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**Special Feature Article**

# Community Support for the Treatment of Eating Disorders

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## Abstract

Eating disorders substantially stress the body due to abnormal eating behavior. Therefore, weight change and biochemical data must be utilized as good or bad parameters. Most of the cases have been treated medically with a strong focus on physical management; this may include hospitalization. On the other hand, patients continue to live their daily lives in the social environment of their homes, schools, and workplaces, which causes the condition to develop further. Outpatient treatment for this disorder helps them acquire skills, other than pathological solutions, in order to support their ability to be aware of medical intervention. At the same time, they may recognize that they are active in their daily lives in the community. This is the case especially for middle-aged and elderly individuals who are highly resistant to treatment and who definitely find themselves following a long chronic course. The treatment goal is not a complete cure but instead focuses on understanding and accepting the disorder, coexisting with the symptoms, and placing emphasis on improving their quality of life. This aligns with the usual treatment of mentally ill individuals, which has shifted from traditional hospitalization and monitored living toward supported independent living within the community. With this, the authors are experimenting with assertive community treatment (ACT). This is a comprehensive community living support program which establishes a facility and staff inside the community and focuses on a self-sustaining service for chronic disorder cases. A facility and system that allows for such trial and



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error in learning and actual experience may be effective in realistically advancing outpatient therapy for this disorder. Such a system respects and ensures the independence and individuality of patients with illnesses.

**Keywords**: eating disorder, independence support, assertive community treatment, social model

## Introduction

While treatment for eating disorders was once largely limited to hospitalization, the nature of the condition, subtypes, and factors underlying onset have changed significantly over time. In this paper, under the theme of "effective outpatient treatment," I would like to examine, as one aspect of a multifaceted approach to this condition, how the community support system newly established in Japan in 1998 has contributed to treatment. I will do so, with all due humility, through the lens of my own clinical experience.

## I. The Necessity of "Daily Life" and "Support" in Eating Disorders

Why are "daily life" and "support" considered necessary and important for those with eating disorders? Simply put, it is because eating disorders are conditions in which, literally, "daily life" cannot be sustained due to symptoms, and "support" is essential.

"Daily life" refers to "living" as a biological being, and "thriving" by expressing one's individuality and abilities within society. Eating disorders, due to symptoms such as dietary restrictions, excessive exercise, and purging behaviors like self-induced vomiting, lead to life-threatening conditions such as low body weight and malnutrition, putting "survival" itself at risk. Consequently, various restrictions are placed on social life, such as academic pursuits and employment. This constitutes a restriction on the "living actively" aspect of one's activities. Viewed in this light, treatment for this condition is about rebuilding a rich and fulfilling life as a human being.

Specifically, it involves improving eating behaviors and physical health to ensure "survival," and acquiring and practicing the psychosocial skills necessary for "living actively." While managing eating behaviors and physical aspects such as weight is necessary, patients often exhibit strong resistance to weight gain. Even in an



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inpatient setting, where every effort is made, complete control is impossible; in outpatient treatment without restrictions, it is nearly impossible. In the early stages of the illness or during physical crises, objective metrics such as weight and various laboratory test results are easily used to establish a unified understanding of treatment outcomes. However, if we focus solely on these metrics for "survival," it leads to a worsening of the core problem of this disorder: avoidance of reality through compulsive self-management. In outpatient treatment, the author focuses on the latter aspect: "living fully," which means consistently inquiring about the patient's daily life, regardless of their current condition. Through this process, patients become aware of the connection between their behaviors and emotions, and their current physical and psychological issues. Consequently, their perspective broadens beyond just weight and body shape, leading to concrete skill training to resolve their painful and conflict-ridden circumstances. Furthermore, by demonstrating this mind-body correlation, it can be shown that current distressing behavioral and emotional difficulties can also be alleviated through improvements in diet and physical and psychological symptoms. This is precisely why the importance of improving eating behaviors, weight, and body image can be used to justify the treatment. Outpatient treatment for this condition can thus be approached from the perspective of "daily life," aiming to improve both "survival" and "living actively" through skill development. However, the specific issues vary depending on the clinical condition and duration of the illness, and the emphasis placed on each aspect differs accordingly. Generally, in early-stage or acute cases, the focus is on medical treatment for "survival" (the medical model), while in chronic cases where time has elapsed since onset, the emphasis shifts to social welfare support for "living actively" (the social model). This paper focuses primarily on support for the latter, chronic cases.

