ACT for PTSD in persons with psychosis: A case-series analysis

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Trauma and psychosis

• Persons diagnosed with schizophrenia report high levels of trauma (Varese et al., 2012; Trauelsen et al., 2015). While these may reach clinical levels of PTSD (12 to 29%), they often go unnoticed (Buckley et al, 2009) in the psychiatric system.
• Untreated trauma increases the risk of relapse, exacerbate psychotic symptoms and complicates the course of illness.

Aims

• A pilot study to examine whether Acceptance and Commitment Therapy (ACT) is a feasible and acceptable intervention for PTSD and trauma-related problems in persons with psychotic disorders.
• To examine whether ACT can reduce: 1) trauma symptoms, and 2) depression and anxiety.

Method

• Three persons with recent onset Schizophrenia and comorbid PTSD symptoms (IES-R ≤ 33) were consecutively referred for 12 sessions of ACT.
• Measures: Impact of Event Scale – Revised (IES-R); PTSD Checklist (PCL-C); Beck’s Anxiety Inventory (BAI); Beck’s Depression Inventory (BDI-II); Acceptance and Action Questionnaire (AAQ-II).
• The ACT intervention is based on the standard ACT model (Hayes et al, 1999) adjusted for psychosis (Morris et al, 2013) and PTSD (Walser et al, 2006).
• ACT is modern CBT treatment, that combines acceptance- and mindfulness- interventions with techniques from behavioural therapies to support a more vital and meaningful life.

Result

Conclusion and clinical implications

• All three cases showed clinical significant reduction on all symptom measures at end of treatment and 2 months follow-up, and the PTSD symptoms were below the threshold for clinical distress.
• With the limitations of a small sample and lack of control condition, this case-series shows that ACT may be a feasible and acceptable intervention for person with psychosis.
• These initial findings are promising and add to the body of research showing that ACT is useful for persons with psychosis (Bach & Hayes, 2002; White et al., 2011). They also appear to justify a more controlled evaluation of the brief intervention, as a stand-alone intervention or as integrated within specialised first-episode services.

Table 1. Depression and anxiety during the course of treatment

<table>
<thead>
<tr>
<th>Beck’s Depression Inventory</th>
<th>Baseline</th>
<th>Mid-treatment</th>
<th>End of treatment</th>
<th>Follow-up</th>
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</thead>
<tbody>
<tr>
<td>Maria</td>
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<td>28</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Sarah</td>
<td>28</td>
<td>12</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>John</td>
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<td>7</td>
<td>1</td>
<td>0</td>
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</table>

<table>
<thead>
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<th>Beck’s Anxiety Inventory</th>
<th>Baseline</th>
<th>Mid-treatment</th>
<th>End of treatment</th>
<th>Follow-up</th>
</tr>
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<tbody>
<tr>
<td>Maria</td>
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<td>14</td>
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<td>Sarah</td>
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<td>6</td>
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<tr>
<td>John</td>
<td>21</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

‘Maria’ – 20 years old; Schizophrenia diagnosis and childhoods sexual abuse
‘Sarah’ – 22 years old; Schizophrenia diagnosis and childhoods sexual abuse
‘John’ – 26 years old; Schizophrenia diagnosis; traumatized by an acute psychotic episode and forced admission

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