Acceptance and Commitment Therapy for Treatment-Resistant Posttraumatic Stress Disorder: A Case Study

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An adult woman with chronic posttraumatic stress disorder (PTSD) and major depressive disorder who was nonresponsive to 20 sessions of cognitive behavior therapy (CBT) is presented in this case study. Two months after her CBT trial, she was treated with 21 sessions of Acceptance and Commitment Therapy (ACT) for PTSD. Measurements of PTSD severity, depression, anxiety, psychological flexibility and trauma-related thoughts and beliefs were taken at pretreatment, after Sessions 8 and 16, and at posttreatment. Results showed significant reduction on all measures throughout treatment, except for trauma-related thoughts and beliefs, which did not decrease until near the end of treatment. Strengths, limitations, and future directions are discussed.

Effective treatments for posttraumatic stress disorder (PTSD) are necessary because approximately 8% of the population will meet diagnostic criteria for this disorder at some point in their lives (American Psychiatric Association, 2000). The need for successful treatments has been highlighted in Western countries since the attacks on September 11, 2001 (Jordan et al., 2004) and the wars in Afghanistan and Iraq (Hoge et al., 2004), where it has been found that 16.6% of individuals returning from Iraq meet criteria for PTSD (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). Cognitive behavioral therapies (CBT) for PTSD—including exposure therapies such as prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007), exposure therapy with cognitive therapy techniques such as cognitive processing therapy (CPT; Shipherd, Street, & Resick, 2006), and eye movement desensitization and reprocessing (Shapiro, 2002)—have been found to be highly effective treatments.

Meta-analytic reviews show that CBTs have strong pretreatment-to-posttreatment effect sizes, and that 67% of participants do not meet criteria for PTSD after therapy (Bradley, Greene, Russ, Dutra, & Westen, 2005). Yet, these data also show that approximately one third of participants do not respond to these treatments. Additionally, treatment refusal and dropout is a noted problem in PTSD treatment research (Bradley et al.; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Thus, even though there are useful treatments for PTSD, it is also clear that many clients will either refuse or not respond to the most supported interventions.

There are multiple factors that play into undesirable treatment outcomes: poor administration, therapy-interfering behaviors or external events, limited dosage, timing of the treatment, or the treatment might not have been the right match for the presentation. In cases where the treatment is not the appropriate match, alternative interventions such as pharmacotherapy or other psychotherapies are logical options. One alternative psychological approach to the treatment of PTSD that has been receiving increased attention is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999).

ACT is a form of CBT, where “CBT” is defined as an overarching umbrella that encompasses treatments from a similar theoretical and empirical tradition but each treatment is considered distinct. For example, PE and CPT are types of CBT for PTSD, but they do not define CBT. It is very likely that all types of CBT share similarities, but there is an assumption that there is something unique to each intervention—unless it is empirically shown otherwise. Even though there is overlap between ACT and other types of CBT, ACT focuses on specific processes that are not directly targeted by other treatments. ACT does not focus on the form or frequency of inner experiences but instead targets their functional effects on behavior. This approach is shared with other therapies such as Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002). ACT also uses behavioral procedures to promote values-consistent actions that promote increases in quality of life. These types of procedures are present in most forms
of CBT. ACT targets the function of thoughts, feelings, and bodily sensations using acceptance and mindfulness procedures on the one hand, and targets behavior change using traditional behavioral procedures on the other.

ACT also targets particular constructs that are partially but not wholly shared with other therapies, including: cognitive fusion (treating cognitions as literal events that need to be responded to), experiential avoidance (attempting to avoid or control certain inner experiences even though these attempts result in negative effects on one’s quality of life), and unclear values (a lack of awareness of areas of life that are important to the client). These constructs are targeted in the hopes of increasing psychological flexibility (the ability to act in accordance with one’s values regardless of inner experiences).

