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Conceptualization and treatment of the bulimic client from an Adlerian perspective

Abstract

They are your friends, your employees, your students, and your clients. In many respects, these individuals may appear to lead very normal lives. 1 Their outward appearance may seem to be calm and collected. Yet in private, they wage a personal war with food. In order to deal with issues that remain hidden form others, they secretly binge on large masses of food. A pint of ice cream or a bag of chips may only be the beginning of what could be hours of eating and then ultimately purging. This type of behavior is indicative of a serious eating disorder requiring clinical attention.

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CONCEPTUALIZATION AND TREATMENT OF THE BULIMIC CLIENT FROM AN ADLERIAN PERSPECTIVE

A Research Paper

Presented to

The Department of Educational Administration

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Master of Arts.

by

Denise M. McCormick

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They are your friends, your employees, your students, and your clients. In many respects, these individuals may appear to lead very normal lives. Their outward appearance may seem to be calm and collected. Yet in private, they wage a personal war with food. In order to deal with issues that remain hidden form others, they secretly binge on large masses of food. A pint of ice cream or a bag of chips may only be the beginning of what could be hours of eating and then ultimately purging. This type of behavior is indicative of a serious eating disorder requiring clinical attention.

According to the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), bulimia nervosa affects 1%-3% of adolescent and young adult females. Bulimia is characterized by binge-eating large quantities of food followed by purging behavior. The purging behavior may include self-induced vomiting, laxative, and dieuretic use. Cesari (1986) noted that 20%-30% of college females engage in bulimic behaviors. Due to the secrecy and feelings of shame which surround the disorder, the incidence of bulimia may actually be much higher. Those individuals who do enter counseling may expect immediate results and may become easily

frustrated with therapy (Yates, 1989). Bulimic clients' frustration and resistance to counseling could lead to a premature dropping out and lack of further counseling. Without clinical attention, these individuals are bound to face continued emotional and physical difficulties. The physical difficulties that these clients may face include electrolyte imbalances, loss of dental enamel, enlarged parotid glands, and menstrual irregularity or amenorrhea. Individuals suffering from bulimia may also have more serious problems such as esophageal tears, gastric ruptures, or cardiac arrhytmias which are potentially fatal (APA, 1994).

The chances of counselors having to treat a bulimic client are very great, so there is an increasing need for counselors to be prepared to deal with these individuals as effectively as possible. However, the question of what treatment will be effective still remains. There are many theoretical models available for mental health counselors to use in treating these clients. Each of these models, such as Cognitive-Behavioral or Psychoanalytic, can prove effective with some clients. However, these theoretical models may not always be sufficient. Some

practitioners prefer to use a more integrated eclectic intervention strategies. Corey (1991) found that the most popular approach chosen by clinical and counseling psychologists was eclectic. During the process of developing an integrated approach, counselors may look towards many different theories to find effective ways to conceptualize and treat their clients.

One approach which might be appropriate to consider in this process is Individual Psychology. While Adlerian theory has received little attention in the literature related to the treatment of bulimia, it may be a valuable and viable approach which can be used to treat these individuals. Sperry and Carlson (1993) noted that successful treatment for individuals suffering from bulimia needs to involve a multimodal approach. Adlerian theory offers such an approach.

According to Adlerian theory, an individual can best be understood holistically as a total being (Sherman & Dinkmeyer, 1987). The thoughts, feelings, and behaviors of the individual are all taken into account when utillizing the theory. Adlerian theory is also based on a growth model which emphasizes an individual's choices and potential to change (Sperry & Carlson, 1993). Bulimic clients may present with

control issues with which the therapist will need to address and deal effectively. By utilizing Adlerian theory, the bulimic client may be less resistant and realize that he or she has choices and may choose to control his or her own behavior.

The focus of this paper is to offer mental health counselors one way in which to conceptualize and treat the bulimic client in addition to the usual interventions and approaches to this disorder. The basic tenets of Adlerian theory will be discussed, as will an Adlerian conceptualization of the bulimic client and treatment interventions.