## II Understanding Chronic Eating Disorders

Even if anorexia nervosa is the initial condition, it may persist for decades with continued food refusal or a transition to binge eating accompanied by depressive states, and a persistent fixation on maintaining a low body weight through purging behaviors such as self-induced vomiting or laxative abuse due to fear of weight gain. This is the so-called chronic phase, and it requires a different understanding of the disorder itself compared with the earlier initial and acute phases.



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Chronicity is characterized by strong and prolonged treatment resistance, as well as the following psychosocial features.

1. Lack of social experience due to early onset and insufficient coping skills

This disorder has traditionally been associated with individuals who were considered "good children" from an early age. However, as times have changed, the label of "good child" is no longer viewed as a positive evaluation. Nevertheless, patients generally continue to strive to be "good children." They excessively suppress their true selves and overcome internal difficulties through "effort and endurance." They have never failed and know no setbacks. Because they lack other coping skills, they are unable to bounce back. Due to their limited experience with failure, their stress tolerance is overwhelmingly low, and they often tend to be vulnerable to adversity.

2. Immeasurable anxiety and fear of "change"

However, upon entering adolescence and joining adult society, the "good child" experiences for the first time the frustration of realizing that the aforementioned "effort and endurance" alone are completely inadequate. Normally, one would take time to confront and accept the depression resulting from this frustration and inner conflict. However, because "good children" lack other coping skills, they cannot endure this anxiety. Consequently, they quickly seek out areas where "effort and perseverance" are effective; areas that, at this age, clearly demonstrate results the more they are pursued. These areas are academic performance and dieting. Their extraordinary obsession with these activities is already a symptom of this condition.

3. Hypothesis of self-treatment for stress[2)]

This condition is an addictive disorder similar to alcohol or drug addiction and can be considered a "process addiction," in which one becomes dependent on the behavior or process itself. These behaviors are not performed for the purpose of seeking pleasure but are pursued out of necessity to alleviate one's own sense of difficulty in living. For example, healthy individuals use various skills to resolve negative emotions arising from interpersonal relationships. However, as mentioned earlier, "good children" who lack these skills simply hold onto their negative emotions (repression), and a psychological mechanism (dissociation, denial) arises that stops the very process of recognizing the pain of holding and confronting these emotions.



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For example, praise from others regarding the success of a diet becomes a reinforcing factor, causing the individual to become increasingly obsessed with losing weight.

Similarly, in the case of binge eating and purging, even if one yields to the urge to eat, the act of purging is carried out to prevent weight gain. Since the weak self that gave in is effectively erased, these behaviors succeed as psychological defenses. However, the individual continues to be tormented by the intense physiological and psychological feelings of hunger and craving brought on by purging behaviors such as vomiting.

Viewed in this light, this disorder was previously characterized by "generalized and thorough avoidance,"[9] stemming from the immaturity of the "good child" who lacked adaptive avoidance skills. If we consider that the significance of this illness lies in escapism,[4] immersing oneself in a fantasy world fueled by a sense of omnipotence and narcissism, then becoming healthy, or recovery, means that the patient returns to reality from this fantasy world and is forced back into an environment where they must confront the pain they have turned their back on.

In front of the therapist, they adopt a model-patient attitude, saying: "Once I'm cured, I want to do this," but deep down, they already realize they cannot return to their lives as they were before the illness. They don't know how to live, and cannot face the challenge of such uncertainty; therefore, they cannot get better. "I won't get better, I can't get better": this is actually the true sentiment of those with eating disorders.

## III. The Role of "Living Support" for Those with Eating Disorders

Morning comes equally for everyone, even for those who "cannot be cured." Whether they are thin or their symptoms persist, daily "life" begins regardless. In outpatient treatment rooted in such "daily life," the role of the local community can be reduced to two main points. The first is supporting the medical treatment provided at healthcare facilities, given the disease characteristics. The second is ensuring a realistic foundation for daily life that allows patients to engage in outpatient treatment with peace of mind. It is necessary to provide various information and resources, as well as the personnel and facilities to support their actual daily lives.

### 1. Complementing outpatient treatment

Due to the disease characteristics, this condition frequently involves physical complications, and the risk of suicide arising from mental instability is high; therefore, specialized care at



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medical institutions that manage the safety of the patient's mind, body, and life is indispensable. Furthermore, even after escaping a crisis, patients often follow a chronic course that falls far short of the lives of healthy individuals; even if they recover and are able to lead a normal life for a time, relapses due to life events are common, and the problem of skill deficits has a longer-lasting impact than expected.

