Harm Reduction for Disordered Eating and Body Control Behaviours

Approaches for Harmful Drinking and Eating Behaviour

An Information Resource and Guide for Clinicians

CEED harm reduction resources are designed for clinicians and are not for distribution to people experiencing eating disorders. *Clinicians are advised to use discretion when exploring disordered eating behaviours with people experiencing eating disorders as mentioning specific behaviours can motivate some to augment, or take up new harmful behaviours.*

A person's weight, shape or body size is not a reliable indicator of the engagement in or severity of disordered eating/drinking or the impact on their health.

Key Features & Considerations

- Significant alteration in eating and drinking behaviour (disordered eating) is core to eating disorders.
- Behaviours that can be identified as disordered eating include **over control/over regulation behaviours** (i.e. restricted eating or restriction of fluid intake) and **under-regulated or loss of control of behaviours** (i.e. binge eating) and high fluid consumption that may lead to physical harm.
- Features of restrictive practices of relevance in eating disorders is the degree of selectivity, rigidity and persistence of the practice.

Disordered eating is linked with:

- Rapid weight loss, malnutrition and numerous short and long term health complications.
- Reduced coping, poorer general mental health as well as decreased quality of life.
- The risk of physical health complications is increased when disordered eating and fluid intake behaviours occur in combination with other behaviours such as purging, excessive exercise and substance misuse
- Harm reduction approaches seek to address health and/or functional impairment arising from the practice.

Restrictive eating practices are commonly undertaken and endorsed in the Australian community, thus working with people to address restriction can be met with substantial internal and cultural resistance, as well as misunderstandings around basic dietary needs and health.

Behaviours Covered in this Resource (1):

Restrictive Eating & Drinking

- Eating or drinking is considered **restrictive** when food and or fluid intake is below the level of biological need.
- As little as 10-15% persistent / ongoing reduction in energy intake may be associated with malnutrition / starvation related physiological & cognitive impacts seen in eating disorders
- Dietary restraint relates to cognitive & behavioural efforts to control & reduce energy, nutrient or fluid intake in order to control body weight &/ or shape
- Examples: Fasting, chronic restrained eating, skipping meals, unbalanced eating, (e.g. restricting a major food group)
- Examples: drinking carbonated drinks to feel "full", drinking minimal fluid to avoid fullness sensations and/or to dehydrate the body for desired body appearance (i.e. "dry out" muscles to make them more pronounced)

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Behaviours Covered in this Resource (2):

Binge Eating & Overconsumption

- Overeating behaviours are generally viewed on a continuum of **severity** and **compulsiveness**
- **Compulsive consumption** is characterised by irresistible urges to continue to consume beyond biological need & hedonic reward
- **Binge eating** is characterised by experiencing **loss of control** & reduced ability to regulate the amount and type of food they ingest
- Binge eating is often accompanied by feelings of guilt, shame and disgust
- **Objective binge eating (OBE)** refers to binge eating an unusually large amount of food. Associated with bulimia nervosa and binge eating disorder
- **Subjective binge eating (SBE)** refers to eating a small or moderate amount of food (that is perceived as large)
- **Overconsumption** of food may be also characterised by excessive grazing and extreme reward-driven eating

▶ Review and Assess the Person's Disordered Eating and Fluid Intake Behaviours

Collaboratively review the person's current Disordered Eating Behaviours alongside other ED related behaviours. Engage family, supports and community to add their perspectives where possible. Seek medical input regarding physical safety and consider involvement of a dietitian.

