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The Lived Experiences of Counselors Trained in Brainspotting with Clients Who Have Experienced Trauma

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Walden University
2024

Abstract

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MA, Southeastern University, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Exposure to trauma continues to be a significant issue for many individuals and is one of the leading reasons why clients seek counseling. Therefore, more trauma-informed and effective counseling interventions are needed to address the impact of trauma. Brainspotting has begun to rise in recognition as an intervention to treat trauma. The purpose of this qualitative transcendental phenomenological study was to explore the lived experiences of counselors trained in brainspotting with clients who have experienced trauma. The phenomenological study followed Husserl's framework to understand the essence of the lived experiences of 12 counselors who integrate brainspotting with clients who have experienced trauma. Yin's five phases of data analysis were used to hand code data and make meaning from the counselors' experiences. The five themes that emerged from their experiences include (a) counselors should engage in brainspotting as a client, (b) psychoeducation can help clients to overcome resistance or barriers with brainspotting, (c) consultation with other brainspotting providers can help to improve practices with clients who have experienced trauma, (d) brainspotting is flexible to meet the needs of clients, and (e) brainspotting leads to positive outcomes for clients who have experienced trauma. The study adds to existing literature on the treatment of trauma and advances the practice of brainspotting. The study also provides information that can be used to improve the clinical practice of brainspotting to treat clients who have experienced trauma.

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Dedication

I dedicate my work to my amazing family. First, to my wonderful husband, who was so supportive during this process; I couldn't imagine a more supportive partner. I'm so grateful for you. To my wonderful children, Asher, Gavin, Adalynn, and Harper, who always offered me a sense of joy throughout this process, our love helped me persevere. To my younger sister, Amanda, I could not have done this without your encouragement or support. I am forever grateful for you. I also dedicate my dissertation to my parents, who always believed in me and supported me throughout this process by offering to help with anything I needed. You both always showed me how to persevere when things get hard and to always believe in myself. I'm so grateful for all of you, for the laughs and distraction when I needed it, and for your unwavering support. I also want to dedicate my work to my client's past, present, and future. Your strength is inspiring, and I pray for healing for each of you. Finally, to all the brainspotting community, you provide healing space for so many; your passion for others is contagious, and I'm forever grateful to be a brainspotting professional.

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I am so grateful for the continued support and guidance of my chair and committee members. Dr. Bradley, I know it has been a long journey up to this point, and I am so grateful for all the time and support you provided. Doing this was not easy with four kids, but your continued support helped me to push through and not lose faith in myself. Your feedback was always what I needed to make me a better researcher and develop my scholarly voice. I can't express how appreciative I am that you would push through meetings with me with a baby in my arms and children yelling in the background. We need more educators like you. Dr. Reese, I sincerely appreciate all your feedback and always being available when I needed it; your feedback has been so helpful, and I could not have done this without you. Your insight has been so helpful, and I'm forever grateful for you always being in my corner, cheering me on, and helping me to grow as a researcher.

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Chapter 1: Introduction to the Study

The National Institute of Mental Health (NIMH, 2020) has identified that in recent years exposure to traumatic experiences continues to increase in the United States. This increased exposure to trauma increases the risk of individuals developing post-traumatic stress disorder (PTSD; NIMH, 2020). PTSD has negative implications for individuals, including increasing health problems and a lasting need for mental health services (NIMH, 2020). Due to the recent increase in trauma and PTSD among the population, more effective and well-researched modalities are necessary to treat trauma and PTSD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022).

Brainspotting is a psychotherapy treatment method developed in 2003 by David Grand to aid in decreasing trauma symptoms (Grand, 2009). Since the inception of brainspotting, over 1,000 psychotherapists have sought training in brainspotting, and the treatment method continues to gain recognition in the counseling field (Grand, 2009). Brainspotting is most frequently used to treat individuals who have experienced trauma and are diagnosed with PTSD (Grand, 2009). Several studies have identified that brainspotting is equivalent in effectiveness for treating trauma compared to other treatment modalities (D'Antoni et al., 2022), which will be discussed later in this chapter.

Although research supports the effectiveness of brainspotting, there is a lack of information on the lived experiences of counselors who are trained in providing brainspotting who work with clients who have encountered trauma. The lack of information on counselors' lived experiences with using brainspotting with clients who

have experienced trauma leaves a gap in research for the brainspotting community. For this reason, I conducted a qualitative transcendental, phenomenological study that explored the lived experiences of counselors who integrate brainspotting into their counseling practice with clients who have experienced trauma. The study contributes to social change by providing insight that can enhance brainspotting trainings by providing information grounded in an understanding of counselors' experiences, which can ultimately improve the treatment of trauma.

In this chapter, I will highlight the need for a deeper understanding of counselors' experiences with brainspotting. I will also explore the background information on brainspotting, the problem statement, the purpose of the study, the research question, theoretical framework, nature of the study, definitions, assumptions, scope of the study, delimitations, limitations, and the significance of the study. Furthermore, I will address the nature of the study, possible types and sources of data, challenges, and barriers. Finally, the study's ethical and social implications will be discussed.

Background

Counselors have noted that PTSD has become increasingly prevalent, with a lifetime prevalence of 6.8% of the general population (Manzoni et al., 2021). The SAMHSA (2022) has also identified that exposure to traumatic experiences within the United States has increased in recent years. The SAMHSA (2022) reported that two out of three children reported experiencing at least one traumatic event prior to age 16. According to the U.S. Department of Veteran Affairs (n.d.), six of 10 men and five of 10 women will experience at least one trauma in their lives. Men are more likely to

experience a physical accident, physical assault, disaster, witness an injury/death, or encounter combat; while women are more likely to experience sexual assault and sexual abuse as children (U.S. Department of Veteran Affairs, n.d.).

Some individuals who experience traumas will experience PTSD. PTSD is a psychiatric diagnosis for an individual who has experienced or witnessed a traumatic event that includes death, violence, or severe injury (American Psychiatric Association [APA], 2022). Individuals with PTSD have lasting thoughts and emotional distress associated with the event (APA, 2022). Emotional distress includes nightmares, flashbacks, anxiety, and avoidance of situations or people associated with the event (APA, 2022). PTSD can have lasting adverse effects on health, including increased hospitalizations and medical care usage (Dennis, 2009), increased risk of developing heart problems and an increased risk of developing comorbid mental health issues (Beckham et al., 2002).

PTSD can also cause neurological changes to the brain leading to long-lasting health impacts on individuals diagnosed with PTSD (Usta et al., 2018). Additionally, PTSD can harm the brain and overall brain function (Dennis et al., 2009). PTSD causes increased prefrontal brain arousal, which confirms that individuals are in a heightened state of stress and anxiety after experiencing a traumatic event (Felmingham et al., 2008). PTSD can also lead to increased DHEA-S/cortisol levels and low brain connectivity causing issues with memory and focus (Usta et al., 2018). PTSD can cause an increase in stress hormone production in the brain, which leads to increased anxiety and depression (Santarnecchi et al., 2019).

Counselors encounter PTSD among clients and rely on various treatment modalities like brainspotting, eye movement desensitization and reprocessing (EMDR), cognitive behavior therapy (CBT), and somatic experiencing (SE; Dennis et al., 2009) to provide interventions to decrease symptoms of trauma/PTSD. A growing number of counselors are seeking additional training to have the necessary interventions to treat PTSD, trauma, and other mental health issues, including EMDR, SE, and brainspotting (Manzoni et al., 2021). Brainspotting was created to decrease symptoms of trauma and PTSD for clients through eye movement interventions (Corrigan & Grand, 2013). David Grand initially founded brainspotting by implementing slow flow EMDR and combining eye movement with focused mindfulness on body sensations (Corrigan et al., 2015). Grand (2009) noted the improvement that the client experienced with their trauma symptoms and then continued to develop his theory of brainspotting. Grand created trainings once he refined his intervention for other counselors to utilize brainspotting in sessions to treat various mental health issues, predominantly trauma, and PTSD.

The need for effective treatment modalities to treat trauma and PTSD continues to increase as exposure to trauma increases (SAMHSA, 2022). Initially, there was not much research conducted on brainspotting; however, as time has gone on more research has been completed and published on brainspotting to support its efficacy. Initially, the theory behind brainspotting was supported by single case studies and literature reviews based on an understanding of neuroscience (Corrigan et al., 2015). For instance, Gurda (2015) conducted a literature review on new trauma therapies that have gained recognition among counselors and identified brainspotting as an emerging new therapy to

treat PTSD and trauma. Hildebrand et al. (2013) also conducted one of the initial studies to support brainspotting, finding that it was effective in treating PTSD and that clients reported a decrease in symptoms of PTSD. Andergregg (2015) similarly found that brainspotting was an effective intervention to decrease anxiety. Over time, more researchers began conducting studies on brainspotting with PTSD and trauma. For example, Hildebrand et al. (2017) compared brainspotting to EMDR and found that brainspotting was an effective alternative to treat PTSD in comparison to EMDR. The Newton-Sandy Hook Community Foundation (2016) also noted that brainspotting was the most effective at treating PTSD among adults in comparison to other trauma therapy interventions.

Despite these studies, a gap in the research exists on the counselor's lived experiences with integrating brainspotting into counseling practices with clients who have experienced trauma. This study was the first transcendental phenomenological study on brainspotting. Information gained from the experiences of counselor with integrating brainspotting in their work with clients who have experienced trauma can improve practices among counselors trained in brainspotting. More information on the lived experiences of counselors who use brainspotting with clients who have experienced trauma can provide insight into evidence-based practices regarding the integration of brainspotting. The integration processes include what potential theories to integrate with brainspotting and which interventions to implement. The results from the study can also aid to improve treatment for clients who have experienced trauma.

Problem Statement

The exposure to trauma and the prevalence of PTSD among the U.S. population continues to increase (SAMHSA, 2022). Specifically, there has been an increase in the prevalence of trauma exposure and PTSD due to the COVID-19 pandemic (Whitt-Woosley et al., 2022). Therefore, more individuals with PTSD and those struggling with symptoms of trauma are now seeking counseling than in previous years (SAMHSA, 2022). Due to the increase in PTSD and exposure to trauma, well-researched and effective counseling interventions and treatments are necessary to combat this phenomenon (SAMHSA, 2022). Research has identified the effectiveness of treating various mental health diagnoses including PTSD with brainspotting (Hildebrand et al., 2017). While research has identified the effectiveness of EMDR, not every client will benefit from EMDR, some clients will require a different intervention to treat their exposure to trauma and PTSD (Hildebrand et al., 2017), such as brainspotting. However, there is also a lack of information on brainspotting, despite it being shown to significantly decrease trauma symptoms compared to EMDR, specifically concerning recollection of distressing memories (Hildebrand et al., 2017). Similarly, Newton-Sandy Hook Community Foundation (2016) also found that brainspotting was the most effective counseling intervention to decrease symptoms of PTSD for the adult survivors of the Sandy Hook Massacre.

Although research shows that brainspotting is an effective intervention to treat PTSD and other diagnoses, there is a lack of understanding of the lived experiences of counselors with integrating brainspotting in practice with clients who have experienced

trauma diagnoses. Scholarly research on the lived experience of counselors with the integration of brainspotting into counseling with clients who have experienced trauma could provide rich information to other counseling professionals on the integration process of brainspotting into practice. The practice of brainspotting can vary among counselors due to the integrative nature of the therapy in conjunction with various interventions and theoretical orientations (Grand, 2009). For example, there is no requirement that brainspotting be used in each session or as the only intervention; therefore, having information on counselors' experiences with integrating brainspotting can be helpful to other counseling professionals (Brainspotting, 2019). Specifically, research on the experiences of counselors trained in brainspotting can provide insight into overcoming potential difficulties with various traumas, including domestic violence, sexual assault, shootings, and physical abuse. The findings from this study provide information to improve training for brainspotting professionals with detailed information on the experiences of brainspotting counselors. Through the understanding of counselors' lived experiences with brainspotting, other brainspotting professionals can learn ways to improve client outcomes and practices with various traumas. Insight on this can inform future trainings for counselors trained in brainspotting to aid in providing clients quality care. Information from counselors' experiences can also identify strengths of brainspotting and ways to overcome any challenges associated with integrating brainspotting with clients who have experienced trauma.

Purpose of the Study

The purpose of this transcendental phenomenological study was to explore the

lived experiences of counselors with integrating brainspotting into counseling practice with clients who have experienced trauma. I used a phenomenological approach to gather accounts from counselors in the counseling profession who are trained in brainspotting. Participants were licensed counselors in the state where they practice who have been trained in brainspotting Phases 1 and 2. Phases 1 and 2 are the initial trainings required for certification in brainspotting; each phase is 3 days of training that focuses on beginning brainspotting skills (Grand, 2009). Phase 1 is an introduction to brainspotting and consists of demonstrations of beginning brainspotting skills, and then practitioners deepen those skills in Phase 2 (Grand, 2009). The study can inform future trainings on brainspotting by providing additional information on the practice of brainspotting grounded in actual counselor experiences with integrating brainspotting into professional practice. The research provides insight into various therapies and theoretical orientations commonly integrated with brainspotting. The study also provides information on the strengths and limitations of brainspotting among counselors in their practice with clients who have experienced trauma. Counselors can glean ways to improve client experiences and interventions best used with brainspotting for clients who have experienced trauma.

Research Question

What are the lived experiences of counselors with integrating brainspotting in counseling practice with clients who have experienced trauma?

Theoretical and Conceptual Framework

The study utilized a transcendental phenomenological framework. A phenomenological study is conducted to explore a shared phenomenon among

participants from the first person (Moustakas, 1994). Phenomenology has been around for centuries; however, it began to gain recognition in the 20th century through the practice of Husserl (Smith, 2018). The transcendental phenomenological theory implements Husserl's (1976) framework to suggest that a researcher must gather information on the individual's perceptions of their experiences to understand a phenomenon. The theory behind Husserl's transcendental phenomenology identifies that experiencing a phenomenon is subjective to the individual who experiences it, and only they can make meaning from their experiences (Moustakas,1994). The phenomenology philosophy investigates all aspects of an experience, including physical sensations, memories, emotions, imagination, desire, perception, and thought (Moustakas, 1994). In a transcendental phenomenological approach, researchers set aside personal biases and experiences, report on the experiences of others, and offer an unaltered report of findings unaffected by personal experience (Moustakas, 1994). The meaning can then be reported and compared with others who experienced the same phenomenon, then analyzed for themes and patterns that arise from experience. In this study, the phenomenological approach provided an open framework to explore counselors' experiences integrating brainspotting into clinical practice with clients who have experienced trauma (Creswell, 2013). A phenomenological framework allowed me to explore the meaning and understanding of experiences and illuminated themes within reported lived experiences (Sloan & Bowe, 2014). A more detailed description and analysis of background information on the proposed study will be explored in Chapter 2.

Nature of the Study

The study conducted was a transcendental phenomenological study exploring counselors' lived experiences with brainspotting in their clinical practice with clients who have experienced trauma. Qualitative research involves understanding, describing, and understanding experiences (Ravitch & Carl, 2016). Transcendental phenomenological studies are specifically used when a researcher's goal is to explore a shared experience among participants (Moustakas, 1994). A transcendental study's aim is to focus more on description, gather the essence of the human experience, and understand how a group of people experience a phenomenon (Moustakas, 1994). As a counselor trained in brainspotting, a transcendental phenomenological study allowed me to focus on my participants' experiences by bracketing my own experiences and perceptions of brainspotting to ensure my experiences did not impact the findings of the study (Moustakas, 1994).

This study implemented qualitative methods to gather information through semistructured interviews focused on understanding the phenomenon of brainspotting and counselors' experiences with brainspotting with clients who have experienced trauma (Creswell, 2013). The semistructured interviews had pre-determined interview questions with *dig deeper* follow-up questions (Ravitch & Carl, 2016). The semistructured interviews were conducted via the HIPAA-compliant platform Zoom with audio recording. Interviews were conducted with 12 licensed professional counselors trained in minimally Phase 1 and Phase 2 of brainspotting to ensure experience with using brainspotting. The questions were created to gather adequate information to understand

the explored phenomenon of brainspotting (Ravitch & Carl, 2016). The interviews lasted from 35 to 45 minutes. The interviews of participants were transcribed; the data analysis was hand-coded to ensure the trustworthiness of the data collected. I followed Yin's (2016) five phases method of data analysis, which allowed me to analyze the information gathered from my participants' interview to make meaning from their experiences. The study aimed to provide a deeper understanding of brainspotting among counselors to aid in improving training for professionals trained in brainspotting and provided insight into the lived experiences of counselors with brainspotting with clients who have experienced trauma.

