A Dialectical Perspective of Trauma Processing

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Abstract:

This article presents a dialectical perspective, which attempts to elucidate the integrative components of trauma processing in therapy. It is proposed that the inherent movement toward greater integration is an expanding dialectical movement. It is conceived as a spiral resulting from the synergy of two dialectical movements. The horizontal line moves between the opposite aspects of the individual (thesis vs. antithesis) toward a synthesis. The vertical line moves upward via whole/part shifts toward greater integration, or downward toward disintegration and fragmentation. It is proposed that the complementary processes of differentiation and linking are the building blocks of the integrative/dialectical movement. Differentiation relates to the separation of parts and linking relates to their connection. The role of differentiation and linking in three basic interacting systems of trauma work is discussed. It is proposed that the dialectical principles are applicable to various therapeutic approaches and clinical vignettes are included to illustrate.

Key words: dialectical therapy, integrative therapy, mindfulness, dual awareness, trauma processing. EMDR, voice dialogue.

In this article a dialectical perspective is suggested which elucidates the integrative components of trauma processing in therapy. Trauma is regarded as any event that has a lasting negative effect on the self or psyche (Shapiro 2001). It includes not only “Big T traumas” such as the shattering experiences of earthquakes or war, but also any of the ubiquitous experiences of childhood that can qualify as “Small t traumas” like humiliation or abandonment. Cvetek adds to “Small t traumas” life difficulties such as divorce or unemployment if “…recalling them from memory still causes a certain degree of anxiety and brings forth negative images, feelings, and cognitions that were present at the time of event” (2008, p.2).

The dialectical principles of three major systems of trauma work will be discussed; the therapeutic relationship, Mindful Dual Awareness (MDA) and integrative trauma processing. The dialectical perspective can be helpful for therapists of various approaches in understanding and using dialectical principles in their clinical work.

The dialectical perspective

Bopp and Weeks (1984) present a thorough description of dialectical principles in systems. Its essentials are that motion inherently proceeds in an unfolding process of thesis, antithesis and synthesis. The synthesis is not a simple sum of both but entails a transformation. Motion is a developmental process having an end-state toward which change proceeds. This process is not linear but a function of reciprocal interactions. The universe is seen as a vastly differentiated organism in which interacting systems are organized hierarchically with phenomena being parts of larger wholes.

The dialectical movement between opposites

The dialectical tension between opposites is a universal phenomena which is expressed in nature (darkness vs. light) as well as in various levels of the individual such as the sensorimotor (inhaling vs. exhaling), the emotional (happiness vs. sadness) and the cognitive (worthiness vs. unworthiness). The dialectical perspective, rooted in Eastern (Watts, 1963) and Western (Rychlack, 1968) philosophy, plays a significant role in different therapeutic approaches both ancient (Harner, 1990) and modern. Both Jung (1963) and Perls (1959) discuss various polarities in the psyche. Psychosynthesis (Assiagoli, 1965) and Voice Dialogue (Stone & Winkelman, 1985) deal with opposing sub-personalities. Somatic Experiencing (Levine, 1997) relies on the natural movement between the "trauma vortex" and the "healing vortex." Dialectical thinking is predominant in Linehan's (2006) dialectical behavior model for borderline clients. Systemic family therapy is based on dialectical principles (Bopp and Weeks, 1984) and many family therapists have specifically elaborated these concepts (Pepp, 1994; Hoffmann, Gafni & Laub, 1994; Hoffman & Laub, 2006); Almagor, 2011). Laub & Weiner (2007) in their pyramid model proposed that the integrative movement in therapy is dialectical and moves in a spiral (fig.1). This article further elaborates these dialectical concepts.

A dialectical perspective of integrative trauma processing

Integrative trauma processing is based on the tenet that there is an inherent tendency of the individual to move toward self-actualization (Maslow, 1970; Rogers, 1951) and greater integration (Piaget, 1970; Klein, 1976; Koestler, 1978; Wilber, 1996, Siegel, 2012). Siegel (2012) suggests that there is a self-organizing tendency of systems to move toward maximizing complexity and harmony. It is proposed that this integrative movement toward well being and wholeness is dialectical and proceeds via the tension between the opposite aspects of the individual toward a new synthesis. Levine (1997) relates to this as the universal law of polarity "… which is available to us as a tool to help us transform our traumas" (p.119).