Basic Tenets

Purpose of Behavior/Social Context

Adlerian theory is based on several assumptions. A primary assumption is that individuals are social beings whose behavior can best be understood within a social context (Dinkmeyer, Dinkmeyer, & Sperry, 1979). From infancy into old age, individuals continually interact with others and the environment that surrounds them. As a result of these interactions and the individual's interpretation of them, a unique set of attitudes and beliefs are developed (Corey, 1991). Alfred Adler believed that individuals use their

natural and learned traits to move through life (Sperry & Carlson, 1993). The attitudes, beliefs, and natural or learned traits then guide the individual's behavior.

Gaining Significance and Belonging

The goal of belonging or gaining significance is a second assumption underlying Individual Psychology (Dinkmeyer, Dinkmeyer & Sperry, 1979). The goal of belonging can be understood as the central goal which guides an individual's behavior (Corey, 1991). This central goal is the movement of the individual towards the achievement of a unique identity and belonging (Dinkmeyer et al., 1979). As the individual moves towards this goal, he or she may choose, consciously or unconsciously, to display behaviors which gain him or her significance. Each individual also has the creative power to interpret past and present events (Corey, 1991). Based on the individual's interpretation of past and present events, and the formation of attitudes and beliefs based on that interpretation, he or she will choose to behave in ways which gain a sense of belonging. According to the first two assumptions, behavior is not merely random action. Behavior can be conceptualized in terms of the purpose and goal that it serves for the individual

(Dinkmeyer et al., 1979).

Striving for Superiority and Feelings of Inferiority

According to Adlerian theory, individuals are striving for superiority. The striving for superiority has also been termed as the movement from a perceived minus to a perceived plus (Sperry & Carlson, 1993). Striving for superiority represents a striving for one's own potential rather than gaining superiority over others (Corey, 1991). The striving for superiority gives the individual feelings of power, competency, and security (Sperry & Carlson, 1993). All individuals will experience a perceived minus at some point in their lives. Sperry and Carlson (1993) referred to these perceived minus experiences as feelings of inferiority. These feelings of inferiority can cause an individual to feel helpless or discouraged (Corey, 1991). In order to deal with these feelings of discouragement, the individual will attempt to compensate for his or her weaknesses and again strive towards superiority (Sperry & Carlson, 1993). Most individuals will experience feelings of inferiority at some point in their lives. These feelings are not viewed as being pathalogical. Yet some of the actions taken by an individual to compensate for these

perceived weakneses may be viewed as unhealthy or unhelpful (Sperry & Carlson, 1993).

Formation of the Lifestyle and Personality Priorities

Based on these assumption which include the purpose of the individual's behavior, how he or she gains significance, and how he or she strives for superiority and deals with feelings of inferiority, a lifestyle develops which includes personality priorities. The lifestyle refers to the individual's basic orientation and movement through life (Sperry & Carlson, 1993). The lifestyle can be conceptualized as a set of basic convictions that the individual has about self, others, and the world, and the behaviors based on those beliefs (Corey, 1991; Sperry & Carlson, 1993). The beliefs and attitudes that the individual develops about self, others, and the world may be based on either common sense or on private logic (Sperry & Carlson, 1993). Common sense is thoughts and attitudes that are found in the general population. Private logic, however, is based on purely individual, unshared perspectives. These unshared perspectives forming the individual's private logic are not pathological, but may not help the individual function as effectively as he or she could function (Sperry & Carlson, 1993). An

individual who acts in a manner which is inconsistent with what the situation calls for may be acting based on his or her private logic (Dinkmeyer et al., 1979).

