Talking about Trauma and Emotion-Focused Therapy with Dr Sandra Paivio

Dr Michelle Webster *

Dr Sandra Paivio is one of the developers of Emotion-Focused therapy particularly applied to complex relational trauma. Dr. Paivio is a practicing clinical psychologist, Head of the Psychology Department, and Director of the Psychotherapy Research Centre at the University of Windsor in Canada. She is an internationally recognised scholar and therapist with more than 20 years of experience. Dr. Paivio is an invited member to the American Psychological Association (APA, Division 56) Committee, which aims to develop treatment/best practice guidelines for complex trauma. She given a Lifetime Achievement Award (2014) by the Trauma Division of the Canadian Psychological Association for her work on complex trauma.

Dr. Paivio is the author of numerous publications and conference presentations on psychotherapy and problems related to trauma. She has co-authored two books, *Emotion-Focused Therapy for Complex Trauma* with Antonio Pascual-Leone and *Working with Emotion in Psychotherapy* with Leslie Greenberg, both published by the APA. Her research has focused on evaluating the efficacy of Emotion-Focused therapy and on in-session processes of change. She has been extensively involved in clinical training with graduate students and professionals, and maintains a part-time clinical practice.

Dr Sandra Paivio came to Australia and New Zealand in 2011 to lead a series of two-day workshops dealing with the nature of complex trauma and the central roles of attachment relationships and emotional processes in the development of disturbance. She presented the Emotion-Focused Therapy for trauma (EFTT) treatment model, how EFTT addresses central features of disturbance, and the distinctive features and advantages of EFTT compared to other treatment approaches (including the general model of Emotion-Focused therapy).

* Dr Michelle Webster, Director, Institute for Emotionally Focused Therapy.
Address for correspondence: Michelle@EFTherapy.com
Webster, M. (2015) Talking about Trauma and Emotion-Focused Therapy with Dr Sandra Paivio.
EFT-Online, First edition, Volume 1, No.1, October, 2015

Michelle: *Sandra, it's lovely to have you in Australia and we welcome you to the Institute for Emotionally Focused Therapy.*

Sandra: It's lovely to be here.

Michelle: *It would be great if we could chat about some of the things that you have been doing and what has emerged from the workshops you conducted in New Zealand and Australia. Maybe a place to start would be your involvement in Emotion-Focused work. Can you tell us a little bit about that?*

Sandra: Well, it could be a very long story or a very short story, but originally I was a visual artist and I

needed to make a career change. I did a lot of research and psychology emerged as something that I might like to do. Originally I was in a Masters program where I was introduced to Emotionally Focused Therapy (EFT). My research on process outcome studies led me directly to Professor Leslie Greenberg who then took me on as a doctoral student.

Michelle: *What attracted you to EFT?*

Sandra: The ideas really resonated with me partly because of my background with the arts. Like Les, I also liked the research aspect – the combination of being able to do therapy and examine therapy processes was extremely attractive.

Michelle: *You've been working mainly in the area of trauma – was there something about trauma compared to the process-experiential work with the*

general client population that especially interested you?

Sandra: I think that was quite serendipitous because it was a function of doing my PhD dissertation where I completed an outcome study on unfinished business. There was a sub-group of people in that client sample who were dealing with complex trauma – that word wasn't used at that time – and I just found the processes very interesting, in terms of trauma. It was very rich work in terms of emotional processes. In addition we tend to think of trauma as, "it's going to be all horrible and distressing", but it's also exposure to tremendous human strength and resilience. I just found it incredibly rich work. At that time there was also a gap in the research literature, there was almost nothing in terms of outcome research in the individual therapies.

Michelle: *Are there any differences in processes or outcomes with the different abuse types such as verbal, physical or sexual abuse?*

Sandra: My understanding is that there are specific differences in terms of sexual abuse and sexual dysfunction, physical abuse and aggression, aggressive behaviour to name a few, but there are also a lot of commonalities in terms of the damage that those very negative attachment relationships have on self-esteem, trust in relationships and so on. I think there are many similarities and the approach that I have taken addresses the similarities.

