



SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

MAJOR RESEARCH PROJECT

An exploratory study into the association between Acceptance and Commitment Therapy (ACT) coping styles, Posttraumatic Stress, and Posttraumatic Growth in working age adults who have experienced a traumatic life event

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Declaration

I certify that all the material in this dissertation that is not my own has been identified, and that no material is included for which a degree has previously been conferred on me.

Signed: Jade West

Part one: Major Research Substantive Literature Review

The potential relevance of ACT coping styles for trauma survivors

Introduction

The first part of this research project consists of a literature review which aims to explore the potential relevance of ACT coping styles for trauma survivors. Research suggests that a proportion of trauma survivors are unable to emotionally engage and therefore sufficiently benefit from traditional trauma-focused treatments, particularly those with high levels of experiential avoidance and limited emotion regulation skills. The review explores the potential of Acceptance and Commitment Therapy (ACT) as a useful adjunctive therapy to trauma-focused treatments, in order to facilitate ACT coping styles, and therefore create more accessible and effective approaches for these individuals. In light of the limited research exploring approach-based coping styles of trauma survivors, the review explores the potential associations between ACT coping styles, posttraumatic stress disorder (PTSD) symptomology, and posttraumatic growth (PTG); the ability to create positive meaning from the traumatic event. The second part of the research project consists of a correlational study which aims to explore these associations in a sample of individuals with a history of psychological trauma.

How the review will be organised

The literature review will begin with a brief overview of PTSD and the role of avoidance in the maintenance of the disorder. The current trauma-focused interventions for PTSD and some of the potential barriers to benefiting from these

treatments will then be outlined. The next section will describe ACT and its theoretical roots. The potential benefits and current support of ACT for PTSD will then be outlined, with consideration as to how ACT differs from traditional trauma-focused interventions. This will be followed by an introduction to PTG and its relationship with PTSD and coping styles. Finally, the relationships between ACT coping styles, PTSD, and PTG will be explored.

Search strategy

Relevant reviews and articles were identified via Google Scholar and the computerised databases PsycINFO and PsycARTICLES. The search terms were: posttraumatic stress disorder; posttraumatic growth; experiential avoidance; Acceptance and Commitment Therapy; mindfulness; coping styles/skills. There were no date limits and, given the small literature on ACT for PTSD, no exclusion criteria. Articles were included only if the study: (1) was in an English peer-reviewed journal and (2) included adult participants (3) with a traumatic life event and/or diagnosed PTSD.

Posttraumatic stress disorder (PTSD)

Posttraumatic stress disorder (PTSD) is a common psychiatric outcome following a traumatic event. In order to satisfy the DSM-IV diagnostic criteria of PTSD (American Psychiatric Association, 2000) an individual has to be exposed to a traumatic event that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Criterion A). It is also essential that the individual experience a response at the time that involves intense fear, helplessness or horror. The disorder is characterised by three symptom clusters; Criterion B: re-

experiencing of the traumatic event (including flashbacks), Criterion C: persistent avoidance of trauma-reminders (including avoiding memories or activities), and Criterion D: hyperarousal (including irritability and hypervigilance) (APA, 2000).¹

It is estimated that 8% of the population will meet the diagnostic criteria of PTSD at some point in their lifetime (APA, 2000). However, given that the majority of individuals exposed to traumatic events do not develop PTSD, there may be important risk and protective factors which interact to determine the development of the disorder. Individual differences in the coping styles of trauma survivors may have important implications for the development, maintenance, and treatment of PTSD symptoms (Dorfel, Rabe & Karl, 2008). Ehlers and Clark's (2000) cognitive model of persistent PTSD proposes that maladaptive avoidance-based coping styles maintain PTSD symptomology. Research has shown that experiential avoidance (the deliberate effort to avoid unwanted inner experiences) is one of the core psychological processes responsible for the development and maintenance of PTSD (Steil & Ehlers, 2000).

Therapeutic interventions for PTSD

Current treatment guidelines recommend trauma-focused cognitive behavior therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR;

¹ For a clinical diagnosis of PTSD, Criterion A is necessary, Criterion B requires at least one symptom, Criterion C requires three, and criterion D requires two symptoms. Furthermore, the duration of these symptoms must have been present for at least one month since the traumatic event (Criterion E), and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F) (APA, 2000). Individuals meet the criteria for sub-syndromal PTSD if they report having been at least moderately bothered by one or more re-experiencing symptoms, and either three or more avoidance symptoms *or* two or more arousal symptoms over the past month (Blanchard, Hickling, Barton, Taylor, Loos, & Jones-Alexander, 1996).

