CEED

THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

HARM REDUCTION

FOR ADULTS WITH HARMFUL EATING AND BODY CONTROL BEHAVIOURS

CEED RESOURCES 2024

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Foreword

In the context of COVID 19 and subsequent lockdown and social distancing interventions, Victorian health services observed an increase in people presenting with higher severity eating disorder behaviours, medical instability, higher rates of lapse/relapse, and increased first-time treatment seeking. This intensification in presentations and severity created large-scale and substantial challenges to the health system's capacity to adequately respond, with impacts upon safety and wellbeing through limited access to appropriate care for people experiencing eating disorders.

These challenges highlighted a number of gaps within the Victorian eating disorders service system response. We believe that one important gap is a lack of clarity and skill in providing upstream interventions designed to reduce physical harm and prevent medical crisis. One way to proactively address this issue is to support the provision of interventions within outpatient settings designed to empower people to take action to reduce their risk of physical harm associated with their disordered eating and weight control behaviours.

In light of this, CEED undertook a project to develop a series of harm reduction practice guidance resources for public mental health clinicians.

Key objectives & target audience

The goal of this resource is to provide a synthesis of current evidence-informed harm reduction frameworks and guidance in order to support clinicians to apply harm reduction, alongside their evidence-based treatment, in their work with adults engaging in disordered eating and weight control behaviours.

The resource series was targeted particularly toward Victorian Public Mental Health clinicians who are often providing commune-based care for people experiencing eating disorders who engage in severe eating disorder behaviours, experience complex and co-occurring mental health challenges and challenges to psychosocial wellbeing related to poverty, homelessness, unemployment and domestic violence.

Key qualities of the resources:

- The tone and stance is empowering of the clinician, the person experiencing an eating disorder, their family, supports and community
- The resources honour complexity and encourage clinicians to be curious about the person's experience and reflect on complexity of both harms and benefits of behaviours
- The resources centre lived experience, and integrate feedback and perspectives of people who have/had an eating disorder, their families, supports and communities
- The resources honour the role of families, friends and communities, in supporting the person to engage in their treatment and care. They acknowledge the impact of eating disorders on families and loved ones.

- The resources are practical and tailored; they offer practical suggestions and guidance, whilst not prescribing a 'one size fits all' approach. They support clinicians to meet people at their current level of readiness and to work on enhancing readiness.
- The resources are clear in their application, where harm reduction fits within the treatment and recovery continuum, its ethos and aims.
- The resources set clear parameters around safety, supporting clinicians to work with the person collaboratively and compassionately, whilst clarifying non-negotiable aspects of care and being clear about situations in which treatment focus may change to address risks of harm to self.

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Copyright and use of information

The CEED harm reduction resource provides a summary and guidance for clinicians regarding the application of harm reduction. The aim of harm reduction in this context is to support adults to reduce the physical harms associated with engaging in disordered eating and weight control behaviours.
The guidelines in this document are based upon:

- A review of published research evidence
- Consultation with Victorian experts in the area of eating disorders

The information contained in the resources reflects the knowledge and evidence at the time of their release. As new research emerges, the resources will evolve to ensure that practice is based on the best evidence. Efforts for continuing quality improvement, as well as opportunities for knowledge exchange and consultation are critical to ensuring that clinical practices remain current, and that Victorians and Australians receive services that result in the best possible outcomes.

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Disclaimer

This resource is designed 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.

OVERVIEW

of Harm Reduction and eating disorders

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

Eating Disorders involve a range of behaviours that may put the person at risk of physical harm. Persistent, prolonged, or escalating disordered eating behaviours may result in malnutrition, electrolyte disturbance and organ damage that put people at risk of medical instability requiring acute, inpatient medical rescue, chronic health consequences and early death.

