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EVIDENCE-BASED TRAUMA PSYCHOTHERAPY: LIMITATIONS OF APPROACHES AND PROSPECTS FOR THE APPLICATION OF DEEP BRAIN REORIENTING

Relevance of the study. The relevance of this study is determined by the growing need for scientifically grounded and effective approaches to trauma psychotherapy in the context of mass and prolonged traumatization of the population caused by war, as well as by the need to identify methods that can provide not only effectiveness but also an adequate level of safety and tolerability. The article presents the results of a theoretical-methodological and empirically oriented analysis of contemporary evidence-based approaches to trauma psychotherapy. Particular attention is paid to work with post-traumatic stress disorder (PTSD) across different therapeutic modalities. It is shown that, despite strong empirical support, these approaches have limitations when applied to complex, chronic, or prolonged traumatization.

Aim of the article. The aim of the article is to provide a theoretical and empirical substantiation of Deep Brain Reorienting (DBR) as a neurobiologically oriented approach to working with psychological trauma, to analyze the possibilities of its application in the context of war-related traumatization, and to delineate the place of DBR in Ukrainian scientific and practical discourse.

Methodology. The methodology of the study is based on an analysis of contemporary neurobiological models of trauma, findings from randomized controlled trials, synthesized meta-analytic data on the effectiveness of selected contemporary psychotherapeutic approaches, as well as materials from clinical and supervisory practice and narrative reviews.

Results. The article outlines the place of neurobiologically oriented approaches, in particular Deep Brain Reorienting, which remains insufficiently represented in Ukrainian scientific discourse. Its role within the system of contemporary evidence-based trauma psychotherapy is demonstrated, taking into account the limitations of traditional methods when working with chronic and repeated traumatization. It is determined that Deep Brain Reorienting provides access to early pre-cortical components of the traumatic response, thereby making it possible to reduce the level of affective activation without intensive exposure to traumatic content. It is shown that this mechanism of intervention expands the possibilities of psychotherapy in cases of heightened psychophysiological reactivity, dissociative manifestations, and limited affect tolerance. Empirical data are presented

indicating the effectiveness of the method in reducing PTSD symptoms, its high tolerability, and its potential for remote delivery.

Conclusions and prospects for further research. The practical and social significance of DBR for psychosocial support systems in Ukraine is emphasized, particularly in work with individuals who have experienced the consequences of war-related traumatization. The need for further research to clarify the effectiveness of the method and its place within the system of evidence-based psychotherapy is outlined.

Keywords: psychological trauma; post-traumatic stress disorder; Deep Brain Reorienting; war trauma; evidence-based psychotherapy; combatants.

Problem Statement and Its Connection with Important Scientific or Practical Tasks

Psychological trauma in the context of the full-scale war in Ukraine has acquired a mass and chronic character, which substantially changes the demand placed on the mental health and psychosocial support system. We are speaking not only about an increase in the number of individuals with symptoms of post-traumatic stress disorder (PTSD), but also about the spread of complex forms of traumatization associated with repeated threats, prolonged exposure to danger, and disruption of the basic sense of safety (Cloitre et al., 2011; Herman, 2019). Under such conditions, specialists face the task not only of expanding access to psychological assistance, but above all of making a well-grounded choice of adequate, safe, and scientifically evidence-based psychotherapeutic methods.

According to the position of the American Psychological Association, evidence-based practice in psychotherapy is grounded in the integration of three interrelated components: the best available scientific evidence on the effectiveness of psychotherapeutic interventions, the clinician's expertise, and the individual characteristics, needs, and values of the client (APA Presidential Task Force..., 2006). A key feature of evidence-based psychotherapy is reliance on systematically obtained empirical data, including findings from randomized controlled trials, systematic reviews, and meta-analyses, which make it possible to assess both the statistical and clinical significance of change (Cusack et al., 2016; Lewis et al., 2020). Evidence-based practice is not reducible to the mechanical application of protocols; rather, it presupposes the therapist's capacity to adapt scientifically supported approaches to a specific clinical case, taking into account the client's level of regulation, the complexity of the traumatic experience, and the cultural and social context (Norcross & Wampold, 2018). In the field of trauma psychotherapy, even methods with a high level of evidence have limited suitability for certain groups of clients, particularly individuals with high levels of dissociation or complex traumatization. In such cases, intensive exposure or premature activation of traumatic material may be accompanied by affective overload, dissociative shutdowns, and an increased risk of retraumatization (van der Kolk et al., 2007; Lanius et al., 2012).