Shapiro, et al., 1999) as first-line treatments for PTSD (APA, 2004; National Institute of Clinical Excellence, 2005). TF-CBT attempts to counteract experiential avoidance and to facilitate the processing of the trauma memory through imagery and in vivo exposure exercises (Ehlers and Clark, 2000). Research has found that exposure therapy leads to greater reductions in PTSD symptoms compared to no treatment or other interventions such as supportive counselling (e.g. Duffy, Gillespie, & Clark, 2007; Litz, Engel, Bryant, & Papa, 2007). EMDR, developed by Shapiro in 1987 (Shapiro, 1995) uses dual attention tasks to enable the patient to process the traumatic memory whilst engaging in a task involving some form of bilateral stimulation such as eye movements (Shapiro & Maxfield, 2002). A number of recent reviews (e.g., Ponniah & Hollon, 2009) and meta-analyses (e.g., Bisson, Ehlers, Mathews, Pilling, Richards & Turner, 2007) conclude that EMDR is an effective treatment for PTSD.

Many of the studies included in meta-analyses of PTSD treatment studies have methodological flaws (as cited by Ehlers et al., 2010). Ponniah and Hollon (2009) point out that these studies often have heterogeneous groups of subjects with a wide variety of trauma types, making it difficult to determine whether the findings are applicable to all those with PTSD or only to those with particular trauma types. Jonas et al. (2013) reported that studies they reviewed were often unable to determine whether subjects were receiving other treatments during the studies. Furthermore, many studies do not include any follow-ups (Bradley, Greene, Russ, Dutra, & Western, 2005). Cloitre, Cohen and Koenen (2006) argue that many studies are insufficiently powered to detect differences between treatments, and propose that larger samples sizes are necessary in order to conduct meaningful head-to-head comparisons of treatments.

The potential barriers to benefiting from trauma-focused treatments

Although exposure therapy is considered to be the gold standard treatment for PTSD, not all trauma survivors benefit from this treatment (Thompson, Luoma, & LeJeune, 2013). Studies suggest that this may relate to poor treatment engagement, as reflected in poor homework compliance (Scott & Stradling, 1997), drop-out rates ranging from 20.5 to 41% (Hembree et al., 2003; van Minnen et al., 2002), and not seeking treatment or treatment refusal (e.g., Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). This leaves a large number of people in clinically significant distress.

I propose that experiential avoidance of trauma related material, a key symptom and arguably the most important process in the maintenance of PTSD symptoms, is likely to be a significant reason why these individuals do not access or are unable to engage in these treatments. Trauma-focused treatments attempt to target experiential avoidance through the client "re-living" the trauma. However, by the very nature of their diagnoses, individuals with PTSD are often unwilling or unable to "relive" their traumatic memories (Scott & Stradling, 1997).

Bisson (2007) argues that there is a need to develop more tolerable treatments for trauma survivors. Some but not all studies have indicated that those with complex PTSD may respond to trauma-focused therapy less optimally than those who do not have these complexities (Hembree, Street, Riggs, & Foa, 2004; Resick, Nishith, & Griffin, 2003). Cloitre, Cohen and Koenen (2006) argue that without preparation through developing affect regulation skills, only 20% of individuals with complex PTSD can participate in exposure treatment. Consequently, it seems that a key

objective of effective treatment would be to enhance coping skills and the ability to emotionally engage. A potentially helpful approach that has been receiving increased attention in the field of PTSD is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999).

Acceptance and Commitment Therapy (ACT)

I have chosen to focus the review on ACT and to subsequently explore the role of ACT coping styles. In brief, the reasons are twofold; Firstly, as ACT is a therapeutic approach specifically designed to reduce experiential avoidance, one of the defining symptoms and maintaining factors of PTSD, it may be a treatment that is particularly suited for individuals with PTSD (Orsillo & Batten, 2005). Secondly, I propose that ACT may have the potential to be a useful adjunctive therapy to trauma-focused therapy (rather than an alternative). This section will now describe ACT and its theoretical roots. Both of these potential benefits of ACT for trauma survivors will then be outlined.

