28). In the completer sample, the interaction effect was also statistically significant for career engagement (see the [Supplemental Materials](#) for more details).

Hypothesis 2

Interactions between condition and Time 3 versus Time 2 were statistically significant for all variables, except for well-being and distress (see Figure 3). Simple-slopes decomposition of these interactions showed that, as expected, there were no significant changes in any of the process or outcome variables in the intervention group. Therefore, intervention effects were maintained for these variables, which is consistent with Hypothesis 2.

The Time 2–Time 3 interval corresponded to the period when participants in the control group took part in the intervention. As expected, they reported increases in PF ($b^* = 0.35$, $B = 3.78$, $SE = 1.20$, $p < .01$), meaning of life ($b^* = 0.40$, $B = 2.62$, $SE = 0.67$, $p < .01$), and career engagement ($b^* = 0.27$, $B = 2.25$, $SE = 0.98$, $p = .02$) and decreases in PIF ($b^* = -0.53$, $B = -5.48$, $SE = 1.19$, $p < .01$) and distress ($b^* = -0.37$, $B = -4.14$, $SE = 1.35$, $p < .01$). There were only marginal changes in well-being for participants in this group ($p = .06$), which may be explained by the fairly large increase that had already occurred while they were waiting for the intervention. In the completer sample, the interaction effect for well-being was statistically nonsignificant.

Exploratory Moderations Among Participants in the Intervention Group

The moderation by baseline distress (Time 1) of the intervention effect was significant for PF, PIF, distress, and well-being. Simple-slopes decomposition showed that for participants who reported high baseline distress (+1 *SD*), taking part in the intervention was strongly associated with increases in PF ($b^* = 0.95$) and well-being ($b^* = 1.33$) and decreases in PIF ($b^* = -1.18$) and distress ($b^* = -1.61$) at Time 2.

In contrast, for participants who reported low distress at baseline (−1 *SD*), there was a smaller improvement in PF ($b^* = 0.53$) and a decrease in PIF ($b^* = -0.35$) but no change in distress ($b^* = 0.13$) and well-being ($b^* = 0.05$).

We also explored the moderation of intervention effects by work status among participants in the intervention group. All the interaction terms were statistically nonsignificant ($.10 < ps < .91$). For a more thorough investigation, we tested a different operationalization of work status, with stable permanent employment contrasted with all other status categories (self-employed, unemployed, on sick leave, temporary). All interaction terms were nonsignificant except for meaning in life, $B (SE) = -2.52 (1.13)$, $p = .03$. Simple-slope decomposition showed that although meaning in life increased statistically significantly at Time 2 for both categories, the increase was stronger for participants with more precarious work statuses ($b^* = 0.81$) than for those in stable permanent employment ($b^* = 0.44$).

In a final exploration of the role of vulnerability, we tested the moderating role of income, contrasting participants earning \$50,000 a year or less versus more than \$50,000 a year (roughly aligned with the median income in Quebec). As for stable permanent versus other work statuses, the only statistically significant interaction term was for meaning in life, $b (SE) = -3.92 (1.20)$, $p = .001$. Although meaning in life increased across income categories between Time 1 and Time 2, the increase was stronger for intervention participants earning less than \$50,000 a year ($b^* = 1.00$) than for those earning more ($b^* = 0.43$).