Trauma processing is conceived as a developmental process based on the synergy of two inherent dialectical movements, horizontal and vertical (Laub & Weiner, 2007). The horizontal moves between opposite aspects of the individual such as a sense of threat vs. safety, or dependence vs. independence. This movement enables the client to relate more flexibly to her opposites and see them within a new whole. The vertical movement consists of expanding levels of integration, which enable the client to shift from a partial perspective of her experiences to a more complex and whole perspective. It is proposed in this article that this expansion moves via whole/part shifts, in which a whole becomes a part of a greater whole, which then transcends the former one (Koestler, 1978; Wilber, 1996). For example an intrusive sensation becomes part of a wider emotional experience that expands further to include cognitive understanding. During processing, the parts of traumatic experiences are gradually integrated into a whole; a coherent autobiographical story. According to our perspective disintegration and fragmentation resulting from trauma (Janet, 1925) reflect a disruption of the dialectical movement while trauma processing attempts to restore it.

Siegel defines integration as "linking differentiated parts into a functional whole" (Siegel, 2012, p. 9). It is proposed that from a dialectical perspective differentiation and linking are complementary processes that are at the core of the integrative/dialectical movement. Differentiation relates to the movement to be apart from, to separate, to distance, to put a boundary. Linking relates to the movement to be a part of, to connect, to get close, to identify with. They are also referred to as separation and connection (Klein, 1976; Pipp, 1990; Laub & Weiner, 2007), autonomy and intimacy (Bowlby, 1973) individuation and fusion (Bowen, 1978), self-definition and interpersonal relatedness (Blatt, 1995), agency and communion (Wilber, 1996).

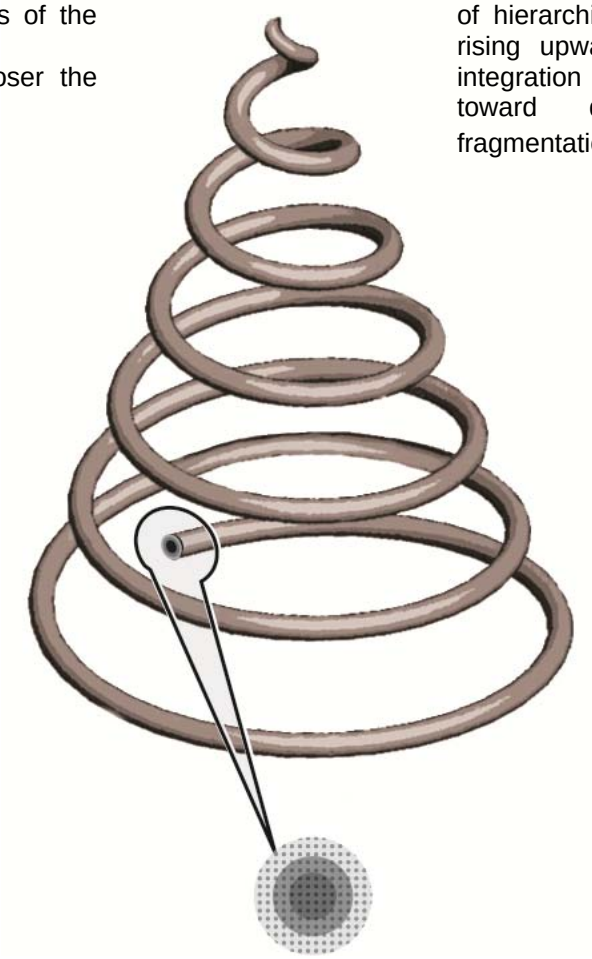
As clients focus on their inner experience, associative connections begin to be activated. These differentiate the condensed traumatic experience into different parts promoting new links. The way this process unfolds depends on the client's trauma history, her resources and the nature of the therapeutic relationship. Differentiation and linking are illustrated in the following example. Itamar came to EMDR (Eye Movement Desensitization Reprocessing) therapy (Shapiro, 2001) after a recent car accident. In EMDR therapy the client begins by focusing on a traumatic event while receiving Bilateral Stimulation (BLS) and then relates his associations to the therapist. At first Itamar focused on being hit suddenly in his chest. He recalled the strong pain and feeling choked. He also felt sadness for himself at having to go through such suffering. He then noticed that the intensity of his distress was somewhat reduced. A little later he recalled the compassionate man who took him out of the car. As processing proceeded, the suffocating sensations were associated with early memories of his fear of diving and suffocating from asthma. In this example the condensed sensation of being hit began to differentiate into many parts; the pain, the choking, the fear and the sadness. It also began to link to some relief and to new positive elements

of the traumatic event such as the compassionate man who helped him. Further associative connections expanded to memories of his childhood with a domineering mother with whom he felt "choked." He differentiated various aspects of his loneliness, suffering and constriction as a child. As he connected to his earlier traumatic experiences, new links to positive memories also came up. He linked to his inherent joy in companionship and self- expression.