Personality priorities develop as part of the individual's lifestyle. In Adlerian theory, there are four basic personality priorities (Dinkmeyer et al., 1979). They consist of the comfort type, the pleasing type, the controlling type, and the superior type (Dewey, 1978). The comfort type attempts to avoid stress, responsibility, and expectations. The pleasing type tries to avoid rejection from others and tries to meet the needs of others. The controlling type seeks self control, or control of others and situations. Individuals with this priority attempt to avoid humiliation or surprises. The superiority type seeks greater levels of competency and usefulness as compared to others. These individuals try to avoid feelings of inferiority. Each personality priority type reflects the manner in which the individual strives for belonging (Dewey, 1978). Dewey (1978) noted that there are both positive and negative aspects for each priority. An understanding of the personality priority of the individual allows insight into how he or she gains significance and what must be avoided at all

costs (Dinkmeyer et al., 1979). Many times, personality priorities are based on the individual's private logic or mistaken assumptions. In order to better understand the individual's personality priority, the counselor needs to explore the client's core convictions and short-term and long-term goals. The lifestyle and the personality priorities of an individual are adaptable until a challenge arises that the individual cannot meet (Sperry & Carlson, 1993). An individual may functin based on a certain personality priority yet utilizing a particular priority mayt not fulfill the his or her needs. However, as stated before, individuals are creative beings who can choose to change, modify, or alter their lifestyles and personality priorities in order to function more effectively.

Intervention Focus and the Unity of the Person

Adlerian counseling interventions primarily focus on the client's cognitions. Adlerian therapy takes this focus because many of an individual's behaviors are viewed as the result of his or her cognitions (Dinkmeyer et al., 1979). These cognitions may or may not be at the level of consciousness (Dinkmeyer et al., 1979). As discussed earlier, the individual begins to

develop a lifestyle early in life, usually within the first six years of age (Corey, 1991). The primary focus in counseling may then reflect the individual's cognitions and perceptions about both past and current events. Although treatment interventions may focus primarily on cognitions, personality can only be understood as a unified, indivisible whole (Corey, 1991). Within the individual's personality, the thoughts, feelings, and behaviors are interrelated. Together they reflect the individual's lifestyle (Corey, 1991). Therefore, although the primary interventions focus on cognitions and challenging the client's private logic, there is also an understanding that thoughts, feelings, and behaviors are interrelated and unified.

Adlerian Conceptualization of the Bulimic Client

Pleasing and Control Personality Priorities

The counselor working with the bulimic client will need to begin to understand his or her personality priorities. By gaining a better understanding of these priorities, the purpose of the bulimic's behavior may be made clearer. Based on the author's clinical experience, it seems that the bulimic client functions based on either the pleasing type or control type

priority. The bulimic client with a pleasing priority may be overly sensitive to other's expectations (Britzman & Henkin, 1992). A pleasing personality priority may be identified by success in relationships, friendliness, peace keeping, and non-competitive traits (Britzman & Henkin, 1992). The bulimic client may also believe that he or she needs to be thin in order to fit in and belong in a diet-crazed society (Sperry & Carlson, 1993). By pleasing others, and assuming responsibility for maintaining relationships, the bulimic client may gain his or her sense of belonging. However, as the bulimic client utilizes this pleasing personality, he or she battles with food by binging and purging rather than with others. The client may choose to stuff food similar to the manner in which he or she stuffs his or her feelings and needs in order to avoid displeasing others by asking for nurturing or consideration.

The bulimic client may also function based on the control personality priority. The bulimic client may feel that his or her life is uncontrollable (Brouwers, 1994). Closely connected to the perceived lack of control over his or her life is a perceived lack of choices. The bulimic's response to that perceived lack

of choice and control is the movement to take control over his or her body. Brouwers (1994) found that a perceived lack of control was a common theme among many bulimic clients. Sperry and Carlson (1993) found that bulimics are characterized by their feelings of being out of control. The bulimic client may attempt to control those around him or her and believe that he or she can control his or her own world by focusing on controlling his or her own body (Sperry & Carlson, 1993).

