

Introducing ACT Into the Field of Voice Therapy

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SUMMARY: Voice disorders are multidimensional phenomena involving anatomical and physiological features alongside emotional, behavioral, and psychological aspects. Although the literature acknowledges the relevance of psychological factors in voice disorders, the structured incorporation of psychological approaches into voice therapy remains limited. This article addresses that gap by presenting a preliminary framework for integrating acceptance and commitment therapy (ACT) principles into voice therapy. ACT is a well-established psychological approach with demonstrated adaptability across various professions and contexts. The six core processes of ACT are briefly outlined and contextualized, followed by practical suggestions and clinical examples illustrating their potential application in routine voice therapy. ACT is presented as a flexible, accessible, and theoretically coherent approach that may enhance the personalization and effectiveness of voice therapy. While these suggestions are grounded in conceptual reasoning and extensive clinical experience, further research is needed to systematically examine their application and outcomes. Moreover, training models for speech-language pathologists should be developed to provide clinicians with the tools and confidence to apply ACT principles as part of their professional scope. While this article is not intended to serve as a comprehensive manual for therapy, it offers an initial conceptual framework. This preliminary contribution aims to encourage clinicians and researchers to expand the therapeutic framework of voice therapy by incorporating psychological flexibility, acceptance, and values-based action.

Keywords: Voice disorders–Dysphonia–Voice therapy–Acceptance and commitment therapy–Cognitive behavioral therapy.

INTRODUCTION

Voice disorders can result from various combinations of organic and nonorganic factors.¹ The classification and even the terminology used to describe the nonorganic aspects of voice disorders have been debated extensively by clinicians and researchers. Historically, voice disorders have been classified as “organic” or “functional”.² Gradually, with the realization that this binary classification might be oversimplified, researchers have suggested alternative and more comprehensive categorical schemes. Over time, even the use of the term “functional” within this context has become controversial.^{3–9} While the categorical schemes for arranging voice disorders are invaluable for defining groups of pathologies, a novel classification system for voice disorders has been presented recently that arranges all voice disorders on two intersecting continuous scales.^{10,11} This view demonstrates that, to varying degrees, all voice pathologies could have complex etiologies and be affected, to some degree, by different organic and non-organic factors.

The growing interest in the psychological characteristics of people with voice disorders has spurred numerous

studies in the field. The majority of these studies have focused on people diagnosed with “functional dysphonia”.^{9,12–18} Yet, evidence suggests that psychological factors may also affect people with “organic” voice disorders, and not only “non-organic” ones. For example, patients diagnosed with unilateral vocal fold paralysis have been found to exhibit elevated levels of depression. In contrast, patients with laryngeal carcinoma have shown increased symptoms of both depression and anxiety.^{19,20} Moreover, high levels of stress, depression, anxiety, as well as high neuroticism and low openness were found among heterogeneous groups of dysphonic speakers with various laryngeal pathologies.^{21–23} This growing body of research highlights the relevance of psychological factors across all types of voice disorders. These findings imply a level of comorbidity that challenges strict etiological distinctions and encourages broader clinical integration.²⁴

Considering this emerging perspective, researchers and clinicians advocate for incorporating psychological approaches into voice therapy.^{17,20,22,25} This viewpoint was expressed, for example, back in the 1990s by Aronson, who noted that “...we feel safer working at the laryngeal-mechanical level: breathing exercises, optimum pitch, biofeedback, and relaxation. These techniques have a place, but they fail to deal with the heart of the problem”²⁶ (p. 288). Aronson did not advocate for replacing voice therapy with psychological therapy. Instead, he suggested that speech-language pathologists (SLPs) should acquire basic psychotherapy skills and apply them as part of voice therapy.²⁶ This view was echoed by Baker,¹² who emphasized that SLPs are obligated, professionally and ethically, to address psychosocial issues associated with or arising from voice

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disorders. Nowadays, many professionals share this view and suggest that SLPs should apply basic psychological therapeutic approaches in voice therapy.^{17,22,25,27} Nevertheless, studies on the clinical and practical integration of psychological therapeutic methods into voice therapy are still scarce. Behlau et al²⁸ suggested that this lacuna could be attributed, in part, to the professional education of SLPs, which is typically nested within the medical and health sciences and less so within psychological and behavioral sciences. This might hinder the incorporation of psychological elements into the routine mainstream clinical work of SLPs.

APPLYING PSYCHOLOGICAL APPROACHES TO VOICE THERAPY

As noted, the use of psychological approaches in voice therapy has been reported sporadically. For the most part, selected elements from cognitive behavioral therapy (CBT) were applied for treating people with “functional dysphonia”, demonstrating feasibility and effectiveness (for a detailed review, see Gray et al²⁴). Studies have also shown that incorporating elements from CBT into voice therapy favorably affected patients’ general health and quality of life.^{24,25,29} Consequently, CBT is generally viewed as an appropriate approach that can be integrated into voice therapy.