Michelle: *Is there anything in particular for the physical abuse group, or can you use the core processes for them?*

Sandra: Yes, you can use those core processes. The research I've been doing is more concerned with screening people for particular symptoms rather than for diagnostic categories or types of abuse. If somebody's main presenting problem is severe aggression, they would not be appropriate for the type of work that I do. They would need to work with that problem somewhere else, and then they might be ready to do EFT for trauma.

Michelle: *For the research, you are looking for a group that has common dimensions or common symptoms.*

Sandra: I think it's more than the research. I also think in terms of suitability for a short-term treatment. EFTT is a short-term, trauma-focused treatment with 20 sessions designed to help individuals resolve trauma issues. If a person is not ready for trauma work, they need to be doing something else.

Michelle: *In the trauma work that you've been developing with EFTT, you've been calling it "imaginal confrontation" (IC), as compared to "empty-chair" work. Can you speak about that?*

Sandra: I think that from the very beginning, one of the things that I wanted to do is to make EFTT more accessible to practitioners from other theoretical orientations. I think a term like "empty-chair" is aligned with Gestalt theory and practitioners from other modalities might be turned off. In order to speak to a wider audience and to people affected by trauma, I wanted to use terms that were accessible to a wider audience and so imaginal confrontation seemed appropriate. In addition, it was also the idea that the empty chair work for trauma was performing an exposure function as well as an interpersonal function.

Michelle: *Has using the term "imaginal confrontation" (IC) been successful in that practitioners have been able to take on these ideas?*

Sandra: Slowly but surely. I think the proof is in the pudding as they say. Having been invited to be on an American Psychological Association (APA) panel with Judith Herman, Francine Shapiro and Christine Courtois developing treatment guidelines is recognition that EFT definitely has something to contribute to the whole area of complex trauma.

Michelle: *In your research you've discovered that some people really work well with IC, but there's a group that doesn't do so well. What have you designed for them? How have they been helped?*

Sandra: About 25% of clients were not able to participate in the IC intervention so we developed a comparable procedure, "empathic exploration" (EE). It follows the exact model of resolution and intervention principles to parallel imagined confrontation as closely as possible, but without the chair. I'm not sure I'm so happy with that title, but the main intervention would be empathic responding to client feelings and needs, only without the chair intervention.

Michelle: *It's imaginal because you're still asking them to have the perpetrator in their mind's eye?*

Sandra: Exactly. I thought, "maybe it's also IC, only without the chair", but it's actually still about evoking trauma feelings and memories. So increasing arousal and evoking that material is a central part of it.

Michelle: *Can you explain why making arousal so significant is important in Emotion-Focused work? What is the aim there?*

Sandra: From both an emotion theory and a trauma perspective, the theory of emotional processing is that emotional schemes or trauma memories or, if you like, cognitive structures need to be activated. These emotion structures need to be activated in order to be available for change. It's not until they're activated, up and running – alive – that change can occur and new information can be brought to bear.

Michelle: *Some people call them "hot emotions". What enables a change to occur?*

Sandra: I think there are a number of things that take place. One of them would be simple desensitization, where people tolerate and learn the difference between remembering and actually experiencing again, so they learn to tolerate trauma feelings and memories. Once material that has been avoided, that has not been available for exploration or for construction of new meaning, is open in the therapy session, clients can start talking and processing things with the therapist, to arrive at a new perspective of their previous thoughts and beliefs and feelings.

Michelle: *Does this connect with the very important phrase that you "change emotion with emotion" and that clients are able to access other reactions and emotions they couldn't have otherwise? Rather than having fear and shame, they may have adaptive anger or sadness?*

Sandra: I think that is one process. I think that is what Leslie Greenberg calls "emotional transformation" – where anger would help to transform emotions such as shame and fear. Because of the fear and other emotions, and high arousal during trauma, information is not processed and people have distorted beliefs around, "I should have done something", "I should have done something to solve it, why didn't I do something", or "I was somehow complicit, I was to blame", and those sorts of things. It's not until they go back into those memories and

can re-experience from the inside out that the inner dialogue changes to, "No, I was utterly powerless", "There was nothing that I could have done to change that", "I didn't want that to happen", and "I was in no way complicit." So I think that's an important change process as well.