Table 3
Correlations Among the Study Variables

Variable	Time 1				Time 2							Time 3							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Age	—	.02	-.13	-.22**	.08	-.05	-.10	.03	.05	-.21*	.09	.06	-.08	-.02	-.07	-.10	.03	-.07	.01
Time 1																			
2. MPFI-FLEX		—	-.46***	-.36***	.59***	.40***	.29***	.57***	-.28***	-.13	.27**	.30***	.17*	.41***	-.01	-.11	.24**	.19*	.17
3. MPFI-INFLEX			—	.64***	-.51***	-.30***	-.04	-.24**	.48***	.33	-.24**	-.28***	-.02	-.23**	.37***	.19*	-.19*	-.21*	-.07
4. DASS				—	-.66***	-.19*	.00	-.18*	.36***	.44***	-.33***	-.19*	.00	-.23*	.23*	.36***	-.26**	-.24*	.00
5. WEMWBS					—	.31***	.19*	.39***	-.33***	-.28***	.47***	.31***	.17*	.39***	-.20*	-.34***	.46***	.29**	.07
6. MLQ						—	.27***	.28***	-.19*	-.07	.07	.62***	.19*	.21*	-.08	-.04	.12	.55***	.15
7. CE							—	.21*	-.01	.09	.04	.17*	.51***	.20*	.09	-.07	.20*	.08	.46***
Time 2																			
8. MPFI-FLEX								—	-.51***	-.44***	.58***	.47***	.41***	.61***	-.14	-.16	.31***	.32***	.27**
9. MPFI-INFLEX									—	.62***	-.49***	-.41***	-.18*	-.34***	.49***	.28**	-.33***	-.39***	-.17
10. DASS										—	-.70***	-.32***	-.13	-.30***	.38***	.50***	-.20*	-.20*	-.07
11. WEMWBS											—	.39***	.37***	.44***	-.25**	-.42***	.53***	.32***	.25**
12. MLQ												—	.45***	.29**	-.16	-.13	.20*	.68***	.27**
13. CE													—	.27**	.10	-.02	.18	.27**	.53***
Time 3																			
14. MPFI-FLEX														—	-.40***	-.44***	.64***	.46***	.39***
15. MPFI-INFLEX															—	.58***	-.45***	-.44***	-.11
16. DASS																—	-.75***	-.33***	-.19*
17. WEMWBS																	—	.44***	.37***
18. MLQ																		—	.35***
19. CE																			—

Note. MPFI-FLEX = Multidimensional Psychological Flexibility Inventory–Psychological Flexibility; MPFI-INFLEX = Multidimensional Psychological Flexibility Inventory–Psychological Inflexibility; DASS = Depression Anxiety Stress Scales; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; MLQ = Meaning in Life Questionnaire; CE = Career Engagement Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4*Results of Mixed-Effects Regressions Testing Hypotheses 1 and 2*

Predictor	Process and outcome variable					
	Flexibility	Inflexibility	Distress	Well-being	Meaning in life	Career engagement
	<i>B</i> (<i>SE</i>)	<i>B</i> (<i>SE</i>)	<i>B</i> (<i>SE</i>)	<i>B</i> (<i>SE</i>)	<i>B</i> (<i>SE</i>)	<i>B</i> (<i>SE</i>)
Constant	42.19*** (1.68)	35.44*** (1.62)	18.65*** (1.84)	47.40*** (1.23)	21.12*** (0.98)	25.12*** (1.35)
Age	−0.04 (0.04)	0.03 (0.04)	−0.06 (0.05)	−0.00 (0.03)	0.01 (0.03)	−0.02 (0.04)
Work status (regular vs. other)	−0.35 (0.87)	−0.87 (0.83)	−0.47 (0.95)	−0.05 (0.64)	0.12 (0.52)	0.44 (0.70)
Gender (other vs. man)	4.61* (2.23)	0.05 (2.14)	1.31 (2.43)	−0.22 (1.65)	1.10 (1.31)	1.53 (1.80)
Gender (woman vs. man)	1.55 (1.19)	−1.14 (1.15)	0.75 (1.30)	−0.97 (0.88)	0.81 (0.72)	1.48 (0.96)
Cohort (2 vs. 1)	−1.43 (1.07)	0.37 (1.03)	1.90 (1.17)	−0.90 (0.80)	−0.55 (0.62)	−0.31 (0.87)
Cohort (3 vs. 1)	−3.28** (1.24)	0.59 (1.19)	1.98 (1.35)	−1.95* (0.91)	−0.71 (0.73)	−2.00* (1.00)
Cohort (4 vs. 1)	−0.35 (1.32)	0.52 (1.27)	0.05 (1.45)	−0.06 (0.97)	0.04 (0.78)	−0.85 (1.07)
Baseline values	0.68*** (0.04)	0.67*** (0.04)	0.64*** (0.04)	0.70*** (0.05)	0.76*** (0.04)	0.68*** (0.04)
Condition (intervention vs. control)	5.57*** (1.29)	−5.32*** (1.25)	−3.64* (1.42)	1.74 (0.93)	2.77*** (0.73)	1.53 (1.04)
Time 2 versus Time 1	1.27 (1.13)	−2.36* (1.12)	−2.71* (1.27)	1.78* (0.82)	1.51* (0.60)	2.39** (0.92)
Time 3 versus Time 2	3.78** (1.20)	−5.48*** (1.19)	−4.14** (1.35)	1.63 (0.87)	2.62*** (0.67)	2.25* (0.98)
Time 2 Versus Time 1 × Condition	6.30*** (1.62)	−5.29*** (1.61)	−4.13* (1.83)	2.24 (1.17)	3.01*** (0.88)	1.54 (1.32)
Time 3 Versus Time 2 × Condition	−5.34** (1.73)	5.53** (1.71)	4.14* (1.95)	−1.48 (1.25)	−3.38*** (0.96)	−4.34** (1.41)
Random effects						
σ ² (residuals)	49.63	48.68	63.01	25.90	13.98	32.70
τ ₀₀ (intercepts)	7.90	6.24	7.91	4.52	3.59	4.98
Cohen's <i>d</i>	0.64	−0.51	−0.36	0.32	0.42	0.19