The synergy of the horizontal and vertical dialectical movements, consisting of differentiating and linking associative connections, is depicted as a spiral (fig.1). The spiral of integration narrows as the gap between opposite aspects of the individual gets smaller and they begin to be perceived as parts of one whole.

Fig. 1 *The spiral of integration - results from the synergy of horizontal and vertical dialectical movements*

Horizontal dialectical movement between opposite aspects of the individual.
As the opposites get closer the spiral narrows.



Vertical dialectical movement of hierarchical whole/part shifts rising upward towards greater integration and downward toward disintegration and fragmentation.

A session with another client illustrates the spiral movement. Sharon came to therapy and complained of feeling trapped in her marriage, especially on weekends when there was a lot of tension. The therapist used the Voice Dialogue method (Stone & Winkelman, 1998) in which it is assumed that the client has a multitude of parts that are not harmoniously connected. The therapist helps the client become aware of these parts and makes them accessible by interviewing each part. The client, in the role of the part, sits in a different place and links to the energy, feelings, thoughts and memories of this part. As the client links to these they become more differentiated. When the client returns to her seat the therapist invites her to identify the opposite part. She chooses another seat and this part is interviewed. In this process some parts with which the client is over- identified become more differentiated from her, and others to which she is less connected, begin to be more linked.

In this meeting the therapist helped Sharon access the part of her that wanted to run away from situations in which there was stress and conflict. She felt it strongly in her stomach and was asked to focus on that. It became clear that she identified strongly with this part, which had been very important in her childhood. This part helped her leave the house when her parents where fighting at home. As Sharon focused inward she recalled many situations in which the part had suggested avenues of escape. She also became aware of the link of this part to her sense of aliveness stating, "I gave Sharon the option to breathe." When Sharon returned to her seat the therapist asked her to focus inward and access the less acknowledged opposite part. She called it the coping part, which told her to stick around and see things more in proportion. After Sharon moved to another seat the therapist talked to the coping part. She told the therapist she believed she helped Sharon stay in work situations when there was a lot of tension. The therapist asked the coping part where it had learned this and it answered immediately, "I am like her Dad. Her Dad never ran away when Mom was nervous or depressed."

With more work in therapy Sharon began to move more flexibly between these opposing parts, accepting them both as important aspects of her. As she externalized the running away part and linked to it, she differentiated her condensed sense of being trapped in various experiences and linked these to her past. She also made a new link to her sense of aliveness when she could escape. Similarly, as she linked to her coping part she also differentiated it, noticing when it functioned well, and where and from whom she had learned to use it. As the horizontal dialectical movement between her running away part and her coping part became more flexible, an upward vertical shift took place in which she was able to contain both. In this wider, more whole perspective she could envision staying in her present family during stress and still feel alive and well.

It is proposed that the vertical whole/part shifts relate to *sensorimotor*, *emotional*, *cognitive* and *spiritual* levels of information (Wilber, 1996*).* Each higher level includes the previous one and transcends it. Ogden, Minton & Pain