Key features & considerations

- Physical and nutritional rehabilitation are generally accepted as central aspects of physical and mental recovery for people experiencing an eating disorder.
- The degree to which these aspects of wellbeing can be addressed varies between people and over time.
- Harm reduction is routinely used to address harms related to substance use, however there is limited guidance about the application of harm reduction approaches to reduce risk of physical harm from disordered eating behaviours.

Clinicians are called to consider how harm reduction approaches fit alongside:

- Supporting improved treatment outcomes via early intervention and early behaviour change
- Supporting nutritional and physical restoration for recovery
- The challenge of neuroprogression and interpersonal perpetuating factors to recovery
- Limited evidence for the effective treatment of severe and enduring eating disorders
- Challenges related to autonomy and decision making

Definitions

Harm reduction approaches (Marlatt, 1996) invite people to reduce the negative effects of behaviours and take steps toward improved safety and greater self-care whilst keeping opportunities for further healing and recovery open.

This resource is designed for clinicians

CEED's Harm Reduction Resource is designed to support clinicians to empower adults experiencing eating disorders to enhance physical safety, and improve wellbeing and quality of life. Behaviours include:

Eating & Drinking Behaviours	Purging Behaviours	Physical Activity	Substance Use
• Dietary restriction • Binge Eating • Fluid restriction • Excess fluid intake	• Self-induced vomiting (physical or substance induced) • Laxative use	• Excessive or compulsive physical activity • Compulsive incidental activity	• Psychoactive substances • Appearance & performance enhancing • Appetite suppressants & stimulants

Harm reduction approaches keep the door open to recovery.

- Harm reduction can support meaningful engagement in self-care and professional support
- Harm reduction invites the examination of values, aspirations and wishes, enhanced health, and improved quality of life
- Harm reduction provides opportunities to safely experiment with small changes that can increase suitability for more intensive treatment options (Geller et al., 2012)
- Harm reduction actions could save someone's life

A Back Door *approach to treatment and recovery*

"Paradoxically, in helping clients build a more meaningful life for themselves with their ED, they often choose, over time, to decrease its impact in their lives on their terms. We describe this as a 'back door approach to recovery'" (Geller et al., 2012).

Harm reduction approaches do not stand alone

- Follow general principles and clinical practice standards (Heruc et al., 2020).
- Utilise an evidence-based practice framework (Peterson et al., 2016).
- Practice trauma-informed care.
- Offer the most appropriate intervention in the most appropriate setting tailored to the needs of the individual (see NICE Guidelines and Treatment Setting Decision Matrix).

