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Treating Eating Disorder Patients Who Have Had Traumatic Experiences: A Self-Regulatory Approach

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Eating disorder (ED) patients are presenting with increasingly complex symptom pictures consisting of layers of potential interaction between their eating disorder, impact of their traumatic experiences, and their social environment. Consequently, clinicians are challenged to utilize approaches that efficiently and effectively organize treatment for this particular population. This paper describes an therapeutic organizational model, based on self-regulation theory, that clinically has been found to be useful and effective for working with complex, multi-symptomatic ED patients.

When I am in an adult body, I am absolutely vulnerable.
Then I feel like I'm not deserving, filthy, dirty, and worthless.

Anonymous

Eating disorder (ED) patients are presenting with increasingly complex symptom pictures (Levitt, Sansone, & Cohn, 2004; Sansone & Levitt, 2004). In addition to self-harm behaviors, substance abuse, and personality disorders, the symptom presentations of ED patients are often compounded by recent or past histories of traumatic experiences (TEs). While the role of TEs in contributing to the development of EDs has yet to be clearly established (Brewerton, 2005; Connors, 2001; Wonderlich, Brewerton, Jocic, Dansky & Abbott, 1997), the *potential* impact of these experiences on an individual's psychological, emotional, and relational development has been clearly established (e.g., American Psychiatric Association, 1994; Herman, 1992).

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Clinicians who work with patients that present with both EDs and traumatic TEs need approaches that are practical—i.e., approaches that address the layers of potential interaction between the individual and their ED; the impact of TEs on the individual; and the interactions among the individual, EDs, TEs, and the social environment. Consequently, an approach that efficiently and effectively organizes treatment for the patient and their social environment, and for the patient that presents with an ED and/or TEs, would seem useful.

This paper describes an organizational model based on self-regulation theory that clinically has been found to be useful in working with complex, multi-symptomatic ED patients (Allen, 1995; Levitt, 2004, 2006). It was originally developed for patients who exhibited various ED symptom patterns and other co-occurring symptomotology including self-harm, substance abuse, and/or trauma-related symptoms. These patients have been previously described as "disorganized" (Levitt, 1998) or multi-symptomatic (Levitt et al., 2004).

TRAUMA AND EDS: A BRIEF LITERATURE SUMMARY

A full review of the literature concerning the relationships between EDs and trauma is beyond the scope of this paper. A few significant concepts derived from the literature are, however, important to serve as a backdrop for treating these groups of patients.

First, the reported prevalence of patients who present with both EDs and TEs tends to vary quite extensively from 18–85% depending upon the study (Brewerton, 2005; Connors, 2001; Vanderlinden & Vandereycken, 1997; Wonderlich et al., 1997). What this suggests is multi-fold. Despite the variance, the prevalence rates indicate that we, as therapists, are likely to experience traumatized ED patients at a fairly high rate. In addition, the considerable range in prevalence suggests that clinicians must be quite careful not to assume, or presume, the likelihood of abuse or TEs in all individuals with EDs. In other words, it is paramount to be exceptionally conservative in assessing this patient population.

Second, the discrepancy in prevalence rates appears to be, in part, a result of differing definitions regarding what constitutes a traumatic/abusive experience (Brewerton, 2005; Miller, 1996). Specifically, across studies, various researchers define differently an event, situation, or experience as "traumatic." Similarly, patients also have differing definitions of what are abuse, neglect, and trauma. Each patient's view and understanding of what is abusive and/or traumatic tends to be quite uniquely specific to them. Understanding the patient's world view is vital in any effective treatment, but especially important when dealing with personal definitions of psychological or physical injuries, harm, or abuse—particularly when these are caused by significant others (e.g., sexual and/or physical abuse).

Because the concept of trauma is dependent upon the patient identifying an experience as traumatic or abusive, the general willingness of any particular individual to openly self-report TEs, or to even identify the experience as abusive or traumatic, may vary greatly. This may be due to a variety of cultural, familial, personal, psychological, and/or developmental issues (Miller, 1996). In particular, concepts of emotional and psychological abuse and neglect (versus sexual or physical abuse) are relatively difficult to consistently operationalize and define with patients. In this context, it is critical for clinicians to be aware that patients may not view situations in the same way that clinicians do. Furthermore, even when the patient identifies a situation as traumatic or abusive, he/she may not accurately report the presence of clinically significant symptomotology (Fallon & Wonderlich, 1997).