Belonging in the Family and Family Atmosphere

The development of the bulimic's personality priority is tied to the family atmosphere and how he or she belongs within the family system. Sperry and Carlson (1993) found that the bulimic client's family tends to be low in cohesiveness and high in conflict. The bulimic family may also be one which promotes a sense of psychological isolation from others (Sperry & Carlson, 1993). These families may also overcontrol, overindulge, and overprotect the bulimic client. These typically middle to upper class families may focus on the importance of maintaining appearances (Lacey, Gowers, & Bhat, 1991). Dewey (1973), described the family atmosphere as the characteristic pattern of

interaction and expectations which are established by the parents and presented to the children. The family atmosphere presented to the children serves as the standard for social living and affects the development of the child's lifestyle. The bulimic client may have either an inconsistent or overindulgent family atmosphere. The inconsistent atmosphere as described by Dewey (1973), may represent the bulimic client's family style. The inconsistent atmosphere is one in which discipline is erratic, and there is no sense of routine (Dewey, 1973). In this type of environment, the bulimic client never understands or learns what is expected of him or her. Living in an inconsistent and chaotic atmosphere may lead the bulimic client to try to control others or his or her own body.

The second family atmosphere is the overindulgent atmosphere. In order to better understand how the bulimic client fits into this type of family atmosphere, it may be helpful to identify his or her birth order in the family. Lacey, Gowers, and Bhat (1991) found that bulimic clients are likely to be the oldest or first born child. According to Adlerian theory, the oldest child may be somewhat spoiled, hard working, and striving to keep ahead (Corey, 1991).

These characteristics fit with the overindulgent, highly expectant family atmosphere described by Sperry and Carlson (1993). It may be speculated that the bulimic client has been expected to succeed because he or she is the first born or oldest child. He or she may have received messages from his or her family that he or she is expected to be no less than perfect. The bulimic client may begin to try to please others in order to gain their approval yet neglect his or her own needs. New siblings may be viewed as competition to the oldest child (Corey, 1991). The presence of a new sibling may then reinforce the bulimic client's need to succeed and appear without imperfections. In other cases, attempts to succeed may be met with failure. The inability to succeed may lead to feelings of being out of control and develop into a control personality priority.

Bulimic's Level of Functioning in the Five Life Tasks

The bulimic client may appear to feel much better that he or she actually feels (Sperry & Carlson, 1993). The bulimic client appears strong, sociable, and assertive to others who have interacted with him or her (Sperry & Carlson, 1993). Yet, beneath this mask lies difficulties with intimacy and self-esteem. The

bulimic's feelings of inferiority are expressed through anxiety, depression, and self-criticism (Sperry & Carlson, 1993). There almost seem to be two halves or sides to the bulimic client's personality. Outward appearances appear healthy and involve involvements with friends and successful lifestyles (Sperry & Carlson, 1993). Yet the disorder leads to isolation and social difficulties (Sperry & Carlson, 1993). The bulimic client tends to continue to deal with these difficulties and feelings of anxiety by trying to control his or her body.

The five life tasks include work, friendship, love, spirituality, and self. On the surface the bulimic may appear to function in each of the five life tasks adequately (Sperry & Carlson, 1993). However, it is speculated here that this adequate functioning is a facade or mask that the bulimic client assumes. The bulimic client overtly manages to maintain friendships and other relationships, yet fears intimacy and isolates himself or herself (Sperry & Carlson, 1993). The bulimic client may also struggle with a poor self-esteem and be very self-critical (Sperry & Carlson, 1993). The bulimic client may be an overachiever and overambitious. This drive to achieve, to be perfect,

and to be in control may benefit the bulimic in his or her successes. Yet the drive behind these successes are not his or her own. Rather, these standards are typically ones set by others (Sperry & Carlson, 1993). The bulimic client has been pressured to succeed based on goals which were determined by his or her family rather than by himself or herself (Sperry & Carlson, 1993).