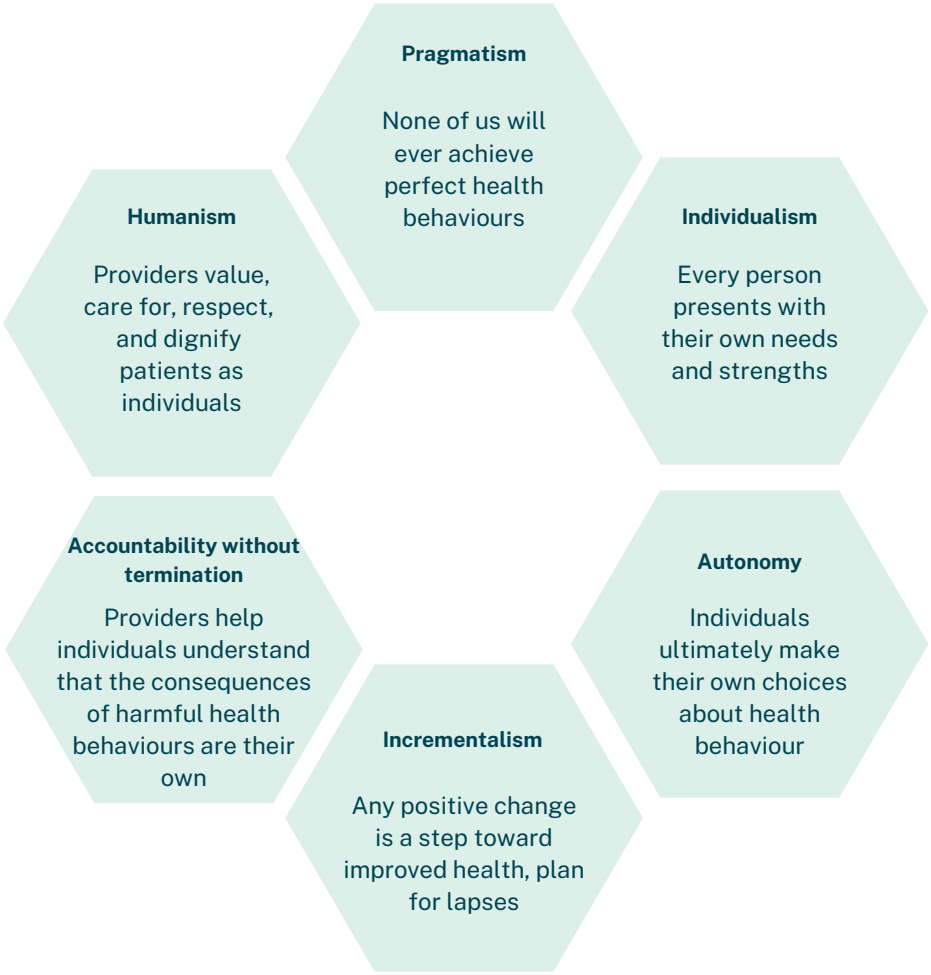
Use harm reduction approaches as an adjunct to evidence-based behaviour change treatments for eating disorders where motivation to change is moderate to high however harmful behaviours are yet to completely cease.

Use harm reduction approaches as an adjunct to evidence-based QoL and readiness interventions for eating disorders where motivation to change is low and harmful behaviours are present.

Harm reduction approaches consider the function of behaviours

- Eating disorder behaviours help the person to cope.
- Benefits to coping must be thoughtfully considered to understand the balance between harms and benefits that support basic motivation for change.
- Ego syntonic behaviours are actions and behaviours that correlate with the goals of the eating disorder.
- Disordered eating behaviours can provide powerful reinforcement such as gaining a sense of control, achievement & success.
- For the person/client, moving against this cycle can be extremely challenging, and behaviour change can feel aversive.
- Ego dystonic behaviours are actions and behaviours that the person may detest but feel unable to stop due their strong compulsive nature (i.e., binge/purge). People may feel distressed, helpless and ashamed.
- Help the person understand these dynamics and validate the challenge of change.

The 6 key principles of harm reduction in healthcare setting



Developed from Hawk et el., 2017

CHALLENGES

of Harm Reduction and eating disorders

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

Autonomy, choice and denial of seriousness

Key to harm reduction approaches is the concept of autonomy, or the assertion that people ought to be given the opportunity to make their own decisions when it comes to their quality of life and treatment (Buchman & Lynch, 2018).

Denial about eating disorder seriousness

Autonomy in the context of an eating disorder is complex, particularly as denial of the seriousness of the problem may be core to the experience (DSM-5; American Psychiatric Association, 2013). Cognitive distortions inherent in eating disorders, can act as a significant barrier to setting change-related recovery goals despite an intellectual understanding of risk of physical harm related to ED behaviours (Bianchi, 2020). It may be difficult to determine if a person is making a truly autonomous decision about their care and quality of life or whether, in fact, their decision would be different if they were in a different cognitive state.

Relational autonomy

Whilst autonomy is often conceptualised as 'complete self-governance', Bianchi (2020) suggests that a more useful conceptualisation is that of relational autonomy for which there is a foundational assumption that individual decisions will influence and be influenced by others because of the social constructs in which we live.

