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The Effectiveness of Advanced Integrative Therapy in Treating Attention Deficit Hyperactivity Disorder: A Preliminary Case Report

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Abstract

With the rapid advancement of technology and social media, research and awareness about the correlation between neurodevelopmental disorders, such as ADHD, and technology use has increased (Steve & Grubb, 2018). The ADHD diagnosis dates back to the 1960s, and due to its more recent origins, psychiatrists, behavioral health, and medical providers have an evolving understanding of the causes, impacts, prognosis, and outcomes of ADHD (Cortese & Coghill, 2018). ADHD is a complex mental health diagnosis due to its high levels of overdiagnosis, misdiagnosis, and under recognition in both children and adults (Montano, 2004). In this case study, Advanced Integrative Therapy (AIT), a novel treatment, was used to treat ADHD symptomatology and the underlying relational trauma related to the client's symptomology. Throughout AIT treatment, the client was simultaneously treating ADHD symptomatology with psychiatric medication. AIT was utilized to assist the client in identifying the functionality of maladaptive intrapersonal patterns such as dissociation, intellectualization, overthinking, anxiety, denial, decision paralysis, and rumination with the goal of supporting the client in reprocessing and treating underlying relational wounds and traumas experienced from their family of origin.

The case study took place over a span of 6 60-minute sessions. The clinician assessed client progress and symptomology using the Adverse Childhood Experiences (ACE) Questionnaire, Resilience Questionnaire, GAD-7 which measures anxiety symptomology, Experiences in Close Relationships-Revised (ECR-R) Questionnaire which examines attachment patterns in relationships, The International Trauma Questionnaire (ITQ) which assess for PTSD/CPTSD symptomology, and Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist which assesses for ADHD symptomatology. After treatment with AIT, the client self-reported that their ADHD symptoms were reduced. Additionally, the client reported that insight building allowed them to manage their symptomatology differently in the present day. The

clinician/client found AIT to be effective at treating maladaptive intrapersonal patterns when traditional talk therapy resulted in a feeling of being stuck by either the client and/or counselor. Use of AIT with clients with ADHD could interrupt the prevalence of ADHD symptomatology by increasing emotional regulation and resilience thus increasing the chances for clients to reduce transmission of intergenerational trauma yielding a reduction/prevention of ACEs. This warrants more research on AIT as a viable treatment intervention for ADHD.

Keywords: ADHD, Advanced Integrative Therapy, Trauma, Case Report, AIT

Introduction

With the advance of technology and social media, there has been increased research and awareness about the correlation between neurodevelopmental disorders, such as ADHD, and the rapid advancement of technology (Steve & Grubb, 2018). ADHD is a fairly new diagnosis, with its origins dating back to the 1960s when it was first recognized by the American Psychiatric Association as "hyperkinetic reaction of childhood" and later as ADHD with or without hyperactivity (Stanborough, 2021). Due to its more recent origin, psychiatrists, behavioral health, and medical providers have an evolving understanding of the origins, impacts, prognosis, and outcomes of ADHD (Cortese & Coghill, 2018). What makes ADHD even more complex is its high level of overdiagnosis, misdiagnosis, and under recognition in both children and adults (Montano, 2004).

Historically, within the United States, the predominant treatment of ADHD is pharmacotherapy provided by a primary care provider and/or psychiatrist (Antshel et al., 2011). However, there are limitations and reluctance by both patients and providers to use this method of treatment. Additionally, pharmacotherapy poses additional barriers such as negative side effects, cost, lengthy evaluation process for adult ADHD, and stigma associated with the diagnosis (Kemppinen et al., 2013). Kemppinen et al. (2013) highlight the complexity in the diagnosis of adult ADHD noting it requires the presence of both current and past symptomatology, the latter often requiring corroboration from a third party such as a parent. Additionally, Montano (2004) states:

"Many primary care physicians have historically been reluctant to prescribe—and some patients may be reluctant to take—a controlled substance that has the potential for abuse, can cause positive drug screen results, and usually needs a new written prescription monthly for each treated patient. The risk of psychostimulant abuse and side effects, such as tics, severe loss of appetite, and insomnia, the inconvenience of multiple daily dosing of psychostimulants, and the high rate of psychiatric comorbidity among patients with ADHD have fueled ongoing research aimed toward alternative pharmacotherapy."