Finally, the ED literature identifies a varying relationship between EDs and abuse/trauma. This is particularly evident in the area of childhood sexual abuse (CSA), though many of the findings extend to physical abuse, as well. For example, both Brewerton (2005) and Wonderlich et al. (1997) support connections between CSA and EDs. While CSA does not appear to specifically represent a risk factor for the development of an ED or to be related to the severity of ED symptomatology, it is associated with bulimic symptomatology as well as other psychiatric comorbidity in ED patients (e.g., post-traumatic stress disorder [PTSD]) (Sansone & Levitt, 2005). Because CSA does not appear to cause the development of ED symptoms, models of treatment for these patients need to take into account that addressing the "trauma" or abuse is unlikely to directly eradicate the ED.

TRAUMA DEFINITIONS

Oftentimes, the concepts of abuse and trauma are often used to describe similar events. For example, in the ED literature, there is a wide range of described abusive/neglect experiences including both direct and indirect (e.g., witnessing abuse) experiences (Vanderlinden & Vandereycken, 1997).

I have adopted the concept of "trauma" in this paper for several reasons. First, the concept of "trauma" in its most expansive meanings (Fallon & Wonderlich, 1997) encourages the incorporation of the patient's unique interpretations of events and experiences. This is in contrast to being limited to an externally applied definition or meaning of events. It is the patient's view of what he/she experienced that is focused upon versus an event-based definition, which can be found in the criteria for various diagnoses (e.g., acute stress disorder [ASD], PTSD; American Psychiatric Association, 1994). Clinical models need to address the patient's world view and interpretation of their own experiences as well as to assist the patient in operationalizing his/her experience (Fallon & Wonderlich, 1997; van der Kolk, McFarlane, & Weisaeth, 1996; Vanderlinden & Vandereycken, 1997).

Second, utilizing a patient-specific definition of trauma leads to a broader exploration of trauma-based response patterns *with* the patient and is useful in assisting him/her in identifying and understanding the effects that trauma may have had on learning and self-regulation. Thus, this working definition of "trauma" refers to a patient's experience, not an event; as a result, the characteristics, scenery, and ambience of the event may provide added insight into the experience itself. The importance of this concept will continue to become more evident.

TRAUMA-RELATED SYMPTOMS

General interactions between EDs and TEs have been discussed in the ED literature (e.g., Brewerton, 2005; Fallon & Wonderlich, 1997; Levitt, 1998; Vanderlinden & Vandereycken, 1997; Wonderlich et al., 1997). Essentially, an individual brings to bear a variety of individual psychosocial and familial resources to confront an overwhelming situation, and responds either by mastering the situation or, when mastery is limited, by developing symptoms (Herman, 1992; Horowitz, 1986; McCann & Pearlman, 1990). Mastery refers to: (a) the ability to make sense of an experience (i.e., to assimilate and incorporate the experience into life functioning without becoming too overwhelmed; van der kolk & McFarlane, 1996) and (b) to be able to return to daily functioning with minimal dysfunction. In other words, with mastery, the individual is able to regulate their thoughts, feelings, and/or behaviors and to return to a *coherent* sense of physical and psychological self. When these conditions are not met, the individual may develop trauma-related symptoms.

Typical trauma-related symptoms are generally diagnosed under the rubrics of ASD or PTSD (American Psychiatric Association, 1994). ASD and PTSD are quite similar in symptomatology with two exceptions. First, ASD is only used for diagnosis during the first month following the traumatic event. Second, ASD has a greater emphasis on dissociative symptoms (i.e., ASD requires the presence of three dissociative symptoms such as numbing, reduced awareness, depersonalization, derealization, or amnesia). While a person with PTSD may present with dissociative features, these are not required for diagnosis. Thus, the individual who experiences a traumatic experience may, soon after the experience, develop and present with a variety of symptoms including anxiety, depression, and dissociative symptoms along with other trauma-related symptoms. These reactions are thought to contribute to the later development of EDs (e.g., Fallon & Wonderlich, 1997).

What does this timeframe for symptoms mean? The ED may have developed as an effort to manage the symptoms associated with ASD or PTSD; the ED and trauma-related symptoms (e.g., ASD or PTSD) may have developed separately from each other but co-exist in the same person albeit somewhat uniquely from each other; or the ED and trauma-related symptoms

may have developed from either of the above paths but eventually interacted with each other and become dually integrated into the individual's approach to managing day-to-day life.