Definitions

The following definitions are from the brainspotting training manual, the EMDR website, the somatic experiencing website, and the Diagnostic and Statistical Manual of Mental Disorders (APA, 2022; Shapiro, 2012; Grand, 2009; SE, 2020). The following definitions will help to clarify various aspects of the proposed research study.

Brainspotting: A therapeutic intervention that uses single eye movement techniques to help clients to process trauma (Grand, 2009).

Counselor: This term includes licensed master's level trained counselors who are independently licensed mental health counselors or licensed professional counselors depending on the title in the state in which they practice (American Counseling Association [ACA], 2004).

Eye movement desensitization and reprocessing (EMDR): A therapeutic intervention that uses eye-movement techniques to decrease the intensity of the emotional

reaction to traumatic memories (Shapiro, 2012).

Post-traumatic stress disorder (PTSD): Exposure or experiencing a traumatic event, including threatened death, serious injury, or sexual assault (APA, 2022). Exposure to a traumatic event can be through personal experience, exposure to details, or discovering a close friend or family member experienced a traumatic event (APA, 2022). An individual with PTSD would also have symptoms of nightmares of the event, distressing memories of the event, disassociation, emotional distress when exposed to triggers of the event, avoidance of anything associated with the traumatic event, memory issues associated with the event, negative emotions associated with the event, hypervigilance, loss of interest in activities, concentration issues, or sleep disturbances (APA, 2022).

Natural flow EMDR: Natural flow EMDR was an intervention created by Dr. David Grand, who was trained in EMDR (BioLateral, 2017). He used natural flow EMDR as a slowed down intervention derived from EMDR (BioLateral, 2017). The intervention is a combination of EMDR with somatic experiencing interventions (BioLateral, 2017).

Somatic experiencing (SE): SE is a body-based intervention based on the theory that trauma stores somatically in the body (SE, 2022). Trauma can be relieved by focusing on bodily sensations when recalling traumatic memories (SE, 2022).

Trauma: Exposure to an event that causes a noticeable reaction (SAMHSA, 2022). Events include sexual assault, domestic violence, physical aggression, natural disaster, or accidents (U.S. Department of Veteran Affairs, 2022). When exposed to a

traumatic event, an individual will experience emotional, physical, social, and spiritual distress (SAMHSA, 2022).

Assumptions

The only way to understand a phenomenon is to gather information and understand individual experience from the participant's perspective; thus, learning the most about the phenomenon through their experience as they have lived it. As a result, I assumed the transcendental phenomenological approach would provide detailed descriptions of the phenomenon to aid in understanding experiences (see Creswell, 2013). A qualitative, phenomenological study assumes each participant will respond honestly to each question and provide information from their experience; an additional assumption includes that meaning can be made from the participants' experiences (Patton, 2015). Another assumption is that I was able bracket my experience to provide an unbiased report of patterns and themes that emerge from the study (see Creswell, 2013). Within the research study another assumption is that humans who experience a phenomenon have their perspective and experience and know their experience and what their experience means (see Patton, 2015). I also assumed the participants met the criteria before beginning the study (see Patton, 2015). Therefore, the only way to honestly know about an individual experience is to experience that phenomenon as closely as possible (see Patton, 2015). These assumptions are crucial for the study to gather the necessary information on the lived experiences of counselors with integrating counseling into professional practice with clients who have experienced trauma.

Scope and Delimitations

The purpose of the research study was to explore counselors' experiences with integrating brainspotting in clinical practice with clients who have experienced trauma. I sought to gather information to add to the existing research on brainspotting to inform future trainings on brainspotting, specifically in the use with clients who have experienced trauma. The findings gained from the study provide insight into treating trauma and PTSD and create social change through informing interventions on decreasing symptoms of trauma and PTSD. Specifically, the findings from the study can inform counseling practices for counselors providing services to clients impacted by COVID-19 who are experiencing symptoms of trauma or PTSD.

The study provided insight into the strengths and limitations of using brainspotting with clients and shared practices among counselors trained in brainspotting. Participants in the study were limited to counselors trained in brainspotting that are licensed in the state where they practice as a counselor. The participants were also required to have completed Phase 1 and Phase 2 brainspotting trainings and to be actively practicing brainspotting in their counseling practice with clients who have experienced trauma. Actively practicing counselors include professionals who currently have an active caseload of clients with a history of trauma with whom they utilize brainspotting. Participants who were excluded from the study include social workers, psychologists, marriage and family therapists, and psychiatrists. These clinicians were excluded from the study because I completed this dissertation in fulfilment for a PhD in counselor education and supervision; therefore, I will add to the existing literature that is focused on

counselors. Other exclusions include individuals who have not completed brainspotting trainings Phase 1e and Phase 2. The findings from the study can only be applied to counselors and other mental health professionals trained in brainspotting who integrate or will integrate brainspotting in their practice with clients who have experienced trauma. Ultimately, the focus of the study was to gather insight on the in-depth experiences of counselors trained in brainspotting to inform strengths and weaknesses of integrating brainspotting with clients who have experienced trauma.

Limitations

One limitation of the study is that I am trained in brainspotting and have biases due to my perception of brainspotting; therefore, I could have inadvertently decreased the dependability of the study. One way I attempted to limit this is by using a transcendental framework to allow for bracketing personal experiences (see Creswell, 2013). Another potential limitation is that I created the questions for the interview. In some studies, the researcher could lead participants with questions to achieve desired answers (Patton, 2015). To mitigate these limitations I had my chair and committee member review my interview protocol to provide quality assurance that my questions were not biased or leading and helped to ensure the trustworthiness of my study.

Another potential challenge was the interviews. I conducted the interviews over a web-based video conferencing platform, Zoom. The potential for technical issues increases when conducting web-based interviews. However, no technical issues occurred during my interviews. I limited these disruptions by ensuring I had quality internet connection before conducting the interview and prompted the participants to ensure

adequate internet connection. I also decreased limitations by building rapport with the participants to ensure they felt at ease to discuss their experiences.

A limitation of transcendental phenomenological studies includes that the study is limited to only individuals who have experienced the phenomenon (see Creswell, 2013). Another limitation of the study was that the study was limited to Phase 1 and Phase 2 trained brainspotting professionals with experience using brainspotting in professional practice. Therefore, other brainspotting professionals not trained in the two phases were not included in the study despite their experience with brainspotting. If a counselor has completed Phase 1 and 2 of brainspotting they are eligible for certification and have obtained the required trainings to implement with clients on a more advanced level. While there is the opportunity to be trained in four phases, the other phases are for more in-depth training not required for certification and will not be required for this study. Another limitation is the transferability of the results to only counselors trained in brainspotting who have used brainspotting with clients who have experienced trauma. Brainspotting can also be used for various mental health conditions including anxiety, depression, bipolar disorder, and other somatic conditions (Grand, 2009); however, this study did not explore these.

Another limitation is that the study focused on brainspotting counselors in the United States. There are counselors trained in brainspotting across the world in various countries. Cultural differences and variations in traumatic experiences may make the results of the study not generalizable to those counselors in other countries. The phenomenological framework is also limiting because the data gathered are based on

participants exploring their experiences with brainspotting retrospectively and on personal interpretation of their experiences (see Creswell, 2013).

Significance

Research shows that trauma has a significant impact on an individual's health and well-being and that the prevalence of trauma continues to increase (SAMHSA, 2022; Usta et al., 2018). Therefore, adequate training and effective therapies are essential to treating trauma and PTSD worldwide (D'Antoni et al., 2022). The study added to the limited research on brainspotting, a widely used trauma therapy. The implications for positive social change include gathering information that will inform future trainings on brainspotting, improving client experiences, and attempting to decrease the significant impact trauma has on the United States. These impacts include increased health problems, emotional distress, potential development of PTSD, and poor relationships with others (SAMHSA, 2022). Additional positive social changes include the study can inform strengths and limitations of brainspotting counseling. The information gathered from the lived experiences of the counselors included gaining insight into counselors' experience with brainspotting with trauma and PTSD. Therefore, information on counselor experiences with integrating brainspotting into practice with clients who have experienced trauma has added additional information to current trainings focused on interventions to address trauma and PTSD.

Summary

The prevalence of trauma continues to increase in the United States (SAMHSA, 2022). Trauma has significant implications on the physical and mental health of those

who experience these phenomena (Usta et al., 2018). Brainspotting is a psychotherapy treatment used to treat trauma through eye movement, focused mindfulness, and attunement of the counselor (Grand, 2009). Research supports the effectiveness of brainspotting in treating trauma and PTSD; however, there is a lack of information on the experiences of professionals trained in brainspotting with integrating brainspotting into counseling practice. My research study was a transcendental phenomenological study exploring counselors' experiences with integrating brainspotting in counseling practice. The study provided insight on integrating brainspotting in practice with clients who have experienced trauma or PTSD. The study also provided information for future trainings to include information on counselor experiences. The following chapter provides an examination of the research supporting the study.

Chapter 2: Literature Review

The prevalence of trauma and PTSD continues to increase throughout society, and counseling professionals have noted a need for training to treat trauma and PTSD (SAMHSA, 2022). One therapy that has recently gained recognition for trauma treatment includes brainspotting (Grand, 2009). Brainspotting is a psychotherapy technique used by mental health counselors, clinical social workers, marriage and family therapists, and psychologists to treat various traumas or PTSD (Grand, 2009). Brainspotting is an eye movement intervention created by Dr. David Grand derived from EMDR and SE (Grand, 2009). Research supports the effectiveness of brainspotting and has identified that this intervention is just as effective as other therapies commonly used for PTSD (Usta et al., 2018). Other therapies commonly used to treat trauma and PTSD that are as effective as brainspotting include EMDR and trauma-focused cognitive behavior therapy (TFCBT; Shapiro, 2012; Walker, 2017).

There is currently a lack of research on counselors' experiences with integrating brainspotting in professional practice. My transcendental phenomenological study was conducted to explore the experiences of counselors to gain understanding about the integration of brainspotting in counseling practice. In this chapter, I will explore research supporting the purpose and significance of the proposed study. I will first share my literature review search strategy and explain how I found the research studies I am analyzing. I will also provide information on the definition of trauma and PTSD and examine the history of trauma treatment, which led to the development of brainspotting. I will discuss the history of brainspotting and will examine studies that have confirmed

brainspotting to be an effective treatment of trauma. I will explore the use of brainspotting in present clinical practice. I will analyze research studies focused on the effectiveness of brainspotting and counselors' experiences with brainspotting.

Literature Review Search Strategy

The following literature was collected through Walden University library database searches. The search engines and library databases include EBSCO Search Complete, PsychINFO, Proquest, Google Scholar, and Academic Search Complete. The following is a list of key word searches used to gather research articles: *brainspotting, somatic experiencing, EMDR, brainspotting and EMDR, brainspotting and trauma, neuroscience and trauma, neuroscience and brainspotting, neuroscience and EMDR, EMDR and somatic experiencing, EMDR and trauma, PTSD and brainspotting, EMDR and PTSD, trauma, somatic experiencing and PTSD,* and *neuroscience and PTSD*.

My research process consisted of five steps to gather the necessary data: (a) identify content areas to gather data (i.e., brainspotting, EMDR, somatic experiencing), (b) begin conducting research with key terms related to content areas, (c) save studies that are related to the topic being searched, (d) explore the research articles and data gathered, (e) organize data systematically, and then (f) conduct more searches with different key words to ensure all related data were collected (see Creswell, 2013). After a review of the literature, I found a significant lack of information on the experiences of counselors with brainspotting. Therefore, I included an interview between Dr. David Grand, the founder of brainspotting, and a fellow brainspotting trainer that was published on the brainspotting webpage where they explored their personal experiences with

brainspotting. Due to the lack of peer reviewed research, I included the interview to provide some information on the experiences of other mental health professionals with brainspotting.

Conceptual Framework

I used Hussler's philosophy on transcendental phenomenology as the theoretical framework for the study (Moustakas, 1994). A phenomenological study uses in-depth interviews to gather information on the shared experience among research participants (Bloomberg & Volpe, 2018). here are two branches of framework within phenomenological research, including transcendental and hermeneutic (Bloomberg & Volpe, 2018). By utilizing a transcendental framework, I bracketed my biases and focused on gathering descriptions of the participants' lived experiences rather than making interpretations of the experiences (Bloomberg & Volpe, 2018).

Literature Review Related to Key Concepts

What is Trauma?

Trauma is defined as an emotional reaction to an adverse event such as a natural disaster, physical violence, sexual assault, an accident, or witnessing a life altering event (APA, 2022). Emotional reactions include unpredictable emotions, physiological symptoms, unstable relationships, and flashbacks (APA, 2022). Sigmund Freud was the first to recognize symptoms of trauma in the 1890s (Walker, 2017). Trauma does not discriminate and can happen to anyone regardless of age, race, ethnicity, socioeconomic status, or sexual identity/orientation. Trauma is associated with mental and physical health implications, including developing PTSD, depression, anxiety, suicidal ideations,

substance use, or self-harming behaviors (SAMHSA, 2022).

Additionally, trauma negatively impacts the brain (Hogberg et al., 2011). Research using EEGs, SPECTs, PETs, and fMRI has found that PTSD significantly affects the brain's functioning including neural connections in the brain (Högberg et al., 2011; Meng et al., 2018). Trauma can affect blood flow and white matter in the brain, causing emotional distress, and decrease white matter found through brain imaging resources (Meng et al., 2018). Further, researchers like Fitzgerald et al. (2017) examined PTSD among veterans and found that when veterans had a diagnosis of PTSD the neural activity was very high in the amygdala, which led to poor emotion regulation. When individuals encounter a traumatic experience, they often display acute stress disorder, which includes symptoms of anxiety, hypervigilance, or stress, for roughly a month (Högberg et al., 2011). When an individual continues to display symptoms of hypervigilance, anxiety, avoidance of triggers or places related to the trauma, and experience flashbacks for over a month, the individual has developed PTSD (APA, 2022). When PTSD develops after experiencing a traumatic event, the symptoms of acute stress intensify, leading to somatic responses when an individual is trying to relax or even sleep (Högberg et al., 2011). Further, when an individual encounters a traumatic experience that evokes fear or anxiety, this triggers the amygdala to activate and engages the sympathetic nervous system into a fight or flight response. PTSD develops when the brain consistently goes into a state of fight or flight when presented with a trigger to the traumatic memory (Högberg et al., 2011). Therefore, a trigger of the traumatic memory can lead to an emotional or physiological reaction to non-threatening stimuli (Högberg et

al., 2011).

The COVID-19 pandemic which began in March 2020 is an example of a significant and recent trauma that has impacted millions of individuals around the world and has increased recognition of trauma and PTSD (Whitt-Woosley et al., 2022). The Centers for Disease Control and Prevention (2023) reported there were 1,113,254 deaths from COVID-19, and over 102,998,014 cases of COVID-19, causing a significant impact on society. Many individuals impacted by COVID-19 have displayed symptoms of acute stress disorder and PTSD (Whitt-Woosley et al., 2022). The exposure rates to indirect trauma through the pandemic have increased the number of individuals with trauma symptoms (Whitt-Woosley et al., 2022). Similarly, the COVID-19 pandemic has had a direct impact on nurses and medical personnel directly exposed to treating patients with COVID-19 (Hernandez et al., 2021). Research also suggests that survivors of COVID-19 with severe virus cases also have symptoms of PTSD and require trauma treatment to aid in emotional recovery from the physical illness endured (Nagarajan et al., 2021).

History of Trauma Treatments

Many clinicians indicate that trauma received recognition in the 1980s with the addition of PTSD to the DSM as a diagnosable disorder (Walker, 2017). However, there is evidence of the impact of trauma by psychiatrists earlier than 1883 in the recorded work of Sigmund Freud (Walker, 2017). But there is evidence that there was a lack of recognition of trauma due to the potentially devastating impact on society (SAMHSA, 2014). Many individuals in leadership were hesitant to believe Freud's work on trauma because they did not want to believe traumatic experiences were occurring within society

including physical, sexual, emotional, and psychological abuse within families (SAMHSA, 2014). Recognizing the abuse that occurred in society would have caused negative implications and significant uproar among communities (SAMHSA, 2014). There has also been documentation of soldiers experiencing symptoms of trauma after every war experienced. However, many politicians and world leaders forbade the information from being published because of fear the information may undermine the war efforts or increase the frequency of symptoms (SAMHSA, 2014). In the 1800s PTSD was mainly associated with combat veterans and was often called "soldiers' fatigue" or "battle exhaustion" (SAMHSA, 2014, p.76). The primary source of treatment for trauma during this time, from the 1800s to the late 1900s, was talk therapy, and when that was not effective, electroshock therapy (SAMHSA, 2014).

