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Brainspotting after singular stressful/traumatizing experiences

Evaluation of a combination of Brainspotting and cognitive behavioral therapy

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Assuming that specific eye positions correspond to therapy-relevant stressful experiences, Brainspotting was developed out of EMDR as a treatment to trigger processing via the body. Acquired patterns of stress or trauma reactions can be restructured using affect bridges. Brainspotting can be integrated into the psychotherapeutic method used by the therapist.

The study investigates the effectiveness of Brainspotting combined with cognitive behavioural therapy in a randomised two-arm study ("Brainspotting immediately" vs. "Brainspotting later").

Early response was significantly higher in the "Brainspotting immediately" group than in those receiving Brainspotting after the early response measurement. At the end of therapy and catamnestically, there were large effects on the IES-R for both groups. Anxiety and depression symptoms improved significantly and sustainably; the moderator effect of the therapeutic relationship was not confirmed.

The combined use of Brainspotting and cognitive behavioural therapy showed clinically significant effects at an early stage. The generalization of these results is considerably restricted through limitations. Randomized controlled trials are necessary for more evidence-based results.

Keywords: Cognitive behavioural therapy, Brainspotting, trauma, effectiveness, early response

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Introduction

Psychotherapy has proven to be an effective method for treating the consequences of traumatic experiences. Various factors of influence can affect therapeutic outcomes, including the therapeutic relationship, expectancy and placebo effects, extratherapeutic factors, as well as technique- and model-related factors (Asay & Lambert, 2001). Early success in psychotherapy—referred to as "early response"—is considered a positive predictor for overall treatment success (Lambert, 2005). This is of particular relevance in the treatment of stress reactions or post-traumatic stress disorder (PTSD), as the consequences not only severely impair the quality of life of those affected but can also lead to lasting changes in brain structures.

Numerous findings on the neural correlates of PTSD indicate structural and functional alterations. According to Grawe (2004), individuals who have experienced trauma in childhood are particularly vulnerable to developing PTSD following a traumatic event. Trauma is predominantly stored in implicit memory, while it is insufficiently encoded in explicit memory. A traumatic event represents an intense anxiety stimulus to which the amygdala reacts strongly and immediately. Due to the association with multiple sensory channels—such as smells, images, or sounds—fear responses can be readily reactivated. Grawe (2004) posits that improvement is possible through the integration of explicit and implicit trauma memories, which requires repeated exposure to triggering stimuli.

EMDR

Eye Movement Desensitization and Reprocessing (EMDR) did not emerge from systematic research; rather, its discovery was purely accidental (Hofmann, 2006). In the summer of 1987, the American psychologist Francine Shapiro noticed during a walk that distressing memories and their negative effects diminished when she spontaneously moved her eyes back and forth (Shapiro, 1998; Shapiro & Forrest, 2007).

Subsequent investigations revealed that not only eye movements but also bilateral auditory and sensory stimulations were highly effective (Hofmann, 2006). Shapiro developed a standardized protocol that included an initial and a concluding phase, initially naming the method EMD—Eye Movement Desensitization (Schubbe et al., 2006) — as her therapeutic approach at the time was rooted in behavioral therapy.

Over time, elements from numerous psychotherapeutic schools have been integrated into the EMDR method, including psychodynamic, behavioral, cognitive, body-oriented, and systemic components (Shapiro & Forrest, 2007). In 1997, EMDR was recognized by the American Psychological Association (APA) as an empirically supported treatment for PTSD. The range of indications for EMDR has since continually expanded, and disorder-specific protocols have been developed (Schubbe et al., 2006).

Brainspotting

Wolfrum (2020) defines the core principle of Brainspotting (BSP) as follows: "Where we look affects how we feel." One's emotional state in response to a distressing memory can shift simply by changing one's gaze direction (Wolfrum, 2020).

