SUMMARY OF MASTER'S THESIS:Integration of Brainspotting Therapy into Cognitive-Behavioral Therapy

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Abstract

In contemporary psychotherapeutic practice, therapists encounter various client issues and employ different methods to achieve positive therapy outcomes. Many of these issues addressed in psychotherapy stem from psychological traumas and traumatic memories. In the master's thesis titled "Integration of Brainspotting Therapy into Cognitive-Behavioral Therapy," we addressed the question of whether integrating Brainspotting therapy into Cognitive-Behavioral Therapy is meaningful in terms of the effectiveness of the therapeutic process.

The main objective of the master's thesis was to examine the feasibility of integrating Brainspotting therapy into Cognitive-Behavioral Therapy for addressing issues caused by psychological traumas and traumatic memories. This was achieved through a study that involved a review of academic literature and gathered therapists' opinions. The aim of the empirical part of the thesis was to investigate the possibilities of integrating Brainspotting Therapy into Cognitive-Behavioral Therapy, relying on the insights and experiences of therapists. Another objective was to assess the advantages and disadvantages that therapists observed in implementing each approach and to determine the cases in which they considered the integration of Brainspotting therapy into Cognitive-Behavioral Therapy suitable, as well as the situations in which they believed such integration or combination of approaches was not meaningful or had no effect.

This kind of research can provide a significant contribution to psychotherapeutic practice and, consequently, benefit individuals dealing with psychological traumas. Clients often face challenges arising from traumatic memories, making it crucial to employ an appropriate psychotherapeutic approach that contributes to their recovery. Integrating Brainspotting therapy into Cognitive-Behavioral Therapy could represent an innovative and effective approach to addressing these issues, potentially enhancing the quality of life for those facing them. The research results could also benefit therapists by providing them with additional knowledge on how to combine different psychotherapeutic methods to achieve optimal therapeutic outcomes, as such research has not been conducted before.

Keywords: integration, cognitive-behavioural therapy, brainspotting therapy, psychological trauma.

1. Introduction

Cognitive-Behavioral Therapy (CBT) and Brainspotting Therapy (BSP) are both effective in addressing psychological issues, but they differ in their approach. Cognitive-Behavioral Therapy focuses on changing negative thought processes and behavioral patterns in clients, while Brainspotting Therapy focuses on identifying and processing deep neurophysiological processes related to emotional and psychological issues. It accesses traumatic experiences stored in the subcortical part of the brain through a point of gaze in the visual field (Beck, 2011; Grand, 2013). While these therapies differ significantly in their foundation, the question has arisen as to whether integrating BSP therapy into CBT therapy would make sense and be beneficial from the perspective of achieving a better and more effective therapeutic outcome for the client.

2. Cognitive-Behavioral Therapy

Thus, CBT is a form of talk therapy that involves identifying and changing negative thoughts in a way that helps an individual learn alternative patterns of thinking and behavior, which can improve their emotions and experiences. CBT examines the relationship between thoughts, emotions, and behavior, drawing from two psychological schools: behaviorism and cognitive therapy (Morrow, 2022).

2.1. Research on the effectiveness of CBT

Numerous research studies provide evidence of the effectiveness of CBT, and below are some of them.

Hall et al. (2016) conducted a systematic review of meta-analyses on CBT for generalized anxiety disorder (GAD) in older adults. The study found that CBT is effective in treating this condition, leading to a significant reduction in anxiety symptoms compared to the control group. The therapy's effectiveness was not influenced by age or gender.

In their 2016 study, Ye et al. conducted a meta-analysis of randomized controlled trials on CBT for bipolar disorder (BD). It was found that symptoms in clients were effectively reduced by CBT, and the condition was shown to be comparable to medications in terms of treatment. Moreover, even greater effective-

ness in treating bipolar disorder was observed when CBT was combined with medications.

In 2017, Linardon et al. undertook a systematic review of meta-analyses on the effectiveness of CBT for eating disorders (ED). The review showed that CBT is effective in treating eating disorders as it contributes to reducing symptoms and improving the quality of life for clients with ED. They found that CBT is equally effective as other psychotherapies but is superior to interpersonal psychotherapy in improving clients' conditions.

Young, Moghaddam, and Tickle (2020) conducted a systematic review and meta-analysis of randomized controlled trials on CBT for adults with ADHD. The study found that CBT effectively treats ADHD in adults, showing a significant reduction in symptoms compared to the control group. Morever, individual delivery of CBT was found to be more effective than group therapy.

Fordham et al. (2021) conducted a meta-review and panoramic meta-analysis on the effectiveness of CBT across different conditions and populations. The study found CBT to be effective in treating various psychiatric and neuropsychiatric disorders, such as anxiety, depression, PTSD, OCD, ED, chronic pain, and substance abuse. Additionally, the findings indicated a superiority of CBT over other forms of psychotherapy and pharmacological treatments.

In 2007, Bisson et al. conducted a systematic review and meta-analysis of 38 controlled trials on psychological therapies for chronic PTSD. They found that trauma-focused CBT and EMDR therapy were effective in treating chronic PTSD compared to other therapies. Moreover, both CBT and EMDR therapy were more effective in managing stress than other treatment approaches.

Therefore, CBT is an effective, empirically supported approach that focuses on cognitive processes and the connection between thoughts, emotions, and behavior in a specific context. It targets the ability to change cognitive processes and behaviors, utilizing various techniques through which the therapist guides the client to gain insight into the link between thoughts, emotions, and behavior. This helps in problem-solving and coping with various mental difficulties.

3. Brainspotting Therapy (BSP)

BSP is a relatively new form of therapy aimed at accessing, processing, and overcoming trauma, negative emotions, as well as physical and psychological pain. It is a psychotherapeutic approach that focuses on discovering and activating points in the visual field associated with specific traumatic experiences, enabling processing and integration of these experiences on a deeper neurological level (Grand 2013). Compared to traditional talk therapy, which reaches conscious thought processes in the brain's neocortex with limited access to deeper brain regions, the goal of BSP is to bypass the neocortex and reach deeper areas. This allows access to the traumatic memory stored in various brain regions, including the amygdala, hippocampus, cortex, and other parts of the limbic system. This psychotherapeutic approach utilizes the visual field as a crucial element of therapy to determine the appropriate eye position or brainspot where the client experiences a strong emotional and physical response. The theoretical foundation of this method is that the chosen brainspot aligns with deeper brain regions where information about trauma and other psychological and physical symptoms is stored (Grand 2013). By identifying the brainspot, we can precisely access these regions and process issues in a way that cannot be achieved through conversation alone (Grand, 2013; Corrigan and Grand, 2013; Blanchfield, 2022).