The 1950s led to additional treatment modalities for PTSD. However, many individuals did not admit to any trauma symptoms due to the stigma and poor treatment of those with mental illness (Walker, 2017). In the 1970s, researchers began to find that populations other than veterans also experience trauma and PTSD (Walker, 2017). Peter Levine was part of this movement when he began the development of somatic experiencing (SE) in the 1970s through his work with military veterans (Somatic Experiencing International, 2023). His discoveries led to the development of somatic therapies focusing on body sensations instead of talk therapy (Somatic Experiencing International, 2023). Somatic therapy identifies the connection between mind, body, emotions, and spirit and addresses each part's role in the healing process (Somatic Experiencing International, 2023).

Francine Shapiro created eye movement desensitization reprocessing (EMDR) in 1987 (Shapiro, 2012; Whitehouse, 2021), which has since become one of the most recognized interventions to treat trauma and PTSD (Whitehouse, 2021). The development of EMDR led to increased recognition of trauma (Whitehouse, 2021). EMDR was the foundation for other eye-movement therapies that treat traumatic memories; these include accelerated resolution therapy (ART) and brainspotting (Shapiro & Brown, 2019). EMDR helps to make significant changes to brain function, especially in the functional connectivity of the brain (Santarnecchi et al., 2019; Walker, 2017). Walker (2017) noted that increased myelination after EMDR interventions improved the ability for neurons to move through neurological synapses in the outer cortex of brain. The improvement in brain function would translate to improved cognition and decreased symptoms of hypervigilance in individuals who experienced trauma or have PTSD (Santarnecchi et al., 2019).

After the development of EMDR in 1987, TFCBT was developed in the early 1990s (Walker, 2017). In the early 2000s, research increased on effective trauma therapies which provided an opportunity to develop new interventions to aid in treating the increased trauma experienced by individuals (SAMHSA, 2014). Therefore, therapies like EMDR and TFCBT became more researched (SAMHSA, 2014). TFCBT is recognized as one of the most effective therapies for the treatment of trauma among children and has been in use for the past 25 years (Walker, 2017). Unlike EMDR, TFCBT uses talk therapy to aid in stabilization, along with psychoeducation, relationship building, and narrative therapy to aid the client in processing the trauma they experienced

(Cisler et al., 2016). TFCBT is widely researched and supported by the American Psychological Association (2022) as the most effective form of trauma treatment, followed by EMDR. Neuroscience has also begun to support TFCBT through brain imaging studies before and after the use of TFCBT (Cisler et al., 2016). Research studies comparing EMDR and TFCBT have found TFCBT to be a more effective treatment for trauma and PTSD (Lewey et al., 2018). Following the growth and recognition of TFCBT and EMDR was the development of other exposure therapies that would prompt clients to re-tell their traumatic experiences (Neuner, 2004). The exposure therapies would also incorporate psychoeducation on reactions to trauma and psychoeducation on the various interventions used to treat trauma (Neuner, 2004).

A newer trauma intervention that has gained recognition includes reconsolidation of traumatic memories (RTM; Gray et al., 2021). RTM is not derived from EMDR and was created with a different theory and framework (Gray et al., 2021). RTM was created by Dr. Frank Bourke after 9/11/2001, through his work with survivors of the 9/11 terrorist attacks (Vermes et al., 2020). One of the major goals of RTM was to treat PTSD and trauma more time efficiently as opposed to approaches that are longer in length of treatment, and RTM was more solution focused (Gray et al., 2021) This therapy was created around the same time as brainspotting; however, brainspotting has gained more recognition (Grand, 2009). Both RTM and brainspotting require more research and peer reviewed support to further the treatment of trauma and PTSD (Gray et al., 2021; Gurda, 2015). Another therapy derived from EMDR to treat trauma includes ART (Kip et al., 2019). In 2008, Dr. Rosenzweig developed ART through her work with integrating

EMDR with other modalities such as CBT, Gestalt, and brief psychodynamic therapy (Kip et al., 2019). ART has some components of EMDR but can be used in one session, as opposed to EMDR that is used over the course of several sessions (Kip et al., 2019).

More recently, neuroscience has supported therapeutic techniques and models for psychotherapy interventions, creating the branch of psychotherapy called neurocounseling, which includes interventions such as EMDR (Society for Neuroscience, 2020). Neurocounseling describes interventions supported by brain imaging research that focuses on various therapies that alter brain function (Society for Neuroscience, 2020). Some of these therapies supported by neuroscience include EMDR, TFCBT, and brainspotting (Society for Neuroscience, 2020). The recent use of neuroscience and brain imagining now supports EMDR and the use of EMDR in treating trauma (Verger et al., 2020). Initially, when EMDR was created, evidence suggested the effectiveness of EMDR through client reports of reduction in symptoms; however, more recently EMDR has become supported by neuroscience and brain imaging (Verger et al., 2020), showing the significant impact on brain connectivity changes in clients who have PTSD (Santarnecchi et al., 2019). Other therapies supported by neuroscience continues to increase as the access to brain imaging research continues to become more accessible (Santarnecchi et al., 2019).

The number of therapies used to treat trauma has significantly increased in the past 5 years (NIMH, 2022). This is due to increased awareness of the impact of trauma and the prevalence of trauma (NIMH, 2022). This increase in therapies continues to rise as the awareness of trauma and of the negative impact trauma has on individuals and

society has grown (NIMH, 2022). Next, I will explore the background on brainspotting, a trauma therapy that has recently gained recognition as a treatment for trauma.

Background of Brainspotting

Dr. David Grand began to develop brainspotting in his counseling practice through combining EMDR and SE in 2003 (Gurda, 2015). Grand (2009) was an EMDR and Somatic Experience trained therapist. Grand identified that when he slowed the eye movement intervention used in EMDR and engaged somatic body sensations, clients began to experience significant reduction in symptoms of PTSD and improved overall performance. Brainspotting is theorized to improve neurological processes and is gaining support through neuroscience as well (Gurda, 2015). While brainspotting does not have the same empirical support as EMDR or TFCT, emerging studies on the therapy are suggesting the effectiveness of brainspotting (Gurda, 2015).

Dr. Grand (2009) worked with a figure skater while engaging in natural flow EMDR. Dr. Grand was slowly moving his fingers across the skater's field of vision when he noticed a subtle eye movement where her eyes suddenly began to wobble then freeze where his fingers had stopped and encouraged the skater to hold her gaze. Over time, the skater began to express memories of traumatic and various childhood experiences, which was quite different from the previous year of therapy she had been experiencing. Dr. Grand began to implement the technique with others and found it highly effective, and thus he continued to develop the therapeutic intervention.

Since the development of brainspotting by Dr. Grand, brainspotting has expanded, and become a sought-after training for many mental health professionals (Gurda, 2015).

The Brainspotting Institute offers four phases of training (Grand, 2009). However, becoming certified as a clinician only requires training in two of the four phases (Grand, 2009). Over 6,000 clinicians have become trained in brainspotting (Grand, 2009). Social workers, mental health counselors, marriage and family therapists, and psychologists can attend training in brainspotting. Brainspotting is often used to treat various mental health issues/diagnoses, including anxiety, depression, PTSD, Bipolar Disorder, and adjustment disorders (Grand, 2009).

Brainspotting is an integrative therapy that can be used with different theoretical approaches; therefore, clinicians use brainspotting with various theoretical orientations and counseling interventions (Grand, 2009). Brainspotting is derived from EMDR, but Grand noted that the only similarity to EMDR is the use of the eyes; all other components are very different from EMDR and focus more on interventions/components gained from SE (Gurda, 2015). One significant difference between EMDR versus brainspotting includes that brainspotting uses a single eyespot in a session (Grand, 2009). In contrast, EMDR uses rapid eye movement of consistently moving an eye stimulus back and forth in a client's field of vision (Grand, 2009).

The neuroscience behind brainspotting theorizes that a brainspot is the activated neural activity within the subcortical brain (i.e., amygdala, basal ganglia, and central nervous system) identified through the stimulation of the eyespot (Grand, 2009). An eyespot is a spot in a visual space where a client has a physiological reaction; the reaction may be excessive blinking or body twitching (Grand, 2009). Researchers have theorized that the cortical brain is where conscious thinking occurs. Deep subconscious reactions

occur in the subcortical brain, such as unproductive behaviors after a traumatic experience (Badenoch, 2008). PET scans have noted that when engaging in brainspotting, the subcortical brain's activations increase over time; once the client has completed processing, the activity lessens (Grand, 2009).

Carter (2009) noted that the amygdala is responsible for triggering the sympathetic nervous system, or fight or flight response, after a traumatic experience. Brainspotting appears to access the right brain, the limbic system, and the brainstem or midbrain (Grand, 2009). By accessing this part of the brain researchers have noted that healing of distressing traumatic memories within the midbrain can occur (Corrigan & Grand, 2013). Holding an eyespot leads to deep healing and regulation of the sympathetic nervous system, which places the brain in a regulated state (Corrigan & Grand, 2013). Another theory is that brainspotting accesses the superior colliculi's visual, tactile, and auditory layers which aids in regulating the amygdala (Grand, 2009).

Ultimately, by accessing these brain parts, the client can process trauma on a subconscious level to decrease involuntary symptoms such as hypervigilance, insomnia, flashbacks, and other somatic responses to trauma (Corrigan & Grand, 2013). The initial step of brainspotting focuses on identifying a traumatic event, experience, or presenting problem (Grand, 2009). The clinician then guides the client to an eyespot (Corrigan & Grand, 2013). The client focuses their gaze until the client reports there is no longer a physiological or emotional response when recalling the identified stressor (Corrigan & Grand, 2013). Processing of the trauma is achieved through several different components and methods, which will be explored in depth in the following section.

Brainspotting in Practice

The practice of brainspotting is unique and adaptive. Brainspotting is a therapeutic approach that has recently gained attention in the treatment of PTSD and trauma, which allows a client to process a traumatic experience within the brain's subcortex through eye movement (Grand, 2009). Brainspotting is not required to be used in every session and may be integrated with other theoretical orientations or therapeutic interventions (Gurda, 2015). In the following section, I will explore the two models used within brainspotting and how a counselor can determine which of the two models to use. The two models include the activation model and the resource model (Grand, 2009). Then, I will explore commonly used interventions in brainspotting that can be used in either model. Finally, I will explain a brainspotting setup which is a procedure for a counselor to follow for a brainspotting session (Grand, 2009).

The brainspot is a spot within the subcortical brain that is theorized to be associated with a traumatic memory or experience (Corrigan & Grand, 2013). By activating the brainspot with the eyes, the client can then process the trauma on a subcortical level, which researchers noted may have previously been inaccessible through other modalities (Gurda, 2015). Eye positions can be located by the counselor through noticing where the client is looking, or by using a brainspotting pointer (Grand, 2009). The pointer used in brainspotting is a retractable telescopic pointer, often used in education settings, that helps the client and counselor to locate an eye position (Grand, 2009). This pointer expands so the counselor can comfortably hold the pointer while moving it horizontally and vertically across the client's field of vision (Grand, 2009). Eye

position interventions are what aid the counselor in treating symptoms of trauma or PTSD (Gurda, 2015).

The practice of brainspotting is very integrative and creative and requires dual attunement of the counselor with the client, which involves the focused energy of the counselor on the client (Corrigan et al., 2015). The dual attunement in brainspotting provides a safe emotional space where the counselor can attend to the needs of the client and help the client process traumatic experiences (Grand, 2009). Dual attunement is done by the counselor maintaining eye contact with the client, and for the counselor to be focused on the needs of the client (Grand, 2009). For example, if a counselor is attuned to the client, they are focused on the needs of the client and ensuring a feeling of safety. Dual attunement of the counselor with the client allows the counselor to notice reflexive movements that locate an eye position to activate a brainspot (Hildebrand et al., 2017). Through fixed visual attention, the client mindfully observes cognitions and physiological responses to come to a natural state of resolution of the identified issue (Hildebrand et al., 2017). Dual attunement allows for the safe space for mindfulness and exploration and processing of physiological responses to trauma (Hildebrand et al., 2017).

The two models used in brainspotting are the resource and activation model. The interventions used in brainspotting include gazespot, inside window, and outside window. Often a counselor will use only one intervention per session. While there are other interventions used in brainspotting, these three are the foundation from which all other interventions build (Grand, 2009). Brainspotting professionals use setups, which refers

tosetup the intervention and model used with the client for a particular session (Grand, 2009).setup A setup could look differently for each client and each counselor may do a setup differently. There is no specific timeline for when a counselor might start using brainspotting in counseling with a particular client.

Models

One model used in brainspotting is the activation model, and the other is the resources model. A brainspotting counselor would first determine which model to use before identifying which brainspotting intervention to use in the session. The brainspotting model chosen by the counselor would be determined by what is best for the client based on several factors discussed in the next sections.

Activation Model. The activation model is used when a client identifies where they feel activated or physiological distress in their body when recalling their identified issue, traumatic memory, problem, or experience (Grand, 2009). For example, when using the activation model a client may identify that when they speak about the fight they had with their parents, they notice a tight feeling in their chest and muscle tension in their shoulders. The client would then be prompted to find the eye position where they notice an increase in physiological distress when they look at that specific spot (Hildebrand et al., 2017). The client will also be prompted to find the eye position that increases the physiological distress, with the intention that once the internal processing is done, there will be significantly less of a physiological reaction to the presenting problem (Grand, 2009). The activation model is also known as the access spot, which provides access to what the client wants to work on to decrease any physiological reaction to the identified

problem (Grand, 2009). This model is best used for clients who are willing and able to experience the physiological distress in a safe space (Grand, 2009). The resource model can be used for individuals who are not willing or are unable to experience the physiological distress.

Resource Model. When a counselor implements the resource model the client is prompted to identify the feeling of calm or grounded located in the body when recalling the issue they wish to address (Grand, 2009). For example, a client may discuss the time they were left at school as a child and share that they feel the calmest and most grounded in their left leg. Following the resource model, a counselor would find an eye position that when the client looks there, they feel an increase in the calm and grounded feeling in the client's body (Hildebrand et al., 2017). The counselor would aid the client to identify the eye position where the calm and grounded feeling increases for the client (Grand, 2009). The resource model is best used for clients experiencing severe PTSD or dissociation, and who are unable to emotionally regulate to use the activation model (Grand, 2009). A counselor would choose the resource model over the activation model if a client experiences significant activation or emotional distress when discussing or recalling the identified problem (Grand, 2009). Once a model is identified for the session, the counselor can then determine the appropriate intervention to use in the session that best suits the client's identified issue/problem (Grand, 2009).

Interventions

The following sections explore the three most used interventions in brainspotting. The three interventions include gazespot, inside window, and outside window. All are

different in various ways and can be integrated into a session differently. The following section will identify how to choose an intervention for a client and a description of the use of the intervention. The following examples will aid in understanding the integrative nature of brainspotting and how interventions can be used differently based on the client needs. While there are more interventions used in brainspotting, the other interventions are different variations of these three interventions.

Gazespot. The gazespot is an intervention in brainspotting that can be used for various clients to identify an eyespot (Grand, 2009). The brainspotting pointer is not used in this intervention and this is the only intervention that does not use the brainspotting pointer (Grand, 2009).This intervention is beneficial for clients who are just learning about brainspotting or have no previous experience with brainspotting (Grand, 2009). The gazespot is an eyespot that arises naturally when in session with a client (Grand, 2009). For example, a counselor may notice that a client looks down often when speaking about the problem or trauma with which they are struggling (Grand,2009). When identifying a gaze spot the counselor encourages the client to continue to look where their eyes naturally fall (Grand, 2009). When the gazespot has been identified, the counselor will prompt the client to continue to look down and notice what happens in their body when they look down (Grand, 2009). When using gazespotting, the client can continue to discuss their presenting problem, or they can simply focus on the eye position (Grand, 2009). The gazespot is the most integrative technique and can be implemented at any point in the session (Grand, 2009). A counselor does not have to follow the gazespot

protocol specifically outlined in the brainspotting manual that I just described; this intervention is very adaptable to each clinician (Grand, 2009).

