

***Commentary on Combining Expressive Writing with an Affect- and Attachment-Focused Psychotherapeutic Approach in the Treatment of a Single-Incident Trauma Survivor: The Case of "Grace"***

**The Case of "Grace"—A Commentary**

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**ABSTRACT**

This commentary focuses on the case of "Grace" treated by Erica Pass (2012) through the use of Accelerated Experiential Dynamic Psychotherapy with writing assignments (the "AEDP-Writing" model) delivered over 40-sessions. Grace was experiencing some PTSD symptoms resulting from a single index trauma and was viewed as having a positive outcome by herself, by her therapist, and by her supervisor. The case study included Grace completing self-report measures at the end of therapy both about her present status at the end of therapy and a retrospective view of her status at the beginning of therapy. The significant limitations of change scores based on such retrospective estimates are discussed as well as the advantages of session-by-session tracking of Grace's mental health and symptomatology as a means of calibrating change over the course of therapy and estimating final treatment status. In addition we discuss fundamental factors for consideration in facilitating trauma-focused treatment for clients with PTSD symptomatology, such as avoidance, approach, and approach-resultant rises in symptomatology, and related recommendations for psychoeducation.

*Keywords:* Post-Traumatic Stress Disorder (PTSD); systematic case studies; Outcome Questionnaire-45; psychotherapy outcome; clinical case study; case study

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Traumatic events are not an anomaly in life. In fact, a national study in the United States reported that 60% of people are expected to experience at least one traumatic event in their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Fortunately, only 8 – 14% of these trauma survivors will go on to develop post-traumatic stress disorder (PTSD). Unfortunately, studies have shown that women are at twice the risk of men for developing the disorder, which also has a high rate of comorbidity with other syndromes—particularly mood, substance abuse, and anxiety disorders (Kessler et al., 1995). Given the propensity for the symptoms of PTSD to cause significant disruption in the social, occupational, familial, and recreational functioning of trauma survivors (as well as increased long-term health problems—Schnurr & Green, 2004), there is a great interest in finding treatments that can aid recovery and improve functioning. This article will focus on one such approach, and will also proffer

recommendations for incorporating additional elements that can aid therapists and clients in addressing the challenges of treating PTSD.

In this issue of PCSP, Erica Pass (2012) presents a case study of "Grace," a client who was experiencing some symptoms of PTSD resulting from a single-index trauma whom Pass saw in therapy for 40 sessions. This commentary on her case will begin with a summary of Pass' therapy and then proceed to comment on two aspects of her case: (a) the measurement of outcome, and (b) fundamental factors for consideration in facilitating trauma-focused treatment for clients with PTSD symptomatology (avoidance, approach, and approach-resultant rises in symptomatology) along with recommendations for psychoeducation.

## **SUMMARY OF THE CASE OF GRACE**

### *The Client*

Grace was a 24-year old, married, Caucasian woman. Her isolated index trauma had occurred 4 years prior when she was the first to find the body of her brother after he had hung himself in her bedroom. While not necessarily fulfilling full criteria for PTSD, she certainly manifested significant post-traumatic stress symptomatology—such as intrusive and disturbing recollections, psychological distress, avoidance related to things associated with the trauma, and irritability—that was disrupting her life in numerous arenas (e.g., social, familial, and occupational). Grace also fit the clinician's inclusion criteria for the treatment: (a) age range of 18 – 55 years old, (b) fluent in English, (c) seeking treatment to obtain relief from the after-effects of a single index trauma, (d) motivated sufficiently by emotional distress to seek treatment, (e) possessing adequate hope and trust to attend regular appointments and being candid sharing herself, (f) possessing the capacity for distancing herself from feelings in order to examine/observe her affect, and (g) the ability to relate to the clinician (i.e., secure attachment style) and tolerate separation between sessions and at termination without experiencing intense discomfort. In many ways this made for an ideal client who would be likely to have a positive treatment response.

### *Intervention Used*

In formulating the treatment approach therapist Pass wished to work with a client who presented with ongoing post-traumatic stress symptomatology who had experienced a single index trauma. The goals for treatment included: (a) decrease client irritability and other posttraumatic symptoms; (b) grieve in a genuine way; (c) facilitate the establishment of an attachment with Grace and an atmosphere of safety and trust; (d) identify feelings and increase affect tolerance, working within the Accelerated Experiential Dynamic Psychotherapy (AEDP) Triangle of Experience (composed of two top corners—defenses and "red-signal affects" like anxiety and shame—and the bottom corner of authentic affect) to reach the core affect underlying defenses and anxiety); (e) challenge Grace's defenses while maintaining therapeutic attachment; (f) expose Grace to her traumatic memories and develop a linear narrative; (g) increase ability to enjoy alone time; and (h) solidify Grace's "sense of self."