(2006) adopted the first three levels in their conceptualization of sensorimotor therapy. Another whole/part sequence proposed in the memory consolidation process after recent trauma (Shapiro & Laub 2008; Laub & Weiner, 2010) moves from a *fragment*, to an *event*, to an *episode* which includes many events, to a *theme* which organizes many events, to an *identity* with many themes. Both expanding sequences interact closely. This is illustrated in a session with Ron who asked for therapy two months after a fire ruined his house. In the adapted EMDR protocol for recent trauma (Shapiro & Laub, 2008) Ron first focused on his sensations of discomfort (*sensorimotor fragment*) while staying at the shabby apartment of his neighbor who hosted him. On the first set of BLS, his associations were mostly sensory differentiating his discomfort into his difficulty with taking a shower in the neighbor's dirty bathroom and eating in the messy kitchen. After additional BLS sets he seemed calmer and said, "Now it occurs to me that she (the neighbor) was very distressed by the fire and didn't change the table cloth." This new adaptive link reflected the expansion of the horizontal movement from the sensorimotor opposites of discomfort and relief to the more complex *emotional* opposites of criticism and acceptance in the *episode*. This facilitated a vertical shift in which he could integrate the opposites of cleanliness and dirt, and see the neighbor from a wider perspective. "The other rooms were in order and only the bathroom and kitchen were shabby but not dirty." Later his processing shifted to the *cognitive* level expressed in his ambivalence between authentic gratitude and rigid obligation. He wanted to put boundaries on his need to compensate his neighbor so as to be authentically grateful. This was another vertical shift in which he began to balance gratitude and duty in a more integrated way (*a new theme organization*). The expanding nature of the whole/part sequences can be more easily seen in recent trauma processing, than in non-recent trauma work where the levels of integration may overlap more.

Differentiation and linking processes in the therapeutic relationship

The dialectical/integrative movement in therapy develops within an attuned therapeutic relationship. It is possible to identify within this relationship the complementary interaction of the basic integrative processes of differentiation and linking. The therapist links to the client's inner world empathically, while at the same time staying apart and differentiating herself. This process is similar to what takes place in the secure attachment relationship. The mother is empathic to the child's experience, providing mirroring and attunement (*linking*), and at the same time respecting the infant's autonomy (*differentiation*) (Winnicott, 1965). Fonagy, Gergely, Jurist & Target (2004) claim that there is a dialectical process, in which the secure caregiver soothes the child by combining mirroring with a display that is incompatible with the child's affect, implying that it is possible to cope with the current situation. Bion (1962) also emphasized the idea that the mother contains the affect state that feels intolerable to the baby, acknowledging his mental state while also modulating unmanageable feelings. When the caregiver is in an attuned, predictable relationship with the child, respecting her

individuality as well as identifying with her, the child can develop a sense of autonomy, integrity and self-regulation (Siegel and Hartzell, 2003; Schore, 1994). If the caregiver identifies too closely with the child, feeling overwhelmed and anxious herself, the child will have trouble organizing his affective world coherently. If the caregiver is too remote and not attuned, the child will have difficulty identifying his own feelings and intentions. In both cases the parent does not create for the child a coherent image of the child's internal mental life and her intentionality, thus hampering her affect regulation, self agency and integration (Fonagy et al, 2004). The lack of a secure attachment relationship "is carried forward as internal processes in the child that directly influence how the child interacts with others in the future" (Siegel and Hartzell, 2003, p.104). The child may develop an avoidant/dismissive stance, an ambivalent/preoccupied stance, or in more severe cases a disorganized stance (Ainsworth, Belhar, Waters, & Wall, 1978; Main, 1995). All these can lead to impairments in the integrative capacities of the individual, to inflexible ways of adaption and to a diminished sense of well-being (Siegel, 2012).

Likewise, in the secure therapeutic relationship integration and healing are enhanced if the therapist is closely attuned to the client and at the same time encourages her on her own path. In Linehan's (2006) work with borderline clients, she stresses both the importance of validating the client (*linking)* and challenging her to take responsibility for change (differentiating). In dialectical co-therapy (Hoffman et al, 1994, Hoffman & Laub, 2006), one therapist is close and empathic to the client *(linking*) and the other is more distant and challenging *(differentiating*). In addition, the therapist needs to be aware of the attachment history of her clients and its effects on their need for closeness and/or distance in the therapeutic relationship. Clients with insecure attachment styles tend to be more wary about the availability of the attachment figure (Liotti, 2004) and may stay distant and/or come close too quickly. The therapist should move between closeness and distance in an attuned, predictable way so the client can begin to experience elements of a secure attachment. Integration can take place as the client begins to feel safe in the therapeutic relationship, allowing herself to trust the therapist and bring her authentic self to the process. With an empathic, sensitive therapist the client can begin to form a bond, and re- experience highly stressful, dysregulating affects in a safe environment so that the overwhelming traumatic feelings can be regulated and integrated (Schore, 1994).

