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Research Paper

In-depth consultation: Deep brain reorienting (DBR) as a potential tool for transforming countertransference reactions in trauma therapists

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Objective: To (*i*) explore whether or not the deep brain reorienting (DBR) method ameliorates countertransference reactions and distress in psychotherapists who provide trauma therapies and (*ii*) describe specific burdens on psychotherapists, who work with severe traumatization and dissociation.
Methods: All participants in this small, naturalistic study ($n = 16$) were experienced trauma psychotherapists who were in ongoing consultations. When they raised relational difficulties and/or distress related to their clinical work, they were offered an opportunity to process their reactions with DBR during the consultation hours. The participants' self-assessed experiences of discomfort before and after DBR processing were measured with the *Subjective Units of Distress Scale* (SUDS). They also provided verbal and written statements regarding their experiences after DBR intervention.
Results: SUDS ratings/values related to participants' experiences of discomfort before and after the DBR moment were all lowered ($p = 0.00003$, binomial calculation). Also lowered after the DBR moment ($p = 0.00024$, binomial calculation) were ratings related to how disturbing it was for the participants after their clients left their last session – compared to how disturbing the participants thought that it *would be* when their clients would leave the next session. These subjective ratings were aligned with the participants' summarized verbal and written statements.
Conclusions: Preliminary results are promising. Potentially, DBR seems to diminish trauma-generated countertransference and related reactions. Use of DBR during consultation must be further researched; interventions for ameliorating countertransference reactions have been requested in contemporary research. New knowledge must be further acquired and implemented in clinical work and consultation/supervision – regarding ways in which traumas affect the brain's functional networks and subcortical regions in those suffering severe traumatization (and vicariously their therapists). Whether or not DBR is a helpful method during consultations (among more inexperienced colleagues) should be investigated.

Introduction

As psychotherapists, we meet and share our clients' inner worlds including those who have developed trauma-related disorders. As trauma therapists, we share with our clients the aftereffects of natural disasters, human shortcomings, and deliberate malice – sometimes long before these events have become part of our clients' narratives. We cannot help everyone, and some of the experiences our clients share or unconsciously stage together with us are truly reprehensible. Sometimes we will be overwhelmed in these encounters. We then must manage our distress, feelings of frustration and helplessness, and our transference and countertransference reactions. Such reactions (made conscious) provide useful insights into the inner worlds of our clients and ourselves. They are important process tools, especially when the psychotherapeutic work is burdened by trauma-generated countertransference (CT). Therapists' skills (e.g., therapists who dare to be present with what is evoked and function as witnesses) may enhance opportunities for increased empathy, personal understanding, and redress for their clients. But these gains come at a certain price as described later.

To be a trauma therapist means being human in the face of inhumanity. And interventions are necessary – to be used in consultation and supervision to soothe the implicit experiences of working close to human traumatization and suffering that sometime defy narrative or logical expression. The deep brain reorienting (DBR) method (Corrigan & Christie-Sands, 2020) is one such possible, promising intervention.

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Trauma-generated countertransference

Countertransference (CT) has been conceptualized from different perspectives since Freud (1910/1957) and Sandor Ferenczi (1909, 1919) defined it as an unconscious phenomenon based in the therapist's unresolved issues; a view called the classical definition of CT (Hofsess & Tracey 2010; Kernberg, 1965). The contemporary expanded view of CT includes therapists' conscious and unconscious reactions to their clients. These reactions can become therapeutically counterproductive if they are unrecognized and unexplored (Bhola & Mehrotra, 2021). Then, heightened existential hopelessness might be resolved by withdrawal and isolation or by over-engagement (Wilson & Lindy, 1994; Wilson & Thomas, 2004). CT reactions are bidirectional and refer to the inter-subjectivity of the psychotherapeutic dyad of the client and the therapist (El Husseini et al., 2016; Shubs, 2008), which includes the totality of (unconscious) reactions of the therapist to the client and to the client's transference in therapy.

Although CT as a construct has its origins in psychoanalysis, there is agreement on what CT is and on its role in psychotherapy of different orientations (Gelso & Hayes, 2007; Hofsess & Tracey 2010) including CBT (Prasko et al., 2022). Gelso and Heyes (2007) defined CT as the therapist's feelings, cognitions, and behaviors occurring in response to dynamics in the therapeutic relationship, stemming from either the therapist's unresolved issues or from maladaptive behaviors elicited by the client. Such "maladaptive" behaviors often make sense when knowing more about the client's life experiences.

As per Cavanagh et al. (2015), therapists, who have experienced trauma in their lives and/or genealogy, showed stronger CT emotions and reactions, compared to therapists who had not experienced trauma. Of course these phenomena can also occur due to reactivation of the therapists' own primary traumas. Wilson offers a description (2004) of the interpersonal effects and processes in therapies with clients with PTSD. He particularly emphasizes trauma-specific CT reactions, see also (Kluft, 2009; Loewenstewin & Brand, 2023; Sinason & Silver, 2009) for descriptions of transference power and of CT phenomena in therapies with highly dissociative (and consequently severely traumatized) clients. Cavanagh et al. (2015) stated that those, who were still early in their careers, showed relatively low emotional and physical CT responses, because they tended to suppress strong reactions. These findings point to the importance of enhancing strategies for self-reflection and of addressing trauma-generated CT in supervision and consultation.

In work with adult violent-crime victims, Shubs (2008) found that empathic strain and vicarious traumatization affected clinicians. Data on CT in therapies with several types of complex traumatization show that basic transference patterns were negative and post-traumatic (e.g., in Vietnam veterans and incest and childhood sexual abuse survivors) (Davis & Frawley, 1994; 2009; Wilson, 2004). Both Type I CT (avoidance) and Type II CT (overidentification) (Wilson et al., 1994) and their respective manifestations burdened professionals. Such traumatic transference can be concealed and overtly avoided but can be paradoxically hidden in dangerous or otherwise high-risk behaviors – acting in and acting out to self or others (Kluft, 1994, 2017; Loewenstein & Brand, 2023). This can affect clinicians.