Evidence in psychotherapy should be considered not merely as a fixed list of validated methods, but as a dynamic clinical approach within which the choice of psychotherapeutic intervention must be based on the correspondence between the method's mechanisms of action, the structure of the traumatic experience, the client's level of psychophysiological regulation, and the actual conditions under which professional assistance is provided in a situation of war.

One of the debated questions in contemporary psychotraumatology is determining the optimal balance between approaches implemented according to a “top-down” logic (cognitive reappraisal, meaning reconstruction, verbal integration of experience) and “bottom-up” approaches oriented toward the bodily-affective components of the traumatic response and implicit memory (Ogden et al., 2006; Payne et al., 2015). This distinction reflects different levels of processing traumatic experience and points to the need for their coordinated use depending on the client’s clinical characteristics and state of regulation.

Under conditions of prolonged exposure to stressors and repeated traumatization, a specific profile of the traumatic response gradually forms. It manifests in heightened psychophysiological sensitivity, disturbances of emotional and bodily regulation, a tendency toward dissociative states, and persistent avoidance of traumatic material. At the same time, the ability and/or willingness to verbalize experience narrows, and the capacity to tolerate affective tension decreases (Lanius et al., 2012; WHO, 2013). Under these conditions, approaches that involve intensive activation of traumatic memories often prove excessive or ineffective. Other solutions are needed—approaches that make it possible to work with the traumatic response without overloading the client. These are methods that combine effectiveness with a sufficient level of safety and tolerability, especially in situations of limited resources and an unstable environment. This naturally increases interest in analyzing contemporary psychotherapeutic approaches, above all with regard to their mechanisms of action and the real limits of their application. From this perspective, it becomes possible to define more clearly both their possibilities and their limitations, as well as to determine the place of neurobiologically oriented methods, including Deep Brain Reorienting, in contemporary trauma psychotherapy.

Analysis of Recent Research and Publications and Identification of Unresolved Aspects of the General Problem

It is important to turn to contemporary scientific works that represent the main evidence-based approaches to psychotherapy for the consequences of traumatic experience. A substantial proportion of empirical research in this field focuses on post-traumatic stress disorder (PTSD). PTSD is the most operationalized model of traumatic response, which makes it possible to use standardized criteria and valid instruments for evaluating intervention effectiveness. However, traumatic experience is not exhausted by the boundaries of PTSD; it encompasses a broader spectrum of manifestations: subclinical, complex, and contextually determined, which becomes particularly evident in conditions of war.

Complex traumatization (Complex PTSD, CPTSD) requires separate consideration. It may arise as a consequence of prolonged, repeated, or interpersonal traumatic exposure. Above all, this includes situations of chronic neglect, physical, emotional, and sexual violence, as well as the experience of losing basic safety in significant relationships. This spectrum also includes circumstances of prolonged exposure to threat, forced displacement, and disruption of social ties, which are typical of the war context. In such cases, traumatic experience is not limited to a single event but acquires a processual character, influencing the formation of regulatory systems, the image of the self, and patterns of interaction with others.

Unlike classical PTSD, CPTSD involves not only re-experiencing, avoidance, and hyperarousal, but also persistent disturbances in emotional regulation, negative self-concept, and difficulties in relationships (Cloitre et al., 2013; WHO, 2019). In the war context, this configuration of symptoms often predominates. This complicates the use of approaches directed only at PTSD symptomatology.

The problem is deeper. A significant proportion of traumatic reactions forms at a level that is not fully accessible to verbalization and cognitive processing. Regulatory disturbances, bodily-affective responses, and implicit patterns of experience may persist regardless of how integrated the narrative level of experience may be. In such situations, intensive activation of traumatic material is not always appropriate. Nor is it always safe.

Let us examine contemporary psychotherapeutic approaches in more detail.