Note. *SE* = standard error.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Hypothesis 3

Figure 4 and Table 5 show the results of path analyses testing whether process variables at Time 2 statistically account for the effect of group conditions on outcome variables at Time 2, controlling for process variables at Time 1. The indirect effect of conditions on outcome via PF was significant for all outcome variables. Consistent with Hypothesis 3, participation in the intervention led to increases in PF, which were then associated with increases in well-being, meaning in life, and career engagement and decreases in distress. The indirect effect via PIF was statistically significant only for distress. Participating in the intervention led to decreases in PIF, which were then associated with decreases in distress, but not in well-being, meaning in life, or career engagement. The pattern of results was identical in the completer sample, with one exception: The indirect effect via PIF was also statistically significant for well-being.

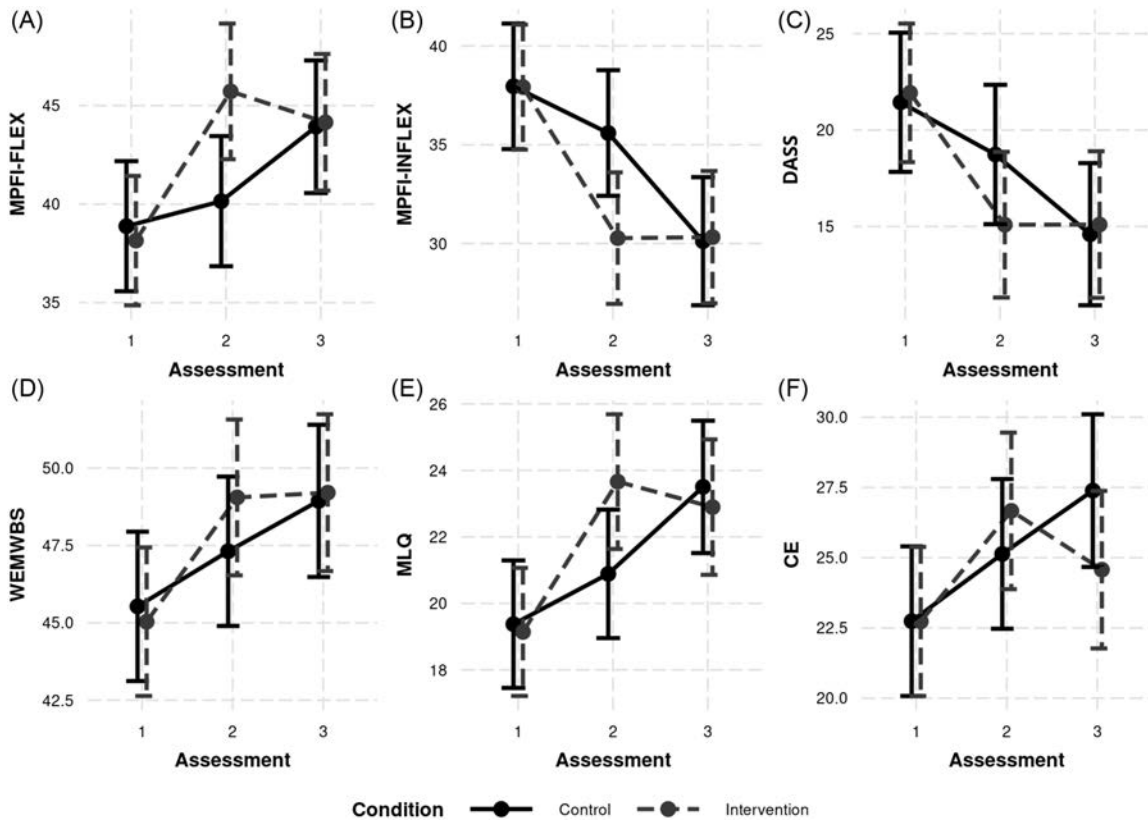
Discussion

This RCT aimed to evaluate the effectiveness of a group intervention based on ACT designed for individuals facing work- or career-related challenges. Compared with participants in the control group, those who took part in the Oreka intervention reported more PF and less PIF at Time 2. These effects were moderate, maintained at Time 3, and significant in both the ITT and completer samples. Such results are promising, as the primary goal of ACT is to promote PF and reduce PIF, and these processes are assumed to be its main mechanisms of action. Additionally, research suggests that PF is fundamental to personal well-being and social functioning. It enables individuals to adapt to a variety of situations and serves as a protective factor against mental health issues (Kashdan & Rottenberg, 2010). PIF, on the other hand, is associated with distress symptoms such as depression and anxiety (Ruiz, 2010) and various mental health problems (Chawla & Ostafin, 2007; Cherry et al., 2021).

As expected, the intervention also helped reduce psychological distress, with a comparable effect size (Cohen $d = -.36$) to recent meta-analyses (Prudenzi et al., 2021; Reeve et al., 2018; Towey-Swift et al., 2023). This suggests that the Oreka intervention represents an effective way to reduce symptoms of distress among people who experience work- or career-related challenges. As previously mentioned, evidence regarding the effect of ACT interventions on workers' well-being has been mixed (McConachie et al., 2014; Unruh et al., 2022; Wersebe et al., 2018). This study found a positive effect on psychological well-being, particularly for the completer sample. Similar to others (Unruh et al., 2022), we believe that more research is needed to understand the impact of ACT interventions on well-being, as mental health is affected by both the absence of psychological distress and the presence of well-being (World Health Organization, 2004). It is worth mentioning that the effects of the intervention on PIF, well-being, and distress at Time 2 were moderated by psychological distress at Time 1. This is consistent with results obtained in other studies indicating that ACT interventions seem to be more beneficial for workers reporting high distress levels at baseline (Prudenzi et al., 2022; Reeve et al., 2018). Our results also suggest that ACT might also be more beneficial for vulnerable employees, that is, those with low income and precarious work statuses.