David Grand, regarded as the developer of Brainspotting, had worked for several years with the EMDR method and was previously a member of Francine Shapiro's EMDR Institute. Based on his own clinical observations, he developed this therapeutic approach for traumatized individuals in 2003 (Grand, 2011). He postulates that therapy-relevant physiological processes and emotional sensations correspond with specific eye positions, which can be purposefully activated through the visual field (Wolfrum, 2017). In this therapeutic context, a brainspot

refers to a particular eye position at which clients exhibit strong bodily reactions believed to be associated with stress- or trauma-related neural processes. The assumption is that gaze direction influences emotional states. The underlying theory suggests that while the eyes scan the external environment for threats, they simultaneously access relevant information within brain networks, thus directing attention inward and facilitating access to stored traumatic memories. Two key mechanisms are described: the focused activation of implicit memory contents and the focused mindfulness during the therapeutic process (Wolfrum, 2017).

Both Brainspotting and EMDR utilize self-regulation processes to resolve a blocking hyperactivation in the brain that has previously impaired the proper processing of emotions and memories (Kollar, 2024). In both methods, parasympathetic activation is used to support the therapeutic process: in Brainspotting through bilateral auditory stimulation, and in EMDR through auditory, tactile, and eye movement stimulation (Wolfrum, 2020).

Application Areas of Brainspotting

Wolfrum (2020) also concludes that Brainspotting can be applied much more broadly than methods such as EMDR or various screening techniques. Brainspotting is suitable not only for "classic" trauma, but also for experiences of devaluation, humiliation, or seemingly "minor everyday problems" and conflicts that clients perceive as distressing. Wolfrum (2020) conceptualizes the brain as a self-regulating, self-referential, nonlinear complex system that requires re-regulation following stressful or traumatic experiences.

Wolfrum (2017) identifies a wide range of application areas for Brainspotting, including psychotherapy, sports psychology, the arts, and pain therapy. In this study, Brainspotting was explicitly not used as a standalone therapeutic method, but rather as a therapeutic tool integrated within an ongoing psychotherapeutic treatment.

Research Objective

The following research questions were formulated for this study:

1. Does the combined use of Cognitive Behavioural Therapy (CBT) and Brainspotting result in a significantly higher degree of early response after the first four to five therapy sessions compared to the group receiving CBT alone?
2. Does the combination of Cognitive Behavioural Therapy with Brainspotting lead to a clinically significant and sustained improvement in symptoms?
3. How do clients experience the Brainspotting intervention, and how do they describe its effects?

Study Design and Methods

The study was designed as a two-arm randomized intervention study with four measurement points and was conducted in the author's psychotherapy practice between December 2018 and October 2019. The conducting therapist, a cognitive behavioural therapist with additional training in trauma therapy, is also a clinical and health psychologist. Clients sought treatment independently and without referral due to their level of distress and financed the therapy themselves.

Clients were included if they reported severe distress resulting from a stressful or traumatic experience (with or without a formal PTSD diagnosis) and exhibited elevated scores on both the Impact of Event Scale (IES-R) and the HADS-D (*Hospital Anxiety and Depression Scale*). Inclusion criteria required voluntary participation, informed consent, and a minimum age of 18 years. Exclusion criteria included acute suicidality, schizophrenia spectrum disorders, and substance dependence. The study was approved as part of the author's doctoral dissertation by the Social Sciences Ethics Review Board (SSERB) of the University of Nicosia (Glantschnig, 2021).

Measurement Methods

The Life Events Checklist 5 (LEC-5) was used to assess 17 potential traumatic events and whether these had been personally experienced or witnessed (Weathers et al., 2013). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; German version) was used to screen for PTSD. A score above the cutoff of 33 indicates a potential PTSD diagnosis (Krüger-Gottschalk et al., 2017). In such cases, a structured interview using the Clinician-Administered PTSD Scale (CAPS) was conducted for further assessment (Weathers et al., 2013). Current distress related to the explored experiences was measured using the Impact of Event Scale—Revised (IES-R) (Maercker & Schützwohl, 1998). Anxiety and depressive symptoms were assessed using the HADS-D (*Hospital Anxiety and Depression Scale, German version*) (Herrmann-Lingen et al., 2005). All data were pseudonymized and analyzed using SPSS 25. Statistical analyses included analyses of vaiances with repeated measures and paired t-tests, with additional calculation of effect sizes.

