PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

The Significance of Outpatient Treatment and the Importance of Active Participation of Patients in the Treatment of Eating Disorders

Aya NISHIZONO-MAHER
Faculty of Psychology, Meiji Gakuin University
Psychiatria et Neurologia Japonica 126: 186-194, 2024

Abstract

Eating disorders are psychiatric illnesses with high prevalence and mortality. However, currently, outpatient treatment is not adequately delivered. After some period, from the start of treatment, many patients receive inpatient treatment for renutrition. Inpatient treatment is effective in increasing body weight. However, if that is the only treatment target, relapse after discharge is highly likely. A more effective outpatient intervention and a closer link between inpatient and outpatient treatment are necessary.

"Treatment in the community" is regarded as a basic principle in psychiatry today. It should also be the best treatment for eating disorders and, for that purpose, outpatient treatment should be the core of patient care. Unlike in inpatient treatment, doctors and medical staff at outpatient clinics for eating disorder patients cannot exert full control over the food intake and the level of activity of patients. In the case of outpatient treatment, patients themselves are expected to participate actively in the treatment.

How best can patients, who often deny their illness, participate in their own treatment? Psychoeducation, in particular, learning the concept of externalization is the start. If a patient externalizes their anorexia or bulimia nervosa, it is easier for them to work, together with medical staff to combat the illness which is troubling them. A guided self-help approach should be harnessed to monitor and control their pathological eating behaviour. Excessive exercise and activity should be controlled in a guided self-help

method; moreover, the anxiety that occurs following the cessation of excessive activity should be discussed, in order to examine the psychological background of the anxiety. A reduction of physical activity will be accepted by patients only when there is a clear treatment plan at the onset of treatment. Building trust and advance treatment planning is crucial.

The importance of weight restoration and the reduction of other symptoms are regularly emphasized in the treatment of eating disorders. However, other aspects such as social participation and acquiring a job are also crucial to the process of recovery. Currently, social and professional support for people with eating disorders to look for work and adapt to a work environment is inadequate compared to the support given to people with other psychiatric illnesses. Eating disorder patients are left to their personal motivation and effort. In addition to symptom reduction, outpatient treatment should include such elements as social skills training to enable them to look for employment, and to help patients communicate and assert themselves in the work environment. Updating industrial doctors and staff with such knowledge may be necessary.

If eating disorders are treated early, before physical and mental conditions become complicated, these illnesses are manageable for general psychiatrists, not just by specialists who are specialized in the field. In this way, better treatment opportunities for patients are available.

Keywords: anorexia nervosa, bulimia nervosa, outpatient treatment, hyperactivity, guided self-help

Introduction

Eating disorders, such as anorexia nervosa and bulimia nervosa, have a high prevalence and high mortality, yet treatment in Japan is not sufficiently effective. Eating disorders are classified as mental disorders both in the ICD-10[16] and ICD-11,[17] as well as in the American Psychiatric Association's DSM-5-TR.[1] While it is certain that eating disorders are mental disorders because they present with psychiatric symptoms and involve underlying psychological factors, the extreme malnutrition associated with anorexia nervosa makes it difficult for psychiatrists to treat the condition.

In the case of bulimia nervosa, there are often no physical symptoms that complicate psychiatric treatment; however, patients tend not to report their symptoms clearly, making it

difficult to ascertain the true nature of their condition. Patients often feel shame or guilt regarding their symptoms, and that self-stigma makes it difficult to establish a therapeutic relationship.[9)]

While some patients seek treatment with the hope of "stopping binge eating," stopping the behavior itself presents a different kind of difficulty from alleviating psychiatric symptoms such as anxiety or depression through pharmacotherapy. It is desirable to address the underlying psychology of binge eating, even when the patient's primary request is simply "I want to stop bingeing." Treatment often breaks down if the patient's focus cannot be shifted toward psychological factors. As such, eating disorders possess characteristics distinct from other mental disorders. Establishing a therapeutic relationship presents significant challenges.