BSP therapy combines elements of EMDR therapy, mindfulness, and brain and Somatic Experiencing (SE). It is based on the belief that specific eye positions can trigger emotions, sensations, and memories, accessing certain brain points called brainspots, where traumatic memories are stored (Carrigan and Grand, 2013; Hildebrand, Grand, and Stemmler, 2014). In addition to using eye positions to access traumatic memories, this approach also incorporates mindful awareness to process these memories and bodily sensations (Hildebrand, Grand, and Stemmler, 2014; Van der Kolk, 2014).

Thus, BSP is a tool that allows access to the subcortical part of the brain to address emotional and physiological capsules where unprocessed or unintegrated traumatic experiences are stored. The method's founder, David Grand, and neuroscientist Frank Corrigan confirmed in 2013 that BSP works on the neocortex, limbic system, and brainstem, indicating the physiological basis of the therapy. The authors also note that BSP particularly emphasizes accessing the right hemisphere, which plays a significant role in processing sensory information and emotions, aiding in the healing of traumatic experiences. These findings characterize the method as a physiological process with psychological consequences (Corrigan and Grand, 2013).

The brain and body are interconnected as a whole through the nervous system. The brain's ability allows it to observe both the body itself and specific activities occurring within the brain, both on psychological and physical levels. When a traumatic experience happens in the body, the brain does perceive it, but it is unable to process and integrate it into the entire nervous system. Due to the survival instinct and the desire to restore balance in the entire nervous system, this experience is pushed into deeper, unconscious subcortical regions of the brain or subcortex. Thus, the experience remains stored in the nervous system as somatic memory in the body, and in the subcortex as a "stuck" or "frozen" emotional and physiological capsule, containing all memories, sensations, and feelings related to the event. Because the event is still present in the brain, every time something within us or in the environment reminds us of it, the subcortex activates to protect us from re-experiencing the memory (Corrigan and Grand, 2013).

3.1. Research on the effectiveness of BSP

Hildebrand, Grand, and Stemmler (2014) conducted a study on the effectiveness of BSP with 22 clients diagnosed with PTSD. The results of the study showed that BSP is an effective therapeutic method for treating PTSD. Both therapists and clients reported a significant reduction in PTSD symptoms after three therapeutic sessions of BSP. Clients reported a decrease in

emotional burden resulting from reduced negative cognition related to the traumatic experience. The same authors conducted another study in 2017, comparing the effectiveness of two methods for treating PTSD: BSP and EMDR. The study involved 76 adults with a history of traumatic events. Half of the participants underwent EMDR, with three 60-minute therapeutic sessions, while the other half underwent three 60-minute therapeutic sessions of BSP. Both methods showed a significant improvement in symptoms of PTSD. The authors concluded that BSP, like EMDR, is an effective and successful method for treating PTSD (Hildebrand, Grand, and Stemmler, 2017).

The case study of a 30-year-old individual with PTSD, who survived the shooting at the Bataclan in Paris in 2015, also confirms BSP as a highly effective method for processing the traumatic experience. Seven months after the traumatic event, the individual exhibited pronounced PTSD symptoms, which significantly reduced after just one therapeutic session of BSP, as this method facilitated the processing of the traumatic memory. An important finding was that the reduced symptoms persisted even three months after the therapeutic session. However, occasional nightmares still occurred, indicating the need for additional therapeutic sessions to fully process the trauma (Masson, Bernoussi, and Requrd-Laizeau, 2016).

In their article discussing the neurological aspects of BSP research, Corrigan, Grand, and Raju (2015) argued that traumatic experiences are not fully integrated when certain aspects of the experience are not accessible on a cognitive level. Reconnecting with specific elements below the level of consciousness requires attention to the bodily sensations triggered by fragments of the memory of the experience. These bodily sensations, arising from the memory of the traumatic experience, travel to higher brain centers through existing spinotthalamic tracts (the sensory connection between the brain and body responsible for transmitting pain, temperature, itchiness, and coarse touch). In both BSP and other PTSD therapies, effective treatment occurs when a complete orientation is established in the memory through specific neural pathways, enabling coherent thalamocortical processing. This neutralizes the brain's response to the traumatic memory, and the emotional reaction to that memory is no longer disruptive. As a result, the memory can be experienced without stress, as the physiological activation of the memory no longer occurs (Corrigan, Grand, and Raju, 2015).

The effectiveness of BSP is also confirmed by the report of the Newtown-Sandy Hook Community Foundation, established to support individuals and the community affected by the tragic shooting at Sandy Hook Elementary School on December 14, 2012. Among all the methods used to alleviate traumatic symptoms, BSP was rated the most highly by individuals who experienced the traumatic event (Newtown-Sandy Hook Community Foundation, 2016).

In a clinical experimental study conducted by Dr. Andregg (2015), three therapeutic techniques for treating generalized anxiety disorder (GAD) were compared to a control group. The techniques included CBT, EMDR, and BSP. The study included a total of 78 individuals with generalized anxiety disorder, who were randomly assigned to the therapeutic groups with 19 individuals in each group (CBT, EMDR, and BSP), while 19 individuals remained in the control group. Clients did not receive any other therapies to alleviate GAD symptoms before the study. The effectiveness of therapeutic approaches was assessed based on the following psychometric measures: Spielberger State-Trait Anxiety Inventory (STAI), Beck Anxiety Inventory (BAI), and Subjective Units of Disturbance Scale (SUDS).

The study to measure the effectiveness of three psychotherapeutic approaches was conducted based on 12 individual therapy sessions. The effectiveness of the therapies was assessed before, after, and during a follow-up phase, six months after completing the therapy. The study revealed that all three therapies significantly influenced the treatment of GAD in most individuals. However, therapies based on reprocessing with neurobiological foundations, such as EMDR and BSP, were more effective than traditional CBT, especially BSP. While symptoms improved with CBT, clients experienced a slight worsening of symptoms after 6 months. Post-treatment analysis did not show significant differences between EMDR and BSP, as clients maintained their results. However, in further psychometric analysis 6 months after completing the treatment, BSP demonstrated significantly better results compared to EMDR, as the outcomes not only were maintained but also further improved (Andregg, 2015).

