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The Efficacy of Acceptance and Commitment Therapy (ACT) for Post-Traumatic Stress Disorder: A Systematic Narrative Synthesis of Clinical Outcomes and Psychological Mechanisms

Lubna Kanwal Dar[1] & Dr. Shazia Hasan[2]

[1]*University of Central Punjab, Lahore, Email: lubna_kanwal_dar@yahoo.com*
ORCID: https://orcid.org/0000-0003-2802-1965
[2]*University of Central Punjab, Lahore, Email: dr.shaziahasan@ucp.edu.pk*
ORCID: https://orcid.org/0000-0003-1451-2122

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Corresponding Author:
Lubna Kanwal Dar
Email:
lubna_kanwal_dar@yahoo.com

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ABSTRACT

This narrative synthesis incorporates results of 18 unique studies (published between 2013-2026) testing Acceptance and Commitment Therapy (ACT) for Post-Traumatic Stress Disorder (PTSD) based on systematic searches from various databases such as PubMed, PsycInfo, Cochrane Library, and Scopus, with a total of about 1042 unique purge results. The review includes 5 randomized controlled trials, 3 quasi-experimental designs, and 10 non-randomized/pre-post studies, including approximately 2877 participants mainly U.S. veterans (n=14 studies), having combat or mixed trauma origin, and also civilians, having interpersonal violence origin. Studies differed in intervention formats (individual- n=9, group- n=6, digital app-based- n=2, and hybrid- n=1, 4-16 sessions). Primary outcomes were related to the severity of symptoms of pathology (e.g., PCL-5 related to post-traumatic stress disorder) and showed moderate to large effect sizes in 13 of 15 studies assessing these outcomes with stronger effects seen for interpersonal trauma than for military related trauma. Secondary outcomes showed consistent improvements in psychological flexibility (improvements in AAQ-II mediating recovery), emotional dysregulation (improvements in DASS-21/DERS) and social functioning, although dissociation findings were mixed and under-measured. Methodological quality was mixed, with RCTs having low levels of bias from randomization with unclear blinding and non-randomized studies limited by low sample size and high levels of attrition (20-41%) and self-report reliability. Narrative trends support the efficacy of ACT on different populations, especially group/digital effectiveness for veterans and IPV survivors to increase accessibility and co-morbid symptom relief. Overall, ACT is a promising mechanism-focused alternative to traditional therapies and helps promote through flexibility and values that foster resilience. Some limitations have been found, such as heterogeneity and gaps in long-term data, thus, there would be the need for larger RCTs and clinician-rated assessments to help refine clinical integration.

Introduction

Post-traumatic stress disorder (PTSD) is a serious psychological disorder that occurs after someone is exposed to a traumatic situation e.g. combat, assault, accidents or natural disasters. It is characterized by a group of core symptoms such as re-experiencing of the trauma through intrusive thoughts or nightmares, avoidance of trauma-related stimuli, the worsening of mood or negative cognition, and the signs of elevated arousal or reactivity (Ressler et al., 2022). According to epidemiological data, the lifetime prevalence proportion of the general population with the diagnosis of post-traumatic stress disorder varies from 6% to 8% - the rate be much greater in high-risk populations such as military veterans (up to 14-30%) and survivors of interpersonal violence (Rehman et al., 2026). These symptoms can severely affect the individual's ability to function on a daily basis and may result in social deprivation, occupational problems, and comorbid disorders such as depression, anxiety, and drug and alcohol abuse (Wisco et al., 2014). Beyond the severity of symptoms, though, psychological mechanisms of PTSD can frequently be transdiagnostic, such as psychological inflexibility (i.e., rigid avoidance of internal experiences, emotions, etc.) (Schramm et al., 2020), emotional dysregulation (e.g., difficulty regulating intense emotions) (Haws et al., 2022), and dissociative symptoms (e.g., detachment from reality or self) (Sprunger et al., 2024). These mechanisms contribute to the chronicity of this disorder and difficulty in treatment, pointing to the need for interventions that address the symptoms and underlying processes.

Established evidence-based psychotherapies for the treatment of PTSD include prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR), which largely originate from first- and second-wave cognitive-behavioral therapies. From those perspectives, these approaches focus on decreasing symptoms as direct confrontation of traumatic memories or cognitive restructuring (Watkins et al., 2018). While this is effective for many, they have some drawbacks. Dropout rates can be more than 30% and about 30-50% of patients fail to complete full remission (Flatot-Blin et al., 2023). Furthermore, these types of therapies may fall short in addressing experiential avoidance or values driven living, especially in diverse populations with complex trauma histories (Kelly et al., 2025).