CBT is considered the “second wave” of cognitive-behavioral therapy approaches. It is a short-term, problem-focused approach to decrease maladaptive behaviors and increase adaptive ones.³⁰ Although this paradigm is widely accepted, limitations that could undermine its validity have been gradually noticed. For example, a significant restriction of CBT arises from its inherent structured nature. Specifically, CBT often applies recommended protocols intended to provide a holistic framework, but the structured nature of these protocols may sometimes limit flexibility and adaptability to the unique needs of specific individuals.³¹

Acknowledging the therapeutic value of the second wave of cognitive-behavioral approaches (eg, CBT) while recognizing its limitations, the “third wave” of CBT approaches has gradually emerged. This wave integrates methods from earlier waves while emphasizing acceptance, mindfulness, and values-based living within a collaborative, nonhierarchical therapeutic process.³¹ As part of this third wave of therapy approaches, the current article focuses on a specific approach that is widely acknowledged and applied in various disciplines: acceptance and commitment therapy (ACT).³¹

ACT was developed in the 1980s.³² It aims to “*maximize human potential for a rich and meaningful life while effectively handling the pain that inevitably goes with it*”³² (p. 3). This is achieved through psychological flexibility, defined as the capacity to be fully conscious, open to self-experience, and live by values.³² ACT is based on six core therapeutic processes, typically illustrated by the ACT

“Hexaflex” (Figure 1). The six core processes are (a) contacting the present moment, (b) defusion, (c) acceptance, (d) self-as-context, (e) values, and (f) committed action.³²

ACT offers several advancements compared with the second-wave therapy approaches. One prominent advantage is the promotion of psychological flexibility.³² As a basic concept, flexibility is viewed as a methodological approach and an overall therapeutic goal. While the second-wave therapy approaches relied chiefly on standardized protocols, ACT is primarily a nonlinear modular approach.^{32,33} The six core processes can be applied independently or in unison depending on the therapeutic context. To that end, ACT offers various techniques to meet the patient’s needs. Therapists are not expected to adhere to a predetermined sequence or follow a hierarchy of techniques during therapy. This enables flexibility and tailoring interventions dynamically. Moreover, the possibility of using selected features of the approach, as needed, facilitates short-term therapy when suitable.

The choice to focus on ACT is grounded in its proven adaptability, conceptual clarity, and applicability across professions.³² ACT has been effectively taught and implemented not only by psychologists but also by nurses, construction workers, community health providers, and SLPs. It has also proven effective in treating a wide array of conditions, including chronic pain, fibromyalgia, anxiety, obsessive-compulsive disorders, social phobia, smoking, and weight loss.^{34–36} In speech pathology, ACT has been widely applied in treating individuals who stutter to enhance psychological flexibility when faced with communication challenges.^{37,38} This broad dissemination illustrates its relative simplicity and feasibility, and demonstrates its potential for training SLPs in psychological skills that can be integrated into voice therapy.^{32,39} In line with these reports, a recent review of the psychological characteristics of dysphonic individuals suggested that ACT may provide potential benefits as an added component to voice therapy.²²

In summary, while the psychological aspects of voice disorders have been extensively recognized and discussed, the use of psychological approaches in voice therapy is still not considered a common practice. Hence, to pave the way for clinical work and future research in the field, this article briefly reviews ACT’s six core elements and suggests how they can be applied to voice therapy. The goal of this article is not to outline a full intervention model, but to present preliminary ideas intended to inspire further exploration, discussion, and development.

ACT’S SIX CORE ELEMENTS IN THE CONTEXT OF VOICE THERAPY

This section will briefly describe how ACT can be applied to voice therapy. Each of the six core elements will be described and briefly discussed in the context of voice therapy. In addition, each subsection will provide a short clinical example.