As research and understanding of ADHD continues to advance, experts have begun to discuss multiple origins of ADHD

such as a genetic predisposition as well as early childhood environmental factors including trauma (Nigg, 2012). As providers continue to deepen their knowledge and understanding on the origins of ADHD, they can implement other types of treatment interventions including trauma informed mental health care such as gentle somatic therapies including Advanced Integrative Therapy (AIT).

Brown et al. (2023) state, "Advanced Integrative Therapy (AIT) is a novel therapy grounded in Energy Psychology combined with cognitive and somatic therapy techniques." Advanced Integrative Therapy offers a manualized approach for how to treat traumatic patterns that present as both "present day problems, symptoms, or issues" or what AIT refers to as Initiating Traumas (ITs) as well as "underlying causes of present-day issues often found in the client's childhood" or what AIT refers to as Originating Traumas (OTs) (Clinton, 2019). This case study is unique in that the client and counselor were able to address deeper root traumas that contributed to the client's presenting ADHD symptomatology in the present day. It is noteworthy to mention that the client in this case study was concurrently under the care of a psychiatrist to treat their ADHD symptomatology with pharmacotherapy. Although the pharmacotherapy treated the current symptomatology, this intervention is limited in that it does not address or treat potential underlying causes of the client's ADHD symptomatology. The use of AIT allowed the client and clinician to explore childhood traumas (OTs) related to the client's presenting symptomatology (ITs).

Patient information

The client is a 27-year-old white female. The client started treatment in September 2022 noting that their primary motivation for starting treatment was due to conflict they were experiencing in their romantic relationship, as well as feelings of sadness, anger, and anxiety. The client reported no significant medical concerns, but did identify a previous diagnosis of ADHD and sporadic skin condition outbreaks as a result of increased stress. Prior to ADHD specific AIT treatment, the client was in therapy from September 2022 to September 2023 (39 sessions), receiving care that integrated Relational Cultural Theory interventions, Family Systems Theory interventions, Cognitive Behavioral Therapy interventions, expressive arts interventions, and intermittent AIT, a gentle somatic therapy intervention.

Medical, family, and psychosocial history including relevant genetic information.

When the client entered treatment she stated on her psychosocial assessment that *"I love my parents so much and I had an as good as it gets divorce situation,"* noting that both parents were remarried. The client was 5 years old when her parents got divorced. Throughout the client's initial treatment in therapy, she described a variety of maladaptive relational patterns that were formed as a result of witnessing and

navigating her parents' ongoing interpersonal conflicts prior to their divorce as well as after her parents' divorce. Notable maladaptive intrapersonal patterns include dissociation, intellectualization, overthinking, anxiety, denial, decision paralysis, and rumination. Notable maladaptive interpersonal patterns include people-pleasing tendencies, overfunctioning, and triangulation initiated by her parents.

The client reported having a positive relationship with her mother during childhood, however noting a shift in their relational dynamic during adolescence after her parents' divorce. During treatment, the client reported a specific incident that occurred at 16 years old when her mother kicked her out of the house and told her to go live with her father. Client discussed multiple instances leading up to her mother kicking her out of the house where her mother compared her to her father and made statements such as *"I love you, but I don't like you right now."* The client reported developing an internalized belief that her *"mother doesn't like her father so that means she doesn't like me"* due to these interactions with her mother.

The client reported that her relationship with her mother has further evolved during her ongoing transition into adulthood. The client reported that her mother did remarry. The client reported experiencing a sexual assault when she was in older adolescence after being raped by her stepfather's (mother's current husband) son at a party while in undergraduate school. The client reported sharing details of the sexual assault with her mother after it occurred. During treatment, the counselor noted unresolved betrayal trauma. Freyd (2008) notes that betrayal trauma "occurs when the people or institutions on which a person depends for survival significantly violate that person's trust or wellbeing." The clinician noted the presence of betrayal trauma between the client and her mother upon hearing the paradox described in their relationship with one another. The betrayal trauma was initiated when the client's mother chose to stay in relationship with the client's stepfather (the parent of the client's perpetrator). The client noted her mother *"says she has my back, but still goes to family events where her husband's children are (including the client's perpetrator) and is still married to stepfather."* Through the counselor's support, the client has explored this ongoing dynamic with her mother through AIT and psychodrama informed interventions.