An example of the dialectical interplay of differentiation and linking in the therapeutic relationship is illustrated with Tom. In therapy he focused on his traumatic relationship with his father, in which he felt pushed aside and neglected. As he recalled these childhood memories a great deal of anger came up. At this stage in the therapy Tom became very angry with the therapist, especially if she had to cancel a session. When the therapist was sick for a week Tom sent many demanding messages and raged at her when she came back. The therapist empathized with his feelings (*linking*) and tried to help him see where they were coming from (*differentiating*). As new memories of neglect came

up and Tom exposed more of his vulnerability, any change in the setting made Tom agitated and he accused the therapist of being continually neglectful. The therapist became aware of feelings of guilt and anger at Tom and recalled her own memories of her relationship with her father. She felt bad about having been sick or making changes, but also irritated and attacked unreasonably just as she had been as a child. Differentiating herself from Tom's reaction and linking to her own pain with her father enabled the therapist to contain her anger and resume a more balanced attitude of getting closer to Tom while putting appropriate limits on his outbursts outside the clinical setting.

Differentiation and linking processes in Mindful Dual Awareness (MDA)

The dual awareness setting in certain therapeutic approaches (Ogden et al, 2006; Gendlin, 1981; Shapiro, 2001; Levine, 1997; Rossi, 1996; Zvelc, 2012) emphasizes both the client's focus on her internal processing (sensory, somatic, emotional and cognitive), usually of a distressing experience, and an awareness of the present safety of the therapeutic situation. These approaches use brief intervals of moment to moment tracking of the internal experience and sharing it with an attuned therapist. Shapiro (2012) emphasizes that in traumatic experiences there is a sense of terrible aloneness and that the therapist's felt presence is very important during processing. Dual awareness also plays an important role in other experiential therapies such as Gestalt (Perls, 1959), psychodrama (Moreno, 1987), Voice Dialogue (Stone & Winkelman,1985), and Internal Family Systems Therapy (Schwartz,1995), in which the therapist may be more directive.

According to Porges's hierarchical Polyvagal Theory (2003) the experience of threat sends the sympathetic nervous system into the flight-or fight arousal pattern. Higher levels of threat and more helplessness send the dorsal vagal branch of the parasympathetic nervous systems into immobilization, freeze and collapse. The sense of safety, connected to the "social engagement system" which operates through the ventral vagal branch of the parasympathetic nervous system, ensures a calm state. It may be that dual awareness in trauma processing facilitates the dialectical/integrative movement between these two systems of threat (the distressing inner experience) and safety (the therapeutic situation). This movement promotes a differentiation between them thus enabling new links to occur.

Most of the therapies which emphasize dual awareness in trauma work (Shapiro, 2001; Ogden et al, 2006; Gendlin, 1981; Levine, 1997; Rossi, 1996, Zvelc, 2012) use mindful instructions (Kabat-Zinn, 1990; Siegel, 2007), which ask the client to notice and track her experience without judging it. Mindful instructions promote the client's ability to observe and process her traumatic experience within a "window of tolerance" where the client is not in hyper or hypo aroused zones (Ogden et al, 2006; Siegel, 2012). Ogden and her colleagues

suggest that with mindful awareness "retraumatization is minimized because the prefrontal cortex remains 'online' to observe inner experience, thus inhibiting escalation of subcortical activation" (2006, p.195). In EMDR Bi-lateral Stimulation (BLS) is added to mindful instructions, promoting a relaxation response via distracting eye movements (Maxfield, Melnyk & Hayman, 2008; Gunter & Budner, 2009). Present feelings and 'felt senses' are also used to facilitate the client's mindful inner exploration (Gendlin, 1981; Levine, 1997; Teasdale and Bernard (1993).

In this article Mindful Dual Awareness (MDA) is referred to as the client's ability to be in touch (*linking*) with her experiences while keeping an appropriate distance (*differentiation*) in a mindful, non-judgmental way. Shapiro emphasizes both processes and writes, "It may be that the effectiveness of EMDR arises from its ability to evoke exactly the right balance between re-experiencing emotional disturbances and attaining a non-evaluative 'observer' stance" (2001, p. 323). The therapist, modeling mindfulness, may suggest to a detached client that she notice her body sensations, feelings and images, so as to help her to get closer (*linking)* to the traumatic experience. When the client is overwhelmed the therapist may suggest a distancing metaphor such as viewing the threatening traumatic experience on a TV screen (*differentiation).*