Inside Window. The inside window is an intervention where the counselor aids the client in identifying a trauma, presenting problem, memory, or issue that the client would like to address (Grand, 2009). A counselor who is doing an inside window intervention would use a pointer to locate an eye position that activates a 'brainspot' (Grand, 2009). The counselor would guide the pointer horizontally through the client's field of vision, and the client then communicates with the counselor where they feel the most physiological distress, based on where they are looking (Grand, 2009). Once a spot has been determined horizontally then the therapist would inquire with the client where they feel activation in their body when moving the pointer vertically (Grand, 2009). For example, the counselor would inquire of the client, "how do you feel in your body when you look here?" while moving the pointer horizontally then vertically across the client's field of vision (Grand, 2009). The client will aid the counselor in determining where they feel the most physiological reaction to a specific eye position (Grand, 2009). Ultimately, this intervention can be used with any client and is appropriate for various types of problems or traumatic memories/experiences (Grand, 2009).

Outside Window. For the outside window intervention, the counselor would find the relevant eye position for the client's identified problem without any feedback from the client (Grand, 2009). This intervention focuses on the counselor observing the client's eye movement (Grand, 2009). First the counselor would use their pointer moving it horizontally very slowly looking for any eye movement or reflexive reactions to an eye

position (Grand, 2009). Reflexive reactions include excessive blinking, facial twitching, or body movements (Grand, 2000). Then, once an eye position has been found, the therapist would move the pointer vertically in the client's field of vision to determine a vertical eye position (Grand, 2009). For example, when moving the pointer horizontally a counselor may notice frequent blinking or facial twitching, and they will move the pointer vertically to identify in that space where there is continued facial twitching (Grand, 2009). Once an eyespot has been located the counselor would encourage the client to continue to hold their gaze on the pointe (Grand, 2009). When engaging in outside window a counselor would rely on reflexive response and dual attunement to identify the eye position that activates the brainspot (Grand, 2009).

Brainspotting Setup

The brainspotting setup is a term used to identify the procedure to follow when conducting a brainspotting session or when a counselor wants to use a brainspotting intervention (Grand, 2009). While the setup offers step by step procedures, the counselor does not have to follow them exactly and the procedures can vary from counselor to counselor (Grand, 2009). The brainspotting setup is going to look different depending on the client and counselor (Grand, 2009). While brainspotting is an integrative approach that can be incorporated with any therapeutic style or clinical approach, there is a setup for using brainspotting in a client session (Gurda, 2015). For example, in one session a counselor may use the brainspotting setup to locate an eyespot, and in the next session the therapist may use CBT interventions and strictly talk therapy. The setup simply offers a guide and does not have to be strictly followed by the counselor. The setup offers

leniency on how to introduce or integrate the components of brainspotting into a session (Gurda, 2015).

The Beginning—Identifying an Issue. A counselor implementing brainspotting would assist the client in setting the frame and identifying a presenting issue to work on with brainspotting (Brainspotting, 2022). "Setting the frame" is a term used in brainspotting to describe the beginning steps of a brainspotting session to determine the appropriate brainspotting intervention to use (Brainspotting, 2022, p. 7). Clients may choose a traumatic memory, cognition, transference, or presenting problem that causes emotional distress to work on during the session (Brainspotting, 2022). In this step, the counselor may ask additional questions and aid the client in exploring what presenting issue the client would like to choose for the session (Brainspotting, 2022).

Check on Activation. In this stage, a counselor would check in with the client on how activated they are feeling when discussing the identified issue (Corrigan & Grand, 2013). The counselor may simply ask "how activated are you surrounding this issue?" Activation in brainspotting is defined as emotional distress the client is experiencing (Brainspotting, 2022). The brainspotting counselor would also gather a history of activation surrounding the issue. For example, inquiring "when do you feel the most activated surrounding this issue in comparison to now?" The level of activation will aid the counselor in determining if the activation or resource model would be most appropriate (Corrigan & Grand, 2013). Strong consistent activation surrounding the presenting issue would potentially cause the counselor to use the resource model (Grand,

2009). Lower activation would potentially mean that the counselor would use the activation model (Grand, 2009).

Subjective Units of Distress Level. Once the activation has been explored the counselor aids the client in identifying the Subjective Units of Distress (SUDS) level on a scale of 0 to 10 (Grand, 2009). When scaling to determine the SUDS level, 10 is typically high activation, often described as close to a panic attack, or high hypervigilance (Grand, 2009). The scaling and description are determined by the counselor (Grand, 2009). A SUDS level of 0 is described as little to no activation; for example, described as feeling calm and relaxed and in one's "happy place" (Grand, 2009, p. 15). This stage provides the counselor a numerical value that will be compared later in the brainspotting session (Grand, 2009). SUDS level can be used in conjunction with the previous stage to best aid the counselor in determining the best model to use and to aid the client in limiting emotional distress (Grand, 2009).

Location of Activation in the Body. Following choosing an issue, the counselor would help the client identify body sensations associated with the traumatic event, memory, cognition, or transferences (Grand, 2009). An example includes a client stating, "when I think about this trauma, my chest gets tight." The purpose of this stage is to increase focus for the client and to aid in the brain-body connection to allow processing of the somatic sensations of the trauma (Grand, 2009). For example, in the previous stage the counselor would ask, "what is your level of activation?" In this stage the counselor would ask the client, "where is activation located in your body?"

Locate Eye Position (Inside or Outside Window). Once the location of the activation in the body has been identified, the therapist then guides the client's eyes across the visual field and looks for behavioral cues to determine an eyespot that activates a brainspot (Brainspotting, 2022). The counselor would prompt the client to focus on the activation in the body while determining an eyespot, as the theory supports that somatic response can aid in determining a brainspot (Grand, 2009). When a brainspot is activated the subcortical brain sends a reflex signal that is outside of the client's conscious awareness, such as blinking or other reflexive responses (Grand, 2009). The eyespot is determined through the attunement of the clinician for any subtle physiological changes in facial expression or blinking (Brainspotting, 2022). For example, the location of an eyespot may cause a client to have facial twitching or excessive blinking.

Focused Mindfulness. Once the clinician locates an eyespot, they encourage the client to focus their gaze on the eye position until emotional and physiological distress has decreased (Grand, 2009). The clinician instructs the client to hold the gaze for as long as they need; processing time often varies from client to client. Suggested times for a brainspotting session are roughly 60 to 90 minutes to allow the client adequate time to engage in focused mindfulness (Grand, 2009). Grand theorized that having a client hold an eyespot in their visual field allows access to the brain's subcortex, which aids in decrease emotional distress (Brainspotting, 2019).

Go Back to the Beginning to Assess Change. During the assessing change stage of a brainspotting session, the counselor may inquire how the client is processing the identified issue (Grand, 2009). This step may not always be necessary as the counselor is

not to interrupt the client's process; however, if the client comes to a natural place of inquiring about the next steps, the counselor may inquire about the client's current SUDS level (Grand, 2009). Ultimately, this stage allows the counselor to identify any change that has occurred (Grand, 2009). For example, a client may note the activation in their chest went from a 10 to a 5 or may not have changed at all. This stage also allows for the counselor to use some grounding techniques if the client feels activated and does not notice any physiological decrease in activation (Grand, 2009).

Squeeze the Lemon. The final stage in brainspotting includes "squeezing the lemon." The term "squeezing the lemon" is used to provide a metaphor for ridding, or squeezing out, any activation associated with the client's identified problem (Grand, 2009). In this stage the counselor may prompt the client to recall the initial problem and notice if they continue to feel activation in their body or emotionally (Grand, 2009). If the client continues to report activation surrounding the issue, the counselor may then prompt the client to continue to focus their gaze on the eye position to allow continued processing (Grand, 2009). This stage aids in decreasing all physiological and emotional distress associated with the identified issue (Grand, 2009). For example, a counselor would prompt the client to examine their body and notice any activation or emotional distress that has not gone away. If the client states they have some activation still in their chest, the counselor could encourage the client to focus on that part of the body while looking at the eye position (Grand, 2009). If the client notes that there is no more physiological or emotional distress the counselor would discontinue the use of the eye position. The counselor could then continue the session how the counselor determines is

best for the client (Grand, 2009). This could include discussing the issue with talk therapy and processing the session with various interventions from other therapies or modalities.

Effectiveness of Brainspotting

Currently, there is a lack of research on brainspotting; however, there have been some studies conducted that do support the effectiveness of brainspotting. Additional studies have also been conducted that compare EMDR and brainspotting as a treatment approach for trauma. While majority of the studies conducted on brainspotting are focused on PTSD and trauma, there have been studies identifying the effectiveness of brainspotting on other mental health disorders in addition to PTSD and trauma. However, for the purpose of this literature review I focused on studies supporting brainspotting as a therapy for trauma and PTSD. One study by Corrigan and Grand (2013) gathered literature supporting how a brainspot is created during a traumatic event and brainspotting can access the brainspot to alleviate symptoms of the distressing memory. The literature review by Corrigan and Grand (2013) identified support for brainspotting in treating trauma and PTSD. In another literature review, Gurda (2015) explored relevant research on yoga, brainspotting, and energy psychology. There is a need for continued research on brainspotting and how brainspotting continues to gain recognition as a treatment for trauma and PTSD (Corrigan & Grand, 2013; Gurda, 2015).

A study on the comparison of EMDR with brainspotting, examined the effectiveness of the therapies with PTSD (Hildebrand et al., 2017). Similarly, D'Antoni et al. (2022) explored the effectiveness of brainspotting in comparison to EMDR and body scan meditation with distressing trauma memories. The findings on the comparison of

EMDR and brainspottingincludedthat brainspotting significantly decreased symptoms of trauma. and noted the effectiveness of brainspotting in comparison to EMDR (Hildebrand et al., 2017). Similarly, D'Antoni et al. (2022) found that brainspotting is just as effective as EMDR and body scan meditation. Another study that examined the effectiveness of various interventions to treat PTSD was The Newton-Sandy Hook Community Foundation Inc. survey (2016) which reported similar findings to Hildebrand et al. (2017). The Newton-Sandy Hook Community Foundation (2016) found that brainspotting was the most effective counseling intervention to decrease symptoms of PTSD for the adult survivors of the Sandy Hook Massacre and was also effective in treating PTSD for children as well; however, the most effective treatment for children was TF-CBT.

A case study conducted by Masson et al. (2017) explored the use of brainspotting with a survivor of the Bactaclan attack in Paris in 2015. The individual in the case study had received a diagnosis of PTSD and had been under the care of mental health professionals after the attack (Masson et al., 2017). This study shared similarities to the study by Newton-Sandy Hook Community Foundation (2016) as they both explored PTSD after a horrific attack that impacted a community. Both studies also found that brainspotting was effective at reducing symptoms of PTSD including nightmares, hypervigilance, anxiety, and depression (Masson et al., 2017; The Newton-Sandy Hook Community Foundation Inc., 2016). Specifically, Masson et al. (2017) explored experiences with brainspotting with distressing memories from the traumatic experience. Similarly, the study by D'Antoni et al. (2022) explored the effectiveness of brainspotting

with distressing memories. Both studies noted that prior to the interventions the participants would experience emotional and physical distress when recalling the traumatic memory; however, after brainspotting the emotional and physical distress went down in intensity significantly (D'Antoni et al., 2022; Masson et al., 2017). A need for more research conducted on brainspotting and use with various traumas including sexual assault has been outlined in the existing literature on brainspotting (Masson et al., 2017).

The case study of an individual with persistent genital arousal disorder and the use of brainspotting to treat this diagnosis identified the effectiveness of brainspotting (Ferreira-Mattos et al., 2015). The authors approached the diagnosis as a dissociative symptom of childhood sexual abuse and used brainspotting to treat the arousal disorder (Ferreira-Mattos et al., 2015). Therefore, the brainspotting interventions aided the client in identifying that the genital arousal disorder was associated with their childhood sexual trauma (Ferreira-Mattos et al., 2015). The case studies by Masson et al. (2017) and Ferreira-Mattos et al. (2015) both focused on decreasing symptoms associated with the trauma experienced with the use of brainspotting. The case study by Ferreira-Mattos et al. (2015) differed from the study by Masson et al. (2017) in that the brainspots used were often related specifically to the genital arousal disorder, which eventually led to the processing of the traumatic experience the participant experienced in childhood. The participants in the Ferreira-Mattos et al. (2015) study noted a significant decrease of the genital arousal disorder after 6 months of brainspotting counseling, then noted no symptoms after engaging in brainspotting counseling for 1 year.

Counselors' Experiences with Brainspotting

There are currently no peer reviewed resources addressing the topic of counselors' experiences using brainspotting with individuals who have experienced trauma. with brainspotting. While there is a lack of peer reviewed research on the experiences of brainspotting counselors, there has been research conducted on the experiences of practitioners with their perceptions of EMDR. While the study by Dagia (2017) did not investigate brainspotting, the study could be beneficial if replicated on understanding counselor experiences of brainspotting. Dagia (2017) noted that psychotherapists reported perceiving EMDR as a beneficial intervention in treating trauma. In addition to the current study exploring brainspotting instead of EMDR, an additional difference is that in the study by Dagia (2017) is that participants were not formally trained in EMDR. The study explored the perceptions and experiences of psychotherapists with EMDR and did not use formal training of the psychotherapists in EMDR as an inclusion criterion. The participants for the proposed study have been trained in brainspotting. Therefore, my study was more focused on the experiences of counselors trained in brainspotting.

Summary

A significant issue that has been highlighted throughout history, and currently impacts society, is trauma. Research has highlighted that trauma has a negative impact on the brain and on emotional regulation. Counselors continue to identify and explore effective therapeutic treatments and interventions to best treat trauma. One technique that has recently gained recognition as a modality to treat trauma is brainspotting, a technique

derived from SE and EMDR (Brainspotting, 2022). While brainspotting is an integrative therapy that can be integrated with various therapies and interventions, there are models, interventions, and an integrative set-up for a brainspotting session created by Dr. Grand (2009). The integration of brainspotting varies based on the professional trained in brainspotting (Grand, 2009). Brainspotting is also supported by neuroscience because brainspotting positively impacts brain function that has been altered by trauma (Grand, 2009). Through a review of the existing literature on brainspotting, A gap in the existing literature includes a lack of peer reviewed studies conducted on the experiences of counselors trained in brainspotting, and there has not been a transcendental phenomenological study done on brainspotting or professionals trained in brainspotting. There is support within existing research on the effectiveness of brainspotting: however, more research on counselor experiences with integrating brainspotting in practice can offer additional insight into the collective experiences of counselors who use brainspotting with clients who have experienced trauma. The next chapter will explore the research method.

Chapter 3: Research Method

The purpose of this transcendental phenomenological study was to explore the lived experiences of counselors with integrating brainspotting into their counseling practice with clients who have experienced trauma. Trauma and PSTD are significant issues impacting society (SAMHSA, 2022). Researchers have identified brainspotting as an effective treatment for trauma (Grand, 2009); however, there is currently a lack of information on the lived experiences of counselors with integrating brainspotting into counseling practice with clients who have experienced trauma. I chose to follow a transcendental phenomenological design to gather an understanding of the lived experiences of participants. Counselors' descriptions of their lived experiences provided the field of counseling with rich information that is essential to understanding brainspotting. A qualitative design provided the opportunity to explore the participants' lived experiences and to gather the essence of those experiences through thick descriptions and personal narratives (see Creswell, 2013). The following chapter explores the design and rationale of the study, my role as a researcher, recruitment procedures, and participant criteria. I will identify the instrumentation used in the study and the data collection procedures, which includes information on the interview and follow-up questions in a semi-structured interview. Finally, I will explore data analysis, credibility, dependability, confirmability, and ethics.

Research Design and Rationale

The purpose of the study and the research question guided the design and rationale of the study. I chose a transcendental phenomenological framework to explore

the lived experiences of counselors who have experience in integrating brainspotting into counseling practice with clients who have experienced trauma. The study was designed to answer the research question "What are the lived experiences of counselors with integrating brainspotting into counseling practice with clients who have experienced trauma?" I used a phenomenological framework to allow me to explore the rich narratives and personal meanings of counselors who have experience with integrating brainspotting into their counseling practice. A transcendental framework allowed me to bracket my biases and experiences to ensure that the data collection or analysis was not impacted (see Husserl, 1976; Peoples, 2020). Using a phenomenological framework allowed me to identify themes within the lived experiences of counselors (see Creswell, 2013; Yin, 2016) and make interpretations of themes that emerge from the semistructured interviews with participants (Sloan & Bowe, 2014). Through exploring personal experiences, a phenomenological framework allowed me to gain a deep understanding of challenges, struggles, conflicts, benefits, and strengths gained or experienced through the phenomenon (see Yin, 2016). The information from this study can provide insight for other counselors trained in brainspotting and inform future trainings for brainspotting providers.