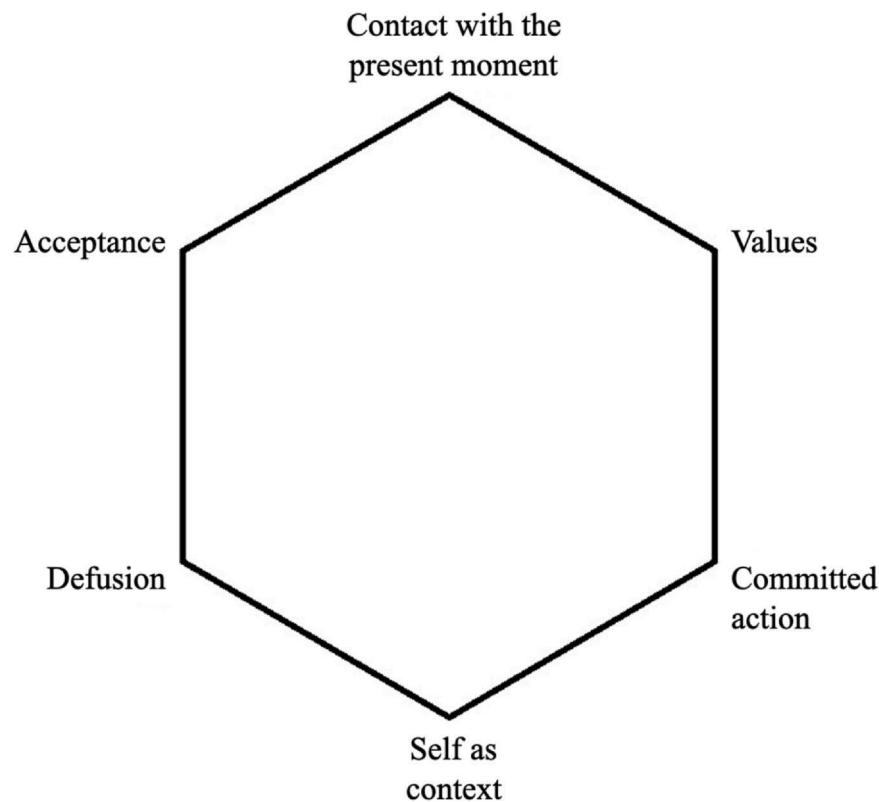


FIGURE 1. The ACT “hexaflex”. ACT, acceptance and commitment therapy.
Adapted from Harris³²

Element I: contact with the present moment

ACT encourages individuals to focus on the present moment while maintaining an open, nonjudgmental approach. To that end, the patient is gradually directed to observe the external environment and the individual internal experience, free of judgment.^{32,33} This mindful awareness is intended to help the individual become more attentive to their surroundings, accurately evaluate the details of the present situation, and perform effectively within it.³²

As a means to promote “awareness of the present moment”, mindfulness techniques are practiced, such as breathing exercises and “body scans”^{32,33} (for a more detailed information, see, eg, Harris,³² chapter 17). During this process, patients are guided to focus on different parts of their body or on specific body organs to identify particular physical sensations. Patients may be instructed, for instance, to close their eyes and identify various sensations, shifting gradually from one body part to another. They are encouraged to notice each physical sensation openly without trying to modify it. For example, the exercise may start by noticing the sensation of their feet touching the ground, then gradually shifting awareness to the body’s position on the chair, followed by focusing on the sensation in their hands, then continuing this guided process to other parts of their body.³³ During this exercise, patients are encouraged to openly acknowledge the different physical sensations, without evaluating them as either positive or negative, and with no attempt to change them. This

nonjudgmental awareness can serve as an initial step toward behavioral change. It creates a more open space for future exploration, where patients can reflect on which sensations they might wish to reduce and which to accept or reinforce.³²

Application to voice therapy

The concept of “awareness of the present moment” can be easily and intuitively integrated into traditional voice therapy, which often includes relaxation, breathing, and resonance exercises.² While breathing exercises are common practice in treating people with voice disorders, the integration of “body scan” exercises within this setting is intended to increase awareness of physical sensations.

Increasing and refining self-awareness enables patients to observe better and identify habitual behaviors, automatic responses, and internal experiences—laying the groundwork for behavioral changes.²⁸ This self-observation process can extend beyond bodily sensations to include a wide range of moment-to-moment experiences relevant to voice therapy. Once clinicians introduce and practice mindfulness with the patient, they can collaboratively begin to “notice and name” these experiences together.^{40,41} This may involve attending to compensatory habits or symptom-exacerbating behaviors, identifying physical sensations during voice production, or observing emotional reactions when listening to one’s recorded voice. Such

mindful attention not only supports the patient in the therapeutic process but also provides valuable insights for therapists, who gain a clearer understanding of the patient's evolving experience.

These flexible focal points can be creatively adapted to the patient's goals, needs, and context, making present-moment awareness a versatile tool in ACT-informed voice therapy. Moreover, such interventions foster a therapeutic atmosphere that is open and genuinely attuned to the patient's experiences. The clinician remains attentive to the patient's unique concerns and is willing to engage with the specific subjective aspects of the problem without judgment. By openly validating the patient's sensations, the therapist demonstrates acceptance and confidence, assuring the patient that a collaborative endeavor can effectively address these difficulties. This approach is expected to support and strengthen the therapeutic alliance and enhance the patient's trust in the therapist. Consequently, patients may feel more confident and encouraged to engage in the therapeutic process, thus enhancing motivation and commitment to therapy.

Clinical example

A 30-year-old swimming instructor came to voice therapy with mild dysphonia after being diagnosed with bilateral vocal fold nodules. Beyond the mild dysphonia, her primary complaint was a general, unfocused sensation of discomfort and "pain in her throat", which she struggled to describe or localize. A body scan exercise was introduced to enhance her awareness of these sensations, encouraging the patient to explore different physical sensations. Next, the clinician invited her to focus on any tension or discomfort in her body and merely observe the sensations without judgment. She was then encouraged to describe the sensations verbally, facilitating a deeper connection between her physical experience and her perception of her voice. By the end of this short exercise, she reported feeling relaxed and more "centered" and could describe physical sensations that had previously gone unnoticed. During the discussion that followed the exercise, she associated the newly reported sensation with her primary complaint and suggested that her discomfort might be related to dryness and phlegm. Based on her insight, strategies were explored to mitigate the effects of her work environment and daily routine, such as ensuring adequate hydration before and after work, limiting unnecessary throat clearing, and incorporating vocal warm-ups. One week later, in the subsequent meeting, the patient reported significant relief in her overall discomfort and the specific physical sensations she had described.