Contemporary international clinical guidelines for the treatment of post-traumatic stress disorder (PTSD) recommend exposure-oriented and cognitive-behavioral approaches as first-line therapies (APA, 2017; WHO, 2013). These include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and a number of other variants of trauma-focused cognitive-behavioral therapy. The effectiveness of these methods is supported by numerous randomized controlled trials and meta-analyses demonstrating significant reductions in PTSD symptoms compared with control conditions (Cusack et al., 2016; Resick et al., 2017).

Prolonged Exposure and Cognitive Processing Therapy are based on the mechanisms of cognitive reappraisal and extinction of conditioned fear responses through repeated, controlled revisiting of traumatic memories. These approaches involve active work with the narrative of the traumatic event and are aimed at developing cortical control over fear and avoidance responses (Foa et al., 2007; Resick et al., 2017). At the same time, a number of studies indicate substantial limitations of exposure methods when working with clients with complex traumatization, high levels of dissociation, or low affect tolerance. For such clients, exposure may be accompanied by an increased risk of affective overload, fragmentation of experience, and premature termination of therapy (Cloitre et al., 2012; Lanius et al., 2012). Clients with this symptom profile often show a limited response to first-line therapies, as confirmed by data on high dropout rates and incomplete symptom remission (Lewis et al., 2020).

Eye Movement Desensitization and Reprocessing (EMDR) occupies a distinct place among evidence-based methods. It is a method that combines elements of exposure with bilateral stimulation and bodily regulation. EMDR therapy has broad international support and is recommended by the WHO as an effective method for the treatment of PTSD (Shapiro, 2018; World Health Organization, 2013). The Adaptive Information Processing (AIP) model underlying EMDR assumes the integration of the traumatic memory into more adaptive neural networks.

One practically significant advantage of EMDR is that the method does not require mandatory homework between sessions, which distinguishes it favorably from classical cognitive-behavioral approaches. In wartime, this is important because clients are often in unstable environments and have limited resources for completing additional therapeutic tasks. EMDR can be applied in intensive or early intervention formats, which is important in crisis conditions (Shapiro, 2012). Studies show that using the method during the first weeks or months after a traumatic event may contribute to a rapid

reduction in distress symptoms and potentially prevent the development of PTSD (Jarero et al., 2015; Shapiro, 2012). When working with service members and individuals who have experienced combat events, an advantage of EMDR therapy is the possibility of processing traumatic memories without detailed verbal reproduction of the experience, which is significant in situations of moral injury, avoidance, or high distress (Bisson et al., 2013; Watts et al., 2013). At the same time, the application of EMDR has certain limitations. The method requires the client to be able to hold traumatic material in the focus of attention and maintain a sufficient level of dual attention, which may complicate the use of EMDR in cases of pronounced dissociation or low affect tolerance (Lanius et al., 2018).

Somatic Experiencing (SE) and Sensorimotor Psychotherapy (SP) are body-oriented approaches implemented primarily according to a “bottom-up” logic and aimed at regulating the autonomic nervous system, working with implicit memory, and addressing the bodily components of the traumatic response (Ogden et al., 2006; Payne et al., 2015). A significant advantage of these approaches is their greater tolerability when working with clients with complex or repeated traumatization, since they do not require detailed verbal reproduction of traumatic experience and make it possible gradually to restore psychophysiological regulation. They are especially relevant for individuals with pronounced somatized or dissociative reactions, as well as in cases of limited capacity to verbalize experience.

The application of SE and SP is associated with a number of limitations: insufficient standardization of interventions, variability of clinical protocols, and a relatively smaller number of randomized controlled trials, which complicates an unequivocal assessment of their effectiveness. Therapy outcomes depend substantially on the specialist’s level of training and capacity to work sensitively with the client’s bodily manifestations. Therefore, the evidence base for these approaches remains less developed than that for exposure methods, which gives rise to debates about their status within the standards of evidence-based psychotherapy (Watkins et al., 2018).

Thus, contemporary research demonstrates that no psychotherapeutic approach to trauma therapy can claim universality. Exposure-based and cognitive methods have a high level of empirical support, but their application is complicated in situations of complex, chronic, or repeated traumatization. Integrative and body-oriented approaches expand the possibilities of psychotherapeutic assistance, but require further empirical substantiation and a clearer definition of indications.