Assessment Tasks & Strategies:

Routinely include exploration of eating & drinking behaviour / self-care as part of MSE

▶ Use food & fluid intake monitoring strategies (paper based diaries, apps, etc. & review with the person

▶ Take a diet history or 24 hr dietary recall examining range & pattern of eating & drinking

Assess the extent & severity of DE behaviours & underlying beliefs

▶ Ask about beliefs & values underpinning eating behaviour

▶ Ask about weight and shape concerns (& intensity of concerns/ fragility of control)

Assess the possible impact on physical health

▶ Ask about experience of any history of physical health impact associated with eating patterns

▶ Liaise with medical & dietetic team members

Assessment Tools:

EDE-Q 6 (Fairburn & Beglin)

Healthy Eating Quiz (Nutritional quality / adequacy: U Newcastle)

Nutritional Assessment Template Inside Out Institute

Paper: Assessing for Dehydration in Adults (Nursing; Rushing, 2009)

Understand the interaction between harmful behaviours and risk for self-injury and suicide. *One important function that eating disorder behaviours might have is to reduce or avoid states of extreme distress that place the person at risk of self-injury or suicide. Consider ways in which harm reduction also supports psychological safety and support skill development to help the person expand their window of tolerance.* ***See CEED handout – Distress Tolerance.***

▶ **Get to Know the Function** of the person's eating and drinking behaviours in order to work with them on safer alternatives

Function	Overview	Tips for helping the person meet their needs in healthier ways
Control of body weight, shape & appearance	Restriction and use of fluids to avoid eating or dehydrate may be related to controlling appearance	• **EXPLORE:** To what degree does restrictive eating serve an important function in reducing body-related distress? • **EXPLORE:** Does the person gain a sense of worth or success/achievement to the degree that they approximate the thin ideal that has been internalised, or to the degree to which they avoid being in a larger body to avoid internalised weight bias or broader biases and discrimination related to body size? • **EXPLORE:** Beneath this may be a longing for worthiness and connection, or avoidance of trauma/distress, tending to body appearance may be a way of addressing deeper unmet needs. Does this fir for them? • **EDUCATE:** Help the person understand the role of body image and starvation in perpetuating the eating disorder. • **SUPPORT:** Help the person to reduce harms associated with malnutrition and dehydration whilst addressing unhelpful beliefs.
Emotion & Sensory Regulation	Restriction and binge eating practices may be important emotional coping strategies	• **EXPLORE:** To what extent might this person be trying to manage fear, guilt, shame & other emotions by engaging in disordered eating behaviours? Might binge eating produce some positive emotional experience for them in the moment? Chain analysis can support the identification of an emotion-regulation function of eating behaviour. • **CONSIDER:** People experiencing eating disorders are at **increased risk of having experienced trauma, domestic violence and emotional neglect**. To what extent might restriction or binge eating help the person to manage historical or current trauma? • **EXPLORE:** Might altered eating behaviour reflect variable sensory sensitivity: aversion to certain food flavours, aromas, textures? • **EDUCATE:** Restriction of dietary intake may produce an anxiolytic or numbing effect. On the other hand, people may also experience a paradoxical (fear-based) response to food. • **SUPPORT:** Practice **trauma-informed care**. Support safety. Support the person to reduce harms associated with disordered eating behaviour and develop alternate coping skills.
Control of Physical Sensations	Restriction and binge eating may help the person feel in control of unpleasant physical sensations	• **EXPLORE:** To what extent does the person feel a sense of mastery over normal physiological drives like appetite and hunger? • **EXPLORE:** People with eating disorders may experience disrupted interoceptive awareness. To what degree might this person be experiencing heightened awareness of internal physical sensations? To what degree might restriction assist them to avoid feeling full/reduce uncomfortable physical sensations? See CCI Gastrointestinal problems in eating disorders. • **SUPPORT**: Practice **trauma-informed care**. Support safety. Support alternate ways **of managing challenging internal sensations, (i.e., sensory approaches)**. Consider the impact of gastroparesis and ways to reduce discomfort (See Gaudiani Clinic Resource)
Deliberate Self Harm/ Punishment	Some people restrict or binge as a deliberate act of self-harm.	• **EXPLORE:** To what extent might restriction or binge eating function as a **self-punishing response to beliefs about themselves in relation to food** (i.e., one has eaten too much, or the "wrong thing" or over indulged, disgusting). To what extent might binges or restriction follow **events** during or after which **the person has felt extreme shame, guilt and/or self-disgust or hatred?** • **SUPPORT:** Support the person to reduce the harms associated with disordered eating. Help them to develop other ways of expressing or tolerating distress. How might they act in the direction of self-tolerance as a precursor to self-acceptance?