To help Grace to reach these objectives, the therapeutic model that guided her approach involved 3 phases of treatment. The first two included (a) AEDP—an experiential approach which values Grace’s experience of genuine affect (especially in the presence of attachment to an empathetic, emotionally available therapist) over the achievement of insight (Fosha & Slowiaczek, 1997), and (b) expressive writing (Calhoun & Resick, 1993). Pass notes that while both approaches had been developed and utilized with trauma survivors independently, this would be the first time that the approaches would be used in combination (a model referred to hereafter as AEDP-Writing). Pass expected that identification of an isolated traumatic incident would serve as a focus and provide a concrete goal for a third phase of treatment, the consolidation of treatment gains.

Briefly, in the first phase of treatment, the clinician utilized AEDP to develop a secure working alliance with safety and rapport, to familiarize the client with exploration of a range of affects, and to set the stage for “deeper” work in the second phase of expressive writing. This writing component was designed to expose Grace directly to her index trauma in an effort to process the event at a more “comprehensive and deep level.” Lastly, the third phase of treatment involved reflection on previous work, consolidation/integration of changes made, and a “celebration of the patient’s true self state of being” (Pass, 2012, p. 60). Ultimately, the course of treatment consisted of 40 weekly sessions, with no post-treatment follow up. A brief review of the two principal components of the therapy (AEDP and expressive writing) and related research follows.

### *AEDP and Therapeutic Relationship*

Consistent with AEDP, the clinician’s primary goal during the first phase of treatment (and throughout) was to foster “a deep interpersonal connection within the therapy, one that facilitates the exploration of memories that may have been locked away and frozen in time,” achieving a “safe and affect-friendly environment,” and “activating a patient-therapist relationship in which it is clear that the patient is deeply valued and will not be alone with emotional experience” (Fosha 2003, p. 245). According to Fosha (2000) this is achieved through the therapist maintaining attunement to the client from moment to moment and tracking nonverbal, paraverbal, and verbal shifts in presentation. This validation and reflection on the part of the therapist is said to allow the patient’s true self to emerge so that, in the end, the patient can reach affective competence (i.e., the ultimate goal of "feeling and dealing" while relating to a safe other).

This therapeutic alliance was in service of the goal of approaching the index trauma in order

to help "undo" the client’s feeling alone with . . . her traumatic history and to help the client begin to feel confident in tackling what can feel like overwhelming affect and disjointed memories (Pass, 2012, p. 67).

Specifically, AEDP is designed to decrease PTSD symptomatology through increasing a client’s ability, in the presence of an empathetic and caring other, to transform “diffuse distress, fear, and anxiety into more fully articulated and better regulated emotions, memories, and adaptive action

on behalf of the self" (Gleiser, Ford, & Fosha, 2008, p.345) and create a cohesive, fluent autobiographical narrative (Fosha, 2007). Pass hypothesized that the expressive writing component of the treatment would aid in this endeavor.

This focus on the therapeutic relationship seems wise as research has consistently revealed that, "the quality of the therapeutic alliance is one of the better predictors of outcome across the range of different treatment modalities" (Safran, Muran, Samstag, & Stevens, 2002 p.235). Moreover, systematic reviews of research by Norcross & Lambert (2011) on the role of relationship factors in therapy research has revealed that alliance and empathy, key components of Pass' approach in the case of Grace, are demonstrably effective in facilitating positive therapy outcomes. Also present in Pass' therapeutic relationship with Grace were goal consensus, collaboration, and positive regard, which in their review Norcross and Lambert found to be "probably effective" components of therapy.

### *Expressive Writing and the Inclusion of Homework.*

In addition to AEDP, Pass incorporated a series of expressive writing activities that were assigned at the end of sessions in phase two, completed out-of-session, and then read by Grace and reviewed at the next meeting. This homework was utilized as an approach mechanism. Its goal was to gradually expose Grace to her index trauma—in this case, the harrowing event of finding her brother's body after he had hung himself in her bedroom—in order to aid in the processing and integration of the cognitive, affective, and somatic dimensions of Grace's experience. In addition to being a theoretically consistent vehicle for exploration of affect and attachment, Grace's writing and sharing of her homework with her therapist appeared to be an effective vehicle for inducing Grace to approach the memories, thoughts, and feelings that she had been trying to avoid for years.

