# Utilizing Advanced Integrative Therapy to Treat Anxiety and PTSD in a Pregnant Woman

*A Single Design Case Report*

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## ABSTRACT

Many women experience pre-birth anxiety during pregnancy, especially during their first pregnancy because so much is unknown. This case study was conducted to explore the efficacy of Advanced Integrative Therapy (AIT), a somatic energy psychology (EP) trauma treatment modality, in reducing the anxiety symptoms of a woman carrying her first pregnancy. The author hypothesized that the client's symptoms of anxiety and her scores on multiple trauma assessment measures would be reduced after utilizing Advanced Integrative Therapy as the only treatment intervention. The study was conducted in the office of the author, who met with the client weekly for six sessions, each lasting 60 minutes. The client's self-report and subjective units of disturbance (SUDS), a basic anxiety scale (GAD-7), a dissociative experiences scale (DES-II), a posttraumatic stress checklist (PCL-5), and a complex posttraumatic stress checklist (ITQ) were completed pre- and post-treatment. The client met criteria for a probable diagnosis of post-traumatic stress disorder (PTSD) upon completion of the screening instruments. This was a single study case design utilizing AIT as the only treatment intervention, completed with a patient after she became pregnant with her first child. Data collection began when the patient was 18 weeks pregnant, in her second trimester. The study found that the client's anxiety and posttraumatic stress scores were significantly reduced and that her subjective units of disturbance (SUDS) were also reduced. When the screening instruments were re-administered at the end of treatment, the client no longer met the criteria for generalized anxiety or PTSD. Previous case studies have found AIT to be effective in desensitizing and reprocessing stored traumatic memories that lead to an overactive nervous system and symptoms of anxiety. More research on AIT's potential as a gentle treatment intervention for maternal mental health is needed.

***Keywords:*** Advanced Integrative Therapy, AIT, pregnancy, anxiety, trauma

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***An estimated 15.6% of women meet criteria for an anxiety disorder during pregnancy – making anxiety more common than depressive disorders in the perinatal period.***

Research in medicine and psychology clearly indicates that maternal mental health is extremely important for the physical health and emotional well-being of mothers and their children (Shea et al., 2007). Pregnancy-related anxiety (PrA) "can be distinguished from general measures of anxiety in pregnancy in terms of longitudinal course, associated features, and prediction to postnatal mood disturbance, and may warrant specific clinical attention" (Blackmore, et al., 2017, p. 2). Pregnancy-related anxiety refers to "worry or distress particular to pregnancy, including the health of the developing child, changes in appearance, labor and birth, and future parenting concerns" (Blackmore et al., 2016, p. 251). High levels of PrA have been connected to shorter gestation, preterm birth, miscarriage, and hypertension in pregnant women (Tarafa et al., 2022). Furthermore, awareness of the negative effects of PrA can have a looping effect, provoking more anxiety for expecting mothers and causing feelings of guilt and self-blame (Yannati et al., 2020). An estimated 15.6% of women meet criteria for an anxiety disorder during pregnancy – making anxiety more common than depressive disorders in the perinatal period (Fairbrother et al., 2016). Many research studies have been conducted on the effectiveness of cognitive behavioral therapy for the reduction of PrA (Green et al., 2020), but there are significantly fewer studies conducted on the use of combined cognitive and somatic therapies, such as Advanced Integrative Therapy. To date, only six research studies about the effectiveness of Advanced Integrative Therapy have been published: a paper introducing AIT to the clinical community (then called Seemorg Matrix Work) by Dr. Asha Clinton (2006), two case studies (Pace, 2021, & Bird Weaver, 2021), an evaluation of therapists' experience of the effectiveness of AIT (Brown et al., 2022), a theory paper that included a section about AIT's effectiveness on treating trauma-related dissociation (Brown, Bird Weaver, & Pace, 2023), and a randomized controlled trial (RCT) comparing the effectiveness of Emotional Freedom Techniques and Quick AIT (Clinton, 2019) in desensitizing the subjective disturbance of emotions. The results of Dr. Brown's (2023) RCT show that Quick AIT (QAIT) is as effective as EFT in desensitizing the subjective units of disturbance (SUDS) in a memory from childhood. Of note, QAIT was found to desensitize the difficult emotions of participants in fewer rounds of the protocol than EFT (Brown et al., 2023).

A recently published RCT comparing Emotional Freedom Techniques and music therapy found that using gentle somatic energy therapies like EFT reduced self-reported symptoms of anxiety, encouraged posttraumatic growth, and lowered cortisol levels in pregnant women in Turkey who had experienced a pregnancy loss before their current pregnancy during the study (Okyay & Uçar, 2023). In psychology, research is increasingly focusing on intergenerational trauma and the transmission of adverse childhood experiences (ACEs) in the DNA of trauma survivors (Roy, 2019 & Abbott et al., 2022). Psychotherapists can intervene by applying evidence-based trauma treatments designed to interrupt the inheritance of epigenetic trauma (Moog, 2016). This case report also illustrates intergenerational patterns of trauma and how AIT helped alleviate symptoms of PTSD related to the client's chronically stressful childhood.

This report is unique in that the clinician utilized a novel somatic energy therapy to treat symptoms of PrA in a woman carrying her first pregnancy. Advanced Integrative Therapy posits that virtually all psychological issues, as well as many physical ones, have their roots in trauma (Freedom, 2022). The client reported a long history of chronic stress in her childhood, including being unstably-housed and transient with her mother, and being sexually abused by her mother's partner from ages two to 10. She reported feeling very anxious about making everything "perfect" for the baby she was bringing into the world in order to prevent the re-creation of some of her own ACES. The client met criteria for a probable diagnosis of posttraumatic stress disorder on the International Trauma Questionnaire (ITQ) and the PTSD Checklist for DSM-5 (PCL-5). The use of AIT with expecting mothers could interrupt the transmission of intergenerational trauma, thereby reducing or preventing ACES for the client's gestating fetus by increasing emotional regulation and resilience in the mother. A previous case report on Advanced Integrative Therapy also documented a significant reduction in the study subject's PCL-5, from meeting criteria for PTSD on their pretreatment screens, to not meeting criteria for PTSD on their post-treatment screens (Bird Weaver, 2021).

