Comparison Chart between the Acute Stress Syndrome Stabilization (ASSYST) Individual Treatment Intervention and the Eye Movement Desensitization (EMD).

Acute Stress Syndrome Stabilization (ASSYST) Individual (1-2)	**Eye Movements Desensitization (EMD) Francine Shapiro (3-4)**	**NOTES**
PROCEDURE'S OBJECTIVES AND PHASE ONE		
This Adaptive Information Processing (AIP)-informed Treatment Intervention is an **evidence-based psychophysiological algorithmic symptom-focused trauma-sensitive approach** 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 reactivity caused by the disorder's **intrusion symptoms** associated with the traumatic event(s) or adverse experience(s) **(recent or old) memories.** The **objective** of this treatment intervention is focused on the **client's autonomic nervous system regulation** through the reduction or removal of the activation produced by the components of the pathogenic memories of the adverse expererience(s) to achieve optimal levels of nervous system activation; thus, **facilitating the AIP system the subsequent adaptive processing of the information.**	This AIP-informed procedure is for **selected clients who can easily get emotionally overwhelmed and dysregulated**. This procedure aims to **reduce arousal and increase stability.**	Note: The ASSYST Individual (ASSYST-I) is a **timeless treatment intervention to address ASD or PTSD Intrusion Symptoms.** Note: the ASSYST Individual **fills the gap between Psychological First Aid (PFA) and High-Intensity Intervention psychotherapy** (e.g., EMDR, TF-CBT). Note: The ASSYST Individual can be used **during the standard EMDR protocol to increase the prevention of dissociative reactions while reprocessing consolidated pathogenic memories.**

Ask the client to briefly describe the adverse experience (no more than 5 minutes). No details. No Bilateral Stimulation (BLS). No probe for early client history. Asks for mental health problems, prescribed psychiatric medications, and for emergency contact.	Collects history according to EMDR standard protocol procedures.	
PHASE TWO		
The clinician obtains informed consent, teaches eye movements (EM), tapping, the Butterfly Hug (BH), and asks the client to tap on his/her own legs and to march while sited. Also, the clinician explains the meaning of the word disturbance.	Follows standard EMDR protocol procedures.	
Uses Jarero & Artigas's post-disaster self-soothing strategies.	Uses standard EMDR protocol safe place and phase 2 strategies.	
PHASE THREE FOR INITIAL TARGET		
To encompass the whole traumatic stress spectrum, the clinician asks the client to run a mental movie of the whole event from right before the beginning until today, or even looking into the future (to scan for flash-forwards) and at the end, to mention the worst part. Then, the worst part is assessed for specific somatic-sensory information using the SUD scale. The location of body sensations is identified. There is no NC, PC, or VOC.	Use the standard Phase 3 assessment with image, Negative Cognition (NC), Positive Cognition (PC), Validity of Cognition (VOC), emotion, SUD, and location of body sensations.	

PHASE FOUR FOR INITIAL TARGET		
The instruction to the client, "Let whatever happens happen," **allows for spontaneous memory associations.**	Instruct the client to **hold in mind** the image and negative cognition during bilateral stimulation (BLS).	Note: The ASSYST-I does not confine the spontaneous memory associations **but the memory association's reprocessing by returning to the target after each set of BLS.**
Apply fast and long sets (50+ passes) of BLS. Eye Movements (EM) are the first option. At the end of each set, the client is instructed to take a deep breath, return to the target, observe his/her body, and give a SUD on the intensity of the somatic-sensory memory component. Then, the clinician asks for the location of the body sensation and instructs the client to follow the fingers and let whatever happens happen to allow for free-associative reprocessing. After each set, the clinician returns to the target until SUD reduces between 0 and 3, which is an optimal activation level inside the Window of Tolerance.	**Apply short sets** (12-20 passes) of bilateral stimulation (BLS). **At the end of each set**, the client is instructed to "Blank it out" (the image) or "Let it go and take a deep breath." To "blank it out," clients can be coached to simply draw a curtain over the material. Then, the clinician asks, **"What are you noticing now?"** or **"What do you get?"** The clinician returns to the target image and negative cognition after each set until SUD reduces to 0 or is ecologically appropriate.	Note. In the ASSYST Individual, the clinician **does not instruct** "Blank it out" or "Let it go." Note. In the ASSYST Individual, the clinician **does not instruct,** "What are you noticing now? or What do you get?" Note. During the ASSYST Individual, if the SUD does not decrease or decreases very slowly, the clinician can ask the client to do other BLS methods while doing the EM **to increase the working memory taxation**.
PHASE FIVE FOR INITIAL TARGET		
This part is not carried out because treatment intervention aims to reduce or remove the disturbance produced by the somatic-sensory components of the pathogenic memory, not to obtain a positive belief and to ensure that it accurately reflects the client's experience of self.	Once the desired treatment effect has been achieved, begin Phase 5. Installation of the PC uses standard EMDR procedures, which include focusing on both positive cognition and the target memory while doing BLS and frequently checking VOC.	

PHASE THREE FOR OTHER DISTURBING PARTS		
The clinician asks the client to run a mental movie of the whole event from right before the beginning until today or even into the future (to scan for flash-forwards) and report the remaining parts with disturbance.	If other associations arise, shorten subsequent sets. Use a containment strategy and return to the initial target.	**Note: EMD does not reprocess any other parts with disturbance, while the ASSYST-I does.**
Each disturbing part is assessed by measuring specific somatic-sensory information with the SUD scale. Body sensation location is identified. No NC, PC, or VOC.		
PHASE FOUR FOR OTHER DISTURBING PARTS		
The instruction to the client, "Let whatever happens happen," **allows for spontaneous memory associations.**	It is not conducted.	
Apply fast and long sets (50+ passes) of BLS. Eye Movements are the first option. Follow the same instructions as the ones described before. Once the entire event can be visualized without high distress, the clinician moves to phase 6.	It is not conducted.	
PHASE FIVE FOR OTHER DISTURBING PARTS		
This part is not carried out because this treatment intervention aims to reduce or remove the disturbance produced by the somatic-sensory components of the pathogenic memory, not to obtain a positive belief and to ensure that it accurately reflects the client's experience of self.	It is not conducted.	

PHASE SIX BODY SCAN		
The patient is instructed to close his/her eyes, think about the whole event, scan his/her body from head to feet, and open the eyes when finished. If a disturbing body sensation is reported, it is measured with the SUD scale and located in the body. The clinician applies fast and long sets of BLS until disturbance reaches SUD between 0 and 3. The clinician repeats all phase 6 instructions after each set of BLS to be sure the body scan is clear.	**Do not do a Body Scan when using EMD.** **The body scan is skipped.**	
PHASES SEVEN AND EIGHT		
Phase seven uses Jarero & Artigas's post-disaster self-soothing strategies.	Phase seven uses standard EMDR state shift strategy.	
Phase eight. If in the previous session the most disturbing part remains unfinished (SUDS higher than 3), go back to this part in the next session. In any other circumstance, we go to Phase 3 to scan for other disturbing parts.	Phase eight. Once the desired treatment effect has been achieved, **re-access the original target and resume treatment.**	

Note: This table does not contain the full steps description for any of the procedures, but lists those elements that are similar and dissimilar.

References.

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3. Shapiro, F. (2018). **Eye movements desensitization and reprocessing. Basic principles, protocols, and procedures** (Third edition). Guilford Press.

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