Since the start of treatment, the client briefly discussed her relationship with her father. The client reported mixed messaging from her father in regard to caretaking, noting that her father reinforced caretaking patterns in the client but also made statements such as, *"if you always do what other people want, you will never be happy."* The client reported multiple scenarios when she felt like her parents put her in the middle of their disagreements after their divorce. The client reported her biological father does not know about her sexual assault.

Since the start of treatment, the client briefly discussed her relationship with her step-father (mother's current husband). She did not discuss any interpersonal dynamics in detail, but did report her stepfather knows about her sexual assault as a result of being told by his child (client's reported perpetrator).

Relevant past interventions and their outcomes

In the client's treatment timeline, there were 39 sessions of therapy wherein the clinician worked primarily from a relational cultural theory (RCT) lens. In addition to RCT interventions, the clinician also integrated Family Systems Theory, elements of expressive arts (psychodrama and art therapy techniques), and Advanced Integrative Therapy (AIT). What is notable about the client's AIT treatment prior to the start of the case study is that it focused on initiating traumas (ITs) with a few instances of the clinician treating originating traumas (OTs) and positive instillations.

After the clinician was trained in Advanced Integrative Therapy Basics, and upon discussing AIT with the client, the client expressed interest in using AIT. The first AIT treatment sessions began in March 2023 and the client/clinician completed 9 sessions between March and August 2023. The initial rationale for the use of AIT throughout treatment was to assist the client in identifying the functionality of maladaptive intrapersonal patterns such as dissociation, intellectualization, overthinking, anxiety, denial, decision paralysis, and rumination in order to support the client in reprocessing and treating underlying relational wounds and traumas experienced from the client's family of origin. The clinician found AIT to be effective at treating maladaptive intrapersonal patterns when traditional talk therapy resulted in a feeling of being stuck by either the client and/or counselor. The second round of AIT treatment began in September 2023 and is ongoing up until the time of this writing.

Clinical findings:

It was observed by the clinician in the beginning of treatment that the client suffered from low self-worth and low levels of differentiation within their family system. Additionally, the client struggled to implement self-advocacy skills and engaged in maladaptive people pleasing behaviors in her life in order to maintain relational safety and avoid relational conflicts/barriers. Based upon the client's intake interview, psychosocial assessment, and clinical observations pretreatment, when the client first started treatment, they highlighted relational stressors as the primary motivator for entering therapy. The client's self-identified goals included:

1. Become a better person
2. Heal her trauma (being cheated on by her partner and sexual assault by step-brother)

The client presented with an ability to identify and express emotions. However, the client struggled to emotionally regulate

and identify and communicate her needs within close relationships with family, friends, and her partner. The client presented a consistent pattern of prioritizing the needs of others over her own. When faced with a difficult situation and/or emotion that was dysregulating, the client experienced high levels of decision paralysis and often requested the clinician to make her decisions for her. At the start of treatment, the client reported, *"I love my parents so much. I am super super close with my two real sisters, I talk to them every day. On my father's side I have a half brother and we are semi close, he is 15, and two step siblings who we are kinda close but not really. On my mother's side I have two step brothers. I am not close with either one of them, though I used to be."*

Timeline

Prior to ADHD focused AIT treatment, the client was in therapy for 12 months (39 sessions) with the clinician receiving therapy that integrated Relational Cultural Theory (RCT) interventions, Family Systems Theory interventions, Cognitive Behavioral Therapy interventions, expressive arts interventions (primarily psychodrama techniques), somatic therapy interventions, and intermittent AIT.

Diagnostic Assessment

A thorough psychosocial history was completed prior to the start of treatment. This was a written self-evaluation conducted prior to the client's intake session. The history included current social information (presenting problems, goals, living situation, environmental factors, social supports, significant relationships), family history (history of mental illness, cultural identity, sexual history, history of abuse), spiritual/religious history, substance use/abuse, educational history, employment and financial history, activities of daily living, medical history, and a risk assessment (history of suicidality/homicidality). The client's initial provisional diagnosis upon intake was F43.20 - Adjustment disorder, unspecified based on the client's self-reported symptoms and reason for starting counseling as a result of ongoing relational issues with the partner. Upon intake, the client reported an additional diagnosis of ADHD by a psychiatrist.

