

EXTENDED ASSYST PROCEDURES EXPLANATION

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Syndrome and Mental Disorder

In pathology and psychiatry, a syndrome is defined as “a group of symptoms that together are characteristics of a specific disorder, disease, or the like” [1]. “A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognitive, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities” (p.20) [2].

Acute Stress Disorder and Posttraumatic Stress Disorder

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition; DSM-5), Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) are trauma-and stressor-related disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnosis criterion [2]. Acute Stress Disorder (ASD) is a mental disorder in which the essential feature “is the development of characteristic symptoms lasting from 3 days to 1 month following exposure to one or more traumatic events” (p. 281). The ASD has five symptom categories 1) Intrusion Symptoms, 2) Negative Mood, 3) Dissociative Symptoms, 4) Avoidance Symptoms, and 5) Arousal Symptoms. To meet the full diagnosis criteria, the client has to show the presence of nine or more symptoms from any of the five categories previously mentioned. It is important to note that “approximately half of individuals who eventually develop PTSD initially present with acute stress disorder” (p. 284) [2].

Posttraumatic Stress Disorder (PTSD) is a mental disorder occurring after exposure to one or more traumatic events (Criterion A), and is characterized by intense reliving of the traumatic event through intrusive memories and nightmares (intrusion symptoms; criterion B); avoidance of reminders of the event (avoidance symptoms; criterion C); negative alterations in cognitions and mood associated with the traumatic event (criterion D); hypervigilance toward potential threats in the environment (arousal symptoms; criterion E); and in some cases, persistent or recurrent depersonalization symptoms. Criteria A events include, but are not limited to, threatened or actual physical assault (e.g., childhood physical abuse, physical attack) and/or threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking) (p.274) [2].

Of special interest to this paper are the ASD and PTSD Intrusion Symptoms associated with the traumatic event(s), beginning after the traumatic event occurred, which are: B1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). B2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). B3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. B4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an

aspect of the traumatic event(s). B5. Marked physiological reactions to internal or external clues that symbolize or resemble an aspect of the traumatic event(s). *“These intrusive memories often include sensory (e.g., sensing the intense heat that was perceived in a house fire), emotional (e.g., experiencing the fear of believing that one was about to be stabbed), or physiological (e.g., experiencing the shortness of breath that one suffered during a near-drowning experience) components...Some individuals with the disorder do not have intrusive memories of the event itself, but instead experience intense psychological distress or physiological reactivity when they are exposed to triggering events that resemble or symbolize an aspect of the traumatic event”* (p.271, 282 & 283) [2].

Early Intervention Recommendations

“Early intervention” is a term used to describe psychotherapeutic interventions that are conducted shortly after a recent traumatic incident with four main purposes: 1) to treat ASD or PTSD symptoms, to reduce the acute distress, 2) to prevent the exacerbation of these symptoms, 3) to prevent the consolidation and accumulation of traumatic memories, and 4) to prevent the development of PTSD and other disorders. There is a consensus in the traumatic stress field that interventions within a three-month time frame are considered early. However, with prolonged adverse experiences (e.g., pandemics, sexual and/or physical violence, interpersonal violence, prolonged disasters, ongoing or prolonged traumatic stress), this time frame is less meaningful [3].

The World Health Organization (WHO), the International Society for Traumatic Stress Studies (ISTSS), and the National Institute for Health and Clinical Excellence (NICE) Clinical Guidelines recommend Early Psychosocial Treatment Interventions within the first three months of a traumatic event for the reduction/prevention of PTSD symptoms and the improvement of functioning/quality of life [4-6].

Emotions and the Nervous System Sympathetic Branch Hyperactivation

The most vivid and lasting memories are those of events accompanied by strong physical sensations associated with affective states (emotions /feelings, e.g., fear, helplessness, horror, anger, guilt, shame). Those physical sensations associated with feeling states seem to facilitate the consolidation of a long-term memory trace through the three major stress hormones: adrenaline (epinephrine), noradrenaline (norepinephrine), and cortisol via the adrenergic amygdala receptors. Specifically, norepinephrine has been found to enhance the memory consolidation process by which new learning, initially labile and susceptible to disruption, is transformed into long-term memories. Also, elevated noradrenergic activity (norepinephrine) is associated with the persistence and severity of PTSD symptoms [7].

These stress hormones are related to the nervous system sympathetic branch hyperactivation and contribute to a stronger consolidation of memories of high emotional arousal experiences, by causing noradrenergic excitement of the basolateral amygdala [8]. Persons with PTSD may experience emotional dysregulation, during which heightened affective-related bodily sensations, due to extreme fluctuations in arousal, may promote dysregulated affect and impulsivity [9].

Internal (e.g., nightmares, flashbacks, intrusive memories) or external (e.g., smells, noises, physical sensations, images on TV) triggers lead to a synthesis of the stress hormones that further reinforces the persistence of the traumatic memory [10]. Sympathetic peritraumatic activation and the subsequent elevated noradrenergic state are now considered to be the true factors of the chronitization of disorders and the best predictor of long-term PTSD [10-12].

The Importance of Sensory Processing

Sensory processing forms a significant basis for an individual's physiological state and is a critical determinant for one's engagement with the external world. On a neural level, the brainstem is critical for receiving raw sensory information, and then relays this information to higher-order cortical areas in the brain, including the Insula and the Prefrontal Cortex, which are principally involved in multisensory integration and emotional regulation (one's ability to control and manage emotional situations, including traumatic experiences), which shapes the perception of a sensory experience [13].