(It seems important to note that Cognitive Processing Therapy (CPT)—an empirically-supported, trauma-focused therapy developed by Resick and colleagues (e.g., Resick, Monson & Chard, 2008)—also utilizes writing and sharing of these entries with the therapist; however, the timing, content, and structure of the writing components in CPT and AEDP-Writing differ appreciably. In CPT, writing assignments begin in the very first session and are utilized in every session thereafter, all assignments are directly trauma- and cognition-based [with a focus on the index trauma and its consequent impact on the individual in the areas of trust, safety, power/control, esteem, and intimacy], and specific cognitive restructuring sheets are also utilized throughout the course of therapy [typically 12 sessions]. In AEDP-Writing, assignments did not begin until the therapist determined that an emotional bond and adequate trust was established (session 14); only half of the writing assignments were trauma-based while the remainder were chosen at Pass' discretion [they included childhood memory, letter to a friend, good memory of brother, comparative list of stress and soothing resources, free write, and disappointment as if it were a person]; and the structure of therapy was open, flexible, and emotion- and relationship-focused [ultimately lasting 40 sessions].)

Pass' inclusion of writing assignments in Grace's case also seemed prudent for other reasons. In their meta-analysis about homework effects, Kazantzis, Whittington, and Dattilio (2010) concluded that "there is a clear benefit for homework assignments over and above the

effects of an already effective therapy,” and that “present findings provided good evidence to support the hypothesis that homework makes clinically meaningful contributions” (p.151). Though focused on CBT, these conclusions seem applicable to the present case and to the AEDP-Writing model generally for two reasons. First, writing assignments were utilized as an intervention for such purposes as making meanings clearer; examining explicit thoughts/interpretations/beliefs about the traumatic event; facilitating insight and incorporation of information not available or recognized at time of the trauma; and processing of emotions, in writing as well as sharing work with the therapist. Second, homework appeared to play an important role in adherence to non-avoidance, maximizing the generalizability of gains and providing opportunities for Grace to process and organize information out of session, throughout the week. Furthermore, the clinician’s careful consideration of topics and timing for these assignments followed the recommendation of Kyuken, Padesky, and Dudley (2009), who urged that any assigned homework assignments be linked to case conceptualization to help maximize positive outcome. In all, Grace’s expressive writing homework and sharing of her writings with her therapist seems to have facilitated the healing process in her therapy.

### *Therapy Outcome*

Pass reported both qualitative and quantitative outcome data in Grace's case. Qualitatively, at the end of treatment, Grace reported that she had ceased having angry outbursts/“meltdowns” on a regular basis; possessed more tools for coping with distress; had an increased ability to communicate about distress; felt more empowered and more comfortable being assertive; was better able to differentiate and "own" her feelings; was less negative towards herself; was less self-conscious; and only rarely experienced flashbacks/intrusive thoughts and, if she did, felt that she was able to self-soothe and seek out supportive others when upset. In addition, Grace described an improvement in her relationship with her spouse; increased differentiation from family; decreased anxiety; and increased contentment, calmness, and happiness. By all reports (her’s and her therapist’s), Grace had accomplished the goals she set at the beginning of treatment.

In addition, at session 38 Grace filled out the Trauma Symptom Inventory (TSI; Briere, 1995) and the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996) as “post-treatment” measures (there were 40 total sessions of treatment). At session 39, the clinician requested that Grace fill out a second set of assessments—a TSI and an OQ-45—using a retrospective view. Specifically, Grace was asked to complete these instruments in terms of how

she remembered her psychological state pre-treatment...while this is not a standard, psychometrically valid administration of these measures, it does provide Grace’s subjective view of her growth and progress from before treatment to after” (Pass, 2012, p. 98).

Upon comparison of Grace's retrospective, “pre-treatment” scores and her end-of-therapy scores on the TSI, Pass (2012) found that

all five scales [of the TSI] that were initially above 60 (i.e., one standard deviation above the clinical norm) decreased to a level below the clinical norm. The average decrease for these five scales was 16.6 points, or 1.66 standard deviations, indicating a sizable and clinically meaningful decrease in her PTSD-related symptoms (p. 99).

In terms of the OQ-45, Grace's retrospective, "pre-treatment" Total Score was 72 (T score = 64; 91.9 percentile of the normal population). Such a score is typical of outpatients entering treatment (i.e., above the clinical cut-off point of 63). Grace's post-test Total Score was 18 (T score = 33; 4.5 percentile of the normal population), indicating that Grace left treatment well within the normal range of functioning. Were we to take the "pre-treatment" score of 72 at face value, this would suggest that Grace went from the clinical range into the normal range and changed reliably, therefore meeting the criteria set forth by Jacobson and Truax (1991).