At this level of analysis, a methodological gap becomes evident: a substantial proportion of existing approaches work either with the already formed narrative of the traumatic event or with the bodily-affective consequences of the traumatic response. At the same time, the early, pre-cortical level at which the response to threat only begins to form—before the full unfolding of affect, cognitive appraisal, or dissociative defense—remains less well studied.

Deep Brain Reorienting (DBR) addresses precisely this level. It focuses on the early orienting components of threat responding and offers a logic of access to traumatic experience that differs from classical exposure models (Corrigan & Christie-Sands, 2020; Kearney et al., 2023). Despite the growing number of international studies on DBR—including a randomized controlled trial demonstrating the effectiveness of the method in reducing PTSD symptoms (Kearney et al., 2023)—this approach remains insufficiently represented in Ukrainian scientific discourse and has not yet received systematic theoretical and empirical examination. Hence the need for a separate scientific

analysis of DBR as a method that may potentially meet the challenges of psychotherapeutic work under conditions of chronic, repeated, and war-related traumatization.

The aim of the article is to conduct a theoretical-methodological and empirically oriented analysis of contemporary evidence-based psychotherapeutic approaches to working with psychological trauma, and to determine the place and prospects for the application of Deep Brain Reorienting as a neurobiologically oriented approach to trauma psychotherapy.

Presentation of the Main Research Material

In contemporary psychotraumatology, an approach is becoming increasingly clear according to which psychological trauma is not reducible to dysfunctional beliefs or maladaptive cognitive schemas, but has a deep neurobiological basis associated with disrupted integration between pre-cortical and cortical levels of information processing (Lanius et al., 2012; Panksepp, 1998). This view changes the optics through which trauma is understood: trauma appears not only as an experience to be interpreted, but as a mode of responding embedded in the functioning of the nervous system. In this context, traumatic experience is not so much the content of a memory as the reproduction of a certain sequence of threat responses that can be automatically activated in response to triggers. A significant part of these processes unfolds before conscious awareness and is therefore not fully accessible to verbal processing. This raises not only the question of what is being processed in therapy, but also at what level of the organization of experience this processing takes place. If key elements of the traumatic response form before cognitive appraisal, then access to them cannot be limited to narrative work alone. This mismatch explains the limitations of some evidence-based approaches and, at the same time, indicates the direction for seeking other solutions.

One approach that directly corresponds to this logic is Deep Brain Reorienting (DBR), which offers a different way of accessing traumatic experience—through work with early orienting responses and the neurophysiological processes associated with them.

The British psychiatrist and psychotherapist Frank Corrigan, the developer of this method, integrated within it achievements from affective neuroscience, attachment theory, and clinical practice. The emergence of the method is connected with the search for ways of influencing those levels of traumatic experience that remain insufficiently addressed within traditional cognitive-exposure approaches. In the Ukrainian context, DBR is currently represented primarily at the level of training programs and clinical practice (Center for Educational Projects “Tree of Knowledge”, 2026), while its systematic scientific conceptualization remains limited. In view of this, the present work is aimed at filling this gap.

The Neurobiological Model of Deep Brain Reorienting

Contemporary neurobiological studies demonstrate the key role of the brainstem and midbrain in the initiation and maintenance of traumatic symptomatology, particularly through disturbances in the regulation of arousal, affect, and the bodily sense of safety (van der Kolk, 2015; Lanius et al., 2017). At this level, primary orienting and defensive responses are formed; in the context of a traumatic event, they may become consolidated and subsequently reproduced automatically.

Theoretically, DBR is based on a model of relational and shock trauma (Corrigan & Christie-Sands, 2020). At its core is the idea that significant interactions activate systems of orientation, affective appraisal, and motivational engagement localized at the level of the midbrain.

Key components include:

- the superior colliculi, which provide rapid orientation toward a significant or potentially threatening stimulus;
- the periaqueductal gray (PAG), which shapes the affective valence of the situation and coordinates defensive responses;
- the mesolimbic and mesocortical dopaminergic systems, associated with seeking, motivation, and relational engagement (Panksepp & Northoff, 2009).