Biology & Trait Expression	Harmful eating or fluid intake behaviours may be linked to underlying temperament. And/or variation in the person's regulation of eating and appetite	• **EXPLORE:** To what degree might the person have a basic temperament that sees them more on the side of obsessiveness, rigidity & persistence, conscientiousness, perfectionism, high achievement, striving, relishing challenge? • **EXPLORE:** To what degree might this person experience natural variation in their regulation of eating and appetite? • **EXPLORE:** Is there a co-occurring illness requiring dietary modification (e.g., diabetes, coeliac disease or G/I conditions) • **EDUCATE**: Traits may be viewed as dual vulnerabilities and strengths. In what way might this person's temperament by hijacked by their eating disorder/expressed in their eating behaviour? • S**UPPORT**: Support the person to reduce the severity of their behaviour, and consider how they may move toward more productive trait expression (e.g., Hill et al., 2016). Make sure they have an eating disorder informed medical team assisting with any co-occurring medical conditions.
Starvation & compulsivity	As starvation worsens, some people experience an intensification in the drive for thinness or fear of weight gain	• **EDUCATE:** Some people experience impairment of their awareness of the impact of starvation on their body, see CCI Starvation Syndrome. Binge eating may result from normal biological counter-regulatory drives to prevent starvation (following restriction) • **EDUCATE:** Starvation also exaggerates underlying temperamental traits related to conscientiousness, obsessiveness and detail focus, resulting in impaired decision making ability and subtle impaired judgement regarding health risk. Starvation is likely to impair emotional regulation and appetite regulation (making the person more vulnerable to loss of control eating), which may paradoxically reinforces the need to maintain tight control over intake. • S**UPPORT**: Support the person to understand the impacts of starvation and take action to reduce harms. Help the person to move toward increased nutritional intake and weight restoration.
Food environment & diet culture	Cultural beliefs and practices related to food, and food availability may influence disordered eating	• **EDUCATE:** Help the person to understand and see the ways in which diet culture pervades beliefs, behaviours and expectations related to food and bodies in western cultures. Help them to also understand how this may have impacted upon their health care and interpersonal experiences. • **EDUCATE:** Help the person to consider whether they exist or grew up within an environment that is food & food choice abundant, & food consumption promoting, versus one that is/was food insecure, and how this impacts upon their experience. • **SUPPORT:** Support the person to address food insecurity. Help them to reduce harms associated with malnutrition and/or binge eating. Help them to reframe internalised messages about diet culture
Athletic Performance & Aesthetics	Athletes may be exposed to coaches, cultures and systems that pressure adherence to strong aesthetic ideals	• **All athletes are at higher risk of eating disorders.** Some combat sports with weight divisions, people who are jockeys & dancers may be at risk of restriction of food or fluids for weight 'shredding'. Endurance athletes are at high risk. • **EXPLORE:** To what degree does restriction/shredding support belonging to their sport/craft via adherence to aesthetics? **Athletes come in all shapes and sizes.** • **SUPPORT** the person to consider better nourishing themselves to perform in their chosen area and/or reduce their activity whilst still retaining connection to their team/coaches and protective factors. See SEES for Athletes

▶ Disordered Eating and Drinking: Possible Physical Harms & Harm Reduction Approaches

Signs to stop physical activity immediately:
For an overview of indicators of increased physical risk & required actions (for MH clinicians), see: **Physical Risk in Suspected Eating Disorders – MH Clinician Response Guide**