ACT (Hayes, Strosahl and Wilson, 1999) is one of the most representative therapies of the ‘third wave cognitive behavioural therapies’ (Ruiz, 2010). ACT uses a “hexaflex” model (see Figure 1) to display its six components: (1) acceptance, (2) defusion, (3) self as context, (4) committed action, (5) values, and (6) contact with the present moment. The hexaflex can be divided into two larger sections; acceptance and mindfulness processes, and commitment and behaviour change processes. These processes are targeted in the hope to increase “psychological flexibility”; the ability to act in accordance with one’s meaningful values in life, regardless of unwanted inner experiences (Hayes, Strosahl and Wilson, 1999).

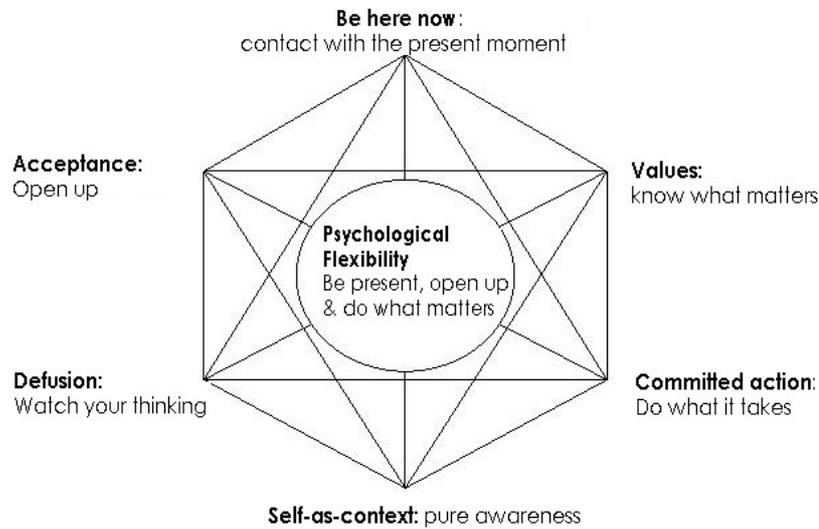


Figure 1. A model of ACT’s six core processes

Underlying ACT is a behavioural theory of human language and cognition called Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). ACT theorists (e.g., Hayes et al., 1996) contend that experiential avoidance stems, in part, from human verbal behaviour itself. From an RFT perspective, human language enables people to learn arbitrary ways of evaluating themselves and their experiences (e.g. “being weak is bad”), and to act as if these tenuous evaluations are absolute truths (Flaxman, Blackledge, & Bond, 2011). Language begins to override direct experience, making this process itself aversive and leading to increasingly inflexible behaviour (Hayes et al., 1999, 2001). Published empirical studies have consistently supported RFT (e.g. Matthews, Shimoff, Catania, & Savgolden, 1977).

ACT as a potentially useful approach for reducing experiential avoidance in PTSD

As with trauma-focused treatments, ACT may break the maintenance cycle of PTSD outlined by Ehlers and Clark (2000) by targeting experiential avoidance. Both TF-CBT and ACT use forms of exposure to unwanted inner experiences which may reduce levels of experiential avoidance. However, ACT's approach to exposure has different treatments aims and uses different methods. In contrast to TF-CBT, ACT does not aim to extinguish, reduce, or alter the form of inner experiences. Instead, ACT targets their *function*, so that they no longer have a significant effect on one's behaviour.² ACT uses paradoxes, metaphors and willingness exercises with the aim of enabling individuals to learn to be present with their unwanted inner experiences without attempts to avoid, control, or modify them (Hayes, Strosahl and Wilson, 1999). It uses a more skills-based approach to reducing experiential avoidance. Acceptance and mindfulness techniques are used to allow the client to notice and observe unwanted experiences, in the present moment, non-judgementally (Hayes 2004). It is possible that both TF-CBT and ACT may tap into the same processes to reduce experiential avoidance, but the different aims of ACT are made clear to clients.

ACT has been successfully applied to a wide variety of mental health problems, reducing overall experiential avoidance and increasing psychological flexibility (as reviewed in Hayes, Luoma, Bond, Masuda and Lillis, 2006). To date, support for the use of ACT for PTSD is limited to a few case studies and open trials. Twohig (2008) reported a single case study of a female client with chronic PTSD who was non-responsive to TF-CBT. Following 21 sessions of ACT, the client's PTSD severity score reduced by nearly 50%, and psychological flexibility decreased by 43% (lower scores reflect greater psychological flexibility). However, the findings from

² Specifically, ACT aims to change the way one *relates* to unwanted thoughts and feelings (through being more willing to experience them), as opposed to efforts to change the content, frequency, or intensity of the thoughts and feelings themselves.

case studies cannot be generalised to wider clinical populations. Furthermore, it is unknown whether the client retained some skills that she learned from 20 sessions of TF-CBT prior to the ACT intervention. Therefore, the positive outcomes may not be attributed to the ACT intervention alone.