Element II: cognitive defusion

Cognitive defusion is an approach designed to direct individuals to realize that their thoughts are not necessarily accurate reflections of reality. In CBT, the individual's thoughts, while subjective and internal, are strongly

acknowledged as influencing behavior, whether consciously or unconsciously.³² If an individual believes, for example, that another person dislikes them, their attitude and behavior toward that person are likely to be affected. Such thoughts/beliefs shape actions before verifying their accuracy, and are often perceived as "the truth". This condition, where thoughts dominate and dictate behavior, is referred to in ACT as "fusion"—a state in which individuals become so entangled with their thoughts that they regard them as objective truths.

ACT posits that creating a "mental distance" between individuals and their thoughts, images, or memories is essential for preventing these mental events from controlling behavior.³² Without this "mental distance", thoughts might *automatically* shape actions, leading individuals to perceive their thoughts as absolute truths rather than subjective interpretations. This can reinforce unhelpful behavioral patterns, making it challenging to adopt alternative perspectives or respond flexibly to different situations. This process is particularly relevant when addressing distressing internal experience—such as worries, fears, or harsh self-judgments—that can feel intrusive and emotionally overwhelming. "Mental distance" is maintained by recognizing that thoughts are mental constructs, not objective realities. This process, referred to as "cognitive defusion", enables individuals to step back from their thoughts and evaluate them, rather than becoming consumed by them.³³

ACT facilitates cognitive defusion by encouraging individuals to examine the situational contexts in which cognitions arise and to observe how different appraisals can emerge from identical events. This meta-cognitive exploration promotes experiential distance between the person and the cognitive event, thereby weakening the effect these thoughts have on behavior. This process may be illustrated by considering the thought "I am bad".³¹ When perceived as an objective truth, such a thought reflects a global negative self-appraisal that may not correspond to reality, yet can significantly distort one's self-perception and contribute to emotional distress. However, through defusion, ACT directs individuals to modify their perspective and recognize a distinction between the content of a thought and the person who observes it. In this example, by *reframing* the thought "I am bad" as "I am having the thought that I am bad", the individual may begin to experience the thought as a subjective mental event rather than an objective truth. This seemingly linguistic shift enables patients to view their thoughts as transient mental events rather than fixed truths that define their identity, hence leading to a conceptual change. Consequently, such thoughts exert less negative influence on behavior and overall well-being.³¹

Application to voice therapy

When individuals with dysphonia are asked about their voice disorder and its impact, a wide range of self-directed thoughts often arise, particularly concerning how their

voice affects daily functioning and social interactions.⁴² Since voice is often regarded as a “mirror to personality”,²³ and evidence shows that voice disorders can indeed influence listeners’ impressions of a speaker’s personality traits and social attributes,⁴³ negative self-evaluations in this context may arise naturally and carry far-reaching implications.⁴⁴

While some of these self-directed thoughts may reflect genuine difficulties or socially relevant concerns, other thoughts do not align with the patient’s vocal function or therapeutic progress. These thoughts are often perceived as objective facts rather than subjective interpretations and may be expressed in rigid, global, or self-critical terms. Such perceptions can distort self-assessment, reduce motivation, and interfere with active engagement in therapy—even when perceivable and measurable improvement is evident.

To address this challenge, surfacing and examining such thoughts within the therapeutic process may be helpful (eg, Harris,³² chapter 11). Cognitive defusion techniques, as advocated in ACT, may help patients maintain distance from their thoughts by recognizing them as transient mental events. This process facilitates realistic self-assessment, supports more flexible behavioral responses, and ultimately promotes engagement in therapy.

Clinical example

A 40-year-old secretary was referred to voice therapy following a diagnosis of mild functional dysphonia. Laryngeal examination confirmed normal vocal fold structure and mobility, with no evidence of organic pathology or abnormality. Acoustic and perceptual assessments supported the clinical impression of a mild voice disorder, characterized primarily by mild breathiness. The patient herself reported only minimal additional symptoms. However, despite these findings, she described her voice in strongly negative terms, such as “horrible”, “disgusting”, and “embarrassing”. The clinician noted her emotional distress and the noticeable gap between her clinical status and personal experience. Early in therapy, it became apparent that she regarded her judgments as facts rather than personal interpretations. To address this issue, the clinician introduced a reframing exercise, encouraging her to phrase her evaluations as thoughts (eg, “I have a thought that my voice sounds...”) rather than statements of fact (eg, “My voice sounds...”). This subtle “linguistic” shift supported her in recognizing the subjective nature of her judgments and in considering alternative perspectives. To further support this process, self-assessment scales were used, enabling her to rate her voice quality in different contexts. These tools helped her anchor her evaluations more accurately and notice when her judgments may have been overly critical. Over time, the patient began to recognize her tendency to focus on small imperfections and generalize them. As this awareness increased, her engagement in therapy improved, enabling her to approach therapy with greater

openness and reduced emotional burden, ultimately supporting more constructive therapeutic progress.