The study on the effectiveness of BSP was conducted in the Philippines, involving 13 women who had experienced severe interpersonal trauma and had significant PTSD symptoms for at least 2 years. Each participant attended 3 BSP sessions, and their condition was assessed at 3 points: before therapy, after therapy, and two weeks after completing the therapy. The effectiveness of BSP therapy was measured using the Complex PTSD Symptoms Scale (CAPS-5) and the PTSD Checklist for DSM-5 (PCL-5), a self-assessment scale for measuring the presence and severity of PTSD symptoms. The results showed a significant improvement in PTSD symptoms, both on the CAPS-5 scale and the self-assessment PCL-5 scale. After the 3 therapy sessions, the study participants reported positive effects, such as the absence of symptoms or very mild PTSD symptoms. This improvement was maintained during the short-term follow-up. The research thus demonstrated the high effectiveness of BSP in reducing PTSD symptoms (Palismon, 2022).

Although an individual study conducted on a smaller sample size, further research is needed to confirm the effectiveness of BSP fully. However, there is sufficient evidence to consider BSP as an effective tool in treating various psychological conditions caused by traumatic memories.

4. Top-down and Bottom-up approaches

CBT and BSP approaches also differ in terms of information processing.

CBT falls under the ”top-down” approaches, which refers to the processing of information located in parts of the brain responsible for thinking, speech, and current emotional awareness. These are areas where the highest developed way of processing information occurs (neocortex). It involves changing thought processes using cognitive and behavioral techniques, such as redirecting attention, checking reality, identifying and

changing negative thoughts, and more (Brickel, 2019). The "top-down" approach in psychotherapy refers to observing the interpretation of information by the mind, where therapeutic methods aim to change thoughts, with the main idea being that if an individual thinks "right," they will make healthier decisions. It focuses on cognitive, frontal lobes, which are higher-developed parts of the brain responsible for logic. This certainly applies to cognitive-behavioral therapy, which helps become aware of distorted and negative thinking and replace it with more rational thoughts to improve responses in challenging situations. This approach is effective for many issues, but somewhat less successful in processing traumatic information, as the response to trauma disables cognitive areas and activates lower parts of the brain (subcortex) responsible for reflexes, memory, and automatic survival reactions, triggering "fight," "flight," or "freeze" response. In this case, thinking cannot override the response of the brain's primary parts, which happens at an unconscious level. Processing emotions resulting from trauma on a cognitive level is not sufficient to heal the nervous system damage caused by the trauma. The prefrontal cortex cannot function properly if the subcortex (responsible for sensory functions and survival) is not functioning well. Trauma responses occur before the prefrontal cortex can grasp what is happening. When awareness or thought occurs on a conscious level, it is often too late to avoid the response, as the subcortex has already sent the message of threat to the body. In fact, reliving unregulated emotions without processing them can reawaken the trauma (Brickel, 2019; Reagan, 2021).

BSP, on the other hand, falls under the "bottom-up" approaches, as labeled for therapies involving parts of the brain responsible for reflexes, memory, and automatic survival responses, which also play a crucial role in learning (brainstem and limbic system). This approach focuses on changing physiological processes (breathing, heart rate, muscle tension, etc.) using techniques such as breathing exercises, progressive muscle relaxation, and others (Brickel, 2019). The "bottom-up" approaches focus on information obtained from bodily sensations, as it assumes that bodily sensations occur before cognitive processing begins. This primarily pertains to automatic responses and feelings related to perceived threat, where there is a noticeable stress response causing individuals to act in an unregulated manner. Often, we may not even be aware of what triggers memories of past traumatic experiences, especially if we are disconnected from our own bodies. When symptoms of a traumatic experience are triggered, we often feel anxiety, anger, and sadness. We may also experience strong physical sensations such as headaches, nausea, muscle tension, rapid heart rate, and other symptoms. In "bottom-up" therapy, in a safe therapeutic relationship, reasons for feeling threatened and subsequently unable to control thoughts and emotions are explored without becoming overwhelmed. The safe therapeutic relationship involves the connection between the therapist and the client. Safety and stability allow the client to develop dual awareness - the ability to maintain attention on internal experiences (memories, emotions, and feelings) associated with the traumatic event, and on the external reality happening in the therapeutic environment. This enables the client to realize that the threat to which they are responding is actually "old" and can be placed in the past, allowing them to feel safe in the present. From this safe position, the client can then look back into the past and understand these feelings by consciously processing the information. The "bottom-up" approach thus contributes to finding new skills for managing these feelings, as without learning to be present in one's body with the ability to feel one's feelings, it is impossible to fully process the trauma (Brickel, 2019; Reagan, 2021).

4.1. Integration of Top-down and Bottom-up approaches

Integration of "top-down" and "bottom-up" approaches can harness the advantages of both approaches and provide a more comprehensive approach to trauma treatment. The "bottom-up" approach allows the therapist to focus on the client holistically, not just their symptoms, and engages in the processing while considering the client's individual experience and sensitivity. At the same time, the "top-down" approach aids in understanding the causes and consequences of trauma and in developing strategies for emotion regulation, which is crucial for addressing the long-term effects of trauma (Courtois and Ford, 2009). As stated by Brickel (2019), integrating these approaches is meaningful when there is a need to process traumatic experiences, allowing the trauma stored in the body to be addressed through the "bottom-up" approach, while acquiring skills to manage bodily responses through the "top-down" approach, such as saying, "I am experiencing a flashback, and at the same time I know I am safe in the therapist's office." Therefore, we can conclude that by integrating both approaches, the processing of information can be addressed comprehensively, both at the conscious and unconscious levels, where processes occur automatically without awareness, while also influencing conscious cognitive responses. With this holistic processing of brain processes and information, we prevent the traumatic memory from the past from causing issues in the cognitive domain in the present.

5. Research in the Master's thesis

5.1. Research Problem

Cognitive Behavioral Therapy (CBT) is a therapy designed for a wide range of issues, as it encompasses psychological knowledge, methods, and techniques through which the therapist helps the client understand their own problems and change thought and behavioral patterns that perpetuate those problems. The main framework of CBT is based on the cognitive model, which assumes that our emotions and behaviors are a result of interpretations or meanings we give to external events, rather than a direct result of those events. CBT is a talk therapy that addresses an individual's cognition in a way that influences changes in thinking, behavior, and emotional responses (Beck, 2011; Brickel, 2019; Dobson, 2012; Pastrik, 2004). In terms of information processing, CBT is referred to as "top-down" therapy. Brainspotting therapy (BSP), on the other hand, enables the processing and release of neurophysiological sources of trauma, dissociation, and various types of psychological and

physical symptoms. The therapy, using the visual field, allows the processing of specific negative and traumatic memories that may not be accessible through talk therapy alone. Through the use of bilateral stimulation, access to traumatic memories from the past, which cause difficulties in the present, is facilitated for the client (Grand, 2003; Brickel, 2019). Although both therapies have been found to be successful in addressing issues related to traumatic and distressing memories, despite their significant differences, therapists' opinions on the feasibility of integrating brainspotting therapy into cognitive-behavioral therapy were examined, considering the potential for enhancing the therapeutic process's effectiveness.