ACT may be an appropriate treatment for PTSD because there is a considerable body of research showing that PTSD is associated with poor awareness of emotions and the use of avoidance and psychologically inflexible responses to difficult emotions (e.g., Marx & Sloan, 2005; Nexhmedin, 2007; Plumb, Orsillo, & Luterek, 2004; Tull, Barrett, McMillan, & Roemer, 2007). Empirical support exists for ACT as a treatment for psychosis, social phobia, smoking cessation, polysubstance abuse, depression, chronic pain, worksite stress and poor innovation, dealing with end stage cancer, managing diabetes, stigma and burnout, agoraphobia, epilepsy, and trichotillomania, as well as other disorders (as reviewed in Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Masuda, Bissett, Luoma, Guerrero, 2004). But support for the use of ACT as a treatment for PTSD is limited to case studies (i.e., Batten & Hayes, 2005; Orsillo & Batten, 2005). The lack of support for ACT as a treatment of PTSD is of major importance because ACT is being used as a treatment in many therapeutic settings, clinicians are being trained in its use, and recently a practitioner’s guide (Walser & Westrup, 2007) and self-help version (Follette & Pistorello, 2007) of ACT as a treatment for PTSD have been published. There is a clear need for more data on whether ACT is an effective treatment for PTSD.

In this case study, a woman diagnosed with treatment-resistant PTSD is treated with a trial of ACT. Measures of PTSD severity, psychological inflexibility, and trauma-related thoughts and beliefs are given at pretreatment, posttreatment, and at regular intervals throughout treatment. The goals of this case study are to (a) determine if ACT can successfully treat a resistant case of PTSD, and (b) monitor a primary ACT process measure and a commonly used measure of “trauma related thoughts and beliefs” (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) to see their associations with symptom change.

Method

Identifying Information

Tracy was a 43-year-old Caucasian woman who lived alone and worked full time in the food service industry and part time as an actor. She was referred for treatment of PTSD and depression. In the 20 years prior to her trial of CBT, she received 13 psychotherapy sessions with three different therapists. She terminated her previous services because of a lack of therapeutic alliance and/or financial difficulties.

Pertinent Historical Information and Trauma History

Tracy's father abused alcohol and her mother was "explosive and unpredictable." Her parents were verbally and physically abusive towards each other, and Tracy often unsuccessfully attempted to resolve these fights. Tracy was the recipient of regular and unpredictable physical and verbal abuse by her mother, including: being yelled at, having items thrown at her, and being hit and choked. The same abuse did not occur to her siblings, and Tracy's sister would side with the mother and offer suggestions of ways to punish Tracy.

Because the abuse was unprovoked and unpredictable, Tracy lived in constant fear. Tracy responded to this uncertainty by "welcoming" the abuse because it reduced the uncertainty of when it would occur. In response to this abuse, she spent as much time as possible away from her home and moved out when she was 17 years of age. The abuse continued when she visited her mother. Her last in-person interaction with her mother occurred 16 years prior when Tracy graduated from college. At this time, Tracy's mother became irate for no apparent reason and threw items, hit, and choked her. Tracy has had no contact with her mother since then, and very little contact with the rest of her family.

As a result of this abuse, Tracy experienced flashbacks and intrusive recollections and dreams of the abuse. Additionally, she experienced intense psychological distress and arousal in response to particular stimuli that reminded her of the assaults, such as thoughts of the assaults, being in arguments or confrontations, and loud noises. Her symptoms were similar to a limited-symptom panic attack and included heart palpitations, chest pain, hot flashes, cold chills, shortness of breath, choking sensations, and tension in her abdomen. Tracy also had difficulty remembering certain aspects of the assaults and avoided situations that reminded her of the abuse or evoked emotions that were similar to ones experienced during the abuse. She often experienced "numbness" or feelings of depersonalization or derealization whenever she experienced intense emotions; she reported that this was a coping response because she feared that if she let...
herself experience the emotion something bad would happen to her.

Tracy had trouble sleeping and concentrating, as well as heightened irritability, hypervigilance, and an exaggerated startle response. She had not established any long-term intimate relationships and also experienced chronic feelings of depression, was generally inactive, and slept approximately 10 hours per night. She reported feelings of unworthiness and would not share her opinion, ask for things she deserved, or stand up for herself in social situations. Because she tended bar in an upscale restaurant, she had easy access to alcohol and would consume approximately four alcoholic drinks in addition to five cigarettes nightly. She reported that the alcohol consumption mainly functioned to reduce the anxiety that occurred at work. Even though her consumption was elevated, her use of these substances did not rise to diagnostic levels.

Treatment History

At the suggestion of her acting coach Tracy sought treatment for her trauma history at a large metropolitan anxiety disorders clinic. She completed 20 individual 1-hour sessions of CBT (which included cognitive challenging techniques and script-based exposure) for PTSD. This was the first time she completed a trial of therapy. She had previously withdrawn from three trials of therapy in the past 20 years. Her trial of CBT took place over the course of 7 months and was provided by a psychology intern trained in CBT for anxiety disorders and supervised by an experienced CBT therapist who is certified in cognitive and behavioral therapy by the American Board of Professional Psychology, and an additional CBT therapist who specializes in the treatment of PTSD.

