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Research Study

Efficacy of a brief group intervention from Advanced Integrative Therapy (AIT) in female survivors of intimate partner violence with post-traumatic stress disorder (PTSD): A Pilot Cohort Case Study.

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Abstract

Objective: This pilot cohort case study evaluates the empirical efficacy of a brief trauma-focused group intervention based on Advanced Integrative Therapy (AIT) to help women survivors of intimate partner violence (IPV) suffering from posttraumatic stress disorder (PTSD) and dissociative symptoms.

Methods: The research employed an intragroup design with pre- and post-treatment measurements taken before and two months after the intervention. The sample consisted of 12 women, all of whom had experienced IPV and clinical symptoms of PTSD. The Revised PTSD Symptom Severity Scale-Revised (EGS-R) served as the assessment instrument. The group

treatment consisted of 15 structured sessions, organized into four core components and two integrative elements.

Results: Post-treatment assessments indicated a significant reduction in all DSM-5 criteria subgroups, with 91.66% of participants moving out of the clinical category.

Conclusions: This case study provides compelling evidence supporting the efficacy of group AIT treatment in alleviating PTSD and associated dissociative symptoms among female IPV survivors. As more evidence on AIT accumulates, exploring its potential applicability in public institutions and nongovernmental organizations is warranted**.**

Keywords: Intimate partner violence, somatic and energetic therapies, group intervention, Advanced Integrative Therapy, Post Traumatic Stress Disorder (PTSD)

Introduction

Numerous investigations have shown that women survivors of intimate partner violence (IPV) suffer severe physical and psychological consequences that affect their lives, family, and society (Aguirre et al., 2010; Lozano et al., 2017; Méndez et al., 2022). For this study, we define IPV as a pattern of behaviors that encompasses physical, sexual, or psychological abuse used by a man in an intimate relationship with a woman, aimed at maintaining control and domination.

Violence can generate a wide variety of symptoms and constitutes a risk factor for the development of various disorders such as post-traumatic stress disorder (PTSD), depression, anxiety, and eating and sleeping disorders (Matud et al., 2005; Pico-Alfonso, 2005; Mazza et al., 2021). In addition, dysfunctional thoughts about self, the world, and others occur that predict a higher prevalence of PTSD, depression,

and anxiety (Taylor, Magnusem, & Amundson, 2001; Karakurt et al., 2014; O'Neill & Kerig, 2000).

Extensive studies have established a significant relationship between IPV and the diagnosis of PTSD and depressive disorders (Sabri, 2021; Rincón et al., 2004). PTSD resulting from IPV presents unique characteristics due to the repetitive and constant nature of the aggression, which often occurs in domestic or intimate settings (Birkley et al., 2016).This situation subjects women to chronic and long-term stress, affecting their normal life development, and may alter the nervous system and metabolism, including dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and cortisol levels (Daskalakis et al., 2013; Romero-Martinez et al., 2019).

Cognitive behavioral therapy (CBT), rational emotive behavioral therapy (RET), contextual therapies, and compassion-focused group therapy (CFGT) are empirically supported approaches for working with IPV survivors. Vaca-Ferrer et al. (2021) highlight these therapies for their efficacy in treating emotional consequences. Keynejad, Hanlon, and Howard (2020) and Felix-Montes et al. (2020) support these findings, emphasizing the importance of addressing both emotional and cognitive symptoms. Naismith et al. (2020) provide additional support for these approaches, especially CFT, which focuses on reducing self-criticism and increasing self-compassion, critical aspects of recovery.

However, many approaches only address the effects of violence without addressing the root causes of trauma and the emotional charge that remains stuck in the body and nervous system. These complex dimensions require therapeutic interventions that simultaneously address the psychological, emotional and somatic aspects of trauma, which justifies the need to explore integrative approaches such as Advanced Integrative Therapy (AIT).

Theoretical framework

When a traumatic event is experienced, processing may not be integrated correctly, becoming locked in the nervous system (NS). These unprocessed memories may be automatically reactivated beyond consciousness to similar stimuli, causing the original reactions to become dysfunctional coping strategies, resulting in symptoms and disorders.