In Japan, treatment for eating disorders involves not only psychiatrists but also physicians in internal medicine, gynecology, and other fields. In many cases, careful clinical care is provided with a counseling mindset. However, there is considerable potential to enhance treatment by positioning eating disorders as mental disorders and drawing upon approaches used for mental disorders in general.

In this paper, we position eating disorders as mental disorders. We examine the role of outpatient treatment within this framework, as well as what kind of treatment should be implemented, in collaboration with the patient. While there are established treatment formats for eating disorders, such as cognitive behavioral therapy,[8)] this discussion will focus primarily on general outpatient treatment.

I. The Significance of Outpatient Treatment for Eating Disorders

The principles of treatment for mental disorders are outlined in Table 1. Schizophrenia serves as a typical example, but the current, fundamental approach to treating mental disorders centers on community-based care. Specifically, this involves providing pharmacotherapy and psychological support in outpatient settings while at the same time promoting social participation through programs such as day care. Internationally, the nature of community-based treatment for eating disorders is now being discussed from a psychiatric perspective.[12)]

In recent years, the concept of "recovery" has gained recognition.[2)] However, it is not only 'clinical recovery' defined as symptom reduction that is considered important, but also 'personal recovery'. The latter involves the enrichment of one's personal life, and

'social recovery,' which refers to social participation. It is difficult to achieve personal and social recovery through inpatient treatment alone, making outpatient treatment crucial. Hospitalization may be necessary during the course of treatment for any disorder. However, this contingency is limited to situations in which particular circumstances cannot be managed in outpatient care. Furthermore, coordination between outpatient and inpatient treatment is necessary. Moreover, when different clinicians are involved, it is desirable that the patient and the clinician share the treatment goals together. In chronic cases, whether onset occurred in adulthood or childhood, it is often preferable to approach treatment using a model for treating mental disorders. In such a model,, the patient participates in treatment through psychoeducation, lives in the community while engaging in social activities, and focuses on relapse prevention.

Currently, there is a tendency for inpatient care to be the primary setting for treating eating disorders. This is likely due, in part, to the fact that nutritional support on a ward is easy to standardize and implement. On the other hand, it is regrettable that outpatient treatment tends to be limited to monitoring the patient's condition until the next hospitalization. If symptoms worsen, the patient is hospitalized to receive tube feeding to gain weight and is then immediately returned to the community. To use an analogy, this is equivalent to hospitalizing a patient with schizophrenia, administering a long-acting injectable medication, and discharging them immediately once symptoms subside—without providing any psychosocial support. If we define the outcomes of inpatient treatment as weight gain or a reduction in auditory hallucinations, then the treatment would be considered effective. However, relying solely on these measures leads to repeated relapses, and a favorable long-term prognosis cannot be expected. If instead, we set outcomes such as the patient's understanding of their illness and their motivation to participate in treatment, both the content of inpatient care and the preparation for transitioning to outpatient care could change. Some argue that nothing can be done in outpatient settings because doctors cannot monitor food intake or level of activity. At the same time, it cannot be said that good treatment requires doctors to control everything. Given the treatment outcomes described above, what factors are essential for effective outpatient treatment—one in which the patient actively participates and goes beyond mere observation?

II. Elements of Effective Outpatient Treatment

1. Psychoeducation and externalization

In schizophrenia, it is difficult to maintain medication therapy unless the patient has a good understanding of their illness. Similarly, in eating disorders, it is extremely important for the patient to understand that they have an eating disorder.

Among mental disorders, symptoms can be either ego-syntonic or ego-dystonic. In conditions such as obsessive-compulsive disorder, the individual experiences distress from frequently washing their hands despite feeling a sense of dissonance, thinking, "I know I don't need to worry about germs this much." In eating disorders, however, there is no such sense of dissonance—such as "I don't need to worry about my weight this much"—at the onset of the illness, and the desire to be thin is highly ego-syntonic.