Tracy’s trial of CBT focused on (1) education on the basic model of CBT and the relationship between thoughts, feelings, and behaviors; (2) education about the CBT formulation of PTSD, such as the characteristics of PTSD symptoms and the concept of “stuck points” resulting from dysfunctional beliefs resulting from the trauma; (3) goal setting; (4) cognitive exposure to trauma scripts; (5) methods of cognitive restructuring focused on challenging maladaptive beliefs resulting from the trauma; (6) providing a cognitive conceptualization of her symptomatology and assistance in recognizing the relationship between her dysfunctional core beliefs about herself and maladaptive coping behaviors; and (7) behavioral activation exercises to target depression. The majority of sessions covered cognitive restructuring and reinterpretations of PTSD-related cognitions. Tracy was also assigned homework that involved recording her activating events, beliefs, and consequences (ABCs), and these were discussed in session. Developing and reviewing scripts of traumatic events occurred in many sessions, and Tracy was asked to review the trauma script every day between most sessions. In general, she complied with treatment, attended and participated in therapy sessions, completed all homework, and practiced skills that were taught by the therapist.

Tracy showed a gradual reduction in PTSD severity during therapy, but the reduction was not clinically significant and she was back at pretreatment levels at the completion of treatment. Tracy’s primary difficulties in her trial of CBT included tolerating fears that “treatment would not be helpful and that she would never improve”, enduring high levels of distress when completing exposure scripts; and continued negative reactions to PTSD triggers (e.g., arguments or being reprimanded at work), which often resulted in increased PTSD symptoms. Even though she participated in a full trial of CBT, she continued to experience high levels of PTSD at posttreatment. Therefore, it was decided that an alternative approach to her PTSD was warranted.

Assessment

Symptom Measures. Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988). The BAI is a 21-item self-report measure that assesses anxiety. The BAI has high internal consistency (Cronbach’s alpha = .85), adequate test-retest reliability (r = .75), and high convergent and discriminant validity.

Beck Depression Inventory-II (BDI-II; Beck, 1996). The BDI-II is a 21-item self-report measure that assesses depression. The BDI-II has shown high internal consistency (Cronbach’s alpha = .91), good test-retest reliability (r = .93), and a high correlation with the original BDI (r = .93).

PTSD Checklist–Civilian Version (PCL-C; Ruggiero, Del Ben, Scotti, & Rabalais, 2003). The PCL-C is a 17-item self-report measure that assesses symptoms of PTSD in civilians. The PCL-C has high internal consistency (Cronbach’s alpha = .85), good test-retest reliability (r = .92), and high correlations with other well-established measures of PTSD (r = .75). Mean scores in a college student population are 29.4, and a score of 44 has been suggested as the clinical cutoff for PTSD (Ruggiero et al., 2003).

Process Measures. Acceptance and Action Questionnaire (AAQ; Hayes, Strosahl, et al., 2004). The AAQ is a 9-item questionnaire that measures psychological inflexibility. Questions are rated on a 7-point Likert-type scale. Lower scores reflect greater psychological flexibility. Upper quartile scores for clinical samples is 42, and 38 for nonclinical samples. The AAQ has adequate internal consistency (Cronbach’s alpha = .70) and acceptable test-retest reliability.

Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999). The PTCI, a 36-item inventory, has a total score and measures three constructs related to trauma-related
thoughts and beliefs: negative cognitions about self (NTAS), negative cognitions about the world (NCAW), and self-blame (SB). Questions are answered on a 7-point Likert scale (1 = totally disagree, 4 = neutral, and 7 = totally agree). Mean total score for individuals diagnosed with PTSD is 133. Scores on subscales are presented as mean scores for all questions for each subscale so scores can be compared to the likert scale. Clinical means for subscales are as follows: NTAS = 3.6, NCAW = 5, and SB = 3.2. The PTCI has high internal consistency (Cronbach’s alpha = .97), adequate test-retest reliability (r = .74), and high correlations with other well-established measures of PTSD (r = .75). This measure has been found to be sensitive to change in exposure and CBT trials (Mueser et al., 2008; Wald & Taylor, 2007).