## Patient Information, Primary Concerns and Symptoms

The client was a 33-year-old white European American woman who had never been pregnant at the time of intake. She reported she had been in a very supportive relationship with her partner for 1.5 years. In her intake paperwork, in response to the question of what brought her to counseling, she wrote that she was generally looking for new ways to respond to her problems. She also mentioned experiencing bouts of crying and feeling overwhelmed, and was uncertain as to why. The client reported her emotional symptoms upon intake as trouble concentrating, difficulty sleeping, low motivation, fatigue/low energy, tearful or crying spells, anxiety, fear, and panic.

She originally presented to the author's office on May 25, 2022, and reported that her presenting problem was experiencing challenges in her relationship with a business partner. She stated that she wanted to improve her ability to set boundaries, and to "people please" less. When asked to describe some of her symptoms further, she identified her symptoms of anxiety as: *"General anxiety. The funny thing is that I'm not anxious in times of crisis. I've always lived in crisis; the way I grew up and was raised, I'm very used to that kind of thing. I get more anxious when I'm not in crisis; when I don't have anything to deal with that is disastrous."*

As the client began to prepare for the birth of her child, she chose to cancel sessions with the therapist for financial reasons on August 31, 2022. The author contacted the client in early October 2022 to ask if she would be willing to participate in a case study for her presenting symptoms of PrA at a reduced session rate. The client happily agreed. The second episode of care began on October 12, 2022 and pre-treatment assessments were done at this time. The informed consent procedure for participating in a case study was also completed with the client in office.

## Family and Biopsychosocial History

The client's biopsychosocial intake was reviewed in the office by the client and clinician on June 9, 2022. She reported that her family history had an impact on her gestation. Her maternal grandfather was verbally abusive to her mother and grandmother, and the client reported that he had *"anger problems."* The client also stated that her mother became pregnant with her when she was 15, that her grandfather's reaction to the news that his daughter was pregnant was not supportive, and that he rejected his daughter for becoming pregnant. The client was told by her mother that this pregnancy was the activating event that resulted in her grandparents' divorce because of her grandfather's extreme reaction to the news of her pregnancy.

The client reported that her mother and father were not together for very long. The client was the only child born from that partnership, although she had multiple half-siblings from her parents' subsequent relationships. The client noted that during her childhood, her mother *"struggled and often didn't have custody. She was very loving, but didn't 'get her act together' until I was in high school."* The client described her childhood as very transient, staying with her mother *"in a truck, [with] lots of interstate moves."* She lived with her mother when she was able to have custody, but also stayed with other family members when her mother was not stably housed. She reported living with her maternal grandmother in first and second grade, with her aunt in third grade, with her father for one year during fourth and fifth grade, and then with her mother from sixth grade onwards. She lived with both of her mother's parents at different times in her life, and said she was very close to both of them. She reported not knowing her father well, and that she spent only one year with him, between the ages of 10 and 11. In her intake, she described him as *"an angry alcoholic and a criminal."* During the year she lived with him, she said the household was very chaotic, and her father and stepmother would have physical altercations in the family home. She also noted that he was often gone during the year she stayed with him: *"Just me, raising myself."* The client had not spoken to her father for more than 13 years at the time of intake, and described that relationship as strained.

When asked to describe childhood traumas, upsets, and issues on the intake form, the client wrote that her chronic homelessness, unstable housing, and transience were major traumas from childhood. She also reported being sexually abused on multiple occasions by her mother's partner, with whom her mother stayed intermittently because he provided financial support. She reported the abuse happening when she was between the ages

of two to 10: *"When we [my mother and I] came to our hometown, we would stay with this man out of financial necessity."* The abuse stopped when her mother became more financially stable and was able to obtain more permanent housing for herself and her daughter.

The client had recently discovered that she was pregnant after only two psychotherapy sessions. She was in a long-term partnership with the baby's father, and reported that they both welcomed the pregnancy. The client stated that as a result of this pregnancy, her new goal for treatment was to *"be well equipped to raise my child in a healthy and nurturing household."* She added that she wanted to be able to ask for help, and was *"tired of being comfortable in chaos."* When she discovered she was pregnant, she stopped using alcohol and cannabis, and received psychoeducation about withdrawal syndrome after daily cannabis use. She reported having "weird" dreams in the initial weeks of abstinence, as well as feeling less rested after awakening, but reported no other symptoms of withdrawal.

The client said she had received mental health treatment several years earlier for anxiety and romantic relationship issues. She stated that she did not find it helpful. Her previous therapist was a "talk therapist," but she did not specify the type of treatment intervention used.

She was under the care of an obstetrician after discovering that she was pregnant, and she reported receiving routine testing, examinations, and medical care from this doctor. No physical examinations were performed in the author's office.

## Timeline for Treatment

**Table 1**.

| | | | |
|---|---|---|---|
| 10/12/22 | Session #1 | Informed Consent, Pre-Test Assessments: DES-II, PCL-5, GAD-7 | Client Took ITQ Home for completion |
| 10/17/22 | Session #2 | Treating Psychological Reversals and deeply rooted core beliefs | |
| 10/26/22 | Session #3 | Treating Deeply Rooted Core beliefs | |
| 11/3/22 | | Appointment Cancelled | |
| 11/9/23 | Session #4 | Completing the AIT "Alliance." | |
| 11/18/22 | Session #5 | Begin AIT "5 Step Transformation" on Chronic Instability in Childhood. | |
| 11/21/22 | Session #6 | AIT 5 Step on Chronic Instability Complete. Post-test assessments completed | |