Codd, Twohig, Crosby, and Enno (2011) treated three consecutive cases who presented with a range of anxiety disorders (including one with PTSD) with 9–13 sessions of ACT. Changes in anxiety and avoidance were tracked using a time series design. All participants showed clinical improvement and increases in psychological flexibility, with gains maintained at follow-up (8 months). However, as with Twohig's (2008) study, the clients received psychological input prior to ACT. Another limitation of this study is the lack of control participants, making it unclear what effect non-specific treatment factors had on the outcomes.³ Ultimately, a greater amount of research needs to be carried out in order to clarify the assumptions that ACT could be an effective intervention for PTSD.

ACT as a potential adjunctive therapy to trauma-focused therapy

As ACT involves willingness and mindfulness exercises as opposed repeatedly describing the details of the traumatic event through reliving exercises, some trauma survivors may experience ACT exercises as less threatening, and may therefore be more likely to try such a therapy, as well as engage with it for longer, or

³ These case studies used outcome measures such as the PTSD Checklist (PCL-C, Weathers, Huska, & Keane, 1991) to measure PTSD symptoms based on DSM-IV diagnostic criteria (APA, 1994), which has demonstrated robust psychometric properties with a variety of trauma populations (Blanchard, Jones, Buckley, & Fomeris, 1996). The case studies also used the Acceptance and Action Questionnaire AAQ II (AAQ-II; Bond et al., 2007) to assess several key features of ACT. The AAQ-II has been shown to have good psychometric properties and good convergent, discriminant, and incremental validity (Bond et al., 2007).

be less likely to drop-out. Indeed, Orsillo and Batten (2005) describe a case study of a combat veteran with PTSD who refused exposure therapy, but was able to benefit from ACT. Furthermore, learning different ways of engaging with one's unwanted inner experiences may increase willingness to have these experiences, and to approach the previously avoided traumatic material.

ACT could be a useful adjunctive therapy to trauma-focused therapy, in order to address the experiential avoidance that prevents this subgroup of trauma survivors from benefiting from the traditional exposure-based treatments. Specifically, ACT could prepare these individuals with the approach-based coping styles (willingness/acceptance) needed to engage in these emotionally demanding treatments. These ACT coping styles could also be integrated into trauma-focused treatments in order to maintain engagement, or offered to individuals who still have residual symptoms or high experiential avoidance following trauma-focused therapy despite treatment compliance. Recent developments such as Skill Training in Affective and Interpersonal Regulation (STAIR; Cloitre, Cohen & Koenen, 2006) have already begun to demonstrate the value of enhancing tolerance of trauma-focused therapy through building emotional regulation skills (e.g. Cloitre, Koenen, Cohen, & Han, 2002).

An exploratory step forward may be to examine the relationships between particular ACT coping styles, PTSD symptomology, and PTG. Little research has been carried out examining these associations. Before exploring particular ACT coping styles, the review will now introduce PTG and its relationship with PTSD symptomology and general coping styles.

Posttraumatic Growth (PTG), coping styles, and PTSD symptomology

Some trauma survivors have experienced the phenomenon of posttraumatic growth (PTG) following PTSD; the ability to create positive meaning from the traumatic event (Tedeschi and Calhoun, 1996, 2004). Common examples of PTG include a greater appreciation of life, a changed sense of priorities, and a greater sense of personal strength (Tedeschi and Calhoun, 1996).

Tedeschi and Calhoun's (1995, 2004) functional-descriptive model of PTG describes PTG as a positive and adaptive outcome of the psychological struggle following a traumatic event. However, studies have found PTG to be related to higher wellbeing and lower distress, higher distress and higher PTSD symptoms, and no relationship (see review by Zoellner & Maercker, 2006). The inconsistent findings may suggest that PTG is related to other factors that either interact with or mediate the effect of PTG on distress. Zoellner and Maercker (2006) have hypothesised that some of these may reflect individual differences in coping styles. As would be expected, avoidant coping is negatively related to the experience of PTG (Aldwin, 1994). Prati and Pietrantonio (2009) found that seeking social support, spirituality, and optimism were related to PTG. Optimism is defined as a self-reported general expectancy of good things to happen relative to bad things (Scheier, Carver, & Bridge, 1994). Taylor (1983) developed a theory of cognitive adaptation to threatening events, which regards PTG as a "self-enhancing positive illusion" coping strategy.