In many cases, clinicians find that ED patients report the presence of and seek treatment for TEs a considerable length of time after the adversity has occurred (e.g., Brewerton 2005; Fallon & Wonderlich, 1997; Palmer, 1995; Vanderlinden & Vandereycken, 1997). In these situations, the third alternative described above is most likely (i.e., that the ED symptoms and trauma symptoms have come to regularly interact and impact each other).

EDs and TEs have often been reported to have a number of interactions, to the point where the body has been described as a "battleground" for many patients (e.g., Miller, 1994). For example, Motz (2001) states that, ". . . anorexia can be considered an act of violence against adult female sexuality . . ." (p. 194) and that bulimia is ". . . a kind of sadistic alternation of gratification and deprivation of the body . . ." (p. 197).

The most frequently reported trauma-related symptoms in ED patients are summarized in Table 1 (Miller, 1994; Motz, 2001; Schwartz & Gay, 1996; van der kolk, McFarlane, & Weisaeth, 1996; Vanderlinden &Vandereycken, 1997; see also Schwartz & Gay, 1996, p. 95, for an additional list of adaptive functions of the ED symptoms). The aftermath of trauma may include difficulties managing arousal, numbing, and other trauma-related symptoms (e.g., flashbacks/intrusions, numbing); deficits in body signal recognition (i.e., alexythymia, enteroceptive cues); body image distortion; utilization of the body to directly or indirectly address meanings related to the trauma (e.g., punishment, caretaking); and the development of trauma-related relationships (e.g., reenactments, safety). As illustrated in Table 1, ED behaviors may provide a variety of adaptive functional purposes for those who have trauma-related experiences.

Over time, many trauma patients develop extensive coping strategies in order to function. These strategies may become routine and organized, and present as a variety of psychological symptom clusters that may be

TABLE 1 Common Trauma-Related Symptoms in Eating Disorder Patients

- Body image distortion
- The body as a target for guilt, shame, self-blame, stigmatization
- Eating disorder "acts" as revictimization (i.e., reenactment)
- Poor hunger recognition and satiety discrimination as a result of numbing, arousal, avoidance, etc.
- Starving or purging as punishment
- Use of the body to reduce trauma-related symptoms
- Use of the body to shut down sexual impulses
- Use of the body to avoid relationships
- Use of the body or symptoms to obtain "safe" caretaking
- Use of the body or symptoms to "forget" or indirectly "remember"

observed in ED/TEs patients (e.g., Garner & Garfinkel, 1997; Levitt, 1998, 2006; Schwartz & Cohn, 1996; Schwartz & Gay, 1996; Vanderlinden & Vandereycken, 1997). The literature suggests that while many of these symptoms are common in patients who present with either anorexic or bulimic EDs, they are particularly frequent among the latter (Garner & Garfinkel, 1997; Johnson & Connors, 1987) or among those with trauma-related symptoms (e.g., Anderson & Bulik, 2004; Levitt, 1998; Levitt & Sansone, 2004; Schwartz & Cohn, 1996). These symptom clusters are presented in Table 2.

As described in Table 2, these patients have difficulties in many areas of life functioning. In particular, they tend to present with identity and psychological concerns (e.g., "control" issues), get easily overwhelmed, act in role-dependent patterns (Bruch, 1973), exhibit problems with affect regulation, have difficulties with relationship management (e.g., boundaries), exhibit impulse control difficulties, and/or present with problems as a result of utilizing dissociative coping behaviors (Levitt, 1998, 2004; Sansone & Levitt, 2004).

Effective clinical approaches for working with ED/TEs patients need to address broad-based symptom constellations such as those presented in Tables 1 and 2. Because patients with these symptom clusters often appear "disorganized" (Levitt, 1998; Levitt, Sansone, & Cohn, 2004), efficacious treatments need to address the "whole" patient—i.e., their symptom clusters and the interactions among them. The following section describes an overview of the Structural-Process Model, a clinical approach that is useful for treating these types of complex patients (Levitt & Sansone, 2003; Levitt, Sansone, & Sansone, 2003); a more in-depth presentation of this approach is provided elsewhere (Levitt, 2004).

THE STRUCTURAL-PROCESS MODEL (SPM): TREATING THE ED/TES PATIENT

Before introducing the Structural-Process Model (SPM) for ED/TEs patients, I will briefly discuss an overview of self-regulation. This will be followed by an overview of the role of symptoms, data, position, the therapeutic relationship, and finally, relevant dimensions of treatment in the SPM.