## Diagnostic Assessment

The diagnostic methods utilized were the client's self-report and subjective units of disturbance (SUDS), a basic anxiety screening, a dissociative experiences scale, a posttraumatic stress assessment, and a complex posttraumatic stress assessment. All screening measures were completed pre- and post-treatment. Initial intake assessments were conducted during session one of treatment. The client scored a 19 on the Generalized Anxiety Disorder 7 Item (GAD-7). Any score over 15 is designated as severe anxiety (Saunders et al., 2023). The client's self-report on the optional impact of the functioning question was that these symptoms of anxiety made it *"somewhat difficult"* to

do work, take care of things at home, or get along with other people. The client completed a Dissociative Experiences Scale, 2nd Edition (DES-II), and scored 20.71. In average DES scores, a 5.4 is correlated with the general adult population, with a score of 7.0 being correlated with anxiety disorders. Average DES-II scores for people diagnosed with posttraumatic stress disorder are in a higher range, with mean scores of 31 and higher (Carlson & Putnam, 1993). Dissociation is characterized by the alteration of those functions that normally allow integration of the self, including identity, memory, consciousness, affectivity, perception, and cognition (Dell, 2006).

The client also completed two assessments to measure symptoms of posttraumatic stress: the Post Traumatic Stress Disorder Checklist (PCL-5) and the International Trauma Questionnaire (ITQ).

On the PCL-5, the client scored a 37. The cutoff score for PTSD is 31-33 (Weathers, 2013), which indicates a probable diagnosis of PTSD. The client also met criteria for a provisional diagnosis of PTSD on the ITQ, with a PTSD score of 17. On this instrument, a diagnosis of PTSD requires the endorsement of one of two symptoms from the symptom clusters of (1) re-experiencing in the here and now, (2) avoidance, and (3) sense of current threat, plus the endorsement of at least one indicator of functional impairment associated with these symptoms (Redican et al., 2021). Based upon the ITQ results, the client did not meet criteria for complex PTSD, but did meet criteria for PTSD. Upon compiling diagnostic assessments, clinician observation, intake interview, biopsychosocial history, and client self-report, the client was given a probable diagnosis of posttraumatic stress disorder.

On the date the assessments were completed (October 12, 2022), the client was also interviewed about her definition of her problems and symptoms. She stated that her primary symptom was *"stress related to control. I have a big problem when I can't 'fix something'"*. She further described her anxiety symptoms: *"I can't shut off. I have racing thoughts, frantically ruminating about issues."* She reported that her physical symptoms were exhaustion and poor sleep quality as a result of waking up in the middle of the night with racing thoughts and being unable to go back to sleep. In her own words, *"My initial reaction to stress is to overdo it physically. Once I complete the list of tasks, even menial tasks to distract myself, the end result is that I'm totally wiped out and exhausted."* She stated that the byproduct of this exhaustion was that she found herself *"crying out of nowhere,"* and having trouble breathing. She also reported that she suffered from headaches that arose from stress.

The client identified that her desired result from AIT treatment would be stability. When asked what kind of mother she wanted to be, the client replied: *"prepared."* She defined stability as being able to rest, get better sleep, and feel less tired throughout the day. By her definition, stability also meant feeling calm and self-assured, with a greater sense of safety in the world. She was also asked to give a scaling answer for symptoms that she wanted to decrease, and for positive outcomes that she wanted to increase.

**Table 2**.

| Goals | Self-Reported Scaling 0-10 (10/12/22) | Self-Reported Scaling 0-10 (11/9/22) | Change in SUDS |
|---|---|---|---|
| *Anxiety: "can't shut off, racing thoughts frantically ruminating about issues"* | 7/10 | 4/10 | 3 |
| *Rest, better sleep, less tired* | 1/10 | 6/10 | 5 |
| *Calm, self-assured* | 3/10 | 7/10 | 4 |
| *A sense of safety in the world* | 2/10 | 5/10 | 3 |

## Diagnostic Challenges

The client reported daily cannabis use at the time of her initial intake (May 19, 2022), and stated that it was a way she managed her anxiety symptoms: *"I smoke weed regularly – every day, multiple times a day."* She also reported social alcohol use on weekends, but did not identify alcohol use as a concern or an issue. Upon discovering she was pregnant, she stopped using alcohol and cannabis. The detox syndrome from cannabis, as well as the eventual rebalancing of her neurochemicals eight to 10 weeks post-abstinence, may have had an impact on her mood and symptoms of anxiety, which may have led her anxiety to appear more prevalent upon administration of diagnostic assessments. The resolution of detox symptoms may have had an impact on the significant reduction of her symptoms of anxiety.

## Prognostic Characteristics

One of the prognostic characteristics of this case was that the pregnancy was planned and welcomed by both the client and her partner, although she did report that she and her partner were planning to wait until their finances were more stable before starting a family. The prognostic characteristics for the case were the client's robust physical health, as she reported that health and fitness were very important to her, her self-reported very secure and supportive relationship with her partner, and her partner's extended family. The client also was self-referred to therapy, and asked to utilize somatic interventions at the recommendation of a friend. She was thereby very receptive to treatment. Her pregnancy was uncomplicated, and the absence of any additional health concerns allowed her to focus on treating her mental health issues. She was also able to stop using cannabis and alcohol voluntarily when she discovered that she was pregnant.

## Therapeutic Intervention

Advanced Integrative Therapy was utilized, with two treatment protocols used. Advanced Integrative Therapy is defined by Dr. Asha Clinton as "a new transpersonal energy psychotherapy that supports and generates healing, development, and illumination by gently removing traumatic symptoms and replacing them with positive beliefs and qualities, spaciousness, and a strengthening connection between ego and center" in her seminal paper on this treatment modality (Clinton, 2006, p. 95). In a more recently published theory paper designed to introduce AIT to researchers and interested clinicians, AIT was defined as "a novel therapy grounded in Energy Psychology combined with cognitive and somatic techniques" (Brown et al., 2023, p. 31).

Advanced Integrative Therapy is unique in that it utilizes kinesiology-style manual muscle testing (kMMT) as a supplementary tool to identify and triage treatment order in therapy sessions, as well as to confirm that the subjective units of disturbance (SUDS) of a treatment phrase are decreasing or have been extinguished. "Kinesiology-style manual muscle testing (kMMT) is a non-invasive assessment method used by various types of practitioners to detect a wide range of target conditions (Jensen, 2014, p. ii)". KMMT is used to assess muscle strength and weakness in chiropractic and physical therapy settings. In AIT practice and psychotherapy, kMMT is utilized as a cue to confirm the need to treat unconscious or dissociated material. Dissociated experiences and "forgotten traumas" (Clinton, 2019) can be difficult to access and may make traditional "talk therapy" challenging for clients with ACES that resulted in trauma-related dissociation or trauma splitting (Fischer & Ayoub, 1994). A clinical research study of 89 healthy college students used a computerized dynamometer to test their deltoid strength after making congruent and incongruent statements. The study showed that after congruent statements were made, muscles were able to resist significantly more force compared to after making incongruent statements. For the purposes of the study, a congruent statement was defined as one the speaker believes to be true, whether or not their belief reflects actual reality. It was found that congruent statements usually result in strong MMTs, while incongruent statements usually result in weak MMTs (Monti et al., 1999).

AIT Therapists utilize kMMT to confirm clients' psychological readiness to treat traumas, described in the AIT Basics Manual as their ego strength (Clinton, 2010). AIT therapists and their clients construct treatment phrases, and then test the strength of their muscles in response to the client repeating that statement aloud. If the muscles (usually in the arm) that are being tested remain

strong, then that would be a confirmation indicating a "true" statement. An example in this case report involved creating the treatment phrase, "I give permission for my being to be healed," and then using kMMT to confirm whether the client's arm muscles remained strong when she repeated this phrase. If this statement tests "strong" using kMMT, indicating muscle strength after repetition, the client is ready to progress to psychotherapeutic depth work. This suggests she is giving both conscious and somatic (or unconscious) permission to release stored traumas.

Manual muscle testing has a growing basis in clinical research, and is statistically better than chance or intuition, which would be correct 50% of the time (Jensen 2014). KMMT is currently contested in the research community as to its "legitimacy" as a diagnostic tool, but this is beyond the scope addressed by this paper. In AIT practice, kMMT is used as a confirmation and a cue of the client's somatic or embodied readiness to proceed with treatment. As a consideration, good therapy strives to "meet the client where they are," and those clients who respond favorably to kMMT in the clinician's practice describe it as a helpful tool to establish a deeper relationship with themselves and their unconscious processes, as well as to diminish their reliance on overly intellectualizing their therapy or treatment, which is a common barrier to successful resolution of trauma-related dissociation.

The Core Belief Protocol of AIT includes initially identifying a phrase that will require treatment. If this is a maladaptive core belief, the client identifies how true or strong it feels to them, utilizing a 0 to 10 scale with 10 being "completely true" or "distressing and strong." AIT clinicians utilize the Subjective Units of Disturbance (SUDS) scale to document either the sensation of veracity or the disturbance caused by the statement (Tanner, 2012). As an example, when a treatment phrase is identified, such as "I'm not worth being protected or comforted," the client would identify that it feels "like a 7" to them on the 0 to 10 scale. The treatment intervention begins with the client identifying where they feel the sensation in their body when they hear this phrase. They place a stationary hand at the sensation location for the duration of a "round" of AIT. For clients who struggle with bodily awareness or experiencing somatic sensations, kinesiology-style manual muscle testing (kMMT) can be used to identify where they will place their

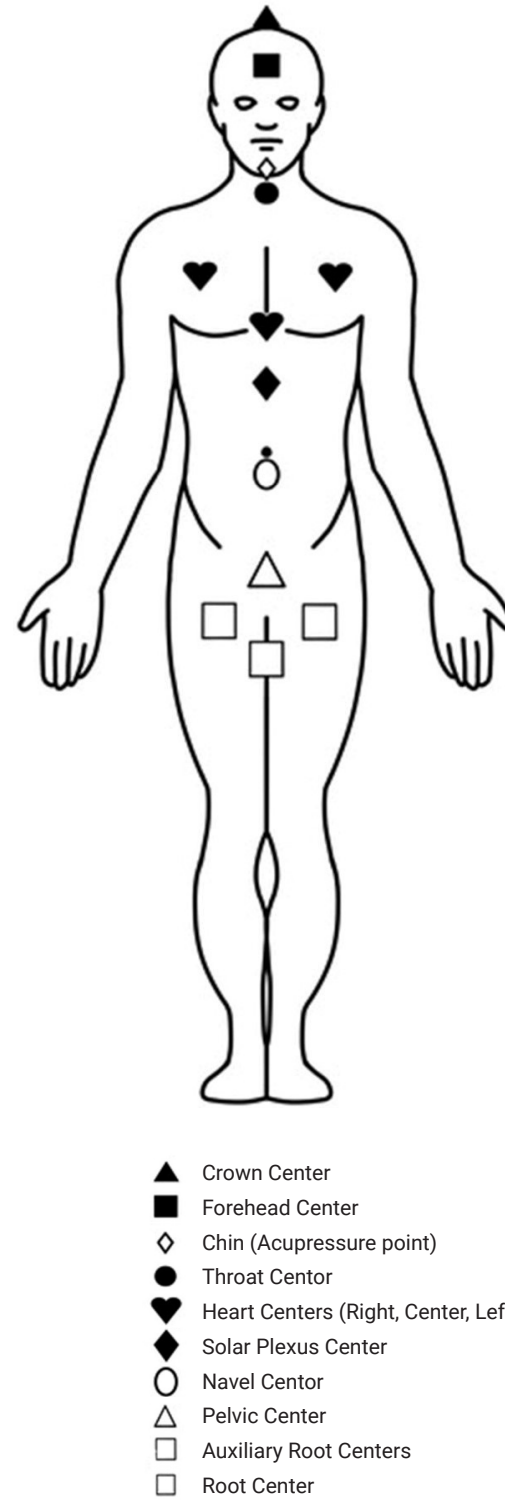


**Figure 1**. *Energy centers in AIT.*
*Illustration: Paul Weaver, 2021. Image: Brown et al., 2023*

stationary hand. After the sensation location of sensation is identified, the client places their "movement hand" at the crown of their head and states the identified phrase, such as "I'm not worth being comforted or protected." The client next moves their hand to their forehead, and repeats the phrase. The order of hand placement for a round of AIT goes as follows: crown, forehead, chin, throat, center of chest, left chest, right chest, solar plexus, belly button, pelvis, left hip crease, right hip crease, and root (base of tailbone). After a round of AIT, defined as moving one hand through each energy center and repeating the phrase, the client identifies whether the SUDS score has gone down. This is repeated until the SUDS score is extinguished to zero. At that point, the client then instills a positive cognition to replace the deeply rooted maladaptive core belief. The opposite of the negative cognition above is "I am worth being protected and comforted." The client again identifies how strong the statement feels on a 0 to 10 scale, with the intention of strengthening this positive cognition to a 10 on the scale. To instill positive cognitions, the client again identifies the location where they feel the sensation, and then begins their movement hand at the root, going up to the pelvis (skipping the hip creases), belly button, solar plexus, center chest, left chest, right chest, throat, chin, forehead, and finally the crown (see figure 1, Brown et al., 2023). At each energy center, the client repeats the phrase: "I'm worth being protected and comforted." The instillation of the positive cognition is complete when the score reaches 10.

The first protocol is an AIT Basics protocol titled the "Alliance Agreement." It uses the AIT Core Belief protocol to extinguish deeply held core beliefs. It is the stance of AIT practitioners that these 24 core beliefs can be such impediments to successful treatment outcomes that they must be desensitized and reprocessed before starting deeper trauma treatment work. This is also an opportunity for psychoeducation, practicing distress tolerance, helping to familiarize the client with AIT protocols, and countering sabotaging or blocking core beliefs with more adaptive thinking and processing. The Alliance treatment phrases that were identified as blocking beliefs for this client were: "I'm not in touch with my deepest, wisest self," "I'll be deprived if I'm healed," "I can't bear or survive all my feelings," "People tease me," and "I want to die."

The blocking belief that required the most treatment and the most rounds of AIT Core Belief protocol to desensitize was "I can't bear or survive all my feelings." When desensitizing this belief, the client shared that her mother disclosed that she had also been sexually abused as a child. The client recalled her mother telling her that when she told her own mother (the client's grandmother), the grandmother had stated, "Well, it happened to all of us" in a helpless and dismissive way. The client reported that when she disclosed her experiences of sexual abuse to her mother in high school, her mother had responded by saying, "What do you want us to do?" The client clarified that she felt her mother meant this in a supportive way, but the subtext of her response seemed to be that the client was responsible for making a choice, or deciding what happened next. No child services report was made at the time. The client stated that her mother did a better job of responding than her grandmother had done, but that it was still insufficient. The client made the connection that she suppressed the unbearable feelings associated with her chronic sexual abuse traumas because she felt her mother was not capable of helping her work through those feelings at the time. Processing core beliefs using AIT can be analogously compared to finding and opening a time capsule of thoughts, memories, emotions, and sensations stored in the body at the time of the trauma. Simply repeating the statement, "I can't bear or survive all my feelings" with hands placed at each center allowed the client to access unconscious or forgotten memories, as well as make the connection between her emotional suppression and her family's ancestral or legacy trauma. Additionally, the core belief, "It's dangerous to express my feelings" was desensitized and reprocessed.

The next step of the Alliance protocol is to align the client's biopsychosocial spiritual systems to make an agreement between the conscious and unconscious self. The beliefs that required extinguishing were: "My unconscious mind will not allow me to use Advanced Integrative Therapy (AIT) to heal all the wounds I choose to heal in my spirit," and "My unconscious mind will not allow me to use AIT to heal all the wounds I choose to heal in my conscious mind." After extinguishing the charge or SUDS score on these two phrases, the agreement was completed after the client repeated the following phrase: "With every trauma or traumatic pattern

I treat, I will not only eliminate all the traumatic reactions, but also everything that would make me keep them, ever take them back again, allow them to come back, be receptive to their coming back, or ever permit them to return. My unconscious will do that for me every time." In the flow of treatment, completing the Alliance agreement prior to depth AIT is defined as a necessity for thorough and lasting treatment (Clinton, 2019). Treating blocking beliefs first is therapeutic as a stand-alone intervention, but it also serves to help acclimate the client to AIT protocols, to become conscious of their resistance, and to build ego strength or distress tolerance for treating deeper issues.

After completing the Alliance agreement, the next protocol utilized was the AIT 5-Step Transformation, which can be found in the Advanced Integrative Therapy Attachment Theory and Treatment Manual (Clinton, 2019). The rationale for the change from the Standard AIT 3-Step Transformation was that the AIT 5-Step Transformation was suited to treat the chronic patterns of stress and instability in the client's childhood. The standard AIT 3-Step Transformation from AIT basic training identifies the Initiating Trauma (IT) statement that is causing the symptoms, disturbance, or distress in the present day, the Originating Trauma (OT) statement, which identifies the experience at the root of the present-day disturbance, and a Connecting Trauma (CT) statement, which brings the connection between these events into the conscious mind. For example, if the IT statement is "When I don't have anything to do I feel anxious," and the OT statement is "When I was a child my life was constantly chaotic and unstable," then the CT statement would be the combination of the two: "Because my childhood was constantly chaotic and unstable, today I feel anxious when I don't have anything to do."

To begin a round of treatment, the client identifies the SUDS on a scale of 0 to 10 for the statement being treated first, which is the OT statement. The client will also identify the area of the body where 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 hand placement centers on the body, starting at the crown, while repeating aloud the identified statement. For example, "When I was a child my life was constantly chaotic and unstable." The client repeats the phrase at each center as the clinician mirrors the client's movements. The energy centers for hand placement are the same as the Core Belief protocol (Figure 1). After a round of desensitization and reprocessing using the AIT 3-step protocol, the clinician assesses if the client's SUDS score has decreased, using client self-report or kMMT. The Originating Trauma (OT) statement will be processed using the AIT protocol until the SUDS score is zero. After the OT is treated, the Initiating Trauma (IT) is treated with the same protocol. When the Initiating Trauma statement, e.g., "When I don't have anything to do I feel anxious," has been desensitized to a zero SUDS score, the Connecting Trauma (CT) statement is created and then treated using the same protocol. For example: "Because my childhood was constantly chaotic and unstable, today I feel anxious when I don't have anything to do." When the CT has also reached a zero SUDS score, the AIT 3-step transformation is said to be completed.

The AIT 5-step transformation is more thorough and appropriate for attachment and complex traumas because it includes 1) the traumatic event, 2) the client's reactions to this trauma (how they coped), 3) the dissociated emotions as a result of this trauma, 4) somatized emotions stored in the body as a result of this trauma, and 5) the connecting trauma statements, or how this is impacting their present-day life, symptomatology, and functioning (Clinton, 2014). The same process of creating a treatment phrase, identifying a SUDS score, hand placement, and the repetition of the phrase at each energy center is applied for the AIT 5-step transformation. The client's 5-step transformation phrases were constructed as follows:

**Table 3**. *Advanced Integrative Therapy Five Step Transformation for the theme of Chronic Instability*

| STEP | Treatment Phrase |
|---|---|
| 1. Originating Trauma | *All the times and ways my family was chaotic, unsettled or not comfortable when I was a child (treating the pattern).* |
| 2. Originating Trauma Reactions | *Because my family life was chaotic and unstable, I reacted by always having to do something to make it work, masking my feelings, and feeling like I'm in control.* |
| Emotional Aspects | *All my feelings of independence, anxiety, perfectionism, 'can't relax,' and frustration because I got accustomed to managing tasks and trying to create stability in my family.* |
| 3. Dissociated Emotions | *All my dissociated emotions of fear, loneliness, confusion, seeking safety, anger, frustration, and abandonment because my family life was chaotic and unstable.* |
| 4. Somatized Emotions | *All my somatized emotions of anxiety, exhaustion, dissociation, overdoing it, isolation, independence & pride, restlessness, avoiding feeling out of control, resentment, short tempered, explosive anger that have settled in my body as adrenaline spikes, elevated cortisol, insomnia, exhaustion, crying, GI issues, lower back pain.* |
| 5. Connecting Trauma Statements | *Because my family life was chaotic and unstable, and my emotions were neglected, today I'm anxious about having a baby because I want everything to be perfect, stable, and I WON'T NEGLECT ANYTHING!* |
| | *Because my childhood was chaotic and unstable, I'm unconsciously trying to heal that wound by making everything perfect for my baby.* |

Utilizing the AIT 5-step transformation took place over the last two sessions. After each round, the client was able to describe the sensations, emotions, thoughts, memories, or new awareness that arose as a result of repeating the treatment phrase at each energy center. The client was able to desensitize and reprocess the trapped emotions and sensations that were stored in her body and not released because her life was not stable at the time of their origin. Most notably, the client was able to identify that her expectations of herself in creating a perfect family were not reasonable or possible for her to do, and that the behavioral manifestations of these expectations were more costly than they were beneficial.

## Follow-Up and Outcomes

At the final session, post-test measures were taken, and the reduction in self-reported symptoms on the Post Traumatic Stress Disorder Checklist (PCL-5) was considered to be clinically meaningful. At her initial screening, the client scored 37 on the PCL-5. Five sessions after the initial assessment, the client's PCL-5 score was 4, and she did not meet criteria for a diagnosis of probable PTSD as defined by this assessment. The PCL-5 was found by Roberts et al. (2021) to be psychometrically sound. It can be used to assess symptoms of post-traumatic stress and provide a provisional diagnosis of PTSD with a cut-point score of 31-33. A total score of 31-33 or higher suggests that a patient may benefit from PTSD treatment. Evidence for the PCL-5 for DSM-IV suggests that a minimum threshold of 5 points indicates a treatment response, while a 10-point change is needed for clinically meaningful improvement (Weathers et al., 2013). Marx et al. (2022) found the reliable change index (RCI) for the PCL-5 was ≥ 15 and ≥ 18 in two samples in a population of combat veterans. Thereby the change of 33 points on the PCL-5 from 37 to 4 could be interpreted as clinically meaningful.

The International Trauma Questionnaire (ITQ) was also utilized to screen the client for a probable diagnosis of PTSD or complex PTSD (CPTSD). The client scored 17 on the PTSD scale, and met criteria for a probable diagnosis of PTSD. The client did not meet screening criteria for CPTSD. "The ITQ was developed to be consistent with the organizing principles of the ICD-11, as set forth by the World Health Organization, which are to maximize clinical utility and ensure international applicability through a focus on the core symptoms of a given disorder" (Cloitre et al., 2018, p. 1). The ITQ was found to be responsive to change, and appropriate as an evaluative measure (Cloitre et al., 2021). In a study of 254 United States veterans, the ITQ captured reliable and clinically significant change during treatment. For the PTSD symptom cluster of the ITQ, Cloitre et al. (2021) calculated the reliable change index (RCI) to be 3.79. The client's change in PTSD score of 16 points, from 17 on her pre-treatment ITQ to 1 on her post-treatment assessment, would appear to be clinically significant. The client's total score for the PTSD criteria on the ITQ post-treatment was 1, and she no longer met criteria for a probable PTSD diagnosis based on this assessment.

At the post-treatment follow-up screening, the client scored 3 on the GAD-7. When asked what impact these symptoms of anxiety had on her ability to function, the client reported, "Not at all." GAD-7 scores between 0 and 4 are described as "minimal anxiety." In multiple studies, the GAD-7 has shown good psychometric properties (Kroenke et al., 2010; Lowe et al., 2008). Bischoff et al. (2020) established an RCI of 6 for the GAD-7 in both clinical and non-clinical populations, and found that the GAD-7 had good test-retest reliability. The client's reduction of 16 points from a score of 19 on the pre-treatment GAD-7 to 3 on her post-treatment GAD-7 screening is likely to be a reliable change as a result of treatment.

The Dissociative Experiences Scale (2nd ed.) (DES-II) can be used to track progress over time in treatment (Buchanan, 2023). A further review of the psychometric properties of the DES-II finds that while "the DES seems to measure the current view on past dissociative experiences," (van IJzendoorn & Schuengel, 1996, p. 365), it may not be a reliable indicator of clinically significant change as a result of treatment (Trujillo et al., 2022). The client was originally given the DES-II to screen

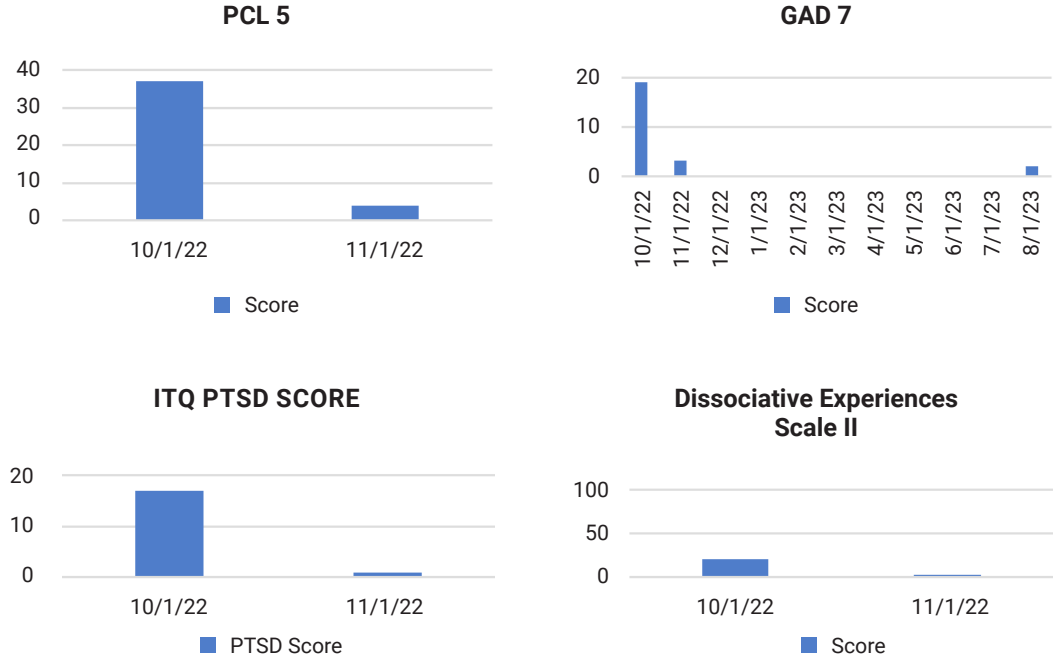


**Figure 2**.

for symptoms of trauma-related dissociation that might require additional treatment or make her a poor candidate for a case study. Her pre-test score was 20.71, and after six sessions of AIT treatment, she scored 10.71. The client's outcome on the post-assessment DES-II is noteworthy, but may not indicate clinically meaningful change.

The client consented to participate in a nine-month follow-up interview (8/23/23) with the clinician. She gave birth to her baby with no complications, and reported to the clinician that she was coping well with motherhood, and that reducing her pregnancy-related anxiety during treatment had generalized into being better able to manage her anxiety while parenting her newborn daughter. At the time of the follow-up interview, the GAD-7 was administered again, and the client's GAD-7 score was 2, with the client reporting that these anxiety symptoms made it "somewhat difficult" to do work, take care of things at home, or get along with other people. Scores of 0 to 4 on the GAD-7 indicate minimal anxiety, which is stable with her post-treatment score on the GAD-7, which was 3.

Utilizing SUDS scores is an ongoing cornerstone of AIT treatment that enables the clinician to assess the client's tolerance to interventions throughout the sessions. A midpoint check-in was also completed on 11/9/22 to assess if the client was experiencing any positive effects from treatment (see Table 3), and assessed whether treatment was having an impact on the client's identified goals. From her self-report and SUDS scale, the client identified that Advanced Integrative Therapy was helping her reach her treatment goals (see Table 3).

## Discussion

One of the strengths of this case was the thoroughness of the documentation pre- and post-intervention. Utilizing one intervention increased the clinician's ability to posit that Advanced Integrative Therapy had contributed to such a stark decrease in scores on her PTSD and anxiety screens. Conducting a nine-month follow-up assessment also adds validity to the claims of AIT's creator that it is "thorough and lasting" (Clinton, 2006). Another strength of the case is that the clinician utilizing Advanced Integrative Therapy has taken multiple advanced AIT trainings, and this skillset may have had an impact on the significant reduction of anxiety and PTSD symptoms. However, this may make such a study difficult to replicate on a larger scale. A final strength of this case is that AIT relies on manualized protocols, and is therefore easy to follow for novice and less experienced clinicians.