Support the person to improve nutrition & stabilise health, along with initial & ongoing medical assessment & monitoring of cardiac function and general physical presentation, especially if presenting with excessive exercise. Build in opportunities to support readiness for change

Get to know the persons' behaviours → **Get clear + be direct about the consequences of the behaviour,** → **Be clear, direct, and collaborate around what they can do to be safer**

Behaviour	Possible Physical Harms	Harm Reduction Approaches
Dietary restriction – persistent low energy intake (≤ 1500kcal / 6 MJ/day) & or significantly restricted food variety)	**The following risks have been associated with dietary restriction:** Acute: Dehydration; electrolyte abnormalities; acute medical instability (Westmoreland et al., 2016) Increased Risk of Refeeding Syndrome Increase risk of inadequate micronutrient & distorted macronutrient intake & subsequent deficiency syndromes (Setnick, 2010) - Nutrients of High risk of & high concern: Vit D; Vit B12; Ca++; Fe; (Zn / B vits) - Lead to protein-energy malnutrition (with or without oedema) - Gastro intestinal: Constipation - Dental decay & damage - Endocrine: low M / F sex hormones – osteopenia & osteoporosis; fracture risk - Lead to protein-energy malnutrition (with or without oedema) - Gastro intestinal: Constipation - Dental decay & damage - Endocrine: low M / F sex hormones – osteopenia & osteoporosis; fracture risk (Westmoreland et al., 2016). In nutrition related health conditions: E.g. Diabetes – low blood sugar readings & associated problems (Winston, 2020)	General principles: Regular engagement with a medical professional who understands the **current level of disordered eating behaviour** to identify and manage potential physical risk early. Review & update (increase) non-negotiable medical monitoring arrangements. Encourage increased regular medical monitoring & team communication with medical practitioner Refer for dental assessment & management. Assess for other factors that may increase (complicate) harm: Fluid intake, physical activity, environmental extremes exposure; substance use The gold standard treatment for malnutrition is increased caloric intake and weight restoration. Encourage return to regular & adequate eating (focussed on health stabilisation/basic physical safety). Consider ways to help the person move toward this. Helpful resources: • **THE REAL Food Guide for CBT-T Clinicians:** Basic Food and Eating Training for Eating Disorders. Susan Hart & Caitlin McMaster • http://cbt-t.group.shef.ac.uk/?smd_process_download=1&download_id=202 • RAVES ™ Framework Shane Jeffrey APD. https://eatingdisorderscarerhelpkit.com.au/wp-content/uploads/2019/10/RAVES-Model.pdf • Being a Competent Eater – Ellyn Satter Institute ESI https://o3uyn13i47lqv7h542ed6i5p-wpengine.netdna-ssl.com/wp-content/uploads/Being-a-competent-eater.pdf

Binge eating	**The following risks have been associated with binge eating:** Dental caries & damage (Pallier et al, 2019) Gastro-intestinal complications: Inflamed and swollen salivary glands Gastric dilatation Diarrhoea In nutrition related conditions: - ***Diabetes Mellitus*** – impaired diabetic control (Winston, 2020) - ***Coeliac Disease*** – poor dietary 'compliance' resulting in G/I damage & impaired G/I function (Leffler et al., 2007) - Metabolic Syndrome (specifically Binge Eating Disorder (Mitchell, 2016)	Consider whether the person is binge eating on dangerous substances, such as non-food items (paperclips, cotton balls to 'feel full'), or rancid/poisonous foods such as food found in bins. Collaborate around what might reduce this extremely harmful behaviour. Seek (secondary) consultation from a dietitian re complex presentations (other physical health presentations (e.g., diabetes; coeliac disease; food intolerances / allergies); or very rigid dietary choice. Utilise collaborative ERP approaches to expand food variety to meet adequacy needs. Utilise written meal guides; hierarchies & agreements & (negotiate sharing) share with persons in support system to promote accountability & provide support material (financial; food related housekeeping) support psychological (meal support) support) Resources for supporters / carers: e.g., the shared table https://edqsharedtable.com.au/ Utilise CBT-Guided Self Help strategies to re-establish pattern or regular eating & intervene to reduce the chance of binge eating CEED CBT-Guided Self Help for Binge Eating handouts – Steps 1 - 6 (https://ceed.org.au) Step 1: Monitoring Eating | Step 2: Meal Plan & Monitoring | Step 3: Intervening to prevent binge eating | Step 4: Problem Solving | Step 5: Eliminating Dieting | Step 6: Changing your Mind
Other eating e.g. 'chew and spit'	**The following risks have been associated with 'chew and spit':** - Damage to teeth, stomach ulcers, and hormonal imbalances (Aouad et al., 2016)	**Approaches to reduce physical harms** • Adequate hydration & nutrition, use of electrolyte drinks, reminders & strategies to support hydration (Careful not to over-hydrate due to water intoxication) • Medical practitioner may consider prescribing potassium supplements • Consider need for higher intensity support to reduce immediate risks in the context of rapid weight loss. • Dental care • Support to improve nutritional adequacy and weight restoration
Fluid restriction	**The following risks have been associated with fluid restriction:** - Dehydration - Kidney stress / kidney stones (Hart et al., 2005)	
Fluid over-consumption	**The following risks have been associated with fluid overconsumption:** - Dilutional hyponatraemia (water intoxication) – low sodium, cerebral convulsions; - Bed wetting (nocturnal enuresis); urinary incontinence	**Approaches to reduce physical harms** • Continue close medical monitoring • Consider function of overconsumption and swap in alternate behaviours • Educate re harms: Dilutional Hyponatraemia handout Toxicology Education Foundation https://toxedfoundation.org/water-intoxication-dilutional-hyponatremia/

High caffeine consumption	**The following risks have been associated with high caffeine consumption:** • Caffeine toxicity • Worsening of anxiety symptoms • Impaired sleep and sleep pattern • Impulse dysregulation	**Approaches to reduce physical harms** • Educate: https://www.mhc.wa.gov.au/media/1223/caffeine-the-facts-booklet.pdf • Swap out some caffeinated drinks for other substances that have similar qualities (i.e. soda water, decaf coffee, carbonated water in a can), being mindful of impacts of fluid overconsumption • Refer to CEED harm reduction handout: Co-occurring substance use www.ceed.org.au
+ increased incidental or intentional physical activity	**The following risks have been associated with restriction and physical activity:** • Dehydration, abnormal electrolytes • Heat exhaustion / heat stroke • High risk of injury; slow injury repair & recovery • Relative Energy Deficiency in Sport (RED-S) • Impaired sports performance • Increased risk of heat related illness	**Approaches to reduce physical harms** • Consider Extent: time; frequency; repetition; demand on body (sprint, endurance, strength, flexibility related activity) • Refer to CEED harm reduction handout: Harmful Physical Activity www.ceed.org.au **Education & Assessment:** • RED-S • RED-S Clinical Assessment Tool
+ environmental extremes exposure	**The following risks have been associated with disordered eating and exposure to environmental extremes** • Increased risk of heat related illness Malnutrition and weight suppression reduce the body's capacity for thermoregulation as blood is diverted away from extremities toward the centre of the body, and the body works harder to maintain temperature.	**Approaches to reduce physical harms** • Support the person to reduce exposure to extreme temperatures, wear appropriate clothing for weather **Information:** • Better Health – Heat Stress & Heat Related Illness • Better Health - Hypothermia
+ alcohol	**The following risks have been associated with disordered eating and alcohol use (binge/dependence)** • Increased refeeding syndrome risk • Altered (low) BSL, Liver inflammation • Upper G/I problems	**Approaches to reduce physical harms** • Refer to CEED harm reduction handout: Co-occurring substance use www.ceed.org.au
+ other substance use - Refer to CEED harm reduction handout: Co-occurring substance use www.ceed.org.au		

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