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Prior to the 6 sessions of ADHD focused AIT treatment, the clinician issued 6 pre-assessments. Pre-treatment measures were selected to assess the effectiveness of AIT on ADHD Symptoms. Adverse Childhood Experiences (ACE) Questionnaire, Resilience Questionnaire, GAD-7, Experiences in Close Relationships-Revised (ECR-R) Questionnaire, The International Trauma Questionnaire (ITQ), and Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist. The client self-reported an ACE score of 2 and resilience score of 14. The clinician administered the GAD-7 to assess for the presence of generalized anxiety symptomatology. In the pre-assessment, the client scored 0 and reported "not difficult at all" for

symptomology making it difficult for her to do work, take care of things at home, or get along with other people. This score did not indicate the presence of GAD prior to ADHD focused AIT. The clinician administered The Experiences in Close Relationships-Revised (ECR-R) Questionnaire. "The ECR-R measures individuals on two subscales of attachment: Avoidance and Anxiety. In general, Avoidant individuals find discomfort with intimacy and [desk]-? independence, whereas Anxious individuals tend to fear rejection and abandonment (Fraley el al. 2000)." On the pre-assessment, the client had an anxiety score of 1.67 and an avoidance score of 1.11 showing higher levels of anxiety than avoidance. The clinician administered The International Trauma Questionnaire (ITQ) which assessed for PTSD and/or CPTSD as a result of the client's reported sexual assault occurring during their later adolescence (5-10 years prior to starting treatment). The pre-assessment scores showed 1). Reexperiencing criteria not met 2). Avoidance criteria met 3). Sense of current threat criteria met and 4). Criteria for PTSD or CPTSD not met. Finally, the clinician administered the Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist. In the pre-assessment, the client checked 3 grey boxes in part A and 5 grey boxes in part B. Based on the pre-assessment outcomes, the presence of ADHD symptoms were the most clinically significant issues reported by the client prior to ADHD focused AIT treatment.

Diagnostic challenges

One significant diagnostic challenge is that self-reporting screening tools are more susceptible to responses based upon social desirability, or the 'right response.'

Therapeutic interventions

Prior to ADHD focused AIT treatment, the client was in therapy for 12 months (39 sessions) receiving care that integrated Relational Cultural Theory (RCT) interventions, Family Systems Theory interventions, Cognitive Behavioral Therapy interventions, expressive arts interventions (primarily psychodrama techniques), somatic therapy interventions, and intermittent AIT. RCT was and is the primary theoretical framework from which the clinician administered treatment.

Relational Cultural Theory (RCT) was developed in 1976 by Jean Baker Miller to create an inclusive theoretical framework for populations such as "women and persons in other devalued cultural groups" that were often overlooked in earlier clinical mental health theoretical frameworks (Comstock et al., 2018). RCT aims to support clients in increasing insight about their relational patterns, increasing their ability to differentiate between adaptive vs maladaptive patterns, identifying relational barriers and conflicts, and supporting the client in learning and practicing adaptive relational patterns. Healing occurs when clients experience "mutually empathic and growth-fostering relationships" first within the therapeutic relationship and then within

relationships outside of clinical settings (Comstock et al., 2018).

Family Systems Theory is rooted in the premise that maladaptive patterns and behaviors (physiological and psychosocial) are formed in response to anxiety that is present within all family systems. Family systems theory aims to assist clients in increasing their "awareness of how the emotional system functions" and recentering the focus on self rather than others to support clients in increasing their levels of differentiation from family members and the family system as a whole (Brown, 1999).

This was a previous client who consented to a case study utilizing AIT only. "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; Pace, 2021)."