The Janus face model of self-perceived PTG (Maercker & Zoellner, 2004) is a two-component model of PTG. In contrast to the other theories of PTG outlined

above, the Janus face model conceptualises PTG as *both* a coping strategy and an outcome. In line with Taylor (1983), it considers the possibility of an illusory component. It proposes that optimism may be related to a dysfunctional, illusory side of PTG, which prevents adaptation and maintains distress; whilst “openness to experience” may be related to functional, true PTG, which is associated with more successful coping and healthy adjustment (Maercker & Zoellner, 2004). Openness to experience is defined as the tendency to be interested in new ideas and new experiences (Costa & McCrae, 1985).

Zoellner, Rabe, Karl and Maercker (2011) randomly assigned forty trauma survivors with PTSD symptoms to TF-CBT or a waiting condition. The TF-CBT proved highly effective in terms of PTSD symptom reduction. However, in contrast to previous findings (e.g., Wagner et al., 2007), there was no treatment effect on overall PTG. However, they did find that there were significant growth increases in the PTG sub-domains “new possibilities” and “personal strength” for the TF-CBT group that were maintained at follow-up. Furthermore, the TF-CBT group showed increases in openness from pre- to post-treatment that were marginally positively related with a higher PTG at post-test. This result may provide evidence for the Janus-face model. It may suggest that therapy may increase openness to experience, which may be related to increases in the adaptive form of PTG. However, the sample size was relatively small and included only motor vehicle accident survivors, and therefore the results may not be generalisable to other trauma types.

A recent prospective and longitudinal study by Dekel, Tsachi Ein-Dor and Solomon (2012) found that initial PTSD predicted subsequent PTG above and beyond

PTG stability. Growth being an outcome of distress is in line with Tedeschi and Calhoun's model (2004). Alternatively, the elevated PTG over time may signify that these individuals have failed to restore well-being and still need to deploy the dysfunctional PTG as a defensive coping strategy, as proposed by Maercker and Zoellner (2004). The authors suggest that PTG may not have a significant value in lessening PTSD symptoms, but may improve other aspects of wellbeing. They propose that treatments could aim to strengthen the patient's capacity for growth, be it illusionary or real. However, the study did not measure other forms of positive wellbeing.

As pointed out by Maercker and Zoellner (2004), PTG is still a concept not well positioned within the theoretical and conceptual realm. Although the evidence-base of the Janus face model is in its infancy, the review has focused on this model of PTG because its assumptions may help to explain the mixed results regarding the relationship between PTG and PTSD symptomology. Specifically, PTG related to lower distress may reflect the adaptive form of PTG, whilst PTG related to higher distress may reflect dysfunctional PTG. Another reason the review has focused on the Janus face model is because it may be relevant in the understanding of the relationships between approach-based coping styles and adaptive PTG. Openness, similar to the ACT concept of acceptance, may be related to higher willingness to experience unwanted trauma-related inner experiences. I hypothesise that, as with openness, acceptance may also be associated with higher levels of adaptive PTG. I propose that integrating ACT coping styles into trauma-focused treatments may facilitate adaptive PTG.

ACT coping styles, PTSD symptomology, and PTG

This paper will now discuss the main problematic appraisals outlined by Ehlers and Clark's (2000) cognitive model of PTSD, the resulting maladaptive coping styles, and how ACT coping styles could break the maintenance cycle of PTSD, leading to lower PTSD symptomology and higher PTG.

Acceptance

Higher PTSD symptom severity has been associated with lower acceptance of emotional experiences (Tull, Barrett, McMillan, & Roemer, 2007). From an ACT theory perspective, it could be hypothesised that as individuals begin to find unwanted inner experiences less personally threatening through increased acceptance, experiential avoidance would decrease (Follette et al., 2006).

Although ACT does not aim to change the form or frequency of unwanted inner experiences, the reduced experiential avoidance may *indirectly* lead to re-appraisals. Indeed, Twohig's (2008) case study found that, following an ACT intervention, a trauma survivor showed decreased PTSD symptom severity, without a decrease on a measure of trauma-related cognitions (appraisals) until the later stages of therapy. This finding may support ACT theory; however, substantially more research is needed in order to test these processes further. An example of a re-appraisal may be seeing the trauma sequelae as necessary for personal growth. This example may also be related to the experience of PTG. According to Ehlers and Clark's (2000) PTSD model, experiential avoidance and negative appraisals need to be targeted because they prevent change in the trauma memory. Although ACT does not aim to facilitate memory processing, from a theoretical point of view it could be

hypothesised that the indirect re-appraisals and the reduction in experiential avoidance may both indirectly contribute to memory processing.