On the whole, Pass concluded that while her AEDP-Writing model had been successful for Grace, it was not a "one size fits all treatment," given that the majority of clients who present for PTSD treatment have complex trauma histories, insecure or disorganized attachments, low motivation, failing hope/trust, and so forth, and, hence, would not meet Pass' inclusion criteria. Pass recommended that further case studies using the AEDP-Writing model be conducted with persons of different backgrounds, ages, and concerns.

## DESIGN ISSUES

Two primary design issues, "retrospective" administration of assessments and consequent possible misleading characterization of the study as a pretest-posttest design, will be discussed here as well as pertinent research and potential avenues of remedy that could provide additional, valuable information and possibly serve to enhance therapy outcomes with more difficult cases.

### *“Retrospective” Administration of Assessments*

A primary issue (noted by Pass) in the case of Grace was the “retrospective” administration of outcome assessments in session 39 (when Grace was instructed to fill out another TSI and OQ-45 "as she remembered her psychological state pre-treatment"). Such retrospective administration of measures has been shown in empirical studies to pose significant risks to the validity of quantitative results as these estimations of functioning and emotional state have been found to vary significantly from what would be obtained if the data were collected in real time. Specifically, in 2004, researchers (Nielsen, Smart, Isakson, Worthen, Gregersen & Lambert) replicated the *Consumer Reports* (CR, 1995) retrospective satisfaction study wherein clients were asked to retrospectively reflect on their therapy experience (e.g., emotional state and functioning) and to report the progress and benefit they achieved as a result of psychotherapeutic treatment. In addition to the retrospective self-report of clients, Nielsen et al. (2004) also had access to the OQ-45 outcome scores that had been obtained throughout the course of treatment. These scores provided weekly estimations of symptom distress, quality of life, social role functioning, and interpersonal relationships.

The researchers found that retrospective estimates of psychological dysfunction when clients began treatment was overestimated in relation to measured functioning, and at the same time, psychological dysfunction was underestimated at the end of treatment in relation to measured change on the OQ-45 at termination. Ratings of emotional state tended to be reliably shifted towards more positive representations in relation to symptomatic states at follow up. While the latter finding by Nielsen et al. (2004) does not necessarily apply to the case of Grace where the OQ-45 was administered at session 38 rather than at follow-up, the former findings

seem a key factor for consideration. Recalling one's symptomatic state at the start of therapy one year earlier and comparing it with current functioning is likely to provide an over-estimate of change in Grace's case and in general.

Moreover, it has been found that change is also often confused with satisfaction in treatment (Mintz, Drake, & Cris-Christoph, 1996; Nielsen et al. 2004). While both are important aspects of client experience and are often related ( $r = .50$ ), these concepts are not interchangeable. Below we describe how the use of initial and ongoing measurement of outcomes throughout the course of therapy can help to distinguish between these constructs, provide clarification, and offer a host of other benefits that can optimize therapeutic outcomes.

### *Pretest-Posttest Vs. "One-Shot" Case Study*

Though outcomes in the case of Grace were presented as a pretest-posttest design, her case seems most accurately defined as a "one-shot" case study. Iwakabe (2011) asserts that case studies are an invaluable method of research as data is drawn from the fundamental unit in psychotherapy—direct contact between the therapist and client. He cites that this is advantageous as case studies provide information that manuals or group-based outcome research cannot—namely, concrete detail about how the therapy unfolds for a specific client and, through providing background information regarding the patient and therapist, useful contextual information regarding how a particular treatment was implemented. Unfortunately, the generalizability of a single case study can be limited—hence, to increase generalizable knowledge and insight into change processes, Iwakabe advocates the use of case study comparisons through the juxtapositioning of successful and unsuccessful cases as this technique highlights both the features that promote as well as the factors that impede therapeutic change. Were, as proposed by Pass, another client to be treated with the AEDP-Writing approach (especially should the outcome be unsuccessful), comparing and contrasting the two analyses could provide useful information regarding therapeutic versus anti-therapeutic factors, mechanisms of change, interactional patterns, etc. In the future, should further findings wished to be gleaned from Grace's case study, a case comparison could be very valuable.

## **DESIGN REMEDIES AND RELATED BENEFITS**

### *Continuous Administration of Outcome Measures*

In terms of measurements in the case of Grace we would like to recommend that, in addition to an administration of an initial assessment at the onset of treatment, that ongoing outcome measures be utilized as the use of such can add important information to guide treatment. Continuous use of outcome measures throughout the course of therapy may also help to enhance treatment outcomes, e.g., by alerting the therapist to changes such as increases in symptoms, interpersonal difficulties, life functioning, substance use, and/or suicidal ideation. The great advantage of such measures is that therapists who must concentrate on providing treatment cannot afford to spend significant portions of time every session assessing client mental health functioning (e.g., sleep difficulties, tiredness, loneliness, physiological indicators of anxiety, anger, etc.).