The term "externalization" has been frequently used in recent years[10)13)]. This refers to the concept of separating the individual from the illness—that is, viewing the illness as existing outside the person. In the case of anorexia nervosa, externalization involves an understanding that the extreme preoccupation with weight is not one's own natural thought but a symptom of the illness, and that one is being controlled by the illness. To give a concrete example, if the individual can recognize thoughts such as, "I don't really need to worry about my weight this much, but because of my eating disorder, I've started worrying about it again," or "I feel like my tendency to worry about my weight intensifies when I lose confidence in my interpersonal relationships," then externalization has been achieved. Compared to the initial stage of thinking "I must lose weight," it can be said that the "desire to be thin" has become ego-dissonant.

Once externalization is achieved, the individual can collaborate with the therapist on how to address the symptoms. However, externalizing ego-syntonic symptoms is a time-consuming process. While this process is difficult for the patient, there are times when the therapist also fails to externalize these symptoms. When the patient says, "I want to go to club practice like everyone else" or "I want to compete in matches," the therapist can sometimes become dominated by these "voices of the illness." Care must be taken while intending to listen to the patient, not to listen to the voice of the illness. Once externalization is achieved, it becomes possible to listen to the patient's sense of distress, such as, "I know I'm sick, but I immediately think I want to lose weight, and I get tired of fighting against myself."

There is also an opinion that calling eating disorders "mental disorders" is unfair to the patients themselves. However, viewing eating disorders as merely "one aspect of personality," as is sometimes done in discussions of developmental disorders, makes externalization difficult. This is an area that requires thorough discussion with the patient and their family.

2. Patient participation in treatment—guided self-help—

It can be stated that if the kind of psychoeducation described above is provided and the patient actively participates in treatment, significant change can be achieved even through outpatient care. First, regarding nutrition, it is necessary to clarify precisely what the patient should plan to eat, assign this as homework, and then verify whether behavioral change occurs. Vague advice like "just eat more" is unlikely to bring about change. Furthermore, specifying a total daily calorie intake—such as "1,800 kcal per day"—is difficult if a registered dietitian cannot be involved in outpatient care. In such cases, one can aim for gradual weight gain based on the principle that an increase of approximately 7,000 kcal is expected to result in a 1 kg weight gain. This is a rough estimate[5] of the calories required to increase 1 kg of adipose tissue. Moreover, this varies depending on metabolic rate and physical activity. However, if there is a concrete guideline stating that, at least, a little over 200 kcal per day is needed to gain 1 kg per month, it becomes easier for the patient to participate in treatment. If the patient seeks treatment early in the course of the illness, a treatment plan can be devised, such as, "aiming for a 1 kg weight gain per month, and if this does not work, utilizing the summer vacation to be hospitalized." Since patients with eating disorders, particularly those with anorexia nervosa, often have impaired digestive and absorptive capacity, it is advisable to aim for an additional 300 kcal on top of their current diet, or to aim for an additional 300 kcal per day by adding food to their diet. This is in addition to controlling excessive activity, as described in the next section.

In the field of eating disorders, the patient's active participation in treatment is referred to as "guided self-help" (supervised self-help.)"[7] Patients with eating disorders often employ their own coping strategies, such as "choosing foods that don't cause abdominal pain and forcing themselves to eat" or "avoiding carbohydrates as much as possible to prevent binge eating." However, these "self-help efforts" often constitute the very source of their symptoms. Conversely, if the patient is too passive, this also makes it difficult

to achieve improvement. Aside from the period of hospitalization, patients must take an active role in managing their diet and daily life. For this reason, self-help efforts, guided by the therapist, are crucial. An approach that incorporates cognitive behavioral therapy techniques is referred to as 'guided self-help'. The UK's NICE guidelines[4] recommend guided self-help using workbooks and other materials as the first stage of treatment for bulimia nervosa. Regarding patient participation in treatment, the term "shared decision making"[14] is also current. This concept emphasizes choices—such as selecting Treatment B over Treatment A—and ,fundamentally, views treatment as medical care provided by the clinician. In contrast, guided self-help adopts the perspective that it is the patient who takes the central role in managing daily life and coping with symptoms, with the clinician's guidance added to this process.