Participants who received the intervention reported greater meaning in life at Time 2 than those in the control group, and these effects were sustained at follow-up. Given the large amount of time they spend at work, many people look to their careers as a source of meaning and want their work to be more than just a way to earn a paycheck or spend their time (Steger et al., 2012). When facing difficult situations such as burnout or job loss, they may lose sight of what provides meaning to their lives. The results of this study suggest that the exercises and strategies contained in the Oreka intervention had a positive impact on people's subjective experience of having meaning.

We expected that the intervention would increase participants' engagement toward their careers, but we found no such effect. There

Figure 3*Moderation of Time by Condition for Process and Outcome Variables Using the Intention-to-Treat Sample*

Note. Graphs A to F compare the control and intervention conditions across three assessment time points. At the second time point, the intervention group scored higher on MPFI-FLEX (A), WEMWBS (D), and MLQ (E) and lower on MPFI-INFLEX (B) and DASS (C) than the control group; all of these differences had disappeared by the third time point. Panel F shows a similar pattern for CE scores, but the difference at the second time point was not significant. MPFI-FLEX = Multidimensional Psychological Flexibility Inventory–Psychological Flexibility; MPFI-INFLEX = Multidimensional Psychological Flexibility Inventory–Psychological Inflexibility; DASS = Depression Anxiety Stress Scales; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; MLQ = Meaning in Life Questionnaire; CE = Career Engagement Scale.

are at least two possible explanations for this result. First, the CE measures involvement in career-related activities, including career exploration, career planning, and networking. It helps understand how involved people are in their career development. As previously mentioned, some participants in our study were unemployed (13.5%) or on sick leave (7.3%). They may have enrolled in the intervention less with the intention of learning how to manage their careers and

more with the aim of making sense of their difficulties or attending to their personal well-being. As a result, some items of the CE may have been confusing for them, potentially compromising the validity of our measurement and contributing to the absence of significant changes on this scale. Second, it is possible that some participants came to recognize during the intervention that their current employment was not, or was no longer, aligned with their personal values. Others may