A quantitative design would not be appropriate for the study because a quantitative design is used to identify correlations and examine variables within a research study (Yin, 2016). The study's goal was to understand experiences, not examine variables. A phenomenological study is used to understand the essence of individual experiences, which is not offered in a quantitative design (Creswell, 2013; Patton, 2015).

A mixed-method design employs qualitative and quantitative data collection and analysis methods (see Creswell, 2013). A mixed method design would also not have been appropriate for the study due to the lack of exploration in this area of experiences of brainspotting counselors. A researcher can gather more detail on experiences of participants through a qualitative research design (Moustakas, 1994).

A hermeneutic framework was also not appropriate for the study as a hermeneutic framework is used when a researcher includes their opinion in the study to make meaning from participants' experiences. I am biased as a current brainspotting professional (see Peoples, 2020). Therefore, based on the nature of the study, a hermeneutic framework would not fulfill the study's goals. An ethnography framework would also not have been appropriate for the study because I do not seek to identify themes within a specific cultural group (Creswell, 2013). A grounded theory study would also not be appropriate for the study because the purpose of the study was not to identify a theory based on the data collected (see Creswell, 2013).

Role of the Researcher

The role of the researcher is to collect data by conversing with participants in their professional roles (Yin, 2016). My role as the researcher is to listen to counselors' experiences with brainspotting and then gather information on the meaning of the participants' experiences (see Yin, 2016). The researcher conducts the interviews and gathers information by asking appropriate questions while maintaining the integrity of the participants' experiences (Yin, 2016). As the researcher, I conducted semistructured interviews, transcribed the interviews using Zoom transcription, engaged in member

checking, and analyzed the data using hand coding. A significant role of the researcher is to ensure ethical practices and ensure the integrity of the research (Yin, 2016). As the researcher, I immersed myself in my participants' experiences to ensure I understood their lived experiences (see Peoples, 2020).

One potential ethical issue was that I may have participants who have attended a brainspotting training with me or trained with other professionals in brainspotting. However, I did not encounter any participants from previous trainings. While many professionals have become trained in brainspotting, I was trained by the Southeast Brainspotting Institute, which is an organization that trains brainspotting professionals in the southeastern parts of the United States (Brainspotting, 2017). The Southeast Brainspotting Institute is a smaller group of trainers and counselors, which increases the likelihood of recruiting a participant I may know through this organization (Brainspotting, 2017). I also have previous coworkers who have been trained in brainspotting. Therefore, I consulted with IRB to ensure that in the event these relationships arose they did not affect the integrity of the research study. I determined that I would not accept any participants who I had ever worked with or with whom I had been in a position of authority. Walden University (n.d.) state that sampling in the workplace falls within IRB ethical guidelines; however, the researcher is responsible for ensuring ethical practices for the integrity and reliability of the study.

I also engaged in bracketing to prevent researcher biases from impacting the results and interpretation of the research study (see Yin, 2016). I bracketed any preconceived thoughts regarding the phenomenon and explored the experiences of others

from the most objective perspective possible. I bracketed my biases by writing my personal biases and beliefs in a personal journal. By engaging in this practice, I became aware of my personal experiences and how they may impact my perspective as a researcher (see Yin, 2016).

Another ethical concern within the role of the researcher is cognitive priming, which can be described as the researcher influencing responses from participants by suggesting specific responses (Walden University, n.d.). To ensure this did not occur, I was consciously aware of my biases and avoided leading questions for participants. I engaged in journaling to increase my conscious awareness of my biases. I also consulted with my chair to review any biases that arose during the interview and data collection process. Another potential concern was social desirability, the potential that the participant may respond in a way they perceive the researcher desired (Walden University, n.d.). To help mitigate these potential ethical concerns, I did not recruit participants I had supervised or been in authority over. I also did not recruit participants with whom I have had an ongoing relationship or have previously worked with to prevent these ethical concerns. I also communicated to the participants that they were to respond honestly regarding personal experiences with brainspotting to ensure truthful reports of their experiences (see Yin, 2016). I also ensured the confidentiality of my participants by conducting interviews from a secure location and not disclosing the identity of participants in my study. I used Zoom transcription, an automated service; therefore, no transcription was needed to be completed by an outside source to protect the confidentiality of my participants. Once transcribed, I eliminated all identifying

information from the transcription, and a pseudonym was given to each participant. Another way I maintained the integrity of the study was by providing informed consent (see Peoples, 2020). I also communicated to the participants that they were to respond honestly regarding personal experiences with brainspotting to ensure truthful reports of their experiences (see Yin, 2016).

Methodology

The methodology of the transcendental, phenomenological research study identifies the procedures followed to conduct the study, including participant selection, instrumentation, data collection, and data analysis. Data collection aligned with the transcendental, phenomenological methodology and data analysis. The following section will examine the step-by-step procedures I followed to ensure the integrity of the study.

Participant Selection Logic

The research study focused on gathering information on the lived experiences of counselors who have experience with integrating brainspotting into professional practice with clients who have experienced trauma. Therefore, the required participants were licensed mental health counselors/professional counselors who have been, at minimum, trained in Phase 1 and Phase 2 in brainspotting. The participant requirements included counselors licensed in their state as professional counselors or mental health counselors trained in brainspotting and have completed at least Phase 1 and Phase 2 of the four-phase brainspotting training. Participants were at least 18 years or older. The participants were required to have active clients who have experienced trauma. Peoples (2020) identified that eight to 15 participants are adequate for a phenomenological study. Due to

the small number of qualified/trained brainspotting professionals, 12 participants were an appropriate representation of the population.

One of the sampling methods I used was purposive sampling. Purposive sampling is used when participants are required to have specific characteristics that the researcher intends to explore (Patton, 2015). Purposive sampling is appropriate when a researcher explores a small population (Patton, 2015). Purposive sampling was appropriate for this study because the participants must have experienced a specific phenomenon, specifically that of providing brainspotting to clients who have experienced trauma. The participants were also required to be licensed in the state where they practice, be trained in minimally brainspotting Phases 1 and 2 and have an active caseload of clients who have experienced trauma. Snowball sampling allows current participants to refer other professionals that would fit the study's criteria and can aid in gathering adequate participants (Patton, 2015). I intended to utilize snowball sampling to recruit more participants if I was unable to recruit an adequate number of participants with purposeful sampling. However, I was able to recruit enough participants with purposive sampling..

Instrumentation

A demographic survey and semistructured interview were the instrumentation used in the research study. Participants were asked to complete a demographic survey first to ensure that each of the participants met the criteria for the research study. Once the demographic survey was complete, I then scheduled the in-depth interview with participants. Another type of instrumentation used in the study was member checking to ensure the accurate collection of data. I engaged in journaling to bracket my own biases;

my journal was reviewed during data analysis but was not analyzed in the data analysis procedures.

I created the interview questions for the study, which were verified by my chair and committee member to ensure clarity of the questions. I met with my dissertation chair and went through each question to ensure alignment with the research study framework and research question. I also identified specific *dig deeper* questions to gather an understanding of the experiences of counselors trained in brainspotting such as providing examples to ensure consistency with the framework. I engaged in journaling to bracket and prevent any researcher bias. I wrote down my personal experiences and biases in a journal, which allowed me to identify any biases that arise throughout the study and provided conscious awareness of the identified biases that could have altered my results (see Creswell, 2013). The interviews with participants were audio recorded through the HIPAA-compliant platform, Zoom.

Procedures for Recruitment, Participation, and Data Collection

I recruited licensed counselors trained in brainspotting through the brainspotting website (www.brainspotting.com) and Facebook groups for brainspotting practitioners (https://www.facebook.com/groups/brainspottingpractitioners/?ref=share&mibextid=S66gvF). The brainspotting website has contact information for professionals trained in brainspotting who apply to be added to the website, which is updated as professionals apply (Brainspotting, 2017). First, I created a contact list from the Brainspotting (2017) website list of providers who werecounselors. I sent a recruitment email to each brainspotting counselor with information regarding the study and identifying criteria for

participants. Simultaneously, I posted on a professional brainspotting providers' Facebook group where I asked counselors trained in brainspotting to participate in my research study to advance the field of brainspotting with trauma. The flyer asked participants to email the researcher if interested in participating in the study. I also posted on CESNET-L to recruit participants (CESNET-L, 2023). Due to the high response from the emails of providers off the brainspotting website, no further data collections procedures were required. The same recruitment flyer was used for Facebook and CESNET-L. Participants were prompted to reply to the email with the informed consent stating, 'I consent'. Once the participants consented to the study, they were provided the demographic survey. Then participants were asked to complete the demographic survey before scheduling an interview to ensure they meet the criteria for the study.

Once participants replied with 'I consent' and completed the demographic survey, I emailed a request for the best day and time to conduct the semi-structured interview. Once a day and time was determined by the participant, I emailed the secure Zoom link for the meeting. The interviews were conducted over Zoom, a HIPAA-compliant platform with no limitations on time and allows audio recording of the interview (Zoom, 2021). I used Zoom transcription to provide the transcription of the interviews. I also used Zoom audio recording. I audio recorded with a voice recorder as well to ensure all interviews are recorded accurately and that a backup exists in case of technology interruption or failure. I requested that the participants engage in the interviews from a private location to ensure confidentiality. I conducted the interviews from my private office via Zoom using my computer and a built-in webcam. Data was stored on an

external hard drive kept in my personal office in a locked cabinet; then, once interviews were transcribed, transcriptions were stored on the researcher's external hard drive. Data from the study will be stored on my external hard drive in a locked cabinet for the next five years and then will be deleted.

At the beginning of the interview, I reviewed the informed consent, and the purpose of the study with the participants. During this time, I went over the storage of data, information on the conclusion of the study and the impact the study may have on the field, procedures to ensure confidentiality, and potential risks of participating in the study. I ensured that each participant had the same information regarding the study procedures. I encouraged the participants to answer the questions truthfully and ensured their identity would be kept confidential. The participants were informed of any benefits and risks associated with the research study. Participants were informed that they could ask for clarification. I allowed for time for questions the participants may have regarding this information. For the interview, I reviewed the questions I created with my committee member and chair with pre-determined follow-up questions and allowed the participant adequate time to answer each question and repeated the question when asked (See Appendix A). I bracketed my experience with brainspotting and attempted to clarify without leading the participants to an answer when the participants asked for clarification. I did this by using reflection and restating the question when participants prompted. I did not ask questions outside of my identified interview questions, and I did not share about my experiences with brainspotting to prevent any bias. I journaled electronically throughout the interview process and after each interview to ensure my

biases did not impact the study. Participants were debriefed at the end of the interview. At the end of the interview, I explained to the participants the member-checking procedures for after I have completed transcriptions and initial coding of the interviews.

Follow-up procedures included reviewing field notes (written after each interview) and my journals. After the interviews had been transcribed and coded, I engaged in member checking. Member checking allowed me to provide the participants with their transcription and initial coding to offer an opportunity for the participants to offer any additional information or clarification. The participants were able to provide clarification or additional information on patterns or themes the researcher identified. I also provided my contact information and informed participants that they can contact me with any questions or if they needed to add or clarify any information they provided for the study. None of the participants requested to meet again. Two participants did not respond to member checking procedures. I also reiterated to the participants that identifying information would be removed from the study in the follow-up email.

Data Analysis Plan

For this research study, qualitative data analysis procedures were used to maintain the transcendental phenomenological framework. Researchers have noted that data emerges and changes throughout the data analysis procedure of the research study (Peoples, 2020). ualitative researchers must immerse themselves in the data and coding process to understand the essence of the experience; this includes a deep exploration of the experiences reported by each participant (Saldana, 2021). A deep understanding is best achieved through thorough coding for themes that emerge throughout the exploration

of the data collected. The data analysis for this study gathered information regarding the lived experiences of counselors with brainspotting in clinical practice with clients who have experienced trauma. Prior to beginning data analysis, and after completing the interviews with participants, I listened to each audio recording of each participant's interview and reviewed each Zoom transcription to ensure accuracy of the transcription.

I followed the five phases of data analysis outlined by Yin (2016). The first phase includes gathering all data collected, including interview transcriptions and journal notes (Yin, 2016). During this phase, I gathered all the transcriptions and organized the collected data to make the data easier to analyze. To organize the data, I assigned each participant a number that was recorded in a word document. I saved each transcription in a file labeled 'transcriptions' on my external hard drive with the assigned participant number. I also created a separate file on my external hard drive labeled 'data coding.' In this file I created an excel spreadsheet to be used in coding and to help keep my data analysis organized. In Phase two, I familiarized myself with the data collected (Yin, 2016). During this phase, I read the transcriptions and field notes several times while thinking back to the initial research question. I also began to think of meaning that can be made from the data gathered on my participants' experiences with brainspotting.

Phase three outlined by Yin (2016) includes the beginning of coding, where I started to take apart the data. I examined each participant's transcription in this phase (Yin, 2016). Peoples (2020) noted that this phase would include reviewing the transcriptions of the interviews and eliminating unrelated words, or words often described as filler words in conversation. After eliminating unnecessary words, I began to create

initial codes of the data, which is the foundation of codes that were eventually explored on a deeper level to create the themes that led to the final narrative of my participants' experiences (Yin, 2016). The differences between codes and themes is that themes are patterns or concepts, whereas a code is specific words (Saldana, 2021).

I initially focused on each participant individually and begin to identify codes that summarize each response from each question as outlined by Peoples (2020). This step included recording words or phrases that stand out as a potential code and created initial codes (Peoples, 2020). In phase four, I went through each participant and each question, I began to look at common response codes that emerge among all the participants compared to one another (Yin, 2016). In this phase, I also compared the responses to each question between all my participants for common codes (Peoples, 2020). Yin (2016) noted that while looking at all participants, I should look for themes among the participants' responses. Finally, in phase five, I created a summary of findings for each participant for themes that emerged and then created a summary of the similarities and differences in themes that emerged among all participants.

Since the study is a transcendental phenomenological study, I also implemented bracketing in my data analysis. I engaged in journaling throughout data collection and data analysis to bracket my biases. I journaled after each interview during data collection, I also journaled before beginning data analysis, and throughout data analysis to ensure my personal biases did not impact the findings from my research study. Bracketing allowed me to become aware of any biases and explore it as a varying experience. My journal was reviewed during data analysis, but it was not coded or analyzed. Journaling

throughout data analysis prevents any personal biases from impacting the results of the study or data analysis procedures (Yin, 2016). Only information gathered from the participants is to be analyzed and coded (Saldana, 2021). I reviewed my journal to ensure that I was bracketing my experiences to ensure the integrity of the study. A discrepant case did not occur; therefore, I did not need to report the information and saturation was reached.

Issues of Trustworthiness

The trustworthiness of a qualitative study determines its credibility, transferability, dependability, and confirmability (Yin, 2016). The trustworthiness of a study can be maintained through cognitive awareness of biases, following outlined procedures, and protecting the integrity of a study (Yin, 2016). One way I maintained trustworthiness was through exploring and revealing my biases concerning brainspotting and how my biases could have impacted my research study. Member checking is another procedure I implemented to ensure trustworthiness, which allowed participants to be authentic and transparent in their responses to the interview questions (Peoples, 2020). Rich descriptions coded with an understanding of shared experiences was also used to increase trustworthiness (Saldana, 2021). Rich descriptions included having participants provide a detailed account of their experiences without coercion and I encouraged genuineness (Yin, 2016).

Credibility

The credibility of a study can be described as ensuring the data gathered is accurate and captures the essence of the participants' experiences as they experience the

phenomenon (Yin, 2016). I maintained the credibility of my study by engaging in member checking. Member checking allowed me to provide the transcription of the interview to participants, then allow the participants to provide clarification, and additional information to ensure I captured the essence of their experiences. Additionally, as a novice researcher, I had the guidance of my chair and committee member to ensure data analysis and data collection procedures were trustworthy and credible (Patton, 2015). Another way I maintained the credibility of my study was by following the specific procedures I outlined to conduct the study and asked the questions I had created for my semi-structured interviews.