5.2. Research Questions

The main research question in the master's thesis is: What is the opinion of cognitive-behavioral therapists who practice brainspotting therapy regarding the possibility of integrating brainspotting therapy into cognitive-behavioral therapy? In addition to the main research question, four research sub-questions have been formulated: - According to therapists, what are the advantages of each approach? - According to therapists, what are the disadvantages of each approach? - In which issues do therapists believe the integration of brainspotting therapy into cognitive-behavioral therapy is effective? - According to therapists, in which cases is such integration not suitable for clients?

5.3. Methodology

To obtain answers to the research questions, we decided to conduct a qualitative research study, which focuses on collecting experiential data, such as verbal descriptions or narratives, which are then processed and analyzed using textual methods, without employing numerical measurement procedures (Mesec, 2007). For the analysis, the technique of open coding was used, where we identified key concepts in the responses and grouped them into categories. With the obtained data, we aimed to address the main research question and sub-questions. A qualitative approach was utilized to gather and analyze therapists' opinions, with an emphasis on the quality of the answers, and the sample was small and non-random. For data collection, a questionnaire with open-ended questions was selected, facilitating the acquisition of a more extensive set of responses. A total of 30 completed questionnaires were obtained. To ensure information was gathered based on extensive experience, responses from therapists with a minimum of 10 years of experience in CBT and at least 3 years of experience in BSP were considered, aiming to derive more profound insights from their answers. In the study, the responses of 14 therapists who met the criteria regarding years of experience in each therapy were considered, of whom 13 were female, and only 1 therapist was male. The majority of therapists (7) are from the United States, with 6 females and 1 male. Two therapists are from Turkey, and one therapist each is from the Czech Republic, France, Italy, Canada, and New Zealand.

5.4. Analysis and Interpretation

5.4.1. Years of experience in CBT and BSP

Therapists who have been practicing CBT for at least 10 years and BSP for at least 3 years were included in the analysis. The average years of practicing CBT, according to the received data, are 16.8 years, ranging from 12 to 25 years, while the average years of practicing BSP are 5.8 years, ranging from 3 to 16 years. All therapists have supplemented their CBT knowledge with knowledge of BSP and not vice versa. From this, certain shortcomings in CBT were identified by them, which they compensated for with BSP, as will be further confirmed in the following analysis.

5.4.2. Reasons for upgrading knowledge with BSP therapy

Based on the responses, it was evident that therapists sought to enhance their knowledge with BSP therapy primarily to address trauma cases that conventional talk therapies had not successfully processed. They justified this decision by noting that talk therapies often focus solely on cognition and do not effectively address traumatic memories. Therapists expressed a desire for an approach that targets both the brain and body to facilitate clients' self-regulation and enable faster and deeper processing of trauma. Some therapists mentioned that their experience with CBT or talk therapies, which proved ineffective or even retraumatizing for clients with traumatic histories, served as another reason for pursuing knowledge in BSP therapy. These findings align with the information in the academic literature, which defines BSP therapy as a valuable tool in addressing PTSD and other traumatic conditions, effectively reducing symptoms associated with traumatic memories (Ehlers and Clark 2000; Shapiro 2001). The therapy's focus on processing traumatic memory located in subcortical brain regions, such as the amygdala, hippocampus, cortex, and other structures of the limbic system, offers an effective method to address issues that cannot be adequately resolved through talk therapy alone (Grand, 2013; Grand and Corrigan, 2013). (Grand, 2013; Grand and Corrigan, 2013).

5.4.3. Advantagens and disadvantages ob CBT

1 Advantages of CBT

Therapists have reported numerous advantages of CBT as described in the following. It is a versatile therapy that effectively addresses a wide range of mental issues and often has shorter durations compared to traditional psychotherapy. CBT enables clients to understand their core beliefs and develop rational responses to their challenges. This approach is particularly fast and effective in treating conditions like depression, anxiety, and OCD, while also empowering clients to cope with similar challenges in the future through psychoeducation. CBT is present-focused, meaning it minimizes excessive focus on past events. It provides a well-structured framework that helps clients recognize and work on specific thoughts, emotions, and behaviors that are the focus of treatment, giving clients a sense of control and teaching them skills that can be useful for a lifetime. Additionally, CBT is suitable for clients who may not be ready to delve into issues beyond their current thinking, allowing for

a smoother entry into the therapeutic process. It offers a wide array of effective techniques for problem-solving and can incorporate homework assignments and imagination exercises to further reinforce the learning process.

The results are consistent with numerous studies and findings in the academic literature mentioned in the introduction (Ye et al. 2016; Linardon et al. 2017; Young, Moghaddam, and Tickle 2020; Fordham et al. 2021), all of which confirm the effectiveness of CBT in treating a wide range of issues, including depression and anxiety. Therapists' responses also support Beck's (2021) assertion that CBT focuses on understanding and changing the cognitive processes and behavioral patterns that contribute to mental difficulties and through this approach, clients can develop new ways of thinking and behaving, leading to lasting positive changes in their lives.

2 Disdavantages of CBT

According to therapists, CBT has several weaknesses that need to be considered. One of the most significant drawbacks of CBT is that it does not address the origin of traumas but only their consequences, as it mainly influences the neocortex. Additionally, traumatic memories can resurface after therapy concludes because CBT does not take into account the fact that trauma is stored in the subcortex, and trauma responses can hinder the success of CBT. This means that it does not address somatic symptoms that clients often experience and does not delve deeply enough into the issues, as it does not intervene in the subcortical part of the brain. The therapists' responses confirm Repič's theory (2008) that the brain responds to sensory information before the signal is interpreted at a cognitive level. This implies that on a cognitive level, we process only those pieces of information that are accessible to cognition, and considering the flow of information from the subcortex to the cognitive part of the brain, we can say that talk therapy addresses only the consequences of trauma.