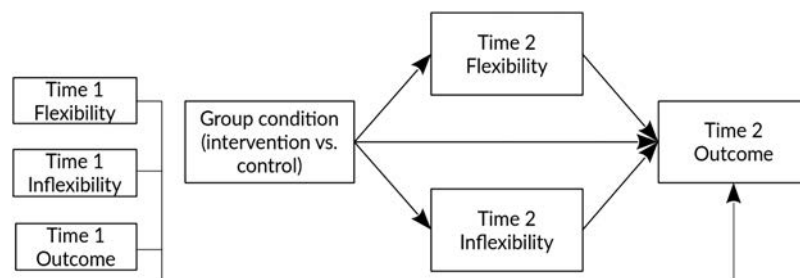
Figure 4*Indirect Effect Models Tested*

Table 5*Results of Indirect Effect Analyses Testing Hypothesis 3*

Dependent variable (Time 2)	Term	<i>b</i> *	<i>SE</i>	<i>z</i>	<i>p</i>	95% CI
Distress	<i>X</i> → M-flexibility	0.21	0.08	2.61	.009	[0.05, 0.37]
	<i>X</i> → M-inflexibility	−0.24	0.08	−3.07	.002	[−0.40, −0.09]
	M-flexibility ↔ <i>Y</i>	−0.35	0.09	−3.99	<.001	[−0.52, −0.18]
	M-inflexibility ↔ <i>Y</i>	0.45	0.09	5.10	<.001	[0.28, 0.62]
	<i>X</i> → <i>Y</i>	0.04	0.08	0.51	.611	[−0.11, 0.19]
	Indirect effect flexibility	−0.07	0.03	−2.29	.022	[−0.13, −0.01]
Well-being	Indirect effect inflexibility	−0.11	0.04	−2.56	.010	[−0.19, −0.03]
	<i>X</i> → M-flexibility	0.21	0.08	2.63	.009	[0.05, 0.36]
	<i>X</i> → M-inflexibility	−0.24	0.08	−3.02	.002	[−0.40, −0.09]
	M-flexibility ↔ <i>Y</i>	0.53	0.07	7.10	<.001	[0.38, 0.68]
	M-inflexibility ↔ <i>Y</i>	−0.25	0.10	−2.43	.015	[−0.45, −0.05]
	<i>X</i> → <i>Y</i>	−0.08	0.08	−0.99	.323	[−0.24, 0.08]
Meaning in life	Indirect effect flexibility	0.11	0.04	2.53	.011	[0.02, 0.20]
	Indirect effect inflexibility	0.06	0.03	1.88	.060	[−0.00, 0.12]
	<i>X</i> → M-flexibility	0.23	0.08	2.85	.004	[0.07, 0.39]
	<i>X</i> → M-inflexibility	−0.24	0.08	−2.95	.003	[−0.40, −0.08]
	M-flexibility ↔ <i>Y</i>	0.36	0.09	4.07	<.001	[0.18, 0.53]
	M-inflexibility ↔ <i>Y</i>	−0.15	0.11	−1.40	.161	[−0.36, 0.06]
Career engagement	<i>X</i> → <i>Y</i>	0.08	0.07	1.03	.304	[−0.07, 0.22]
	Indirect effect flexibility	0.08	0.03	2.38	.017	[0.01, 0.15]
	Indirect effect inflexibility	0.04	0.03	1.29	.198	[−0.02, 0.09]
	<i>X</i> → M-flexibility	0.21	0.08	2.67	.008	[0.06, 0.36]
	<i>X</i> → M-inflexibility	−0.24	0.08	−3.03	.002	[−0.40, −0.09]
	M-flexibility ↔ <i>Y</i>	0.44	0.08	5.40	<.001	[0.28, 0.60]
	M-inflexibility ↔ <i>Y</i>	−0.04	0.09	−0.48	.633	[−0.22, 0.13]
	<i>X</i> → <i>Y</i>	−0.04	0.07	−0.51	.611	[−0.18, 0.11]
	Indirect effect flexibility	0.09	0.04	2.45	.014	[0.02, 0.16]
	Indirect effect inflexibility	0.01	0.02	0.47	.638	[−0.03, 0.05]

Note. *b** = standardized path coefficients; *SE* = standard error; CI = confidence interval; M = process variables.

have chosen to pursue value-congruent activities outside the professional domain, such as engaging in new hobbies or volunteer work. Such dynamics may help to account for the absence of a significant effect of the intervention on participants' career engagement.