The ability to develop MDA is rooted in the secure attachment relationship. Through attuned interactions with caregivers the child develops her reflective abilities; what Fonagy (2004) and colleagues have named *mentalization*. The child finds in the mind of the sensitive caregiver an image of herself as motivated by beliefs, feelings and intentions. She also learns to have conceptions about other's beliefs, feelings and attitudes, which make their behavior meaningful and predictable for her. She begins to see her ideas as merely ideas and not facts, to play with different points of view and to test ideas against reality so as to moderate their impact. Ogden and her colleagues suggest that "…one of the skills that enables mentalizing is the mother's ability to perceive her child's world, identify with it and align with it while simultaneously realizing that the child is a separate person" (Ogden, et. al., 2006, p.44). It seems that the complementary working of the integrative functions of aligning with the inner world of the child (*linking*) and acknowledging her autonomy (*differentiation*) are at the core of the development of the child's reflective capacity. This capacity is impaired by early insecure and disorganized attachment relationships (Siegel, 2012; Liotti, 2004). Therefore with clients with early traumatic experiences the therapist needs to be especially aware of first strengthening their resources and sense of safety in the therapeutic relationship. She can then help them develop dual awareness by a slow and gradual exposure to traumatic material while keeping the link to the safety of the therapeutic situation (Ogden et al, 2006; Knipe, 2008).

Siegel (2007) suggests that mindfulness can be looked at as the empathic capacity of the observing self toward the experiencing self. How does the observing stance in trauma processing acquire an empathic hue? It is proposed

that MDA goes through various levels toward greater integration during trauma processing. Incorporating Siegel's (2007) four components of mindfulness, which are curiosity, openness, acceptance and love (COAL), we suggest that in trauma processing these components develop in a whole/part sequence in which each new one includes the previous one. In order for the client to allow herself to *open* mindfully to her distressing inner experience, she needs to feel safe enough to allow some experience of threat. The client's MDA can widen to *curiosity* about the various hues of her unfolding inner experience, as her trust in the relationship with the therapist and the processing grows. MDA expands further, becoming an *open*, *curious* and *accepting* stance towards conflicting sensations, emotions and thoughts as the client, with the help of the therapist, moves toward a wider and more whole perspective. When integration continues to higher levels, MDA expands even further to experiences of *love* toward oneself, others and the universe. Zvelc (2012) suggests that the therapist, during mindful processing, should accept his own experience, while also inviting the client to explore and accept hers. "Therapeutic involvement includes acknowledgment, validation, normalization and presence" (Zvelc, 2012, p. 44).

The following example illustrates the development of the client's MDA in a couple's session. Udi and his spouse had been in therapy for several months. At first Udi was very closed to the idea that his problems with his wife had anything to do with his childhood. He insisted that she was demanding and bossy without taking his opinions into account. As the therapist asked him to recollect a time in his childhood when his opinions had been ignored, he said there was no connection and that the therapist was not making sense. At this stage there was very little *openness*. The therapist remained open to her own feelings of being pushed away, allowing herself to be affected by them and linking them to Udi's constant feeling of being pushed around. As the therapist gave him space to express the feelings of being dominated by his wife, Udi began to observe more openly that these feelings kept repeating themselves. The therapist, linking to Udi's vulnerability, said in a slow, gentle accepting voice that she wondered if, in his family of very hardworking holocaust survivors, he had ever been asked about his feelings and needs. For the first time he showed a glint of *curiosity* and began to wonder about how he had lived in a home where no one asked him anything. He recalled that his father was always working and his mother was concerned with basics such as food and clothing. He went into himself again, looking rather sad, and said he had also hardly ever been hugged or kissed. The therapist was touched and conveyed empathy for the child who had been so neglected. Udi met the therapist's eyes and said he could connect to his loneliness then. There seemed to be a beginning of some empathy and *acceptance* toward his denied feelings of neediness. At the end of the session he realized for the first time that it was hard for his wife that he stayed distant when she was needy.

The Interaction between the Therapeutic Relationship, Mindful Dual Awareness (MDA), and Integrative Trauma Processing

From a dialectical perspective three basic integrative systems in trauma work inter-relate and resonate with each other; the therapeutic relationship, Mindful Dual Awareness (MDA), and integrative trauma processing. All three aim toward greater integration by moving dialectically between opposites. Figure 1 illustrates the spiral of integrative trauma processing as enveloped both by the therapeutic relationship and MDA. The safe and attuned therapeutic relationship provides a container for integrative trauma processing just as the secure attachment relationship offers the appropriate container for the integrative development of the child. MDA is depicted as a further container providing the client with a non-judgmental observing stance. This is similar to the way that mentalization is crucial for the child's growing self-regulation and reflective capacities.