Evidence shows that successful recovery from trauma depends on the regulation of the hypothalamic-pituitary-adrenal (HPA) axis and the autonomic nervous system (ANS) through increased availability of Brain Derived Neurotrophic Factor (BDNF) (Lawrence & Manning, 1999; Zarate et al., 2014). This neurotrophic factor promotes neuronal survival, development and function, essential for brain health and resilience in trauma recovery. Porges (2009) demonstrated that extreme stress or fear without escape can cause bodily or mental mutism, leading to traumatic dissociation.

Interventions targeting the NS could improve emotional regulation, cognitive function and overall mental health. Working with the body releases trapped emotions and unlocks physical responses registered in the NS. Energy psychology techniques, such as Emotional Freedom Therapy (EFT) and Mental Field Therapy (MFT), aim to release energetic blockages to alleviate symptoms of trauma and anxiety.

Although relatively new, energy psychology has shown promising results in relieving traumatic symptoms and memories (Feinstein, 2022). Advanced Integrative Therapy (AIT), created by Asha Clinton in 1990, is a transpersonal, energetic somatic psychotherapeutic model. While EFT uses manual touch on specific body points to reduce arousal, AIT stimulates the sympathetic and parasympathetic ganglionic chain in the NS.

AIT focuses on reprocessing unresolved traumatic material through dual pathways: somatic reprocessing with manual ganglionic chain stimulation and language use

to evoke complex trauma memory networks. This dual activation serves multiple purposes:

- Reactivating sensory and emotional experiences linked to trauma to release pending allostatic charge.
- Providing a self-regulation mode that safely avoids re-victimization.
- Anchoring individuals in the present while evoking sensory elements of trauma.

AIT constantly regulates the NS through various techniques before and after reprocessing work. Specific exercises, brain movements, and acupressure on neurovascular and lymphatic points stimulate the vagus nerve, regulating the NS and facilitating blocked trauma release.

Treatment efficacy is assessed using a subjective distress rating scale (0-10) and applied kinesiology techniques. Recent research has demonstrated the efficacy of AIT in the treatment of complex PTSD and intergenerational trauma (Brown et al., 2022; Weaver, 2021; Pace, 2021). A comparative study also demonstrated the benefits of AIT over EFT in reducing negative emotions associated with memories (Brown et al., 2023).

The main objective of this study is to evaluate the efficacy of a psychological intervention program for female IPV victims presenting with clinical symptoms of PTSD. We hypothesize that focusing on trauma, especially incorporating bodywork and NS as in AIT, will significantly improve PTSD symptoms. We will analyze the clinical significance of post-treatment changes and their maintenance up to two months, expecting an improvement in clinical symptoms associated with PTSD following group treatment of AIT trauma.

Method

Participants

This study involved 12 women from rural northern Morazán, El Salvador, an impoverished region. Participants ranged in age from 29 to 70 years, and half of them had suffered systematic violence for more than six

years. Nine participants had fled their homes without support. All met DSM-5 criteria for PTSD, with a score ≥ 16 on the Posttraumatic Stress Disorder Symptom Severity Scale (PTSD-R).

Recruitment was facilitated by the Women's Network in Morazán, a local gender rights support organization, which connected researchers with IPV survivors through community support programs. Of the 25 women initially contacted, 12 met the inclusion criteria and agreed to participate.

Inclusion criteria:

- Female, 18 years or older
- Experience of IPV by a male intimate partner for at least 1 year
- Signed informed consent
- Presenting posttraumatic symptoms according to the EGS-R

Exclusion criteria included concurrent psychotherapy and clinical diagnosis of other mental disorders.

Participants completed a demographic survey and a questionnaire about their experiences of violence. The EGS-R was used to assess PTSD symptoms, which fit DSM-5 criteria, including re-experiencing, avoidance, negative cognitions and mood, and arousal.

Survivor-centered and trauma-informed approaches were employed in this study to ensure the safety and well-being of participants throughout the research process.

Table 1

Description of the sample according to age groups, schooling level, type of abuse and duration of abuse

Instruments

The Revised Posttraumatic Stress Disorder Symptom Severity Scale-Revised (EGS-R) (Echeburúa et al., 2016) was used to assess treatment-induced changes. This hetero-applied scale assesses PTSD symptoms according to DSM-5 criteria and was chosen for its validation with IPV survivors and Spanish language availability. It demonstrates strong psychometric properties with a diagnostic efficacy of 82.48%.