Park et al. (1996) argue that ‘acceptance coping’ is one of the most relevant coping strategies in relation to PTG. Prati and Pietrantonio’s (2009) meta-analytic review found that acceptance coping was a small but significant predictor of PTG. Zoellner and Maercker (2006) suggest that the ability to accept situations that cannot be altered is crucial for the development of PTG. However, many studies fail to define ‘acceptance-based coping’, and therefore it is unclear as to whether their definitions reflect the ACT concept of acceptance.

Some recent studies have explored the role of mindfulness on PTSD symptomology. Thompson and Waltz (2010) found that mindfulness, specifically the ‘non-judgment of experiences’ element, was negatively correlated with PTSD avoidance symptoms. A similar study by Vujanovic, Youngwirth, Johnson and Zvolensky (2009) found that the ‘accepting with judgment’ subscale of a mindfulness measure was incrementally associated with PTSD symptoms.

Other studies have examined coping responses that appear to reflect the ACT concept of acceptance. As with acceptance, individuals high in openness to experience may be more willing to experience and approach (rather than avoid) unwanted inner experiences. Openness may be related to the adaptive side of PTG (Maercker & Zoellner, 2004). Tedeschi and Calhoun (1996) found a small, but significant cross-sectional correlation between openness and PTG.

In line with acceptance, forgiveness (Orcutt, Pickett & Pope, 2005) and self-compassion (Neff, 2003a, 2003b)⁴ requires a willingness to engage painful thoughts and emotions, and a lower need to avoid painful experiences (Leary, Tate, Adams, Batts Allen, & Hancock, 2007; Neff et al., 2007). Orcutt, Pickett and Pope (2005) found that trauma survivors who were lower in forgiveness and higher in experiential avoidance reported higher PTSD symptoms. Thompson and Waltz (2008) found that PTSD avoidance symptoms showed a significant negative correlation with self-compassion. Their findings suggest that individuals high in self-compassion may engage in less avoidance strategies (Thompson and Waltz, 2008). However, the majority of the studies described in this section used samples of trauma-exposed individuals from the community setting or college students. Therefore, it is not clear whether the findings would generalise to a clinical sample.

Commitment to values-based action

Other appraisals identified by Ehlers and Clark (2000) appear to be related to the avoidance of valued actions e.g. ‘if I do things I used to enjoy, I will be punished again’. Indeed, individuals with PTSD are often inactive around a number of important values (Wasler and Hayes, 2006) and often experience "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (DSM-IV; APA, 2000). The avoidance of valued actions further reinforces problematic appraisals about the trauma making them a ‘permanently damaged person’.

⁴ Neff 's (2003a) notion of self-compassion consists of three components: (a) an attitude of kindness and understanding to one's self; (b) perceiving one's experiences as part of the larger human condition; (c) being mindfully aware of painful experiences without over-identifying with them.

Another core ACT coping style is the commitment to actively live consistently by one's meaningful values (values-based action), regardless of the presence of unwanted inner experiences. Ehlers and Clark (2000) suggested that an important part of treatment would be to encourage trauma survivors to resume valued and meaningful activities, as this may help to contextualise the trauma memory. Values-based action may also indirectly improve processing of the trauma memory, and indirectly lead to re-appraisals of the trauma sequelae.

Taking meaningful action may be also related to adaptive PTG. Hobfoll et al. (2007) found that participants only experienced positive benefits from PTG when individuals actively translated the meaningful cognitions of PTG into meaningful actions ('action-focused growth'). An Example of a PTG-consistent valued action may be spending time on newly discovered priorities. Therefore, the ACT coping style of values-based action may also be related to and/or facilitate the meaningful *actions* element of PTG.

Summary

The ACT coping styles facilitated in ACT therapy may inform trauma-focused treatments for PTSD in order to create more accessible and effective approaches for trauma survivors, particularly those with high levels of experiential avoidance and limited emotion regulation skills. The review has explored the potential relationships between ACT coping styles, PTSD symptomology, and PTG. The present study aims to explore these associations in a sample of individuals with a history of psychological trauma.

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