Upon identifying an IT, OT, or CT, the client identifies the intensity of the statement on a scale of 0 to 10. The client's rating is assessed for accuracy through a process called muscle testing (Jensen et al., 2014). Next, the client identifies a stationary hand that functions as an energetic anchor while the statement is being treated. The stationary hand is correlated to what AIT refers to as an "energy center" but what other modalities may refer to as "chakras" (Pace, 2021). Once the energy center is located for a stationary hand, one hand is placed on the identified energy center while the client's other hand moves sequentially through all of the 13 energy centers of the body from top to bottom (crown, forehead, chin, throat, center heart, left heart, right heart, solar plexus, navel, pelvis, left hip crease, right hip crease, root). At each energy center, the identified statement is repeated. A client completes a round of treatment once the statement has been repeated while placing their hand on each of the 13 energy centers of the body. At the end of each round, the client rates the intensity of the statement on a scale of 0 to 10 and the client's self-report is confirmed through kinesiology style manual muscle testing, also referred to as kMMT. A statement is considered to be desensitized once the client reaches a rating of 0. A full treatment cycle involves a full "three step transformation" which includes utilizing this process with at least one IT, one OT, and one CT (Clinton, 2019).

In addition to the three-step transformation process, AIT also offers a manualized process to "instill positive qualities (at any time) (Clinton, 2019)." In the AIT Basics Manual, Clinton (2019) states that this process is implemented:

1. "When a client needs strengthening during the treatment of a difficult trauma
2. When a major thematic piece has been completed
3. Any time you feel a client's ego needs strengthening"

The installation process works similarly to the three-step transformation

process except that the client typically starts with an intensity rating closer to 0 with the goal of increasing the intensity to 10 instead of reducing it to 0. Additionally, there is no stationary hand needed when completing installations. During installations, the client repeats the identified statement at each energy center and moves their hands through 12 energy centers (root, pelvis, naval, solar plexus, center heart, left heart, right heart, throat, chin, forehead, crown) instead of 13 and moves from the root to the crown instead of from the crown to the root. At the end of each round, the client rates the intensity of the statement on a scale of 0 to 10 and the client's rating is assessed for accuracy through muscle testing. A statement is considered to be instilled once the client reaches a rating of 10.

A summary of treatment statements can be seen in the table below:

9/7/23 Session 1

AIT Session, Session #40, Episode 1 of Treatment:
Pre Assessments completed: ● ACE Questionnaire ● Resilience Questionnaire ● GAD-7 ● ARSR-v1.1 ● ECR-R ● ITQ AIT Covenant completed

9/14/23 Session 2

AIT Session, Session #41, Episode 2 of Treatment:
Initiating Trauma 1: All the times and ways I feel restless, fidget, and move my legs Intensity: 10, 3 Stationary hand: heart Number of rounds: 2 Other notes: ● added in eyes as an additional energy center ● IT 1 was modified to: All the times and ways I feel restless, fidget, and move my legs and head (daydreaming) for round 2 of treatment IT 1 what came up round 1: ● Kept wanting to say "head" in place of legs ● Fidget the most when she's bored and thinks "you should really pay attention to this" and brain says "no this isn't interesting so we're not going to pay attention" ○ Inattentive when she classifies in her brain as "not important" even if it is objectively important

    - Could be actively telling herself to pay attention but if it's not in the category of "(client's name) important", she won't pay attention
- Doesn't notice fidgeting until someone points it out
    - When she gets called out, it's annoying to her
    - Tries not to be distracting to other people, so when people say something to her, it annoys her

IT 1 (modified) what came up round 2:

- Moving feet instead of legs
- Can't get statement right until she gets past mid point of her body
    - Makes her frustrated at herself that she couldn't get it right
- If there is no deadline and she's not interested in doing a task, it's hard for her to do it
    - Even if she is interested in doing it she can't if she doesn't have a deadline/accountability

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Initiating Trauma 2: all the times and ways I feel frustrated at myself because I can't get the statement right
Intensity: between 5-7, 0
Stationary hand: throat
Number of rounds: 1
Other notes: Added in eyes again
What came up round 1:

- Reminded her of toxic culture at former place of employment & frustration she felt at herself for not being able to remember details right after submitting a project & boss would call her up and ask her
- Has to write everything down to remember it at her current job; otherwise she can't remember it
- Annoying that she remembers things that are interesting but not important, but not details

