Using Advanced Integrative Therapy With C-PTSD: A Case Report

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Key Words

Case Report, C-PTSD, AIT, Advanced Integrative Therapy, Complex Trauma

Abstract

Complex post traumatic stress disorder (C-PTSD) and adverse childhood experiences (ACE) pose health problems in the United States, and intergenerational relational trauma plays a role in the continuation and transmission of these issues. Advanced Integrative Therapy (AIT) was used to treat a case of C-PTSD with rapid elimination of distressing symptoms as well as marked improvement in the intergenerational relationship.. The client's primary concern was a flare-up of anxiety, relational distress, and fibromyalgia that occurred upon accepting custody of their nephew. Over a span of nine 90-minute sessions, the clinician measured progress using the multiple scales including the PTSD Checklist for DSM-5, the International Trauma Questionnaire and the the Child-Parent Relationship Scale which measures connection and conflict in the caregiver-child Relationship; The clinician also used the self-report questionnaires to measure client experience and perspective. After treatment with AIT, the client no longer met criteria for C-PTSD and showed dramatic improvement in intergenerational relationship satisfaction. Post treatment, there was a rapid reduction of hard to eradicate C-PTSD symptoms as well as reduction in the quantity and intensity of fibromyalgia induced pain. Use of AIT with caregivers could interrupt the transmission of intergenerational trauma thereby reducing preventing ACEs by increasing emotional regulation

and resilience.

Introduction

The connection between intergenerational relational trauma and C-PTSD is strong (Pears; Capaldi, 2001). Intergenerational relational trauma transmission occurs in a combination psychological, physiological, and social processes, which are the primary source (Aguiar;Halseth, 2015). Social transmission occurs when children learn and continue maladaptive behaviors such as substance use and violence (Bombay et al., 2009) and unskilled parenting and attachment rupture (Cicchetti & Toth, 1995; Spinazzola et al., 2018). Adult survivors of childhood trauma have been shown to perpetuate child abuse or neglect because their ability to appropriately respond to their children is inhibited (van der Kolk, 1989). This case is interesting and provides hope for the reduction of intergenerational social transmission of trauma because it indicates that relational conflict can be reduced and closeness can be increased through treatment of a caregiver's traumatic history. The case is also intriguing because the client no longer met criteria for C-PTSD after three sessions of AIT, and continued to report subclinically for at least three months post treatment.

Patient Information

Hazel (H) self-describes as "35 y.o., white, non-binary, biologically female, lower middle class using they/them pronouns." H was the second oldest child of five siblings whose biological mother "is an addict and severely mentally ill" and whose father was not present in their early childhood. H describes their childhood as "full of chaos, trauma, and severe emotional abuse and neglect. There were aspects of physical and sexual abuse intertwined throughout my childhood as well."

H describes the current relationships with biological mother and siblings as, "very distant

because any attempt at a relationship with her [mother] leaves me harmed. I am not close to
any of my siblings. It is painful to interact with them." H reported "a close emotional connection which feels meaningful and fulfilling" with their biological father and stepfamily. H is a licensed psychotherapist with training in Internal Family Systems and trauma recovery who reported they had already processed much of their intergenerational relational trauma. They reported feeling "stable" until their nephew (J) came to live with them in response to his mother's substance use and mental health issues. This change is what prompted reentry into treatment with the clinician.

Clinical Findings

H met criteria for C-PTSD and is diagnosed from their medical provider as having fibromyalgia. H's score related to their relationships with their nephew indicated high levels of conflict and low levels of closeness. H no longer met criteria for C-PTSD by the third AIT session in this series, and continued to remain subclinical for at least three months post treatment. Their relational scores reversed with a substantial reduction in conflict and a substantial increase in closeness at the end of treatment. The client reported that they had a reduction in physical pain, an increase in self worth and confidence and an increase in their experience of feeling loved and connected.

Treatment Timeline

	CPRS conflict CPRS Connection PCL-5	ITQ-11
Session One	40 21 58	49
Session Two	58	
Session Three	58	49
Session Four	45	

Session Five	22	23
Session Six	5	
Session Seven	26 34 12	8
Post Treatment Interview	3	1
One Month	8	2
Two Months	18 36 13	8
Four Months		11