3. Restriction of overactivity

In inpatient treatment for underweight individuals, where weight gain is the treatment outcome, it is common to first maintain bed rest and then implement behavioral therapy that gradually lifts activity restrictions based on weight gain as an indicator. While absolute bed rest in an outpatient setting is difficult, unlike during hospitalization, absolute bed rest is not a necessity if the patient's health condition allows for outpatient treatment. For example, a high school student could reduce energy expenditure by switching from cycling to taking the bus to school, or by limiting the number of days spent on club activities. In inpatient treatment, the approach typically starts with absolute bed rest and uses weight gain as an indicator to grant specific rewards, such as permission to walk within the room; therefore, clinicians rarely calculate energy expenditure. In outpatient settings, it is necessary to know what types of activity restrictions reduce energy expenditure and by how much. This can be determined using a table of physical activity METs (Metabolic Equivalents). Such knowledge is essential even during hospitalization to prevent weight loss after discharge.

After discharge, attention tends to focus solely on maintaining food intake, but suppressing energy expenditure is also important. Behavioral therapy during hospitalization often takes the form of rewarding weight gain rather than rewarding the performance of specific behaviors, making it somewhat unique as a form of behavioral therapy based on learning theory. On the other hand, methods for restricting specific excessive activities in outpatient

settings may be easier for patients to implement.

Behavioral restriction serves not only to reduce energy expenditure but also has psychological significance. As noted in anorexia nervosa, there is an expression that it has a "metabo-psychiatric" background,[15] various psychological factors overlap with physical predispositions—such as those in the appetite center—leading to abnormal eating behaviors. Once established, abnormal eating behaviors—such as anorexia, binge eating, purging, and hyperactivity—continue automatically, making it difficult to recognize the underlying psychology (Figure 1). Partially curtailing hyperactivity may temporarily increase anxiety (Figure 2), but this can serve as a trigger for recognizing the anxiety underlying these pathological behaviors.

For example, when instructed to reduce hyperactivity by limiting the number of days spent on club activities, anxiety increases in most cases. The immediate anxieties that come to mind at this point include weight gain or being reprimanded by the club advisor; however, upon further discussion, concerns such as "If I'm not valued in the club, where does my self-worth lie?" may emerge. Emotions related to questions such as why they chose this club in the first place, whether choosing this school was a mistake, and why their parents strongly recommended this school may also surface. While such psychological issues are almost always present behind eating disorders, at the time of onset, they are difficult to recognize or articulate due to the individual's tendency toward alexithymia. In many cases, it is only by reflecting on the anxiety associated with restricting excessive activity that the patient finally understands the meaning of their illness.

Limiting the number of days spent on club activities is a partial restriction of "excessive activity" rather than a full-scale restriction of behavior. Issuing such instructions suddenly can provoke strong resistance. We often hear from outpatient clinicians that it is more difficult to stop club activities in an outpatient setting than to order absolute bed rest during hospitalization. Absolute bed rest requires consideration of human rights, in terms of restricting freedom of movement. However, from a medical professional's perspective, it is likely easier to implement as a medical intervention. Ideally, in an outpatient setting, we should thoroughly provide the psychoeducation mentioned earlier and discuss how the desire not to rest might be a symptom of the illness or a sign that the body is fatigued. Furthermore, it is essential to outline the treatment

outlook early on and discuss a treatment plan that includes restricting excessive activity in such cases. Naturally, this requires the cooperation of stakeholders other than the physician. Even club activity coaches with high standards would likely accept restrictions on physical activity in the event of a fracture. Similarly, we need to educate coaches that similar restrictions on physical activity are necessary when low body weight resulting from excessive activity in eating disorders leads to severe anemia, extreme bradycardia, or decreased thyroid hormone levels.