9/21/23

AIT Session, Session #42, Episode 3 of Treatment:

Initiating Trauma 1: all the times and ways I dissociate by daydreaming
Intensity: 5, 0
Stationary hand: forehead
Number of rounds: 1
Other notes:

- Added in eyes as an additional point

IT 1 what came up round 1:

- Gets songs stuck in her head → wonder if that's a way she dissociates
- In her mind, daydreaming is good
    - Brings feeling of relaxation (same as feeling of being on the beach)
- If she's at the treadmill at the gym
    - When she gets bored she starts to daydream to stop thinking about it

- Dissociated during treating statement
- Daydreaming related to school
    - Hated school and wasn't really good at it, bored

Originating Trauma 1: All the times and ways I felt disrespected, belittled, disregarded and abandoned by my parents and teachers for not understanding me
Intensity: 7-8, 0
Stationary hand: heart
Number of rounds: 1
What came up round 1:

- Always annoyed as a kid because people would always say "you're so sensitive"
    - In her head always asked her "why is it a bad thing that I'm in touch with my feelings"
- When you stop caring if people understand you is when you're the happiest
    - Certain people (people she cares about) she wants to understand her and that's why she overcommunicates

9/28/23

AIT Session, Session #43, Episode 4 of Treatment:

Originating Trauma 2: All the times and ways I dissociated when I felt disrespected, belittled, disregarded and abandoned by my parents and teachers for not understanding me
Intensity: between 5-7, 5
Stationary hand: heart
Number of rounds: 2
Other notes:

- OT 2 was revised after round 1 to: All the times and ways I dissociated and dysregulated when I felt disrespected, belittled, disregarded and abandoned by my parents and teachers for not understanding me
- Stationary hand moved to solar plexus after round 1

OT 2 what came up round 1:

- Seeing yellow
    - Crown & solar plexus
- Heart: no words could come out → mind went blank
- Thought about 4th grade class & teacher

OT 2 what came up round 2:

- Wrote it down before treating it to see if it would help it stick
    - Said it 2x with hand on solar plexus
- Mind was fighting her (especially when she got to heart/solar plexus area)
    - You need to stop and tell Oriel this thought right now, otherwise you won't remember it
    - Reminded herself "you're strong enough to do this"
- Likes to sit on the floor crisscross but feels like she can't release energy until legs are straight

- Easier when she gets past core
- With breath she felt like she had to force it out
- Brought up sadness
- Story popped into her head
    - Teacher from HS and parent teacher conference and got mad at her for asking a lot of questions

10/3/23

AIT Session, Session #44, Episode 5 of Treatment:
Connecting Statement (CT) 1: Because I had to dissociate and dysregulate when I felt disrespected, belittled, disregarded, and abandoned then, I have to dissociate and dysregulate when I feel disrespected, belittled, disregarded, and abandoned now Intensity: 5 Stationary hand: crown Number of rounds: 1 CT what came up round 1: ● Chest: felt like she had to stop and tell her what she was thinking immediately ○ When she pushes out her breath, it's releasing tired & brings about gratitude ● At the top, felt more true, at the bottom half, felt less true ● Feels better ○ Chest feels lighter
Connecting Statement (CT) 2: Because I had to dissociate and dysregulate then, I feel restless, fidget, and move my legs, hands/arms, and head, and daydream now. Intensity: 7, 3-5, 3, 0 Stationary hand: eyes, legs, forehead Number of rounds: 3 Other notes: ● Stationary hand moved to a different location prior to each round of treatment What came up round 1: ● Felt relieved when she added in daydream ● Head kept trying to wander off & think about other random things ● Wants to add in legs ● Annoyed she took so long to get to AIT today ○ Annoyed she used it as a way to delay AIT What came up round 2: ● Felt restless until she got to her legs ○ When she got to her legs she got down to a 3 ● Feels really awkward when people apologize to her ○ Popped up when she apologized to Asia ○ Conflict avoidance response ● Able to ask for reassurance from me What came up round 3:

● By the time she got to her head she felt clarity and didn’t feel like she needed to do it anymore ● Stopped fidgeting by end of statement