The EGS-R consists of 21 items rated on a Likert scale of 0-3, which assess the duration and intensity of symptoms during the last month. It covers four symptom groups:

- Reexperiencing (5 items, range 0-15)
- Behavioral/cognitive avoidance (3 items, range 0-9)
- Negative alterations in cognition and mood (7 items, range 0-21)
- Psychophysiological reactivity (6 items, range 0-18)

The global scale ranges from 0 to 63 points

Additionally, the EGS-R includes four items assessing dissociative symptoms and six items evaluating everyday dysfunction. A global cut-off point ≥ 20 and partial cut-off points ≥ 3, 3, 5, and 5 for the respective subscales were established for diagnostic efficiency.

The scale was administered orally by the same professional before treatment and two months post-intervention to ensure consistency and address potential language comprehension issues. A semi-structured interview supplemented the EGS-R to assess the type, duration, and life consequences of experienced violence

Design

The study was based on the therapeutic model developed by AIT. It consisted of 15 sessions, each lasting approximately 2.5 hours, totaling 37.5 hours of treatment. The entire process was designed and implemented by a team of three female therapists certified by the AIT Institute, all of whom have professional experience in treating IPV.

The treatment structure included four main components and two cross-cutting components:

- **Psychoeducational component:** This component aims to help participants understand the effects of violence on the NS and learn how AIT works (three sessions).
- **Ego-strengthening component:** This component focuses on restoring the integration between the unconscious and conscious mind-body, which trauma can

weaken. Participants learn to regulate their body by identifying, creating and practicing a list of resources to reduce arousal (two sessions).

- **Trauma Reprocessing Component:** This component begins the process of addressing traumatic memories using the AIT model. Traumatic events are introduced gradually, with therapeutic work focusing on dual processing to trigger low-level ANS activation, thus unblocking or releasing the traumatic charge stored in the NS and body (seven sessions).
- **Cognitive resignification component:** This component addresses distorted beliefs held by the trauma and protective mechanisms. In the last session, participants focus on maintaining therapeutic gains, managing stress levels, and exploring future directions after the trauma (three session**s).**

The two **cross-cutting components** were:

- **Peer Bonding**: Strengthening and restoring healthy connections among participants.
- **Ancestral Component**: Incorporating a spiritual context for healing and support

This structured approach aims to provide a comprehensive therapeutic experience, addressing both psychological and somatic aspects of trauma recovery.

Table 2

Structure of main components of the program with brief group AIT treatment.

Results

Pre-Test Phase

The 12 women in the study exhibited PTSD scores consistent with a clinical population, with overall scores meeting DSM-5 criteria. Specifically, 25% of the sample (n = 3) scored above the established

threshold of +15 points/20, indicating severe PTSD symptoms. Additionally, three participants scored +5 points/20, reflecting a medium-high degree of severity. In total, nearly 50% of the sample (n = 6) fell into the medium-high or severe PTSD discomfort range, while the remaining participants were classified as experiencing mild symptoms. However, it is important to acknowledge the significant distress that these symptoms cause in their lives.

In semi-structured interviews, 91.66% of participants (n = 11) reported experiencing abuse during childhood. When assessing the impact of IPV on their lives, most women indicated that their lives were considerably affected (mean score = "a lot"), with an overall impact score approaching the maximum possible range (mean = 32/36). The family domain was identified as the most affected area (mean = 22/36).

Examining individual subscales revealed that many women scored significantly above the established cut-off points. Specifically:

- In the re-experiencing subscale, scores exceeded double the cut-off point.
- A similar trend was observed in the avoidance subscale.
- In the alterations in cognition and mood subscale, only one participant scored below the cut-off point (4/5), although she indicated experiencing symptoms on four of the seven items.
- In the psychophysiological activation subscale, two women scored below the cut-off point (n = 3), with one rating three items as low intensity and another rating one item as high intensity.
- On the dissociative symptom's subscale, over half of the participants tested positive for dissociation, with only 33.33% (n = 4) scoring negative. Among those who tested positive, 16.66% (n = 2) had notably high scores (≥ 6), suggesting a more severe impact

and greater difficulty being present in their lives due to trauma.

The most frequently reported dissociative symptom was related to not remembering violent events, indicating dissociative amnesia associated with trauma; seven women acknowledged this symptom, with five reporting it is occurring frequently.