Most people with an eating disorder would likely be making decisions with the support of those around them (e.g. healthcare practitioners, family, partners, friends etc.) and those around them would be influenced by their decision to pursue a harm reduction approach. Thus clinicians are called to consider the role and influence they, and the persons supports, play in supporting choices and autonomy.

In addition to relational autonomy, Bianchi (2020) suggests clinicians consider the following:

- The persons understanding and appreciation of their illness (i.e. criteria used to determine capacity in Victoria's Mental Health Act (2022))
- The number of attempts at full recovery. This may make them more informed to make a decision about not starting with a goal to be entirely symptom-free
- The consistency with which the person expresses their goals

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First do no Harm: Be aware of possible iatrogenic maintaining factors in eating disorders

Support autonomy and responsibility: Services can become a reinforcing influence by providing an overly protective, palliating environment which ensures safety, security and acceptance whilst reducing loneliness and isolation. This can reduce the individuals' sense of responsibility, autonomy and independence, promoting avoidance. Careful planning of service provision, reflective practice, supervision and regular team feedback is essential to prevent iatrogenic harm (Treasure et al. 2011).

Suicide risk

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.

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Tasks & Considerations

of Harm reduction and eating disorders

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 (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 of 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 hyperlinks:

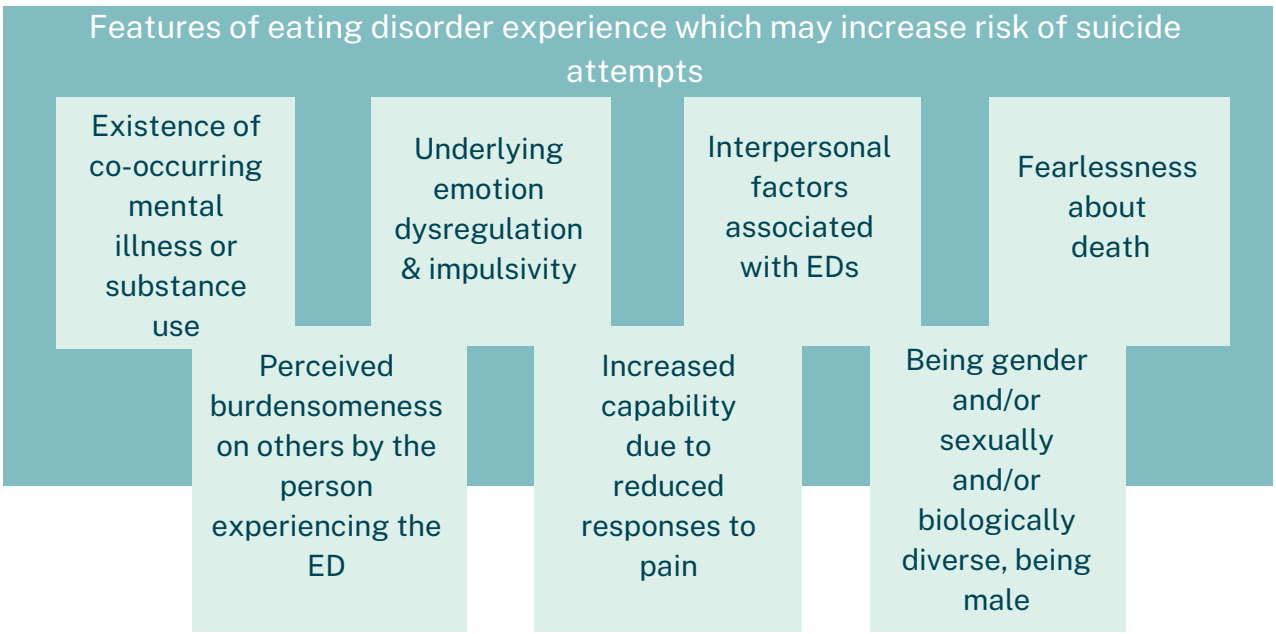
Physical Risk in Eating Disorders: MH Clinician Response Guide ceed.org.au