10/12/23

AIT Session, Session #45, Episode 6 of Treatment:
Instillation 1: It’s ok to be still and relax Intensity: 6, 8-9, 0 (neutral) Stationary hand: heart Number of rounds: 2 What came up round 1: ● Imagined breath filling up in place of smiley face in her head ● Made her think of hibernation time (fall candle smells) → more relaxing time of year ● Wanted to put her hands on her cheeks What came round 2: ● Picked herself sitting on her couch on a weekend with a blanket crisscross & chilling ● Breathing in/out made her feel more and more comfortable in the spot on the couch ● Bought a lumbar support for herself
Installation 2: It’s ok to be ok with being uncomfortable Intensity: 3, 5-6, 7-8 Stationary hand: heart Number of rounds: 3 What came up round 1: ● Felt harder → hard to remember ● Saw yellow ○ Muscle tested this is the color i see when i’m uncomfortable What came up round 2: ● When uncomfortable in situations with people she knows, it’s ok ● When uncomfortable in situations where she doesn’t know people, she’s scrambling ● It’s fine to be uncomfortable when she’s safe ● Feeling: between 7-8 What came up round 3: ● One part of her is always going to wish she was comfortable ● Last round started at solar plexus ● Stopped at 8ish ● Psycho ed around white right to comfort ● Muscle tested to stop where she was and come back to it later to unpack what else is around that

Follow up and outcomes Upon completion of the 6 sessions of ADHD focused AIT treatment, the clinician

issued 6 post-assessments: Adverse Childhood Experiences (ACE) Questionnaire, Resilience Questionnaire, GAD-7, Experiences in Close Relationships-Revised (ECR-R) Questionnaire, The International Trauma Questionnaire (ITQ), and Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist. The client self-reported an ACE score of 1 and resilience score of 13. Both scores decreased by one point from the pre to the post assessment. The clinician administered the GAD-7 and the client scored 0 and reported "somewhat difficult" for symptomology, making it difficult for her to do work, take care of things at home, or get along with other people. The clinician attributed the change in difficulty score to the client's increased awareness of their anxiety due to treating multiple OTs during the AIT treatment. The clinician administered The Experiences in Close Relationships-Revised (ECR-R) Questionnaire and on the post-assessment, the client had an anxiety score of 1.389 and an avoidance score of 1.39. These shows indicate anxiety decreased by 0.281 and avoidance increased by 0.28 and showed that contrary to the pre-assessment, the client showed higher levels of avoidance than anxiety.

The clinician administered The International Trauma Questionnaire (ITQ) which assessed for PTSD and/or CPTSD as a result of the client's reported sexual assault occurring during their later adolescence (5-10 years prior to starting treatment). The post-assessment scores were consistent with the pre-assessment scores which showed 1. Reexperiencing criteria not met 2, Avoidance criteria met 3. Sense of current threat criteria met and 4. Criteria for PTSD or CPTSD not met. Finally, the clinician administered the Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist. In the post-assessment, the client checked one grey box in part A and 6 grey boxes in part B. Based on the post-assessment outcomes, The client's self-report of ADHD symptoms was reduced. Additionally, insight building allowed them to manage their symptomatology differently in the present day. This warrants more research on AIT as a viable treatment intervention for ADHD.

After identifying current ADHD symptomatology through the use of DSM criteria, the clinician requested the client to rate their restlessness, fidgeting, and moving legs and head (includes daydreaming) at the same time at the end of each day using the scale below. The clinician encouraged the client to make any other notes that they would like to share with them on the calendar. The client started self-reporting on 9/14/23, after completion of session 2.

Rating Scale

1	2	3	4	5
Never	Rarely	Sometimes	Often	Very often

Below is the client's self-reported symptomatology:

Day/session	Rating
Day 1/Session 1	No rating given
2	No rating given
3	No rating given
4	No rating given
5	No rating given
6	No rating given
7	No rating given
Day 8/Session 2	**5 very often**
9	**3 sometimes**
10	**2 rarely**
11	**2 rarely**
12	**3 sometimes**
13	**4 often**
14	**5 very often**
Day 15/Session 3	**3.5**
16	**3**
17	**2**
18	**3**
19	**3**
20	**4**
21	**5**
Day 22/Session 4	**3.5**
23	**2**
24	**2**
25	**3**
26	**3**
Day 27/Session 5	**3.5**
28	**4**
29	**4**
30	**3**
31	**1**
32	**2**
33	**3**
34	**2**
35	**2**
Day 36/Session 6	**2**