Of course, the usefulness of the assessment information provided is contingent upon the nature, appropriateness, and psychometric soundness of the measure utilized. Assessment instruments vary greatly in length, depth, sensitivity, feasibility of administration, summary of results, degree of validity and reliability, and focus or scope (e.g., disorder-specific versus global). Measurements specific to trauma, like the TSI which was used in the case of Grace, provide a detailed look at a specific symptomatology and their impact on various areas of functioning.

The second instrument utilized in Grace's case was the OQ-45, which is a global outcome measure that assesses general domains and functioning, including symptom distress, interpersonal relationships, social role functioning, and quality of life. Additional features of the OQ-45 include ease of administration (approximately 5 minutes) and the incorporation of software—the OQ Analyst (<http://www.oqmeasures.com/page.asp?PageId=62>)—that scores the measure, applies score-specific algorithms in a single second, and provides a summary report of the information that requires only 20 seconds for clinician review. This report includes quick reference of critical areas such as suicidal/angry ideation, a graph of ongoing progress in treatment, and most importantly, alert signals for "off track" cases predicted to have a negative outcome. In addition, a problem-solving tool called the Assessment for Signal Clients (ASC; <http://www.oqmeasures.com/page.asp?PageId=61>) can also be incorporated to identify possible causes of negative change (such as alliance problems) and possible solutions.

### ***What Would Ongoing Assessment Have Likely Revealed About the Course of Therapy With Grace?***

There are three major advantages that might accrue if ongoing monitoring of mental health functioning had been used in this case study—efficiency, obtaining continuous "vital signs" of psychological functioning to inform treatment course, and utilization of a signal alert system to aid in preventing premature termination and/or deterioration. As will be discussed further, these are particularly salient aspects of treatment when working with clients with PTSD symptomatology.

#### **Effectiveness and Efficiency**

First, ongoing assessment would help us detect when specific changes occurred in therapy for Grace. Outcome assessment information could also have been used to consider shortening the length of treatment—that is, to note when significant improvement had ensued and to spark a decision to discuss termination. Without ongoing outcome measurement, we are unsure if, given the strong alliance with her therapist and Grace's adherence to the AEDP-Writing therapy procedures, Grace was significantly improved (i.e., returned to normal levels of functioning) by the fifteenth, twentieth, or thirtieth session. When such improvement occurred, this would obviate the need to continue the protocol-driven, 40-session treatment. Continuous monitoring allows the therapy to be tailored specifically to the client's ongoing needs and responses to treatment, maximizing the likelihood of not only effective treatment but efficient treatment.

Especially given that this case involved a securely-attached client with an uncomplicated, single-index trauma, one wonders if equivalent outcomes could have been attained with fewer sessions. This seems especially salient given that other trauma-focused therapies (e.g., Prolonged Exposure therapy [Foa, Hembree, & Rothbaum, 2007] and Cognitive Processing Therapy [Resick, Monson, & Chard, 2008]) tout significant improvement/recovery for PTSD within 12 – 15 sessions. It is notable that these therapies are symptom-specific rather than holistic and relationship-based like AEDP-Writing. In fact, the Cognitive Processing Therapy manual reads:

We are frequently asked if it is important to develop a relationship with the patient before beginning any trauma work. Our answer is no, this is not necessary. In fact, if a therapist waits for weeks or months to begin trauma work in the absence of any of the contraindications . . . the patient may receive the message that the therapist thinks that she is not ready to handle trauma-focused therapy. This reluctance on the therapist's may collude with the natural desire to avoid this work (as part of PTSD avoidance coping). The therapeutic relationship develops quickly within the protocol (Resick, Monson, & Chard, 2008, p. 4).

Hence, we recommend further research studies that compare the AEDP-Writing model with other trauma-focused therapies so that the approaches may be compared and contrasted. In such comparative studies, outcome measures that focus not only on symptom reduction but on relational constructs (e.g., attachment), well-being, and overall global functioning could aid in highlighting effectiveness as well as unique aspects/benefits of various therapies. This would allow clinicians and clients to make informed decisions about which therapeutic option seems most appropriate to pursue given the presenting concerns, goals, and individual characteristics of the client at hand.

#### Timing and Progress Versus Deterioration Throughout Treatment

Second, ongoing assessment also allows monitoring of psychological functioning in relation to the phases of treatment Pass employed. Ongoing assessment can assist in determining the timing of various phases, such as when to incorporate the phase two writing/exposure assignments, and when the exposure has resulted in sufficient habituation so as to move into the third, consolidation phase of the treatment. In addition, ongoing assessment highlights the progress and improvement—as well as any regression or decline—that is attained in each phase.

