Harm Reduction for Adults with Harmful Eating and Body Control Behaviours

TASKS of Harm Reduction and Eating Disorders

A Series of Information Resources and Guides for Clinicians

Support all people experiencing eating disorders, their families and supports to address personal safety with dignity & compassion

Uphold the most hopeful and challenging treatment goals possible.

Treatment for people experiencing eating disorders is typically most effective during the first 3 years of the eating disorder (Treasure et al., 2015). Furthermore, current effective recovery-based interventions require substantial behaviour change, with early behaviour change predicting best outcomes (Linardon et al., 2016). Thus early intervention and behaviour change should be the first consideration for clients and therapists.

However, these more active treatments require a degree of intrinsic motivation for change that may not yet be present. Thus, clinicians are called to work motivationally, provide tailored treatment and care, and to set **collaborative "high enough" goals** so as not to strengthen the eating disorder and feelings of hopelessness, nor risk demoralisation via pursuit of unworkable goals.

Useful goals may include **decrease in suffering and psychiatric symptoms**, and an **increase in meaning, pleasure, purpose and personal fulfilment** (Duckworth et al., 2005).

Help the person build their support network.

In addition to intrinsic motivation, eating disorder recovery can be largely influenced by the person's sense of connection to and support from others (Bardon-Cone et al, 2018).

Help people to build a system of social, environmental and community supports and reinforcements around them that supports their efforts to improve physical safety, wellbeing and movement in the direction of their goals.

Families, supports, and communities often offer insights and alternate perspectives that are unique and valuable, and can help people remain accountable to their harm reduction plan.

Work with the person to determine the nature of support they want or need, in what form and from whom. Support them to engage in discussion with their supports to become clear about everyone's role in supporting the person to move in the direction of their goals.

Every choice about eating disorder behaviour involves both the possibility of failure and success. Harm reduction supports people to achieve successes in the direction of safety and enhanced self-care

▶ Maintain a hopeful stance, look for strengths and seek out opportunity

Hope is the possibility of change. Eating disorders include a continuum of behaviour from severe to total cessation Acknowledge the significance of any positive meaningful change that people make in their lives. The most useful hope is realistic and genuine.

▶ Underpin Harm Reduction with a Clear Safety Net

▶ Physical Safety.

Some eating disorder behaviours place people at risk of extreme harm. Harm reduction approaches need to **sit within a clear risk response framework** that includes early discussion and agreement about the non-negotiable aspects of treatment (see Geller & Srikameswaran, 2006), expectations for medical monitoring and care, conditions requiring hospitalisation and reasonable and clear next steps if these are not met.

Care Team: The basic care team required to support a person to establish greater physical and psychological safety includes

- **The person** experiencing an eating disorder
- The persons **family and/or supports**
- A **mental health** practitioner
- A community-based **medical** practitioner (preferably the persons GP

Medical oversight: Agree with the person in collaboration with their medical practitioner the frequency of medical monitoring appointments required to provide a physical health safety net. See guidelines for admission.

Be clear about the roles of all care team members in monitoring safety and methods for communication. Be clear and direct about the pathways to more intensive levels of care (medical and psychiatric) and under what conditions these will be required.

Include physical impacts of eating disorder behaviours as part of routine safety planning and monitoring.

Mental health clinicians should familiarise themselves, their clients and families/support with signs of increased medical risk, and when to seek urgent medical care.

Supporting Resource Hyperlink:
Physical Risk in Eating Disorders:
MH Clinician Response Guide ceed.org.au

Supporting Resource Hyperlink:
Treatment Non-Negotiables: Why we need them and how to make them work (Geller & Srikameswaran, 2006)

▶ Underpin Harm Reduction with a Clear Safety Net

▶ Psychological Safety.