The mutual interaction of these systems can be illustrated in an EMDR session with Tali who came to therapy after a traumatic divorce. In one session she focused on a humiliating scene in which she heard her ex-husband's father speak to her ex-husband about how to manipulate her financially in the divorce process. Connecting to her pain and hurt she began to cry and asked to stop the processing. The therapist validated her helplessness gently but encouraged her to stay with her distress a little longer, challenging her to continue the processing. The therapist's trust in Tali's abilities to stay with her pain while being supported enabled her to dare to go on in the session, opening further to MDA. Soon after she felt some relief saying, "I can breathe… I feel relieved… I can see myself from the outside." This indicated an initial horizontal movement between the *sensorimotor* opposites of distress and relief and more of a balance in her MDA from being absorbed in her distress to being able to distance from it. On the next set of BLS she said: "…it was not **me** who was humiliated." This indicated that she could begin to differentiate herself from her humiliated part. She shifted to the emotional level, moving horizontally between humiliation and self-worth.

As her integrative processing expanded, so did her MDA, exploring *(curiosity of MDA*) her father's role in the situation. She realized that her highly respectful father had been willing to be humiliated by her ex-father-in-law in order to help get her a divorce. Now she could see her father's humiliation as a noble act of love in which his humiliation and worthiness were integrated. This was a vertical shift to a cognitive level in which her MDA expanded to empathy and *acceptance.* In the next session strong feelings of anger toward her ex-father-in-law came up. The therapist acknowledged these feelings and encouraged her to discharge her anger toward her ex-father-in-law in her imagination. The therapist's message that strong anger could be contained and expressed allowed Tali to accept it. This led to Tali's insightful recognition that her ex-father-in-law's behavior was connected to his insecurities and desire to help his son. The horizontal movement between anger and acceptance enabled a vertical shift in

which her MDA expanded to some compassion for her previous enemy (*love of MDA*). The therapist was very moved and inspired by the transformation in Tali's attitude toward herself and others, and shared this with her.

A Dialectical Perspective to Information Processing Models

Can a dialectical perspective contribute to information processing based models? As the science of neurobiology progresses, many therapeutic approaches and models of trauma work base their theoretical formulations on information processing of memory networks. Examples are the Adaptive Information Processing (AIP) model of EMDR (Shapiro, 2001, Solomon & Shapiro, 2008), Sensorimotor Therapy (Ogden, et al, 2006), Emotional Processing Theory (Foa & Rothbaum, 1998), the Cognitive Model of PTSD (Ehlers & Clark, 2000), Dual-Representation Theory (Berwin, Dalgesleich, & Joseph, 1996), Emotion Focused Therapy (EFT) (Greenberg, 2010), and Coherence Therapy (Ecker & Toomey, 2008). From an information processing lens the dialectical perspective may account for three phenomena. The first is the way the inherent integrative movement proceeds via complementary cycles of associative connections, which differentiate the condensed traumatic memory into parts, enabling new associative links to occur. The second is the spontaneous associative connection between the traumatic memory networks and adaptive ones, moving between opposites toward a new synthesis. The third is the transformation reflected in a new self-affirmation or 'post traumatic growth' due to the expanding nature of the integrative/dialectical movement. All three phenomena lead to the integration of the traumatic memory network, via associative connections of differentiation and linking, into a coherent semantic memory network.

Recent studies (Schiller, Monfils, Raio, Johnson, Ledoux & Phelps, 2010) of the malleability of memory and the adaptive role of reconsolidation as a window of opportunity suggest a possible neuro-biological mechanism behind the transformation of memories. The dialectical perspective suggested in this article may shed some light on the way this transformation occurs.

Conclusion

This article addresses the basic principles and characteristics of the integrative process during trauma processing. It is proposed that a dialectical perspective can contribute to an understanding of the way integrative trauma processing takes place. Discussions regarding trauma processing must take into account the interaction of three basic systems; the therapeutic relationship, Mindful Dual Awareness and integrative trauma processing. An appreciation of the dialectical principles in all three may help therapists of various approaches enhance their skills in facilitating the inherent integrative/dialectical movement,

thus promoting the healing process. Hopefully the dialectical perspective may also encourage research in the field of therapeutic change.

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