In the case of Grace, outcome measures specific to the therapeutic relationship (e.g., the Working Alliance Inventory – Short Revised, Hatcher and Gillaspay, 2006) would likely have evidenced that phase two could have commenced earlier in the course of treatment as, in addition to extrapolation from Grace's comments that a sufficient emotional bond and adequate trust had been forged, concurrent assessment could also have indicated the realization of this goal. (Ongoing monitoring can also reveal relationship ruptures or other difficulties, thus allowing a timely opportunity to address and repair them.).

In addition, the OQ-45 was specifically designed to track patient well-being on a weekly basis during routine care and, in this sense, provides an ongoing mental health "vital sign" at each administration to help inform treatment (Lambert, 2010). This type of data can prove valuable regardless of course of treatment. For instance, in cases where treatment has been

successful, the compilation of information obtained throughout therapy and the ongoing sharing of this information with the client can help to achieve a number of functions. Examples of these are to illustrate and/or solidify progress over time; to reinforce gains made; to demonstrate maintenance of adjustment/improvement over time; to increase client confidence; and to prompt the timely conclusion of treatment. Alternatively, when the course of treatment is proving unsuccessful, this ongoing monitoring may prove even more valuable as the therapist is made cognizant of an unexpectedly negative response and, hence, can intervene as necessary to help prevent premature termination and/or deterioration. Such intervention can include such elements as psychoeducation, a safety plan for suicidal/homicidal ideation or substance abuse, the modification of planned interventions, and/or referrals. (The manner in which the OQ-Analyst--the accompanying software to the OQ-45—can support this endeavor is discussed next.)

### Providing a Signal Alert System

Lastly, ongoing tracking of patient outcomes also provides a signal alert system to help the clinician ascertain whether or not the client is responding as expected (e.g., engaging in treatment and tolerating exposure-oriented interventions). In many PTSD-focused treatments, various means of measurement are incorporated to provide feedback and track the course of treatment. For example, Prolonged Exposure (PE) utilizes the Subjective Units of Distress Scale (SUDS) to track distress and habituation throughout the course of therapy; these SUDS scores are also utilized to make treatment decisions about when to advance to the next imaginal exposure or activity in the in vivo hierarchy. In addition, both Prolonged Exposure (Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (Resick, Monson, & Chard, 2008) utilize measures like the PTSD Checklist (PCL; Weathers, Litz, Herman, & Keane, 1993) on a session-by-session basis to track PTSD symptoms and client response to therapy.

Had Pass in her case of Grace utilized the OQ-45 in a similar manner, in addition to obtaining and tracking OQ-45 scores, she could have also utilized the OQ-Analyst as a resource. The OQ-Analyst software employs algorithms to detect progress and deterioration of therapy. These algorithms are based on models that have been developed with a large database of test scores drawn from a wide variety of treatments and a broad array of patient disorders. The value of such a resource was demonstrated in a study by Hannan et al. (2005) who tested the actuarial predictive algorithms of the OQ-Analyst against the clinical judgment, insight, and experience of therapists to see which method was most accurate in predicting which clients would experience final negative treatment outcome.

Hannan et al.'s study included 550 clients and 40 therapists who made forecasts about their clients' ultimate treatment outcome after each session of therapy. The OQ-45 was utilized for tracking progress yet the scores were not made available to the clinicians or clients. Hannan et al. (2005) discovered that out of 550 clients there were only 3 (0.01%) who were predicted by their therapists to deteriorate; unfortunately, OQ-scores revealed that in actuality there were 40 clients (7.3%) who had significantly worsened by the end of their treatment. Whereas clinicians only correctly identified 1 of the 40 clients who worsened, the OQ-Analyst algorithms correctly predicted 36 of the 40 clients (90%). Results clearly attested to the superiority of applying actuarial predictive methods to clinician guesstimates. Given the therapists' inability to correctly foresee negative therapy outcomes, using software like the OQ-Analyst can help alert therapists

to worsening early on in the course of therapy so that adjustments can be made that help prevent premature termination and further deterioration.

While further research (Finch, Lambert & Schaalje, 2001; Lambert, Whipple, et al. 2002) with the OQ has found that while the general picture for psychotherapy seems clear—worsening during treatment that reaches certain critical thresholds predicts final treatment failure—we do not yet know if these particular predictive algorithms would apply to the special case of clients with PTSD in the context of exposure-oriented, trauma-focused therapies such as that used with Grace. Nonetheless, we believe the OQ-45 and OQ-Analyst (or comparable procedures) could provide clinically relevant, helpful information to aid therapists and guide therapy (as well as provide future opportunities for research in delineating the expected course of PTSD-focused treatment and/or creating a model of PTSD treatment with corresponding algorithms).