Element III: acceptance

In ACT, acceptance refers to opening up to present sensations, thoughts, and emotions, even when they are uncomfortable, without trying to resist, suppress, or avoid them.³² This approach does not involve giving up or resigning oneself to chronic symptoms. Rather, it reflects a flexible stance: recognizing what is happening in the moment while continuing to take steps toward meaningful change and improved functioning.³³

Based on ACT’s theory, individuals have a natural (and understandable) tendency to try to control or eliminate uncomfortable internal experiences such as distressing thoughts, emotions, or bodily sensations. These efforts often manifest as either *struggle* (suppressing, arguing with, or trying to neutralize the experience) or *avoidance* (shifting attention elsewhere or avoiding triggering situations). While such strategies may provide short-term relief, they intensify the experience over time and increase psychological distress.³³ A well-known example of this process is thought suppression: the more individuals try not to think about something, the more persistent and emotionally charged the thought becomes.³¹

ACT suggests that the ongoing struggle to control internal experiences is often more detrimental than the initial discomfort.^{31,33} Accordingly, recognizing this pattern is a critical first step toward fostering acceptance. Once individuals become aware of how their efforts to suppress or avoid unpleasant experiences may intensify distress, they can begin to reassess their approach. This is achieved through understanding that certain events or internal experiences are beyond one’s control, and that continued struggle or avoidance is unlikely to change them. Following this realization, ACT encourages individuals to distinguish between what can and cannot be controlled. This shift enables them to redirect their efforts toward meaningful, values-driven actions rather than exhausting themselves in ineffective attempts to eliminate discomfort.³² By allowing unpleasant experiences to be present instead of resisting them, individuals become better equipped to deal with challenges with adaptability.³²

To foster acceptance, ACT incorporates techniques drawn from experiential therapies, such as mindfulness-based practices.³³ These techniques are designed to help individuals shift from a mindset focused on control to one characterized by openness and willingness to experience discomfort. This shift fosters greater psychological flexibility, enabling individuals to respond to challenges with increased resilience and emotional balance.

Application to voice therapy

Voice therapy often involves a dynamic interplay between controllable and uncontrollable factors, each contributing to vocal function and therapeutic outcomes. Patients often

enter therapy with preexisting conditions beyond their control, such as laryngeal pathologies, age-related changes, general health, and anatomical features. These factors shape the baseline of vocal function and establish certain limits within which therapy must operate. Alongside these, patients typically present with modifiable factors, such as voice production habits, vocal behaviors, and vocal-hygiene practices, which may be the primary focus of intervention and the clinical justification for referral to voice therapy. The interaction between these factors influences the severity and persistence of voice disorders, underscoring the importance of addressing both while determining the appropriate therapeutic focus.

When patients do not clearly distinguish between these factors, they may become entangled in unproductive efforts to control the uncontrollable, leading to frustration, avoidance, or disengagement.³² Recognizing this unproductive pattern and guiding patients to direct their energy toward actionable changes can reduce unnecessary struggle and support greater therapeutic engagement.

Differentiating between what can and cannot be changed is thus a valuable starting point in the therapeutic process. It helps to align expectations and foster a realistic understanding of potential outcomes. Importantly, it enables patients to acknowledge inherent limitations while focusing on practical strategies for improvement. In some cases, this stage may also serve as an opportunity to discuss the support of other professionals, such as psychologists or medical specialists, when the patient's needs extend beyond the scope of voice therapy. By emphasizing this balance, therapists can guide patients toward a more constructive and empowering rehabilitation process.

Clinical example

A 40-year-old woman was referred to voice therapy after being diagnosed with adductor spasmodic dysphonia. For over five years, she had received various misdiagnoses and consequently underwent therapeutic interventions that were not appropriately targeted to her condition, and did not lead to improvement. These experiences had left her feeling discouraged and uncertain about the possibility of change. After receiving a more accurate diagnosis, she arrived at therapy with hope that treatment would completely resolve her condition. Early in the process, it became evident that this expectation created some difficulties in her engagement. Although she was motivated, her underlying hope for a full recovery hindered consideration of the possibility of partial progress or considering alternative goals. To support her in this process, the clinician introduced the distinction between controllable and uncontrollable factors in voice therapy. Together, they explored how certain aspects of her condition (such as the underlying neurological basis of spasmodic dysphonia) were not subject to change through therapy alone. At the same time, they emphasized that many elements of her vocal function could be improved and managed effectively

within the given limits. Gradually, this shift in focus helped her release the hope of fully controlling her condition and instead engage with therapy in a more grounded and purposeful way. As she came to accept what could and could not be changed, she became more attuned to progress and more active in the therapeutic process. This adjustment supported a more constructive approach to rehabilitation and allowed for a meaningful improvement in her vocal functioning and confidence. This has also facilitated a realistic and productive discussion on alternative therapeutic options, while considering their pros and cons.