Persons with PTSD have shown unique neural signatures that overlap with key brain regions involved in the sensory transmission of incoming internal and external sensations, including the brainstem, the insula, and the prefrontal cortex. In individuals with PTSD, the reception and relay of sensory information are altered at the foundational level of the brainstem as a result of emotional reactivity due to chronic stress. Therefore, interruptions in sensory transmission from the brainstem to the cortex can lead to persistent activation of the innate alarm system, which may sustain instinctual defensive posturing behaviors [14-16]. Also, the impairments of the prefrontal cortex may potentiate dysregulated affective behaviors (emotion dysregulation), including alterations in emotion reactivity, that can directly influence the perception of incoming sensory input from within the body and the external world [17].

Adaptive Information Processing Theoretical Model

Each school of psychotherapy has its own theoretical framework to explain how therapy works. EMDR therapy has the Adaptive Information Processing (AIP) theoretical framework. Briefly stated, the AIP theoretical model, is a memory-related model of pathogenesis and change. According to this model, memory networks (patterns of linked individual memories with similar components) of stored experiences are the basis of both human mental health and human pathology across the clinical spectrum. Dr. Francine Shapiro posits that all human beings have an innate physical information processing system in the brain naturally geared toward health. When an experience is successfully processed, it is adaptively stored in the brain with other similar experiences. However, disruptions to this processing system due to high arousal states from critical incidents or adverse life experiences result in memories that are inadequately processed and maladaptively stored in the brain. These pathogenic memories are triggered by similar stimuli/information from the present and the person reacts to the present as if it were the same situation as the past. In other words, the past is present for these persons [18].

Acute Stress Syndrome Stabilization Procedures

The Acute Stress Syndrome Stabilization (ASSYST) © procedures in group, individual, and Web-based formats are AIP-informed, carefully field-tested, refined, and user-friendly psychophysiological algorithmic approaches, whose references are the EMDR Integrative Group Treatment Protocol for Ongoing Traumatic Stress (EMDR-IGTP-OTS) © and the EMDR Protocol for Recent Critical Incidents and Ongoing Traumatic Stress (EMDR-PRECI) © [19-23].

These treatment procedures are specifically designed to provide in-person or online support to clients who present Acute Stress Disorder (ASD) or Posttraumatic Stress Disorder (PTSD) intense psychological distress and/or physiological/somatic reactivity caused by the disorders' intrusion symptoms associated with the traumatic event(s) or adverse experience(s) memories. For example, recurrent memories, in the here and now, of the adverse experience(s) that include one or more of the following components:

Sensory (e.g., images, smells, sounds, touch or be touched, taste).

Emotional (physical sensations associated with affective states).

Physiological (visceral sensations: vomiting sensation, sense of heat for a burn victim, shortness of breath for a near-drowning experience survivor).

Intrusion symptoms are a core ASD and PTSD dimension. Traumatic reexperiencing can lead to extreme fear, horror, and fear of losing control when reliving the trauma. Therefore, focusing on this domain could identify targets uniquely related to trauma [24].

For the research and treatment fields, it is important to take into consideration that “*a focus on the unique symptom domain of intrusive and involuntary recollection and reexperiencing of the trauma in the here and now could guide mechanisms-oriented research and provide concrete strategies for enhancing treatment of posttraumatic psychopathology*” [25, p.119].

The ASSYST© procedures are Low-Intensity-Interventions (LII) that give us the possibility of direct, non-intrusive, physiological engagement with the client's distressing/pathogenic memories and their original components causing the nervous system hyperactivation (e.g., sensory, emotional [affective-related bodily sensations], and physiological encoded information).

LII are treatments with low utilization of a specialized therapist's time or brief versions of evidence-based approaches (max 6 sessions). LII are less resource-intensive, less expensive, less complex, shorter, effective, efficient, and more accessible than high-intensity treatments (face-to-face psychotherapy provided by a mental health specialist over extended periods of time) [26].

These procedures can be administered within the first hours or days after an adverse experience, or as an early intervention to approach ongoing traumatic stress situations, when the person shows severe symptoms of psychological distress, physiological reactivity, and/or deterioration in current functioning.

The objective of these procedures is focused on the client's nervous system hyperactivation regulation, through the reduction or removal of the activation produced by the sensory, emotional, or physiological components of the distressing/pathogenic memories of the adverse experience(s) to achieve optimal levels of nervous system activation; thus, facilitating the AIP system, the subsequent adaptive processing of the information [27].

The ASSYST© procedures fill the gap between Psychological First Aid (PFA) and High-Intensity Intervention psychotherapy (e.g., EMDR, TF-CBT) after a critical incident or adverse experience, when the person shows severe symptoms of psychological distress, physiological reactivity, and/or deterioration in current functioning.

These procedures must be administered within a Stepped Care Context to help the person achieve a state of adaptive functioning or, via screening, to facilitate access to High-Intensity Intervention psychotherapy when necessary.

ASSYST Research

The ASSYST procedures in-person have been used with hundreds of natural and human provoked disaster survivors (e.g., earthquakes, hurricanes, landslides, gas explosion), mass shooting victims, and political riots.

The ASSYST-Remote procedures, in individual and group formats, were used extensively as early interventions to approach the COVID-19 ongoing trauma during the year 2020. Over one-thousand persons living with ongoing traumatic stress were treated on a pro-bono basis in Latin America, the United States, and the United Kingdom. Two published research studies provided evidence of the effectiveness, efficacy, feasibility, and safety of the ASSYST procedures in reducing subjective perceived disturbance and posttraumatic stress disorder, anxiety, and depression symptoms in the general population living with ongoing traumatic stress during the COVID-19 pandemic [27-28].

More Information about the ASSYST Procedures

To learn more about the ASSYST procedures, please visit

<https://www.scalingupemdr.com/assyst-remote-online-training>

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