Ten, international, disaster-relief workers, who offered humanitarian aid, were interviewed; interpretative phenomenological analysis methods were used to analyze their responses. One finding was that "trauma calls into question the very identity of the therapist" (El Husseini et al., 2016). The therapists' bodies were affected – as indicted by physical symptoms they reported while working with clients on the trauma narrative.

Countertransference related to severe traumatization and dissociation

Early during treatment of severe secondary and especially tertiary structural dissociation (Steele et al., 2005), the therapists' capacities to know about what they experience in their inner worlds are crucial. When working with survivors of severe childhood traumatization and/or crimes against humanity, the premonitions of what happens in the client's inner world can be activated as parallel and multiple CT phenomena in the trauma therapist. Living in abusive relations earlier or later in life or being imprisoned and tortured, establishes a memory fragmentation mixture and personality changes (Howell, 2009; Howell & Blizard 2009; Liddell et al., 2022). Clients with complex PTSD and other disorders of secondary structural dissociation (Van der Hart et al., 2006), or diagnoses beyond those mentioned, have changes in their brains' functional networks (Dimitrova et al., 2024; Kearney et al., 2023a) and brain functions (Liddell et al., 2022; Teicher & Samson, 2016). These changes make their treatments more burdensome for themselves and their therapists. Information can manifest in flashes, phantasms, and night dreams with aggressive, sadistic, and/or bizarre content that differs from the therapist's habitual way of gaining information from her/his inner world.

In all three stages of trauma work with highly traumatized and dissociative clients, CT phenomena can occur because therapists may feel incapable of effecting change, partly because their clients' trauma histories are often disavowed. Clients with dissociative identity disorder (DID) may have switching self-states that embody trauma experiences. These can be projected onto the therapy and the therapist as trauma-based and dissociation-based CT. This type of CT phenomena is crucial to decode in trauma therapies, because as they provide information from which narratives can grow.

In the *stabilization and safety* stage (I), vehement dreams or flashes of the atrocities (when sitting with clients) can give therapists premonitions of the clients' experiences – even when clients claim that what they have been through has not affected them or that it has not happened.

Dimitrova et al. (2024) proposed heightened cognitive control and inter-identity avoidance of trauma-related knowledge in DID, because the frontoparietal network (central executive network) seems to be used to *not know* about the self. Instead, it is used to prevent the DID clients from finding out about themselves. So the therapy can be a game of not knowing, while therapists must withhold unbearable information until clients can bear to know it about themselves.

Strong CT phenomena can appear as beta elements (raw, unthinkable, unlinked sensations) as per Bion (1962). Through processing our CT, beta elements can transform into alpha elements (representable, metabolizable elements). Discrimination of a therapist's own different CT feelings requires the ability to make interpretations based on recognition of one's own emotional states, (Bateman et al., 2023; Laine, 2007) – a capacity hopefully heightened due to consultation with an experienced consultant, counselor, or supervisor. This applies already when the therapy still focusses on emotion regulation, grounding, safe stabilization, and during initial weathering of barriers put up by clients to cognitively and emotionally avoid traumatic material.

In the *trauma processing* stage (II), therapists may feel overwhelmed by the enormity of their clients' trauma histories – including ongoing traumatization where losses of function, agency, and memory can be used as information in ongoing sessions. This applies if therapists can recognize whether the activated state, emotion, or arousal level is a projective identification of the client's state or if it is of the therapist's own contribution. As per Loewenstein and Brand (2023), therapists can experience flashbacks and memories of what clients felt and thought during traumatic events.

In the *integration* phase (III), deep sorrow regarding all possibilities, which the traumatization made impossible, must be shared to open to the opportunities of the present and the future. Sharing the realization of lost time and wasted opportunities, places a certain existential burden on therapists, which leads to specific CT reactions.

The most burdened clients often fulfill criteria for a disorganized attachment (D attachment) style (Liotti, 2011), due to attachment wounds underlying their complex PTSD and trauma-related dissociative disorders (Kearney & Lanius, 2022; Liotti, 2009; Schore, 2009). Treating

sufferers of developmental adaptations to chaotic and abusive childhood experiences can be a chaotic and an abusive experience. And the deep pain of loneliness, which must be transformed when working with D attachment sufferers, will inevitably affect therapists and their mentalizing capabilities.

Hyperaroused clients use emotional under-modulation, whereby subcortical regions, such as the periaqueductal gray (PAG) and amygdala, are chronically activated. Then, the sympathetic nervous system's active-defense states (fight and flight) are easily triggered or continuously activated (Lanius et al., 2018; Terpou et al., 2019). When hyperaroused clients process threat through over-regulation of amygdala and PAG by higher cortical regions, this then leads to emotional detachment and heightened depersonalization and derealization levels. The latter client category often has more complex trauma histories and is prone to passive defenses and release of endogenous opioids, such as mu-opioids (Lanius et al., 2018; Terpou et al., 2019). This may be a partial explanation why therapists often describe drowsiness when they begin to work with severely dissociative clients.

As per Del Río-Casanova et al. (2016) a gradient regarding over and under-regulation can be seen in trauma-related disorders, where under-regulated clients (borderline personality disorder [BPD] and PTSD with re-experiencing and dissociative disorders with positive symptoms) are at one end of the continuum. Clients with somatoform and psychoform dissociative disorders (with mainly negative symptoms and emotional shutdown) are found on the other end. But over- and under-regulation might oscillate, even if one type might be predominant (Del Río-Casanova et al., 2016).