Element IV: self-as-context

A central aim of ACT is to enhance psychological flexibility by encouraging individuals to relate to their internal experiences in more flexible and adaptive ways. One such process involves shifting from a rigid, concept-based identity toward a more flexible and resilient sense of self. This perception is referred to in ACT as "*self as context*".³³

Generally, individuals tend to define themselves through conceptualized identities or roles, such as gender ("I'm a man"), vocation ("I'm a manager"), work experience ("I'm an experienced teacher"), or family roles ("I'm a father").³³ In ACT, these are referred to as "*self-as-content*". These identities are not inherently problematic, but when held too rigidly, they can limit psychological flexibility and create distress if circumstances challenge or conflict with them. For example, an individual who strongly identifies as "I'm a manager" may experience disproportionate distress when confronted with contradictory feedback, interpreting such moments as a threat to their core identity.

The "*self as context*" perspective encourages individuals to step back from their self-concepts and recognize them as part of their ongoing experience, not as the entirety of who they are.³³ This observer stance reduces the emotional impact of negative or inconsistent self-appraisals and supports greater psychological flexibility.^{32,33} To enhance a more flexible sense of self, ACT employs various techniques, including mindfulness practices, experiential exercises, and the use of metaphors. One widely used example is the "Good Self / Bad Self" exercise. This exercise targets overly rigid or dichotomous self-perceptions. In this exercise, individuals are guided through reflective questions related to familiar daily situations to explore how personal traits and behaviors may be perceived differently across contexts. The exercise emphasizes that self-judgments, such as being "good" or "bad", are not fixed characteristics but subjective appraisals shaped by situational factors. This awareness helps patients untie their attachment to rigid self-concepts and progress toward a more adaptive and context-sensitive view of themselves.³²

Application to voice therapy

In voice therapy, contextual awareness is particularly important given the inherently dynamic nature of the human voice. The voice is continuously shaped by internal and

external factors, including emotional states, physical conditions, and situational contexts.^{9,12} This variability is reflected in the common view of voice as an “indicator of the speaker’s mood”, responsive to emotional and environmental shifts.⁴⁵ Such fluctuations in voice and in mood often become apparent in therapy. For example, when a patient reports, “my voice sounds better at home”. By acknowledging both the contextual variability of the voice and the fluidity of self-perception, patients may be better able to integrate therapeutic strategies into everyday situations.

Clinical example

A 14-year-old boy was referred to voice therapy with moderate dysphonia following a diagnosis of bilateral vocal fold nodules. In contrast with the clinician’s initial expectations, he was habitually speaking in a quiet voice with limited mouth opening. After being introduced to resonance techniques,⁴⁶ he became ambivalent about continuing his home practice, explaining that his voice felt “too loud”. In a subsequent discussion, he expressed that he viewed himself as a quiet person. To explore this self-perception, the therapist introduced the “Good Self / Bad Self” exercise.³² Together, they identified contexts where a quiet voice aligned with social expectations, such as during chess lessons, family dinners, or while watching movies. They then contrasted these with situations where a louder voice was functionally advantageous, such as basketball games and school breaks. During this exploration, the patient acknowledged that in some of these contexts, he naturally used a louder voice. This realization led him to recognize that effective use of voice requires the ability to vocally adjust to the situation. Rather than seeing himself as inherently “quiet”, he noted that both soft and loud voice qualities were part of his communication style and could be used intentionally pending on context. With this broader perspective, he became more open to practice, and therapy could then be shifted toward applying resonance techniques in settings that felt appropriate to him. This promoted his ability to use his voice with greater control, confidence, and flexibility across different situations.

Element V: values

In ACT, values are defined as desired qualities that shape how individuals aspire to live, providing meaning and a sense of purpose.^{32,33} Values are frequently regarded as an inner compass, as they provide an internal reference point that enables individuals to orient their actions toward what is personally meaningful to them. Contrary to external norms or prescriptive ideas of what is “right”, values are inherently subjective, individually determined, and can vary considerably among individuals.³² Examples of values include striving to be adventurous, compassionate, assertive, or intimate.³²

Unlike goals, which refer to specific outcomes to be achieved at a particular point in the future, values represent

enduring directions and guiding principles that continuously shape an individual’s behavior over time.³² Within ACT, individuals are encouraged to identify and clarify their core values across different domains of life. This process serves as a foundation for acting in alignment with those values, which is considered an essential element of psychological flexibility.^{31,33} Values clarification helps individuals stay connected to the broader purpose that guides their actions. By keeping in touch with this broader perspective, individuals are better able to observe temporary setbacks as a step toward their overall direction. This helps sustain engagement and motivation throughout different life challenges and therapeutic processes.³²