Among the highest-scoring items within each subscale:

- In the re-experiencing scale, item 4 received a mean score of 23/36, indicating significant distress when recalling traumatic experiences. Item 1, referring to intrusive flashbacks, also scored highly at 22/26.
- In the avoidance scale, item 7 scored highest at 27/36, indicating that women actively worked to suppress memories to avoid discomfort. Item 6 also had a high score at 21/36 for avoidance of people and places associated with trauma.
- In the alterations in cognition and mood scale, item 15 received a mean score of 21/36, reflecting feelings of being blocked from experiencing positive emotions. High levels of guilt, shame, hopelessness, and demotivation were also noted across other items in this scale.
- For psychophysiological activation, item 16 scored highest at 21/36 for irritability and anger outbursts related to their experiences, followed by difficulties concentrating in daily life with a score of 16/36.

Post-Test Phase

Following the intervention, all participants demonstrated clinically significant improvement. A substantial decrease in total EGS-R scores was observed two months post-treatment. Only one woman remained above the positive PTSD threshold despite improvements

across all subscales (final score: x = 24/20).

Descriptive statistics presented in Table 3 and illustrated in Figure 1 indicate a marked reduction in PTSD symptoms both globally and across subscales following brief AIT treatment. Notably, 91.66% of participants (n = 11) no longer exhibited clinical PTSD symptoms.

The Wilcoxon signed-rank test confirmed that AIT treatment significantly reduced symptoms across all subscales compared to pre-treatment scores. The effect size measured by the point biserial correlation coefficient indicated a very high effect size close to +1 for both global scores and individual subscales. Hodges-Lehmann estimates of magnitude differences closely aligned with median differences, affirming that the treatment was likely responsible for these changes and demonstrating its effectiveness.

Table 3

Mean data for total EGS-R scores and respective subscales along with significance levels and effect size estimates.

Figure 1

Illustrates box plots and scatter plots comparing global EGS-R scores pre and post-test.

Regarding individual subscale results:

- The re-experiencing subscale showed significant decreases across all items; particularly items that had previously scored highest (items 1 and 4) reduced to scores of 15 and 14 points respectively.
- The avoidance scale exhibited clinically significant reductions across all items.
- In the alterations in cognition and mood subscale, previously high-scoring items showed significant reductions post-intervention.
- Similarly, reductions were observed in psychophysiological activation items; notably, one item decreased by 12 points from its pre-test score.

Lastly, on the dissociation scale, there was a notable decrease in participants testing positive for dissociation; only one woman continued to exhibit positive symptoms after treatment, scoring two points by marking two items on the scale. All other items on this scale demonstrated significant decreases in reported symptoms among participants.

Conclusion

Prolonged exposure to violence, coupled with high rates of poverty and lack of safety and support, likely contribute to the elevated PTSD and dissociative symptoms observed at pretest. In addition, experiences of violence during childhood further explain these findings, as adverse childhood experiences (ACEs) significantly increase vulnerability to developing PTSD in adulthood.

The simultaneous report of irritability or difficulty sleeping along with high scores on the dissociative and avoidance scales suggests a state of neurophysiological dysregulation, like when the nervous system steps on the brake and accelerator at the same time. This observation is consistent with polyvagal theory, which postulates that hyperactive and hyporreactive pathways can coexist, requiring regularization tools to manage reactivity during trauma processing. Individuals may appear stabilized while operating at the limit of their window of tolerance, risking dissociation and under-reporting of symptoms, which may confuse therapists as to the true level of nervous system overload or collapse.

Significant symptom reductions on the reexperiencing and avoidance subscales following treatment indicate successful self-regulation. Participants were able to process their traumatic experiences without exacerbating their distress, resulting in a release of allostatic, somatic, and emotional burdens after two months of intervention. Notably, no rebound effect was observed on any of the items of the

psychophysiological arousal subscale, nor a resurgence of dissociative symptoms after treatment.

The regulation process employed by AIT, combined with the three-step transformation model focused on the enhancement of vagal nervous activity and HPA axis regulation, demonstrated efficacy in the management of PTSD symptoms. Women demonstrated an increased ability to experience emotions without feeling overwhelmed, which allowed them to cope with complex life situations without relapsing into their previous states. The integration of somatosensory tools for body reconnection, brain exercises, and interhemispheric balancing contributed to these improvements. Surprisingly, 11 out of 12 women emerged from the clinical state of PTSD during the treatment significantly reducing their symptoms.

Furthermore, AIT's effectiveness in fostering positive qualities is evident from the decrease in cognitive alteration subscale scores. This reduction in negative mood associated with PTSD and limiting beliefs enhances resilience against life's adversities. It is crucial to incorporate treatments that establish these positive qualities permanently and safely.

Through group interventions, participants were able to break the silence and isolation typically associated with violence by openly discussing their traumatic experiences without emotional disconnection. They reported normalizing their reactions upon understanding trauma's effects on the nervous system, allowing them to articulate their experiences while processing their feelings. Most women indicated they had learned coping strategies for managing emotional states that previously incapacitated them. Reconnecting with their bodies and emotions without fear of overflow or suffering while learning neurophysiological regulation tools in a supportive group environment has been vital for their recovery. Gradually, this learning fosters motivation for change and

enhances self-confidence within both oneself and the group, contributing to restored self-esteem and secure emotional bonds.

Despite these positive outcomes, this pilot cohort case study has limitations. Resource constraints prevented us from analyzing a larger sample size or establishing an active control group for comparison. Ethical considerations regarding treatment follow-up after participation in a control group also restricted our approach. Future research should replicate this process in diverse contexts to expand sample sizes and include assessments of co-occurring symptoms such as anxiety and depression alongside PTSD.

Recommendation

It is urgent to develop group intervention programs based on trauma processing that incorporate the body and nervous system, in addition to the already recognized benefits of addressing mental and cognitive symptoms in IPV.

We are currently in the process of financing to expand the sample to other women and contexts. The objective is to present a systematized and replicable intervention of Brief Group AIT program to consolidate these results.

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Tables

Table 1

Description of the Sample according to age groups, schooling level, type of abuse and duration of abuse

Age groups	Nº	Scholarly level					Kind of abuse		Duration of Abuse				
		1st cycle	2nd cycle	3r cycle	bachelor	Univers.	psychological	Various Violences	1 year	2 - 5 years	6 - 10 years	Less 1 year	More 10 years
Between 21 - 29 years	1					1	0	1		1			
Between 30 - 50 years	9		2	1	4	2	5	4	1	3	1	1	3
Between 50 - 70 years	2	1	1				0	2		1			1
Subtotals	12	1	3	1	3	3	5	7	1	5	1	1	4

Table 2.

Structure of main components of the program with brief group AIT treatment.

1. Psychoeducational component	To review symptoms, responses, and thoughts as traumatic stress reactions and PTSD symptoms; to learn how AIT somatic-energetic treatment works: the principles and bases of AIT.
2. Ego strengthening component.	To work with presence and safety training like meditation and brain exercises; to learn skills for emotional management in the face of anxiety and self-perceived bodily and emotional reconnection and to practice neurological reorganization and

	interhemispheric balance exercises. In addition, homework and exercises are offered.
3. Trauma reprocessing component	Through relaxation and visualization exercises, we choose common events in the group in a declarative manner. The AIT dual pathway in a three-step transformation model is applied in different sessions. Combined with reprocessing in all sessions, NS self-regulation exercises are interspersed to ensure its balance and correction typical of processing.
4. Cognitive resignification component	After processing the trauma, we install through somato-energetic processing tools, new positive beliefs, qualities or resources. In addition, homework and exercises are offered.
5. Croos-cutting component: bond between peers and the ancestral component	Using techniques and tools used ancestrally that incorporate different elements of nature, we offer a harmonic stimulation of the NS of each woman which leads them to a state of tranquility and openness that contributes to the opening of a spiritual space of healing, containment, accompaniment and mutual support, where judgment and criticism for what has been lived disappear.

Tabla 3.

Mean data of the total score of the EGS-R and its respective subscales, in addition to their significance, Hodges-Lehmann estimates of the magnitudes, and coefficient of biserial production.