For the traumatized and dissociative victim(s), this process often occurs: Parallel to loss of the image of the world as a sufficiently safe place (if it ever was) follows loss of the experience of the self as competent and congruent. Such phenomena might occur (but to a somewhat lesser extent) in therapists who meet severely traumatized clients. And the therapists *will* meet these clients: complex PTSD has a 1–8 % population prevalence and up to 50 % prevalence in mental health facilities (Maercker et al., 2022). Dissociative disorders have a prevalence of 1 % to 5 % and DID is present in 1 % to 1.5 % in the general population, and the disorders are more common in clinical populations, albeit underdiagnosed (Brand et al., 2016; Hawayek, 2023).

In therapies with clients, who are severely traumatized by others, aspects of the internalized perpetrator may be experienced as an invisible but present force. Aligned with the drama triangle (Berne, 1966), this can contribute to therapists becoming (*i*) overcommitted: "I am the rescuer" or (*ii*) extremely unempathetic: "I am the perpetrator". They may also feel like the victim (rather than the client) by having to face the overwhelming, difficult material that the client brings to therapy (Figley, 1995ab; Gerge, 2011; Loewenstein, 1993; Loewenstein & Brand, 2023; Wilson, 2004).

Loewenstein and Brand (2023) give examples of CT in treatment of clients suffering from DID. This includes the power of the abandonment scenario, whereby clients in therapy act out unconscious or conscious experiences of not having been given what once was needed. Such trauma-related stagings can be reflected in the treatment room, which leads to therapists feeling overwhelmed, which might lead to therapists distancing themselves. Through such activated traumatic transference, the therapy can be experienced as dangerous by client and therapist. This seemingly maladaptive behavior can be seen as an attempt to enact dissociative distancing. If that strategy fails, the client may go into flashbacks and lose psychological distance and reality orientation (Loewenstein & Brand, 2023). Such processes can also be intertwined in multiple transference phenomena. For example, when sitting with a middle-aged DID client a strong tenderness toward an inner state of pre-school age can arise in the therapist. The state may hold memory fragments from early rapes, and this, and the tenderness of the therapist, can evoke disgust and terror in the client, in parallel with a longing for being cared for. At the same time, fright and repulsion toward the introjects of the internalized perpetrators can terrify therapist and client alike, and the therapist can be very worried, and physically alarmed by the client's severe ongoing self-harming, for example, sex as self-injury (SASI; Hedén et al., 2023). To navigate in these CT phenomena is not easy.

Moreover, highly dissociative clients may suffer negative dissociative symptoms, such as memory loss, emotional blurring, sudden loss of functions and skills – including motor and sensory functions and fainting attacks. They may also suffer positive dissociative symptoms, such as intrusions, flashbacks, and pain without an organic cause (Van der Hart & Steele, 2023). Through CT, the clients' positive or negative psychoform and/or somatoform dissociative symptoms will affect their therapists, during the moment when there may be several acknowledged or unacknowledged symptoms.

Trauma therapists' vicarious traumatization

The clinicians' experience of their clients' DSM-5 PTSD symptoms (American Psychiatric Association, 2013) can lead to secondary traumatic stress/vicarious traumatization (VT) due to indirect trauma exposure. The A4 criterion is also relevant for trauma therapists, who experience repeated or extreme exposure to aversive details of the traumatic event(s). Being in sessions, day after day, with severely dysregulated fellow human beings with attachment wounds and/or later traumatization will inevitably affect the psychotherapist working with complex trauma. The CT-driven impact of VT can consist of intrusive imagery, avoidance behaviors, negatively changed cognitions and heightened arousal (Aparicio et al., 2013; Mishori et al., 2014) aligned with the B, C, D, and E criteria of PTSD in the DSM-5.

VT has been used interchangeably with secondary traumatic stress to depict the manifestation of PTSD-like symptoms, such as hypervigilance, nightmares, anxiety, or intrusive images that might arise because of indirect trauma exposure (Canfield, 2005; Figley, 1995ab; Ludick & Figley, 2017; Stamm, 1995). But according to Dealton (2020) and Elwood et al. (2011), secondary traumatic stress is not specific to trauma work but rather, a construct relative to varying types of indirect trauma exposure. VT can occur as a short-term reaction to working with clients/themes or as long-term alterations in therapists' cognitive schemes, beliefs, expectations, and assumptions about themselves and others (Barros et al., 2020; McCann & Pearlman, 1990; Molden & Firestone; 2007). These reactions are natural responses to the highly demanding work with trauma material (Pearlman, and Saakvitne, 1995ab; Saakvitne et al., 1996, 2000).

VT is also labelled traumatic CT reactions whereby feelings of impatience, irritability, and sleep disturbances can occur (Davis, & Frawley, 1991; West, 2013). Other related concepts are (*i*) *compassion fatigue*, a condition in which the therapist's emotional overload leads to reduced capability in bearing the suffering of others (Figley, 1995ab, 2002; Ludick, & Figley, 2017) and (*ii*) *empathic exhaustion* due to the therapist's own vulnerability (Marini & Stebnicki, 2009; Stebnicki, 2008). Then effects such as grief, shame, and rage will affect therapists' meaning-bearing systems. This can happen out of empathy (Wilson & Thomas, 2004).

The ICD-11 (2018/2022) diagnosis of complex PTSD criteria of disturbances in self-organization (DSO) consists of dysregulations of central aspects of the self (Bachem et al., 2021). These can be hypothesized to potentially dysregulate therapists who work closely with clients who suffer from complex PTSD. But the therapists' own traumatic or adverse experiences might also be activated in the we-centered, shared space of therapy (Piedfort-Marin, 2019). Several of the interviewed trauma therapists in the Cavanagh et al. (2015) mentioned silence surrounding personal trauma, which poses major challenges in their capacity to conduct trauma therapy.