Another concern raised by therapists is that CBT lacks an impact on the subconscious, and it has little to no effect on the self-regulation of the brain and body. Lastly, it does not consider the complexity of the human system and the body as a whole, including the brain-body connection. The responses of therapists align with Van der Kolk's theory (2014), which confirms that talk therapies like CBT are not always sufficiently effective in trauma processing because they often focus solely on the verbal aspect of the therapeutic process, while ignoring the role of the body and the unconscious mind in processing traumatic memories. Van der Kolk also emphasizes the importance of using therapies that take into account the connection between the body and mind and incorporate bodily and sensory experiences.

By addressing these weaknesses, therapists find that integrating brainspotting therapy into cognitive-behavioral therapy offers a more comprehensive and effective approach to trauma treatment, allowing for a deeper and more holistic processing of traumatic experiences.

The responses also indicate that due to its characteristics, CBT may not be suitable for clients who are unwilling to actively participate in the therapeutic process, as it requires a high level of client engagement with completing homework assignments and tasks between individual sessions. This could be particularly challenging for clients who are in a very poor mental state and struggle to find meaning in anything. Ineffectiveness in completing homework tasks may lead to the failure to achieve therapy goals and can reinforce negative emotions. The therapists' observations are also confirmed in theory, as Judith Beck (2021) points out that non-completion of homework assignments is one of the most common barriers to the success of CBT. Thus, actively engaging in the therapeutic process outside of therapy sessions is essential for achieving therapy goals, as homework tasks allow for the reinforcement of new thinking and behavioral patterns.

Therapists also recognize that CBT, if not practiced with professionalism and impartiality, can be perceived as a form of psychological manipulation. The impact of the therapy on clients requires therapists to exercise great care. This was also recognized by Padesky (1994), who emphasizes the importance of therapists remaining non-coercive in their approach, refraining from persuading clients about what to think or do. Instead, therapists must understand, accept, and work with clients' beliefs and goals, even if they differ from therapeutic recommendations. Thus, this approach ensures that the therapeutic process is collaborative and respectful of the client's autonomy.

5.4.4. Advantagens and disadvantages ob BSP

1 Advantages of BSP

Therapists, when discussing the benefits of BSP therapy, emphasize its effectiveness in directly addressing trauma. By identifying the appropriate eye position or brainspot, BSP allows the brain and body systems to process trauma and reprocess traumatic memories effectively. Therapists also explained the advantage of BSP in terms of connecting the client to various areas of the brain, facilitating the processing of "stuck" content and surpassing the limitations of CBT by reaching deeper parts of the brain and body. This aligns with Grand's theory (2013) that as a result, BSP bypasses cognitive processes and releases trauma at a deeper level.

Therapists report that sometimes the issue is resolved after just one therapy session, and the therapy does not require homework tasks as seen in traditional talk therapies. Its adaptability allows for tailoring to each individual's emotions and tolerance level, making it an efficient and fast-acting therapy. Clients often experience improvements in their condition within a few days after the therapy. BSP is particularly effective with complex PTSD and adept at addressing the subconscious realm.

The responses validate Parnell's claims (2013) that the therapy's client-centered approach creates a supportive environment for clients to fully open up and achieve self-regulation, facilitated by the limbic part of the brain and the body. It capitalizes on the natural healing process by utilizing internal resources, sensations, and bodily experiences to process emotions.

According to therapists, "bottom-up" approaches, like BSP, are much more effective in identifying the underlying causes of issues, leading to more long-term results. This is also confirmed by Brickle (2019) stating that these approaches focus on information obtained from bodily sensations, recognizing that bod-

ily sensations occur before cognitive processing begins. Thus, learning to be present in one's body and being able to feel sensations are essential for trauma processing to occur effectively.

Based on the experineces, therapists also explain that BSP is not limited to addressing trauma and traumatic symptoms as it has also shown effectiveness in enhancing performance, intellect, and spirituality. One of the notable advantages of BSP therapy is its ability to facilitate deep processing and reprocessing of traumatic memories and symptoms, resulting in a lower likelihood of relapse compared to traditional talk therapies. The therapists' responses coincide with Grand's findings (2013) which are already presented in the introduction, that BSP operates differently from talk therapy, which mainly focuses on conscious thought processes in the neocortex and has limited access to deeper brain regions. Instead, BSP bypasses the neocortex and targets these deeper areas.

The benefits of BSP, as reported by therapists, are also supported by research and studies on the therapy's effectiveness presented in the introduction of this paper. The evidence indicates that BSP can lead to significant improvements beyond trauma treatment, extending to areas such as performance, intellectual functioning, and spirituality. The therapy's unique approach, targeting deeper brain regions, may contribute to its wide-ranging benefits for individuals seeking to enhance various aspects of their lives.

2 Disadvantages of BSP

Therapists have identified several disadvantages of BSP therapy. One aspect is that clients often approach the therapy with skepticism and uncertainty about what to expect. The relatively unfamiliar and less understood nature of BSP therapy can trigger suspicion and doubt among clients, making it challenging for them to choose this form of therapy over more well-known alternatives like EMDR. Even for therapists, conveying a clear understanding of BSP to their clients can sometimes be a challenge.

Another significant concern is related to the therapist's role in the process. Ineffectively or poorly conducted BSP therapy may lead to no improvement in the client's condition, potentially harming the client's trust in the therapy and the therapist providing it. The absence of a strict protocol in BSP, which Grand (2003) actually recognizes as an advantage, is viewed as a weakness by some therapists. This lack of a rigid structure places considerable responsibility on the therapist's choices and decisions. Successful implementation of BSP requires a therapist's willingness, compassion, and attentiveness to closely follow the client's cues and detect even the subtlest changes that may indicate the presence of brainspots.

These findings coincide with the emphasis by Grand (2013), that the therapeutic relationship plays a crucial role in all stages of the BSP process. Thus creating a safe and supportive therapeutic environment is vital for effective BSP, as it enables the therapist to accompany the client in discovering, identifying, and processing emotions, thoughts, and bodily sensations related to traumatic memories. In other words, collaborative and attentive approach of the therapist is essential in guiding the client through the healing process in a way that best suits their individual needs and experiences.

Therapists have identified several considerations and potential weaknesses related to BSP therapy. One such concern is the importance of client stability before commencing therapy. It is essential for therapists to recognize and address any potential negative effects that may occasionally arise during the therapy process, such as nightmares, intense dreams, or feelings of depression.