Patients can be directed to identify and crystallize their values using various methods, ranging from structured questionnaires and checklists of common values³² to informal conversations that explore their beliefs and priorities. Patients often have specific core values, which usually remain unspoken or implicit. Hence, thoughtful questions and reflective dialogue could lead to revealing these underlying values and bring them to the surface. Several exercises have been proposed to support this process (eg, Harris,³² chapter 19). A practical strategy involves guiding patients to reflect on the anticipated impact of reaching a specific goal. This process can clarify the personal significance of the goal and illuminate the values that give it meaning.³²

Application to voice therapy

In voice therapy, clarifying values can be a valuable part of the diagnostic process as well as of the ongoing therapeutic work. Although patients typically seek therapy primarily to improve voice quality, exploring this goal can reveal deeper underlying motivations. For example, a therapist might ask: “If your dysphonia improves or disappears, how would that change your life? What would you do differently? Why is this important to you?” The patients’ responses can offer insight into their core values and priorities, enabling the clinician to better tailor the therapeutic approach. Aligning therapy with what the patient truly values can make the process more personally meaningful and motivating, which may help strengthen engagement and support more sustainable outcomes.

Clinical example

A 60-year-old woman was referred to voice therapy with moderate dysphonia following a diagnosis of presbyphonia. She sought therapy because her voice sounded to her “much older than her actual age”. During the diagnostic process, she shared that she had been avoiding social situations due to concerns about how others perceived her voice. Although she described herself as friendly and outgoing, she felt that her voice no longer reflected this central part of her identity, which led her to limit social activities and to avoid initiating new relationships. To better

understand her motivations and hopes for therapy, the clinician presented several open-ended questions such as “If your voice improved, what would you do more of? What would you feel more comfortable pursuing? Why is this important to you?” In response, she explained that she wished to reconnect with old friends, meet new people, and feel more confident expressing herself in social gatherings. These reflections were discussed as highlighting key values such as intimacy, connection, enjoyment, and open communication. Recognizing these values gave both the patient and the clinician a glimpse into her goals: to fully participate in social life, and to ensure that her voice does not prohibit her from connecting with others. This insight has also led to the planning of specific, values-based actions to support her vocal use. This clinical example will be revisited in the following section to illustrate the application of these insights as part of the therapeutic process.

Element VI: committed action

Committed action refers to taking concrete steps that actively promote one's values in daily life.⁴⁰ In ACT, clarifying values is an essential starting point. However, if these values are not translated into concrete actions, their practical impact remains limited. Taking committed steps that put values into practice promotes psychological flexibility and transforms abstract intentions into meaningful, lasting change.³² Accordingly, ACT encourages individuals to turn their identified values into ongoing, purposeful patterns of behavior that are dynamic and adaptable.^{31,32}

Committed action may feel intuitive and natural at times, yet it often requires overcoming obstacles and discomfort. ACT recognizes that resistance and setbacks are expected when pursuing actions aligned with one's values. To address potential barriers proactively, ACT incorporates structured goal-setting strategies that enable individuals to translate their values into realistic, actionable steps, thereby increasing the likelihood that committed actions will be sustained over time.^{31,32}

The goal-setting process in ACT can be approached either formally or informally, depending on the context and the nature of the goals. Effective goals should be specific, adaptable, realistic, and time-framed.³² In a *formal* approach, the patient identifies a specific life domain—such as work, family, or relationship—and selects one or two core values to focus on within that area. This method is particularly useful for highly specific and challenging goals that require structured guidance. In contrast, *informal* goal-setting integrates goals into therapy, viewing steps like regular session attendance and between-session practice as meaningful actions that align with the patient's values. This approach helps sustain motivation by framing routine therapeutic engagement as part of a broader commitment to values-based living, thereby maintaining awareness of the larger purpose even through small, practical steps.³²

Once a goal is defined, considering how its effectiveness will be evaluated is advisable. Several guiding principles can assist in this process: (1) Goals should specify a

proactive action the patient will take, rather than focusing on actions or behaviors they aim to avoid; (2) Goals should be realistic. Patients are encouraged to rate the feasibility of their goals on a scale, and if the rating is not high, a simpler or more limited goal may be considered; (3) The benefit or “reward” associated with the goal should be emphasized. The therapist can facilitate this by exploring the values it supports, as well as the potential benefits of achieving it.³²

Application to voice therapy

In voice therapy, patient attendance and consistent practice are integral parts of the therapeutic process, supporting progress toward therapy goals.⁴⁷ This process naturally aligns with the informal approach to goal-setting, even when neither the patient nor the clinician are explicitly aware of ACT principles. However, actively refining and clarifying goals can strengthen motivation and reduce the risk of goals becoming ineffective or misaligned with the patient's needs.