Self-Regulation Concepts

Function of Symptoms

Individuals are constantly managing themselves and adapting to varying environmental challenges. Patients with EDs and trauma backgrounds have learned to adapt to experiences that occurred earlier in life. Their ED and

TABLE 2 Common Presenting Symptom Constellations in Patients with Eating Disorders and Traumatic Experiences

Deficits in Self-Cohesion
- Tendency towards internal decompensation or fragmentation
- Tendency to experience self as pieces—especially when under stress
- Tendency to act as though one takes on discrete "roles"

Deficits in the Regulation of Self-Esteem
- Self-esteem is externally modulated
- Self-esteem is regularly under "attack"
- Self-esteem is "controlled" by limited variables (e.g., fat, body size)
- Self-appraisals are regularly distorted

Interpersonal Boundary Confusion
- Porous, diffuse, or unstable identity
- Pervasive sense of interpersonal ineffectiveness
- Distrust or unsafety is regularly experienced in relationships

Deficits in Internal or Affect Regulation
- Difficulty in discriminating enteroceptive cues (alexythymia)
- Limited sense of safety and security
- Deficits in impulse modulation or self-soothing
- Tendencies toward depersonalization
- Temporal instability (e.g., reenactments)
- Affective incongruity and instability (including affect flooding and lability)
- Siphoning experiences through single areas (e.g., body parameter) or compulsive behavior (e.g., self-injury)

Interpersonal Difficulties
- Fears of abandonment, intrusion, closeness
- "Chameleon-like" relationships
- "Perfectionism" which is used to manage closeness and approval
- Unclear, "disreal," and/or concrete communication patterns
- Experience of powerlessness in relationships
- Use of dissociative processes
- Dissociation of feelings, thoughts, memories, and sensations
- Dissociation of the body (i.e., the hated object)
- Disconnection from the environment
- Connection to the environment

General Characteristics
- Body shame
- Sexual shame (e.g., anxiety, guilt)
- Sleep disturbances
- Drug and/or alcohol abuse
- Secrecy and "fears of discovery"
- Reenactments
- Feeling responsible for one's own victimization
- Stigmatization
- Time distortions

other symptoms (see Tables 1 & 2) are likely a result of, or at least interact with, that "learning." Many symptoms, for example, have developed as a result of earlier TEs and serve as either a response to the TE and/or represent an effort to provide protection from past/future TEs. For example, one result of an overwhelming experience might be difficulty with mood management; the ED may be utilized to provide a semblance of affect control. In sum, the patient has learned to regulate him/her self in the aftermath of earlier experience(s) with some of their presenting symptoms (e.g., the ED) serving to regulate or protect themselves, albeit with some negative repercussions.

Throughout the therapeutic interactions in the SPM, presenting symptoms are framed as learned responses to overwhelmingly stressful situations in an effort to adapt and survive (i.e., self-regulate). Indeed, from a self-regulatory perspective, a number of symptoms are viewed as *protective* and designed to keep oneself safe, manage strong affects, develop patterns of attributions for experiencing "control," and to address elements associated with the trauma itself (e.g., dissociative processes such as numbing) (Levitt, 2004). In the SPM, these symptom patterns are viewed as having been learned via interactional experiences and ED behaviors are associated with, or interconnected with, previous TEs.

Role of Data

A fundamental goal in the SPM is for the patient to learn to frame symptoms as learned and adaptive. Many patients have experienced pain or suffering from either "trusted" individuals or from those individuals that they were dependent upon. These patients often enter into treatment feeling stigmatized and/or believe that they were responsible for the experiences that occurred to them (i.e., they are "bad;" Herman, 1992). Engaging the individual at the onset of treatment is critical—even when the trauma is disclosed later in treatment. The manner in which the symptoms are handled at the outset is crucial to the development and consolidation of the therapeutic relationship.

When exploring the function of symptoms with the patient, the concept and role of *data* is introduced. Data is utilized as a way of helping the patient to describe as accurately as possible their experiences, goals, and understandings. Through the therapeutic processing of data, patients are better able to begin to use information in a more neutral and less self-blaming fashion. That is, they learn to recognize, identify, and report facts versus judgments or reactions. Those patients who can accept the role of symptoms as efforts at self-regulation (i.e., protection and adaptation) and neutralize personal data tend to be able to normalize symptoms more efficiently, enhance their power to address difficulties (i.e., have hope), and take a learning, or student, approach (Allen, 1995; Fallon & Wonderlich, 1997; Levitt, 2004). The net effect is to create a therapeutic learning environment that supports the view that the patient is essentially normal and that "safe" change is within his/her abilities.

The Therapeutic Relationship

In the SPM, the relationship is viewed as an opportunity to teach about, monitor, and address the effects of trauma and the ED (e.g., power, control, responsibility) as well as to create a safe and productive recovery environment. A vital treatment focus is to create an environment of empowerment. The analysis of data is one way to facilitate the patient's student role and to understand and apply position.

Concepts of mastery, competency, control, hopefulness, and empowerment (Levitt, 2004, p. 215) may be developed and sustained through the SPM. In addition to the ways that symptoms are framed and data is employed, teaching focuses on several relational concepts based on the SPM—being a student of oneself, position, and relationship accountability.

In the SPM, being a "Student of Oneself" is more than a slogan. It represents a vital orientation to recovery. While symptom development is viewed as learned efforts to self-regulate and data is used to describe learning and its outcomes, re-learning different, efficacious (i.e., safe and secure) relationship patterns is a natural re-direction in recovery. In the SPM, guiding and mentoring patients to adopt a student role as soon as possible facilitates learning the SPM and provides the vehicle for reducing the debilitating impacts of the ED or TEs (i.e., self-blame, stigmatization).

Position

Position refers to the approach or style of interaction that is exhibited between the patient and any situation, event, or experience. An initial therapeutic focus is for the therapist to teach the patient, and for the patient as a Student of Oneself to learn, how to recognize, identify, and change position to a more desired or effective one. To teach the patient to apply the concept of position in a practical and direct way, two types of general positions are highlighted—"victim" and "survivor." The victim position refers to the attitude or posture that individuals take when interacting with their environment as though events, situations, and so forth happen *to* them—i.e., where they act as if they have no power or ability to address the challenge. The survivor position, on the other hand, occurs when individuals accept appropriate responsibility for their own behaviors (and not others), recognize opportunities to face challenges, and exhibit responses that they believe are in their best interest (Levitt, 2004, p.215). Essentially, position focuses on who is in charge of what choices (i.e., control) and what are acceptable and realistic responses (i.e., power). In this treatment process, the patient learns to identify his/her position, determine the characteristics of the situation and interaction, and decide what position he/she wishes to employ. Then, based on the evaluation, positions may be changed from victim to survivor (Levitt, 2004).

Position is used by the therapist to guide interactions with the patient and to teach the patient how to effectively approach any particular situation. Similarly, the position that the therapist uses in patient interactions and generating strategies is important. In employing a survivor position, the therapist will interact with the patient in a style that communicates to the patient that he/she is a worthwhile individual who is capable of and expected to learn effective patterns of managing life. The therapist consistently supports patient choice and integrity in hopes of creating a positive, less threatening, relationship environment (Pearlman & Saakvitne, 1995).

It is easy to see how the concept of position may be useful for ED patients who have had past experiences in which they felt overwhelmed, intruded upon, or taken advantage of. For example, the therapist might use the concept of position to assist the patient to understand how he/she learned to avoid speaking up or challenging authority figures—relational responses learned from earlier difficult experiences (i.e., to protect oneself from potential abuse by an abusive authority figure). While avoidance patterns learned early in life may be extremely functional, or even vital, for self-protection or survival, in the present therapeutic relationship, the therapist can employ the concept of position to help the patient identify and learn new alternative responses. In this process, what is vital for the patient is to be aware that he/she has the option to change position.

Responsibility to the Relationship

All therapeutic relationships entail multiple responsibilities—some belong to the therapist and others belong to the patient. Clarification of this is very important and essential for successful treatment. While these have been described more specifically elsewhere (e.g., Levitt, 2004; Levitt & Sansone, 2004), the concept of responsibility to the relationship is central to the ongoing patient-therapist interactions in the SPM. In its simplest sense, being responsible to the relationship directs the patient's attention to the nature of the engagement with the therapist and makes the relationship, versus the patient or the person of the therapist, the target of central focus. This is important in the SPM for a number of reasons. First, in the SPM, the therapist is a guide and mentor who has training and expertise in the skills and strategies of recovery. Unlike typical medical models, in the SPM, the therapist does not cure or fix the patient. Rather, the patient learns new skills and strategies for self-regulating with the therapist's information and support, and the patient achieves his/her desired goals. Second, many ED patients with trauma backgrounds do not believe that they are actually worthy of better treatment, either from themselves or from others, including being worthy of recovery. Responsibility to the relationship helps address and mediate many of these obstacles and provides a more neutral definition for responsibility. Finally, responsibility to the relationship externalizes interactions. That is, the

patient's attention is drawn away from continual judgment about him/her self, which provides an external vehicle for evaluating and learning the role of symptoms and position. This is especially useful when initiated early in treatment, but must be sustained throughout recovery.

Dimensions of Treatment

The SPM represents a *dimensional* approach to recovery (Levitt 2004, 2006; Levitt & Sansone, 2004). Components of the SPM and the development of strategies and interventions within the SPM are based on the roles, processes, and interactions that are a part of each dimension. Indeed, *all* SPM interventions are organized into one or more of the upcoming three dimensions.

When applying the SPM to ED/TEs patients, it is essential to consistently recognize and employ the underlying principles, or dimensions, that guide clinical work. Because ED/TEs patients tend to be symptomatically complex, it is exceptionally important to *consistently* utilize and monitor the SPM principles and processes. They parallel the basic components of the SPM described elsewhere (i.e., Basics, Foundation Skills, and Actions; Levitt, 2004, 2006). Indeed, the ED/TEs patient needs empowerment and consistency to learn and practice managing physical, psychological, emotional, and relational resources in a new manner (e.g., Allen, 1995; Fallon & Wonderlich, 1997; Herman, 1992; van der Kolk, McFarlane, & Weiaeth, 1996). Of course, skills and processes in these dimensions are taught and practiced with the patient being a Student of Oneself, being mindful of position, using relevant data, and being responsible to the therapeutic relationship.

Representing the cornerstone of treatment, the first dimension is S*elf-Care*. This dimension is associated with the Basics component of the SPM. The Self-Care dimension refers to one's commitment to prioritize the essential aspects of his/her physical, psychological, and interpersonal well-being. In other words, to work to make oneself "complete"—psychologically, physically, and relationally. The basic role practiced in this dimension is being a "*Guardian of Oneself*." Patients learn to accept ownership for their own well-being and to prioritize it as the basis for any successful outcome. From the outset, patient recovery strategies are developed and practiced while being mindful of the skills and processes essential for effective Self-Care.

The second dimension of treatment in applying the SPM to ED/TEs patients is *Self-Awareness*. This dimension is associated with the Foundation Skills component of the SPM. The essential process here is knowing oneself. That is, the ED/TEs patient must learn to select relevant psychological, interpersonal, and physical data to incorporate into recovery strategies. Relevant, here, refers to the patient's views of importance (of course, with interaction from the clinician). The patient who actively applies the dimension of self-awareness will regularly pay attention to him/her self and will practice the role, described earlier, of being a Student of Oneself.

The third SPM dimension, associated with the Actions component of the SPM, is *Self-Determination*. The ED/TEs patient learns and practices behaviors that increase his/her ability to pay attention, stay on-task, and maintain behaviors that are useful for sustaining recovery strategies and/or provide effective direction in life. The processes here are active, versus avoidant, participation in life's challenges and opportunities. The role associated with Self-Determination is being the *director* of one's life and disciplining oneself to "stay the course"—especially in recovery.

These three dimensions, Self-Care, Self-Awareness, and Self-Determination, guide the organization of intervention strategies in the SPM when working with ED/TEs patients. The roles of guardian, student, and director form the backbone for learning and applying new strategies within the SPM. Again, it is important to note that the SPM only organizes the treatment process—it does not determine the content of treatment. Clinicians are encouraged to use their own perspectives to develop individualized treatment strategies for each patient.

SUMMARY

In summary, the SPM represents an organizational approach for treating ED/TEs patients (i.e., it is useful for working with patients who exhibit multiple symptom clusters or have longstanding or chronic symptom patterns). It is very effective for teaching and monitoring the essential skills and strategies necessary for recovery and permits a wide scope of potential interventions. Thus, it can be viewed to some extent as basically pan-theoretical as it can be used by those from a variety of theoretical backgrounds. Indeed, for those patients who have experienced overwhelmingly stressful life events, or experienced situations where trusted individuals have breeched their psychological/physical safety and security, this organizational approach, which emphasizes patient empowerment and choice, skills acquisition, and the fundamental elements of self care, awareness, and determination, can be quite palliative.

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