Lincoln and Guba (1985) identified the importance of following the identified design of the study to ensure trustworthiness. Using a variety of sampling methods also helped to ensure a wide variety of participants have been recruited for the study, with a plan on how to address any issues that may have arisen with participant recruitment aided in upholding the credibility of my study (Yin, 2016). Reflexivity concerns credibility and occurs in every study because a researcher influences participants simply by being present and conducting the study (Yin, 2016). Therefore, to maintain reflexivity, I was aware of reflexivity and how my presence may impact my participants. I limited my biases and preconceptions of my participants' experiences through reflexive journaling. Saturation is a strategy to ensure the credibility of a study because reaching saturation means that no additional information is gathered from participants' responses (Patton, 2016). To ensure the credibility of my study, I interviewed 12 participants to aid in reaching saturation because brainspotting is offered by a small population of counselors.

Transferability

Transferability is described as applying the study's findings to other populations or settings beyond the current study's population (Yin, 2016). For this study transferability was the ability to generalize the findings from the study to the brainspotting population. Transferability was achieved through thick descriptions of participants' personal experiences with brainspotting. Transferability was also achieved by reporting procedures and the descriptions of participants recruited for the study (Yin, 2016). Maintaining transferability also included providing a specific outline of the research context and descriptions of participants recruited to allow the study to be replicated for similar situations or participants (Yin, 2016). Providing specific procedures and criteria for variation in participant selection can also aid in ensuring the transferability of the study (Yin, 2016).

Dependability

Dependability is described as other researchers' ability to repeat my research study (Yin, 2016). To ensure dependability, I outlined step-by-step details of the study so that another researcher could replicate the study. I have provided a detailed outline of the procedures I followed to recruit participants, the interview questions, and a detailed outline of data analysis procedures. I followed Yin's (2016) phases of data analysis so that can be followed as well for data analysis procedures. This would provide consistency of results if the research study were to be replicated (Yin, 2016).

Confirmability

As a brainspotting professional and human with my own opinions and

perceptions, I cannot be entirely unbiased in any research study. However, I ensured my biases did not impact my data by engaging in confirmability. Confirmability is described as the research study being limited to bias (Patton, 2015). I upheld confirmability by seeking consistent feedback from my chair to ensure my personal biases did not impact the study. Reflexivity is described as the potential for a researcher to influence the results or responses from participants due to the researcher's bias (Yin, 2016). I ensured the confirmability of the study through reflexivity in my journaling and continuously engaging in the exploration of my own biases and experiences with brainspotting.

Ethical Procedures

Ethical procedures are essential to conducting a quality research study (Yin, 2016). One crucial ethical procedure for my study was that the study was submitted to, reviewed, and approved by the Institutional Review Board to ensure the protection of participants. All participants were provided an informed consent outlining the nature of the study, confidentiality measures taken to protect their identity, and information about their rights as participants. Informed consent was provided to all participants after receiving a recruitment email and responding with interest to participate in the study. Informed consent was provided and returned electronically before completing the demographic survey or scheduling an interview with the participants. Participants replied to the email with the informed consent by stating 'I consent.' All participants volunteered to participate in the study and could drop out at any point in the research study. I used the virtual platform (Zoom) to conduct the interviews for this study. Although the platform is HIPAA compliant, I cannot ensure confidentiality regarding the participant's setting for

the interview. For example, if someone else was nearby and could overhear the participant during the interview. However, I encouraged participants to complete the interview in a private room with no other individuals present. In the data analysis and transcription, a pseudonym was used to protect the identity of participants. The participants for my study were confidential, not anonymous, as I know the identity of the participants, and their identity was protected in the data analysis.

Another potential ethical concern was the potential discussion of clients and ensuring that participants did not use their clients' names or identifying information. However, none of the participants used client names or identifying information. Professional boundaries were upheld by outlining the study's guidelines and adhering to the identified steps of the study. I also ensured the same treatment for each participant and followed the guidelines and procedures for each participant. I also continued to consult with my dissertation chair and throughout the research study to ensure I maintained ethical standards. If an unpredicted ethical issue arises, I planned to discuss and document this issue with my chair and committee member. However, no ethical issues arose throughout data collection or analysis procedures.

Participants were allowed to leave at any point throughout the study. When the study results are published, the names of participants will not be reported, and personally identifying information will be omitted. My Walden email was used for correspondence with participants. Data from the study was electronically stored on an external hard drive. The external hard drive was kept in a locked cabinet in my personal office. The audio recordings on the backup recording device were also kept in my personal office only the

researcher has access to and is in a locked cabinet that only can be accessed by the researcher. All data from the study will be stored in the external hard drive in a locked cabinet only I can access for five years; after five years, the data will be deleted off the external hard drive.

I obtained approval from Walden University's Institutional Review Board on May 4, 2023, approval number 05-04-23-0515453. The approval expires on May 4, 2024. I recruited participants for my interview by emailing counselors listed as providers on the brainspotting website, which was accessible to the public. I scheduled and completed the interviews over three weeks. Once the participants expressed interest in the study via email, I emailed them the informed consent form and noted if they agreed with the informed consent to reply with "I consent." When the participants consented, I sent them the demographic survey and asked about dates to complete the interview via Zoom.

Summary

For the study, I chose a transcendental phenomenological design to answer the research question, "What are the lived experiences of counselors with integrating brainspotting into counseling practice with clients who have experienced trauma?" A transcendental phenomenological framework allowed me to gather information on counselors' experiences through rich descriptions of their experiences with integrating brainspotting. The research design allowed me to identify patterns and themes that emerged from participants on the integration of brainspotting in practice on benefits and drawbacks of brainspotting and the integration of brainspotting with clients who have experienced trauma. The data from the proposed study was gathered through semi-

structured interviews. Criteria of participants included counselors who are licensed in their state, are minimally phases one and two trained in brainspotting, and were actively working with clients who have experienced trauma.

Sampling methods included purposive sampling. Recruitment was done using Facebook posts in brainspotting professional groups, and emails were sent to counselors trained in brainspotting from the brainspotting website. Interviews were conducted via Zoom and were audio recorded. Data was hand coded, and stages of data analysis included reviewing transcriptions, eliminating unnecessary words, identifying themes or patterns that emerge in each interview, and then exploring themes and patterns that emerge among participants. Measures were identified to ensure the study's trustworthiness, including identification of the researcher's personal biases, bracketing the identified biases, and member checking. The study was conducted after the approval of the university research reviewer and then IRB. Chapter four will discuss the results and findings gathered from the study. Results from the study will include patterns and themes that emerged from counselors' experiences with integrating brainspotting in counseling with clients who have experienced trauma.

Chapter 4: Results

The purpose of the study was to explore the experiences of counselors trained in brainspotting with clients who have experienced trauma. The research question explored the lived experiences of counselors with integrating brain spotting in counseling practice with clients who have experienced trauma. The following chapter will review the results of the study. First, I will review the setting of the study, including any potential influences that could affect the study's results. I will also review the participants' demographics in the study and the data collection methods used for the phenomenological study. The following chapter will contain information regarding the data analysis procedure, codes, themes, and discrepant cases. The trustworthiness of the study will be explored, including credibility, transferability, dependability, and confirmability. Finally, I will share the study's results with supporting evidence and illustrations.

Setting

The data for the research study were gathered through semistructured interviews conducted via the HIPAA-compliant platform, Zoom, at the time and date of the participant's choosing. Before the interview, I provided each participant with a Zoom meeting link. All the participants were located at various locations in the United States. Most participants completed the interview from their homes; however, some completed it from their work offices. I asked each participant to be in a private space that no one had access to during the interview, and each participant reported that they were in a private space. During the Zoom interview, I was in a private office in my home that no one could

access during the semistructured interview. All the participants appeared relaxed during the interview with no emotional distress and did not appear uncomfortable. The participants were also reminded that the interview would be audio-recorded via Zoom. There were no organizational or personal conditions that influenced participants or their experience at the time of their interviews.

Demographics

The participants for the study were recruited through purposeful sampling. Due to the high response from participants for the research study, snowball sampling was unnecessary. The leading recruitment was done through the list of brainspotting providers on the brainspotting.com website. Over 700 emails were gathered from the website of potential participants that may meet the criteria for the study. The inclusion criteria for the participants included being currently licensed as a counselor in the state they practice, over 18 years of age, at least Phase 1 and 2 trained in brainspotting, and presently working with clients who have experienced trauma. Participants were asked to complete a demographic survey before scheduling the semistructured interview that asked if they were over 18, gender, completed phases of brainspotting, years practicing as a counselor, years practicing brainspotting, state licensed and practicing as a counselor, setting for their counseling practice, if they are currently working with clients who have experienced trauma, and areas of specialty, any additional trainings (see Table 1). The demographic survey ensured that the participants met the criteria for the study and provided demographic information. Several individuals expressed interest in the study but did not qualify due to a lack of counseling licensure or not practicing in the United States.

Table 1

Participants' Demographic Data

Participant	Gender	Years Practicing	State Licensed	Practice Setting	Years Practicing with BSP	Phases Completed	Additional Trainings
P01	Female	18	PA	Private Practice	8	1,2,3, and 4	Master Class
P02	Female	14	CO	Private Practice	10	1 and 2	Master Class and expansion
P03	Female	8	IO	Private Practice	3	1 and 2	Mini master class, BSP conference
P04	Female	9	TX	Private Practice	9	1, 2, 3, and 4	Intersectionality, freeze to thaw, and international conference.
P05	Female	12	MI	Private Practice	4.5	1, 2, and 3	Master Class, Intersectionality and social justice, blind spotting, expansion, intake, and money spotting
P06	Female	10	SD	Private Practice		1, 2, 3, and 4	Master class
P07	Female	11	NY	Private Practice	1	1 and 2	Expansion spotting, money spotting, and soul spotting
P08	Female	17	SD	Private Practice	8	1, 2, 3, and 4	Master Class, freeze to thaw, intake training, and expansion
P09	Female	27	IL, WI	Private Practice	4	1, 2, and 3	Internal Family systems and BSP
P10	Male	6.5	PA	Private Practice	1	1 and 2	None
P11	Queer	4	CO	Private Practice	1	1 and 2	None
P12	Male	6	WA	Private Practice	2	1 and 2	None

As noted in Table 1, my participants shared additional trainings beyond Phase1and 2 they had completed that added to their knowledge of brainspotting. While brainspotting offers Phase 1 and 2 training, which is required for certification, there are also Phase 3 and 4 trainings, which are advanced trainings (Brainspotting, 2017). As brainspotting has grown and developed since the founding in 2006 by David Grand, more trainings have been developed to integrate brainspotting with specific issues or more intensive trainings (Brainspotting, 2017). These other trainings include expansion training, which provides additional information on the expansion model and can help clients manifest their true potential and achieve future goals (Brainspotting, 2017). The master class and mini master class are trainings that can be completed after completing Phases 1 and 2 to learn how David Grand uses brainspotting in his office and to allow the provider to understand the flexibility of the brainspotting model (Brainspotting, 2017). Intersectionality is additional training on integrating brainspotting with intersectionality through a social justice lens and learning how to help clients explore their social and cultural identity (Brainspotting, 2017). Freeze to thaw is additional training that can be taken after the completion of phase one, which provides information on what goes on physiologically during a brainspotting session (Brainspotting, 2017). Blindspotting is training on understanding what blind spots are within brainspotting and how to help clients overcome their blind spots or resistance in therapy with brainspotting (Brainspotting, 2017). Moneyspotting is another training taken by some participants focused on integrating brainspotting for clients who want financial freedom and struggle with poor relationships with money (Brainspotting, 2017). Soul spotting is another

training for advanced brainspotting providers, and this training focuses on spirituality and intuition to help clients identify their sense of meaning and purpose (Brainspotting, 2017). Intake and treatment planning is a training that aids providers in creating treatment plans and initiating intakes focused on brainspotting for their clients (Brainspotting, 2017). Another training that participants reported was training on integrating internal family systems and brainspotting and how to best integrate these two models with clients (Brainspotting, 2017).

Data Collection

Twelve participants engaged in the research study. All 12 participants replied to the email with the informed consent stating, "I consent" before the in-depth interviews were conducted via Zoom. Once the participants consented to participate in the study, I emailed them the demographic survey they completed and returned via email before scheduling their interview. In my initial data collection plan, I was also going to implement snowball sampling if I did not recruit enough participants; however, I did not have to utilize any snowball sampling procedures as I recruited enough participants. I did experience this change to the data collection plan; however, no issues arose throughout the data collection process. The interviews were audio recorded with Zoom and with an external recording device. Recordings were used for transcription only. The interviews ranged in time from 31 minutes to 36 minutes long. All the participants stated they were in a private space that no one could access during the interview.

Data Analysis

The purpose of my study was to explore the experiences of counselors with

brainspotting in counseling practice with clients who have experienced trauma. Due to the transcendental phenomenological framework of the study, I followed qualitative data analysis procedures to ensure the integrity of the phenomenological framework. I engaged in bracketing throughout data collection and analysis procedures to ensure my biases did not impact the results of the study. Data analysis in phenomenological research is focused on making meaning from the experiences of the participants (Peoples, 2021). For data analysis I followed Yin's (2016) five phase method of data analysis. In the first phase, I gathered all the data collected, including the transcriptions of my interviews and my journal, which I used to bracket my biases. I also organized the data by assigning participant numbers and creating files on my external hard drive to organize my data collection and data analysis documents. I also created an Excel spreadsheet for coding procedures. In Phase 2, I focused on familiarizing myself with the data by reading each of the transcriptions individually, several times (Yin, 2016). I also read my journal to engage in bracketing. While reviewing the data collected, I reflected on my research question. This helped to understand and immerse myself in the experiences of my participants. I also reflected on meaning that could be made from the experiences of my participants. I engaged in journaling throughout data collection process to bracket my biases.

In Phase 3, I deleted repetitive words and filler words throughout my participants transcriptions. Then, I began to identify clusters of words that stuck out to me that appeared to describe the experiences of my participants. Yin (2016) described this as the beginning stages of coding. Coding offers the opportunity to condense the data and

cluster of words into smaller more manageable meaning chunks (Peoples, 2021). I went through clusters of words that described my participants' experiences, and omitted clusters that didn't relate to the research question. Of the remaining clusters of words, I used those to create initial codes. The initial codes were phrases used by participants or even a few words that were relevant to answering the research question "What are the lived experiences of counselors with integrating brainspotting with clients who have experienced trauma?"

In Phase 4, I input the initial codes into the spreadsheet I created to organize my data. I also compared the codes among all the participants to identify shared experiences. I examined my initial codes for overlap with codes that had similar meaning. Once I started to identify some overlap in the codes, I color coded the codes that were similar. After color coding the related codes, five themes began to emerge among the data. The themes were descriptions of the shared experience among my participants. Then in Phase 5, I further refined and reviewed the themes that emerged among my participants. I continued to compare the codes among the participants and explore the themes that were emerging from the data. While narrowing down my themes, I met with my chair to ensure I was accurately identifying the codes and identifying the themes that were emerging from my participants' experiences. I reflected on my research question to ensure the themes represented the essence of my participants' experiences. I also compared my themes with one another to further explore potential overlap or need for a subtheme. I then created a summary of each of my themes that emerged among all my participants. There were no discrepant cases identified in my data analysis.

Evidence of Trustworthiness

The following section will review how trustworthiness was maintained throughout the study. Trustworthiness was maintained through credibility procedures, maintaining transferability, ensuring the study's dependability, and confirmability. Throughout the study, I engaged in procedures to limit my bias and to engage in accountability with my dissertation chair. The procedures outlined for the study were followed to ensure trustworthiness.

Credibility

The credibility of a study can be obtained by ensuring that the study results accurately represent the participants' experiences (Yin, 2016). Therefore, for data collection I used in depth-interviews and member checking. I engaged in member checking, which allowed participants to provide feedback on their transcript, which allowed for clarification of their experiences (Yin, 2016). Ten of the 12 participants replied to the email with a copy of their transcripts with initial coding. One participant had some clarifications that did not impact the results of the study, and the researcher noted the clarification in the participants' transcription. Research participants were also provided informed consent with an outline of the research process and confidentiality. I also followed the specific data collection and data analysis procedures of Yin's five phases of data analysis (2016).

After conducting the interviews with the participants, I reviewed the transcription from Zoom transcription and listened to the audio of the interviews to ensure the accuracy of the transcription. Then, I created initial codes that stood out as I reviewed the

transcriptions. The initial codes were then emailed to the participants for review, and they could either send an email or schedule a meeting to review the transcription and initial codes. Member checking ensured the reported data was accurate and an appropriate interpretation of the participants' experiences (Patton, 2016).