Therapists also emphasize that the role of the therapist in conducting the therapy is of crucial importance. It is necessary for therapists to undergo regular supervision to ensure that therapy is conducted safely and effectively for their clients. The significance of supervision in psychotherapy was first introduced by Freud and is now considered an indispensable part of therapist training and ongoing development. Supervision contributes to better quality and effectiveness of treatment.

Another potential weakness that therapists observe is that BSP therapy may focus primarily on processing issues on a somatic level, without always addressing the need for further processing on a cognitive level. In some cases, clients may require cognitive interventions to complement the somatic processing provided by BSP therapy.

Overall, we can conclude, while BSP therapy has numerous advantages and is effective in addressing trauma and related symptoms, therapists must be attentive to these potential weaknesses and considerations to ensure the best possible outcomes for their clients.

5.4.5. Meaningfulness of integration BSP into CBT

From therapists' responses, it is evident that integrating BSP into CBT holds significance, especially in cases where CBT techniques alone may not fully address the client's issues. This integration is found to be meaningful in working with clients dealing with trauma, traumatic memories, PTSD, anxiety, depression, OCD, fear, anger, conflicted relationships, and repetitive negative behavior patterns.

Moreover, from the responses it is evident that integrating BSP into CBT can effectively address issues stemming from past experiences, help clients overcome behavioral or thought patterns in which they are stuck, and access subconscious elements that may remain inaccessible through talk therapy alone. This combination of somatic and cognitive modalities has shown to yield positive results.

While the majority of therapists responded positively to the integration, it is worth noting that one therapist expressed reservations, highlighting that opinions on the usefulness and suitability of this integration may vary among professionals, depending on the specific case and client needs.

In conclusion, based on therapists' opinions, integrating BSP into CBT can be meaningful, but its implementation should be tailored to suit the individual needs and issues of each client, as is generally true for any psychotherapeutic approach and its integration.

5.4.6. The contribution of BSP to the effectiveness and upgrade of CBT

The majority of therapists agree that BSP contributes to the effectiveness and enhancement of CBT in several ways. BSP

can expedite the CBT process, as addressing specific issues with BSP can lead to a better understanding of the problem, facilitating the overall therapeutic process. Additionally, BSP can aid in processing issues at a deeper level, reducing the likelihood of relapse.

While CBT primarily deals with the present as presented in the introduction, BSP enables clients to become aware that their current emotions are often a result of past experiences, thus helping them process the root causes of their issues. As described by Van der Kolk (2014), one of the general symptoms of trauma is the feeling of experiencing a 'flashback,' where the traumatic event seems to be repeating in the present. Brickel (2019) explains that BSP allows clients to realize that the threat is actually from the past, enabling them to shift their perspective on the experience.

Based on all the therapists' responses and theoretical information, it can be summarized that BSP assists clients in bridging what they already know on a cognitive level with a deeper understanding of their emotions, leading to a more comprehensive resolution of the issue. Additionally, BSP can help in processing emotional difficulties, further enhancing the effectiveness of the therapeutic process. Consequently, it makes sense to address trauma or traumatic memories with the help of BSP first and then introduce CBT techniques when the client is ready.

Importantly, therapists emphasize that BSP is an open model that can be integrated with other therapeutic modalities. Moreover, as Narcross and Goldfried (2005) point out, the most crucial aspect is that the choice of approach depends on the individual needs and goals of the client, aiming to achieve the best possible outcomes.

5.4.7. Integration of other therapeutic approaches

All therapists responded affirmatively to the question of whether they integrate other approaches into their therapeutic practice. On average, each therapist integrates three different approaches.

The approaches that therapists integrate include reality therapy, logotherapy, ego states, Acceptance and Commitment Therapy (ACT), mindfulness, compassion-focused therapy, sensorimotor psychotherapy, EMDR, reiki, sound therapy, guided imagery, trauma-informed yin yoga, Internal Family Systems (IFS), somatic experiencing, systemic theory, play therapy, schema therapy, biofeedback, yoga therapy, psychodrama, existentialist approach, psychedelic therapy, self-determination theory, attachment theory, polyvagal practices, elements of psychodynamic theory, and combinations of talk and body techniques.

Therapists integrate various psychotherapeutic approaches into their practice, as evident from their responses. The purpose of integration is to enhance the effectiveness of therapy, leading to more efficient and faster problem-solving for individuals. This view is supported by Narcross and Goldfried (2005), who state that therapists often integrate psychotherapies out of dissatisfaction with a single modality and the desire to explore other approaches for the client's benefit. For example, a survey conducted by the Psychotherapy Networker website in 2007, showed that only 4.2 percent of therapists used exclusively one psychotherapeutic approach (Corey 2013). A slightly higher, yet still low percentage, was shown in the study by Zorbe et al. (2016), which confirmed that only 15 percent of therapists used only one theoretical orientation in their practice, with an average of four approaches being used.

Therapists employ various techniques and methods based on the specificity of the client's issue. It is evident from the responses that therapists use combinations of different "bottom-up" and "top-down" methods, contributing to a holistic approach to the client. This confirms the theory as stated by Courtois and Ford (2009) that the "bottom-up" approach aids in processing the root cause, not just the symptoms, while the "top-down" approach helps in understanding the causes and consequences of the issue, enabling the development of strategies for emotional regulation.

5.4.8. Reasons and methods of using BSP in the implementation CBT

Therapists have cited several reasons for using BSP in the implementation of CBT. One reason is BSP's ability to uncover the causes of traumatic experiences or other subconscious reasons that clients may find challenging to articulate specifically. Additionally, BSP helps explore various sources of problems, as emotions and cognition are stored in different parts of the brain. BSP is also utilized to recognize limiting beliefs that cause symptoms and emotional disregulation, as well as to investigate potential deeper meanings when specific issues are detected during CBT.

Therapists have identified different ways of using BSP in the implementation of CBT. Some conduct separate BSP sessions between individual CBT sessions. Others use BSP within CBT to assess its effectiveness, particularly when the client reports their thoughts. Some therapists integrate BSP after a separate session to assess how the information obtained from the BSP session is incorporated. Another approach involves starting with CBT and psychoeducation, then proceeding with separate BSP sessions. Additionally, some therapists integrate Internal Family Systems (IFS) by using CBT as a foundation and incorporating IFS to examine how "parts of the self" are involved in the cognitive triad. During the communication phase with these "parts," BSP is introduced, as bilateral observation facilitates external dialogue with these parts with less effort from the client.