4. Balancing treatment and social life

In the past, when the condition was often referred to as "adolescent anorexia," simply regaining weight and returning to the classroom was considered social participation. For the growing number of adults living with the condition today, however, 'social participation' can involve numerous hurdles. Job hunting is difficult while suffering from low body weight, and once a person drops out of college or quits a job, their connection to society is often severed. For conditions such as schizophrenia, various systems are in place to prepare individuals for employment, including employment systems for people with disabilities. Furthermore, in recent years, reasonable accommodations have become necessary in the field of developmental disorders, and efforts to improve workplace environments are underway.

By contrast, in the field of eating disorders, employment is left to the individual's own efforts. There has also been a tendency among clinicians not to actively provide support for employment. The desire to work is seen as a sign of overactivity or an assumption that individuals will naturally be able to work once their physical strength recovers. While there are certainly many cases where employment is inadvisable for physical reasons, there is a growing number of cases where individuals, even as they reach middle age and their physical strength recovers, lack the skills for social participation and struggle with job hunting out of necessity after their parents pass away. Given that the age range of those with eating disorders is expanding, promoting social participation—whether through employment or other means—should be incorporated into outpatient treatment plans.

Surveys and interviews[6] conducted with individuals with eating disorders who have worked reveal that the difficulties they face in the workplace are often less related to the work itself and more related to challenges such as

coping with lunch times that varied from day to day, or having their eating rhythms disrupted by snacks brought back by colleagues on business trips. This indicates that consideration must be given to how food is managed and how time is used in the workplace outside work duties, such as ensuring consistent meal and departure times and securing time for medical appointments.

Negotiating issues with the workplace requires disclosure, to some extent, that one is undergoing treatment; however, many cases involved difficulties with this very aspect. There were instances where individuals, unable to discuss their eating issues, repeatedly skipped after-work get-togethers over food, feeling as though they were "lying to their colleagues," making it difficult for them to go to work. Also, cases where difficulty having lunch with colleagues at work led to weight loss. Among those who were able to speak with their supervisors or close colleagues, many felt it was a positive experience; however, some reported that "I was treated like a pariah and removed from the schedule" or "I was told they wouldn't have hired me if they'd known from the start, making it uncomfortable to stay at work."

While public awareness regarding conditions like depression has improved, people with eating disorders are often viewed as having "darkness in their hearts." Furthermore, detailed media coverage of purging behaviors has led to stereotypes such as "people who waste food," "people who will do anything for their self-centered desire to be beautiful," or "shoplifters." Obviously, cooperation from the occupational health sector and public awareness campaigns are necessary. It is also believed that social skills training in clinical settings is needed to address what and how to communicate in the workplace. Urgent support that promotes social participation for the social recovery of those with eating disorders is essential. This employs techniques already employed in employment and return-to-work support for other conditions.

Furthermore, individuals who still harbor a psychological denial of their condition tend to think, "Since I've started working, I'm fine now." It is precisely when their life changes after starting work that they need to be vigilant against relapse. To this end, continuing outpatient treatment is essential—even if the frequency decreases. Individuals must communicate with those around them to create a period where they can "balance treatment and social participation." There is no immediate need to start with full-time employment; a step-by-

step return to society is important. Even with infrequent social participation, it is common for individuals who previously had a fixed, low self-esteem within family relationships to gain confidence through interaction with others. Some individuals gain the confidence to function in society, and their preoccupation with body image or eating-related symptoms virtually disappear. While conditions such as schizophrenia rarely become free of the need for maintenance medication even as personal recovery progresses, in the case of eating disorders, clinical recovery may occur through personal or social recovery. When providing counseling on matters such as job selection, it is essential to offer support that links recovery through social participation with recovery from symptoms.

5. Key considerations for daily outpatient care

In daily outpatient practice, paying attention to the following points can facilitate treatment.