By incorporating ACT principles, patients can identify specific, meaningful, values-based goals, transforming routine participation into a more purposeful and motivating experience. This deeper connection to personally held values can strengthen persistence and improve patients' commitment in the face of challenges. As a result, routine therapeutic tasks link more closely to the patient's core values and long-term aspirations, reinforcing engagement throughout the therapeutic process.

Clinical example

The clinical example of this element continues with the previous clinical example of the 60-year-old woman diagnosed with moderate presbyphonia. Even after identifying her core values, she tended to avoid acting on these values due to voice-related discomfort and insecurity. This avoidance was first acknowledged as a natural response. Yet, the therapist gently and gradually emphasized that while avoidance might offer *short-term* relief, it pushes her away from living life in accordance with her values, which prevents her from even experiencing life to its fullest *on the long run*. To support her in taking practical steps, the therapist guided her in setting segmented, realistic goals connected directly to her values. Together, they discussed situations where she felt most comfortable and explored ways to gradually expand her vocal use in meaningful contexts. She was given customized home practice tasks designed to match her comfort level while encouraging gentle progress and expansion. For example, she practiced vocalizing and speaking with a friend in a quiet restaurant and later repeated the same vocal tasks in a more intimate setting (eg, on a date). Each step was then reviewed in therapy, allowing her to reflect on her actions and experience, adjust goals if needed, and recognize gradual and even small successes. This structured process helped sustain her motivation and gradually reduced her avoidance,

supporting progress aligned with her values and therapeutic goals.

SUMMARY, LIMITATIONS, AND FUTURE DIRECTIONS

This article provides a brief overview of ACT and preliminary suggestions for its integration into voice therapy practice. Although the literature increasingly acknowledges the multidimensional nature of voice disorders and the significant role of psychological factors, the structured incorporation of psychological approaches into voice therapy remains limited.

As part of introducing ACT into voice therapy, the six core processes were outlined and contextualized. We also provided practical suggestions and clinical examples to illustrate how these basic principles may be incorporated as part to routine therapy approaches. Incorporating ACT principles into voice therapy may enhance treatment personalization by aligning therapeutic strategies with the unique needs, values, and goals of each patient. Through processes such as values clarification and committed action, therapy can be flexibly adapted to address individual challenges and motivations—moving beyond standardized protocols to foster greater engagement and improved outcomes.⁴⁸

Given the preliminary nature of this article, it is not intended to be a comprehensive manual for implementing ACT in clinical practice, nor does it prescribe specific treatment protocols. Rather, it serves as a conceptual introduction and an initial step designed to raise awareness and foster interest in the potential relevance of ACT principles in voice therapy. As clinicians consider incorporating ACT elements, it is important to do so with clinical sensitivity and professional discernment. Decisions should be informed by supervision, clinical experience, and a clear understanding of the scope of practice of SLPs. This discernment includes recognizing that while some patients may benefit from the integration of one or more ACT components, others may require referral to other professionals. Thoughtful consideration of the needs of each patient, along with collaborative interdisciplinary work when appropriate, is essential to ensure ethical and effective care.

Several limitations should be acknowledged. We present here an overview and preliminary considerations for incorporating a well-established psychological framework into practicing voice therapy. In doing so, it draws primarily on conceptual models and clinical experience rather than empirical evidence derived from statistical or experimental studies, which necessarily limits the generalizability. Future research is therefore essential to expand on these initial suggestions to provide a systematic quantitative and qualitative analysis.

Further developing and refining the practical suggestions outlined here may increase their relevance and adaptability across diverse clinical contexts. Future work could benefit from exploring how ACT principles can be integrated into

different voice therapy protocols and settings, while considering diversity in patient populations, clinical resources, and therapist expertise. It would also be valuable to investigate how these suggestions can be adapted for different cultural or linguistic contexts.

A final issue that warrants further consideration is how SLPs are trained and how they perceive their competence in addressing psychosocial factors within the context of voice therapy. Studies focusing on clinicians' perception of self-efficacy are essential for this purpose and should be promoted. At the same time, academic programs that train SLPs in the field of voice disorders should consider inclusion of training resources, supervision models, and specific courses to equip clinicians with basic practical skills and evidence-based tools for applying ACT principles (or similar approaches) effectively within voice therapy. Importantly, ACT training for SLPs can be delivered in a flexible and scalable manner—from brief introductory workshops to more comprehensive, multisession programs. This adaptability supports integration into both preservice and continuing professional education. Encouragingly, such formats have already demonstrated success in adjacent fields like nursing and education, suggesting promising feasibility for SLP training as well.^{32,49–51} While this article is merely a preliminary step toward the inclusion of ACT in support of voice therapy, it is our hope that it will serve to motivate clinicians and researchers examine it further, to enhance, advance, and improve voice therapy and overall well-being in the broader sense, for individuals with dysphonia.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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