Given the challenging nature of trauma-focused work with clients with PTSD symptomatology (discussed in further detail below), monitoring psychological functioning of the client, ongoing response to phases of treatment, and ability of the client to tolerate interventions (in order to prevent premature drop out) seem especially germane. For, while Grace did not increase her avoidance, develop problematic behaviors, or terminate prematurely, the adoption of such is not uncommon when clients are negotiating the challenges of PTSD-focused therapy. This seems primarily due to the fact that PTSD seems to be distinct from other disorders in ways that provide unique challenges for clients and therapists as well as important implications for treatment.

## **FACILITATING PTSD-FOCUSED TREATMENT: FUNDAMENTAL FACTORS FOR CONSIDERATION**

### *Avoidance of Trauma-Related Stimuli*

One of the most vital tenets in treating clients with PTSD is to remember the following: avoidance is a symptom of PTSD, *not* a healthy/helpful coping strategy. Also imperative to note is that avoidance can take the form of numerous other behaviors such as substance abuse, isolation, self-harm, impulsive sexual practices, high-risk behaviors, and over-eating. In fact, not only does avoidance maintain, perpetuate, and worsen PTSD symptomatology over time, it seems the primary culprit in research findings that when PTSD symptomatology persists over one year following the traumatic event, the condition is unlikely to remit without treatment (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) given that most clients with PTSD use it as a primary tactic to attempt to circumvent distress. Avoidance is problematic as it prevents differentiation, e.g., between trauma and the present, and between memory and real danger. In addition avoidance can maintain problematic beliefs, such as: “If I allow myself to remember I’ll lose control,” “The world is unpredictable and dangerous,” and “I can’t handle it.” Hence, a treatment such as that used by Pass appears to be requisite for treatment and recovery from PTSD.

### ***Approach Towards Trauma-Related Stimuli***

Approach is a necessary component of PTSD treatment, as it is essential for deeper processing of the trauma. In fact, if symptomatology does not rise during points of the treatment, this is evidence that deeper processing is not occurring and that avoidance remains an obstacle to recovery. Numerous therapies utilize various forms of approach with different foci and different goals. In the case of Grace, AEDP-Writing used an emotion-focused approach based in the context of a safe, secure relationship with the goal of the “feeling and dealing” (as opposed to “feeling without dealing” or “dealing without feeling;” Fosha, 2003). Cognitive Processing Therapy utilizes a cognitive-based method grounded in social-cognitive theory where the goal is to dissipate natural emotions and increase accommodation in cognitions and memories (Resick, Monson, & Chard, 2008). Prolonged Exposure is also emotion-based yet places emotional processing in the context of repeated imaginal and in vivo exposures with the goal of altering the fear structure in clients with PTSD (Foa, Hembree, & Rothbaum, 2007). Unfortunately, there are implications for approach regardless of the specific treatment used that can provide a significant challenge for therapy—significant increases in symptomatology.

### ***Approach-Resultant Rises in Symptomatology.***

The knowledge that approach results in increases in symptomatology is important information for both the client and therapist to be aware of as increases in symptomatology are often (and understandably) interpreted as a worsening of the condition rather than as a necessary and preliminary sign of recovery. This is no wonder considering that increases in one or more of the following is expected during part of the treatment: (a) re-experiencing (e.g., nightmares/dreams, flashbacks, or intrusive memories); (b) arousal (e.g., painful emotions, physiological reactions, problems falling/staying asleep, irritability/outbursts of anger, difficulty concentrating, startle reactions, and being on-guard); and/or (c) heightened desires for avoidance.

Due to this expected initial aggravation of symptomatology, awareness and psychoeducation can play a vital role; in fact, manualized therapies directly address this reality and make it a part of, not only psychoeducation, but informed consent as well. Consider the following excerpt from the Prolonged Exposure PTSD Therapist Manual:

When recommending PE to a trauma survivor, the therapist should explain that disclosing trauma-related information and working to process the painful experiences in therapy often cause temporary increases in emotional distress and can also lead to a temporary exacerbation of psychiatric symptoms, including PTSD, anxiety, and depression. This is described to clients as “feeling worse before you feel better.” (Foa et al., 2008, p.17)

Other sample psychoeducational topics that may be addressed (depending on the therapy utilized) may include the role and problem of avoidance, the rationale for treatment, the expected course of therapy, and/or habituation.