Impact of the other as a cause of vicarious traumatization, vicarious resilience and vicarious post-traumatic growth (VPG)

The affective responses to trauma work among helping professionals are positive and negative (Dalenberg, 2004; Deaton, 2020; Gerge, 2011; Pearlman & Caringi, 2009). When working as trauma therapists, our compassion fatigue (Figley, 2002) can change into vicarious resilience (Hernandez et al., 2007), compassion satisfaction (CF; Stamm, 2009), and vicarious post-traumatic growth (VPG; Arnold et al., 2005; Calhoun et al., 2006; Tedeschi & Calhoun, 1996), where moderate VT levels are the strongest predictors of VPG, and high levels impede growth (Tsirimokou et al., 2022).

In a phenomenological study of female psychologists treating survivors of sexual assault, specific types of vicarious trauma-related appraisals were found, including the therapist's self-blame, inequity guilt, shattered assumptions, intrusive re-experiencing, and disengagement (Padmanabhanunni & Gqomfa, 2022). The researchers found one resource-oriented relational theme, namely, re-appraisal of trauma work as a "sharing of the load".

Traumatized clients hypo- and hyperaroused states (Kearney & Lanius, 2022; Lanius et al., 2010, 2018) will impact their therapists. Then, the therapists' relational skills might weaken under the influence of clients' massive psychological traumata (Rothschild, 2006). Therapists' unconscious and neurophysiological driven strategies for managing this impact also includes the possibility of vicarious post-traumatic growth (VPG: Arnold et al., 2005). VPG is defined as the maturation of the personality due to being of help in transforming traumatic experience, even if it comes with the price of indirect trauma exposure. Therapists who work with complex trauma often report positive affective responses and a newfound purpose and meaning, possibly as an offspring to the conducted trauma work (Bartoskova, 2017). VT can be transformed in ways that lead to personal and existential maturity. Compassion satisfaction (CS; Stamm, 2009) is the sense of achievement or enjoyment stemming from one's ability to be of help and perform in a helping professional role. Similarly to vicarious resilience, CS is a vicarious benefit from the clients' improvement, personal growth, and therapeutic gains (Pooler et al., 2014). While negative effects of trauma can "spill over" to those who work with severe mental illness and traumatization, the potentially positive personality development of their clients can affect them and add to maturity and empathic development for the professional (Arnold et al., 2005; Shauben & Frazier, 1995). As therapists, we use our own personal resources to effectively work with trauma – unlike most other professions (Deaton, 2020). This daily use of empathy can potentially support development of fulfillment and satisfaction (Newell et al., 2016). Bartoskova (2017) investigated the experiences of VPG among trauma counselors. The result? Four domains: change in worldview, growth in self, making a difference, and finding personal ways to process the trauma. These domains seemed to have a buffering effect on empathic overload, anxiety, and depression related to secondary traumatic stress for the trauma therapists who were studied.

Consultation for overcoming trauma-specific countertransference (CT) and trauma specific dysregulation

Based on their work as consultants of therapies with Holocaust survivors and traumatized refugees, Lansen and Haans (2004) reported that they often experienced these themes when providing consultation on PTSD therapies: (*i*) problematic case conceptualization, partly due to cultural incompetence and (*ii*) overwhelming emotional impact. As per Pearlman and Saakvitne (1995ab), lack of support, lack of consultation, and overload can lead to VT.

Cavanagh et al. (2015) found that therapists got helped in dealing with CT issues through consultation, specialization, and support, see also Branson (2018) and Ashley-Binge and Cousins (2019) regarding how clinicians can overcome trauma-related cognitive and affective restrictions. Padmanabhanunni and Gqomfa (2022) and others, pointed to the central protective factor of trauma-informed consultation for those involved in trauma work. Consultation can enhance the therapists' ability to envision and mentalize the emotional reactions and life experiences of their clients and engender the same capacity in their clients. Awareness and reflectiveness of their own states and arousal levels might be particularly important to maintain (Bateman et al., 2023). Consultation can be of help in this endeavor, mitigate VT, and enhance vicarious resilience – thus helping to supply well-trained, self-reflective professionals who can stay emotionally present and help their traumatized clients (Reading et al., 2019).

Besides professional competence and understanding of the assignment, specific consultation is required on transference and CT phenomena activated in encounters with clients who suffer severe attachment wounds, complex traumatization, and dissociation (Gerge, 2011; Padmanabhanunni & Gqomfa, 2022). This especially applies when clients' problems and difficulties are a direct result of neglect and abuse.

In parallel with the profession-specific examination of the professional role, consultation should consciously promote well-being (Pearlman & Caringi, 2009; Siegel, 2010), because today, we more clearly understand risk factors linked to empathic exhaustion and VT. As supervisors and counsellors, we must develop and promote self-care and positive thinking, motivation, resilience, and the experience of agency in supervisees and consultees (Gerge, 2011). Independent of methodological orientation, conscious activation of curiosity and joy, playfulness, and reflection within consultations – with safe, clear frameworks – can considerably advance professional roles (Hawkins & Shohet, 2012; Marini & Stebnicki, 2009; Ronnestad & Skovholt, 2003; Scaife, 2008; Stebnicki, 2008). Most likely, consultation will be more effective – the more curiosity and compassion it activates (Gerge, 2011).

In their scoping review on existing interventions intended to address vicarious traumatization among service providers working with traumatized clients, Kim et al. (2022) found that interventions were generally self-care based and tended to focus on general stress reduction and health promotion rather than on specific VT effects. But the interventions generally showed positive effect in their key outcomes; interventions delivered over the longer term in a group setting showed the most promise in addressing service providers' VT symptoms (Kim et al., 2022). They also asked for development of tailored VT interventions in consultations.

Deep brain reorienting (DBR) in consultation

DBR (Corrigan and Christie-Sands, 2020) was investigated as a method to help trauma psychotherapists overcome difficult CT and client-related distress during consultation. In addition, reactions that otherwise potentially could lead to VT (such as clients' over- or under-regulation over time) will impact their therapists.