I also met with my chair biweekly throughout my data collection and reached out in between with any additional questions regarding data collection to ensure the credibility of my study. While reflexivity occurs in every study due to the researcher's presence, I attempted to maintain reflexivity by taking notes after each interview regarding my own biases and responses to the interviews (Yin, 2016). I initially proposed 8 participants; however, after a positive response, I sought approval from IRB to add 4 participants to ensure saturation was met. Throughout the 12 interviews, similar comments and information were provided among participants; therefore, data saturation was achieved. The brainspotting website identified 6,000 brainspotting providers that could meet the criteria for the research study. I did not use snowball sampling, although snowball sampling was in the initial data collection plan if the researcher needed to recruit all 12 participants.

Transferability

A qualitative study is transferable when the results can be transferred to other populations or settings (Yin, 2016). Transferability for the study was the ability to transfer the results of this study to the brainspotting population of counselors trained in brainspotting. The study recruited counselors trained in brainspotting who were over 18, had completed, at least, Phase 1 and 2 training in brainspotting, were licensed in their

state, and were currently working with clients who have experienced trauma. To achieve transferability, I recruited participants from all over the United States with various experience levels and training in brainspotting. I used purposeful sampling to recruit 12 participants.

I also outlined the specific procedures I followed to recruit participants and conduct the study, which allowed the study to be replicated by future researchers. Saturation was met because as I conducted interviews with participants, they began to repeat the same comments or have similar answers to questions. Through the questions asked in the interview, I was also able to gather thick descriptions of the counselors' experiences with integrating brainspotting with clients who have experienced trauma.

Dependability

A qualitative research study is deemed dependable if other researchers can replicate the study (Yin, 2016). Therefore, to ensure the study's dependability, I explicitly followed the procedures I outlined for participant recruitment, data collection, and data analysis. Therefore, another researcher could follow the procedures and conduct the same study to ensure consistency of results. I followed Yin's (2016) five phase data analysis procedures to ensure the study could be replicated for data analysis procedures. I also maintained the dependability of my study by following the same interview procedures in each semi-structured interview. Each participant was read the same information before being asked interview questions and was asked the same follow-up questions. I also provided participants with their transcription from their interview so that they could provide clarification to ensure dependability.

Confirmability

Confirmability can best be achieved through the researcher limiting personal bias (Patton, 2015). As a counselor trained in brainspotting, I have my own biases; however, I managed my biases to ensure the confirmability of the study through several different procedures. I bracketed my bias by meeting with my chair biweekly to ensure I was not projecting my biases during data collection or analysis. I also journaled after each interview, where I examined my biases that arose and identified them to ensure it did not impact my analysis of the information provided by participants. When I conducted the study, I also had not engaged in brainspotting with clients in over nine months, which helped me to bracket my own experiences and not influence the interviews or data analysis. During the interviews with participants, I also focused on asking the questions I previously outlined and reflected on the participant's responses without adding my thoughts or responses to the information they gave about their experiences.

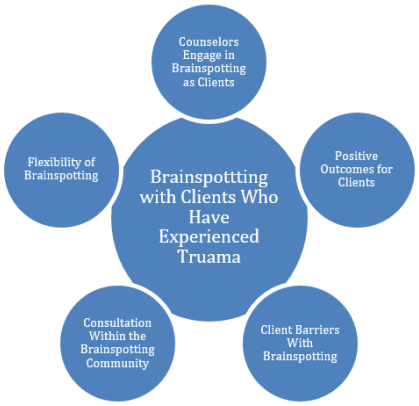
Results

The results of this study aim to share the lived experiences of the counselors trained in brainspotting, specifically, on their practices with clients who have experienced trauma. Five themes emerged from the experiences of the participants. The first theme was the recommendation that counselors should receive their own brainspotting therapy to enhance their work with clients who have experienced trauma. The second theme was that psychoeducation can help overcome client challenges. The third theme that emerged is that consultation within the brainspotting community can improve brainspotting practices with clients who have experienced trauma. The fourth theme that emerged was

that brainspotting is flexible and can be easily integrated into practice with other modalities to improve counseling practices with clients who have experienced trauma. The fifth theme was that brainspotting leads to positive client outcomes. There were no discrepant cases that arose in the study.

Figure 1

Themes Among Participants



Theme 1: Counselors Engaging in Brainspotting as Clients

A significant theme uncovered through the narratives was the importance of counselors trained in brainspotting to engage in brainspotting as clients. Out of 12 participants, 7 reported that in their experience, engaging in brainspotting in the role of the client provided them a greater understanding of the brainspotting process and aided in providing psychoeducation and feedback for their clients who have experienced trauma. The participants also reported that engaging in brainspotting as a client allowed them to gain a new perspective on brainspotting and provided them the opportunity to resolve personal trauma. The participants reported that resolving personal trauma through brainspotting allowed them to focus on the needs of their clients. Participant 6 stated,

> I also think another wonderful thing is that if you're going to be a brainspotting therapist, is to have done a decent amount of brainspotting therapy yourself as a client. Maybe that's where I would be surprised if the people that were hesitant as new therapist using brainspotting had actually done a lot more of their own [brainspotting]. I think if you've done more of that work yourself, you're going to understand and trust the process [of brainspotting] more.

This participant highlighted that the more a counselor engages in brainspotting as an intervention for themselves, the more they understand the process of brainspotting. The counselor can then relay the experience of brainspotting to the client. Participant 7 also stated,

> I think it's important to have the experience [as a client] of working with a practitioner who is doing brainspotting and doing it [brainspotting] well. I know for me that is, that was my gateway into doing this work, having the lived experience and experiencing [brainspotting] for myself feeling the real shift and change that took place from this modality.

Theme 2: Psychoeducation as a Tool to Overcome Barriers with Clients

Eight participants identified a challenge they have experienced with brainspotting is that clients have reported feeling they are not doing brainspotting correctly, they do not understand what they should be doing or experiencing, or clients find the process of brainspotting to be confusing. When discussing an unsuccessful brainspotting session with a client who had experienced trauma, Participant 3 stated that in the session, "there was constant checking in with me about 'what am I supposed to be feeling? What is it

[brainspotting]? What am I supposed to be feeling? What is this supposed to be doing? This [brainspotting] is dumb.'" Other participants noted that failures or challenges tend to look like clients not understanding the process or being reluctant to try brainspotting. Participant 5 also noted struggling with client confusion and noted it was a barrier to integrating brainspotting into counseling practice with clients who have experienced trauma.

However, 7 participants noted that they have found that providing psychoeducation for clients can address some confusion and help them understand the process of brainspotting. For example, Participant 6 stated

> Probably the two main challenges [with brainspotting] I've found would be somebody [client] that says they're willing and curious, but they're resistant. I found working with them and doing the front loading so that they're able to relax enough into the process to allow whatever happens to happen. Then sometimes there are clients that maybe it feels as though nothing is happening.

To provide context, the participant was sharing they had learned to decrease negative outcomes and improve client experiences with brainspotting through providing clients with psychoeducation early in the counseling relationship, which they and other participants refer to as "frontloading." Participant 3 stated

> You know you do your elevator pitch, which I've been fine tuning, and some clients require a little bit more [psychoeducation]. I have a lot of clients that also have higher education and are very research focused and science focused. They want more of the front loading, even more than other clients, to improve overall

client satisfaction.

Similarly, Participant 1 reported that in their experience clients will question the process of brainspotting and if they are doing brainspotting correctly. Participant 1 also noted that some clients who doubt themselves during the intervention of brainspotting may also doubt themselves in other areas of their life and that providing psychoeducation on that experience is helpful for clients to understand the process of brainspotting. The participant also noted that providing psychoeducation on the process helps to prevent client resistance. Participant 1 also noted that they found in their experience that clients would be less hesitant or resistant with brainspotting when the client had a prior understanding of brainspotting or had engaged in brainspotting before.

Theme 3: Importance of Consultation and Support Within the Brainspotting Community

Another theme that emerged among participants was the importance of receiving support from the brainspotting community and engaging in consultation with other brainspotting counselors. Of the 12 participants, 9 noted that one of the best ways to improve their practice of integrating brainspotting with clients who have experienced trauma is to engage in consultation with other brainspotting professionals. These 9 participants also reported positive consultation experiences, which helped improve their clinical skills. Participant 3 noted

> Consultation, for sure. Just because I really do think brainspotting is such a specialized thing, but it's so nuanced that it helps to consult with somebody who knows what they're talking about in terms of brainspotting in general, who can

> also speak to the trauma work. Because there's lots of brainspotting professionals who don't work with trauma.

Two participants identified that the brainspotting community is very positive and supportive of one another. Participant 1 stated, "Within the brainspotting community and the support that we have for each other. It's like none other." Participant 8 stated they thought their practice could be improved by connecting with other brainspotting providers.

In support of consultation, participant 5 reported that they recommend a counselor trained in brainspotting engage in ongoing consultation to improve their brainspotting practices; this is supported in the quote "do consultations and peer support groups and practice yourself." Participant 6 also shared, "I'm part of a consultation group right now for brainspotting therapists, which has been helpful. You meet with other brainspotting therapists and talk about brainspotting client cases." Participant 7 reported that when supervising their supervisees:

> I encourage them [supervisees] to just keep in touch with the people that they might have done previous [brainspotting] trainings with and connect with the Facebook brainspotting community and other practitioners. Just to kind of keep the wheels of learning active.

Theme 4: Brainspotting is Flexible to Meet the Needs of Clients

An additional theme that emerged from the data was that brainspotting is flexible to meet the needs of clients who have experienced trauma compared to other more structured modalities. For example, Participant 1 stated, "I think some of the things I love

about it [brainspotting] is how versatile it is and how easy it is to adapt to people's individual needs." Participants noted that in their experience, brainspotting was easily integrated because it does not follow a strict protocol or set procedures, which also made brainspotting flexible to use with other modalities. Participant 1 shared:

> It's [brainspotting is] not something that we have to just do it this way, and that's the only way to do it. There are other modalities I've been trained in that you do it this way and that's it. It's totally different in our [brainspotting] community. That's why I felt so empowered to blend it with energy healing modalities.

When sharing about the benefits of brainspotting, participant 2 noted "[I] like the fact that it's not super rigid. I really like that about it, I don't like things being super rigid. I like being able to see where this takes us today." When identifying benefits of brainspotting and preferring brainspotting over other modalities that have a strict protocol, Participant 7 noted:

> EMDR is such a protocol, and you kind of really need to follow the procedures that they have laid out. Brainspotting just allows for a lot more fluidity, going from the different setups, or just using gazespotting. I find it to be a lot easier to flow into a brainspotting session.

Ultimately, the participants noted feeling empowered through the flexibility to change and adjust brainspotting to individual clients' needs, specifically to the diverse needs of clients who have experienced trauma.

When discussing how participants determine the appropriate intervention to use with each client, 5 participants noted that this is determined through the counselor

identifying the client's needs and altering the modality to fit the client's needs, highlighting the flexibility of brainspotting. Participant 5 shared "I really feel that all comes down to attunement and to recognize when we're dealing with complex trauma where our clients are at in their window of tolerance and in their ability to regulate." The flexibility of brainspotting is described by Participant 6; when asked how to determine the appropriate intervention, Participant 6 stated, "I think, with experience, it [brainspotting] becomes more kind of intuitive in the way of, you just have a sense of needing to make a shift." Participant 8 noted when discussing how they determine interventions for brainspotting sessions that "it's really creative; I think it's definitely about being very present and attuned while taking in lots of various factors like what's necessary in this moment for my client, or where we're at and being able to shift."

Theme 5: Brainspotting Leads to Positive Outcomes for Clients

The final theme that emerged was that brainspotting leads to positive client outcomes. Of the 12 participants, 3 noted that, in their experience, a small number of clients do not want to engage in brainspotting. These 3 participants also noted that brainspotting does not resonate with specific clients or some clients prefer other modalities. However, all the counselors who participated in the study noted positive outcomes for various clients using brainspotting. In the experience of Participant 10, clients who did not like or respond to brainspotting wanted to talk about their issues through traditional talk therapy. Other participants noted that, as mentioned in the second theme, some clients needed help understanding what was supposed to happen during a brainspotting session.

Overall, some positive outcomes for the participants' clients included processing issues on a deeper level, increasing body awareness, and providing a sense of calm and insight on various issues. Participant 8 noted,

> I think brainspotting creates the most significant change and sustained change, with being able to access trauma. Whether you're changing neural networks or all the things we don't really understand about the brain yet, what you do see is a positive change for the person. I think it's incredible.

Participant 6 noted, "I love having brainspotting to help people really heal from trauma." Participant 6 continued to discuss the positive results they have experienced with clients who have been able to overcome past traumatic experiences and be more emotionally regulated in their lives. In addition to what other participants reported, participant 11 noted,

> Within one brainspotting session, I really saw this individual utilizing their own resources and being able to really create their own level of calmness and resolution to what we were discussing. It was a powerful thing to be able to watch this individual really verbalize what they're experiencing throughout their brainspotting session and be able to share afterward what they were noticing happening in their mind and body.

Participant 1 also reported, "That's what I love about it, it really does help people do much deeper healing, but with a gentler experience." Overall, each participant noted that in their experience clients with trauma had a very positive impact from the integration of brainspotting.

Summary

The purpose of the study was to explore the experiences of counselors trained in brainspotting with clients who have experienced trauma. I recruited 12 participants for the study from various parts of the US with various levels of experience and training in brainspotting. I maintained the trustworthiness of the study by identifying personal bias, following the outlined procedures, and meeting with my chair for accountability. I conducted semi-structured interviews, which were then transcribed and coded for data analysis. After analyzing the data, I identified five themes that emerged from the research. The first theme was that in the experience of the counselors, receiving brainspotting as a therapy for themselves helped to improve their ability to integrate brainspotting with clients who have experienced trauma. The second theme that arose from the experiences of the counselors was that psychoeducation helped overcome client barriers and resistance with understanding brainspotting. The third theme was that consultation with other brainspotting professionals helped to improve their practices with clients who have experienced trauma. The fourth theme that emerged was that counselors trained in brainspotting reported brainspotting was very flexible to meet the needs of clients who have experienced trauma and integrated well with other therapeutic interventions. The fifth theme that emerged through the experiences of counselors trained in brainspotting was that brainspotting led to positive outcomes for clients who have a history of trauma. The following chapter will interpret the findings of the study and connect the findings to research on brainspotting, explore the limitations of the study, provide recommendations for future studies, and identify implications for the study,

including social change implications.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this transcendental phenomenological study was to gain an understanding of the lived experiences of counselors trained in brainspotting with clients who have experienced trauma. The findings from the study included five themes that emerged from the counselors' experiences. The first theme was that through their experience, the counselors feel the most competent in brainspotting and are most equipped to work with clients who had experienced trauma when they had received brainspotting as a client. Another theme that emerged was that psychoeducation could help to overcome client barriers or resistance and aid counselors to help clients feel more comfortable with engaging in brainspotting. The counselors also identified that through their experience with clients who have experienced trauma, seeking consultation helped with brainspotting interventions and improving client outcomes. An additional theme that emerged was that brainspotting provided flexibility to meet the needs of clients who experienced trauma and can be easily blended with various interventions commonly used for trauma. The final theme that emerged was that brainspotting led to positive outcomes for clients who have experienced trauma. In this chapter, I will provide an interpretation of findings in the context of the existing literature, identify limitations of the study, provide recommendations for future research, and discuss implications for social change.

Interpretation of Findings

The findings from the study included five themes that emerged from the experiences of 12 counselors trained in brainspotting. The findings from the study confirm and extend knowledge in the field of counseling regarding trauma and

brainspotting. The purpose of the study was to explore the experiences of counselors trained in brainspotting with clients who have experienced trauma. A phenomenological study has yet to be conducted on brainspotting, prior to this study; therefore, the use of a transcendental phenomenological design added to the existing data on brainspotting. Several studies explored in the literature review noted a significant need for more research on brainspotting to add to the limited data on the topic (Corrigan & Grand., 2013; Hildebrand et al., 2017). In the next section, I will explore how the findings of my study connect to existing literature and how my study added to the existing literature on brainspotting and trauma.

Theme 1: Counselors Engage in Brainspotting as Clients

Participants shared that in their experience that when counselors trained in brainspotting engage in brainspotting themselves as clients, they gain a better understanding of brainspotting and can heal from their own trauma. Several participants noted that engaging in brainspotting can improve practice among counselors trained in brainspotting and can also help the counselor be more present and sensitive to the client's needs, which was also a recommendation in the literature (Grand, 2009). Therefore, the findings from the study confirm that counselors are engaging in brainspotting in the role of client and find this practice to be helpful in their work with clients who have experienced trauma.