The results of indirect effect analyses suggest that promoting PF can have positive effects. In this study, increases in PF were associated with increases in well-being, meaning in life, and career engagement and decreases in distress. A decrease in PIF was associated only with a decrease in psychological distress. However, these results should be interpreted with caution because our process and dependent variables were measured concurrently, limiting conclusions regarding temporal ordering and causal mechanisms. In the future, research designs with more times of measurement should be implemented to ensure that the process variables occur before the dependent variable, which would help clarify the relationships among these variables (Jose, 2016).

This study's strengths include using a RCT to assess an intervention and examining outcomes that have been overlooked in workplace ACT research (e.g., psychological well-being, meaning in life, career engagement). This research was also conducted in collaboration with community organizations to recruit a more diverse working population. Hofer et al. (2018) pointed out that ACT interventions often take place within organizations and target professions such as teachers, social workers, or nurses. They argue that this "renders individuals suffering from burnout and stress symptoms at the mercy of good fortune: if their organization offers a program, they may receive useful help, otherwise individuals are left to their own devices" (Hofer et al., 2018, p. 4). In this study, a

significant portion of the participants worked in precarious jobs or atypical work arrangements. Many were working part-time, were self-employed, or were unemployed. Almost half of them (48.1%) earned less than 70,000 CAD per year.

Despite its strengths, this study also has limitations. First, it is based on self-selected participants providing self-reported data, which may be subject to social desirability bias. Second, as we did not include an active control group, we cannot be certain that the intervention per se produced the observed effects. In the future, the Oreka intervention could be compared with evidence-based programs such as JOBS (Vinokur & Price, 2015). This program was developed to enhance job-searching skills, job-search self-efficacy, and well-being, and it is delivered in groups, making it comparable in some ways to Oreka, even though it has different theoretical roots. Third, participant compliance with the intervention was not measured; therefore, we do not know to what extent they did their homework between sessions (e.g., filling observation grids). Moreover, we did not monitor how our facilitators adhered to the protocol. Both factors may compromise the study's internal validity. Fourth, our switching-replication design limited the extent to which temporally ordered mediation processes could be examined. Specifically, the intervention phases were not aligned equivalently across groups, which prevented the estimation of mediation models with predictor, process, and outcome variables measured sequentially within the intervention period for all participants. As previously mentioned, we conducted indirect-effect analyses in which process and outcome variables were measured concurrently. Although these analyses yielded results consistent with ACT theory,

future studies using more temporally aligned and frequent assessments should test mediation processes more directly.

In the future, we believe additional studies should be conducted with individuals in precarious jobs or atypical work arrangements. Although exploratory and preliminary, our moderation analyses suggest that ACT might be especially beneficial for participants that hold precarious work statuses and low incomes. Efforts could also be directed toward investigating the role of common factors in ACT interventions provided to workers. Although our study, like others, suggests that PF and PIF are key mechanisms of change in these interventions, they may not be the only ones. Recent studies on the mindfulness-based stress reduction program and the mindfulness-based cognitive therapy have shown that aside from factors specific to these interventions (e.g., acceptance, mindfulness), group processes were also at play, such as the sense of receiving support from the group (group cohesion), the affective bond between facilitators and participants (therapeutic alliance), and participants' expectations that the intervention will be beneficial (expectancy; Canby et al., 2021; Goldberg, 2022; Hutchinson et al., 2021). Furthermore, one could argue that the relative lack of superiority of ACT compared with other types of intervention (Gloster et al., 2020; Powers et al., 2009) can be interpreted as indirect support for the importance of common group factors. Although they may allow for a broader understanding of the change mechanisms at play within ACT and inform efforts to increase its effectiveness, studies on common factors are currently lacking in the field.

In summary, this parallel RCT suggests that the Oreka intervention helps promote well-being and flourishing among people struggling with work- or career-related difficulties. Further empirical studies should confirm and extend these initial results.

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