From therapists' responses, it is evident that there is no general rule on how and in what manner integration should be conducted. Each therapist decides based on their thinking, beliefs, and experiences, selecting the most suitable approach for the client. However, most therapists primarily use two types of psychotherapy integration: assimilative integration, where one theoretical approach serves as the foundation, but techniques from other psychotherapeutic approaches are incorporated based on the client's needs or context (Sticker and Gold, 2005); and technical eclecticism, where therapy is not based on a single theoretical approach, but the therapist decides based on prior experiences and knowledge, selecting interventions most suitable for the individual (Narcross and Goldfield, 2005).

The goal of integration is to create a conceptual framework that combines the best aspects of two or more theoretical approaches, assuming that the results will be superior to using a single approach. This blending of approaches emphasizes the incorporation of fundamental theories and corresponding therapeutic techniques (Corey 2013). The therapists' responses confirm the validity of this theory.

5.4.9. The practice of BSP as a independent therapy

In their responses, therapists explained when and in which cases they use BSP as an independent therapy. Out of the therapists surveyed, 64 percent provided a positive response, while the remaining therapists do not practice BSP therapy as a standalone approach. The reasons for using BSP as an independent therapy can be categorized into cases where it is applied for specific mental disorders or issues, and situations where certain factors prompt the choice of using BSP independently, based on either the client's or therapist's judgment.

Cases of mental disorders and issues include trauma and high levels of childhood traumatic experiences, addictions, complex trauma, anxiety, depression, dissociative identity disorder, and other psychosomatic problems.

Certain situations where therapists opt for BSP as an independent therapy include: upon clients' specific request; in cases when a client cannot identify the issue; when other approaches have not yielded results; if a client is unable to engage in homework assignments; in situations where difficult topics arise and the client is unable to talk about them; for clients with disordered eating habits; during couples therapy; for clients with traumatic brain injury; in instances where a client struggles to release a specific past memory; and for athletes dealing with sudden and unexplained loss of specific skills.

Based on the responses, therapists decide to use BSP as a standalone therapy in specific situations or issues. In all cases, therapists aim to address traumatic memories and, based on their judgment (and sometimes the client's request), conduct BSP as an independent therapy without integrating it into another talk therapy.

5.4.10. Preceding issue resolution with CBT approach

Therapists described various CBT techniques that had been previously used in the phase now included in BSP. These techniques included psychoeducation and skill training for independent use, such as problem-solving and homework assignments. Additionally, therapists utilized behavioral experiments, including exposure in imagination or in vivo. They also identified core beliefs and other limiting elements that maintained activation and made use of mindfulness. Furthermore, therapists employed repeated processing of the same problem with a focus on thoughts and behaviors and their mutual influence. Some therapists simultaneously used CBT and psychodrama, while others implemented trauma-focused CBT protocols. These techniques, among numerous others, required significant effort.

An interesting example is given of the timeline of therapy, comparing different CBT techniques with BSP. In the mentioned case, resolving an issue may take up to 6 hours of CBT, whereas the same issue can sometimes be effectively addressed in a single BSP session. Additionally, an explanation is provided regarding the comparison between CBT and BSP. With CBT, triggers may resurface after a certain time, whereas this is not the case with BSP, where the processing of traumatic memories seems to be more comprehensive and lasting.

The responses align with the findings presented in the introduction, where we established that CBT is a talk therapy that involves identifying and changing negative thoughts to develop alternative patterns of thinking and behavior, ultimately leading to improved emotions and feelings (Beck, 2021; Morrow, 2022; Turner and Swearer, 2010). It explores the relationship between thoughts, emotions, and behavior, assisting individuals in recognizing their thoughts and testing them. This confirms that CBT often involves a more extended process of information processing compared to BSP

According to Grand (2013), BSP differs from talk therapy by targeting deeper brain areas, such as the amygdala, hippocampus, cortex, and other parts of the limbic system, where problem processing occurs at a physiological level, without the client consciously changing thoughts. Consequently, there is no need for reinforcement and testing of new information in BSP. Unlike CBT, which often focuses on addressing the consequences of the original problem, BSP can delve into the root cause of the issue. Due to this distinction, the possibility of relapse in CBT is higher compared to BSP, as it may not fully address the underlying triggers.

5.4.11. Limitations ob BSP

According to therapists' responses, certain situations may make the use of BSP techniques less suitable or ineffective for clients. These situations primarily include certain mental disorders and issues, such as borderline personality disorder, narcissistic personality disorder, drug addiction, dementia, and severe mental health problems. Therapists also note that BSP may not be as effective for preschool children or children under 12 years of age. Additionally, certain client-related situations may render BSP unsuitable. For example, when clients are unwilling to explore their issues on a deeper level, when someone else has referred them to therapy, or when overly skeptical individuals lack trust in the process. Moreover, it may not be suitable for clients who resist working on a somatic level and are unwilling to engage in emotional processing. In conclusion, while BSP can be highly effective in many cases, therapists are careful to consider individual client characteristics and specific issues when deciding on the appropriate therapeutic approach.

Therapists generally assessed that the BSP approach is effective and suitable for the majority of clients. While some therapists mentioned certain challenges in implementing BSP, such as difficulties when working with clients who struggle to recognize bodily sensations or experience dissociation, or with clients who are highly rigid and have difficulty relinquishing control reflexes, these challenges were not reasons to consider BSP as ineffective or an unsuitable approach. Instead, they merely highlighted that the implementation might be slightly more challenging in specific cases. Overall, therapists found BSP to be a valuable and beneficial therapeutic approach.

As discussed in the introductory section, working with the body is of great importance in BSP. The process of determining the brainspot, where the issue's processing begins, requires locating the specific point in the gaze where activation occurs (Grand, 2013). Therefore, the effectiveness of BSP therapy in certain situations may be linked to challenges in the second phase of BSP, known as identification. In this phase, the client is supposed to connect with emotional and bodily issues for further processing, which may be influenced by various factors.

5.4.12. Recommendation for upgrading knowledge in the field ob BSP

Therapists unanimously recommend enhancing knowledge in the field of BSP, as they find it crucial for more effective and profound processing of trauma and traumatic memories, leading to achieving the client's optimal balance and therapy goals. BSP addresses parts of the brain that are not easily reached through talk therapy, allowing for deeper and more natural processing. As discussed in the introduction of this paper, Courtois and Ford (2009) recognize the significance of combining 'top-down' and 'bottom-up' approaches to enable a holistic client-centered approach. This comprehensive approach facilitates trauma treatment by allowing 'bottom-up' processing that considers the client's individual experience and sensitivity, while the 'top-down' approach aids in understanding the causes and consequences of trauma, developing strategies for emotional regulation, and addressing long-term trauma effects effectively.