Under ordinary conditions, this system ensures flexible orientation in the environment, adaptive regulation of affect, and maintenance of social contact. In a situation of traumatic threat—especially when it is sudden, intense, or repeated—there is a sharp disruption of integration between these pre-cortical structures and higher cortical regulatory networks. As a result, a stable neurophysiological sequence is formed: “orientation – tension – shock – affect/dissociation,” which may later be reproduced automatically, beyond conscious control (Corrigan & Christie-Sands, 2020; Lanius et al., 2018). In this sense, the traumatic response is not a random disturbance, but a fixation of an unfinished process of orienting to threat. The nervous system, as it were, stops at the point where further processing of external signals becomes impossible. This arrest determines the subsequent reproduction of symptoms.

The Orienting Response as a Key Therapeutic Entry Point

A fundamental distinction of DBR is its focus on the orienting response, which precedes the full affective unfolding of the traumatic response. The orienting response manifests as a brief, often subtle muscular tension around the eyes, forehead, or the back of the neck and reflects the primary neurophysiological response to a significant stimulus.

In the presence of traumatic experience, at this stage the nervous system may become “stuck,” with further information processing blocked by a shock response or dissociative disconnection. Subsequent therapeutic work directed immediately at affect or the cognitive content of the event often occurs only after these defensive mechanisms have already been activated, increasing the risk of overload and retraumatization (Lanius et al., 2012).

DBR proceeds from the assumption that working specifically with orienting tension—before affect unfolds—enables a safer and more tolerable intervention. This approach makes it possible to influence the traumatic response at the level of automated neurophysiological processes that usually remain inaccessible to verbal processing.

The Logic of the Therapeutic Process in DBR

At the practical level, DBR involves gradual approach to a traumatically significant stimulus with a focus on bodily micro-sensations associated with orienting tension. The method has a clearly defined

neurophysiological point of intervention that precedes the unfolding of affect, rather than targeting already formed emotional or cognitive responses (Kearney et al., 2023). The client is not asked to describe the event in detail or deliberately intensify emotions. The work proceeds slowly. The client's state of regulation remains central. This distinguishes DBR from approaches that place the main emphasis on verbalizing experience and maintaining a dual focus of attention—when the person simultaneously touches traumatic material and remains in contact with the present moment. In DBR, this requirement is not determinative. Attention shifts to early bodily processes that precede affect (Corrigan & Christie-Sands, 2020).

Incidentally, there is a fairly common assumption that being able to talk something through is, in itself, helpful. Sometimes this is indeed the case. But in complex or repeated trauma, the situation is different. Repeated returns to the event do not always bring relief: clients become exhausted, tension does not decrease, and a sense emerges that “this is not working.” If the level of regulation is low, such retelling may lead to overload or renewed activation of the traumatic response (van der Kolk et al., 2007; Lanius et al., 2012).

In the DBR approach, detailed recounting is not required. The work is built around attentive tracking of bodily changes. This makes it possible to reduce tension gradually, without sharp peaks. Relief may emerge more quickly, and the process becomes more tolerable.

Empirical Evidence for the Effectiveness of Deep Brain Reorienting: A Randomized Controlled Trial

Deep Brain Reorienting is currently at the stage of forming and refining its evidence base. The main empirical confirmation of the effectiveness of Deep Brain Reorienting is a randomized controlled trial conducted by B. Kearney and colleagues, whose aim was to assess the effectiveness of DBR in the treatment of post-traumatic stress disorder (Kearney et al., 2023). The study included 54 adults diagnosed with PTSD, who were randomized into two groups: an experimental DBR group ($n = 29$) and a waitlist control group ($n = 25$). Participants in the experimental group received eight sessions of Deep Brain Reorienting therapy delivered by certified practitioners according to a standardized protocol for the method. The control group received no active intervention during the corresponding period. Sessions were conducted remotely via video link.

The primary instrument for assessing changes in the severity of PTSD symptoms was the CAPS-5 clinical interview, administered before the intervention, after completion of the therapy course, and at the three-month follow-up. Changes in individual PTSD symptom clusters were also analyzed.

The results of the study demonstrated statistically significant between-group differences in favor of the DBR group on the total CAPS-5 score after treatment and at follow-up. The effect was large (Cohen's $d = 1.17$ after treatment and $d = 1.18$ at the three-month follow-up), indicating not only statistical but also clinical significance of the observed changes (Kearney et al., 2023). In percentage terms, symptom reduction in the DBR group was approximately 36.6% from baseline after completion of therapy and 48.6% at follow-up, whereas no such changes were recorded in the control group.