Prevalence of self-harm has been reported between 13.6 - 42.1% for anorexia nervosa, between 26-55.2% for bulimia nervosa, and 26.2% for OSFED (Claes et al., 2003; Svirko & Hawton, 2007). Risk increases for people in marginalised groups, such as LGBT+ folk and Indigenous Australians. There is an increased risk of suicide for people experiencing eating disorders. Rates of completed suicide have been reported up to 18 times more likely in AN and 7 times more likely in BN compared with the general population (Smith, Zuromski, & Dodd, 2018).

Tend to the persons vulnerability to non-suicidal self-injury and suicide ongoing

Features of eating disorder experience which may increase risk of suicide attempts

Existence of co-occurring mental illness or substance use	Underlying emotion dysregulation & impulsivity	Interpersonal factors associated with EDs	Fearlessness about death	Perceived burdensomeness on others by the person experiencing the ED	Increased capability due to reduced responses to pain	Being gender and/or sexually and/or biologically diverse, being male

…And risk of non-suicidal self-injury

Self-criticism | **Thwarted belongingness** | **Perceived burden on others** | **Body dissatisfaction**

Support people to challenge self-criticism, seek experiences of belonging and contribution, and to tolerate body distress

Understand the interaction between harmful behaviours and risk for self-injury and suicide.
One important function of eating disorder behaviours can be 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 www.ceed.org.au

Safety Net: Create a Clear and Collaborative Harm Reduction and Crisis Plan

Agree Agree up front upon the criteria and process for accessing more assertive medical care and more intensive levels of psychiatric/social support.

Prioritise Help the person to prioritise early intervention and least restrictive treatment environments and interventions. Create a harm reduction plan.

Plan Write down, share and regularly update a clear plan that outlines the steps to be taken if there are indications of significant immediate risk to physical health.

Supporting Resource Hyperlink:
CCI physical risks associated with eating disorders for client cci.health.wa.gov.au

Supporting Resource Hyperlink:
Case Management and Care Leadership for Eating Disorders ceed.org.au

Maintain accountability to the person's "Healthy Self"

e.g., "My therapist and I set a goal that if I purge then I return to planned meals and eating"

Hold the "Not sick enough' narrative.

People experiencing eating disorders may have strong beliefs that their eating disorder isn't serious "enough" to warrant care. Eating disorders tend to minimise and deny the difficulty of person's experience. **Don't wait for the 'not sick enough' narrative to change. Roll with resistance. Keep a firm bottom line around safety.**

Provide information about the physical and psychological impacts of eating disorders (see "Sick Enough" and Gaudiani Clinic Videos) and support the person to reflect on the impacts and discrepancy between their current eating disorder predicament and the life they wish to live.

Be clear and direct about the consequences of behaviours.

Discuss all current eating disorder behaviours and any relevant consequences with the person and their supports.

Conversations should not shy away from being clear and direct with the person, their families and supports so that they are well informed about health consequences of the behaviour.

Listen for what is meaningful to the person. **Provide education** regarding the impacts of the behaviour on physical health, mental health, and wellbeing that is **meaningfully linked to their values, hopes and goals.**

Follow directness about consequences by being clear and direct about what can be done to reduce harms.

Work with the person and their supports to develop **personally relevant, practical, achievable** actions they may take to support their safety. Tailor interventions to the person's strengths.

Know **the interactions between the person's harmful eating disorder behaviours and other risk-related behaviours or vulnerabilities** such as substance use, self-harm, domestic violence, sexual vulnerability, and suicidal ideation. Balance this against disordered eating behaviour harm reduction.

Stance. As health practitioners we must seek to hold hope and positive regard for the person we are working with, regardless of their current behaviours and readiness for change. We must also seek let go of our expectations around outcomes of this regard and hope. Instead, we lean back on genuine care and engagement, our safety net, and motivational stance to support the person to decide whether to engage in harm reduction

▶ Feedback & Review

Help us to continually improve these resources for you and your colleagues.
Complete a short (3min) survey regarding your perspectives on the usefulness and applicability of the information provided and suggestions for improvement.

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