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Efficacy of Advanced Integrative Therapy in Treating Complex Post Traumatic Stress Disorder: A Preliminary Case Report.

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Abstract

This case report documents the need for further research into Advanced Integrative Therapy (AIT), a gentle somatic trauma treatment, as it may be effective in treating complex post-traumatic stress disorder. It also shows the framework that AIT uses to treat intergenerational, or ancestral trauma.

The client's initial presenting concerns were feelings of depression, anger, and sadness. Upon continued work and insight building, the client was able to identify the roots of her anger, which included repetitive emotional neglect and abandonment by her parents as a child, and make connections between relational patterns that served her in childhood, but were contributing to her suffering with symptoms of sadness, depression, and anger in present day, particularly in relationships. The client expressed that understanding her reactions allowed her to have greater trust in herself, which diminished her symptoms of depression, sadness, and anger.

The client's initial diagnosis upon intake was F33.1, Major Depressive Disorder, recurrent, moderate. Upon ongoing assessment, the client was given a working diagnosis of Complex Post Traumatic Stress Disorder, due to multiple traumas and neglect patterns in childhood. Initially, Compassion Focused Therapy (CFT) was utilized to challenge the client's deeply rooted beliefs about herself that were leading to self-blame, anger, and an inability to express her needs in relationships. Eye Movement Desensitization and Reprocessing (EMDR) was also utilized to treat root traumas, or 'touchstone' events that led to the client's current negative cognitions that were causing her distress in present day. Finally, Advanced Integrative Therapy (AIT) was used as the intervention of choice due to its gentleness and thoroughness, as well as the client's expressed interest of *"being able to sense into my body."* The client reports that as a result of using Advanced Integrative Therapy, she has a greater capacity to self-soothe, cope with difficult emotions, ask for what she needs in relationships. Based on a scaling question, the client shared that her trust in herself has increased from 35/100 in April 2020, to 83/100 in April of 2021.

A review of this case demonstrates that treating complex attachment rupture can be extremely challenging. Utilizing Advanced Integrative Therapy as a standardized, manualized approach to treating the earliest origins of traumatic events may be an

effective treatment intervention for Complex Post-Traumatic Stress Disorder, early childhood attachment rupture, intergenerational trauma, and 'ancestral' trauma.

Key Words –CPTSD, Complex Trauma, Case Report, AIT, Advanced Integrative Therapy

Introduction –As the United States comes to terms with its colonialist roots, there has been increased conversation around intergenerational trauma and ancestral trauma. Ancestral trauma, or historical trauma, is defined broadly as:

> Multigenerational trauma experienced by a specific cultural, racial or ethnic group. It is related to major events that oppressed a particular group of people because of their status as oppressed, such as slavery, the Holocaust, forced migration, and the violent colonization of Native Americans. While many in such a group will experience no effects of the historical trauma, others may experience poor overall physical and behavioral health, including low self-esteem, depression, self-destructive behavior, marked propensity for violent or aggressive behavior, substance misuse and addiction, and high rates of suicide and cardiovascular disease. Acute problems of domestic violence or alcohol misuse that are not directly linked to historical trauma may be exacerbated by living in a community with unaddressed grief and behavioral health needs. Parents' experience of trauma may disrupt typical parenting skills and contribute to behavior problems in children. Compounding this familial or intergenerational trauma, historical trauma often involves the additional challenge of a damaged cultural identity…" (Sotero, 2006).

Intergenerational trauma is defined as trauma that is passed down from those who directly experienced an event to their subsequent generations. A research study in mice paired an electric shock with a certain smell, the offspring of the mice in the study were still averse to the smell, with no presence of the electric shock up to two generations later (Dias & Ressler, 2014). Another study conducted on adults who were gestating during the "Dutch Hunger Winter" showed that participants who had been prenatally exposed to famine performed worse on a task to measure cognitive ability compared with unexposed participants (de Rooji et al, 2010). It is reasonable to posit that some of our clients' most baffling clinical presentations may have their roots in intergenerational trauma, which can make such a client difficult to treat. These clients are not 'in denial,' recalcitrant, or unwilling to 'do their work' in treatment, but they can often be treated as such by clinicians who do not understand why their symptoms do not improve.