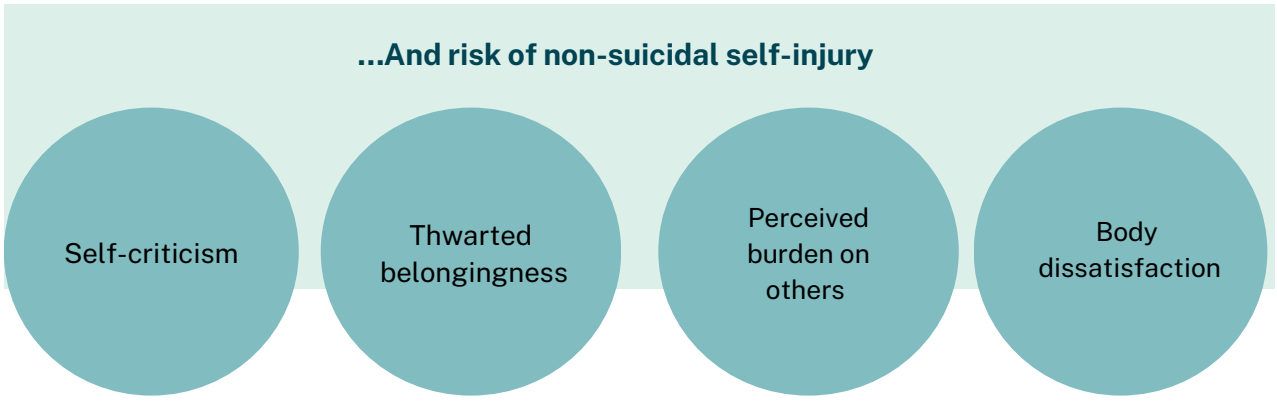
Treatment Non-Negotiables: Why we need them and how to make them work (Geller & Srikameswaran, 2006)

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 LGBTIQ+ 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.





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.

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

Maintain accountability to the person's "healthy self"

"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 to 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.

Harm reduction for Disordered Eating and Body Control Behaviours

Approaches for Harmful Eating and Drinking Behaviour

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 and considerations

- Significant alteration in eating and drinking behaviour is core to eating disorders.
- Behaviours that can be identified as disordered 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.

Restrictive 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

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 & / or to dehydrate the body for desired body appearance (i.e. “dry out” muscles to make them more pronounced)

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

Steps towards a harm reduction approach

Assessment tasks & strategies

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.

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

Get to know the function of the person's eating & 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 fit 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).

Function	Overview	Tips for helping the person meet their needs in healthier ways
Deliberate Self Harm / Punishment	Some people restrict or binge eat 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** 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 may 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? • **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. • **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.

Function	Overview	Tips for helping the person meet their needs in healthier ways
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** 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 person's behaviours	Get clear & be direct about the consequence 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 leading to cardiac arrest; acute medical instability (Westmoreland et al., 2016); low blood sugar leading to hypoglycaemic coma. 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) • Gastrointestinal: Constipation • Dental decay & damage • Endocrine: low M / F sex hormones – osteopenia & osteoporosis; fracture risk • Lead to protein-energy malnutrition (with or without oedema) • Gastrointestinal: 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 • The R.E.A.L. food Pyramid • RAVES ™ Framework Shane Jeffrey APD. • Being a Competent Eater – Ellyn Satter Institute ESI
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	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.