Assessment Procedures

Prior to treatment Tracy completed the Structured Clinical Interview for the Diagnostic and Statistical Manual (IV) for Axis I and was diagnosed with PTSD, chronic; Major Depressive Disorder, Recurrent (MDD); and Eating Disorder, not otherwise specified, in full remission. Prior to starting ACT, Tracy completed the BAI, BDI, PCL-C, AAQ, and PTCI. These were also completed after Sessions 8 and 16, as well as at posttreatment (after Session 21).

Treatment

Tracy presented with the same concerns at the beginning of her trial of ACT that she did at the beginning of her trial of CBT. She felt “unworthy of any good happening to her,” “worthless,” and that whenever anything good happened it was a “fluke.” She was afraid she would never improve in therapy and that she would always struggle with PTSD. She reported suicidal thoughts throughout her life but stated that she would “never act on them.” She was attentive during sessions, but appeared somewhat skeptical of the therapist’s intentions and often asked what the therapist meant when asked simple questions. Tracy was emotional and cried often during therapy. Possibly because of the trial of the CBT, she presented as “psychologically minded”—she was familiar with her thinking patterns and emotions. When asked what she wanted to get out of therapy, she reported that she “wanted to feel good about herself.”

Tracy was informed that she was being referred for ACT because she was not responsive to her trial of CBT. She was told that a primary difference between the CBT that she received and ACT was “that therapy was not going to focus on winning the struggle against her thoughts, but instead therapy was going to help her step out of the struggle.” Challenging cognitions and thought records would not occur in therapy. She was intrigued by the description of ACT and was willing to participate in therapy. Tracy originally contracted for 12 sessions of ACT for PTSD (e.g., Walser & Westrup, 2007) with the agreement that additional sessions could be added if ACT was useful for her.

Sessions 1 and 2. Immediately prior to her first session, Tracy was asked to take a week off of work because she cried while tending bar. Tracy assumed that she was given the week off because she was doing a “bad job” at work. She initially provided alternative interpretations for this event as she was taught in her trial of CBT. Instead of addressing other possible explanations for this event, her rationalizations were put into a class of behaviors called “attempts to control thoughts, emotions, and bodily sensations” (these will be called “inner experiences” from now on). A list of all the steps she took to control or regulate her inner experiences was created under the heading of “can you control your inner experiences?” The list was long and included obvious avoidance behaviors such as avoiding certain people and places and leaving the city on vacations. It also included many “private” activities including telling herself she would be “okay,” figuring out why this happened to her, and cognitive challenging techniques from CBT. The short- and long-term effectiveness of all these techniques was evaluated, and it quickly became apparent that they were neither effective in the short- nor long-term at controlling her negatively evaluated inner experiences. Next, the effects of attempting to control or regulate her inner experiences on her quality of life were evaluated. Tracy quickly recognized that much of her life had been about managing inner experiences and not about doing things that are meaningful to her. In summary, these sessions helped clarify that attempts at controlling inner experiences were generally unsuccessful, and they interfered with her quality of life.

Sessions 3 and 4. Between Sessions 2 and 3 Tracy noticed that she constantly attempted to control and manage her inner experience through avoidance and self-talk. By stepping back and watching this process she became aware of how central it was in her life and how much energy it consumed. An intervention strategy named “control as the problem” was used to help her experience the effects of attempting to control or manage inner experiences. In this ACT strategy, discussions and exercises are used to help clients understand experientially that attempts to control inner experiences are often logical, but in some situations (such as PTSD) they can be counterproductive. To begin with, Tracy was shown that control strategies work very well in many situations in life, but that all these areas are in the real world, not inner experiences. For example, if someone does not like their clothes or hair style they can easily be changed. Tracy experienced through exercises that these same strategies do not have the same effect on inner experiences. Tracy
was asked to (1) not think a particular thought, (2) not to feel anxious if hooked to a polygraph machine, or (3) immediately feel an emotion such as love. She found these tasks to be impossible, but she continued to believe that she should be able to control her negative thoughts and feelings about herself. Instead of proving her incorrect, Tracy was asked to watch how successful she was at controlling these thoughts between sessions.