The client in this case report expressed an interest in ancestral healing early in the counseling relationship, but clinical interventions for treating ancestral trauma seemed beyond the scope of the clinician at the time. Advanced Integrative Therapy offers manualized training for how to treat ancestral trauma, and thereby the clinician was able to meet the expressed needs of the client. This case is unique in that the client and counselor were able to address deeper root traumas that may have been contributing to the client's distress in present day.

Patient Information

The client is a 32 year-old African American female. The client presented in September of 2018 complaining of experiencing conflict in her romantic relationship, feelings of sadness, anger and depression, and a self-reported lack of insight into her own relational patterns. There were two episodes of treatment, From September 2018 to October 2019, and from August 2020 to June 2021. The client reported no significant medical concerns, but did admit to a severe gluten allergy that she had not treated at initial intake. When asked if she received treatment as a child, the client expressed that she tried to tell her mother that gluten and dairy made her sick, but this was ignored, and so she continued to eat these foods. When the clinician asked the follow-up question, "so you were sick your whole childhood and no one did anything about it?" the client replied, *"I thought that was the price you had to pay for people to love you."*

The client described both of her parents as suffering with depression, reporting that *"they would stay in their rooms a lot, most of the day,"* leaving the client and her two younger brothers alone. The client was 16 years old when her parents got divorced. She was studying abroad at the time, and no one told her that her parents were ending their marriage, she simply came home and her parents were no longer together. The client reported a very tenuous relationship with her mother. *"I distinctly remember feeling like she did not like me, and being very angry about that."* Upon further assessment, the client expressed that her mother had a traumatic upbringing, as well: *"My mother told me that she hoped to have a daughter because she wanted a best friend, someone who would understand her. I never felt like there was any space for me to have any emotions, because she didn't respond to them."*

The client reports feeling closer to her father, but only because she played sports and he often was the coach of those sports teams. The client reports that this was not a comfortable experience, because her father was extremely hard on her. The client describes her father as having anger issues, and that the corporal punishment that she and her brothers received felt more like *"he was not trying to discipline us, he was trying to hurt us."* Her father also had a very traumatic childhood, including receiving physical abuse from one of his mother's partners. The client described her paternal grandmother as *"very isolated and not well."* When the client was 2 years old, her grandmother kidnapped her from her parents' home without their consent, and the client reported that her father did not stand up to his mother about this event, and she was eventually brought back. In later sessions, the client identified that her parents will not talk about this event if she brings it up, alleging that they do not remember it happening. Client described her two younger brothers as struggling with addiction and mental health issues, respectively. The client also noted that her father took their family to a "White Church," and that this institution did not feel safe or comfortable to her.

When asked about other formative relationships from childhood, the client described that she *"was always really obsessed with having a best friend*." She shared that she often chose children with very "big personalities" to form close friendships with, but these relationships often became manipulative or controlling. The client identified that she was often the *"only black person"* in her elementary, middle, and high school classes. Client describes her romantic relationship patterning also as *"choosing really big personalities*," who she took emotional care of, and where she described herself as not being able to have space for her emotions. Client describes trying to talk to her partner at the time of the initial episode of treatment, and stated *"I would try to talk to him about my experience, about racism, and he would say 'you're asking me to absorb your anger.'"*

Per the client's intake paperwork, she reported that she would like to have some understanding of her own feelings, *"specifically the anger spirals that occur regularly enough for it to feel like a problem in my life. I want this insight to help me understand and move away from unhelpful patterns."* In the insight building phase, Compassion Focused Therapy was utilized, and the client identified that *"I'm carrying around a lot of things that aren't mine"* which allowed her greater space to move away from self-blame. Eye Movement Desensitization and Reprocessing was utilized, with some initial difficulty, and significant success, to process an early trauma memory in which the client formed the deeply rooted cognition, *"I'm too much."* (See Table Below). The client reports an earlier episode of EMDR treatment with a previous therapist to process a past sexual assault in college, but reports *"it wasn't explained very well, and I didn't feel connected to the therapist, I'm not sure it was helpful."*