In a previous survey conducted by the authors on patients with this disorder, the results showed that such patients had lower social skills regarding interpersonal relationships than patients with general mental disorders or alcohol dependence attending community workshops for psychiatric patients.[6] Thus, if the physical disabilities and psychological impairments caused by eating behaviors at the onset of the disorder are considered the primary disorder, in these chronic cases, the prolonged persistence of the primary disorder (cognitive and thought distortions) exacerbates the pathological preoccupation with eating behaviors and low body weight, resulting in secondary disorders (such as social withdrawal) that impair social functioning and daily living skills. This creates a negative spiral in which these secondary impairments hinder social adaptation, leading to symptom relapse and exacerbation. Therefore, in addition to medical treatment, social therapy is necessary to help patients develop the ability to cope with daily life challenges through assertiveness training, social skills training, and other methods, thereby gaining the strength to break free from this negative spiral.

In recent years, medical institutions have been implementing treatment programs that address both physical and psychological aspects, building on these insights rather than focusing solely on improving physical function. Specific examples include inpatient programs that incorporate psychoeducation and disease education, as well as cognitive behavioral therapy.[1)5)7)] However, in a treatment environment where significant time and energy are required for treatment yet this is not fully reflected in medical reimbursement rates, and where there is a trend toward shortening hospital stays, there has been a challenge in fully utilizing these valuable programs.

In outpatient settings, the use of day care and day hospital services can also be considered.[3)] For patients with this condition who may require urgent intervention, these are relatively safe resources to utilize and they are also desirable from the perspective of medical reimbursement. However, very few patients are actually able to use these services on a continuous basis.



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One reason for this is the gap in clinical presentation between the patient population using these services (those with mental disorders such as schizophrenia or bipolar disorder) and patients with this condition. Consequently, day care programs specialized for patients with this condition have been established in medical institutions in recent years. However, this has led to frequent conflicts stemming from the interpersonal difficulties inherent in those with eating disorders. Because these are group activities, the manipulation of group dynamics is necessary, and this does not always fully satisfy the individual. Nevertheless, the value of day care lies in training to navigate these conflicts through trial and error. When patients with this condition are treated in a group setting, competition and comparison almost inevitably arise among them, which is reflected in their eating behaviors and psychiatric symptoms. Addressing this pattern as a specific issue in individual psychotherapy and providing feedback can bring significant progress to treatment. However, patients with the aforementioned mindset cannot tolerate the wounding of their self-esteem; they express anger and dissatisfaction toward the therapist and day care program through worsening symptoms, and eventually escape from the setting and resulting conflict. Meanwhile, the local community, separate from the therapist, is constantly exposed to such conflicts. It is considered that skills are acquired only through accumulating experiences of being exposed to such a burdensome daily life.

2. Provision of specific information and services for living support

The severe condition and long-term course of patients with this disorder may qualify them for disability welfare services. Specifically, this includes receiving public assistance or disability pensions, obtaining a Mental Health and Welfare Handbook, and introducing home-visit nursing or in-home care services. To cite one example, in cases involving various comorbid conditions such as depressive states or bipolar disorder, it is possible to apply for a disability pension on the grounds of impaired mental functioning. Furthermore, as a measure to address these symptoms and family conflicts, it is possible to separate the individual from the family household to promote their independence, supplementing the disability pension with public assistance to cover any shortfall in living expenses. Of course, this approach is not suitable for every case, and it is entirely possible that utilizing these resources could actually lead to regression and worsen the patient's



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condition. However, as self-understanding and self-insight deepen during the treatment process, it is desirable to calmly assess one's current situation and, after making necessary adjustments to the family environment, utilize these systems proactively when deemed appropriate. By adopting the methods described above, individuals can achieve mental, physical, and economic independence, thereby promoting recovery. In addition to providing information on these resources and offering guidance on their effective use, facilitating appropriate intervention in real-life situations is also an important role that the community can play.

## IV. The Practice of Comprehensive Community-based Living Support Programs for Eating Disorders

Therefore, in 1998, Nobi-no-Kai, the organization to which the author belongs, developed a comprehensive community-based living support program (Assertive Community Treatment: ACT) specialized for this condition and began implementing it in the local community. It began as a "support group" in which therapists (doctors, psychotherapists, etc.) used their medical, psychological, and social welfare–based expertise to support voluntary activities initiated by participants in group psychotherapy for this condition, which had begun at medical institutions in 1992, and by members of a family support group launched in 1996 who were inspired by those activities. This system maximized the autonomy of individuals and their families while providing safety and stability within a therapeutic framework, representing a new initiative unlike anything seen before. Currently, the organization operates as a legal entity with five divisions and nine programs (two of which were discontinued after a limited period) (Figure 1). The author, while affiliated with the psychological counseling office as a psychologist, is also involved in all programs as a board member.

### 1. Division of support for the independence of persons with disabilities: day service facility, community activity support center

As the first step in community activities, we established a "small-scale community workshop for psychiatric patients" in Yokohama City and began independent operations. Subsequently, in 2001, we received official approval from the local government, becoming Japan's first community day service facility dedicated to eating disorders in both name and reality (now renamed the "Community Activity Support Center"). With support and guidance from medical professionals and local



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welfare workers, our staff members, composed of able-bodied individuals, support an average of about 10 clients per day, implementing various programs aimed at securing a sense of belonging and improving their condition. While exploring ways to build interpersonal relationships as a "place to belong," we work to improve pathological eating behaviors according to each individual's condition and wishes, offering social participation tailored to their current capabilities and paving the way for future social reintegration.

1) Training aimed at normalizing eating behavior

This is the top priority in treating the condition. To help patients escape starvation and correct distorted eating behaviors, we hold meal sessions, including lunch and dinner, 5 to 6 times a month, where they experience and learn to manage the content and quantity of normal meals. Succeeding in this builds confidence and increases flexibility; however, for chronic patients, there are countless instances of seemingly irrational behaviors related to meals and food, such as specific dietary content and ways of eating, making complete correction nearly impossible. Therefore, we individually assess the necessity of dietary and physical management tailored to the patient's desired lifestyle, placing emphasis on understanding and practicing desirable dietary content and intake methods, as well as experiencing shared time with others.

2) Training to understand eating disorders and address psychological issues

This is what is commonly referred to as psychoeducation. As mentioned earlier, the psychological issues faced by patients with this condition include both those caused by the illness and those that are innate; however, both are aspects that the individual currently possesses. Furthermore, groups of patients at various stages of the illness can understand and share the distress caused by the condition, which also leads to a more objective view of themselves. This involves confronting one's own interpersonal relationships, which are based on distorted perceptions of reality. Normal interpersonal relationships are not one-sided, as in a clinical setting where support is merely provided. Meetings are not simply a matter of "speaking and listening without engagement," but rather a back-and-forth style of discussion. Interaction with members who share the same illness evokes a range of emotions, but through these meetings, group disease education sessions, assertiveness training, and



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other study groups, the practice of verbalizing insights, objectively assessing those emotions, and considering coping methods through mutual feedback in a safe environment serves as crucial training for social adaptation.

3) Social participation and reintegration training

Unfortunately, it must be acknowledged that prolonged physical and mental symptoms have a significant impact on social adaptation. Consequently, returning to school or work can be difficult in some cases. However, patients whose pride and perfectionism take precedence, preventing them from accurately recognizing their current reality, often continue to demand an unnaturally high level of social reintegration. We often hear people say: "I'll fully reintegrate into society once I lose weight," but based on our understanding, that "someday" may never come. Therefore, as part of "what we can do now," Nobi-no-Kai conducts training to help patients adopt social roles and fulfill responsibilities within a small social system through steady activities, such as producing and selling our own products at the facility and participating in meetings related to events. Through these experiences, patients can regain feelings of accomplishment and fulfillment they have lost since illness onset and build up their self-efficacy.

In addition, the center offers recreational outings such as movie screenings and karaoke, as well as activities like aromatherapy, art, and music programs. Through this diverse range of programs, the goal is for participants to experience and become accustomed to the mindset of "doing what I can now" rather than "doing it when I can someday."

To clarify the achievements of the Community Activity Support Center to date, the authors conducted a survey in 2009 targeting 36 users of the center and examined the findings.[8] A comparison between 14 individuals who had attended the Community Activity Support Center for five years or more and 22 who had attended for less than five years revealed that while the group with attendance of five years or more had a higher average age and longer duration of illness, the frequency of binge eating was equivalent to that of the group with less than five years of attendance, and symptoms of vomiting had decreased. Furthermore, it was found that, compared with the group attending for less than five years, the group attending for five years or more showed a higher proportion of other eating disorders (unclassified), fewer cases of anorexia nervosa, and



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improvement in the symptoms of regular attendees. Although regular attendance at every scheduled session and continued use of the facility were difficult, continuing to attend built up physical strength, their days became more stable, and their lives that had previously been dominated by symptoms became transformed. Furthermore, as self-understanding progressed through participation in programs such as study sessions and meetings, their insight into their inner selves deepened, and they became able to consider a lifestyle suited to their capabilities. These results suggest that community-based day treatment facilities can serve as a foundation for addressing psychological challenges, fostering continuity and resilience, and facilitating social adaptation.

2. Education and counseling division: psychological counseling office

Even within small groups specialized in this condition, patients who struggle with social adaptation in the first place cannot easily fit in. Furthermore, even after joining, their position within the group remains unstable. Therefore, the author, a psychotherapist, has created a separate setting to address individual issues. Here, this service directly addresses psychiatric and psychological aspects and serves as a preliminary step to “effective outpatient treatment” or as a component complementary to current treatment.

3. Family support group activities

While it is no longer the case that the causes are attributed solely to family or mother-child relationships, families are physically and emotionally exhausted by the reality that their child has been constantly on the brink of life and death for many years due to an eating disorder. However, having observed patients and their families over many years, we can actually discern the reasons why the patient came to be in this condition by examining the individual personalities of family members and unique interaction patterns that have developed over time.

Therefore, family intervention, aimed at providing families with accurate knowledge and promoting emotional stability, is indispensable. At present, most cases already require more time and effort than the treatment of other illnesses, and the reality for many healthcare professionals is that it is difficult to allocate even more time for family support. For this reason, support groups and educational classes specifically for families of patients with this condition are increasing nationwide, separate from outpatient treatment. While local self-help groups offer the advantage of providing concrete, practical insights through first-hand



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accounts, they also face disadvantages: a lack of medical knowledge makes it difficult to handle emergent cases, and the group's very foundation is unstable because participation depends on the patient's condition. In response, Nobi-no-Kai organizes family support groups based on the patient's stage of illness, dividing them into groups for the early/acute and chronic phases, and conducts meetings and psychoeducation (disease education) for each group.

4. Awareness and public relations initiatives

We invite external lecturers to hold seminars on eating and personality disorders: comorbid mental disorders in the chronic phase. These events combine keynote lectures with presentations of personal experiences by patients and family members, and the audience also participates in the discussion. This initiative has an aspect of raising public awareness. We also jointly engage in activities such as planning and publishing an information magazine for our members. These initiatives, which serve as awareness-raising efforts, also provide patients and their families with an opportunity to reflect on their own behaviors.

5. Community networking initiatives

The author frequently receives requests to give lectures on eating disorders. In such cases, whenever possible, lectures are given together with patients and their families. As a group, we also respond to requests for research assistance from university students writing their theses, high school students conducting independent studies, and various medical and research institutions.

## Conclusion

Thus far, we have discussed "effectively conducting outpatient treatment" for this condition. However, upon further reflection, we have merely introduced the activities of Nobi-no-Kai, which had already applied ACT for general psychiatric patients, including those with dementia, to patients in the chronic phase of this condition. In Japan's institutional treatment for mental disorders, patients with severe mental illnesses often fail to apply their experiences from hospital to their post-discharge lives, leading to symptom relapse and repeated readmissions. Similarly, even when patients with this condition are forcibly admitted to promote weight gain and correct eating behaviors, they are readmitted shortly after discharge. Both scenarios represent a "revolving door phenomenon" where the same cycle repeats itself. However, in the case of this condition, the cause may lie in the fact that the pathologies of escapism



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and denial, which are at its core, are deeply ingrained in both the patients and therapists.

Given the nature of the pathology, it is inevitable that the patient continues to hold onto the fantasy that "someday, things will surely return to normal." However, might the therapists, who are themselves tormented by a sense of helplessness because no improvement is visible no matter what they do, be affecting treatment by clinging to the very same fantasy that "someday, I want to cure this and return things to normal," and by being unable to let go of that fantasy? Is this not a re-enactment of the family dynamics once referred to as the "golden cage," which hindered a patient's independence and growth?

From the medical model, patients are viewed as "individuals who need to be cured of their illnesses or problems." However, the social model views them as "individuals who possess the right and ability to make judgments and decisions regarding their own lives, and who have the potential to achieve things, even with disabilities or illnesses, through their strengths." Just as the social lives of people with mental disorders have a history of opening up significantly to society, this "effectively conducted" outpatient treatment provided through a watchful, supportive approach will undoubtedly help many patients with this condition realize the effectiveness of their own inherent capabilities, and that they are beings capable of "living (survival and living actively)" within society. With great expectations, I hope to continue providing this modest support over the long term.

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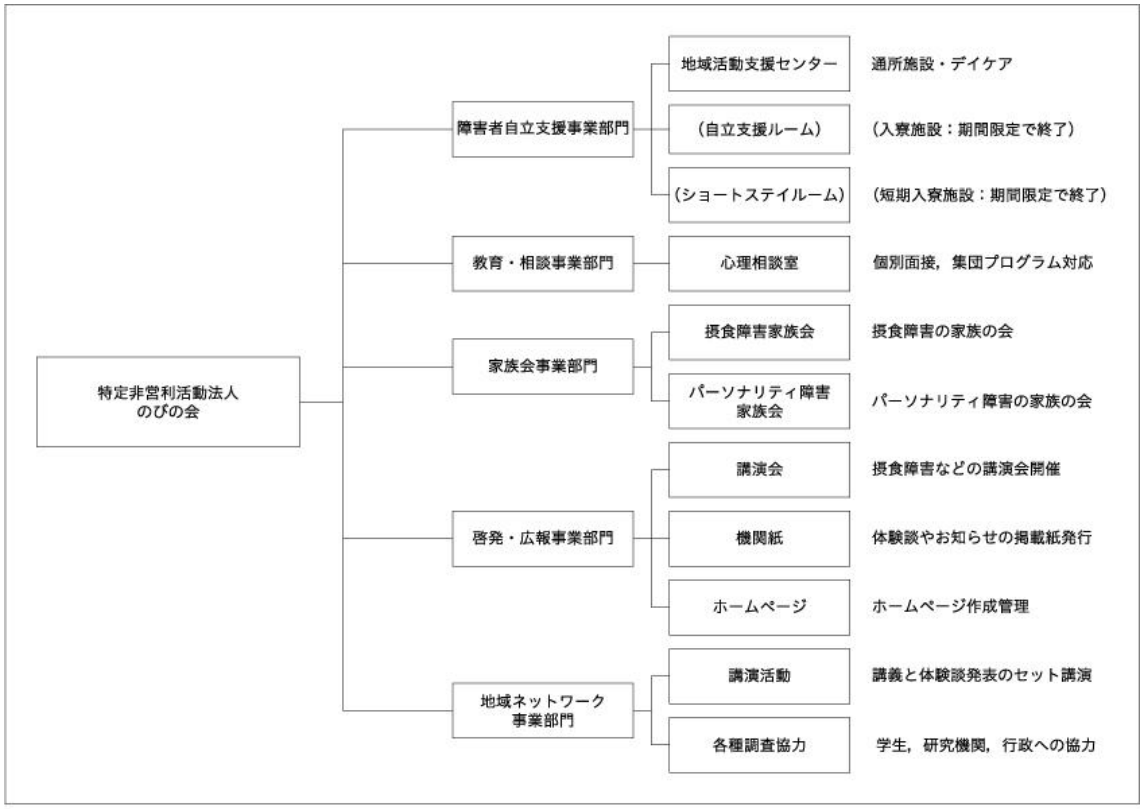


**図 1　特定非営利活動法人のびの会の組織図**

特定非営利活動法人のびの会は，1998 年に市民団体として発足．2001 年自治体より認可され，本邦初の摂食障害者に特化した地域支援が始まる．2009 年に心理相談室が開所し，治療部門と生活福祉支援部門が整備され，患者の生活に基づいた心理治療が可能になった．

Figure 1: Organizational chart of NPO Nobi-no-Kai

NPO Nobi-no-Kai was established in 1998 as a citizens' group. In 2001, it received official recognition from the local government, marking the start of Japan's first community-based support program specifically for people with eating disorders. In 2009, a psychological counseling office was opened, and treatment and social welfare support departments were established, enabling psychotherapy based on patients' daily lives.



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