Michelle: *How does working through one's experience align with the other trauma models? When you think about Babette Rothschild and John Briere, is EFTT in the same park so to speak?*

Sandra: I think there are a lot of similarities, but I think EFTT explicitly emphasises the importance of emotion and adaptive emotion in transformation and change. It is a very fine-grained understanding of emotional processes; an explicit focus on emotional processes and healthy emotional processes is unique to EFTT.

Michelle: *In the workshops that you conducted in New Zealand and Australia, some participants were talking about the processes around regression and inquiring about whether you thought about the client in terms of adult and child parts. Where are you with that kind of language?*

Sandra: Those discussions with you and others were very interesting as I have not explicitly thought in terms of regression, but I have explicitly thought in terms of responding to the most vulnerable parts of clients and seeing clients as highly vulnerable. I very often see my clients – I don't see them as children – but I see them almost as if they are children in the sense of being their most vulnerable self, and I respond to that most vulnerable part of themselves.

Michelle: *Would you respond to that part of them differently compared to the part of them that's more assertive or more adult?*

Sandra: I think so because they're much more vulnerable, fragile and in need of nurturing and support.

Michelle: *Would the response be more empathic, maybe gentler or slower?*

Sandra: I think softer, more mothering, more nurturing, gentler.

Michelle: *When you think about your practice and the practices of practitioners you supervise, do you think that's a more intuitive process, as compared to maybe a marker driven process?*

Sandra: I don't know… maybe it's just a different way of framing the markers because I think markers of vulnerability are definitely explicated and I do talk specifically about the importance of responding to client vulnerability. But my understanding of empathic attunement – excellent empathic attunement – is that you are attuned to when the client is most vulnerable and you respond to that appropriately, whereas you would respond differently if you were attuned to a client who was feeling very assertive.

Michelle: *If I was using the theory of regression the marker that I would think about is, 'who is to be re-experiencing?' Is the adult now looking back on the experience, which is not really a re-experiencing, or would it be that you're inviting the adult to remember or to re-experience that trauma? If the latter is occurring we are actually inviting the person emotionally to be at the age of the trauma. In addition, sometimes when clients are just talking about the trauma they can drop into the experience – suddenly they're there and they lose their adult functioning. So when clients are re-experiencing, "who" in the client do we want to re-experience, if that makes sense?*

Sandra: Who in the client?

Michelle: *Who in the client.*

Sandra: Well, I guess if the client is re-experiencing his or her self as a child then we are wanting them to…that is who.

Michelle: *In doing imaginal confrontation, when clients are putting the perpetrator in their mind's eye or in the chair are we wanting the adult to be dealing with the perpetrator because we can end up with the child in the chair facing the perpetrator?*

Sandra: I think you could do both. I think in some circumstances it would be not very safe to get the child to be dealing with the perpetrator. If it were safe for them to be dealing with them, healing could take place through the child self in dealing with the perpetrator.

Michelle: *What I have experienced in clinical practice is that at times when clients go into imaginal confrontation they often drop into the experience, they become regressed, and often people have…*

Sandra: Sure, they change. You can hear vocal quality change.

Michelle: *That's right. Sometimes people start to speak as an adult and then they find themselves in a child place and they don't have the facility to do the confrontation. Often inexperienced therapists feel that you've got to get this confrontation happening quickly, but maybe the client doesn't have enough adult ego strength. In our practice here at Annandale, we've done a lot of work on what the markers are that tell us that the client is not ready and how to help them hold the child part and be an adult in the empty-chair or the imaginal confrontation. This seems to be a bit of a difference with the Canadian approach in terms of incorporating regression into that process.*

Sandra: Although I certainly have worked with clients where you could see that they have regressed in the sense that you can hear it in their vocal quality, and I guess it would be an intuitive sense that confrontation would not be appropriate. They would be working with me until such a time as they felt stronger and bit by bit, perhaps coming from their adult self to confront the perpetrator.

Michelle: *What you are saying is that in EFTT work you are warming up the clients by having them remember the experience. You're not wanting them to re-experience it, you want them to remember it.*

Sandra: Well, I want them to re-experience it in the sense that I want them to feel how they felt in terms of if they felt helpless or vulnerable or disgusted or whatever. I would want them to re-experience, it's more than just remembering, it's actually very much alive.