Implementation of the Brainspotting Intervention

In a face-to-face seated position, the topic to be addressed is first identified through discussion. Talking about the distressing topic activates a bodily response, the location and intensity of which are assessed using the SUD scale (Subjective Units of Distress). Using a telescopic pointer, the brainspot is then located first horizontally and subsequently vertically. Processing begins immediately afterward. The gaze is held at the identified brainspot until the client's level of distress has decreased, ideally reaching a score of 0 on the SUD scale. Once a score of 0 is reached, the topic is reactivated to identify and process any remaining distress.
Throughout the session, therapists observe clients' facial expressions, posture, breathing, and verbal cues to monitor emotional processing and changes occurring during the treatment.

Sample

Anamnesis and initial diagnostic assessment were conducted at t_0. Upon meeting the inclusion criteria, clients were randomly assigned to either the "BS immediately" group or the "BS later" group (random list). In 11 cases where the PCL-5 score exceeded 32, a structured interview for PTSD diagnosis was conducted using the Clinician-Administered PTSD Scale (CAPS) (see Figure 1). All 100 enrolled clients completed the treatment (follow-up N = 99).
The sample consisted of 62% women. The average age was comparable between groups (35.79 years, SD = 12.05, vs. 32.29 years, SD = 10.74; range: 18 to 68 years).

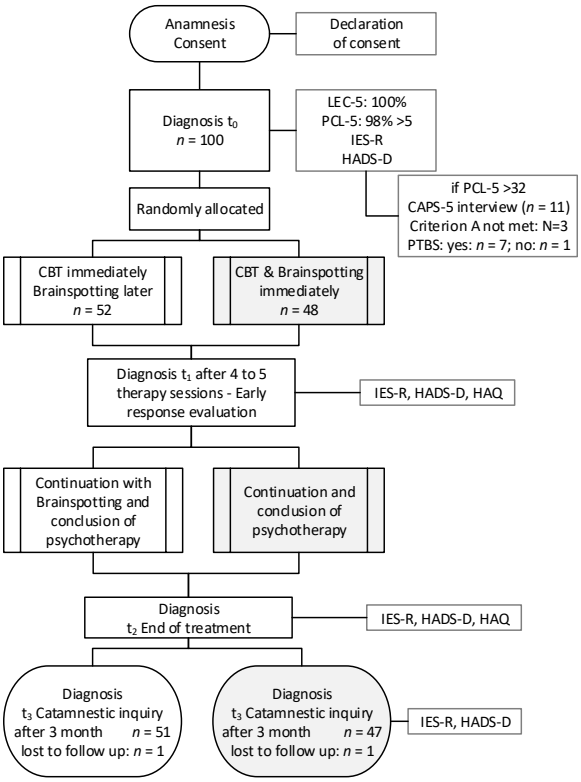

Fig. 1 Flow Diagram of Study Participants

Results

The most frequently reported events on the LEC-5 were from the category of "other stressful events" (61%), such as workplace-related problems, bullying, or distressing experiences during medical procedures. In addition, life-threatening illnesses or injuries (14%), sudden

violent death of close family members (10%), physical assaults (9%), and other events (6%) were recorded. Not all of these experiences meet Criterion A for a PTSD diagnosis; however, clients subjectively experienced them as highly distressing.

On the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5), symptoms were most frequently reported for Criterion B (intrusion symptoms) and Criterion C (avoidance symptoms) (see Table 1). Specifically, 85% reported unwanted memories, 60% reported flashbacks, 91% reported emotional distress when thinking about the event, 79% reported physical reactions, and 86% reported avoidance of memories, thoughts, or feelings.

For Criterion D, two particularly relevant items were assessed: strong negative beliefs about oneself and the world (45%), and feelings of blame towards oneself or others related to the stressful event (61%).