A Bulimic's Lifestyle Conceptualization

The lifestyle conceptualization presented here includes beliefs that bulimic clients may have about themselves, others and the world. The conceptualization presented here is based on research findings and the author's clinical experience.

I must have control over my actions (Sperry & Carlson, 1993).

I am fat and ugly (Sperry & Carlson, 1993).

I am afraid to have intimate relationships for fear of rejection.

I am a pleaser (Axtell & Newlow, 1993).

I am a perfectionist (Axtell & Newlow, 1993).

Others are more social (Axtell & Newlow, 1993).

Others are controlling and critical (Axtell & Newlow, 1993).

Others will not like me if I fail to please them.
Others will think less of me if I am not perfect.
Others are more powerful and abusive (Axtell & Newlow, 1993).
The world is a place where appearances are important.
The world is a scary and unsafe place (Axtell & Newlow, 1993).
The world is a place where control is important.
The world is a place where weakness is frowned upon.
The world is a place where you cannot trust others (Axtell & Newlow, 1993).

Treatment Phases and Interventions

Phases of Counseling

Adlerian counseling involves four main phases of treatment. These phases include establishing the relationship, exploring the individual dynamics, encouraging insight, and helping with reorientation (Corey, 1991). These are not discrete stages which will be passed through. Rather, the stages represent the progression of treatment with various aspects of each stage continuing throughout treatment. Subsequent interventions will be discussed in relation to the phase in which they would be utilized.

During phase one, the counselor begins to develop a collaborative working relationship with the client (Corey, 1991). At this time the counselor supports the client and helps the client identify assets and strengths rather than focusing on weaknesses (Corey, 1991). The counselor shows concern for the client by attending and listening to the client (Dinkmeyer et al, 1979). The counselor and client begin to align the goals of counseling in order to promote an egalitarian relationship (Dinkmeyer et al., 1979). Phase one does not end, but continues on for the duration of treatment. Without the mutual trust and respect of the relationship, there will be only limited psychological movement (Dinkmeyer, Dinkmeyer & Sperry, 1979).

The second phase involves the exploration of individual dynamics. During this phase, two areas are of primary interest. The counselor begins to try to identify and understand the client's lifestyle, and personality priority. The counselor is also concerned with trying to understand how the client function in each of the life tasks (Corey, 1991). The Adlerian counselor begins to help the client understand his or her perspective and begin to view the world differently. This involves a process of helping the

client make connections between his or her past, present, and future behavior (Corey, 1991). The client's feelings are explored along with the beliefs that underlie them (Corey, 1991). Encouragement is an important aspect of this phase. Once the counselor has gathered, interpreted and summarized information regarding the client's lifestyle, he or she encourages the client to examine his or her own mistaken assumptions.

Encouraging insight is the third stage in Adlerian counseling. The counselor continues to be supportive of the client, but now also confronts the mistaken goals and self defeating behaviors (Corey, 1991). The goal is for the client to gain insight into the hidden purposes and goals of his or her behavior. This insight is a step towards change or action (Corey, 1991).

The final stage in counseling is the reorientation stage. It is at this point that the counselor and the client work together to identify and consider alternative beliefs, attitudes, and behaviors (Dinkmeyer et al., 1979). The counselor's task is to remotivate the client to choose more effective behaviors and to take risks to change (Dinkmeyer et

al., 1979). In this final stage, the client begins to make decisions to modify his or her goals and insight is changed into action (Corey, 1991).

Specific Adlerian Interventions

In the first phase of counseling, establishing rapport with the bulimic client will be very important. The client-counselor relationship in Adlerian therapy is based on a sense of deep caring, involvement, and friendship (Corey, 1991). This relationship is viewed as a partnership working towards the benefit of the client (Corey, 1991). Establishing rapport with the bulimic client may prevent premature drop out or termination. Merrill, Mines, and Starkey (1987) noted that premature drop out is a concern for the bulimic client. The process of establishing rapport and encouraging the bulimic client begins at the onset of treatment and continues through termination. The role of the counselor is to help the client become aware of the assets and strengths which he or she has, rather than focusing solely on deficits (Corey, 1991). The Adlerian counselor focuses on these strengths by supporting and encouraging the client (Corey, 1991).