1) Assuming the role of a Primary Care Physician

It is easier to establish a therapeutic relationship when psychiatrists take on basic primary care responsibilities—such as monitoring blood pressure and assessing the severity of anemia—in addition to addressing mental health concerns. If significant physical symptoms arise during the course of treatment, the patient should be referred to an internal medicine specialist. However, in cases where the patient strongly denies their condition and visits multiple departments, laxatives or diuretics may be prescribed in the internal medicine department without the psychiatrist's knowledge. This may prevent the condition from improving.

2) Understand the patient's living situation

While low body weight in anorexia nervosa can be judged by appearance, the extent of binge-eating and purging or the level of hyperactivity cannot be determined unless the patient speaks about it. The patient may have a good understanding of their symptoms but may also avoid acknowledging them due to self-stigma. First, it is necessary to discuss with the patient what their daily life is like, what symptoms they experience, and what factors cause these symptoms to fluctuate.

3) Encourage behavioral change gradually

To reliably bring about behavioral change, after assessing the condition as described in point[2)] above, it is advisable to gradually reduce the amount of

money spent on binge eating and the level of compulsive exercise. “Behavior” does not change dramatically with medication; behavioral change is a gradual process. Ideally, individuals should be able to modify their behavior while psychologically reflecting on what they have been venting through their symptomatic behaviors. In the case of bulimia nervosa, unlike with alcohol or drugs, it is difficult to avoid food altogether. It is important to gradually reduce binge eating and build a sense of control.

Conclusion

Regarding the treatment of eating disorders, there are voices emphasizing specialization, arguing that “eating disorder specialists should be the ones to treat them.” While it is unlikely that any psychiatrist would refuse to treat depression simply because it is not their specialty, the current reality is that the explanation “I don’t treat eating disorders because it’s not my specialty” is widely accepted form of refusal. However, as discussed above, eating disorders that do not require special physical treatment are conditions that can be treated without issue by general psychiatrists. I hope that more people will seek treatment before their condition becomes severe, and that treatment approaches, focused on finding a path to recovery within daily life, will become widespread.

Editor’s Note: This special feature article is based on the symposium held at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology, for which the author of this article served as the representative.

There are no conflicts of interest to disclose in relation to this paper.

References

1) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) American Psychiatric Publishing, Arlington, 2022 (日本精神神経学会 日本語版用語監修, 髙橋三郎, 大野 裕監訳: DSM-5-TR 精神疾患の診断・統計マニュアル. 医学書院, 東京, 2023)

2) 国立精神・神経医療研究センター精神保健研究所地域精神保健・法制度研究部: リカバリー (Recovery), 第 4 回改定版. 2021 (https://www.ncnp.go.jp/nimh/chiiki/about/recovery.html) (参照 2023-01-21) (in Japanese)

3) 中江悟司, 田中茂穂, 宮地元彦: 改訂版『身体活動のメッツ（METs）表』. 国立健康・栄養研究所. 2012 (http://www.nibiohn.go.jp/files/2011mets.pdf) (参照 2023-01-21) (in Japanese)

4) National Institute for Health and Care Excellence (NICE): Eating disorders: recognition and treatment. 2017 (https://www.nice.org.uk/guidance/ng69) (参照 2023-01-21)

5) 日本肥満学会肥満症診療のてびき編集委員会編: 肥満・肥満症の指導マニュアル 医歯薬出版, 東京, 1997 (in Japanese)

6) 日本摂食障害協会: 摂食障害患者の就労実態調査と社会復帰支援報告書. 平成29年度三菱財団社会福祉事業・研究助成金報告書. 2017 (https://www.jafed.jp/pdf/reports/working-survey.pdf) (参照 2023-01-21) (in Japanese)

7) 西園マーハ 文: 摂食障害のセルフヘルプ援助—患者の力を生かすアプローチ—. 医学書院, 東京, 2010 (in Japanese)

8) 西園マーハ 文: 摂食障害の認知行動療法. 精神経誌, 118 (8); 561-569, 2016 (in Japanese)

9) 西園マーハ 文: 摂食障害の啓発と発症予防の取り組み. 精神科治療学, 33 (12); 1449-1454, 2018 (in Japanese)