Discussion

Strengths: The strengths of this case study are the client's commitment to treatment and their willingness and curiosity in identifying underlying traumas related to their present-day symptomatology. Additionally, the client was open and willing to engage in treatment for AIT statements regardless of their emotional weight or intensity. The

strengths of AIT are that it addresses both present and past traumatic patterns and experiences. The client stated on multiple occasions that she would not have made the connections between their present and past traumas on their own or through traditional talk therapy had AIT not been used in session. AIT allowed the client and clinician to streamline the treatment process of moving from present to past traumas by having a manualized method to bypass maladaptive intrapersonal patterns (dissociation, intellectualization, overthinking, anxiety, denial, decision paralysis, and rumination) that historically have delayed trauma treatment by requiring client/counselor to focus on present traumas instead of moving into past underlying relational wounds/traumas.

An additional strength of the AIT method is that the clinician was trained in AIT basics protocol, the first level of training for AIT. This indicates that clinicians can effectively support clients in working through trauma without having to take advanced training or seminars in AIT.

Finally, the clinician used multiple pre-assessment measures which allowed them to rule out co-occurring diagnoses and/or symptomatology and also allowed them to identify and focus on the primary presenting diagnosis and symptomology of ADHD.

Limitations: The assessment utilized by the clinician, Adult ADHD Self-Report Scale (ARSR-v1.1) Symptom checklist, is a self-report checklist that does not provide a numerical value. In utilizing this measure, the clinician was able to confirm the presence of ADHD symptomatology before/after treatment and note a decrease in symptom intensity before/after treatment. However, there is no way to quantify the exact value of symptomatology prior to and post treatment using this measure. Further, the client's GAD-7 score remained the same, but the client indicated an increase in anxiety impacting their ability to do work, take care of things at home, or get along with other people. The clinician attributed the change in difficulty score to the client's increased awareness of their anxiety due to treating multiple OTs during the AIT treatment. However, more research would need to be conducted to further determine the reasons for this increase. The clinician also noted a change in client scores on The Experiences in Close Relationships-Revised (ECR-R) Questionnaire from the pre to the post-assessment. Anxiety decreased by 0.281 and avoidance increased by 0.28 and showed that contrary to the pre-assessment, the client showed higher levels of avoidance than anxiety post treatment. It is beyond the scope of this paper to explain this change. Further research on AIT using a stricter methodology and pre & post assessments for Adult ADHD symptomatology is recommended. There is currently not a body of literature to support AIT or ADHD specific AIT treatment, hence this case report.

Conclusions

The client's expressed goals at the start of treatment were to 1). Become a

better person and 2). Heal their trauma. The clinician's guiding theoretical frameworks (AIT and RCT) both suggest that present day traumas or maladaptive relational patterns can be healed by identifying and healing root traumas and working through relational barriers. Through the use of both of these modalities, the client and clinician were able to identify and heal the client's underlying trauma related to their present-day ADHD symptomatology and thus support the client in working towards their self-identified treatment goals. As the client stated post session 6, she *"feels like she's learning so much more about herself than before."* AIT made her *"more in tune/aware with her feelings, thoughts, and being present in her body."* The client stated *"AIT makes her feel a lot more brave than she would otherwise feel using another modality,"* as evidenced by the client reporting her boss to HR, which she may not have otherwise done prior to treating root traumas. The client also stated she *"had so much insight about herself using this modality."*

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 Adult ADHD symptomatology by identifying and treating underlying traumas related to present symptomatology. A key takeaway from this report is the ability of the AIT treatment protocol to allow the client to increase their insight about and heal the relationship between past relational wounds/traumas and their ADHD symptomatology that they would not have otherwise made without the use of this modality. Research indicates a correlation between childhood trauma and ADHD symptomatology; however, psychiatric care and med management are still the primary treatment modality for this diagnosis and research about trauma informed treatment modalities is limited. This may be an avenue for further research

Informed consent

The patient's written informed consent is on file.

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