Based on the results of the LEC-5, PCL-5, IES-R, and the information from the clinical interview, in eleven cases a structured diagnostic interview using the Clinician-Administered PTSD Scale for DSM-5 (CAPS) was conducted. In three of these cases, Criterion A was not confirmed, so ultimately the full interview was completed with eight clients, of whom seven met all criteria for a PTSD diagnosis.

Tab. 1 Results from Screening with the PCL-5 and the CAPS

Criterion		N and %
PCL-5: Fulfillment of criterion B	Intrusion symptoms	97
PCL-5: Fulfillment of criterion C	Avoidance symptoms	90
PCL-5: Fulfillment of criterion D	Cognitions and mood symptoms	61
PCL-5: Fulfillment of criterion E	Arousal and reactivity symptoms	18
PCL-5: Fulfillment of PTSD criteria - without consideration of criterion A		16
CAPS V: Existence of PTSD (all criteria A-G met?)		7

Results for the Impact of Event Scale (IES-R)

The analysis of group differences regarding early response revealed a significant effect for time ($F [3; 96] = 102.69$; $p < 0.001$) and for the interaction between time and group ($F [3; 96] = 34.91$; $p < 0.001$) on the primary outcome parameter, the IES-R. All data from the univariate comparisons for the subscales Intrusion, Avoidance, and Hyperarousal, including effect sizes and confidence intervals, are presented in Table 2.

Both groups showed a significant reduction in IES-R total scores. In the "BS later" group, a small effect was observed ($p < 0.001$; $d = 0.35$; CI: –0.04 to 0.73), which was not statistically robust. Scores decreased from M = 34.58 (SD = 18.09) to M = 28.38 (SD = 17.45). In contrast, the "BS immediately" group demonstrated a large effect already at t_1 ($p < 0.001$; $d = 1.68$; CI: 1.22 to 2.15), with scores decreasing from M = 34.44 (SD = 14.92) to M = 10.96 (SD = 13.90).

This result clearly indicates a higher proportion of early response in the "BS immediately" group (Figure 2).

At the end of therapy (t_0 vs. t_2), multivariate analysis showed a significant effect for time ($F [3; 95] = 263.91$; $p < 0.001$), whereas the interaction time * group was not significant ($F [3; 95] = 1.46$; $p = 0.229$). This indicates that by the end of therapy, both groups benefited equally.

In the "BS later" group, a very large effect was observed ($p < 0.001$; $d = 2.11$; CI: 1.63 to 2.59), with mean scores decreasing from M = 34.58 (SD = 18.09) to M = 5.29 (SD = 7.12).

Similarly, the "BS immediately" group showed a very large effect ($p < 0.001$; $d = 2.95$; CI: 2.37 to 3.54), with mean scores decreasing from M = 35.57 (SD = 15.05) to M = 3.09 (SD = 3.41).

In all three IES-R subscales, both groups achieved effect sizes between d = 1.82 and d = 3.66.

To assess the sustainability of treatment effects, a repeated measures multivariate ANOVA was conducted (t_0, t_1, t_2, t_3). Significant results were found for both the time factor ($F [9; 864] = 37.656$; $p < 0.001$) and the interaction time * group ($F_{[9; 864]} = 10.59$; $p < 0.001$).

As shown in Figure 2 (IES-R total score), both groups maintained the treatment effects achieved at the end of therapy. For the "BS later" group, a sustained improvement was observed, with scores decreasing from M = 34.53 (SD = 18.27) to M = 4.53 (SD = 6.52) - a very large effect ($p < 0.001$; d = 2.17; CI: 1.68 to 2.66). In the "BS immediately" group, the IES-R total score decreased from M = 35.57 (SD = 15.05) to M = 3.21 (SD = 3.54) - also a very large effect ($p < 0.001$; d = 2.93; CI: 2.35 to 2.53).

Results in the HADS-D

Similar patterns were observed for the anxiety and depression scales of the HADS-D. At the multivariate level, there was a significant effect of time ($F_{[6; 576]} = 61.86$; $p < 0.001$) and a significant interaction between time and group ($F_{[6; 576]} = 11.41$; $p < 0.001$).