10) 西園マーハ 文: 対人援助職のための精神医学講座—グループディスカッションで学ぶ—. 誠信書房, 東京, 2020 (in Japanese)

11) 西園マーハ 文: 摂食障害の精神医学—「心の病気」としての理解と治療—. 日本評論社, 東京, 2022 (in Japanese)

12) Robinson, P. H.: Community Treatment of Eating Disorders. John Wiley & Sons, Chichester, 2006

13) Treasure, J.: Anorexia Nervosa: A Survival Guide for Families, Friends, and Sufferers. Psychology Press, London, 1997 (傳田健三, 北川信樹訳: 拒食症サバイバルガイド—家族, 援助者, そしてあなた自身のために—. 金剛出版, 東京, 2000)

14) 渡邊衡一郎: 共同意思決定（SDM）の概念と現状. 精神医学, 62 (10); 1301-1309, 2020 (in Japanese)

15) Watson, H. J., Yilmaz, Z., Thornton, L. M., et al.: Genome-wide association study identifies eight risk loci and implicates metabo-psychiatric origins for anorexia nervosa. Nat Genet, 51 (8); 1207-1214, 2019

16) World Health Organization: The ICD-10 Classification of Mental and Behavioural Disorders: Clinical

Descriptions and Diagnostic Guidelines. World Health Organization. Geneva, 1992 (融 道男, 中根允文ほか監訳: ICD-10 精神および行動の障害—臨床記述と診断ガイドライン—, 新訂版. 医学書院, 東京, 2005)

17) World Health Organization: International Statistical

Table 1: Principles of treatment for mental disorders applicable to eating disorders

1. Community-based treatment is essential, and hospitalization is only one component of treatment.
2. Certain conditions may require immediate hospitalization. In other cases, however, it is desirable to carefully discuss the treatment plan with the patient in advance and conduct inpatient treatment in a manner that maintains continuity with outpatient treatment.
3. The transition from hospitalization to post-discharge treatment must be handled with care. In cases where contact with medical institutions is likely to diminish after discharge, provide psychoeducation during hospitalization and explain the necessity of continuing treatment.
4. The patient, family, and treating professionals should discuss and agree in advance on the specific medical conditions that would warrant a subsequent hospitalization.
5. The patient, family, and treating professionals should agree in advance on the response to a relapse. It is important for the patient to recognize the signs of a relapse.
6. Supporting social participation is equally important as alleviating symptoms.
7. Treatment is more effective when multiple professionals are involved.

(From Reference 10)

Table 1: Principles of treatment for mental disorders applicable to eating disorders