She found that her inner experiences were difficult if not impossible to immediately control. This experience confused her because she had a friend who went through therapy for PTSD and no longer struggled with feelings of fear. Tracy was confused about how she could get to the same place as her friend if therapy did not teach her to control her inner experiences. This turned out to be a recurring theme in Tracy's therapy: she wanted to know whether behavior occurs) exercises were used to target these types of cognitive processes. One way to foster defusion is to make sessions purposefully confusing and paradoxical. When Tracy was caught analyzing the therapist's comments, the therapist would ask, “What game are you playing?” or “Let's not figure this one out.” When Tracy seemed to “understand” what the therapist was discussing, the therapist would say something such as, “If you are feeling like you get it, then you don’t.” The functions of statements such as these are to decrease the amount she relied on her logical rational thought. She probably assumed that the therapist would agree with her and praise her “logical” thinking. But the therapist instead taught her not to always trust her mind. Even though the content of the thought may have technically been accurate, it was still experienced in a fused fashion. Additional defusion exercises involved teaching her to not take her mind seriously and formal meditation exercises such as watching her thoughts without grabbing onto them.

Treatment specifically addressed acceptance by offering willingness to experience many PTSD-related inner experiences as an alternative to attempting to control or regulate them. Inner experiences were portrayed as outside of her control versus being accepting, which was presented as an action. She was informed that we can act in ways that are accepting, such as approaching feared situations and not reassuring ourselves. Tracy was informed that being accepting was a skill that needed to be practiced, much like playing a sport. Discussions of putting oneself in situations that caused PTSD-related inner experiences took place and were offered as an alternative to avoidance.

The initial trial of CBT also included behavioral activation exercises and exposure scripts. Therefore, Tracy already had conceptions of what this part of therapy meant. To help Tracy use acceptance exercises in an ACT-consistent manner, the therapist explained:

“If we are really going to play game two (moving in a meaningful direction in life with negatively evaluated inner experiences), then we should keep the purpose of acceptance in our minds. We allow our inner experiences to occur and choose not to engage in the fight with them so that we are free to move in meaningful directions in life. We are not allowing the inner experiences to occur so that they may eventually go away—that would be game one. Acceptance of the inner experiences that we have gained in life is a way of living—it is not a means to regulate fear or anxiety.”

Self as context (defined as experiencing a separation between oneself and one’s inner experiences) was addressed through presenting Tracy as separate from
her inner experiences—in the same way that a chessboard is separate from the pieces. A second exercise involved having Tracy picture events at different times in her life: today and 10, 20, and 30 years earlier. She was asked to notice who was noticing the events that were occurring and the inner experiences she was having at the different times. It was then pointed out that although her body grew and changed, the “self” that observed these different events was always the same. Thus, even though her body changed throughout the years, her sense of self was consistent, stable, and separate from her body.

Tracy also started engaging in behavioral commitment exercises. Tracy was taught to approach situations that would increase her PTSD symptoms and practice defusion, acceptance, and self as context in these situations. She was directly instructed that these situations would not necessarily result in decreases in her inner experiences, but would help her function with them. These exercises involved calling her agent and requesting additional auditions, being social, and requesting things at work.

Session 8. For a behavioral commitment exercise she informed her friend that she felt their relationship was one-sided, and that she wanted more involvement from him. Interestingly, she was “successful” at completing the task, but the outcome was not what she was hoping for. The friend did not agree with her and was not willing to change their relationship. This created a unique opportunity to address the difficulties of social situations. It was discussed that she could choose the type of person whom she wanted to be in a relationship, but that did not necessarily mean that the other person would respond according to her wishes. There was no discussion about why this occurred or why the friend was this way. It provided a chance for the therapist to not rescue her from her difficult experience and teach her that she is capable of experiencing the emotions that are associated with such events.

Session 9: First Attempt at Values. Session 9 was an emotionally intense session for Tracy. She was asked to name things that she wanted out of life. She said that she “really never thought about it.” When pressed a little on the topic, she admitted that she avoided thinking about what she wants in life because if she knew what she wanted then she was “set up to fail.” The only clear request she expressed was that she wanted to “stay in therapy until she was finished” (because it was getting close to Session 12—the original amount agreed upon). She reported being very afraid to ask for additional therapy sessions and it took her most of the session to ask for them. She was able to recognize that part of the function of asking for additional sessions was to reduce her fears that she would be removed from treatment too early. A second motivator was that she felt she deserved to receive a full dose of treatment. These two reasons were tied into her initial concerns at the beginning of therapy: Tracy felt “unworthy of any good happening to her,” and she was afraid she would never improve in therapy. On the one hand, informing Tracy that she could stay in therapy until she no longer needed therapy would reinforce avoidance, but on the other hand, it was a wonderful opportunity to reinforce asking for something when she feels “unworthy of any good happening to her.” Clinically, it was deemed worth reinforcing avoidance to reinforce defusion and acceptance. She was told she would “stay in therapy until we were finished.”