A notable difference between the two groups was found only at time point t_1, where the "BS immediately" group showed substantially larger effects on the anxiety scale (d = 1.96; CI: 1.47–2.45) and the depression scale (d = 0.95; CI: 0.52–1.37).

The "BS later" group showed an effect size of d = 0.65 (CI: 0.25–1.05) for anxiety at t_1, and an effect size of d = 0.42 (CI: 0.03–0.82) for depression.

Clients' Experiences of the Brainspotting Intervention

All clients approached this relatively unfamiliar method with an open attitude; only two clients had prior experience with Brainspotting. At the end of a Brainspotting session, they generally reported feeling tired and exhausted. In some cases, clients mentioned mild headaches or eye strain due to the effort involved. For some, their thoughts occasionally drifted during the session, while others remained fully focused throughout.

Clients' statements were categorised into three groups. The majority were classified as **"the open-minded"** (N = 67), who approached the treatment with openness.

Example #75: *"I really didn't know what to expect, but I was willing to give it a try. Now it feels as if I had only heard about it."*

A smaller group was described as **"the effortful"** (N = 28). These clients described the treatment as *"really exhausting"* or reported putting themselves under pressure to find the brainspot.

Example #62: *"I didn't think I would have to do so much during this. Now it feels like watching an old movie."*

Only five clients were classified as **"the sceptics"**. They had no clear expectations prior to the treatment and could not imagine what it would involve.

Example #80: *"I didn't think something like this could work. But now, when I think about it, I don't feel any distress."*

At the end of the intervention, many clients used metaphorical images to describe the effects, such as a faded picture, an (old) film, a photo wallpaper, an old memory, an old photograph, or yesterday's snow.

Many clients reported that they could *"no longer enter into the image."*

From the therapist's perspective, changes in facial expressions and body posture were observed during the treatment, such as clients adopting a more upright sitting posture.

Table 2 Pairwise Comparisons Between t_0 and t_1, t_0 and t_2, and t_0 and t_3 of IES-R and HADS-D Scale Scores for the "Brainspotting Later" Group (N = 51) and the "Brainspotting Immediately" Group (N = 47)

Scale / Comparison	Group	M_{pre}	SD_{pre}	M_{post}	SD_{post}	Cohen`s *d*	*CI LL*	*CI UL*
Intrusion: t_0 - t_1	BS later	14.19	5.51	11.37	5.88	.49	.10	.88
	BS immediately	14.67	5.01	4.13	4.43	2.21	1.70	2.72
Intrusion: t_0 - t_2	BS later	14.19	5.51	2.33	2.56	2.74	2.21	3.28
	BS immediately	14.74	5.04	1.51	1.57	3.52	2.47	4.16
Intrusion: t_0 - t_3	BS later	14.22	5.56	1.57	2.21	2.97	2.41	3.53
	BS immediately	14.74	5.04	1.13	1.21	3.68	3.02	4.35
Avoidance: t_0 - t_1	BS later	12.21	7.80	10.21	7.51	.26	-.13	.65
	BS immediately	13.27	7.86	4.67	7.34	1.12	.69	1.55
Avoidance: t_0 - t_2	BS later	12.21	7.80	1.79	2.91	1.76	1.31	2.21
	BS immediately	13.30	7.95	1.11	1.67	2.11	1.60	2.61
Avoidance: t_0 - t_3	BS later	12.24	7.88	1.45	2.85	1.81	1.35	2.27
	BS immediately	13.30	7.95	1.19	1.94	2.08	1.57	2.58
Hyperarousal: t_0 - t_1	BS later	8.17	7.19	6.81	6.12	.20	-.18	.59
	BS immediately	7.50	5.28	2.17	3.58	1.68	1.22	2.15
Hyperarousal: t_0 - t_2	BS later	8.17	7.19	1.12	2.31	1.31	.89	1.74
	BS immediately	7.53	5.33	0.30	0.69	1.89	1.40	2.37
Hyperarousal: t_0 - t_3	BS later	8.08	7.23	0.96	2.02	1.33	.90	1.76
	BS immediately	7.53	5.33	0.38	0.85	1.86	1.37	2.34
Anxiety: t_0 - t_1	BS later	16.61	3.70	13.90	4.50	.65	.25	1.05
	BS immediately	14.47	3.57	6.32	4.60	1.96	1.47	2.45
Anxiety: t_0 - t_2	BS later	16.61	3.70	4.51	2.80	3.66	3.03	4.30
	BS immediately	14.47	3.57	4.02	2.70	3.27	2.65	3.89
Anxiety: t_0 - t_3	BS later	16.61	3.70	4.98	5.43	2.48	1.97	3.00
	BS immediately	14.47	3.57	3.94	2.47	3.40	2.77	4.03
Depression: t_0 - t_1	BS later	11.67	5.11	9.55	4.79	.42	.03	.82
	BS immediately	11.17	5.51	5.92	5.51	.95	.52	1.37
Depression: t_0 - t_2	BS later	11.67	5.11	2.82	3.07	2.19	1.70	2.69
	BS immediately	11.17	5.51	2.87	3.07	1.85	1.36	2.33
Depression: t_0 - t_3	BS later	11.67	5.11	2.92	2.47	2.16	1.67	2.65
	BS immediately	11.17	5.51	2.91	2.78	1.88	1.39	2.36