DBR is a psychotherapeutic approach that targets the ordered neurophysiological sequence conceptualized to occur in response to a traumatic event and/or dysregulation experience, and which persists when triggered (Corrigan & Christie-Sands, 2020). The method highlights how alterations of subcortical mechanisms of the midbrain and brainstem can be treated in post-traumatic conditions and in attachment wounds. DBR has been proven effective and well-tolerated in a randomized controlled trial with clients suffering PTSD/CPTSD (Kearney et al., 2023b).

DBR intervention consists of a sequence that includes (*i*) activation of an orienting tension (superior colliculus in the midbrain); (*ii*) search for shock/pre-affective shock (locus coeruleus in the brain stem); and (*iii*) affective responses (periaqueductal gray in the brain stem). The aforementioned regions of the brain's deeper levels are activated upon encountering obtrusive stimuli that activate behaviors oriented toward protective and survival-oriented action. These basic neurophysiological responses come before affective and cognitive components (Corrigan &

Christie-Sands, 2020; Lanius et al., 2020; Rabellino et al., 2015; Terpou et al., 2019).

Kearney et al. (2023b) stated that guided bodily awareness is not unique relative to other somatic-based psychotherapy approaches, e.g., *focusing* (Gendlin, 1978), *somatic experiencing* (Levine, 2010), and *sensorimotor psychotherapy* (Ogden et al., 2006). In somatic-based therapies (including DBR), changes in the embodied felt sense are tracked – as opposed, e.g., to clinical hypnosis in which metaphors and images (that might be embodied) are the vehicles of change.

Kearney et al. (2023b) stated that DBR is distinctive in several ways when compared to other methods. Due to DBR's capacity to harness knowledge of midbrain and brainstem neuroanatomy the method makes it possible to direct body awareness by means of a neurobiologically sound sequence. This allows pre-affective shock and emotional overwhelm to be transformed. In DBR, a trained therapist slows down, tracks, and attunes the response. Then enough critical time is given for the embodied memory to become dynamic and open to change, as each time we remember, we remember a new memory. Apart from the precise neuroanatomical sequence, DBR is a truly relational method. When the attuned therapist helps the person to hold initial, focused attention on the orienting tension, processing can occur in a more regulated manner than in traditional therapies (Corrigan & Christie Sands, 2020; Kearney et al., 2023b).

Method

Use of deep brain reorienting (DBR), as a part of psychotherapists' consultations, was investigated by a consultant accustomed to offering experiential methods as part of her consultations – after she had found the method valuable in previous consultations. A small, explorative, naturalistic study was undertaken to see if DBR could be helpful in consultations of therapists with CT reactions, negatively loaded emotional states, and experiences of feeling invaded and physically destabilized. Short-term reactions – in relation to clinical work with clients – were the focus of the intervention. Such reactions could, if not worked through, potentially lead to less effective treatments and affect therapists' ongoing wellbeing.

During six consecutive weekdays, the psychotherapy consultant offered therapists an opportunity to experience DBR in their ongoing consultations. The therapists specialized in complex trauma and dissociation, and they expressed heightened relational difficulties and/or experienced emotional overload related to their clinical work.

Four males and 20 females participated in consultations that involved DBR (individually or in groups); 16 out of 24 participants (67 %) were interested in using DBR to investigate transference and distress – mainly in relation to their clients who demonstrated personality trait morbidities apart from severe, withstanding traumatization. Four, out of the 16 participants who tried DBR, participated in web-based consultation; the others attended in situ. Group size varied from one to four persons.

All participants were certified professionals and seasoned trauma therapists who work with complex PTSD and structural dissociation (Van der Hart et al., 2006) in specialist psychiatry or in private practice. They are also eye movement desensitization and reprocessing (EMDR) practitioners (Shapiro, 2012), all with more than 20 years of clinical experience; see Table 1.

General focus of the consultations was on case conceptualization, risk assessment, and method development, including EMDR and clinical hypnosis/ego state therapy (Gerge, 2013; Watkins, 1978; Watkins & Watkins, 1997) on a relational psychodynamic basis.

Intervention

The 16 participants could choose a burdensome moment in connection with their work with a client or a related theme. Then an individual DBR process led by the consultant took place during the individual consultation or during the group consultation. The *Subjective Units of Disturbance Scale* (SUDS, 0–10) (Wolpe, 1969) was used as a measure of how disturbing the therapist experienced the client/the session and, respectively, how disturbing it had been when the client left the last session.

Table 1
Participants' professions and work experiences.

N(tot)=16 (100 %)*	
Certified clinical psychologists	9 (56 %)
Certified psychotherapists	14 (88 %)
Teachers of (and consultants in) psychotherapeutic work	11 (69 %)

* All participants were EMDR practitioners; each had 20+ years of clinical practice.

SUDS is a self-reporting scale whereby zero is not disturbing at all and 10 is very disturbing. The SUDS helps individuals subjectively evaluate their emotional and/or physiological distress; this widely used tool is implemented for self-help, psychology, and therapy. It assesses the level of distress or activation in an individual's nervous system. SUDS is regularly used in EMDR and CBT (Benjamin et al., 2010; Kiyimba & O'Reilly, 2020), and thus well known by the EMDR therapists in this small explorative, naturalistic study.

After the end of the DBR moment, the therapist was asked about how disturbing, (rating 0–10) it now was to think of the client, respectively, how disturbing it will be, when the client leaves the next session. Thus, a projection into the future (Torem, 2017) was used. Use of the SUDS and the projection into the future is not part of the DBR method, but it was used as an outcome measurement in this study.

Procedure

DBR was used in its basic structure, the orientation-tension-affect sequence, which can be considered as the DBR standard protocol. For each of the participants, who chose to process their CT or other aspects of distress with DBR, the DBR part took less than 20 min, mostly around 10 min.