For homework, she agreed to write down the things that she wants in life. She returned to the following session with a page titled, “What I want in life,” with only a couple things written on it. She knew she was not happy with her job and that she wanted to “enjoy life more,” but she had a difficult time specifying her values. The focus on values was put to the side and therapy shifted back to the other ACT processes of acceptance, defusion, and self as context.

Sessions 10–16: Acceptance, Defusion, Self as Context. During these sessions Tracy reported that she feared that if things started going well in her life then something terrible would happen to her. She said, “I beat myself up enough, so I am so down that nobody can hurt me.” Keeping her mood low and her life depressing was done purposefully to avoid the fear of failing at trying to live a more meaningful life. Even though the results of this were not fulfilling, they were certain. Admitting this suggested movement on the process of acceptance, but she still needed to spend a lot more time on the acceptance and mindfulness processes of ACT.

In each session Tracy and the therapist reviewed her week and discussed places where her inner experiences stopped her from engaging in meaningful activities. Defusion, acceptance, and self as context were targeted in exercises and when opportunities presented themselves in session. Over the course of these sessions, Tracy gradually began shifting on these processes. There were instances where she would catch her mind processing information and trying to figure out the right answer, and she would say something such as, “I am going to just let my mind not understand this one.” Or she would say, “I was afraid to ask for days off, and my mind was telling me all the reasons that I did not deserve them. I just let it do its thing and asked for the days off.”

A defusion exercise aimed at highlighting the limitations of language involved asking Tracy to describe an item (in this case a water bottle). She described its objective properties, such as color and shape. She also described subjective properties such as old, small, utility, as well as properties that were assumed (“that it was made from plastic and plastic comes from oil”). She was told to think about what another person would say about the bottle and which descriptions they would agree on.
Obviously, they would agree on the objective descriptions. She was informed that her inner experiences were like the water bottle because there are objective qualities—such as “words,” “beating heart,” and “sweaty hands”—that everyone would agree on. But that the subjective ones—“scary,” “dangerous,” and “unfair”—are socially constructed and not real qualities. It was discussed how language processes make objective events into “scary” and “negative” events, but if the subjective processes were stripped away, “was there really anything to avoid?” Tracy reported that this was the most meaningful exercise that occurred in therapy and would often refer back to it.

By the end of these sessions Tracy was in a much different spot than at the beginning of therapy. Her daily focus had shifted from attempting to manage her fear and anxiety to focusing on improving her quality of life. The issue of when she would no longer have PTSD stopped coming up and how well she was functioning became more central to her.

Sessions 17–21: Maintenance. Because she had a difficult transition at the end of her previous treatment, it was decided that she would attend sessions every 3 weeks. She experienced many stressors that gave her opportunities to practice ACT skills. Many of the events were not directly related to her PTSD diagnosis.

First, Tracy had lost a noticeable amount of weight at this point in her therapy. Because the loss was noticeable, she received multiple comments/compliments from friends and co-workers. She had a difficult time receiving these comments because she interpreted them to mean she “was not good looking before she lost the weight” and that she would no longer be good looking if she regained the weight. In response to these thoughts, she felt pulls to rigidly maintain her weight through restricting calorie intake and exercising. At times this pattern of behavior felt similar to the time in her life when she was diagnosed with an eating disorder. This frightened her and she feared that she could slip back into that pattern of behavior. Therapy focused on helping her keep her actions consistent with her values and not in the service of controlling inner experiences. In some instances the actions were the same (e.g., running and eating healthy), but there could be multiple functions (e.g., pleasing others or quieting “eating-disordered thoughts” vs. following a value of being healthy). She was able to notice the shifting function of her actions and follow her inner experiences when they were in the service of her values.

At the 19th session, Tracy came in with her sheet titled “What I want in life” completed. She wanted a job that she cared about, a relationship with her dad, brothers, and friends, and to take care of her health: eat better, exercise, and drink less alcohol. This was a remarkable step from the beginning of therapy when she did not know what she wanted after becoming more defused and accepting of her inner experiences.