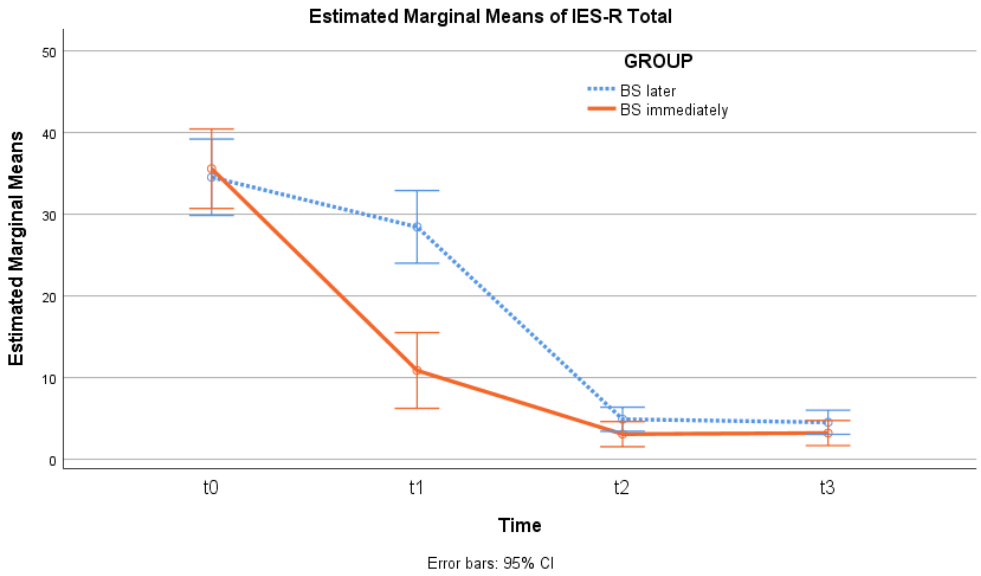

Fig. 2 Mean Scores and 95% Confidence Intervals for the Impact of Event Scale (IES-R) at t_0, t_1, t_2, and t_3

Discussion

The Brainspotting method has gained increasing attention but has not yet been sufficiently evaluated through scientific studies. This study aims to contribute to this area by examining treatment effects at early response (after 4–5 therapy sessions, t_1), at the end of therapy (t_2), and three months post-treatment (t_3). It was hypothesised that the group receiving CBT combined with Brainspotting from the outset would show greater treatment effects at t_1 compared to the group that received Brainspotting only after t_1 in addition to CBT.