The selected initial activating stimulus focused on a poignant moment of the participant's encounter with the client or concerns about the client. After an initial localization of the participant in the here and now – through a grounding exercise specific to DBR, an orienting tension on the upper face or neck provides an anchor in the part of the memory sequence that occurred before the shock or emotional overwhelm. With this anchor, the DBR process occurred and pre-affective shock was transformed (if needed). Release and change of basic affects toward more positive affects followed as per the orientation-tension-affect sequence. The DBR part of the consultation was closed when no residual tension or distress remained. Then the participant was asked for a new perspective. Finally, the therapist was asked to be with the embodied new perspective as much as possible over the following three to four hours, thus enhancing new learning.

Then the participant was asked about (*i*) how disturbing it now was to think of the client (rating between 0 and 10) and (*ii*) how disturbing the participant thought it would be when the client would leave the next session (using future projection, rating between 0 and 10).

The participants were given an opportunity to send a short reflection on how they felt during some of the upcoming days during the next week.

All therapists gave approval to having their processes and numbers used in this manuscript.

Results

Overall, DBR used in consultation seemed to reinstall participants' emotional and cognitive capacities as their embodied felt sense changed and stabilized. This change supposedly happened due to potential

transformation of pre-affective shock at the brainstem level and changes from a negatively loaded periaqueductal gray (PAG) to one with heightened levels of oxytocin in the brainstem – during the DBR process.

SUDS changes – related to the experience of the client before and after the DBR moment – were all lower. The changes resulted in $p = 0.00003$ (binomial calculation). In addition, changes were related to how disturbing it had been when the client left the last session, compared to the assessment of how disturbing the participant thought that it would be when the client would leave the next session; here, ratings were lower after the DBR moment. The probability of that change of measures was less than 0.001 ($p = 0.00024$, binomial calculation).

These subjective scorings were aligned with the participants verbal statements during their DBR processes. Tables 2 and 3 display the changes.

At the end of DBR processing and in their new perspectives, almost half of the therapists (7 out of 16) spontaneously mentioned what could be called healing imagery and the connection to nature, pouring waters, blue sky, trees, free horizons, and broader views. This can be seen as metaphors of an embodied felt sense of having space and freedom and not feeling invaded. Thus an antidote of being hooked in CT.

Three vignettes as examples of the DBR processes undertaken and the hypothesized subcortical changes

Example 1. where a load of negative basic affects likely had activated the columns of the periaqueductal gray (PAG) in the brain stem, and DBR helped the participant to activate more positively charged affects after a brief transformation of pre-affective shock at the locus coeruleus (LC) level:

The participant is an experienced clinical psychologist, psychotherapist, and consultant working in specialist psychiatry. She is accustomed to working with complex traumatization and dysregulation. She feels helplessness related to the risks and the suffering of her client with CPTSD/dissociative disorder/EIPS/eating disorder/recurrent depressions and three suicide attempts. The client has evoked strong CT in the therapist.

Activating stimuli: *My worries concerning this client.*

The participant's frustration eases as pre-affective shock initially transforms the negatively loaded effects – such as worry – to compassion. *There is little left of my frustration, it's almost gone. The questions that come up in me is the waste. She has so many resources and such weaknesses. I would love to help her.*

New perspective: *It's calmer now. I know what to do and I really want to help her.*

The *Subjective units of disturbance scale* (SUDS, ratings, 0–10) was initially used as a measure of how disturbing the therapist experienced the client/session, namely = 7 and lowered to = 2 after DBR. Regarding the therapist's estimation of how disturbing it was when the client left the session, the rating was initially = 6 and, when thinking of how disturbing it would be after next session, the SUDS lowered to = 0 after DBR.

Example 2. where pre-affective shock and negative basic affects are transformed through the brainstem, LC, and PAG being activated as the shock response and tenseness of the neck/back eases, then a shift – to more positive affects – occurs:

The seasoned psychotherapist-consultant works in a psychiatric specialist unit with war and torture victims. The client is a middle-aged woman from a country with a lot of deserts and mountains. She is very hard to treat, and the therapist feels helplessness and despair (just as the client does). The client does not reveal past events, and she doesn't remember anything. She is illiterate and does not answer any questions regarding her symptoms. She has a massive phobic avoidance and strong somatoform dissociative symptoms, including a hand with convulsions that lives "a life of its own".

Activating stimuli: *That which my client evokes in me when I'm thinking of her.*

In DBR processing, the participant initially squints her eyes and feels aridity and blowing wind. The image is transformed, and the participant sees a deep stream of water that moves and flows. More life comes into the image, and she becomes more mobile around her eyes. The participant experiences more distance and can look out over an arid landscape (in her inner experience. She looks away toward the mountains and gets a completely different overview. She experiences more life in her body and feels that it is calmer around her forehead; it becomes brighter and more open in her and she can move her neck, that previously was very stiff due to the shock response that recoiled her head position. Now her neck stretches, and she feel good.

New perspective: *The feeling of stress and frustration has decreased, and I have a greater perspective.*

At the start, SUDS = 9 lowered to = 0 after DBR. When the client leaves session, at the start, SUDS = 10 lowered to = 1 after DBR.

Example 3. Where pre-affective shock is transformed through the brainstem being activated (i.e., LC), then a shift to more positive effects occurs at the PAG in parallel with a deep reregulation:

The participant is an experienced clinical psychologist, psychotherapist, and consultant working in specialist psychiatry. He describes being very affected from meeting a young female client and not really knowing what affects him. The client has been in criminal circles since early teens. She has experienced massive violence and has considerable attachment wounds, mostly linked to betrayal on the part of her father.

Activating stimuli: *That what I don't understand in myself regarding this young client.*

In DBR, the embodied sensation of the participant's experience of being "inadequate" is processed. Pre-affective shock releases through vibrations and shivering. The participant sees a connection between the

Table 2
Themes observed at the start of participants' DBR processes.