Diagnostic Assessment

The clinician used the following quantitative instruments to scale and document client baselines and the change process: PTSD Checklist for DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders,* 5th edition; APA, 2013), abbreviated as PCL-5 (Weathers et al., 2013), which measures PTSD symptoms; International Trauma Questionnaire (ITQ; Cloitre et al, 2018), which measures C-PTSD symptoms according to the criteria of the World Health Organization (WHO) International Classification of Diseases, 11th Revision (ICD-11); Child-Parent Relationship Scale (CPRS; Pianta, 1992), which measures connection and conflict in the caregiver-child relationship; and the Subjective Units of Distress (SUD) scale (Wolpe, 1969), a self-report rating of the client's current level of distress or discomfort. The clinician also used the self-report questionnaire Helpful Aspects of Therapy (HAT; Llewelyn et al, 1988) and the Change Interview (CI) method (Elliott et al., 2001) to measure client experience and perspective. The PCL-5, HAT, and SUD scale were administered each session, the ITQ every other session and the CPRS at the first and last session. The CI was conducted post treatment. All sessions and interviews were conducted as online video sessions and were either audio recorded, contemporaneously auto-transcribed, or both. Transcriptions were edited for computer error and portions used in this report were compacted

and edited for readability.

H's initial scores of 58 on the PCL-5 and 49 on the ITQ indicated that they met the criteria for diagnosis of both PTSD and C-PTSD, with significant levels of distress across multiple criteria including hypervigilance, disruption to relationships, and difficulty transitioning back to emotional regulation. H's score on the CPRS indicated a relationship filled with conflict and very little connection. H also reported significant SUD levels for physical pain, fatigue, and emotional pain. H described their physical pain as " pain in all aspects of my body," emotional pain as "a breakdown at least once a week," and physical fatigue as "I'm tired all the time." All subsequent sessions began with the collection and documentation of scheduled quantitative and qualitative measurements and other paperwork.

Therapeutic Intervention

Nine 90-minute sessions of AIT treatments and interviews were involved. The first two sessions consisted of orientation to the case study, gathering baseline scores for ongoing measurements, and treatment with the client's modality of choice: Solution Focused Brief Therapy (SFT) and Internal Family Systems (IFS). The next five sessions followed AIT protocol with no other modalities used, as agreed to by the client. Sessions eight and nine occurred at H's request when meeting to complete after-care assessments, as previously agreed, and also used AIT as the sole modality. The clinician conducting the sessions (the author of this paper) has advanced certifications in Energy Psychology and AIT, and more than 10 years experience with AIT. In all the AIT sessions, the clinician adhered to AIT protocols and processes. The stationary hand placement, content of the narrative, and the length of each hold were client driven.

H entered services because of "a spike" in C-PTSD symptoms and fibromyalgia-related pain

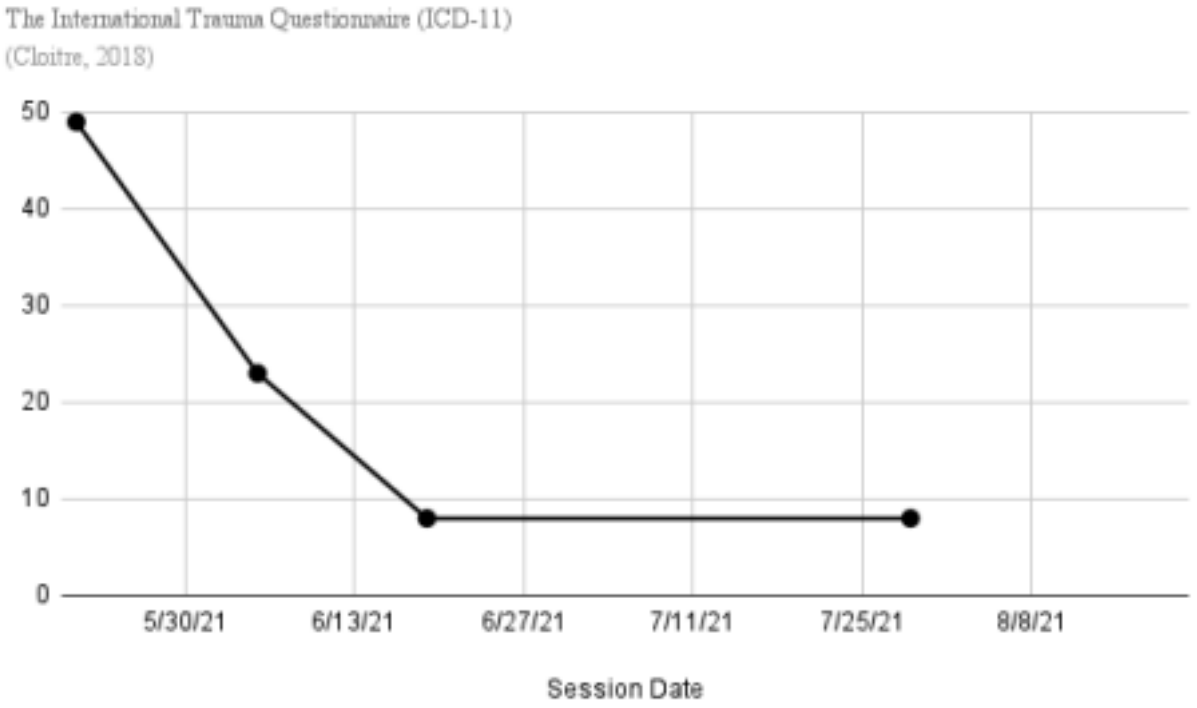
concurrent with them becoming the guardian of their nephew due to his mother's substance use disorder and failing mental health. The first two sessions consisted of orientation to the case study, gathering baseline scores for ongoing measurements, and treatment with the client's modality of choice, SFT and IFS. H reported they felt supported, gained insight, and had some relief. The next five sessions completed the original agreement for number of sessions and followed AIT protocol with no other modalities used. Sessions eight and nine occurred at H's request when meeting to complete after-care assessments, as previously agreed, and also used AIT as the sole modality. H's initial score on the PCL-5 was 58 and they met criteria for PTSD in all sections. At session five, H scored 12 and did not meet criteria in any section. At the final check-in, H scored 13. Their ITQ score at the initial session was 49 and they again met criteria for diagnosis in all sections. At final check-in, their score was 8, with no criteria met in any section. Additionally, their SUD scores for pain and fatigue decreased sustainably, with only fatigue returning, as reported at the two-month check-in. Notably, their scores related to their relationship with their nephew reversed, with conflict decreasing from 40 to 18 and connection increasing from 21 to 36.