It is important that a significant proportion of participants in the experimental group no longer met full diagnostic criteria for PTSD after the intervention, which underscores the practical value of the method. In addition, the rate of premature discontinuation was low, indicating good tolerability of DBR even in a remote format.

In the publication by A. Gerge (2024), the application of Deep Brain Reorienting (DBR) is examined in supervisory and consultative contexts of psychotherapeutic work, particularly for processing countertransference reactions in specialists working with traumatic symptomatology. Sixteen experienced trauma therapists participated in the study. They sought supervisory support because of experiences related to clinical work. They were offered participation in a brief DBR process within the consultation, after which the level of subjective distress was assessed using the SUDS scale before and after the intervention. The results demonstrated a statistically significant reduction in SUDS scores after the DBR moment, both in terms of immediate discomfort and anticipated emotional burden in subsequent sessions ($p < 0.001$), which was consistent with participants' oral and written reports of their experience ($p = 0.00003$).

For methodological synthesis of the findings and visual comparison of psychotherapeutic approaches according to the logic of access to traumatic experience, the level of neurobiological influence, and clinical relevance in the war context, a comparative characterization of the main methods of trauma psychotherapy was compiled (Table) (WHO, 2013; Cusack et al., 2016; Lanius et al., 2018; Kearney et al., 2023).

Table. Comparison of Evidence-Based Psychotherapeutic Methods for Working with Trauma

Criterion of comparison	Exposure-based approaches (PE, CPT)	Integrative approaches (EMDR)	Body-oriented approaches (SE, SP)	Deep Brain Reorienting (DBR)
Therapeutic entry point	content of the traumatic event	image + affect + bodily sensations	bodily reactions, impulses, regulation	orienting tension before affect/shock
Primary level of processing	predominantly cortical (top-down)	cortical-subcortical (integrative)	predominantly subcortical / autonomic (bottom-up)	brainstem-midbrain (pre-affective)
Need for exposure	high	moderate	low / no such necessity	no such necessity
Work with dissociative reactions	limited; requires stabilization	partial; depends on training	favorable within a phase-oriented approach	potentially favorable through access to shock
Risk of affective overload	higher	moderate	lower	lower
Empirical base	high	high	uneven / moderate	initial; RCT available
Clinical relevance in the war context	situational	situational	high	high (potentially)

Note. PE - Prolonged Exposure; CPT - Cognitive Processing Therapy; EMDR - Eye Movement Desensitization and Reprocessing; SE - Somatic Experiencing; SP - Sensorimotor Psychotherapy; DBR - Deep Brain Reorienting.

Interpretation of the Comparative Analysis

The comparative analysis showed that none of the evidence-based approaches works systematically with pre-affective orienting responses at the level of the brainstem. Most approaches are implemented either according to a “top-down” logic—through cognitive processing of experience—or a “bottom-up” logic—through work with the bodily-affective manifestations of an already formed response. At the same time, the level of initial orientation to threat that precedes the unfolding of

affect remains insufficiently addressed. This provides grounds for considering Deep Brain Reorienting as an approach that offers a different level of therapeutic influence—at the stage of formation of the traumatic response, before it unfolds into full affect or dissociation. This approach is consistent with a neurobiological understanding of trauma, according to which the nervous system retains the potential for self-regulation and recovery when access is gained to early levels in the organization of experience (Corrigan & Christie-Sands, 2020).

The War Context of the Study

The full-scale war in our country creates a unique socio-psychological context for studying the phenomenon of traumatization and for substantiating effective approaches to providing psychotherapeutic assistance. A defining characteristic of this context is the duration and unfinished nature of traumatic impact, which substantially limits the applicability of classical psychotherapeutic models oriented toward retrospective processing of events and actualizes the need for their theoretical reconsideration and methodological adaptation. War-related traumatization is accompanied by a set of symptoms in which bodily automated reactions, sleep disturbances, increased physiological arousal, difficulties verbalizing emotional states, and oscillations between hyperactivation and emotional numbing predominate.

