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Case Report

Integrating W.A.R.A.®, Brain-Switch 2.0®, and ReAttach® in the Treatment of Complex Trauma: An Exploratory Single-Case Report

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Abstract

Background: Individuals with complex trauma may continue to experience emotional distress, rumination, and maladaptive response patterns despite pharmacological treatment. Integrative interventions addressing affective responses, maladaptive patterns, and adaptive functioning warrant further clinical investigation.

Case presentation: This report describes a 23-year-old woman diagnosed with complex trauma who her psychiatrist referred because she was not responding adequately to prescribed antidepressant and anti-anxiety medication. She received an eight-session intervention delivered in three phases: one session of Wiring Affect with ReAttach (W.A.R.A.®) on Day 1; one session of Brain-Switch 2.0® on Day 2 to address maladaptive brain patterns; and six subsequent ReAttach® sessions, emphasizing Cognitive Bias Modification (CBM) 3, followed by CBM 1 and CBM 2.

Clinical observations: Following the Day 1 W.A.R.A.® session, the client reported a quieter mind, reduced rumination, greater calmness, and sleeping that night without sleeping medication. Brain-Switch 2.0® was administered on Day 2, which further enhanced her self-agency. Subsequent ReAttach® sessions integrated her sense of identity and improved boundary setting with her parents. At one-month post-therapy follow-up, the client reported improved management of rumination, greater emotional regulation, anxiety within normal ranges, preserved cognitive functioning despite ongoing family difficulties, and greater satisfaction with herself. Pre–post quantitative electroencephalography (qEEG) data showed changes in several recorded measures. The qEEG data indicated the absence of previous mental sluggishness, a clinically significant improvement in the trauma-related marker and emotional regulation within the normative range, and the absence of a depression-related marker.

Conclusion: This case documents the clinical sequence and reported outcomes of an integrative intervention combining W.A.R.A.®, Brain-Switch 2.0®, and ReAttach®. The findings are preliminary. Because the intervention involved multiple components, the case cannot establish conclusive treatment efficacy, causality, or the mechanism underlying the observed changes.

Keywords: Complex Trauma; W.A.R.A.; Brain-Switch 2.0; ReAttach; Cognitive Bias Modification; Affect Regulation; Rumination; Quantitative Electroencephalography; Memory Reconsolidation

Introduction

Complex trauma may be associated with persistent emotional distress, difficulties in affect regulation, heightened emotional reactivity, and disturbances in self-organisation (Cloitre et al., 2013). Trauma-related distress may persist when negative appraisals, strongly associative autobiographical memories, and habitual cognitive or behavioural responses continue to reinforce a perception of current threat, even when individuals have developed a conscious understanding of the experiences underlying their distress (Ehlers & Clark, 2000). Repetitive negative thinking may further contribute to the maintenance of anxiety and depressive symptoms (Watkins, 2008). Although pharmacological interventions can reduce symptoms of post-traumatic stress disorder (PTSD), their effectiveness varies across individuals, highlighting the importance of continued clinical assessment and individualised, evidence-based treatment (Hoskins et al., 2021).

A recurring challenge in clinical practice concerns the distinction between intellectual insight and changes in automatic emotional and behavioural responses. Individuals may recognise the origins of their difficulties while continuing to experience established patterns of anxiety, heightened threat sensitivity, emotional dysregulation, or rumination. This discrepancy suggests that conscious understanding, although potentially valuable, may not be sufficient to modify persistent emotional and behavioural patterns. Consequently, interventions that address affective responses, maladaptive cognitive patterns, and adaptive functioning warrant further clinical investigation.

Allostasis refers to the anticipatory regulation of physiological and behavioural processes in response to changing internal and environmental demands (Sterling, 2012). Complementary predictive approaches to brain function emphasise the contribution of prior experience and ongoing predictions to the interpretation of incoming information and the organisation of responses. Research has also examined large-scale brain systems associated with interoception and allostatic regulation (Kleckner et al., 2017). These frameworks provide a theoretical context for investigating emotional regulation, learned responses, and future-oriented expectations. However, they do not independently demonstrate that a particular therapeutic intervention modifies predictive processing or produces measurable neurobiological changes. Such interpretations require direct assessment and appropriate empirical evidence.