At the start + under initial DBR processing:	N(tot)=16 (100 %)
Dissatisfaction of not being of better help	8
Frustration regarding unreflective clients	8
Concerns regarding clients' high risk	4
Personal issues activated	4
Not getting enough support	4
Countertransference	9
Feeling diminished	2
Helplessness/despair	9
Sadness	8
Aggressivity/rage	5
Fear	1
Shame	2
Feelings of being invaded	7
Out of balance	8
Tenseness/pain	7

Table 3
Themes observed at the end of the participants' DBR processes and within their new perspectives.

DBR process conclusion and within the new perspective:	N(tot)=16 (100 %)
Retaken cognitive function	12
Agency	7
Curiosity	4
Compassion	6
Joy	6
Pride	1
Safety	8
Felt sense of embodied freedom	10
Calmness	11
Relaxation	9
Stability	11
Spontaneous nature scenery	7

client's issues and something with his own father. When the bodily sensations calm down, a strong healing imagery emerges, and it becomes easier to breathe. The participant feels calmer and healthier.

New perspective: *Her difficulties with bearing everything she has been through has affected me too. But it's my stuff that gets activated. I can let it go.*

At the start, SUDS = 5 lowered to = 0 after DBR. When the client leaves a session, at the start = 5 lowered to = 2 after DBR.

Short reflections summary

The participants who chose to process with DBR could send a written reflection regarding their experience during the following week. Those who gave their reflections afterward (n = 11, out of 16) highlighted healthy borders (9), stress reduction (6), lessened negative affect (6), heightened agency (5), realistic assessments (4) and curiosity (3) as withstanding gains after the DBR moment of their consultation; see examples:

Example A. I think about and talk about the case in a more creative way. I am more engaged, clear-headed, and hopeful. I'm engaged but not over-engaged with frustration like I was before. Simultaneously, I'm more aware of what we cannot help this client with.

Example B. For me it still isn't disturbing, because now the focus is on solving and not letting myself be invaded by the person's feelings. DBR served as a reminder inside for another case as well. Now I can move back and forth in my consciousness and observe, based on what is going on in the (therapeutic) process. Overall, it worked for me.

These and the others' reflections are aligned with the participants gains at the end of the DBR processing part of the consultations. These gains seemed to have persisted at least a week after the participants processed their distress using DBR. Such resourcing changes can be considered as an antidote to the impact of being with highly dysregulated clients daily, a quest that potentially can lead to VT (intrusive imagery, avoidance behaviors, negative changes to cognitions and heightened arousal). One of the participants mailed me some weeks later this reflection:

> I don't know if this is an effect of the recent DBR, but I think so. During DBR, I saw pictures from nature (yes, I'm a nature person). During the past weeks when I have worked through something strenuous (both during and after), it is as if I'm in a form of "direct recovery". I see/experience a strong, beautiful landscape and the feeling of it in my body. It is as if I'm going to a safe-place exercise at the same time as I'm working on something stressful/exhausting. I don't know if it's due to all EMDR that I'm conducting in sessions … but I believe more in the DBR effect.

Discussion

Due to the findings and the feedback (in direct connection with the intervention and mailed feedback) during the following week, use of the DBR intervention in consultation seems well worth further investigation. The participants' reflective, compassionate, creative capabilities seemed to be reinstalled as the embodied felt sense changed to an experience of freedom, calmness, and stability. All important aspects of what helps therapists build alliances with clients.

The described change supposedly happened due to a transformation of pre-affective shock at the brain stem level. Then the negative, basic affects of a negatively loaded PAG could change due to heightened oxytocin levels in the brain stem. When DBR, as is hypothesized, eases and stabilizes the brain's deeper regions, and specifically the PAG and the LC of the brainstem, higher cognitive functions stabilize.

A finding from this small, explorative, naturalistic study contrasts with the findings of Bhola and Mehrotra (2021). They found that the more experienced therapists were less likely to give their client special status or be over-concerned or over-involved with them. The experienced therapists reported lower levels of helplessness and inadequacy during sessions. They were less likely to report a sense of being overwhelmed and experiencing negative and avoidance feelings toward their clients with borderline personality disorders (BPDs). In this small study, all therapists were very experienced, but they chose to process experiences of being overwhelmed, invaded, worried, and/or frustrated by their clients in the DBR. It might be that the clients of the participants had higher levels of comorbidities. And subsequently, that the CT derived from the impact of massive traumatization, dissociation, and personality disordered traits in the clients created a more toxic mix (Luyten et al., 2021).

Bateman et al. (2023) hypothesized and found that individuals with concurrent BPD and PTSD, compared to BPD-only clients, will be identifiable by greater BPD severity, more severe dissociative tendencies, and histories of childhood trauma, leading to compromised mentalizing. These clients also met a broader range of BPD diagnostic criteria and self-evaluated their well-being as considerably diminished compared with clients diagnosed with BPD-only. The BPD-PTSD group more frequently expressed feelings of worthlessness and disturbances of self-function related to compromised mentalizing capacity (Bateman et al., 2023). Thus, the price of "being with" this category of clients can be hypothesized to add a stronger empathic strain on therapists, and consequently heighten their need for help to sort out CT material – also on an embodied, felt-sense level.

Most of the participants in this sample chose to process aspects of their clinical work with clients, where they experienced their clients' personality disorder traits more problematic than their clients' post-traumatic conditions. The temporarily activated physical dysregulation and feelings of helplessness, sadness, anger, and shame could be seen as CT reactions regarding their clients' complex PTSD and/or personality traits. The massiveness of the clients' traumatization (severe neglect, rapes, violence, torture and war-experiences) could be reasons for negative impact on the participants. Interestingly enough, the participants reported that it was the personality disorder traits "on the top of the pile" that they felt were most overwhelming.

