

Deep Brain Reorienting (DBR) Quick Reference Card

A Clinical Guide for Trauma-Informed Practice

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Core Principles

Principle	Description
Brainstem-Level Processing	Trauma is stored in the deepest brain structures (midbrain, brainstem), not just the cortex. DBR works at this level.
Orienting Before Affect	The orienting response (tension in eyes, forehead, skull base) occurs BEFORE shock and emotion—this is the therapeutic anchor.
Visceral Shock	Trauma creates “implosive energy” in the brainstem that must be processed, not just emotions or cognitions.
Memory Reconsolidation	Traumatic memories become temporarily labile during processing and can be updated with new information.
Therapeutic Presence	The therapist’s attuned presence is neurobiologically active, counteracting the aloneness at the core of trauma.

“Keep it as slow as possible to pick up those first shock sensations.” — Dr. Frank Corrigan

The DBR Sequence

Step 1: Stimulus/Trigger

What Happens: Client brings attention to traumatic memory or present-day trigger

Clinical Notes:

- Ask client to bring memory to mind without fully immersing
- Notice shifts in breathing, posture, facial expression
- Goal is activation without overwhelm—titrate as needed

Dr. Corrigan: “Turning toward it as much as possible without overwhelming yourself.”

Step 2: Superior Colliculus Activation

What Happens: First brain structure to initiate movement response; directs eye movements toward stimulus

Clinical Notes:

- SC response occurs in milliseconds—faster than conscious awareness
- This is the “collicular self” responding to potential threat
- Eye movements may be subtle or suppressed but neural activation still occurs

Dr. Corrigan: “The first structure capable of initiating a movement response is the superior colliculus, which can direct eye movements.”

Step 3: Orienting Tension (KEY THERAPEUTIC ENTRY POINT)

What Happens: Physical tension in muscles around eyes, forehead, base of skull

Clinical Notes:

- Guide client to notice sensations in these specific areas
- This tension occurred BEFORE the shock or emotional overwhelm
- Staying with this tension provides anchor that prevents being swept away
- For any jolt or gross movement, ask about picking up sensations around that

Dr. Corrigan: “That might be the orienting tension, but do you notice anything in the muscles around your eyes, forehead, or the base of your skull?”

Step 4: Therapeutic Anchor Point

What Happens: Focus on orienting tension BEFORE shock/overwhelm emerges

Clinical Notes:

- Deepening awareness into orienting tension provides grounding
- Client is neither overwhelmed by emotions nor disconnected
- This is the “safe harbor” for processing traumatic material
- Keep it slow—rushing past this point loses the therapeutic anchor

Dr. Corrigan: “Keep it as slow as possible to pick up those first shock sensations.”

Step 5: Shock/Affect Emerges

What Happens: Visceral response from PAG and NGC emerges safely

Shock Markers to Watch For:

- Stomach dropping (“cold shock” from dorsal PAG)
- Hollowing out
- Chills
- Pressure behind the eyes
- Electrical charges
- Shutters or shivers

Clinical Notes:

- Allow shock to be fully in awareness without rushing to resolve
- For HIGH arousal dissociation: use release breathing (long, slow out-breaths)
- For LOW arousal dissociation: presence only—do NOT use release breathing

Dr. Corrigan: “When you notice if there is anything passing fleetingly through the body—any electrical charge, any shutter, any shiver, any pressure behind the eyes, any hollowing, or any emptying—if you notice that, let’s just be with that.”

Step 6: Processing & Integration

What Happens: Processing emerged material with therapist presence

Clinical Notes:

- Your presence is a neurobiological intervention activating connection systems
- Instruct client to hold NEW PERSPECTIVE for 3-4 hours post-session
- This window allows memory reconsolidation to update the traumatic memory
- New learning must be held in awareness during reconsolidation window

Dr. Corrigan: “Staying aware of giving it time and space—but also being here with the client during processing.”

Key Brain Structures

Structure	Location	Function in DBR
Superior Colliculus	Midbrain	Initiates orienting response; directs eye movements; “collicular self”
PAG (Periaqueductal Gray)	Midbrain	Source of visceral shock; dorsal PAG = “cold shock” (stomach drop); ventrolateral PAG = freeze
NGC (Nucleus Gigantocellularis)	Medulla	“First responder” to alarming stimuli; generates implosive brainstem shock
NTS (Nucleus Tractus Solitarius)	Medulla	Part of Protoself; receives vagal input about internal organ states
PBN (Parabrachial Nucleus)	Pons	Part of Protoself; processes pain, temperature, interoception

Session Language

Establishing the Where-Self

- “Can you feel your feet on the floor?”
- “Notice the support of the chair beneath you.”
- “What do you notice about your body in space right now?”

Accessing Orienting Tension

- “Do you notice anything in the muscles around your eyes?”
- “What about in your forehead or the base of your skull?”
- “That might be the orienting tension—can you stay with that?”
- “For any jolt or gross movement, can you pick up sensations around that?”