The present report describes an eight-session intervention integrating three approaches: Wiring Affect with ReAttach (W.A.R.A.®), Brain-Switch 2.0®, and ReAttach®. The intervention consisted of one W.A.R.A.® session on Day 1, one Brain-Switch 2.0® session on Day 2, and six subsequent ReAttach® sessions incorporating Cognitive Bias Modification 3 (CBM3). The report examines the client's subjective experiences across the intervention and considers whether the reported changes may be consistent with a more positive outlook and more adaptive future-oriented expectations. It also explores the hypothesis that the integrated approach may be associated with changes in emotional and cognitive processing. These interpretations remain exploratory and should not be understood as evidence of an established therapeutic mechanism or demonstrated efficacy.

The chronological sequence of the intervention is particularly important when interpreting the reported outcomes. The client described immediate changes following the initial W.A.R.A.® session on Day 1, before Brain-Switch 2.0® was administered on Day 2. Brain-Switch 2.0® was subsequently used to address the targeted maladaptive patterns, while the six ReAttach® sessions continued the therapeutic process. The temporal proximity between the initial session and the client's reported changes is clinically noteworthy; however, temporal association alone cannot establish causation. Similarly, changes observed over the full treatment period cannot be attributed independently to Brain-Switch 2.0®, ReAttach®, or CBM3 without a study design capable of distinguishing their respective contributions.

The report also documents clinician-reported quantitative electroencephalography (qEEG) findings obtained at the one-month follow-up. These findings are considered alongside the client's reported experiences as complementary sources of clinical information. Any interpretation of qEEG results must remain within the limits of the available recordings, acquisition and analysis procedures, and relevant normative or clinical evidence. In particular, qEEG observations alone cannot establish that a specific intervention caused a change in brain function, verify a proposed predictive-processing mechanism, or demonstrate clinical improvement without appropriate supporting evidence. The relationship between subjective improvement and qEEG findings should therefore be described in terms of observed correspondence, where supported by the data, rather than assumed mechanistic or causal links.

The purpose of this report is to document the treatment sequence, the client's reported experiences, and the clinician-reported qEEG findings at one-month follow-up within a clearly defined clinical and theoretical framework. It aims to describe an integrative therapeutic approach and identify questions for further investigation. Given the nature of a single clinical report involving multiple sequential interventions, the observations cannot establish comparative effectiveness, confirm a specific neurobiological mechanism, or determine the independent contribution of any individual treatment component. Further research using standardised outcome measures, clearly specified qEEG protocols, longer follow-up periods, and appropriate controlled designs would be necessary to evaluate the intervention's efficacy and investigate the mechanisms that may underlie any observed changes.

Case presentation

Client and referral

A 23-year-old woman client diagnosed with anxiety, depression and complex trauma. She was referred by her psychiatrist because she was not responding adequately to prescribed antidepressant and anti-anxiety medication.

The client reported taking Xanax and Zoloft and having received psychiatric treatment for the past three years. As her symptoms worsened, she was referred for additional psychotherapeutic intervention. According to the referring psychiatrist, "I think you have complex trauma," and "a neuroscience-informed intervention might be beneficial."

The client described a childhood marked by repeated disruptions in attachment, alongside ongoing emotional and psychological abuse. Her account suggested a prolonged experience of relational adversity within the family. Although the reported family dynamics appeared consistent with emotionally harmful and potentially narcissistic patterns of parenting, no formal diagnosis of either parent was established.

The report focuses on the treatment sequence and the clinical and neurophysiological observations. Identifying details have been omitted to protect the client's confidentiality.