Pre-test	Post-test	Median		SD		W	p	Hodges-Lehmann Estimate	Rank-Biserial Correlation
		Pre	Post	Pre	Post				
Total Scores	Total Scores	25.5	9.5	7.763	6.767	78.000	0.003	18.000	1.000
Subscale A (pre)	Subescala A (post)	7	2	2.209	2.038	76.500	0.004	5.000	0.962
Subscale B (pre)	Subescala B (post)	5	2	1.357	1.467	78.000	0.002	3.500	1.000
Subscale C (pre)	Subescala C (post)	9	2.5	3.397	2.443	66.000	0.004	6.000	1.000
Subscale D (pre)	Subescala D (post)	6	2.5	2.633	2.486	75.500	0.004	3.528	0.936

note: Wilcoxon signed rank test

Subescala A: Reexperimentacion

Subescala B: Evitación cognitivo/conductual

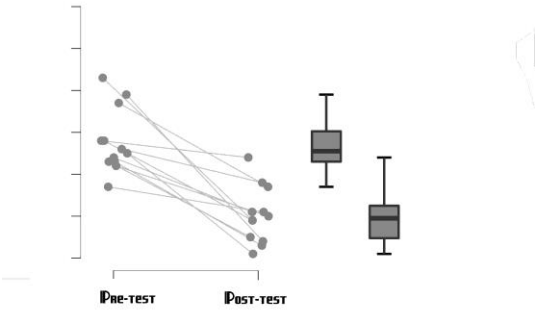
Subescala C: Cognitive resignification component

Subescala D: Activation and psychophysiological reactivity

Figures

Figure 1.

Comparison of the box diagram and cloud of points of the global scores of the EGS-R scale according to pre and post-test.



Appendix A

Items adapted to El Salvador rural context from (EGS-R)
1. Now, do you have, or experience repetitive memories or images related to that abusive relationship that are mostly unpleasant and that appear unexpectedly even though you don't want them to happen?
2. Do you have bad or unpleasant dreams and repetitive nightmares related to the abusive relationship you have experienced?
3. Are there times when, while awake, you find yourself behaving or experiencing sensations or emotions as if you were reliving everything again? (When hearing something or seeing an image, you felt as if you were in that abusive relationship again).
4. When you now think or remember, or talk about some aspect of what you experienced in that relationship, do you experience intense or prolonged psychological discomfort or disgust (fear, hopelessness, anger, anger, crying, lack of desire to live, guilt...)?
5. Do you feel intense physical reactions (startles, sweating, dizziness, racing heart or changed breathing rate; tension or tremors, headaches, diarrhea) when remembering images, or thinking about that situation, or speaking and/or seeing yourself in any situation that reminds you of something you experienced in that relationship?
6. Do you usually avoid people, places, situations or activities that might remind you or make you think or feel things like or related to, what you experienced in that relationship because it creates discomfort or emotional suffering?
7. Do you feel that you must try to get those memories, thoughts or feelings related to what you experienced in that relationship out of your mind to avoid feeling discomfort or emotional suffering?
8. Do you prefer not to talk about certain topics that may cause you to remember or come up with thoughts and/or feelings related to what you experienced in that relationship, because it creates discomfort or emotional suffering?
9. Do you feel that you have difficulty remembering any or important parts of what you experienced in that abusive relationship that you experienced?

10. As a result of what you have experienced, do you have negative beliefs or feelings about yourself, about others or about the future?
11. Do you usually blame yourself or other people around you for what happened or the consequences of having experienced the situation you lived?
12. Do you frequently experience a negative mood in the form of terror, anger, guilt, or shame?
13. Do you feel that your interest or desire to do daily activities has decreased, or have you stopped carrying out or participating in important activities of your daily life?
14. Do you experience a feeling of distance or strangeness or isolation from the people around you?
15. Now, do you feel limited or blocked from feeling, experiencing, or expressing positive emotions (for example, joy, contentment, feelings of love, or enjoying things in life)?
16. Are you usually irritable, angry or in a bad mood, or have outbursts of anger for no apparent reason or for very minor things, since that abusive relationship you lived in?
17. Do you have risk behaviors like uncontrolled eating, dangerous driving, or addictive behaviors to
18. Are you in a state of permanent alertness, for example, stopping suddenly to see who you are around, or if someone is following you or watching you, because of what you experienced in that abusive relationship?
19. Do you startle, live in fear, or become alarmed more easily since you were in that relationship?
20. Do you feel that you have difficulties concentrating, for example, to follow a conversation or attend to your daily obligations, losing track of a story that is told on the radio or television, to study... etc...)?
21. Do you have difficulty falling or staying asleep or having restful sleep?
22. Do you eat sweets, take alcohol or drugs, or do self-destructive or self-injurious behaviors?

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