Working with Shock

- “Let’s just be with that sensation.”
- “Notice if there’s anything passing fleetingly through the body.”
- “Any electrical charge, any shutter, any shiver?”
- “Any pressure behind the eyes, any hollowing, any emptying?”
- “If you notice that, let’s just be with that.”

Processing

- “Staying aware of giving it time and space.”
- “I’m here with you during this.”
- “What do you notice now?”
- “Keep it as slow as possible.”

Closure

- “Hold this new perspective for the next 3-4 hours.”

- “This allows the memory to update.”
 - “Notice what’s different now.”
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Dissociation: Two Types, Two Approaches

High Arousal Dissociation

Presentation: Anxiety, panic, hypervigilance, racing thoughts, agitation

Intervention: Release breathing (long, slow out-breaths)

Rationale: Activates parasympathetic system to reduce arousal

Low Arousal Dissociation

Presentation: Numbness, shutdown, freeze, collapse, feeling far away

Intervention: Presence ONLY—do NOT use release breathing

Rationale: Release breathing would deepen the withdrawn state

Critical Clinical Note: Correctly identifying the type of dissociation is essential. Using the wrong intervention can worsen the client’s state.

Core Concepts

The Protoself

A foundational layer of self, deeper than the core self. A collection of neural patterns mapping the organism’s physical structure, generating primordial feelings—the simplest variety of affect.

Primordial Feelings

The simplest variety of affect that springs up spontaneously from the interior of the organism. These feelings have a valence ranging from pleasure to pain.

Core Aloneness Pain

The deep, aversive experience of being alone and disconnected underlying complex trauma. Felt physically as a “presence of absence”—a deprivation creating emptiness and hollowness.

Visceral Shock

An “implosive energy” generated in the brainstem (particularly NGC) in response to alarming stimuli. Manifests as stomach drop, hollowing, chills, pressure behind eyes, electrical charges.

Memory Reconsolidation

A neurobiological process where reactivated long-term memories become temporarily labile and can be modified before being re-stored. DBR leverages this to transform traumatic memories.

Complex Trauma Modifications

Extended Stabilization

Complex trauma survivors need robust grounding before any deep work.

- Establish Where-Self thoroughly before proceeding
- Build capacity to notice orienting tension without overwhelm
- Multiple sessions may be needed for stabilization

Pacing and Titration

Work with smaller doses of activation.

- Touch activation briefly, return to resource
- “Homeopathic doses” of trauma work
- Honor the body’s pace—don’t rush

Working with Dissociation

Be alert to dissociative responses and respond appropriately.

- Correctly identify HIGH vs. LOW arousal dissociation
- Use appropriate intervention for each type
- Establish grounding protocols before beginning

Addressing Core Aloneness Pain

The “presence of absence” is central to attachment trauma.

- Therapist presence is the primary intervention
 - Oxytocin-mediated connection systems counteract aloneness
 - Don’t rush past this—it needs to be felt and witnessed
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Key Glossary Terms

Term	Definition
Orienting Tension	Physical tension in muscles around eyes, forehead, skull base—the therapeutic entry point
O-T-A Sequence	Orienting-Tension-Affect—the core DBR processing sequence
Protoself	Foundational layer of self generating primordial feelings
Visceral Shock	Implosive brainstem energy from alarming stimuli
Collicular Self	Aspect of self associated with superior colliculus and orienting
Where-Self	Sense of body in space, in present moment
Core Aloneness Pain	Deep experience of disconnection underlying complex trauma
Presence of Absence	Experience of caregiver absence as active, felt deprivation
Release Breathing	Long, slow out-breaths for HIGH arousal dissociation only
Memory Reconsolidation	Process where reactivated memories become temporarily modifiable

Founder & Historical Context

Dr. Frank Corrigan developed Deep Brain Reorienting, integrating neuroscience of the brainstem and midbrain with trauma therapy. DBR is grounded in the work of Antonio Damasio (Protoself, primordial feelings) and Jaak Panksepp (affective neuroscience).

Key Insight: Trauma is stored not just in the cortex but in the deepest brain structures. The orienting response that occurs BEFORE shock and emotion provides a therapeutic anchor for processing.

Foundational Texts:

- Deep Brain Reorienting: Understanding the Neuroscience of Trauma, Attachment Wounding, and DBR Psychotherapy* (Corrigan, Young, Christie-Sands, 2024)
- Self Comes to Mind: Constructing the Conscious Brain* (Damasio, 2010)

- *Unlocking the Emotional Brain* (Ecker, Ticic, Hulley, 2024, 2nd ed.)

Evidence Base:

- First RCT published 2023 (Kearney et al., European Journal of Psychotraumatology) showing significant decreases in PTSD symptoms after eight internet-based sessions
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Professional Organizations

- **DBR Training** - Official training through Dr. Frank Corrigan and associates
 - **Coherence Psychology Institute** - Memory reconsolidation training
 - **International Society for the Study of Trauma and Dissociation (ISSTD)**
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This quick reference card is intended as a clinical aid and does not replace comprehensive DBR training. DBR requires specialized training in brainstem-level trauma processing.

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