The hypothesis that combining Brainspotting with CBT would lead to significantly greater positive effects within the first four to five therapy sessions compared to CBT alone was confirmed. Changes on the Impact of Event Scale between t_0 and t_1, as well as the time * group interaction, were significant. While the "BS immediately" group already showed a large effect of d = 1.68 after four to five therapy sessions, the "BS later" group exhibited only a small effect of d = 0.35, which was not statistically robust. At the end of therapy (t_2) and three months later (t_3), both groups demonstrated very large effect sizes on all IES-R and HADS-D scales (d > 1.8).

Asay & Lambert (2001) summarised effect sizes from psychotherapeutic treatments for various disorders, reporting values ranging from d = 0.14 to d = 2.10, with many studies showing effect sizes above d = 0.7. Lambert & Ogles (2013) similarly found predominantly medium to large effect sizes across diverse conditions following psychotherapy. Against this background, the present effect sizes can be considered very large.

The common factors theory posits that specific techniques contribute only modestly to therapeutic success (Asay & Lambert, 2001), estimating that specific methods account for only 15% of treatment efficacy. Evidence supporting the superiority of specific techniques is viewed as the exception, with examples primarily found in the treatment of phobias and panic disorders. Nonetheless, these authors emphasise the overall efficacy of psychotherapy and suggest that positive effects can already be achieved within short treatment periods (5–10 sessions).

Additionally, early response is consistently described in the literature as a positive predictor of treatment success (Lambert, 2005; Van et al., 2007; Kleinstäuber et al., 2017).

The results of this study suggest that specific factors—in this case, the Brainspotting intervention—can make a substantial contribution to treatment outcomes. In particular, the rapid early response observed when combining Brainspotting with CBT is noteworthy. The sustainability of treatment effects was also confirmed for both study groups. Given the low mean scores on all three IES-R subscales at t_3 and effect sizes between d = 1.3 and d = 3.68 from t_0 to t_3, it can be concluded that there was a clinically significant and sustained reduction in symptoms. For most clients, IES-R total scores at t_1 already fell below clinical cutoff values. The large and stable improvements observed on the HADS-D anxiety and depression scales further support the long-term effectiveness of the intervention.

Limitations

The large effects observed in both treatment groups may, in part, be attributable to the fact that the sample did not consist of "typical clients," as recommended by Kendall et al. (2013), but rather of clients from a private practice. Although these clients exhibited significant levels of distress, they were highly motivated and financed the treatment privately. Most clients had good personal resources, such as a relatively stable and supportive environment. Therefore, the generalisability of the study findings to other settings—such as inpatient psychotherapy or fully-funded treatment settings—is limited.

Additionally, allegiance effects cannot be ruled out, as the conducting psychotherapist had a generally positive attitude toward the method based on prior experience. Another important limitation is that all clients were treated by a single therapist, meaning that there was no variability in therapist-related factors.

In summary, the generalisability of the present study is limited, particularly given the lack of randomised multi-centre studies involving different therapists in Brainspotting research.

Conflict of Interest S. Glantschnig declares that there is no conflict of interest.

References

Asay, T. P. & Lambert, M. J. (2001). Empirische Argumente für die allen Therapien gemeinsamen Faktoren: Quantitative Ergebnisse. In M. A. Hubble, B. L. Duncan & S. D. Miller (Hrsg.), *So wirkt Psychotherapie. Empirische Ergebnisse und praktische Folgerungen* (p. 41–81). Dortmund: Modernes Lernen.

Glantschnig, S. (2021). Wirksamkeit einer Kombination von Brainspotting und Kognitiver Verhaltenstherapie bei KlientInnen nach belastenden oder traumatischen Erlebnissen: Effectiveness of a combination of Brainspotting and