Baseline presentation and qEEG

Quantitative electroencephalography (qEEG) is a computer-assisted method of analysing electrical activity recorded from the scalp. It enables the quantification of EEG characteristics, including frequency-band power, amplitude, spectral features, and measures of functional connectivity. These measures may be compared with normative databases to examine patterns of brain electrical activity. Their interpretation depends on recording quality, analytical procedures, reference standards, and clinical factors such as age, medication, sleep, and level of alertness (Coburn et al., 2006; Livint Popa et al., 2020).

Research has examined qEEG characteristics in relation to trauma-related symptoms, anxiety, depression, and cognitive impairment. Investigated measures include changes in oscillatory activity, frontal alpha asymmetry, cortical arousal, and event-related potentials. Although these findings may contribute to understanding the neurophysiological correlates of psychological distress, substantial overlap exists between diagnostic groups. Accordingly, qEEG findings should not be regarded as standalone diagnostic markers for most psychiatric conditions (Coburn et al., 2006; Newson & Thiagarajan, 2019).

In trauma-related conditions, EEG research has explored patterns associated with heightened arousal, attention to threat, and emotional processing. Research on depression has examined resting-state spectral characteristics and frontal alpha asymmetry, while studies of cognitive impairment have investigated changes in background rhythms and neural slowing. These findings remain dependent on the specific measures and clinical populations studied. No single qEEG pattern can independently establish the presence of psychological trauma, depression, or cognitive impairment.

The presenting concerns in the present case included difficulties with emotional regulation and persistent rumination. The baseline qEEG report identified several areas of concern, described in the supplied case materials as mental sluggishness, trauma, cognitive decline, emotional dysregulation, and depression. These terms are retained as the interpretations reported in the case materials; they should not be understood as independently established psychiatric diagnoses or validated qEEG biomarkers.

The supplied pre- and post-intervention qEEG comparison included measures of alpha activity at Cz and O1, the alpha response and recovery at O1, and theta and beta activity at F4–F3. The corresponding baseline values are presented in the Results section. These measures were examined to document differences in recorded brain electrical activity across the assessment period. Their clinical significance depends on the operational definitions, recording procedures, and interpretation criteria applied to each measure.

The qEEG findings were considered alongside the participant's self reported clinical outcomes. This combined consideration of

physiological recordings and subjective reports provides a broader description of the observed changes than either source of information alone. However, the qEEG differences do not independently establish that the participant's psychological symptoms had resolved, nor do they demonstrate that a specific neural mechanism accounted for the reported changes.

The findings must also be interpreted in the context of the intervention sequence: one session of Wiring Affect with ReAttach (W.A.R.A.®) on Day 1, one session of Brain-Switch 2.0® on Day 2, followed by six sessions of ReAttach® incorporating Cognitive Bias Modification 3 (CBM3). Given the single-case design and the sequential administration of these interventions, their individual contributions cannot be distinguished.

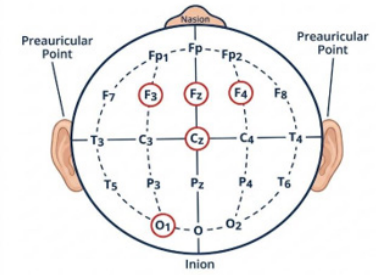


Figure 1: The five locations of the qEEG assessment neuromarker.

Overview of the Interventions

Wiring Affect with ReAttach (W.A.R.A.®) is an ultra fast approach intended to support affective regulation through structured attention to emotional and sensory experiences. Its core technique involves activation of the C-Afferent Fibres through gentle tappings. Their signals project through pathways involving the spinal cord and brain regions implicated in bodily awareness and emotional processing, including the insular cortex.

Brain-Switch 2.0® is a structured, neuroscience-informed intervention designed to interrupt maladaptive brain patterns. Its core technique combines an internal agreement to change, V-A-K (visual, auditory, and kinaesthetic) representations, structured switching imagery, and future-oriented rehearsal. The aim is to help individuals disengage from established responses and practise more adaptive patterns of emotional and behavioural responding through the process of memory reconsolidation.

ReAttach® is an approach that emphasises attention and arousal regulation, sensory integration, and the processing and integration of information. Its core techniques involve structured sensory and cognitive activities intended to support adaptive information processing and social-emotional functioning.

Together, the three approaches were applied sequentially, with W.A.R.A.® preceding Brain-Switch 2.0® and six subsequent ReAttach® sessions incorporating CBM 1, 2 and 3. The clinical rationale was to address affective regulation, interrupt established response patterns, and encourage more adaptive future-oriented expectations. This proposed integration provides a framework for examining changes in self-reported symptoms and qEEG measures.

Intervention

The intervention comprised eight sessions delivered across three phases. W.A.R.A.® and Brain-Switch 2.0® were administered on consecutive days, followed by six ReAttach® sessions.

Phase 1: W.A.R.A.®: Day 1

The first session used Wiring Affect with ReAttach (W.A.R.A.®), an ultra fast approach associated with the ReAttach framework and intended to work with affective responses.

Following this session, the client reported that her mind felt quieter, rumination had reduced, and she felt calmer. She also reported sleeping that night without sleeping medication.

These observations occurred after the Day 1 W.A.R.A.® session and before Brain-Switch 2.0® was administered. The chronology is clinically relevant because the initial subjective changes should not be attributed to a treatment that had not yet taken place.

The reported sleep experience refers to that particular night. The available account does not establish the client's usual medication schedule, whether she had previously been unable to sleep without medication on a consistent basis, or whether any change in medication use was medically supervised. The observation should not be interpreted as evidence that medication was no longer necessary.

A randomized, single-blind crossover pilot study has examined W.A.R.A.® in a heterogeneous clinical sample (Weerkamp-Bartholomeus et al., 2020). This provides preliminary research context for the approach but does not establish efficacy for complex trauma or validate the outcome in this individual case.

Phase 2: Brain-Switch 2.0®: Day 2

Brain-Switch 2.0® was administered one day after W.A.R.A.®. Its role in the treatment plan was to address maladaptive brain patterns and automatic response patterns that could continue to influence the client's emotional and behavioural functioning.

Brain-Switch 2.0® is a clinician-developed, neuroscience-informed approach intended to support work on maladaptive patterns and the development of preferred responses. The intervention was introduced as the second phase of the programme following the client's reported immediate experience after W.A.R.A.®. The clinical rationale for the sequence was to follow the initial affect-focused session with targeted work on maladaptive patterns.

Phase 3: ReAttach® and Cognitive Bias Modification : Six sessions

The third phase comprised six ReAttach® sessions. The treatment sequence emphasized Cognitive Bias Modification (CBM) 3, followed by CBM 1, CBM 2 and a combination of all three CBMs.

Within the framework used in this case, the components were described as follows:

- **CBM 1 - Acceptance and Differentiation:** Focuses on self acceptance and differentiation.
- **CBM 2 - Development and Learning:** Activates development and learning of new skill/s.
- **CBM 3 - Building Optimism Bias:** Focuses on building an optimism bias.

These components were incorporated into the subsequent ReAttach® sessions following the initial W.A.R.A.® and Brain-Switch 2.0® sessions. The six sessions were intended to continue the therapeutic work and support adaptive functioning.

The available account does not provide session-by-session outcome measures or sufficient detail to isolate the contribution of each CBM component. The sequence is therefore reported descriptively.

Results

Immediate response after W.A.R.A.®

Following the Day 1 W.A.R.A.® session, the client reported four immediate changes:

1. A quieter mind.
2. Reduced rumination.

3. Greater calmness.
4. Sleeping that night without sleeping medication.

Table 1: *Overview of the treatment sequence*

Timing	Intervention	Number of sessions	Intended clinical role
Day 1	W.A.R.A.®	1	Initial affect-focused intervention
Day 2	Brain-Switch 2.0®	1	Targeted work on maladaptive brain patterns
Subsequent sessions	ReAttach®	6	Continued therapeutic work incorporating CBM 3, followed by CBM 1 and CBM 2 and a combination of the CBMs in each session
Total	**Three-phase interventions**	**8**	**Integrated clinical programme**

These observations were reported before the Day 2 Brain-Switch 2.0® session. They represent the client's subjective experience following the first session, rather than a measured effect attributable to the full eight-session programme.

No standardized pre- and post-session ratings of rumination, anxiety, affect, or sleep were conducted. The immediate response is therefore presented as a qualitative clinical observation.

Clinical outcomes at one-month post-therapy follow-up

At one-month post-therapy follow-up, after completion of the eight-session programme, the client reportedly described the following changes:

- Better management of rumination and a calmer mental state.
- Improved emotional regulation.
- Anxiety described as being within normal ranges.
- Preserved cognitive functioning despite ongoing difficulties associated with her parents' emotional and psychological abuses and manipulations.
- Greater happiness and satisfaction with herself. In her own words, "I have even restarted my live Tik-Tok online sales of my creations."

These reports suggest that the client perceived improvements beyond the initial session. However, the available case materials do not include validated anxiety or depression scores, a standardized complex-trauma measure, independent ratings, or a detailed account of functional outcomes. The observations should therefore be understood as client self-reported clinical changes rather than independently verified symptom remission.

Pre–post qEEG findings

The supplied qEEG comparison presented baseline values pre – and post - at the one- month post therapy. The values displayed in the supplied image are transcribed below.

The table above summarizes the numerical neuromarker comparisons of the pre and post therapy.

The overall findings suggest the following:

1. **Mental sluggishness:** The marker previously interpreted as indicating mental sluggishness was considered absent after therapy.
2. **Trauma-related marker:** The O1 alpha response changed from −4 to 44. This is described as a clinically significant change in the trauma-related neuromarker.
3. **Emotional regulation:** The post-therapy findings were interpreted as consistent with improved emotional regulation.
4. **Depression-related marker:** The marker previously interpreted as indicating depression was considered absent after therapy.
5. **Cognitive decline:** The alpha recovery post therapy indicated the absence of the neuromarker for cognitive decline.

Table 2: *Pre–post qEEG findings*

qEEG neuromarker	Before therapy (all pre treatment data are negative)	One-month post-therapy (all post data are positive)
Cz alpha peak (Eyes Open)	8	13
O1 alpha response	-4	44
O1 alpha recovery	29	-50
O1 alpha peak (Eyes Close)	8	9.5
O1 alpha peak (Eyes Open)	8	1-
F4–F3 theta	14	7
F4–F3 beta	11	7

The numerical neuromarker related to trauma significantly changed from −4 to 44. It must be noted that the reported absence of a particular qEEG neuromarker does not, by itself, establish the absence or resolution of a psychiatric condition. Conversely, it indicates an absence of the trauma neuromarker. A review of qEEG in clinical psychiatry emphasized the importance of evaluating its clinical value and limitations in relation to specific applications (Coburn et al., 2006).

Integrated interpretation

The case contains three distinct categories of observation:

1. **Immediate subjective response:** The client reported a quieter mind, reduced rumination, greater calmness, and sleeping without sleeping medication following W.A.R.A.® on Day 1.
2. **Post-programme clinical report:** After the full eight-session programme, the client reported better management of rumination, improved emotional regulation, anxiety within normal ranges, preserved cognitive functioning amid ongoing family difficulties, and greater satisfaction with herself.
3. **Neurophysiological observations:** At one-month post-therapy follow-up, qEEG values differed from baseline indicating these changes as improvements in several clinical markers.

The distinction in timing is essential. The immediate response followed W.A.R.A.® and preceded Brain-Switch 2.0®. The later clinical and qEEG findings were documented after the full three-phase programme.

Discussion

A sequenced, integrative intervention

This case documents a three-phase clinical programme combining W.A.R.A.®, Brain-Switch 2.0®, and ReAttach® for a young adult diagnosed with complex trauma who had been referred because of an inadequate reported response to medication. The sequence was deliberate: W.A.R.A.® was administered on Day 1; Brain-Switch 2.0® was introduced on Day 2 to address maladaptive brain patterns; and six subsequent ReAttach® sessions incorporated CBM 3, followed by CBM 1, CBM 2 and a combination of all three CBMs.

The client reported immediate subjective changes after the first session and further positive clinical changes at one-month post-therapy follow-up. This provides a descriptive account of the client's experience across treatment phases.

Immediate response and subsequent change

The client's report after W.A.R.A.® is noteworthy because it was temporally distinct from the later phases. A quieter mind, reduced rumination, greater calmness, and sleeping without sleeping medication were reported after Day 1.

Brain-Switch 2.0® was subsequently administered on Day 2 to address maladaptive brain patterns. Six ReAttach® sessions followed. The later reports of improved emotional regulation and rumination management were recorded after completion of the programme.

This chronology should not be interpreted as proof of causality. The immediate response may have reflected the first intervention, contextual or expectancy effects, natural symptom fluctuation, or other factors. The subsequent outcomes may have reflected the combined programme or influences not measured in the case. Without repeated standardized assessments after each phase, the separate contributions cannot be determined.

A neuroscience-informed conceptual framework

Allostatic and predictive frameworks provide a broad conceptual basis for studying how prior experience, anticipated threat, bodily state, and emotional responses interact (Sterling, 2012; Kleckner et al., 2017). These frameworks may help formulate research questions concerning persistent emotional and behavioural responses following adversity. However, conceptual compatibility with neuroscience does not demonstrate that a particular intervention works through a specific neural mechanism. The present case did not directly measure memory reconsolidation, predictive processing, network-level change, or causal neural pathways. The qEEG findings also cannot independently demonstrate that maladaptive brain patterns were rewritten or that a particular mechanism produced the client's reported improvements.

The proposed clinical roles of W.A.R.A.®, Brain-Switch 2.0®, and ReAttach® should therefore be distinguished from experimentally established mechanisms. Further research would be needed to evaluate both clinical outcomes and proposed mechanisms.

Interpreting the qEEG findings

The pre–post qEEG comparison showed changes in the values reported for Cz alpha peak, O1 alpha response and recovery, O1 alpha peak, and F4–F3 theta and beta measures. The overall findings indicated the absence of previously identified mental sluggishness and depression markers, a change in the trauma-related marker, and improved emotional regulation. The change in the reported O1 alpha response from −4 to 44 is particularly important to be mentioned.

Clinical outcomes should be assessed independently using additional validated symptom and functional measures. Where feasible, follow-up data should be assessed by a clinician who was not responsible for delivering the intervention.

ReAttach Methodology Framework

In this case study, we examined how W.A.R.A., BrainSwitch2.0, and face-to-face ReAttach sessions were consciously and competently deployed in the treatment of complex trauma, and we evaluated the outcomes. When evaluating the therapist's choices against the ReAttach Methodology Framework (Bartholomeus, 2021) and the published protocols for early childhood trauma (Zeestraten-Bartholomeus & Bita, 2025), the use of the M.I.S.T. (Mapping the Individual State of Mind; Zeestraten-Bartholomeus, 2025) and systemic working, and therefore, so characteristic of ReAttach Affect Coaches, is missing. The therapist may have deliberately chosen this approach, which is justifiable given their clinical experience. However, the M.I.S.T. and Steven Painter's ESRM model are essential tools for mapping systemic co-regulation and designing tailored ReAttach sessions adapted to the autonomic state (Painter et al., 2026; Zeestraten-Bartholomeus et al., 2026).

When evaluating clinical practice against the ReAttach Methodology Framework (Bartholomeus, 2021; Zeestraten-Bartholomeus et al. 2026a), we also note the absence of ReAttach New Mind Creation: the technique used not only to establish secure attachment patterns but also to activate the Growth Mindset. This is a key point of consideration for this case study, as well as for education, training, and scientific research, because it does not reflect the complete approach as normally delivered.