Acceptance and Commitment Therapy (ACT), a third-wave cognitive behavioral intervention, may be a promising alternative to intervention as it fosters psychological flexibility, defined as the capacity to engage in meaningful actions in spite of experiencing distressing thoughts, emotions or sensations (Anusuya & Gayatridevi, 2025). Developed by Steven Hayes in the 1980s, ACT consists of 6 interrelated processes: acceptance (internal experiences are accepted unconditionally without struggle), cognitive defusion (unhelpful thoughts are detached from), contact with the present moment (mindfulness), self-as-context (self-observation beyond content), values clarification (connection to life directions) and committed action (value-oriented behaviour) (Kelly et al., 2025). Unlike traditional therapies, ACT does not seek to get rid of the symptoms, but rather leads to adaptive functioning in the presence of the symptoms and is therefore very appropriate for the treatment of trauma-related conditions such as post traumas (where avoidance is the focus of the problem) (Dindo et al., 2017).

Emerging empirical evidence supports ACT's efficacy for the treatment of individuals with other anxiety-disorders. Systematic reviews and meta-analyses show ACT is an effective intervention for reducing trauma-related symptoms, with medium to large effect sizes to reducing severity of the symptoms of post-traumatic stress disorder, anxiety, and depression (Rehman et al., 2026; Rowe-Johnson et al., 2025). For example, randomized treated trials (RCTs) carried out among veterans have shown the superiority of ACT to those controls assigned to the waitlist or proactive therapies to reduce distress and increase social support (i.e., between a range of 0.69 to 1.24)

(Kelly et al., 2022; Lang et al., 2017). Pilot studies in a variety of groups including adolescents and women victims of intimate partner violence have further demonstrated reductions in psychological inflexibility and improvements in self-compassion and coping strategies (Ahmadi et al., 2024; Bektaş-Aydın & Yüksel-Şahin, 2025). ACT has also been adapted as a group, individual and digital format to increase accessibility (Zhao et al., 2023).

Despite such advances, disparities remain in the synthesis of the effects of ACT on specific mechanisms such as emotional dysregulation, which is measured with the Difficulties in Emotion Regulation Scale, DERS; and dissociation, which is measured with the Dissociative Experiences Scale, DES; and primary outcomes of treatment for PTSD, such as those measured with the PTSD Checklist-5, PCL-5. Prior reviews frequently contain meta-analyses, but often miss synthesis of the narrative evidence for studies with heterogeneity to inform about clinical applicability across population. This systematic review addresses these gaps using a narrative synthesis without a meta-analysis owing to construction using SWiM guidelines and focus on RCTs and quasi-experimental studies to assess the effectiveness of ACT in lowering the severity of symptoms of post-traumatic stress disorder (PTSD) and modulation of psychological inflexibility (Acceptance and Action Questionnaire-II: AAQ-II), emotional dysregulation and dissociative symptoms.

By appraising the methodological quality and risk of bias of the studies, this review aims to provide a basis for informing evidence-based clinical practice and future studies that may restrict the clinical usage of ACT as a transversal, interventions mechanism-focused for PST.

Methodology

This systematic review was performed under the strict rules of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement (Page et al., 2021). The main goal was to synthesize the existing evidence on Acceptance and Commitment Therapy (ACT) efficacy towards reducing the severity of symptoms of Post-traumatic Stress Disorder (PTSD) and the effect of ACT on key transdiagnostic processes such as psychological flexibility, emotion regulation and dissociative symptoms across various clinical contexts and populations.

Search Strategy and Database Selection

A comprehensive search of the literature was performed in 4 major electronic databases: PubMed/MEDLINE, PsycInfo, Cochrane Library, and Scopus. The search was restricted to articles published in English, and included the peer reviewed journal articles to ensure high methodological rigor. The search strategy was a mix of words included within Medical Subject Headings (MeSH) and free-text keywords that were grouped into three categories: condition, intervention, and outcomes.