It is also important to align the goals of counseling between the counselor and the bulimic client. It may be speculated that if control is an issue for the bulimic client, then goal alignment is even more important. Counseling must focus on issues which the client deems significant and is willing to address (Corey, 1991). Sperry and Carlson (1993) also noted that developing a strong rapport is an integral part of counseling. The client may have a goal of having control of his or her own life. The therapist needs to acknowledge this and encourage the client to understand that his or her present behavior for achieving that goal may be unhelpful (Sperry & Carlson, 1993).

Early recollections and the Kinetic Family Drawing may be very helpful methods for gathering family data from the bulimic client (Handler & Habenicht, 1994; Clark, 1995). Both of these interventions uncover family dynamics that have or still are affecting the bulimic client's lifestyle. These interventions would be used during the second phase of counseling. Early recollections involve asking the bulimic client to recall specific events or memories that he or she has from early childhood years (Corey, 1991). Early

recollections are helpful in identifying and understanding the client's beliefs and private logic (Corey, 1991). It is important for the counselor to explore the feelings and thoughts associated with each memory. The early recollections give the counselor insight into the lifestyle of the client and how he or she gains significance (Corey, 1991). Clark (1995) stated that clients are often intrigued and challenged by the counselor's request to recall early memories. The early recollections can also be viewed as promoting and empathetic relationship (Clark, 1995). Sperry and Carlson (1993) noted that bulimic clients will often present with power and control issues. Therefore, early recollections may help to identify those issues as well as the bulimic client's interpersonal style and his or her feelings of inferiority (Clark, 1995).

The Kinetic Family Drawing can also be used as an intervention during the second stage of counseling (Handler & Habenicht, 1994). Family drawings as an assessment tools have been advocated by a number of writers (Appel, 1931; DiLeo, 1970; Koppitz, 1968 as cited in Handler & Habenicht, 1994). The Kinetic Family Drawing gives the counselor a clearer understanding of the interpersonal relationships and

emotional relationships between the bulimic client and other family members (Handler & Habenicht, 1994). The counselor asks the client to draw a picture of himself or herself and his or her family doing something (Cook, 1991). The client is asked to draw whole people rather than cartoon or stick figures (Cook, 1991). A variety of questions are then asked about each figuere in the drawing. The counselor may ask the client who each figure represents and what each of these figures needs, feels, and fears. Additional questions about the relationships between each figure and the client are also asked. The Kinetic Family Drawing helps reveal individuals' perceptions of themselves and of other family members (Cook, 1991). There may be feelings of competition, anger, inhibition, or needs for control which may be expressed in the client's responses to the counselor's questions (Cook, 1995).

Both the Kinetic Family Drawing and early recollections are subjective techniques which are useful only in the context of the client's reality (Cook, 1991). The counselor can make interpretations about the Kinetic Family Drawing and the early recollections. However, the interpretations are only valid if they are confirmed by the client (Cook, 1991).

Cook (1991) stated that these interventions can also serve as measures for progress in counseling. Over time, the early recollections and the Kinetic Family Drawing may change as the client's basic attitudes and assumptions change (Cook, 1991). When working with the bulimic client this change may not occur quickly. The bulimic client may deny the illness and may be resistant to changing behaviors or beliefs which continue to be reinforced by his or her lifestyle (Sperry & Carlson, 1993)

As therapy progresses, the counselor can begin to challenge the bulimic client's mistaken beliefs and private logic. The counselor will need to continue to be supportive, yet encourage the bulimic to see that he or she has a choice to change his or her behavior (Sperry & Carlson, 1993). By telling the bulimic client that he or she has choices, his or her sense of control is reinforced, resulting in his or her trying new behaviors or thoughts (Sperry & Carlson, 1993). As noted earlier, the bulimic client may also have many mistaken beliefs related to self, others, and the world. Sperry and Carlson (1993) stated that once these thoughts and beliefs are identified, they need to be examined in terms of feelings which are associated

with them. The counselor can also encourage the client to examine the rationality of these beliefs and the connection between the eating behavior (Sperry & Carlson, 1993).