Implications for future clinical research

This case supports further investigation into the feasibility and acceptability of a structured, multi-component intervention for individuals experiencing complex trauma and continuing difficulties despite pharmacological treatment. A prospective case series could improve the evidence base by including:

1. Validated baseline and follow-up measures of trauma symptoms, anxiety, depression, rumination, sleep, and functioning.
2. Session-by-session records distinguishing immediate responses from later outcomes.
3. Documentation of medication status and any medication changes, with appropriate medical oversight.
4. Follow-up assessments at predefined intervals to evaluate whether improvements are maintained.
5. Clear documentation of the content and timing of each W.A.R.A.®, Brain-Switch 2.0®, and ReAttach® session.
6. Independent outcome assessment where feasible.

Subsequent studies could investigate preliminary outcome patterns and safety, while comparative or dismantling designs would be required to evaluate the relative contribution of each component.

Limitations

Several limitations restrict the conclusions that can be drawn from this report.

First, this is a single-case report. It cannot establish efficacy, generalizability, or superiority over other interventions.

Second, the client received three interventions across eight sessions. Although the immediate response after W.A.R.A.® is temporally distinct from the later outcomes, the contributions of Brain-Switch 2.0® and ReAttach® cannot be isolated.

Third, the immediate and follow-up clinical outcomes were reported qualitatively. Standardized baseline scores, repeated symptom measures, and independent assessments were not available in the supplied material.

Fourth, the qEEG values were available from a pre–post comparison, but the complete technical report and validation information for the displayed measures could have been expanded.

Finally, medication details and the course of pharmacological management were not available. It is therefore not possible to determine how medication, changes in medication, or other aspects of clinical care may have influenced the observed course.

These limitations mean that the findings should be interpreted as a preliminary clinical description that may inform future research to test the efficacy of the integration of three methodologies.

Conclusion

This report describes an eight-session intervention integrating W.A.R.A.®, Brain-Switch 2.0®, and ReAttach® for a 23-year-old woman diagnosed with complex trauma who was referred by her psychiatrist

because of an inadequate reported response to antidepressant and anti-anxiety medication.

Following W.A.R.A.® on Day 1, the client reported a quieter mind, reduced rumination, greater calmness, and sleeping that night without sleeping medication. Brain-Switch 2.0® was administered on Day 2 to address maladaptive brain patterns. Six subsequent ReAttach® sessions emphasized CBM 3, CBM 1, CBM 2 and a combination of all three CBMs.

At one-month post-therapy follow-up, the client reported improved management of rumination, greater emotional regulation, anxiety within normal ranges, preserved cognitive functioning amid ongoing family difficulties, ability to create healthy boundaries with her parents and greater satisfaction with herself. qEEG values indicated an improved brain connectivity and function.

The principal contribution of this report is its documentation of the treatment sequence and the distinction between the immediate subjective response following W.A.R.A.® and the outcomes reported after the complete programme. The qEEG observations provide supplementary descriptive data but cannot independently establish treatment efficacy, resolution of complex trauma, or a specific neurobiological mechanism.

Declarations

Confidentiality: Identifying details have been omitted from this report. Any further details should be reviewed to ensure that the client cannot be identified.

Disclosure

The author is the creator of Brain-Switch 2.0.

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No funding was received.

Author Contributions

Dr. Lee, Duggal, and Dr. Mehrad prepared the clinical account and manuscript, subject to confirmation that the declaration meets the journal's authorship requirements.

Data Availability Statement

The clinical record and qEEG data are confidential and are not publicly available. Any data-sharing statement should comply with the client's consent, applicable law, and institutional policy.

Declaration of Generative AI-Assisted Technologies

Generative AI was used to assist with language editing, improving readability, and refining the structure and presentation of the manuscript. AI was not used as a substitute for the authors' research, clinical judgment, data analysis, or interpretation of the findings.

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