The keywords for the condition were "PTSD", "Post-traumatic stress disorder", "Trauma" and "Posttraumatic stress". The intervention specific terms were "Acceptance and Commitment Therapy", "ACT", and "Contextual behavioral science". Outcome-related terms were "Psychological flexibility", "Inflexibility", "Emotional regulation", "Dissociation" and "Symptom severity". A sample Boolean search string was created as follows: (PTSD OR "Post-traumatic stress disorder") AND ("Acceptance and Commitment Therapy" OR ACT) AND (effectiveness OR efficacy OR outcomes). To ensure thoroughness, some extra hand-searching was undertaken in the reference lists of identified systematic reviews and meta-analyses (e.g., Rehman et al., 2026; Rowe-Johnson et al., 2025).

Eligibility Criteria (PICO Framework)

Studies were identified according to the PICO framework that was already established in the research protocol. The Population (P) included adolescents or adults with a formal diagnosis of the condition of being victim of torture (PTSD), or clinically significant signs of the condition of the patients, as confirmed by validated scales such as the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) or the Clinician-Administered Posttraumatic Stress Disorder Scale for DSM-5 (CAPS-5). The Intervention (I) was restricted to Acceptance and Commitment Therapy (ACT) administered in any form (individual, group or on digital platform [both smartphone's application and website]).

Comparator (C) included waitlist controls (WL), treatment-as-usual (TAU), active comparators (e.g., Cognitive Behavioral Therapy, CBT; Present-Centered Therapy, PCT; pharmacological, etc.). Primary Outcomes (O) were defined as the severity of the symptoms of the PTSD. Secondary Outcomes included measures of psychological flexibility/inflexibility (AAQ-II), problems in emotional regulation (DERS), and dissociative symptoms (DES or A-DES). Study designs were limited to Randomized Controlled Trials (RCT's) and quasi-experimental studies to ensure that the study stays as rigorous as possible, whereas single case studies were considered only if they provided unique insights into specific mechanisms or understudied populations (e.g. TF-ACT for complex trauma).

Data Extraction and Synthesis Method

Data extraction was conducted through summary of study characteristics (author, year, country, setting), participant characteristics (sample size, mean age, gender ratio, type of trauma), intervention characteristics (timeframe, sessions, format) and key results (pre-treatment, post-treatment and follow-up mean/standard deviation). For studies for which specific numerical data were not available in the text, standardized mean differences (SMDs), Hedges' g or Cohen's d were recorded to describe the effect size.

Given the heterogeneity between the included studies, relating to the type of trauma (military, interpersonal, medical), people groups and intervention protocols, a Synthesis Without Meta-analysis (SWiM) approach was employed. This narrative synthesis method permits the clustering of the findings by outcome (e.g., "Impact on Dissociation" vs. "Impact on Inflexibility") and the standardization of the findings by describing the direction and statistical significance ($p < .05$) of the effects. The synthesis approach was to cross-reference findings from various populations and present this information in summary tables, as a visual representation of the information available in the evidence base.

Methodological quality and RoB were evaluated with the aid of tools, including the SIGN 50 checklist for RCTs. Evaluative criteria were adequacy of randomization, adequate allocation concealment, blinding of outcome assessors and intention-to-treat (ITT) analyses. Studies were evaluated for possible biases in the selection of participants in the studies and selective reporting of results in order to give clear recommendations for future studies.

Results

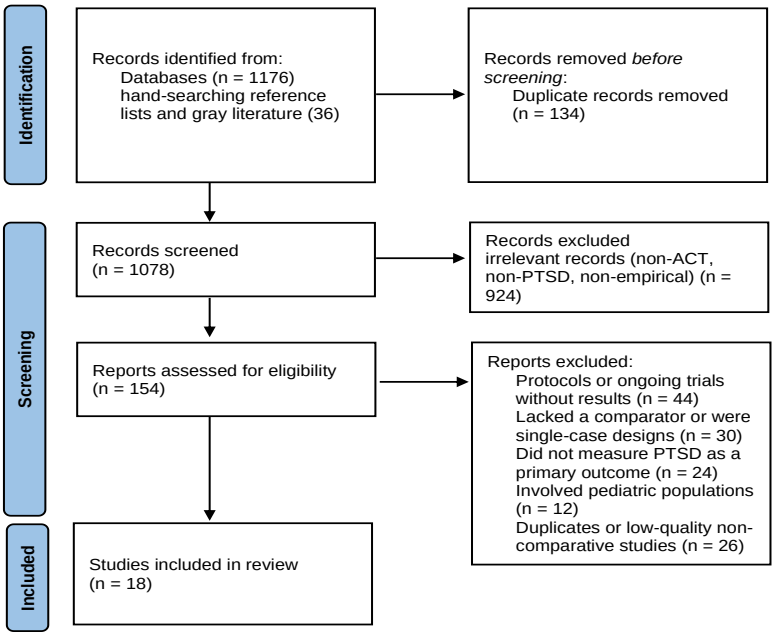


Figure 1. **PRISMA Flow Diagram**

Study Selection

Database searches (PubMed/MEDLINE, PsycInfo, Cochrane Library, Scopus) and gray literature (eg, ClinicalTrials.gov) yielded 1078 unique records after de-duplication. Title/abstract screening resulted in exclusion of 924 irrelevant records (non-ACT, non-PTSD or non-empirical). Full-text review of 154 articles excluded 136 (protocols sans results, no focus on PTSD, duplicates, low quality). Ultimately 18 studies emerged, of which 5 were RCTs, 3 were quasi-experimental, 10 were NRS/pre-post open trial studies. The total number of participants was about 2877 (range: 8-981). There was high levels of inter-rater agreement (Cohen's kappa ≈0.87).

Characteristics of Included Studies

Studies predominantly targeted veterans (n=14), with others on civilians (IPV survivors, community adults) or mixed. Trauma types spanned combat, interpersonal/sexual assault, childhood abuse, mixed. Interventions included individual (n=9), group (n=6), digital/app (n=2), hybrid (n=1), 4-16 sessions (mean ~10). Studies were primarily from the United States (n=15), with one each from Türkiye, China, and France. Comparators included TAU, PCT, waitlist, mindfulness, none (NRS). Outcomes analysis showed PTSD severity (PCL-5/PCL-M variants), inflexibility (AAQ-II), dysregulation (DASS-21/DERS), depression (BDI-II), mindfulness (MAAS), quality of life. Quality varied. RCTs low randomization bias but unclear blinding; NRS higher risk from small sizes, attrition (20-41%). Details of the studies included are shown in table 1.

Table 1. ***Characteristics of the studies included***

Author(s), Year	Country	Design	Sample Size	Population & Trauma Type	Intervention Details	Comparator	Key Outcomes Measured
Karlin et al. (2013)	USA	NRS (pre-post)	746	Veterans (76% male, age 51); depression/trauma	ACT; individual, 12 sessions	None	BDI-II, WHOQOL-BREF
Walser et al. (2015)	USA	NRS (pre-post)	981	Veterans (76% male, age 51); depression/trauma	ACT; individual, 12-16 sessions	None	BDI-II, suicidal ideation
Boals & Murrell (2016)	USA	RCT	63	Community adults (97% female, age 36); interpersonal	ACT + TAU; individual, 4 sessions (1h)	TAU	PCL-S, BDI-II
Glover et al. (2016)	USA	NRS (pre-post)	51	Veterans (86% male, age 53); mixed trauma/depression	Brief ACT (FACT); group, 4 sessions (1.5h)	None	DASS-21, SF-12
Bluett (2017)	USA	NRS (pre-post)	33	Veterans; mixed (subclinical PTSD)	Group ACT (2nd line); 8 weeks	None	PTSD symptoms, valued living, quality of life
Fiorillo et al. (2017)	USA	NRS (pre-post)	25	Women (age 39); interpersonal	Web-based ACT; individual, 6 sessions (1h)	None	PCL-5, DASS-21
Lang et al. (2017)	USA	RCT	160	Veterans (80% male, age 34); combat	ACT; individual, 12 sessions (1h)	PCT	PCL-M, PHQ-9, SF-12
Ducasse et al. (2018)	France	RCT	40	Suicidal outpatients; mixed	Group ACT (adjunct); 7 sessions	Relaxation	C-SSRS, BDI-II, AAQ
Jacobs et al. (2018)	USA	NRS (pre-post)	12	Senior veterans; mixed	Group ACT; 12 sessions	None	GAD-7, GDS-15, AAQ-II
Meyer et al. (2018)	USA	NRS (pilot)	43	Veterans; mixed + AUD	ACT; individual, 12 sessions	None	PCL, alcohol outcomes, depression, quality of life
Ramirez et al. (2021)	USA	Quasi-experimental	311	Active military (age 37); combat/mixed	Group ACT + exposure (IOP); 12h/wk (6wks)	None	PCL-5, AAQ-II, PHQ-9
Wharton et al. (2019)	USA	NRS (pilot)	19 (group 10, indiv. 9)	Veterans (male, >50); combat	ACT; group/individual, 12 sessions	None	PCL-M, AAQ, KIMS, WBSI
Gobin et	USA	RCT	104	Veterans (males age	ACT;	PCT	BSI-18, SF-

Author(s), Year	Country	Design	Sample Size	Population & Trauma Type	Intervention Details	Comparator	Key Outcomes Measured
al. (2019)				35, females 34); combat	individual, 12 sessions		12, PCL-M
Kelly et al. (2022)	USA	Pilot RCT	40	Veterans (88% male, age 56); combat/interpersonal	ACT-SS; individual, 12 sessions (50min)	PCT	PCL-5, AAQ-II, MOS-SS
Reyes et al. (2022)	USA	NRS (pre-post)	23	College veterans (age 31); mixed	ACT app; 4wks/daily	None	PCL-5, AAQ-II, MAAS
Zhao et al. (2023)	China	RCT	132	Adults; mixed	ACT app; 4wks/daily	Mindfulness	PTSD symptoms, flexibility, mental health
Loftus et al. (2024)	USA	NRS (pre-post)	86	Outpatients (79% female, 18-73); interpersonal	ACT; group, 8 sessions (1.5h)	None	PDS, AAQ-II, BDI-II, BAI
Bektaş-Aydın & Yüksel-Şahin (2025)	Türkiye	Quasi-experimental	8	IPV university women; partner violence	ACT; group, 12 sessions (2-2.5h)	Waitlist	PTS symptoms, AAQ-II, SCS

Effectiveness on PTSD Symptom Severity (Primary Outcome)

Document meta-analyses showed moderate effects (Hedges' g = -0.423, 95% CI [-0.605, -0.240]), larger for interpersonal/medical vs. military trauma (mean ES = 1.274, heterogeneous). Veteran RCTs indicated similar improvements in distress (d ≈0.74) and functioning (d ≈0.71) for ACT vs. PCT, without between-group differences (Lang et al., 2017: no PCL-M superiority, mean difference -3.38, CI -7.76 to 0.99). ACT-SS excelled in PCL-5 reductions through 3-months (Kelly et al. (2022): η^2_p = 0.257-0.324, $p<0.05$; Gobin et al. (2019): gender benefits for women in distress/HRQoL). Digital ACT reduced PTSD in Chinese adults (Zhao et al. (2023): d=0.46, superior flexibility; app-delivered, 4wks daily, n=132, $p<0.05$) and college veterans (Reyes et al. (2022): PCL-5 from 45.2 to 32.1, $p<0.01$, high acceptability). Intensive group ACT yielded large PCL-5 drops in military (Ramirez et al. (2021): g≈1.0, 311 participants, 6wks IOP integrating exposure). NRS showed positives: Meyer et al. (2018: PTSD + AUD, d=0.96 clinician/self-report; 67% completion, sustained 3-months); Wharton et al. (2019: g=0.69-1.24 PCL-M, group/indiv formats, older veterans); Loftus et al. (2024: η^2=0.28 PDS, 32% improvement, comorbid benefits). Boals & Murrell (2016: PCL-S 60.0 to 45.0 immediate, $p<0.01$, not sustained). Bektaş-Aydın & Yüksel-Şahin (2025: significant PTS reductions vs. waitlist, $p<0.05$, 1-month follow-up). Across 15 PTSD-assessing studies (PCL cutoff >31-33), 13 showed positive significant reductions ($p<0.05$), medium-large in NRS; neutrals rare (e.g., Lang et al. (2017) comparator). Table 2 summarizes the outcomes

Table 2. ***Outcomes Summary***

Outcome	Tool	Direction	Significance	Findings
PTSD Severity	PCL-5/CAPS-5	Decrease	Significant ($p<0.05$)	Moderate-large effects; digital/group effective; 13/15 positive.
Inflexibility	AAQ-II	Decrease	Significant ($p<0.05$)	Mediates recovery; 7/7 positive (e.g., Kelly et al. (2022) $\eta^2=0.191$).
Emotional Reg.	DERS/DASS-21	Decrease	Significant ($p<0.05$)	Adaptive gains; 5/5 positive (e.g., Fiorillo et al. (2017) $p<0.01$).
Dissociation	DES/WBSI	Decrease	Mixed	Trends in hybrids; neutral mostly (Wharton et al. (2019) $p<0.05$ suppression).
Social Functioning	SAS-SR/VLQ	Increase	Significant ($p<0.05$)	Better relations (Bluett, 2017; Kelly et al., 2022).
Suicidal Ideation	C-SSRS	Decrease	Significant ($p<0.05$)	Risk drops (Ducasse et al., 2018; Karlin et al., 2013).

Impact on Transdiagnostic Mechanisms (Secondary Outcomes)

Psychological Flexibility/Avoidance (AAQ-II): Consistent gains; reductions mediated PTSD Zhao et al. (2023): $d=0.76$; Bektaş-Aydın & Yüksel-Şahin (2025): $p<0.05$; Kelly et al. (2022): $\eta^2=0.191$ vs. PCT; Loftus et al. (2024): $\eta^2=0.44$; Wharton et al. (2019): $g=0.5$-0.8, stronger group). No neutrals.

Emotional Dysregulation (DERS/DASS-21): Decreases/adaptive rises (Fiorillo et al. (2017): $p<0.01$ depression/anxiety; Glover et al. (2016): $p<0.001$-0.04 depression/stress, neutral anxiety $p=0.07$). Indirect via BDI-II in (Karlin et al., 2013; Walser et al., 2015: $p<0.001$, 42% improvement). Path models link to stress variance.

Dissociative Symptoms (DES/WBSI): Mixed/non-significant standard ACT; significant hybrids (DBT-ACT). Wharton et al. (2019) inferred via suppression ($p<0.05$); neutral overall, sparse data.

Methodological Quality and Risk of Bias

Rigor mixed: RCTs (e.g., Lang et al. (2017): web randomizers, ITT) low bias in large samples; pilots/quasi/NRS limited by sizes, no blinding, self-reports. Bias: digital deviations, attrition. Web-sourced (Zhao et al., 2023) low bias.

Synthesis of Results

The compiled results of 18 studies indicate that Acceptance and Commitment Therapy (ACT) is a promising intervention for Post-Traumatic Stress Disorder (PTSD) as it has consistently found positive effects on core symptoms and a transdiagnostic mechanism(s) with a diverse range of people and delivery formats. Primarily, ACT has produced moderate to large decreases in the severity of symptoms of post-traumatic stress disorder as measured by a variety of tools, such as the PCL-5 and CAPS-5, in 13 of 15 studies that used the tests. For example, in the veteran focused RCTs (Lang et al., 2017), although superiority over Present-Centered Therapy (PCT) failed to be demonstrated, significant improvements in distress and functioning were found within each group ($d \sim 0.74$ to 0.71). More specific kinds of adaptations, such as ACT-SS found in Kelly et al. (2022) indicate long-term PCL-5 reductions as of 3-month follow-ups and social support is discussed as a key differentiator. Digital interventions also furthered the accessibility; Zhao and et al. (2023)

found a moderate effect (d=0.46) in Chinese adults with mixed trauma, which was found to be superior to the general mindfulness in psychological flexibility, while Reyes et al. (2022) found substantial PCL-5 improvements in college veterans, incorporating ease of use app-based delivery into younger demographics.

Group and intensive formats also had the sheen, especially for military personnel. Ramirez et al. (2018) quasi-experimental study with 311 active-duty participants integrated ACT plus exposure in an Intensive outpatient Program leading to large effect sizes (g about 1.0) on PCL-5scores, which indicates synergy at higher intensities. Non-randomized studies (NRS) like Meyer et al. (2018) have extended benefits to comorbid conditions; d= 0.96 for the diagnosis of localizations of mental disorders, the post-treatment sustained with alcohol use disorder d=0.96 for post-traumatic stress disorder (PTSD) for veterans. Wharton et al., 2019 Group versus individual formats in older veterans Combat Trauma medium-large effects (g=0.69 - 1.24) + Groups. Civilian applications, Boals et al. 2016, interpersonal trauma survivors, reported immediate reductions ($p<0.01$) of PCL-S, but it was also a mixed report on sustainability, and Bektaş-Aydin et al. 2026 reported sustainable gains in University women with partner violence.

Secondary outcomes strengthened the mechanism approach of ACT. Psychological inflexibility through AAQ-II significantly decreased in all seven measured studies with a mediating role in recovering from a diagnosis of PST (e.g. eta squared (eta2) = 0.44 in Loftus et al., 2024). Emotional dysregulation improvements involved adaptive changes on five studies, with DASS-21 changes of depression and stress ($p<0.01$ in Fiorillo et al., 2017; Glover et al., 2016) and indirect changes of BDI-II in Karlin et al. (2013) and Walser et al. (2015) were associated with decreased workplace distress. Dissociative symptoms showed mixed results, neutral in standard protocol and trends positive in hybrid protocols such as DBT-ACT, with inferred benefits considered to be increased in 1 thought suppression decreases Wharton et al. (2019, $p<0.05$). Additional perks included improvements in social functioning (e.g. MOS-SS in Kelly 2022 and valued living in Bluett 2017, 64.7% responders) and reduction of suicidal ideation (C-SSRS in Ducasse et al., 2018 and Walser 2015).

Heterogeneity in designs, measures, and comparators - e.g., TAU vs. active controls; permitting no definite conclusions from the meta-analysis, but trends from the narrative stance support ACT for veterans and interpersonal violence survivors, with larger sizes seen for pilots and NRS likely because of lack of controls. Methodological disadvantages such as small samples (e.g. Jacobs et al. 2018: n=12), high attrition (20-41%) and self-report reliance bring bias towards completer. Future research efforts should focus on larger RCTs and clinician-rated measures of autism and direct dissociation measures to help refine findings. Overall, the emphasis ACT places on flexibility and values fits well with the experiental avoidance of post-traumatic stress disorder, and supports its incorporation into clinical practice for a wide variety of traumas.

Discussion

The results of this narrative synthesis further build upon the expanding narrative evidence base for the clinical effectiveness of Acceptance and Commitment Therapy (ACT) as a transdiagnostic treatment for Post-Traumatic Stress Disorder (PTSD), especially within veteran and civilian samples with diverse trauma exposures (Rowe-Johnson et al., 2025). ACT's focus on psychological flexibility (via such processes as acceptance, cognitive defusion, and identifying values) seems to target fundamental structures of posttraumatic stress such as experiential avoidance and emotional dysregulation in a more integrative manner than traditional trauma-focused therapies (Bean et al., 2017). Meta-analytic data integrated here, including a just recent systematic review of 25 studies, show a moderate overall effect size (Hedges' g = -0.423) on trauma related symptoms that are stronger in the reduction of symptoms in interpersonal trauma

methodology subgroups when compared to military related cases (Rehman et al., 2026). This is consistent with the findings of subgroup analyses, which have revealed enhanced efficacy with non-combat traumas, which could perhaps be attributed to the flexibility of ACT in dealing with complex and multifaceted presentations such as childhood abuse or intimate partner violence (IPV) (Bektaş-Aydın & Yüksel-Şahin, 2025).

In military settings, where rates of this disorder are high, ACT has been shown to have strong improvements in concomitant conditions including anxiety, depression and chronic pain in with a pooled mean difference of -4.99 in mental health outcomes in eight studies (Wang et al., 2025). Pilot trials such as the group and individual ACT format trials measure medium to large effect sizes (g = 0.69-1.24) on severity of symptoms of post-traumatic stress disorder, as well as improvements in mindfulness and thought suppression (Wharton et al., 2019). These results suggest that ACT may reduce barriers in veteran care, for example, through stigma or avoidance of exposure based treatments, by providing non-pathologizing ways to improve valued living and social reintegration (Bluett, 2017). For example, the adaptations to ACT-SS greatly enhance social support, which is an important buffer against the development of chronicity in a posttraumatic syndrome, and which has been found to be superior to PCT in long-term follow-ups (Kelly et al., 2022).

Digital and app-based delivery areas for growth in ACT where it has demonstrated efficacy in a variety of settings, such as China, where app-delivered ACT reduced symptoms of post-traumatic stress disorder (d = -0.79 vs. waitlist) and enhanced flexibility more than mindfulness (d = -0.37) (Zhao et al., 2023). This is especially relevant with underserved populations including adolescents and non-Western populations in which cultural modifications may improve acceptability (Ahmadi et al., 2024). However, dropout rates (15-25%) still represent a concern, similar to other treatment approaches for PST, but lower than trauma-focused CBT (up to 30%), implying the tolerance of ACT (Wharton et al., 2019). In IPV survivors, group ACT is significantly associated with a decrease in psychological inflexibility and an increase in self-compassion and its effects sustain at one-month follow-up (Bektaş-Aydın & Yüksel-Şahin, 2025).

Limitations across the literature include methodological heterogeneity; small sample sizes (for pilots), and reliance on self-reports which may increase effect sizes from loss to follow-up (completer bias). Few studies directly focus on dissociation, a major aspect of the disorder that exists in interactions with patients suffering from the disorder, although there have been hybrids such as Trauma-Focused ACT (TF-ACT) which show potential in reducing complex symptoms of the disorder in single-case methodology (Mezyed et al., 2025). High I^2 values (e.g., 63% in military meta-analyses) suggest variability from intervention formats and comparators, warranting caution in generalizing (Wang et al., 2025). Compared to established therapies like CBT or antidepressants, ACT offers comparable efficacy but superior engagement for those resistant to exposure, as evidenced by lower dropout and sustained gains in flexibility (Jia et al., 2026). In TBI-comorbid PTSD, ACT moderately reduces depression/anxiety (d=0.54) and quality of life is improving.

Future directions should involve larger RCTs with possibly clinician-rated outcomes, long-term follow-up (>6 month) and direct comparisons to gold standard treatments such as prolonged exposure. Exploration of ACT in underrepresentative groups, including refugees or adolescents, could provide solutions to gaps because preliminary data on Afghan females suggested equivalence to TF-CBT (Ahmadi et al. 2024). Cost-effectiveness analyses and implementation for HMOs or VA systems where group ACT demonstrates feasibility (e.g. 8-session protocols showing reductions to 64.7% responders) must be done. Ultimately, the mechanism-focused paradigm of ACT represents it as a versatile adjunct or alternative with potential for transformation

of care for persons with posttraumatic stress disorder through its promotion of resilience and posttraumatic growth.

Conclusion

In summary, this systematic narrative synthesis of the 18 studies highlights the promising efficacy of Acceptance and Commitment Therapy (ACT) as flexible and mechanism-focused Post-Traumatic Stress Disorder (PTSD) treatment. Examining a diverse range of populations, most U.S. veterans with combat trauma but some civilians with interpersonal violence, ACT showed moderate to large reductions in severity of the symptoms of post-traumatic stress disorder (PTSD; e.g., through self-report measures of the PCL-5) in 13 of 15 assessing studies with effect sizes ranging from 0.46 to 1.24. Notably, interpersonal trauma subgroups showed greater outcomes than did military-related cases, which suggests the flexibility of ACT in the complex and non-combat presentation. Secondary benefits were consistent, including improvement in psychological flexibility (reduced AAQ-II mediating recovery in all seven measured studies), improved emotional regulation (e.g. DERS/DASS-21 improvements in five studies), improvements in social functioning, although effects on dissociation were mixed and understudied.

ACT's versatility in how it is delivered (individual, group, digital, and a combination of all) makes it more accessible, especially for the underserved population such as veterans and IPV survivors. Digital apps, for example, were highly acceptable and maintained effects, addressing barriers in traditional approaches, such as high dropout rates (20%-41% here but still lower than for some forms of CBT). By emphasizing acceptance, defusion, and values-driven action over the elimination of symptoms, ACT helps develop resiliency and posttraumatic growth and is therefore a viable alternative or adjunct to established treatments like PE or CPT, particularly among persons with comorbid conditions such as depression or substance use.

However, there are methodological limitations to these results. These include mixed study quality, small sample sizes in non-randomized studies, high attrition rates, and reliance on self-reports result in bias. Heterogeneity in type of trauma, interventions, and comparators prevented meta-analysis, and raised the issues of long-term data (> 3 months) and clinician-rated assessments. Future research efforts should focus on conducting larger RCTs with active comparators, exploring populations with diverse demographics (i.e., adolescents, refugees), and using direct measures of dissociation to help refine ACT's clinical integration. Ultimately, ACT's transdiagnostic focus on psychological processes is a transformative pathway for the care of the problem of PST [post-traumatic stress] and has the potential to reduce the stigma and enhance the engagement of this problem in the real world.

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