The bulimic client may be asked to explore feelings associated with each belief and to create an alternative thought. The alternative thought should be one which encourages flexibility and self-acceptance (Sperry & Carlson, 1993). The bulimic client may have a difficult time identifying alternative thoughts and may need continued encouragement and support. It is important that the counselor gain a clear understanding of the feelings and messages behind the bulimic client's self-defeating thoughts and mistaken beliefs (Sperry & Carlson, 1993). Without exploring the connected feelings which correspond with the beliefs, treatment may not be effective (Sperry & Carlson, 1993). The counselor needs to continue to identify and focus on the client's strengths as mistaken beliefs are examined and confronted (Corey, 1991). Without this encouragement, the bulimic client may become discouraged and this may prevent change (Corey, 1991).

The last phase in Adlerian therapy focuses on putting the client's insights into action and practice

(Corey, 1991). At this point, the client is encouraged to take risks to change his or her life (Corey, 1991). Interventions to help the client do this may include giving him or her homework assignments, and "spitting in the client's soup." "Spitting in the client's soup" involves determining the purpose and the payoff that the behavior has for the client (Corey, 1991). This technique will be discussed more indepth later. For homework, the client may be asked to keep a journal or his or her behavior (Corey, 1991). The bulimic client could be asked to log binge-purge behavior and the feelings associated with that. The bulimic client could also be asked to write a letter to his or her food which was an intervention used by Brouwers (1994). Brouwers (1994) stated that this intervention allows for expression of thoughts and feelings associated with the bulimic's behavior. Sessions could also be spent helping the bulimic client schedule or brainstorm alternative behaviors which he or she could engage in when the need to purge arises.

As stated earlier, the counselor can now begin to "spit in the client's soup." This intervention involves determining the purpose of the client's behavior and reducing the usefulness of the behavior in

the client's eyes. For example, with the bulimic client, the counselor can spit in his or her soup by confronting him or her when he or she states that he or she has no control. The counselor can continue to show how he or she has a choice to continue or to alter his or her behavior. This may also help the client to see how his or her behavior may be restricting his or her own level of functioning (Dinkmeyer et al., 1979). The counselor can also help the client begin to catch himself or herself before he or she engages in old behavior patterns. As the bulimic client reverts back into destructive or self-defeating behavior, he or she can at least stop and consider new ways in which he or she can choose to respond. Through awareness and continued practice, the bulimic client can learn to anticipate situations which stimulate the binge-purge cycle and learn to either avoid them or change his or her behavior when confronted with them (Dinkmeyer et al., 1979).

Conclusion

Overall, counselors may find it helpful to identify the lifestyle and the personality priorities of their bulimic clients. By identifying the purpose of clients' behavior, counselors can help these clients

find new and more effective ways to meet their needs. Bulimic clients may be resistant to changing behaviors which have served as defense mechanisms in their lives (Sperry & Carlson, 1993). Bulimic clients may experience many failures in terms of falling back into binge-purge behaviors. The counselor needs to continually encourage these clients and help them deal with these setbacks.

The focus of this paper has been to present a conceptualization of the bulimic client from an Adlerian perspective so that mental health counselors can if they wish, integrate various aspects of the Adlerian theory and treatment into their own approach. It may be in the best interest of the bulimic client to look beyond the usual theoretical orientation to seek assistance and alternative views to treating this difficult and resistant disorder.

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