Deep Brain Reorienting can be considered an approach that corresponds to this widespread demand and to these requirements, as it makes it possible to work with the traumatic response before its full unfolding while maintaining a sufficient level of safety and tolerability. Work at the level of orienting responses enables influence on early mechanisms of activation without the need for intensive immersion in traumatic experience. This is especially important under conditions of chronic and repeated stress. Given the specificity of combat experience, the high level of psychophysiological tension, and the possible difficulty of verbalizing traumatic experiences, DBR may be promising in work with service members and veterans. At the same time, its application in the Ukrainian war context requires separate empirical verification, in particular studies on Ukrainian samples of military and civilian individuals experiencing the consequences of prolonged and repeated traumatization.

Practical and Social Significance of the Study

The practical significance of the study lies in expanding the scientifically grounded toolkit of psychotherapeutic assistance for individuals with traumatic disorders under conditions of complex and repeated traumatization. The findings may be used by practitioners for the differentiated selection of psychotherapy methods, taking into account the client's level of psychophysiological regulation, the presence of dissociative manifestations, and the context of ongoing danger. This becomes especially significant when working with service members and veterans, for whom heightened nervous system reactivity, difficulties verbalizing traumatic experience, and the risk of overload in response to intensive forms of therapeutic intervention are characteristic.

The social significance of the study is connected with the current needs of Ukrainian society under conditions of war, particularly the need to ensure the resilience of the psychosocial support system, prevent professional burnout among helping professionals, and preserve human resources.

Substantiating the possibilities of integrating Deep Brain Reorienting into phase-oriented models of assistance may contribute to the development of safer and more adaptive approaches to psychological rehabilitation of the population, especially under conditions of prolonged and repeated traumatization.

Conclusions and Prospects for Further Research

The analysis conducted demonstrates that contemporary evidence-based trauma psychotherapy is characterized by a variety of approaches that differ both in their mechanisms of influence and in the level at which they work with traumatic experience. Exposure-oriented and cognitive-behavioral methods demonstrate high effectiveness within research studies; however, their application is complicated in situations of complex, chronic, or repeated traumatization, when the possibilities for verbalizing experience and sustaining affective tension are limited. Integrative and body-oriented approaches expand the possibilities of psychotherapeutic work, yet their effectiveness depends substantially on the conditions of application and the individual characteristics of the client.

The synthesis of the material prompts us, as researchers, to pay attention to a level that usually remains outside the direct focus of psychotherapeutic influence: early orienting processes that precede the unfolding of affect. It is likely that precisely at this stage the response is formed that later determines the character of its repeated reproduction. Most existing approaches are directed toward working with the consequences of this process, whereas the moment of its emergence remains only indirectly accessible.

Deep Brain Reorienting should be regarded as an approach that shifts the entry point into trauma psychotherapy. The specificity of the method lies in its orientation toward the process of formation of the traumatic response before it stabilizes in the form of affective or dissociative manifestations. This logic of intervention enables more cautious and differentiated work with those affected, which is of particular importance in situations of increased psychophysiological reactivity or limited affect tolerance.

The war context gives these conclusions particular practical weight. Under such conditions, traumatic experience often does not reach a stage of completion, since it is maintained by ongoing external circumstances. Accordingly, psychotherapeutic work is directed not only toward integration of what has been experienced, but also toward sustaining the capacity for regulation under conditions of prolonged tension. This leads to a reconsideration of the criteria for psychotherapy effectiveness, where, alongside depth of processing, maintaining functioning without overload becomes important.

Nevertheless, the results of existing empirical studies do not yet provide grounds for definitively determining the place of Deep Brain Reorienting within the system of evidence-based psychotherapy. The potential of DBR can currently be described as a promising direction that requires further study. In the Ukrainian context, systematic studies using Ukrainian samples are, unfortunately, not yet available. At the same time, the method is already being introduced into practice by specialists who have completed appropriate training with the developer of the approach and who apply it in work with clients, including those with experience of war-related traumatization.

This creates a basis for the accumulation of clinical material and subsequent empirical verification of the method's effectiveness.

In sum, one can speak of a gradual transformation in ideas about the logic of trauma psychotherapy: the focus is shifting from processing already formed experience toward an attempt to influence the process of its formation.

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