Follow-up and Outcomes

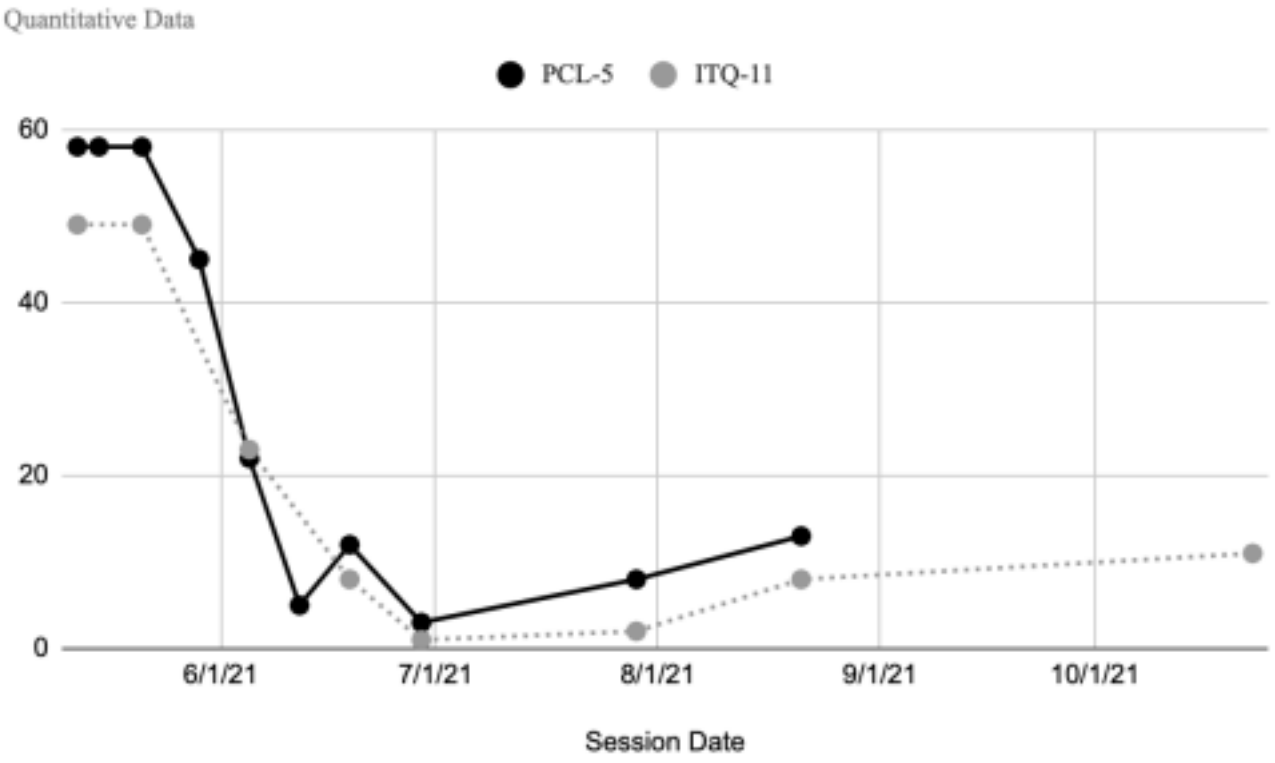
This series of treatments show dramatic and clinically significant quantitative and qualitative results in symptoms and diagnosis. The client no longer met the criteria for C-PTSD or PTSD by AIT session three, and their symptoms continued to decrease after treatment ended. Additionally, the client's CPRS scores showed a substantial and sustained decrease in relational conflict, and increase in closeness. The quantitative scores correlate to and are supported by the client's qualitative report of dramatic improvement in their experience of improved intergenerational relationships, as well as improvements in avoidance,

hypervigilance, reexperiencing traumatic experiences, self-worth, positive emotions, pain, fatigue, and overall functioning.

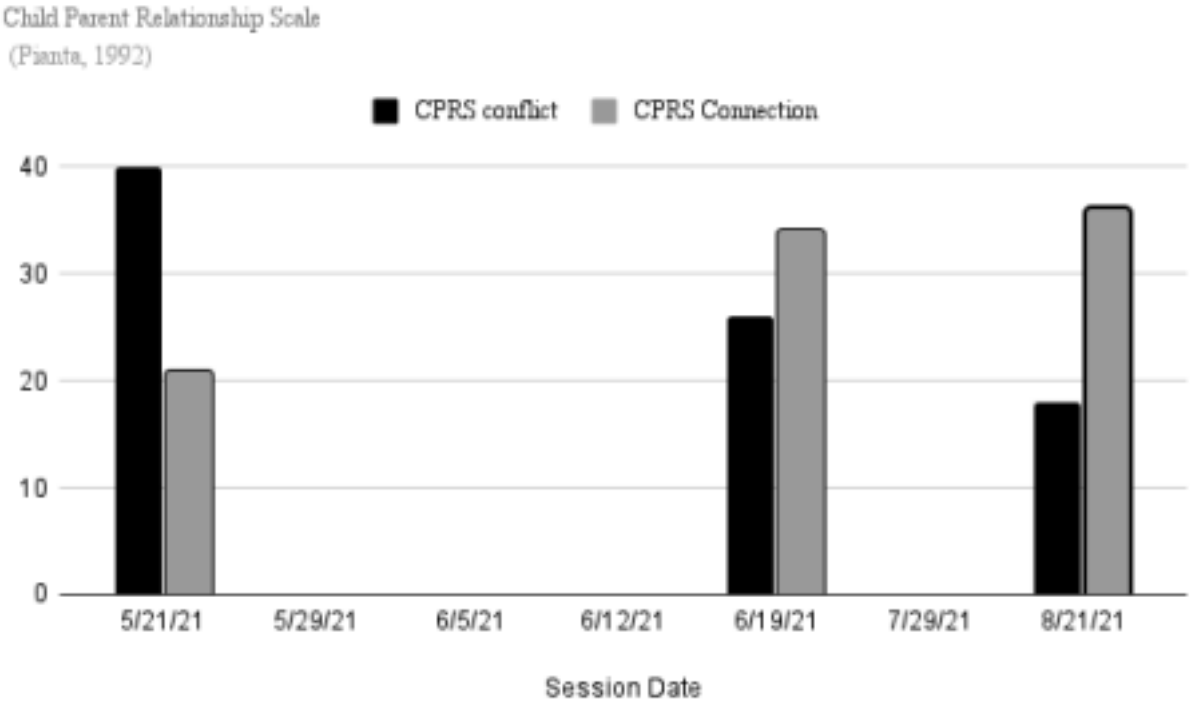
The PTSD Checklist for DSM-5 (PCL-5) data



International Trauma Questionnaire (ITQ) data.



The Child-Parent Relationship Scale (CPRS) data.



Discussion

The primary strength of this case study is that it methodically used many different scales to establish baselines and document change, as well as multiple methods of recording sessions to eliminate the contamination of therapist memory or perception. The primary limitation is the scale of the study, as it documents a single case.

When treatment began, H and the clinician had well-established rapport. H demonstrated ego strength in therapy and was able to decline clinician suggestions and redirect the treatment as desired. This supported H's ability to lead each session, which often resulted in finding unknown pockets of trauma as well as bursts of insight regarding core beliefs connected to the traumas or traumatic patterns. H is in the third stage of trauma recovery, reconnection of relationships, and should be considered advanced in their recovery. H created a clearly themed path for treatment both within sessions and in the series. Their treatment goal was to be able to manage life and the priority theme was processing and healing intergenerational relational trauma. H is insightful and able to access their internal and/or subconscious information during treatment, using body sensation, symbology, life memories, ego states and internal parts, inner children, and relationship dynamics to aid their process. They frequently sighed, moaned, or moved their body in response to treatment, with particular intensity near the end of each hand placement and in AIT sessions three and four during which the bulk of the traumatic narrative and energy were processed. This implies that client ego strength and a rapport of safety with a therapist is supportive and beneficial to the vulnerability required by the client to discover the deeper or hidden traumas as well as use nonverbal and somatic forms of expression.

The clinician experienced the flow of content from the client as clinically progressive and significant. The client's description of no longer feeling trapped and frozen and not having

“emotional meltdowns" are indicators of change in the nervous system. H was able to observe and process subconscious and embodied information in an organized manner where each session built on the one before it. This process that progressed their awareness and competency of (session 1) internal resources, (session 2) self-value, (session 3) self-regulation and nurturing, (session 4) belonging and connection, and (session 5) empowerment and freedom of expression/closeness. This shows some resolution of past trauma and arrested developmental tasks. Moreover, the client translated this their newfound awareness and competencies to their relationships, freeing themselves from the old paradigm of helplessness in relationships to confidence, connection, and satisfaction in partnering and parenting. Considerations of other mechanisms of change include the personal characteristics, therapeutic experience, and stage of recovery of the client; the experience and expertise of the clinician; and extended session length. The client is a mental health professional who had completed significant therapy and training prior to this series of sessions and is in the final stage of trauma recovery. They are emotionally articulate and have significant distress tolerance and ego strength. With this background, the session length could be extended to 90 minutes and include both information gathering and treatment. It is recognized that unless a client and clinician are willing to use extended services, some issues or rounds may take multiple sessions, thereby appearing to slow progress.

Participation in this case study offered H significant results in C-PTSD symptom resolution, pain reduction, and intergenerational relationship health and satisfaction. These results indicate that AIT is worth further investigation. In H’s case, AIT improved C-PTSD symptoms that impact relationships, resulting in decreased emotional dysregulation, negative self-concept, and interpersonal distress and improved relationship satisfaction of a caregiver, indicating that AIT treatment may decrease the transmission of intergenerational relational

trauma. Future generations could be less likely to absorb and transmit that same intergenerational trauma, leading to a positive cascading effect throughout our society if we can clearly identify the change mechanisms. H's results suggest that a long-term AIT study could help identify some of those mechanisms. Particular benefit may be found if AIT is offered to children who have been recently traumatized. AIT requires and deserves more research, both case studies and controlled trials, specifically in the area of epigenetics and the correlation and use of the chakra system for physiological interventions related to the autonomic nervous system and the endocrine system, as well as the clear identification of the mechanisms of AIT.

Patient Perspective

The clinician conducted the Change Interview (Elliott et al., 2001) at a posttreatment session AIT session five, as the was the last scheduled session in the series. Key observations the client reported were: "The full body fibromyalgia pain is gone." "My fatigue is gone, I have moments where I need to rest, and I'm fine resting, but then I feel better and then I'm energized again and that's never been true." "I've never felt such intense positive emotions in my life. I don't feel bogged down, I don't feel depressed, I don't feel anxious, I don't feel overwhelmed or scared. I just genuinely feel happy and joyous. Honestly, I'm kind of speechless about how good I feel." "I'm no longer trapped." "It feels like a very spiritual experience. It does feel like I have leveled up within consciousness."

H attributed their progress directly to the treatment: "I was headed in a direction of crashing and burning—in a significant amount of pain, always exhausted, always emotionally triggered, always feeling hopeless and overwhelmed, and just continuing to feel worse and worse. Once we started AIT, I very quickly progressed to feeling the way that I feel now. So undoubtedly,

there's no question that this is what did it." H also believes they were ready for change: "I've been in therapy for years. I've been working on myself for years and so there was a lot of the pre-work I did so my body was ready to release that trauma energy." H reported that one influence outside of treatment helped: "I've worked hard to build a good support system. And so the changes I was making helped me to feel safe enough and free enough to love and to really value and appreciate the relationships I already had." H also reported characteristics that supported change: "I think that I'm courageous. And I'm committed."

Informed Consent

Full written consent to participate in this case study and publish the results was obtained and the client's name and identifying details have been changed in this case report.