Michelle: *OK, but you would want them to hold adult functioning while they do that, is what you're suggesting?*

Sandra: Yes.

Michelle: *I guess that is the difference between what you are doing and what we are doing in the Annandale approach.*

Sandra: Yes, I don't work with that regressed state.

Michelle: *Well it's interesting then to think about some clients who might actually be screened out because they're not ready and whether that group might end up becoming more regressed, I don't know.*

Sandra: Well, that's possible, although the people who were not able to do IC

were still in the research program. I think there's tons more work to do for these people were who were not able to do the IC. For some of them that could have been the reason, others I think it is performance anxiety, so it had nothing to do with re-experiencing per se. We don't really know yet.

Michelle: *Of the 25% who couldn't do the IC and went into the EE group, how successful were they in that?*

Sandra: It's not like that. People who were in the research were assigned either to IC or to an EE condition. In the original study before we developed EE for people who couldn't do IC, we would intuitively try and get them to do trauma work without using the chair. They were not as successful, so we know that. That was one of the original findings that the better they were engaged in IC, the better they did in that therapy. But then one of the questions was "did they do better because…?" It could have been that the people who did less well maybe thought they were in an inferior treatment condition because they couldn't do IC, or maybe their therapist thought that this default thing was not as good so maybe that accounted for them not doing as well, so we wanted to test this EE using the randomised trial.

Michelle: *And the results for the EE?*

Sandra: The results for the EE using the randomised trial were that they were pretty comparable. But again, we know, we haven't finished analysing that data so we know that there were a certain number of people even in the EE condition who could not do EE. They can't do trauma work, period, whether its IC or EE. And so we have to look at who those people are, what is the percentage of people, and what are the reasons for that.

Michelle: *Yes, and do they need something else prior to going into this?*

Sandra: They're not ready for trauma work. We just don't know yet what those reasons are.

Michelle: *One of the comments people often have is the movement between chairs and that people can be quite active, they can move backwards and forwards a number of times or they can put a different person in the chair according to where they're up to. Do you have any thoughts about the frequency of movement, whether that's difficult or easy, or it doesn't matter whether they do it once or five times?*

Sandra: I'm not sure it matters how much. Some people don't like to be in the other chair at all, and I'm not sure that it's really necessary that they actually do that, as long as they can imagine the perceptions of the other and how the other would be, and are responding to their perceptions of how the other would be. I think the only thing is you wouldn't want a person hopping back and forth so many times that it's confusing and chaotic. So I don't think it would be effective moving back and forth too much.

Michelle: *When you look at Emotion-Focused work and trauma, where do you see it going? You are right at the edge of looking at something very important which is the EE process. If you had a crystal ball, where do you think EFTT is going to take us in the trauma work in the future?*

Sandra: I think it's going to move to – not necessarily about trauma work per se – I think it is going to do more work in terms of Axis II people with personality disorders, and more long-term therapy.

Michelle: *As a long-term practitioner myself, I wonder about how we can do research in long-term therapy and have*

control groups or whether other kinds of therapy are offered. Do you have any thoughts as a researcher about how one would get around that long-term dilemma?

Sandra: The only thing that comes to mind is comparing EFTT to other treatment models, to cognitive behavior therapy (CBT) or eye movement desensitization and reprocessing (EMDR) for complex trauma. And, similarly, I also think teaming up with other long-term treatment models. For instance, I have a colleague doing dialectical behavior therapy (DBT) with borderline clients. With research funding she has compared DBT to the standard psychodynamic model where the treatment went for a couple of years. I think those are the kinds of projects that we need to work towards.

Michelle: *In your travels throughout New Zealand and Australia, you've got to meet a number of different practitioners, all with an interest in – and a lot of them who are passionate about – Emotion-Focused work. Is there anything that you would want to recommend to this audience as a result of your tour?*

Sandra: I would want to recommend publishing; to write and disseminate information about what you're doing. It feels very rich what's happening over here and I can't say we are very aware of it outside of the EFT circle.

Michelle: *Thank you Sandra, it's been lovely being with you on this tour and talking with you. I hope EFT in New Zealand and Australia has a long association with you too.*

Sandra: Thank you so much, it's been a pleasure.