In the second to last session (20th) Tracy reported that she was just diagnosed with type II diabetes. This came as a very large shock to her. She struggled with thoughts about unfairness and urges to ignore the diagnosis. She felt upset that this affected her life so much, and fearful over testing her blood and giving herself injections. During the last two sessions she reported that although these thoughts and feelings were occurring she was “accepting” of them, aware that these were just inner experiences, and was able to continue following her values. She stated that she “was not going to let this diagnosis stop her from doing what she wants in life” and “that she would not have been able to handle this diagnosis if she had not learned ACT.” She was able to shift the skills that she learned regarding PTSD cognitions and feelings over to her current struggle with a diabetes diagnosis.

Results

Assessment measures were used to track changes in PTSD severity, anxiety, and depression, and to assess if changes in psychological flexibility (as measured by the AAQ) or trauma-related thoughts and beliefs (as measured by the PTCI) occurred throughout treatment. To help answer these questions, a questionnaire packet containing the PCL-C, BAI, BDI, PTCI, and AAQ was given at pretreatment, after Sessions 8 and 16, and at the final session—Session 21 (see Table 1 for scores at all assessment points).

Table 1
Test Scores at Pretreatment, Sessions 8 and 16, and Posttreatment

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<th>Treatment Session</th>
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Note. PCL-C = Posttraumatic Checklist-Civilian Version; BDI-II = Beck Depression Inventory-II; BAI = Beck Anxiety Inventory; PTCI = Posttraumatic Cognitions Inventory; NCAS = negative cognitions about self subscale, NCAW = negative cognitions about the world, SB = self-blame; AAQ = Acceptance and Action Questionnaire.
Clinical Outcomes

Scores on all measures are presented in Table 1. Tracy began treatment, even after receiving 20 sessions of CBT for PTSD, with a score on the PCL-C that was well above the clinical cutoff of 44. She had scores in the severe range on the BDI-II and BAI. There were gradual decreases in these measures throughout treatment. At posttreatment Tracy received a 28 on the PCL-C, which is within the standard deviation for non-PTSD samples. She was in the minimal range at posttreatment on measures of depression and anxiety. She also showed improvements that were not necessarily picked up by these measures.

At the beginning of therapy, Tracy reported many actions that were consistent with a diagnosis of PTSD. She was very fearful and avoided confrontation. She did not request things that she wanted or thought she deserved. She was fearful that if she made any major changes in her life (e.g., changing occupation, moving) they would not work out and she would end up homeless. Therefore, she stayed in many situations out of fear of what could occur. Additionally, she was drinking approximately four alcoholic drinks nightly, smoking five cigarettes, sleeping 10 hours a night, and was generally inactive.

At posttreatment she was searching out multiple opportunities for alternative employment, and secured a small part in a movie/television series. She was more active socially and had talked to her brother and father on the telephone. She was exercising daily and eating healthier. She was drinking two drinks per night 4 days a week, smoking one cigarette per day, and was sleeping 8 hours a night.

Psychological Process Assessment

Tracy showed a notable decrease on the AAQ throughout therapy, with the largest reduction occurring between Sessions 16 and 21. The PTCI stayed at the same level throughout treatment, and a reduction only occurred between Sessions 16 and 21. This is notable because the PCL-C had decreased nearly 50% at this point and was well below the clinical range for PTSD, whereas the AAQ deceased 43% at this same time. Additionally, from pre- to posttreatment there was a much larger decrease in the AAQ than the PTCI. Even though these findings cannot suggest mediation, it is notable that a measure of psychological flexibility was associated with clinical changes rather than a measure of trauma-related thoughts and beliefs.

Follow-up

Tracy was contacted 9 months posttreatment. She continues to use the techniques and skills learned in therapy. She has a new job, is managing her diabetes well, and is developing many new useful relationships. She continues to engage in self-care procedures including eating well, exercising, moderate drinking (four glasses of red wine a week), not smoking, and sleeping about 8 hours a night. She said that she was doing “better” than when treatment ended. She also no longer struggles with one of her major PTSD concerns: “When will I be better?” She now focuses on living every day in a meaningful way, saying, “I am always where I am at this moment, and this is great!” Although this is a subjective account, it is supportive of the long-term effects of ACT for this client.

Discussion

In this case study an adult woman diagnosed with PTSD, who was treatment nonresponsive to a form of CBT that focused on cognitive challenging and exposure scripts, was treated with a 21-week trial of ACT. ACT as a treatment for PTSD resulted in clinically significant decreases in PTSD severity, depression, and anxiety. Process measures taken throughout treatment show that psychological flexibility (measured by the AAQ) decreased consistently with PTSD severity, whereas a measure of trauma-related thoughts and beliefs only changed between Sessions 16 and 21—at nearly 50% of the change in PTSD severity occurred and the client was out of the clinical range for PTSD.

This study adds to the small body of literature on the effectiveness of ACT as a treatment for PTSD. To date, the only support for the use of ACT for PTSD is in the form of case studies (e.g., Batten & Hayes, 2005; Orsillo & Batten, 2005). There is some utility to the additive value of these case studies, but the largest benefit of this case report is its success with a difficult-to-treat client. This case indicates that, in some cases, ACT can be an appropriate treatment for individuals who are not responsive to other supported interventions. This is clinically useful because there is a fairly high percentage of participants who do not respond to current treatments (Bradley et al., 2005). But the question still remains: How different is ACT from currently supported treatments for PTSD?

Appropriately, questions have been raised about the true differences between ACT and particular CBT models (DiGiuseppe, 2006; Hayes et al., 2006; Hofmann & Asmundson, 2008). Analyzing differences between ACT and other forms of CBT based on the topography of interventions is of little use because techniques are always changing, and the same psychological procedure can have different functions depending on how it is presented. Thus, differences between ACT and CBT need to be tested at the level of psychological process (as suggested by Hofmann, 2008; Hofmann & Asmundson, 2008). If ACT as a treatment for PTSD works through the same processes as other types of CBT, then the ultimate utility of ACT is questionable. But, if ACT works through a...
different process, ACT may be a useful alternative when more empirically supported procedures are not successful or when ACT processes such as fusion and experiential avoidance are a greater issue for the client than the processes proposed in other types of CBT.

Given the infrequency with which the measures were administered in this case study, it is not possible to determine if decreases in psychological inflexibility or trauma-related thoughts and beliefs mediated outcomes. If measures were completed on a weekly basis there would have been a better chance of determining which process decreased prior to PTSD severity. Still, these limitations should not necessarily detract from the useful scientific and clinical information collected. This particular client was able to decrease her PTSD severity score by nearly 50% without a decrease on a measure of trauma-related thoughts and beliefs, suggesting that those processes are not central to change for all individuals. At the same time, there was a 43% decrease on a measure of psychological flexibility. These findings are more consistent with the ACT model that focuses on the function of inner experiences rather than their form or frequency.

In addition to the strengths of this case study there are limitations that should be addressed in future research. First, data were not collected on the severity of PTSD prior to her trial of CBT. Thus, it is unclear what effect CBT had on her symptoms. It was clear that PTSD was present at the end of her trial of CBT, but it is unclear how improvement occurred partway through treatment. This is a reminder to collect data throughout interventions. Second, there was no measure of treatment process during her trial of CBT; thus, it is unclear how well the therapist moved CBT processes. The therapist was CBT-trained and supervised, but because no formal measures were taken, the quality of CBT the client received is unclear. Third, it is unclear if there was an additive effect of ACT to the CBT skills that she acquired. It is possible that Tracy retained some skills that she learned in CBT that complemented material she learned in ACT. Obvious areas of overlap include training in tolerance of uncertainty in CBT and some of the acceptance work in ACT. Similarly, both treatments focused on behavioral activation exercises and commitments and tried to help Tracy become more active and engaged in valued activities instead of avoiding the fear that they sometimes cause.

Finally, this case study suffers from many of the same limitations that are common to most case studies. Because there are only data from one person and no experimental controls, nonspecific treatment factors such as therapeutic alliance, time in therapy, and the effect of her medical condition (i.e., diabetes) are unknown. Ultimately a greater amount of research needs to be conducted on ACT for PTSD. Its overall efficacy is still in question and its difference from existing interventions is still unknown. Well-designed trials comparing ACT to control conditions, including assessments of mediational processes, need to be conducted. Even with these limitations, this study is clinical and scientifically useful.

This case study shows that ACT effectively treated a case of PTSD that was not responsive to a trial of CBT that focused on cognitive challenging and script-based exposures, and that ACT had a greater effect on psychological flexibility than trauma-related thoughts and beliefs. Hopefully, these findings will spur additional research on the effectiveness of ACT and mechanisms of action in all varieties of CBT.

References


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