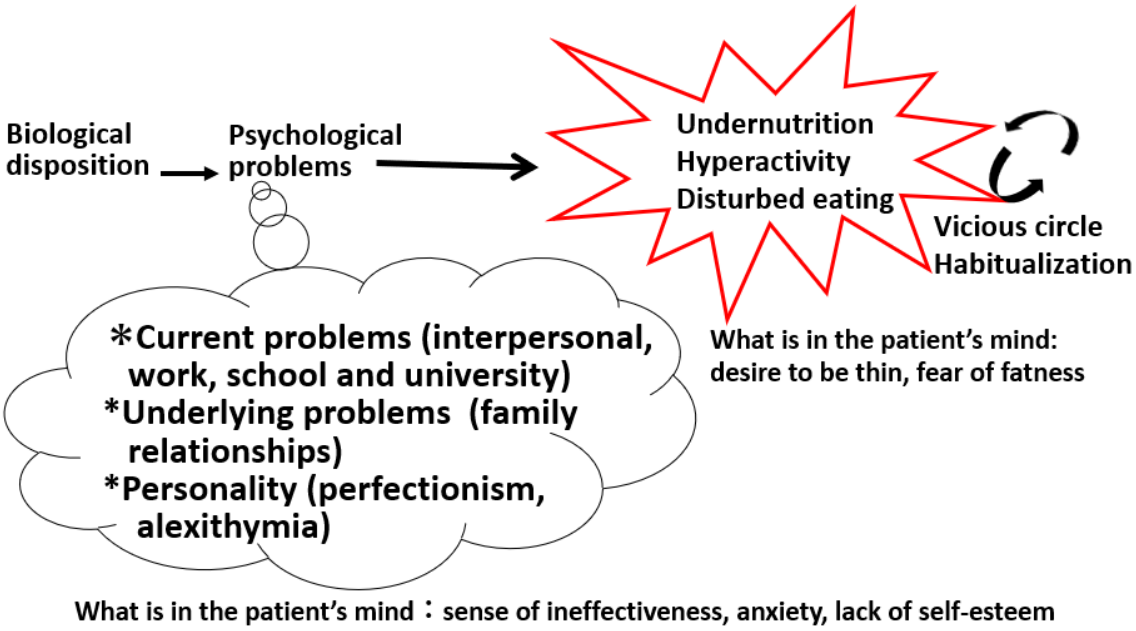

Fig 1 . Structure of eating disorder symptoms (Modified from Reference 11)

Figure 1: Structure of eating disorder symptoms
(Modified from Reference 11)

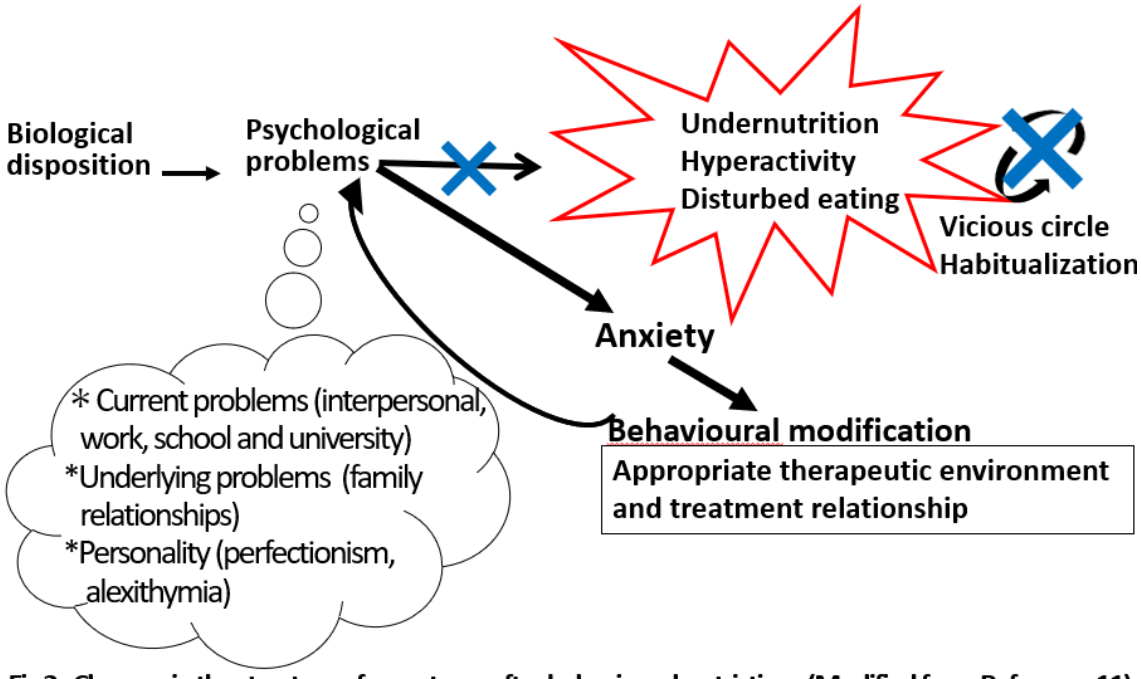

Fig 2 . Changes in the structure of symptoms after behavioural restrictions (Modified from Reference 11)

Figure 2: Changes in the structure of symptoms after behavioral restrictions (Modified from Reference 11)