The recommendation from therapists for upgrading the knowledge with BSP also comes from the perspective of understanding trauma and avoiding getting trapped in a medical model of diagnosis and pathology. This understanding of trauma can open up many possibilities for processing and offer a broader and more effective therapeutic approach.

5.4.13. Additional explanations from therapists

Therapists have had the opportunity to highlight additional information they deemed relevant to the research topic, which was not covered in the questions.

Among the additional information provided by therapists, the effectiveness of BSP therapy stands out, with results that are mostly long-lasting without symptom recurrence. Therapists also emphasized the importance of using a comprehensive approach that incorporates both "top-down" and "bottom-up" methods.

Furthermore, therapists noted that establishing a therapeutic relationship first and then deciding on the method based on it is crucial. It was also mentioned that the majority of counseling or therapeutic postgraduate programs in the USA are based on CBT fundamentals, primarily psychoeducation and behavioral experiments. This has led to most therapists incorporating other modalities rooted in CBT into their practice.

6. Conclusions and findings

The analysis of responses has led to the following findings:

The vast majority of therapists chose to enhance their knowledge in BSP due to a desire for more effective processing of trauma and traumatic memories, complementing their existing knowledge in CBT.

Therapists emphasized several advantages of CBT, including its versatility, making it suitable for a wide range of issues; its practicality, structure, and comprehensibility; the short-term nature of therapy; its focus on the present; its impact on cognitive processes; psychoeducation; empowering clients for independent problem-solving in the future; and the provision of homework assignments aimed at reinforcing new thoughts.

However, therapists acknowledged a drawback of CBT, mainly its inefficiency in processing trauma and trauma-related issues, as it primarily operates at a cognitive level, while trauma processing requires the involvement of subcortical brain areas that are not accessible through talk therapy. They also highlighted the importance of clients completing homework assignments, as the failure to do so may impact the effectiveness of the process and hinder goal achievement.

On the other hand, therapists pointed out the advantages of BSP therapy, primarily its effectiveness in addressing and processing trauma and trauma-related issues by accessing the root of the problems beyond what talk therapy, influencing cognition, can reach. BSP therapy aids in releasing trauma at a deeper level and offers speed and efficiency, as issues are processed relatively quickly without recurring symptoms.

However, therapists also recognized certain weaknesses of BSP therapy. These include concerns about poor therapeutic practice, as improperly conducted therapy may have no effect and can create a negative reputation among clients. Additionally, the relatively new and less-known nature of BSP may contribute to clients' hesitation in trying it. The lack of a prescribed specific protocol in BSP and the reliance on the therapist's judgment were also acknowledged as weaknesses. Furthermore, BSP does not teach coping with future issues, and it does not directly address the cognitive processing of problems that clients may experience at the somatic level. The first two research sub-questions concerning the strengths and weaknesses of each therapy have been successfully addressed with the findings from the theoretical part of the study and responses from therapists. It has been confirmed that both psychotherapeutic approaches have their advantages and disadvantages, and the combined use of both approaches improves positive outcomes in the therapeutic process.

Therapists also indicated that integrating BSP into CBT is effective for various issues. It is used to uncover the roots of traumatic experiences and other subconscious causes that the client cannot express. The use of BSP in CBT implementation assists in exploring different origins of problems, emphasizing activities in various brain regions during emotional and cognitive information processing. Additionally, it is employed to identify limiting beliefs causing emotional symptoms and emotional dysregulation. When a problem is identified at the cognitive level during CBT, BSP can be used to verify its deeper significance.

With this, the third research sub-question about the effectiveness of integrating BSP into CBT for specific client issues,

particularly those related to trauma and traumatic memories, has been addressed, and our expectations have been confirmed based on therapists' feedback.

However, therapists believe that integrating BSP into CBT is not suitable for all clients. They provide several examples: for some mental disorders, such as borderline personality disorder (BPD), narcissistic personality disorder (NPD), drug addiction, dementia, and more severe mental health issues, BSP is not meaningful or effective. Similarly, it is not used for preschool children or children under 12 years old. Integration is also not suitable or effective for clients who are unwilling to explore their issues on a deeper level or those who have been referred to therapy. Additionally, it is not a suitable therapeutic choice for clients who do not trust the process or resist emotional processing.

With this, an answer to the fourth research sub-question, concerning which clients, according to therapists, this type of integration is not suitable, has also been obtained. Our hypothesis that the study would confirm that for certain issues or types of clients, the integration does not enhance the effectiveness of CBT, has been validated.

Based on the responses, therapists commonly integrate various psychotherapeutic approaches, including BSP therapy, into the CBT approach. Additionally, body-oriented techniques stand out as particularly prominent in their practice, emphasizing the crucial connection between the body and mind in recognizing and processing the root causes of issues.

The main research question, namely, whether therapists perceive possibilities for integrating BSP therapy into CBT, can be answered based on all the obtained responses. According to them, integrating BSP therapy in CBT when addressing issues and disorders, especially those stemming from trauma and traumatic memories, is considered relevant and advantageous.

The research results are of great significance for researchers, therapists, counselors in various psychotherapeutic approaches, psychologists, clinical psychologists, and other professionals in the field, as they present possibilities for addressing and processing the root causes of trauma using BSP. This information could be beneficial for them when deciding to upgrade their existing knowledge with the BSP method. The research is also important for clients who are seeking an appropriate approach to assess and address potential traumas and traumatic experiences that may be the cause of certain issues they are dealing with.

The research raises new questions that would be pertinent to explore in the future. For example, what are the potential applications of the combined use of BSP therapy and CBT in addressing disorders beyond trauma-related conditions? How can BSP therapy be effectively integrated with various other therapeutic modalities? Moreover, how can BSP therapy be employed in preventive interventions, particularly in mitigating the development of psychological disorders among individuals exposed to traumatic events?

These and other similar questions are of utmost importance for the further development and application of BSP therapy in clinical practice and other contexts. Therefore, it is essential to continue researching this psychotherapeutic approach and its potential applications based on our findings and insights.

Acknowledgements

Thanks to my menthor Tjaša Stepišnik Perdih, PhD, and comentor Emil Karajić, lect. for their guidance and assistance in the preparation of my master's thesis.

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