One of the limitations of the case is that although sessions were offered to the client at a reduced cost, she was paying privately for therapy with the clinician/researcher, and this may have given rise to social desirability issues, or to the client over-reporting positive changes, and under-reporting negative outcomes due to receiving treatment at a reduced cost (Nederhof, 1985). Another limitation of the case is that the client was previously engaged in psychotherapy with the clinician, and had already been using AIT in psychotherapy. Therefore, she had already "bought in" to the treatment modality. The client was self-referred to treatment, and had specifically requested to receive Advanced Integrative Therapy upon the recommendation of a friend. She then may have had some bias and expectation that the intervention would be successful, which could cause a placebo effect of expected outcomes for Advanced Integrative Therapy (Enck & Zipfel, 2019). Another potential limitation in the case is that the client was also going through physiological changes as a result of her cessation of cannabis use, which may have had an impact on higher scores on her pre-test evaluations. The early symptomatology of cannabis detox had likely resolved by the time that the client took her pre-test measures, but no assessments were taken of THC levels in her body at the time of the evaluation (Bonnet et al., 2015). At the final appointment, the client had been abstinent from cannabis for 20 weeks. An additional limit of this case study is that it used client self-report assessments rather than biometric measures such as cortisol levels or heart rate variability (HRV).

## Medical Literature Review

Currently, the body of literature in which to compare this study is quite small. There is a larger body of literature on the effectiveness of Emotional Freedom Technique (EFT) and Eye Movement Desensitization and Reprocessing (EMDR) on pregnancy-related anxiety (Baas, 2022; Irmak, Vural, & Aslan, 2019). Advanced Integrative Therapy has been compared to these interventions in both proposed mechanisms of action for its effectiveness,

and treatment outcomes for clients (Brown et al., 2023). This is the first case study to document the effectiveness of AIT on PrA, and there is a need for similar studies to be replicated in larger clinical and medical settings. The reduction in the client's scores on her post-treatment anxiety, dissociation, and posttraumatic stress disorder screening measures is significant enough to warrant further research into the viability of Advanced Integrative Therapy as a treatment for pregnancy-related anxiety. Emotional Freedom Technique (EFT) has been shown to be effective in reducing cortisol levels in pregnant women in multiple studies (Mardjan et al., 2018; Okyay et al., 2023), and EFT can be described as a body-based, somatic intervention. Cognitive Behavioral Therapy (CBT) also has a large body of research documenting its effectiveness in treating pregnancy-related anxiety (Donnegan, 2022, & Green, 2020). Advanced Integrative Therapy utilizes the depth framework of Jungian psychoanalysis and transpersonal psychology (Clinton, 2006), the desensitization of negative core beliefs as in CBT (Clinton, 2014), and a body-based, somatic component as with Somatic Experiencing, EMDR, and Emotional Freedom Techniques (Brown et al., 2023). AIT is better described as a psychological framework than simply a treatment intervention tool (Brown et al., 2023; Clinton, 2019). Therefore, it can be posited that AIT can provide the "best of all worlds" as a combined cognitive and somatic therapy that can reach profound psychological depth in a short amount of time. If the significant reduction of symptoms of PTSD and anxiety for the client in this case study is any indication, there is great promise in AIT's capacity to reduce the consequences of stored trauma in the body and break the cycles of intergenerational trauma.

## Key Takeaways of the Case Report

The most relevant takeaway from this case report is the speed with which Advanced Integrative Therapy worked to significantly reduce the client's symptoms of anxiety and posttraumatic stress disorder. AIT's thoroughness is evidenced by the order of treatment: 1) extinguishing blocking beliefs, which also acts as preparation for depth treatment; and 2) treating not only the events of the originating traumas, but also the traumatic lessons learned and the client's reactions, the dissociated emotions trapped in the client's psyche (also described as trauma splitting), and the somatized emotions that were stored in the body as physical manifestations of her symptoms. The nine-month post-treatment follow-up indicates that AIT worked to extinguish the symptoms, and they did not return. From the discussion of the relevant literature, it is evident that there is a need for further quantitative research into AIT's effectiveness that includes biometric measures.

At the time of this writing, one RCT to compare AIT and Emotional Freedom Technique had been recently published (Brown et al., 2023), and plans are underway for another RCT to compare AIT with CBT. This paper aims to garner interest from researchers in conducting more clinical research on the effectiveness of Advanced Integrative Therapy.

## Patient Perspective

In the post-treatment interview, the client was asked to share her perspective on treatment (11/21/22). When asked about her symptom reduction, she stated:

> "Aside from just recognizing when my reactions are related to my past traumas, I'm able to take myself away from them a little bit more, to be more rational in my responses to things. Previously I didn't... Now I can think, "What are the root causes of this? What are the things I can say to [myself] to be realistic and tangible?" Being easier on myself and cutting myself some slack. I'm a big avoider, so having to make these [AIT] statements and participating in AIT makes me give attention to these statements. My M.O. is to cover up, bottle up. Before it was replacement therapy, as in "How can I make myself feel better by being successful at something when I feel bad?" I am able to be more open with my partner because I'm more aware of things, and it's really helped our communication, and why I do the things I do. I definitely feel a lot less physically triggered. I have less of the physical symptoms. I haven't been crying as much this month, which is big for me. Before I was crying at least once a week, and I didn't know why. Over the last month, I cried once, and I knew exactly what it was about, and I addressed it." The client shared that she noticed that her dissociative symptoms were also reduced, saying "I'd make a plan to do something, and I'd forget I'd already done it. I don't know if I'm not forgetting as much, or if

it's actually that I don't feel this frantic effort, or dwelling on something that isn't necessary."

At the nine-month follow-up interview, the client stated:

"My ability to not be freaked out 24/7 about everything, or be in a state of anxiety about stuff, has been really great. That's not to say that things haven't been very challenging, but I'm like, "Oh I can handle it much better now." (Client's infant was seven months old at the time of the nine-month follow-up interview.)

"I think it [AIT] created an awareness...between what was going on in my mind and my body...I became aware of the connection between those two things, and that helped bring myself down. Because even now I have these brief moments where I'll get super anxious, or hyper-fixated on something, and start to feel a panic coming on, and I'm just able to walk myself out of that. I wasn't really aware of how bad the manifestations of my PTSD and my anxiety were affecting me on a day-to-day basis until I had it stop affecting me on a day-to-day basis."

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