Aligned with Bion (1962), we can transform the raw beta elements into alpha elements, then the mental content can be recalled and consciously represented. Then we can manage our CT reactions in safer, more professional ways. DBR seemed to be of help in this undertaking and can supposedly add to therapists' capabilities to recognize dissociation among psychiatric populations. Dissociation is, according to Boyer et al. (2022), an under-recognized and under-treated disabling condition.

As we mature in our roles as psychotherapists, we can develop a preserved or strengthened foundation of values. It is often distinguished by the following: A sense of belonging with other living beings, a moral and ethical anchoring, a realistic assessment of one's own capacity, and gratitude for being able to help (Arnold et al., 2005). As distress turns into growth, development of coping strategies, work satisfaction, and a sense of purpose can expand (Tsirimokou et al., 2022). These factors are aligned with the new perspectives mentioned by the therapists who experienced DBR as a part of their consultations. And in their statements submitted days later, they reported greater access to feelings of meaning and hope, agency, and curiosity.

Conclusion

This study focused on whether or not DBR can potentially help participants counteract emotional overload, inclusive CT, and client-related distress when used in consultations. It investigated whether or not DBR mitigated short-term reactions stemming from working with highly dysregulated clients. Even if the study's results and reflections are anecdotal, they are promising. Aligned with the call for increased efforts to tailor vicarious traumatization interventions to different service

settings and participant characteristics, use of DBR during in-depth consultation seems valuable for experienced trauma psychotherapists and ought to be further researched. Use of DBR in consultation seems to offer an antidote to the impact of clients' dysregulation on therapists. DBR (*i*) opened pathways from distress and potential vicarious traumatization (VT) to professional resilience and (*ii*) recaptured curiosity and agency.

DBR consultations with trauma therapists can help them transform the impact of their trauma-generated CT on cognitions, emotions, and behaviors – including longstanding physio-psychological dysregulation. Strategies for enhanced, embodied reregulation seems to be beneficial for experienced trauma therapists, as suggested in the participants responses. Potentially, DBR seems to contribute to a process during which positive affects and resources are freed, after overwhelming aspects of the CT (such as pre-affective shock and negatively loaded affects) have been transformed. Then self-understanding and professional agency seem to be recaptured.

By consciously embracing and exploring (rather than turning away from and warding off) trauma-influenced states of our clients and other stakeholders, we can grow in humanity and our empathy can deepen. DBR seems to be a valid tool when changing our responses to overwhelming clinical situations.

Flaws and possible further development

A mayor flaw of this small, explorative, naturalistic study is that the researcher was the one who carried out the intervention, and the one who wrote the manuscript. Another flaw is the absence of a control group. In further research on use of DBR in consultation, the interventions undertaken should be teamwork, where roles are not mixed together. A two-prong research design should be used with a more well-structured evaluation with suitable assessment tools before and after the DBR intervention. The SUDS can be part of such broader screening. A longer follow up with adequate assessments is also warranted.

In this small study, most of the clients that activated the therapists' trauma-generated CT and distress fulfilled criteria for complex PTSD or at least the dissociative subtype of PTSD – if not more severe dissociative symptomatology. But the clients' diagnoses where made based on varying screening instruments. Not all clients were formally diagnosed regarding their personality disorder traits, so we do not know exactly what kind of dysregulation the therapists were in contact with. Whether or not these traits were separated from the clients' complex PTSD is not investigated nor is whether or not the clients' mix of hypo-arousal and hyper-arousal added to the dysregulation of their psychotherapists – even if it could be hypothesized.

Further research is warranted on whether the therapists' experiences of being overwhelmed stemmed from the encounter with the clients with personality disorder traits plus traumatization, from the mix of hypo- and hyper regulation and/or dissociation, and multiple transference phenomena. And whether or not the reported distress stemmed from CT, empathy, heavy workload, activated personal issues and/or certain other personal burdens (Nissen-Lie et al., 2021) could and ought to be problematized in further studies.

Whether or not DBR works with less experienced therapists is not investigated; this also should be studied.

Valid tools for measuring how the impact of clients' mix of hypo-arousal and hyper-arousal add to the dysregulation of their psychotherapists ought to be developed.

Valid tools for measuring how the complex PTSD criteria of disturbances in self-organization (DSO) impacts clinicians should be developed.

Assessment tools for measuring transference issues on preverbal levels and/or felt-sense levels ought to be developed (if transformation of pre-affective shock and other midbrain and brainstem-influenced states, as hypothesized, are important in the described processes). To the author's knowledge they do not exist. Such instruments should be updated in relation to a neuro-affective understanding of human appraisal processes, as the "felt-sense" of trauma is expressed in non-verbal, sensory-based, action-oriented forms.

Overall, new knowledge regarding the functional networks of the brain and the impact of traumata on our nervous systems ought to lead to a rethinking of CT and which methods we need to incorporate in consultations with trauma therapists. Maybe now is the time to rethink multiple transference phenomena, not only as ongoing parallel dissociative and unconscious processes aiming at warding off pain, but as information given from different parts of the dysregulated nervous systems of our fellow human beings, i.e., our clients. Especially if they suffer from the dissociative subtype of PTSD, complex PTSD, and developmental trauma disorder, whereby the attachment has been traumatizing (Spinazzola et al., 2018; van der Kolk, 2005) or a dissociative dysregulation beyond these conditions – a dysregulation on brain stem level – can be hypothesized (Corrigan & Christie-Sands, 2020; Kearney & Lanius, 2022). Being with such dysregulations will inevitably put its mark on therapists. If further researched and developed, DBR and other methods (for ameliorating such impact in supervision and consultation) can add considerably to our capabilities to counteract therapists' CT phenomena and distress.

CRediT authorship contribution statement

Anna Gerge: Writing – original draft, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

None.

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Supplementary materials

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