Timeline –In the client's treatment timeline, there were 30 sessions of Compassion Focused Therapy. The treatment intervention shifted from CFT to EMDR when the client presented to session #30 and reported that she had the insight that the patterns she is enacting in her present life are "ancient." She reported treatment readiness for EMDR to treat complex attachment rupture and increase feelings of self-worth. EMDR entails a robust history and case planning phase. The number of EMDR sessions was 12 in the first treatment episode, and 3 in the second episode of treatment, totaling 15 EMDR sessions. After the clinician was trained in Advanced Integrative Therapy Basics, and upon discussing this intervention with the client, she reported that she was very interested in using AIT. The rationale for the transition to AIT as the primary treatment intervention was in response to the client's expressed interest in treating intergenerational trauma. AIT was used as the primary treatment intervention for the remainder of treatment, totaling 29 sessions. The first episode of treatment began in September 2018 and terminated in October 2019. The second episode of treatment began in August 2020, ongoing up until the time of this writing, June 2021.

Clinical Findings

It was observed by the clinician that the client suffered from extremely low self-worth, and was attempting to please people in her life in order to maintain relational safety. The client presented with an external locus of control in that she believed other people had the power to make her feel safe, if she could only give them what they wanted and needed from her. Based upon intake interview and clinical observations pretreatment, when the client presented to counseling she believed that she had an anger problem. She also described herself as the "identified problem" in her romantic partnership. She reported feeling unaware of her own feelings, and because of this lack of awareness, she could not predict or explain the anger spirals that she reported felt like such a *"problem in my life."* She identified the negative cognition: *"I'm loving you by staying small."* The client presented with a lack of emotional attunement to herself, and suppressed her emotions in order to make energetic and mental space to care for others. The client also reported low satisfaction in her job.

Diagnostic Assessment

A thorough biopsychosocial history was completed prior to EMDR treatment. This was an interview style evaluation conducted in the clinician's office over the course of four sessions. The history included traumatic patterns in Family of Origin,

Intergenerational Patterns of Family Dysfunction, Relationship History, Education, Work History, Medical History, when her gluten and dairy intolerances were identified, Legal History, Substance Use History, Suicidal and Homicidal Ideation screening, and History of Therapeutic Interventions. The Dissociative Experiences Scale, Version 2, (DES II) was also administered after the psychosocial history, with a score of 8.9, to screen for trauma related dissociation prior to utilizing EMDR. An 8.9 is a generally low score, with the average DES II scores in research to be 7.0 in anxiety disorders, and 9.35 as the average score for affective disorders. The client's score was also lower than those for late adolescence (16.6), eating disorders (15.8), schizophrenia (15.4) and borderline personality disorder (19.2) and particularly lower than those with posttraumatic stress disorder (31), or dissociative disorder, not otherwise specified (36), dissociative identity disorder (48). (Carlson & Putnam, 1993)

Much of the initial episode of treatment (September 2018 to October 2019) included an insight building phase about the effects and impacts of the client's early attachment rupture, the physical abuse she received, and the neglect of her parents, including psychoeducation on co-dependency, attachment styles, and assertive communication.

The client's initial diagnosis upon intake was F33.1, Major Depressive Disorder, recurrent, moderate, based on the client's self-reported symptoms. Upon ongoing assessment, the client was given a working diagnosis of Complex Post Traumatic Stress Disorder, due to multiple traumas and neglect patterns in childhood.

The client's self-reported prognosis is good. She reports feeling better able to trust herself, ask herself what she wants and needs, articulate her needs to others, and set boundaries where appropriate. This also included applying for graduate school in a different field than the one she is in currently, and making a choice to move far away from her support system.

Therapeutic Interventions

Compassion Focused Therapy (CFT), Eye Movement Desensitization and Reprocessing (EMDR), and Advanced Integrative Therapy (AIT) were used.

Compassion Focused Therapy is an integrative talk therapy approach that combines Cognitive Behavioral Therapy (CBT), Buddhist Psychology, Evolutionary Psychology and neuroscience to support clients in decreasing levels of shame and self-criticism (Gilbert, 2009). CFT works by challenging deeply rooted negative core beliefs that the client holds, offering psychoeducation on the evolution of shame and self-blame as self-preservation mechanisms in families with relational dysfunction. The client's increased awareness of how she "wired her brain for survival," allowed her to cultivate greater understanding and compassion for the coping strategies that she was currently using at work and in relationships. The client reported that CFT was helpful, and allowed her to bring greater awareness to the evolutionary basis for her trauma responses in present day. The client also identified that using the skills she learned from CFT to challenge her own critical inner voice allowed her to feel greater compassion towards herself.

Eye Movement Desensitization and Reprocessing (EMDR) is a somatic trauma treatment that utilizes the Adaptive Integrative Processing Model (AIP). EMDR is posited to work by allowing the left temporal lobe of the brain to support the desensitization and reprocessing of traumatic memories that are stored in the right temporal lobe. Standard EMDR protocol includes identifying mental images that represent the worst part of a trauma memory, the negative cognition that describes the

client as they picture this memory, the emotions that arise in the presence of the memory, where the disturbance is located in the body, and the subjective units of disturbance or distress (SUDS) for the memory on a scale of 1 to 10. An alternative, positive cognition, or how the client would like to feel about themselves as they picture that memory, is also identified, and the validity of that cognition (VOC). Bilateral stimulation; tactile, auditory or visual, is applied in sets as the client is instructed to allow their mind to take them "where it needs to go" in order to desensitize and reprocess the disturbance and distress associated with the memory. The bilateral stimulation (BLS) for processing trauma memories allows for dual attention awareness, so that the client can keep "one foot in the present, and one foot in the past," (Shapiro, 2001). After the emotional disturbance is desensitized to a 0 SUDS score, the positive cognition is then installed. The term "Memory Channel" is used to designate all the memories that may arise associated with the negative cognition, *"I'm too much."* A Memory Channel is considered complete when the Subjective Units of Distress (SUDS) score is a zero (0), and the Validity of the Positive Cognition (VOC) is a seven (7). This Memory Channel is then defined as 'completed' or 'cleared' in EMDR terminology (Shapiro, 2001).

- Administration of therapeutic intervention:

EMDR Session #1, Session #38, Episode 1 of Treatment Memory: Father spanking her brother, client is 11 or 12yo
Mental Image: Both her father and brother are screaming, *"for very different reasons."* Negative Cognition that Describes Client (NC): "I'm too much."
Positive Cognition to be installed after desensitization and reprocessing (PC): "I'm just right." Validity of Positive Cognition (VOC): 2
Emotions: Fear
Subjective Units of Distress (SUDS): 7 Body Sensations: All over tension, hard to focus in the head.
Clinician Notes: Adding fast bilateral stimulation led an earlier memory to arise, associated with the Negative Cognition (NC): I'm too much. The client was 4 years old, and ran into the room where her mother was comforting her 2 year old brother, who was crying. The client reports *"my brother is crying, I come in super happy, my mom shoots me this withering look and tells me to be quiet."* The client believes that her emotions and exuberance are causing her mother and brother's distress. Session Notes: Bilateral Stimulation. Client reports *"nothing new"* after sets of bilateral stimulation. Staying stuck so that she does not have to feel difficult feelings and emotions. Throat closes up at end of session, recognizes that

this happens a lot at work. What does the client need to do to make it safe for her emotions to come up?
EMDR Session #2, Session #39, Episode 1 of Treatment: Memory: Mother's withering look, telling client to be quiet
Image: "*My response to how pissed mom is."*
NC: *"I'm too much."* PC: *"Who I am is the right amount."*
VOC: 1
Emotions: Resentment, weariness, exhaustion, anger SUDS: 5 Body: Stomach, throat
Session Notes: Making connections in patterns of present-day relationships. Mother's anger, (and) yelling. How could the client have imagined that she was "enough?" More anger, grief, resentment, frustration. Memory channel unfinished.

EMDR Session #3, Session #39, Episode 1 of Treatment: Memory: *"Now it's more complex."*
Image: Mom's face, yelling
NC: *"I'm too much"* PC: *"Who I am is the right amount."*
VOC: 5
Emotions: Sadness, grief, frustration SUDS: 3
Body: Chest, stomach (less strong) Final SUDS: 0 Validity of Positive Cognition: 7 (1-7 scale)
Session Notes: *"I'm too much."* Client finishes memory channel, is also able to

identify that the word dramatic, (which her mother often used to describe her) is a label that an audience puts on a story. The word 'emotional' is varied, and encompasses a lot of other emotional states. Client is not "dramatic," and "emotional isn't a dirty word."
Clinician Notes: Memory channel is finished. Client makes the connection that she often feels like she is "too much" in her current romantic relationship with her partner.

Advanced Integrative Therapy is a somatic trauma treatment modality that involves identifying an Initiating Trauma (IT) statement, the Originating Trauma (OT) statement, and a Connecting Trauma (CT) statement, which is described in the AIT Basics Manual as a "Three Step Transformation" (Clinton, 2019). The client will identify the Subjective Units of Distress (SUDS) on a scale of 0 to 10 for the statement being treated first, which is the OT statement. Client will also identify what area of the body they are experiencing somatic sensations or the location of that distress. With their hand on the identified area of the body, the client will then move their other hand through the dominant energy centers of the body (sometimes described as chakras), starting at the crown, repeating aloud the identified statement, ex. *"When I realized I couldn't make my mother happy, I was devastated, but resolved to keep trying,"* at each center, as the clinician mirrors the client's movements. The energy centers for hand placement are the crown, forehead, chin, throat, center chest, left chest, right chest, solar plexus, belly, pelvis, right hip crease, left hip crease, and root. After a round of desensitization and reprocessing using the AIT protocol, the clinician will assess if the client's SUDS score has decreased. The Originating Trauma (OT) statement will be processed using the AIT protocol until the SUDS score is a 0. After the OT is treated, the Initiating Trauma (IT) is treated with the same protocol. When the Initiating Trauma statement, e.g. *"I feel wound up and squeezed,"* has been desensitized to a 0 SUDS score, the Connecting Trauma (CT) statement is created and then treated, eg. *"Because I couldn't make my mother happy, but resolved to keep trying, today I feel wound up and squeezed."*

The AIT True Origins Process and Earliest Originating Trauma Protocol are directive and]manualized treatment interventions (Clinton, et al, 2014). Clients treat 'reversals,' or deeply rooted core beliefs that may be impediments to treatment efficacy, such as "Someone significant won't like it if I get over my mistrust of self." These statements are desensitized and reprocessed using a procesds similar to the AIT Three Step Protocol. When all blocking beliefs have been treated and cleared, the client and clinician identify what may be the traumatic origins of the identified problem, in the case of this client, her mistrust in herself. When the traumatic origins have been identified, in this client's case ancestral origins, the client and clinician treat a long list of statements in the AIT Manual such as "A true ancestral origin of my mistrust of self is slavery." As evidenced by the insight gained by combining somatic body awareness with the repetition of the identified statement, the AIT True Origins Protocol shows promise for treating ancestral or intergenerational trauma.

Example AIT History Taking, Using Somatic Sensations:
AIT Session, Session #21, Episode 2 of Treatment:
Initiating Trauma: *"I feel wound up and squeezed. I can't relax, can't experience pleasure, don't ever feel like I'm doing enough."*
Body Location: *Squeezed: "*At my belly button*."* This has its roots in prenatal period. *"Be a girl, so that I can have a companion."* Prenatal stress, tension and anxiety. Mother's mother died in April, and the client was born in July. *"My great aunt's son, my mother's cousin, died the November before I was born. The details of this death are murky and nefarious." The client's birth was also difficult for client's mother.* The client reports: *"They sort of bullied/scared her into getting a c-section. It was pretty stressful. They got married and I was born 9 months afterwards. My mom was 28 when she had me. She had not known my dad that long, at all, maybe 1.5 years. For most of that time they were not even living in the same city. It happened quickly because my mom wanted to get married and she wanted to have a baby. My mom also told me from a pretty young age, 'I hoped and prayed for a daughter first, because no matter what happened, I would have someone who would 'GET IT,' which is to say, understand me."* The client describes her own maternal grandmother as *"worked hard, worked a lot, mom wasn't really around. Different relationships with men, some of them were abusive, but my mom talks about what a good mother her mother is."* The client reports feeling *"An enormous sense of pressure, and because there is this sense of pressure, there is RESPONSIBILITY."* Clinician notes this intergenerational trauma with the client's mother and her maternal grandmother.

AIT Session, Session #24, Episode 2 of Treatment:
Originating Trauma Statement: *"When I was in the womb, I felt an enormous sense of pressure to be responsible for my mother's happiness."* Body Location: Belly Button, SUDS: 10, 7, 5, 2, 0. Number of Rounds: 4
Originating Trauma Statement (OT): *"When I was in the womb, I accepted the challenge of being responsible for my mother's happiness."*
Body Location: Heart SUDS: 6, 4, 1, 0. Number of Rounds: 3
OT: *"When I realized I couldn't make my mother happy, I was devastated, but resolved to keep trying."* (Between 2-3 yo).
Body Location: Belly

SUDS: 5, 2, 0
Initiating Trauma Statement: I feel wound up and squeezed.
Body: Belly Button. SUDS: 10, 6, 3, 0. Rounds of AIT: 3
Connecting Trauma Statement: *"Because I felt pressure to be responsible for others' happiness, today I feel wound up and squeezed."*
Body: Solar Plexus.
SUDS: 7, 4. 2, 0. Rounds of AIT: 3 Aspects: *"All my responsibility for others."*
Body: Belly Button SUDS: 10, 5, 1, 0. Rounds of AIT: 3

AIT Session, Session #41, Episode 2 of Treatment:

True Origins Protocol, Transcript:

Statement: "*A true ancestral origin of my mistrust of self is abandonment."* Body: Belly, SUDS: 8, 2, 0. Rounds of AIT: 2 Round 1:
Forehead: "*Tingles in my feet and legs"*
Chin: "*No."* Throat: *"The overarching baggage around using my voice. Emotion: frustration, rearview mirror."* Left Heart: "*Nothing."*
Belly: *"Stomach feels a little tight, it makes noise sometimes if we're moving energy."* Clinician: "What is it trying to say?" Client: *"It feels like an affirmation of this fear of abandonment impacting the decisions I make around health, and food in particular."* Clinician: "So it's almost like your stomach is saying 'this is it.'" Client: *"Right."*
Pelvis: *"Nothing."* Round 2:

Hand at Belly, Hand at Throat: *"Nothing came up in that round."*

True Origins Protocol, Transcript

Statement: *"A true ancestral origin of my mistrust of self is rejection."* Body: Crown, SUDS: 6, 1, 0 Rounds of AIT: 2

Round 1:

Chin: Client: *"I'm feeling like a lot of this fear around judgment has to do with my fears of my peers that I grew up around."*

Clinician: "At the chin is shame and humiliation,"

Client: *"Yeah."*

Pelvis: (New Trauma Memory Arises)

Client: *"There is a specific story that is coming up for me, and it came up when I heard the chin has to do with shame and humiliation. I'm struggling to understand how it connects, but when I was in 1st grade, my friend had a diary, it had naked cherubs in it, we hadn't learned about sex, and organs, but we learned the word boobies, we didn't know what they were in relation to the belly button. At recess, I lifted up my shirt in front of the class, and said "who wants to see my boobies?" I got into so much trouble at school. I KNEW I WAS GOING TO GO HOME AND BE PUNISHED. The way (that) my parents punished me was by making me stand in my driveway for hours without my shirt on. I don't know what the connection is, but it does have a connection with my peers, shame and humiliation, and my parents."*

Clinician: Thank you for sharing that with me. What do you think that kid needed in that memory?

Client: *"The opposite of an extreme reaction. Um, yeah, I think she needed to be told what boobs were, second of all, to just…I don't know, anything reasonable. I don't know what she would have needed. Maybe a conversation about why some people don't like that, or why that wasn't appropriate. There was no conversation like that held, to my memory. In my opinion, that's not something a child should be punished for. That seems super stupid."*

Clinician: "So this is just a curious child, who took an action, and was rejected with no explanation and left to stand alone, shirtless, on their driveway. (pause) How are you doing?"

Client: *"That's a sh***y memory, and it pisses me off, honestly. It makes me sad, but more than that it makes me….I just can't understand it."*

Round 2:

Crown and Pelvis: Client: *"It's a zero."*

Clinician: "You did a lot today."

Client: *"Yeah."*

Clinician: "So it's this practice of being there for yourself."

Follow-up and Outcomes

An adverse and unanticipated event in the client's course of treatment was an interruption in treatment between 2019 and 2020 was related to insurance, and the practice discontinuing taking the client's insurance at that time. The client's brother also relapsed early in their second treatment episode, which caused considerable distress, and increased contact with her mother, which was triggering for the client.

It is the impression of the clinician that the client's ability to tolerate emotional distress, communicate assertively in relationships, and to detach from the desire to please her mother are all significant outcomes in this client's case. The client reports that her increased trust in herself is what allowed her to choose to apply for and be accepted into a graduate program that is not in her current line of work, and to move out of state. The client also identified that boundaries are easier for her to set in romantic relationships and friendships, as well as at work. When asked what changed, she stated: *"AIT, (and) listening to my body. There have been some recent events of not trusting myself, and then I got the result of not getting what I wanted. External validation is not going to make me happy."*

Utilizing subjective units of distress (SUDS) is an evidence-based tool for evaluating progress (Kim et al, 2008) (Tanner, 2012), and the primary tool to assess whether AIT and EMDR are working to desensitize and reprocess trauma memories and transform deeply rooted negative cognitions. Ideo-motor cueing, as well as the client's self-reports were utilized to assess the client's tolerance to AIT. In the case of desensitizing and reprocessing the negative cognition "I'm too much," the client's initial SUDS for this memory was 7 and was desensitized to a 0 over the course of 3 EMDR sessions utilizing bilateral stimulation (BLS). When utilizing AIT with the client it was identified that the decrease in SUDS from a 8-10 to a 0 could take place in a single session, although different aspects of the trauma needed to be treated (eg, Originating Trauma Statement, Initiating Trauma Statement, and Connecting Trauma Statement). The client's second Dissociative Experiences Scale showed an increase from 8.9 in June 2019 to a 14.64 in May 2021. One possible explanation of the higher score may be the client's increased insight into how much trauma related dissociation impacts her life.

Post treatment the client reported a marked increase in her ability to make decisions for herself, to seek support from emotionally available friends, and to trust in her own interpretations of situations without seeking to please others to retain relational safety. The client identified that her emotions do not confuse her anymore, and she is better able to express feelings of anger, without experiencing secondary emotions of shame and guilt for feeling that anger. The client also reports being able to bring mindfulness to traumatic relational patterns that are from childhood, and being better able to disengage from those patterns in present day. The client credits this to a greater emotional awareness, and an inner locus of control. The client's job satisfaction has improved concurrent with her ability to communicate assertively at work. She also applied for, and was accepted to a graduate program out of state. She reported that her trust in herself is what gave her the ability to apply to several programs, and then choose the best one for herself.

She also reported that her interpretation of her symptoms of depression and what it means to her has also shifted significantly. She has identified that unexpressed grief over past traumas (in this lifetime and in her family history) and suppressed emotions were leading her to experience a significant episode of depression after her partner ended their relationship (winter 2018/2019). The client also noted that her low self-worth

and self-blame were exacerbating her symptoms of depression early in treatment. Post treatment it is the clinician's observation that as the client's root traumas were treated, and her insight into the intergenerational patterns of trauma and emotional suppression in her family increased, she was better able to cope with difficult feelings and emotions that she used to aggregate under the label of "depression." The client was able to identify and cope with feelings such as hopelessness, despair, and heartache as results of her early attachment rupture in childhood, without having to label herself as a depressed person, or blame herself for having these difficult feelings. She reports now that she can experience her grief, process her emotions without feeling overwhelmed by them, and that she allows mental space for whatever unconscious material needs to come up.

Patient Perspective

When asked to reflect on her initial presenting symptoms in September of 2018, the client stated: "*I thought that my anger was the way that I dealt with anything. I thought I had an anger problem, and that I was incapable of working through a challenge in my relationship. I very much felt like the struggles to move through challenges, or communicate was 100% my fault. I felt like I was toxic."*

When asked if anger is a present-day symptom in her life, the client reported: "*Well, I wouldn't really categorize the emotion of anger as a symptom today. My truth is that my feelings, or if I'm feeling angry, it makes certain people uncomfortable. I think that has a lot to do with Whiteness. I see my anger as an important messenger of information. I don't actively try to push it down, and I don't feel the amount of shame that I felt around anger three years ago. Even if I do feel shame, I have a completely different understanding of my impulse to label it as shameful. It doesn't feel like this giant problem. My impulse to label that anger as shameful comes from an attempt to stay safe, and stay small, and I have conflated small and safe as the same thing."*

When asked to reflect on her initial presenting symptoms of depression, the client said: "*I remember coming in here, especially in the winter of 2018-2019. I have struggled with depression for most of my life, but I think there had been very few moments when I had been honest with myself about it. I had so much fear that I would never not be a depressed person. That heaviness, that weight, I was afraid it would be that way forever. I was also very depressed at the end of my romantic relationship, and I wasn't getting any support in that relationship, which contributed to me feeling like I was the problem. In the winter, I do experience low energy, sometimes I feel like a different person."*

The client was asked to identify if these symptoms have improved, and she stated: "*I'm still coming to an understanding of it (depression), and accepting it. I can understand being depressed without being mad at myself about being depressed. My orientation to depression has changed. I don't see it as this separate part of me that needs an active solution. It is a very small part of me that needs to be acknowledged and addressed, taken care of, also it's not my entire self. When I say 'taken care of,' I mean carving out space for talking about depression, seeking support for it, and changing some of my daily activities to soften its impact. It feels so much more manageable when I'm just being honest about it. It feels less big when I'm not hiding it."*

Discussion

Strengths: The strengths of this case are the client's commitment to treatment, her interest in treating root traumas, and her willingness to "dive deep," into earlier life events, including family history, and her awareness that past events shape her present-day functioning. The strengths of AIT include its gentleness and thoroughness, as well as the focus of bringing the patterns in originating traumas into the present. Clearing the patterns by treating the connecting trauma statement brings greater insight into behavior patterns for clients, which can be empowering. AIT is especially exciting as it offers a standardized, thorough, and manualized approach to treating ancestral trauma, going back further than one or two generations. This was appealing to this client, who reported that it was painful for her to not know where her ancestors are from (due to the enslavement of African people in the United States 400 years ago).

Limitations: The majority of the improvement in the client's case is documented by client self-report and clinician observation through case notes, and not by using pre and post measures such as the GAD7, PQL5, etc. Further, the client's DES II score increased by 5.75 points, which may make it appear that her trauma related dissociation increased, which is not consistent with her own self-report and the observations of the clinician. Conclusions regarding the effectiveness of AIT cannot be drawn due to the lack of pre and post assessments, and due to the fact that three different modalities (CBT, EMDR and AIT) were utilized over the course of treatment. Client progress was assessed, in part, via the use of SUDs ratings in the EMDR and AIT sessions. Verbal feedback from the client and observations by this clinician regarding the use of AIT were suggestive and positive. Further research on AIT using a stricter methodology and pre & post assessments is recommended. There is currently not a body of literature to support AIT, hence this case report.

Conclusions: The client's expressed goals are the focus of any counseling relationship. The client reports that using AIT has allowed her to become more aware of her body, and how she feels, which has increased her trust in herself. She states *"Embodiment allows me to know whether or not relationships are safe places for me to grow."* The client's self-reported increased insight into how early patterns of relating in her family of origin, and intergenerational patterns of trauma and neglect appears to have given her greater insight into her reactions in present day, allowing her to respond to life situations rather than 'react' from a patterned traumatic response. She reports that AIT has increased her feelings of trust in herself.

In summary, further quantitative and qualitative research into the efficacy of Advanced Integrative Therapy as an evidence-based trauma treatment modality is needed. AIT shows promise in offering a standard, manualized approach to treating Complex Post Traumatic Stress Disorder and treating intergenerational traumas stored in the body of clients in present day. A most salient 'take-away' from this report is the ability of the AIT treatment protocol to treat the expressed needs of the client of "ancestral healing," with a modality that is grounded in theory, somatic body awareness, and energy psychology. This will hopefully further legitimize energy work in clinical practice. It was a further observation from the case that the similarities between AIT and EMDR are significant, with moving hands through the dominant energy centers of the body in AIT taking the place of bilateral stimulation in EMDR, as well as the use of Subjective Units of Distress (SUDS) to assess desensitization and reprocessing of trauma memories. This may be an avenue for future research.

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Bio

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