cognitive behavioural therapy in clients after stressful or traumatic experiences (PhD Thesis). University of Nicosia, Nicosia.
Grand, D. (2011). Brainspotting. Ein neues duales Regulationsmodell für den psychotherapeutischen Prozess. *Trauma und Gewalt*, 5(3), 276–285.
Grawe, K. (2004). *Neuropsychotherapie*. Göttingen: Hogrefe.
Herrmann-Lingen, C., Buss, U. & Snaith, P. R. (2018). *HADS-D. Hospital Anxiety and Depression Scale - Deutsche Version*. Bern: Hogrefe.
Hofmann, A. (2006). *EMDR: Therapie psychotraumatischer Belastungssyndrome* (3.Aufl.). Stuttgart: Thieme.
Kendall, P. C., Holmbeck, G. & Verduin, T. (2013). Methodik, Design und Evaluation in der Psychotherapieforschung. In M. J. Lambert & A. E. Bergin (Hrsg.*), Bergin & Garfields Handbuch der Psychotherapie und Verhaltensmodifikation* (p. 53–95). Tübingen: DGVT.
Kleinstäuber, M., Lambert, M. J. & Hiller, W. (2017). Early response in cognitive-behavior therapy for syndromes of medically unexplained symptoms. *BMC Psychiatry*, 17(1), 195. https://doi.org/10.1186/s12888-017-1351-x.
Kollar, A. (2024). *Einführung in Brainspotting*. Heidelberg: Carl-Auer.
Krüger-Gottschalk, A., Knaevelsrud, C., Rau, H., Dyer, A., Schäfer, I., Schellong, J. et al. (2017). The German version of the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): psychometric properties and diagnostic utility. *BMC Psychiatry*, 17(1), 379. https://doi.org/10.1186/s12888-017-1541-6
Lambert, M. J. (2005). Early response in psychotherapy. Further evidence for the importance of common factors rather than "placebo effects". *Journal of Clinical Psychology*, 61(7), 855–869. https://doi.org/10.1002/jclp.20130
Lambert, M.J., & Ogles, B.M. (2013). Die Wirksamkeit und Effektivität von Psychotherapie. In M. J. Lambert & A. E. Bergin (Hrsg.), *Bergin & Garfields Handbuch der Psychotherapie und Verhaltensmodifikation* (S. 243–328). Tübingen: DGVT. Maercker, A., & Schützwohl
Maercker, A. & Schützwohl, M. (1998). Erfassung von psychischen Belastungsfolgen: Die Impact of Event Skala - revdierte Version (IES-R). *Diagnostica*, 44, 130–141.
Schubbe, O., Püschel, I., Gebhardt, K., Renssen, M., & Bambach, S. (2006). *Traumatherapie mit EMDR: Ein Handbuch für die Ausbildung* (2.Aufl.). Göttingen: Vandenhoeck & Ruprecht.
Shapiro, F. (1998). *EMDR – Grundlagen & Praxis. Handbuch zur Behandlung traumatisierter Menschen* (2. Aufl.). Paderborn: Junfermann.
Shapiro, F., & Forrest, M.S. (2007). *EMDR in Aktion: Die neue Kurzzeittherapie in der Praxis* (4. Aufl.). Paderborn: Junfermann.
Van, H. L., Schoevers, R. A., Kool, S., Hendriksen, M., Peen, J. & Dekker, J. (2008). Does early response predict outcome in psychotherapy and combined therapy for major depression? *Journal of Affective Disorders*, 105(1-3), 261–265. https://doi.org/10.1016/j.jad.2007.04.016
Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.D., Marx, B.P., Keane, B.P., & Keane, T.M. (2013). *Clinician-Administered PTSD Scale for DSM-5: Instruction Manual*. Übersetzung aus dem Amerikanischen: Ulrich Schnyder. Retrieved from www.usz.ch/app/uploads/2020/09/CAPS-Interview-DSM-5-deutsch.pdf
Weathers, L., Blake, D., Schnurr, P. P., Kaloupek, D., Marx, B. P. & Keane, T. (2013). The Life Events Checklist for DSM-5 (LEC-5). https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp
Wolfrum, G. (2017). *Grundprinzipien von Brainspotting. Trauma - Zeitschrift für Psychotraumatologie und ihre Anwendungen*, 3, 6–17.
Wolfrum, G. (2020). *Das Lehrbuch Brainspotting. Ein neuer Weg in der Traumatherapie*. Asanger: Kröning: