Anorexia Nervosa:

An Integration of Individual Psychology and Current Treatments

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Abstract:

Individual psychology is an important treatment modality when treating Anorexia Nervosa. This paper will examine how Individual Psychology can be utilized in working with the Anorexic client. Striving for Perfection, Compensation, Inferiority, Masculine Protest, Private Logic, and Birth Order are explored through the lens of treating the Anorexic client. This paper also explores how Individual Psychology can be helpful when understanding the course and treatment of Anorexia Nervosa.
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Anorexia Nervosa is a devastating illness that affects millions of people each year ((Crowther et al., 1992; Wilson & Fairburn, 1998; Gordon, 1990; Hoek, 1995; Shisslak et al., 1995).) Anorexia Nervosa, often referred to as Anorexia, is a complicated mental illness with physical components, emotional components, and psychological components. Anorexia has the highest mortality rate of any other mental illness and a recidivism rate that exceeds many other mental illnesses (Sullivan 1995). There are treatment options available for people suffering from Anorexia, which generally include psychotherapy as a main component of the treatment. Different modalities of therapeutic interventions are used for treating Anorexia although, at this time, no therapeutic model has been proven to be especially successful in treating this disease.

There are standard forms of treatment for Anorexia throughout the western world despite the low recovery rate and high recidivism rate. Standard therapeutic interventions often include Cognitive-Behavioral Therapy and a behavioral modification program (Wilson & Fairburn, 1998). The standard approach uses behavior as an indicator of success (i.e. lower frequency of problematic behavior
indicates improvement). This approach can be useful in halting behaviors that are symptomatic of Anorexia; however, the behavior change tends to be based on a compliance model versus internal change. This has proven to become problematic when clients cannot replicate the healthy behavior that was exhibited in treatment because there is no clear rule/consequence sequence. Traditional approaches to treating Anorexia have generally used symptom reduction as a main component to the treatment process. In recent years clinicians have been recognizing that reduction of symptomatic behavior is not, in fact, a reliable indicator of successful treatment (Wilson & Fairburn, 1998). There are many factors that support the hypothesis that full recovery from Anorexia involves far more than a marked change in behavior. Anorexia is an illness that consumes the life, soul, body, and mind of the sufferer and successful treatment is dependent upon a holistic therapeutic approach.

In order to best understand the treatment of Anorexia Nervosa, one must understand the symptoms and factors that contribute to the development of the illness. The term Anorexia Nervosa is of Greek origin and describes the physical nature of the illness. The term is broken down into several small parts that explain the origin of the
name; an means without, orexis means appetite or to reach out for (Morton 2004). Thus, by combining the smaller increments of the term the idea of without appetite or not to reach for food is presented as a vague description of Anorexia. Nervosa is the Greek feminine version of nervous which is used to describe the presentation of a person with Anorexia. Similar to the word neurosis, nervosa implies a neurotic quality to the condition. Although the illness is far more complex than simply refusing to eat or being without an appetite, the name of the disease does describe the symptoms quite clearly (Morton 2004). Today, the definition of Anorexia Nervosa is clarified in the DSM-IV-TR by a set of symptoms and characteristics used to make distinction between the illness and other causes of caloric restriction and/or weight loss. In order to be diagnosed with Anorexia Nervosa, one must meet the following criteria:

- Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- Intense fear of gaining weight or becoming fat, even
though underweight.

- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

- Amenorrhea (at least three consecutive cycles) in postmenarchal girls and women. Amenorrhea is defined as periods occurring only following hormone (e.g., estrogen) administration (DSM-IV-TR 2000.)

The means by which one can meet the above criteria can vary from case to case although the common approach of Anorexic clients is self-starvation. Most clients restrict their caloric intake in order to achieve and maintain a body weight of less than 85% of the expected body weight based on shape and height. The Anorexic person is driven by the intense fear of weight gain and the disturbance in body image perception; caloric restriction takes precedence over hunger, nutrition, and overall health. The Anorexic client is often creative and manipulative regarding self-starvation tactics. Anorexic clients will often lie about their eating habits when confronted by loved ones, they will feign eating by pushing their food around, or manipulate small amounts of food to look like larger
amounts of food in order to avoid suspicion by others (Crowther et al., 1992). The Anorexic client often protects the disordered behaviors at any cost which can lead to social isolation, complete avoidance of any situation in which food may be involved, and various levels of dishonesty regarding caloric intake. Most Anorexic clients will not entirely abstain from food, rather, picking foods that are considered safe enough to eat. A safe food is often determined by having low calorie content yet still being edible. People who struggle with Anorexia are often resistant to eating any food that is considered to contain a high fat or caloric content. Thus, the Anorexic client is still eating yet not eating enough overall categories in order to support an appropriate body weight. Anorexic individuals will often resort to any means necessary in order to continue the restrictive behavior despite physical and emotional consequences.

**Physical Complications**

Anorexic clients tend to be in poor physical health and can experience a wide range of physical consequences related to extreme calorie restriction. Such consequences include cardiac abnormalities such as low heart rate, irregular heartbeat, hypotension, and orthostasis, which is a drastic jump from low blood pressure to high blood
pressure. Other physical complications can include chronic dehydration, anemia, electrolyte abnormalities, hypothalamic abnormalities, decreased cognitive ability, osteoporosis, muscle weakness, and sleep disruption (Sharp & Freeman, 1993). All of these symptoms can prelude the death of the Anorexic client and/or result in lifelong physical complications. People with Anorexia often experience a severe intolerance to cold temperatures and can even become hypothermic under normal weather conditions. Anorexia has the highest mortality rate of any other mental illness (Sharp & Freeman, 1993). In a study conducted by the National Association of Anorexia Nervosa and Associated Disorders, it was found that 5-10% of people who struggle with Anorexia die within ten years of contracting the illness. 18-20% of people with Anorexia die within twenty years of contraction, and only 30-40% of people who struggle with Anorexia will ever recover. Such grim statistics are motivation to explore different treatment options and therapeutic interventions in order to provide clients with a better outcome and eventually a cure (www.natioanlassociationofanorexicanervosa.com).

Compensation and Striving for Perfection

Adler identified a force that he believed motivated behavior; he called this force striving for perfection.
Striving for perfection describes what Adler believed was innate human desire to fulfill potential. Adler believed all people have an ideal and all people desire to move close to their idea (Backman & Dixon 1992). Theoretically, working toward mastery can be a positive initiative although Adlerian theory addresses how striving for perfection can also be detrimental. Perfection is not only a difficult pursuit but it is, at times, unattainable. Anorexia Nervosa is an illness that thrives on the goal of perfection. The onset of Anorexia often coincides with the individual’s desire for a perfect physical figure. The definition of the perfect physical figure can vary from region to region and culture to culture. In western society bodily perfection is most often associated thinness and muscle tone. The Anorexic client yearns for physical perfection and engages in extreme measures to attain the goal. Extreme behaviors generally include calorie restriction regardless of consequences (Bronwell & Foreyt, 1986). Adler believed that some types of psychopathology could emerge from the person’s desire to reach perfection. The Anorexic client is a perfect example of how striving for perfection can be harmful versus helpful. The Anorexic client strives to reach an idealized physical goal yet compromises their health and wellbeing in the process.
Compensation is a term Adler coined while developing the idea of striving for perfection. Adler maintained that while people work toward fulfilling their potential, they often compensate for shortcomings or weaknesses. The Adlerian theoretical stance on compensation indicates that all people have inferiorities and try to “make up” for these inferiorities through superiority in another area of life (Backman & Dixon 1992). For the Anorexic client this can mean feeling inferior in one or more life tasks and the client compensates through weight loss and calorie restriction. Anorexic clients frequently report feelings of inferiority in a variety of life tasks yet consistently compensate through food and weight. Anorexic clients may have different feelings of inferiority regarding different issues yet the compensation behavior(s) are very similar. Adler believed parts of human behavior could be understood through determining how a client compensates for his or her inferiorities. Once the inferiorities are identified therapeutic interventions can help the client reduce problematic compensation behaviors (Backman & Dixon 1992). When working with the Anorexic client, the therapist must help the client identify the feelings of inferiority and work toward healthier methods of compensation. The Anorexic client may feel insecure in his or her ability to navigate
relationships appropriately, therefore the client may compensate for this inferiority by losing weight in order to feel more accepted in a peer group. The descent into the perils of Anorexia can often start off as a simple diet change or weight loss attempt. People who feel inferior in other life tasks or are struggling to feel accepted within peer groups may turn to weight loss as a way to feel superior over their peers. Anorexic clients frequently report feeling “strong” or “in control” over caloric intake especially when compared to peers who may not exhibit the same level of control (Garfinkel & Garner 1980). The Anorexic client will then feel a sense of superiority over the basic needs of the body.

In order to effectively work with a client from an Adlerian perspective, the therapist and client must explore the relationship between Anorexia and compensation. In the traditional behavioral-modification approach, the client is often confronted with a problematic behavior (caloric restriction) by the therapist and followed with a discussion of leverage to change the behavior (i.e. if the client does not restrict, the client can have a pass away from treatment). While leveraging behavior can help the client be compliant with a treatment plan it is unlikely to produce internal motivation to change behavior. When
applying the Adlerian approach to treating Anorexia, the therapist would instead use therapy time to discuss what the client could be compensating for and where the client may feel inferior. The therapist and client would examine the relationship between problematic behaviors (calorie restriction) and how the behavior helps the client to feel superior. Once the feelings of inferiority and superiority can be identified, the client is more likely to find internal motivation for behavioral change.

**Masculine Protest**

Traditionally, Anorexia Nervosa has been viewed as a female-only disorder. For many decades, Anorexia was considered to be an illness that only females struggled with and males were not at risk for. In the past, treatments for Anorexia focused on a female-perspective and often catered to a female experience. Only in recent years has the prevalence of Anorexia in males received more attention in mainstream media and clinical realms (Andersen 1990). Anorexia affects both genders and although women have a higher rate of Anorexia, men also struggle significantly with the disorder. In Adlerian psychotherapy the term *Masculine Protest* refers to the concept that men and women have different cultural experiences based on social expectations of normative gender behavior. In
Adler’s realm, boys were held in higher esteem than girls, a practice that is still prevalent in western society. Boys have traditionally received more praise for accomplishments and high academic expectations meanwhile girls traditionally receive more feedback based on appearance and performance (Ansbacher & Ansbacher, 1956). Adler maintained that even though social expectations for boys focus primarily on aggression, strength, and control; boys are not innately “better” than girls because of socially constructed characteristics. Adler noted social expectations of girls focus on passive, weak, and dependent behavior. In regard to the Anorexic client, the male client may feel he has lost his masculine qualities because he struggles with a “female” illness (Andersen 1990). Men with Anorexia are often less likely to seek help until the illness has severely ravaged the person (Andersen 1990). Male clients often view seeking treatment as an omission of weakness and lack of personal control. Adler believed that all people were born the ability to “protest” the expected masculinity (or femininity) of the culture. Adler asserted that boys are encouraged to be more assertive than girls, thus, by encouraging girls to be more assertive early on in life, rebellion against the social constructions can be lessened. If boys are nurtured and encouraged to be
authentic from infancy, they will be less likely to feel the pressure of “masculine” behavioral expectations. In the Anorexic client, helping the client, male or female, identify and understand masculinity and femininity within their own experiences is likely to encourage the client to be more authentic versus living up to social expectations. It is important when treating a male Anorexic client to reiterate that Anorexia is not a disorder of the weak, feeble, or dependent people. The clinician must remind the male client that Anorexia is a severe mental illness with several causational factors. It makes sense that male clients who struggle with Anorexia and who are educated on masculine protest and social expectations may be more accepting of treatment and the recovery process.

Private Logic

Similar to masculine protest, of which Adler considered an internal set of thoughts and values regarding gender and social construction, private logic is also an internal set of ideas, beliefs, and values (Kern & Curlette, 2008). All people use different forms of private logic as a means to justify actions, thoughts, and beliefs within the world. The Anorexic client is a perfect example of how private logic can be detrimental to the self. The Anorexic client uses his or her own set of beliefs to
justify dangerous behavior. For example, an Anorexic client may use the private logic of “I am too fat, I shouldn’t eat,” as a way to justify another day of calorie restriction. The client may use this private logic despite indications that he or she is not, in fact, fat by societal standards. Many Anorexic clients develop a private logic that supports the body image distortion and justifies the dangerous behavior. Anorexia Nervosa is a very difficult illness to treat in part because of the strength of the internal negative belief system. The private logic of most Anorexic clients focuses primarily on weight loss at any cost, self-criticism, and self-hatred. Adler’s approach to private logic is to encourage the client to explore and understand his or her own private logic. Once the clinician and client can identify the private logic, the clinician can help the client challenge the private logic with more coherent, empirically supported evidence. Without trying to understand the client’s private logic and internal process, the therapist runs the risk of not understanding the motivation for client’s actions. Attempting to understand the client’s motivations will allow therapy to continue in a motivating direction.
**Social Interest**

Adlerian psychologists believe that human beings are driven by the desire to achieve goals and make decisions (Farber & Farber 1938). Adler maintained that humans were not just mechanically inclined through instincts and organic drive but social beings that need to belong and contribute to the social group (Farber & Farber 1938). Adler used a term called “Gemeinschaftsgefühl” to describe the innate community feelings that he believed all humans inherently strive for (Ansbacher & Ansbacher 1956). As social creatures, people want to fit in with a group, feel connected to one another, and interact with each other. Just as important as connecting with one another is the feeling of contribution to the community. Contribution to the community helps the individual develop a sense of importance and purpose.

Anorexia Nervosa is a disease that breeds on self-centeredness and isolation. The Anorexic client will often become completely obsessed with food, weight, and body shape, which lead little time for other activities or meaningful interactions. Anorexia consumes the client’s thoughts and renders the client unable to appropriately contribute to society. The severely Anorexic client will frequently lose sight of everything outside of the disorder.
and will only attend to needs that encourage the disorder. For example, an Anorexic client may not have enough energy to participate in a neighborhood clean up or a family gathering but instead would use energy to exercise excessively. Instead of participating in a social activity that breeds community contribution the Anorexic client would chose an isolating activity.

When treating an Anorexic client the Adlerian approach to social interest could help the client step outside of him or herself. Encouraging the client to think about and explore his or her own definition of social interest could help the client identify where he or she could improve social functioning (Barlow, Schmidt, & Tobin 2009). The therapist should encourage the Anorexic client to find activities that encourage social interaction and a sense of importance within the community. Volunteering, employment, taking care of a vulnerable being (such as children, the elderly, pets), or creative endeavors will help increase feelings of community contribution and importance, which gives a sense of social belonging. Humans naturally want to feel needed and important to the social structure. By helping the Anorexic client move out of the selfish realm of Anorexia and into a more productive existence, the client will begin to move toward health in order to
maintain a newfound sense of belonging (Ansbacher & Ansbacher 1956).

A person who is lacking social interest seeks personal superiority and personal success. Although it is important to take care of oneself, it is problematic if a person only takes care of himself or herself. Ansbacher & Ansbacher described an Adlerian perspective on social interest:

Neurotics, psychotics, criminals, drunkards, problem children, suicides, perverts, and prostitutes are failures because they are lacking in social interest. They approach the problems of occupation, friendship, and sex without the confidence that they can be solved by cooperation. The meaning they give to life is a private meaning. No one else if benefited of their aims, and their interests stops short at their own persons (p. 156)

Of course it is now known that many mental illnesses have bio-psycho-social origins and not all mental illnesses are created equally. It is true that many people with mental disorders such as Anorexia engage in selfish actions that only hurt the people around them. People with Anorexia often spend hours engaging in Anorexic symptoms while ignoring other demands and responsibilities in his or her
life. When the Anorexic client is encouraged by the therapist to engage in activities that increase social interaction and social responsibility, the hope is that the client will use feelings of social interest as motivation to stop the Anorexic behaviors.

**Birth Order**

The exact cause of Anorexia is not known. Experts theorize there are many different factors that can lead to the development of Anorexia. Biological, emotional, psychological, and environmental factors can be indicators of the development of Anorexia (Bronwell & Foreyt 1986). There is not a prototype for the Anorexic client nor is there a specific personality that leads to Anorexia. Many people, of many different backgrounds and experiences can and do develop Anorexia. Adler’s theory on birth order, however, could provide some guidance for a therapist treating the Anorexic client.

Simply put, Adler believed the order of which one is born into a family inherently effects the development of personality (Strauch & Erez 2009). While there is not a specific personality of the Anorexic client, there are some personality traits that tend to be common in the Anorexic client. Characteristics such as perfectionism, controlling behaviors, rigidity, obsessive behaviors, and difficulty
with change are common among clients with Anorexia (Strauch & Erez 2009). The birth order of the client can effect whether he or she has characteristics that may exacerbate the Anorexic behaviors. For instance, according to Adler if the client is the firstborn child he or she will most likely experience a greater number of problems as an adult. The firstborn child is celebrated and pampered early in life and often receives excessive attention from the parents. The firstborn relishes in the attentions and feels secure being the center of the parents’ attention (Slavik & Carlson, 2006). Once a younger sibling is born, the firstborn no longer receives all of the parental attention and is left feeling confused and insecure. The firstborn begins to question his or her place within the family, begins to feel inferior, and may try desperately to regain the attention he or she once received (Slavik & Carlson, 2006). If the Anorexic client is the firstborn within the family of origin, the therapist should explore a possible connection between the Anorexic behaviors and the client’s birth order. Some Anorexic clients continue to remain ill in order to gain attention and care from parents, family, and friends. If the Anorexic client is a firstborn child, it is possible that the client is acting out feelings of insecurity from childhood inferiorities. The client may use
the Anorexia, as a way to feel important to loved ones considering people who are ill often receive attention and concern.

Firstborn children are also more likely to be rebellious and disobedient (Slavik & Carlson, 2006). Anorexia can often develop out of the client’s need to feel in control of his or her life. If a client is a firstborn, the Anorexia may be a form of rebellion against the parents. Anorexic clients often use caloric restriction as a means of control (i.e. only I control what goes into my body!) If the client begins caloric restriction and sees it as a source of frustration for the parents, the client may be inclined to continue the behavior in order to rebel against the parent’s wishes.

When considering the firstborn birth order as a factor for the development and continuation of Anorexia, the therapist should explore the client’s feelings of inferiority and need for attention. The therapist should encourage the client to find other, more useful means of feeling superior and gaining attention. The therapist should discuss how being the firstborn may be contributing to the Anorexia and how the client can work through feelings of being “dethroned.” The therapist should work with the client to gain an understanding that rebellion,
especially in the form of self-destruction, is not helpful to the client. The client may need reassurance that there are other, healthier ways to receive attention from parents, family, and loved ones.

The second born child who develops Anorexia will be affected by the birth order in a different way than the firstborn. Adler believed the second born child tends to be competitive and constantly trying to “outdo” the opponent, in many cases the other sibling(s) (Slavik & Carlson, 2006). In the Anorexic client the competitive trait may encourage the client to become the thinnest, best anorexic possible. In some cases, a person struggling with Anorexia may be very competitive with other Anorexic clients in terms of who is the sickest, most emaciated, or who has the most severe case (Slavik & Carlson, 2006). In western culture, a thin body is an ideal that many people strive to attain and the second born child may see this as an opportunity to be better than the other siblings, better at being thin. The second born Anorexic client may be driven to be the “best” at being thin which can make therapy very difficult if the client feels they are “winning” by having the disease.

The therapist of the second born Anorexic client must explore the birth order with the client and determine how
it has affected him or her. Since competition is important to the second born, the therapist could challenge the client to “compete” for recovery over the illness. Instead of being the “best” Anorexic the therapist should encourage the client to see recovery as a competition between the Anorexia and a healthier life. The second born child may be able to use the natural competitive drive as an asset to recovery versus a hindrance.

Adler theorized that the youngest child is the most pampered of all the children. The youngest child will never be “dethroned” and therefore often feels secure about receiving attention from the parents (Slavik & Carlson, 2006). The youngest child does, however, have traits that can be detrimental if they are not addressed. The youngest child may feel incredibly inferior due to always being the “last” sibling to achieve milestones (Slavik & Carlson, 2006). The youngest child is often left behind as the older siblings have more privileges because of age and ability. The youngest child who develops Anorexia may be responding to feelings of inferiority through restricting caloric intake, thus feeling superior over feelings of hunger and satiety. The youngest child who is Anorexic may use the false sense of superiority that can come with caloric restriction to feel “better than” the other siblings.
When treating the Anorexic client who is also a youngest child, it is important to consider the tendency of the youngest child to feel inferior (Kern & Curlette, 2008). Therefore, it may be a good idea to use encouragement as a way to build up superior feelings in the client. The client who is already prone to feeling insecure and inferior may need extra encouragement in order to fight through the disorder.

The only child has a unique position within the family. Adler maintained that the only child is the most pampered because there are no siblings to share attention and accolades (Erez & Strauch 2009). The only child is unique because he or she receives all the parental attention and simultaneously shoulders all of the parental anxieties, hopes, and dreams for the offspring (Kern & Curlette, 2008). If there are no siblings to share the load of expectations, the only child may become anxious and perfectionist. The only child may see his or her existence as the “one shot” at success for the parents because there are no siblings to share the responsibility.

The only child who develops Anorexia may be feeling pressure to be successful since there are no siblings to share that burden. The child may develop Anorexia as a means to be “perfect” at losing weight. The only child may
view the Anorexia a means to control the pressure of being the only child. The Anorexic client who is an only child may use the obsessions that accompany Anorexia as a way to “escape” the constant attention of being the only child within a family.

The therapist who is treating the Anorexic client who is an only child must take the birth order into great consideration. The therapist must help the client recognize how the Anorexic behaviors contribute to feelings of being “the one and only” child. It is important for the therapist to recommend activities that would engage the client in relating to other people, thus not being the center of the therapist’s attention. An only child would be the perfect candidate for a therapy group or support group. The client would be able to get support and help for the Anorexia without recreating the childhood role of being the “only” person of concern. The client would learn how to share attention with other group members which would help the client become more comfortable being part of a group versus the center of a group.

Overall Adler considered birth order a heuristic idea that must not be taken too seriously (Kern & Curlette, 2008). Not all children will resemble their birth order model and it is important to take each circumstance and
individual situations into account. The therapist must include the client on any discussions about the relevance of birth order in order to ensure the client can identify with any hypothesis.

Adlerian Therapy as a Treatment Model

There are many pieces of Adlerian therapy that can be used when treating the Anorexic client. Adler subscribed to several ideals that are crucial to treating the Anorexic client. Adlerian therapy focuses on the client as an individual with unique thoughts, feelings, and circumstances. Some of Adler’s ideas can be worked into the treatment of Anorexia Nervosa and would likely be successful. Currently there are no Anorexia treatment facilities that focus specifically on Adlerian therapy, there is however an increased interest in treating Anorexia from a holistic approach (Ansbacher & Ansbacher, 1956).

Adler began the movement toward holistic therapeutic approaches during a time when psychology was extremely focused on treating the presenting psychological problem as within psychotherapy as a necessary approach to understanding the whole person. Adler believed people were more than their psychological struggles and treatment must consist of a holistic approach in order to strive for long-term success (Wilson & Fairburn, 1998).
Anorexia is an illness that affects the mind, body, soul, and environment. There are many different factors that can lead to the development of Anorexia, thus treatment must address many aspects of life. The Anorexic client may feel inferior in many areas of life which contribute to the Anorexia and therefore the client must be treated as a whole person; mind, body, and soul. Birth order, Social Interest, Private Logic, Compensation, Masculine Protest, and Striving for Perfection are only some of the many areas that must be examined when treating an Anorexic client. There is much research to do in order to improve the treatment of Anorexia Nervosa and Adlerian therapy is one modality that offers understanding, acceptance, and hope for the Anorexic client.
References