Given the careful attention Pass paid to the therapeutic relationship with Grace and the creation of an atmosphere of safety and trust, it is possible—and maybe even likely—that the worsening (i.e., an increase in distress) in Grace's case might have been moderated to some degree. Nonetheless, increases in symptomatology were evident for Grace in the second phase of

therapy as she abandoned avoidance as her primary coping strategy and began approaching the memories, places, and people she had hitherto shunned. It is imperative for therapists to be cognizant of this phenomenon (i.e., rises in symptomatology due to approach) as foray into traumatic, graphic material is also often difficult for the therapist and, at times, can tempt the clinician to want to collude with the client in avoiding such matter. However, as avoidance only serves to prolong, heighten, and worsen symptomatology in the long run, continued approach and processing is required for recovery. As exposure to such material can result in secondary or vicarious trauma for the clinician and cause disruption in the therapist's view of self, others, and the world in general (McCann & Pearlman, 1990; Sabin-Farrell, & Turpin, 2003), coping strategies such as self-care activities, leisure time, and supervision are recommended to safeguard the therapists' well-being (Bober & Regher, 2006).

In this case, Pass' work with Grace challenged her both physically ("my stomach was upset at times during the session. . . I had a headache and took a long walk outdoors in order to center myself" [2012, p. 92-93]) and emotionally (feeling accountable for Grace's pain and turmoil as she was "'responsible' for initiating a phase of therapy which is so challenging" [2012, p. 94]). As a result, Pass initially had some difficulties "going even deeper" into this traumatic material. Fortunately supervision, continued approach, and persistence on the part of both therapist and client allowed for processing of these key, intense moments and facilitation of an eventual positive outcome.

### *Anticipated Outcome During the Course of Grace's Treatment for PTSD Symptomatology*

In light of the above expectations, we would speculate that Grace would demonstrate a relatively high level of distress at intake on the assessment measures (as her pain was sufficient to prompt her to seek therapy). During phase one of AEDP-Writing we could expect the score to fluctuate dependent on the tasks presented (e.g., developing the therapeutic relationship and Grace taking risks to be candid about herself). The continuous assessment would also likely coincide with "dealing without feeling" and "feeling without dealing" states.

As Grace entered the second phase of treatment and began to write about, explore, and further process the death of her brother we would anticipate scores that were equal to and/or exceeded those at intake. This symptom increase would likely be manifest in the defense and core affect stages of the AEDP work. It would also likely be manifest in the writing assignments based on approach of previously avoided memories and emotions, for example: in session 14 when Grace talked more in depth about her brother and the aftermath of the suicide; in session 20 in which she wrote about her brother and processed some of her grief/bereavement; in session 21 in sharing a letter she had written to her brother; and in sessions 24 – 29 where the goal was direct processing of the index trauma.

It is likely that Grace's scores would have shown improvement towards the end of phase two as she learned how to better (in the context of the safe and secure relationship) "feel and deal" more effectively in regards to the trauma. This improved capacity was evident in many of the conversations she had with her therapist regarding her recovery, her functioning, and her re-engagement in various parts of her life. It is anticipated that phase three of AEDP-Writing would

likely have shown continuing improvement (i.e., dropping) in scores for Grace providing further evidence that she was ready to terminate.

## DISCUSSION

AEDP-Writing was deemed to be a successful approach for Grace—a 24 year old, married, Caucasian woman with a secure attachment style—in resolving and recovering from her index trauma. Grace’s self-report, her therapist’s observations, and end-of-treatment quantitative results support this assertion. We have argued that additional outcome measurement, not only on an initial basis but on an ongoing one, would have provided additional quantitative data that would have new, important information for therapist Pass' clinical decision-making and for her theoretical analysis of Grace's case. Thus the additional information would have likely served to enhance treatment effects. While Grace did not deteriorate, display increasing levels of avoidance, develop or adopt problematic behaviors, or terminate early, in many cases—and perhaps especially in clients with PTSD—these negative outcomes do occur not infrequently. Hence, the recommendation from Norcross and Lambert (2011) for ongoing assessment seems well-founded as “such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and avoid premature termination” (p. 6). In addition, with PTSD clients, we recommend that therapists share appropriate psychoeducational information with clients to help minimize misinterpretation of response to treatment, strengthen commitment, and reduce the chance of deterioration and ultimate treatment failure.

Lastly, the importance of appreciating the indivisible nature of the alliance and the work done to create and sustain it is another valuable aspect of Pass' case study of Grace. Indeed, the case of Grace surely helps to illustrate that “the value of a treatment method is inextricably bound to the relational context in which it is applied” (Norcross & Lambert 2011, p. 5). Based on our experience with ongoing quantitative measurement within therapy, we conclude that clinicians can be assured that within the context of a sound theory and an effective alliance, the inclusion of ongoing assessment, knowledge, and research can only serve to heighten client outcomes.

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