My results also expand the literature on counseling being a recommended counselor self-care practice to include brainspotting specifically as a modality of counseling that could be used as a self-care strategy. The results indicated that engaging

in counseling as a client prevents compassion fatigue and burnout and provides the opportunity to heal from personal trauma. In the field of counseling, counselors are encouraged to engage in self-care practices on a regular basis to prevent compassion fatigue and burnout (NIMH, 2020). Stress and burnout could be mitigated by self-care practices, including therapy and mindfulness (Litam et al., 2021). Counselors have reported that in their experience, self-care and receiving counseling was recommended to cope during times of personal distress to prevent burnout and compassion fatigue (Baker & Gabriel, 2021). In this study, engaging in brainspotting specifically as a client was reported to help to heal from personal trauma.

Theme 2: Psychoeducation as a Tool to Overcome Barriers with Clients

My participants shared that in their experience, psychoeducation was an important component of overcoming barriers with clients who had experienced trauma. They reported that psychoeducation at the initial appointment with clients and early in the counseling relationship helped clients feel more comfortable with using brainspotting and could help clients to better understand the process of integrating brainspotting in therapy. The participants noted that challenges with clients occurred when there was a lack of awareness of brainspotting or a lack of understanding of what to expect from a brainspotting session, and the best way to overcome this barrier was to provide psychoeducation on brainspotting. The participants noted that, in their experience, psychoeducation could also aid in improving practices with clients who are resistant or hesitant to engage in brainspotting. While not in the brainspotting research literature, psychoeducation was discussed for its role in the training manual for brainspotting;

specifically, the training for brainspotting encourages the use of psychoeducation to aid in client understanding (Grand, 2009). Participants in my study confirmed they are following the training manual outlined by David Grand (2009) and find that it is helpful in treating clients who have experienced trauma.

There is currently a lack of research on the use of psychoeducation with brainspotting specifically; therefore, this study adds to the literature available on psychoeducation and brainspotting. Research currently supports the use of psychoeducation as an intervention for treating trauma among other trauma therapies (Neuner et al., 2003). My study confirmed this finding in research but specifically for psychoeducation in the context of the counselor providing psychoeducation about the intervention brainspotting. In a study focused on EMDR, the researchers found that many clients were unfamiliar with EMDR as a treatment for trauma; therefore, the therapist would need to bring up the intervention and provide psychoeducation on EMDR (Grimmett & Galvin, 2015). Providing psychoeducation helped the clients to feeling comfortable to engage in an EMDR session. My study confirms this finding specifically for the intervention of brainspotting among the experiences of counselors trained in brainspotting. The participants in my study reported that in their experiences brainspotting led to positive outcomes for their clients who experienced trauma.

The results from my study also confirm the existing research on trauma-based interventions and the importance of psychoeducation. TFCBT is another evidence-based trauma intervention that integrates psychoeducation into the treatment protocol for treating trauma and PTSD (Walker, 2017). Research has determined TFCBT is an

effective treatment for trauma (Walker, 2017). One of the stages of TFCBT is psychoeducation about trauma symptoms and the TFCBT protocol and what to expect when the client engages in TFCBT. Therefore, research supports the use of psychoeducation and identifies psychoeducation as a valuable component of treating trauma.

Theme 3: Consultation and Support Within the Brainspotting Community

Another theme that emerged from the participants experiences was the importance of counselors trained in brainspotting to engage in ongoing consultation and support with other brainspotting providers in the community. The participants shared that they were more likely to integrate brainspotting, feel more confident in integrating brainspotting, and learn more about the use of brainspotting with clients who have experienced trauma if they engaged or were currently engaging in consultation. The participants noted that in their experience consultation and support from the brainspotting community provided ongoing improvement of their practice with brainspotting and offer encouragement to continue to use brainspotting with clients. This theme was not discussed in the literature on brainspotting due to the small amount of brainspotting literature available; however, the importance of consultation was supported by literature on the intervention of EMDR.

In a study by Grimmett and Galvin (2015), the researchers explored the experiences of clinicians who continued to use EMDR and clinicians who discontinued the use of EMDR in counseling settings. The study found that in the experience of the clinicians, they were more likely to continue to use EMDR with clients if they engaged in consultation. The benefits of consultation outlined by the participants of the Grimmett

and Galvin (2015) study were that they felt more confident in integrating EMDR with other modalities and were more equipped to provide psychoeducation to their clients about the process of EMDR and expected outcomes of integrating EMDR. Therefore, my study confirms that ongoing consultation improves the clinical practice of counselors with clients who have experienced trauma. My study specifically confirms this for the use of consultation on the practice of brainspotting.

Theme 4: Brainspotting is Flexible to Meet the Needs of Clients

The counselors trained in brainspotting who participated in the study noted that brainspotting is a flexible modality that can be easily integrated with various modalities to meet clients' needs. Four of the participants compared brainspotting with EMDR. The participants noted that they found the EMDR protocol very rigid and inflexible. In comparison, brainspotting was more flexible and dids not require the counselor to follow a strict protocol. The participants also noted that brainspotting was also flexible enough to be incorporated with other approaches. Different approaches used by the participants included internal family systems, cognitive behavior therapy, dialectical behavior therapy, and energy work.

The flexibility of brainspotting is supported in the research study by D'Antoni et al. (2022). The study explored the effectiveness of brainspotting and EMDR on distressing memories (D'Antoni et al., 2022). The authors noted that when the psychotherapists were delivering the brainspotting intervention for the participants, brainspotting allowed flexibility in the way brainspotting was integrated and allowed the psychotherapist to slow down the process when the participant struggled with processing

the traumatic memory (D'Antoni et al., 2022). The flexibility of brainspotting was also supported in the training manual for brainspotting professionals, which identifies that brainspotting is an integrative model that can be altered and is flexible in protocol (Grand, 2009). Therefore, the finding from my study confirms the existing literature that brainspotting is flexible to meet clients' needs. Researchers suggested continued research on the flexibility of brainspotting to integrate with other therapies (D'Antoni et al., 2022). My study also adds to the existing literature on the flexibility of brainspotting to use specifically with clients who have experienced trauma.

Theme 5: Brainspotting Leads to Positive Outcomes for Clients

The final theme that emerged from the experiences of the participants was that brainspotting leads to positive client outcomes. The participants reported that while the outcomes vary for clients, every participant could identify at least one client they worked with who benefited from brainspotting. Some positive outcomes that were highlighted by the participants from brain spotting include clients feeling calmer, less reactive to triggers for trauma, having more positive relationships, and feeling less distressed from traumatic memories. The results of my study confirmed the research conducted by The Newton Sandy Hood Foundation (2016) which found that brainspotting was one of the most effective trauma treatments of the modalities explored. Outcomes for clients included a decrease in symptoms of PTSD (The Newton Sandy Hook Foundation Inc., 2016). A case study by Masson et al. (2017), like the Newton Sandy Hook Foundation Inc. (2016), also found that brainspotting was an effective intervention to decrease symptoms of trauma.

Other peer-reviewed studies also found that brainspotting leads to positive

outcomes, including the study conducted on the effectiveness of brainspotting with distressing trauma memories (D'Antoni et al., 2022). Similarly, the study by D'Antoni et al. (2022) and Hildebrand et al. (2017) also found the effectiveness of brainspotting to decrease the emotional distress of traumatic memories. Another case study also noted how brainspotting led to positive outcomes for a client that experienced childhood trauma (Ferreira-Matos et al., 2015). Therefore, the theme that brainspotting leads to positive outcomes from my study confirms the existing research that has been conducted on the effectiveness of brainspotting in treating trauma.

Limitations of the Study

A limitation of this study was that the study was limited to individuals who experienced the phenomenon of being trained in brainspotting and integrating it with clients who have experienced trauma (Creswell, 2013). Generalizability was another potential limitation; the sample size was small compared to the number of clinicians trained in brainspotting across the world, and the study was limited to licensed counselors instead of all mental health providers. Therefore, the study's results may not be able to be transferred to all mental health providers trained in brainspotting. However, over 7,000 brainspotting providers are counselors (Brainspotting, 2017). Therefore, the findings of my study apply to many brainspotting counselors. I also limited the requirements of the participants to be, at least, phase one and two trained in brainspotting. There are additional training phases in brainspotting; I only required completion of Phases 1 and 2, which means the counselor is eligible for certification. Another limitation is that counselors trained in brainspotting are across the world and in various countries; due to

cultural differences and different trauma experiences of clients, the results may not be generalizable to counselors trained in brainspotting across the world. This study also focused on brainspotting with clients who have experienced trauma; however, brainspotting can be used for clients who have experienced various mental health issues not limited to trauma.

Another limitation of the study was that I created the questions myself, which could be leading for participants; however, I addressed this limitation by having my chair review my interview questions prior to submitting them for IRB approval. Another limitation of the study is that I did not specify if the participants integrated brainspotting in-person vs virtually. Two participants noted that a challenge with integrating brainspotting was adapting it for use virtually. Finally, an additional limitation was the potential bias of the researcher; I am trained in brainspotting, which could have impacted my data analysis. I attempted to mitigate this limitation by bracketing my personal bias via journaling and regular meetings with my chair to become more aware of my biases regarding the study. The framework for the study is an additional limitation because the participants are reporting on their experiences from the perspective of the present of their past experiences, which is biased to their interpretation of their experiences.

Recommendations

The study gathered rich narratives from participants; however, there are recommendations for further research based on the findings and framework of this study. One recommendation for future research is on the integration of brainspotting with distance clients. Two participants noted a challenge of integrating brainspotting with

virtual clients. Another recommendation for future research is to examine the integration of both brainspotting and EMDR. Four of the 12 participants were trained in both EMDR and brainspotting. They noted the strengths and weaknesses of each modality and noted integrating the two in their practice with clients who have experienced trauma. Another recommendation for future studies would be on the integration of brainspotting with specific traumatic experiences (i.e., sexual assault, combat, physical assault, natural disasters, accidents, etc.). Another recommendation would be to conduct more quantitative studies exploring the effectiveness of brainspotting with clients who have trauma or PTSD due to the lack of data available on brainspotting (Grand, 2009). Another recommendation for future studies is to explore the use of brainspotting with other diagnoses in addition to trauma and PTSD, such as generalized anxiety disorder, major depressive disorder, bipolar disorder, etc.

Implications

The study sought to gather information on the experiences of counselors trained in brainspotting with clients who have experienced trauma. Participants in the study shared about the benefits and challenges they experienced with brainspotting. The goal of the study was to provide information on implications for practice with clients who have experienced trauma. Implications for social change include providing data on trauma in general and practice implications for counselors trained in brainspotting. Trauma is a prevalent issue that negatively impacts society (NIMH, 2020). Therefore, when therapists are adequately trained to decrease symptoms and properly treat trauma, the social impact of trauma decreases. The experiences of the counselors highlighted a need for more

studies exploring brainspotting and the implementation of brainspotting with trauma. Improvements in practice include more psychoeducation for clients, the importance of counselors engaging in brainspotting as clients themselves, and counselors immersing themselves in the brainspotting community for support and consultation.

Social Change Implications

The implications for social change include contributing to the existing literature on trauma and providing more literature on the intervention of brainspotting as a treatment for clients who have experienced trauma. Trauma continues to be a significant societal issue (SAMHSA, 2022). Research has noted that 5 out of 10 women and 6 out of 10 men will encounter a traumatic experience (Department of Veteran Affairs, n.d.). Therefore, the need for effective treatment is vital to society to mitigate the impact trauma has on society, including an increase in healthcare costs, homelessness, substance abuse disorders, and unemployment (SAMHSA,2022). Counselors are continuing to use brainspotting more frequently to treat clients who have experienced trauma (Brainspotting, 2017). The study sought to provide insight into the experiences of counselors to improve the treatment of trauma and PTSD. To date, there has not been a qualitative, phenomenological study conducted on brainspotting, specifically illuminating the experiences of counselors with clients who have experienced trauma. The counselors noted that being trained in brainspotting provided confidence and an effective tool to address their clients' trauma effectively. The study provided some insight into a commonly used trauma intervention and ways to improve clinical application from the experiences of other counselors.

Practice Implications

The study's results highlighted some implications to improve practices among counselors trained in brainspotting. One implication for practice was the importance of consistently engaging in consultation with other brainspotting providers to improve brainspotting practices with clients who have experienced trauma. Another implication for practice was the importance of providing psychoeducation on brainspotting for clients who may be resistant or unsure of how to engage in brainspotting. Additional implications include the importance of th counselor engaging in their own personal counselingvia brainspotting to aid in being present for their clients. One of the significant strengths highlighted by the participants was the flexibility of brainspotting to be integrated with other therapeutic techniques; commonly integrated techniques included EMDR and internal family systems. Therefore, the participants noted that brainspotting allows the counselor to be creative to meet their client's needs and not feel the need to follow a strict protocol.

Conclusion

Trauma continues to have a significant impact on society, including increasing health issues, and often leading to long-term mental health issues (NIMH, 2020). The exposure to traumatic events continues to increase among the population, including, but not limited to, domestic abuse, sexual assault, assault, combat, childhood neglect, exposure to violence, and school shootings (NIMH, 2020). The need for effective therapeutic interventions also increases (Corrigan & Grand, 2013). The purpose of the study was to explore the experiences of counselors trained in brainspotting with clients

who have experienced trauma. Five themes emerged from the study, which highlighted implications for the practice among other counselors trained in brainspotting. The study's results confirmed and added to previous studies conducted on brainspotting. Recommendations for future studies include conducting a study exploring the use of brainspotting with virtual clients, examining the integration of EMDR and brainspotting, exploring the use of brainspotting with specific types of traumas, and conducting quantitative studies exploring the effectiveness of brainspotting with trauma.. The study also contributed to existing literature on trauma interventions.

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Appendix A: Data Collection Protocol and Interview Questions

Interview Protocol

Hello, I am Tina Deveau doctoral student at Walden University. How are you? Thank you so much for participating in my study and for sharing your experience with brainspotting. First, I wanted to reference my informed consent and reiterate that this will be recorded and reiterate that you can drop out at any time. I also ask that you are in a private space while we complete the interview, and I want to assure you that I am in a private office that no one else can access at this time. Do you have any questions about the informed consent? I also wanted to quickly go over again the purpose of my study before we begin the official interview, the purpose of my study is to explore the experiences of brainspotting counselors, specifically, with clients who have experienced trauma. I am hoping information from the study can inform future brainspotting trainings including information on best practices to use with client's who have experienced trauma. Do you have any questions about the interview in general? I do have 12 questions that I will ask you. To avoid repetitiveness if you could just keep it in mind that the questions are to be focused specifically on your work with clients who have experienced trauma. Alright, I am going to turn on the recorder and we will get started!

Interview Questions

1. What have been your overall experiences with integrating brainspotting?
2. Describe for me your experience with the process of determining the appropriate interventions to implement in your brainspotting sessions?
    a. Describe for me any challenges you have experienced with integrating

brainspotting?

3. Share with me your experience with one single successful brainspotting *session*?
4. Share with me your experience with one single brainspotting *session* with a client that was not successful?
    a. In what way(s) did you feel that the session was unsuccessful?
    b. How, if at all, did you use brainspotting again with this client in the same/different way during a different session?
5. Can you share with me your experience with a successful *case* (seeing a client for several sessions until termination of counseling services) of integrating brainspotting with a client?
6. Can you share with me your experience with a *case* of integrating brainspotting with a client that was not successful?
7. Describe for me ways brainspotting has improved or hindered your practice with clients?
8. Describe for me your most used interventions with Clients who have experienced trauma ?
9. Describe for me how your practices with integrating brainspotting with clients could be improved?
10. What would you share with another counselor who is considering incorporating brainspotting to their practice?
11. What advice would you give to another counselor who is trained in brainspotting on how they could improve their work with clients who have experienced trauma?

What else you would like to share about your work with integrating brainspotting that I've not specifically asked?

Appendix B: Demographic Survey

1. Are you over age 18?
2. Gender?
3. How many years have you been practicing as a counselor?
4. In which state(s) are you licensed and practicing as a counselor?
5. Setting in which you practice (ie. Private practice, agency, etc.)?
6. How many years have you been you been practicing with brainspotting?
7. Which phases of brainspotting have you completed?
8. Have you attended any additional brainspotting trainings (ie. For children, substance abuse, adoptions etc.)?
9. Are you currently working with clients who have experienced trauma?