Behaviour	Possible physical harms	Harm reduction approaches
	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)	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: The Shared Table 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 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) • 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 (seizure); • 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
High caffeine consumption	**The following risks have been associated with high caffeine consumption**: • Caffeine toxicity • Worsening of anxiety symptoms • Impaired sleep and sleep pattern • Suppression of Appetite • Impulse dysregulation	**Approaches to reduce physical harms** • Educate: Caffeine - the Facts • 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: Co-Occurring Harmful Substance Use

Behaviour	Possible physical harms	Harm reduction approaches
+ 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: Harmful Physical Activity • Explore if the function is related to "earning food" or the bullying/punishing nature of the ED voice **Education & Assessment:** • RED-S Clinical Assessment Tool
+ environmental extremes exposure	**The following risks have been associated with disordered eating and exposure to environmental extremes:** • Hypothermia • 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: Co-occurring substance use
+ other substance use - Refer to CEED harm reduction: Co-occurring substance use		

Harm reduction for Disordered Eating and Body Control Behaviours

Approaches for Purging Behaviours

Purging puts people experiencing eating disorders at increased risk of early death due to cardiac arrest and has also been linked to increased risk of suicide attempts.

Key features and considerations

Clients engaging in purging behaviours are at risk of low serum potassium, high frequency purging causes low serum potassium that can lead to cardiac arrest.

Clinicians must seek to know the frequency of purging as well as the clients serum potassium to assess the level of risk, treatment is regular monitoring of serum potassium and regular potassium supplementation as required and prescribed by a medical doctor. As serum potassium stabilises, the dose of oral potassium could be reduced especially in the context of reported reduction in purging frequency. Note overdose of potassium also can cause cardiac arrest.

Purging behaviours include:

- Self-induced vomiting (manually using fingers, objects or less commonly substances i.e., ipecac)
- Harmful use of laxatives (elimination of solids), diuretics (elimination of fluids), diet pills, enemas
- Omitting or under-dosing insulin in Type I diabetics.
- Compensatory purging behaviours are behaviours intended to relieve the guilt from eating or after binge eating.
- Non-compensatory purging occurs in the absence of recent food intake, such as in purging disorder. It may function as a "routine" method of weight control, or as a strategy for emotion regulation
- Driven and compulsive exercise to compensate for eating, see Physical Activity Harm Minimisation Resource

Purging is largely ineffective as a means of weight control and has potentially dangerous side effects, including electrolyte imbalances, oesophageal tears, dehydration, and kidney damage. Purging puts people at risk of early death by medical complications and has also been linked to increased risk of suicide

CCI Information Sheet: Vomiting and your health

The Medical Complications Associated with Purging (Forney et al., 2007)

Steps towards a harm reduction approach

Review and assess the person's purging behaviours

Collaboratively review the person's current purging behaviour alongside other ED related behaviours. It is important for clinicians to be aware of shame associated with purging behaviours throughout assessment and engagement. Engage family, supports and community to add their perspectives where possible. Seek medical input regarding physical safety and consider involvement of a dietitian regarding nutritional and dietetic impacts

Purging warning signs

- Calluses on knuckles
- Going to the bathroom directly after meals
- Brittle hair and nails
- Swelling of glands in neck & jaw (parotid) → lumps/rounded cheeks
- Diarrhoea, dehydration
- Abdominal pain
- Smelling like vomit
- Burst capillaries in and around eyes
- Evidence of vomit in the toilet or in sinks
- Discoloured teeth / dental problems
- Binge eating / secret eating, food wrappers
- Fatigue

Assessment Tools

SCOFF (Inside Out institute)	Reach out and recover (ROAR)	EDE-Q 6.0 (Fairburn & Beglin, 2008)	EPSI (Forbush, 2013)

The assessment of purging behaviours should include four main aspects:
(1) occurrence, (2) frequency, (3) type, and (4) number of methods
(Haedt-Matt, 2017).

1	**Have you ever made yourself sick (vomited) to control your shape and/or weight?** **(If yes)** How many times in the past month? What method?
2	**Have you ever used diuretics (medications to eliminate fluids) to control your shape and/or weight?** **(If yes)** How many times in the past month? What kind of diuretic? What dosage?
3	**Have you ever taken laxatives (medications to eliminate solids) to control your shape and/or weight?** **(If yes)** How many times in the past month? What kind of laxative? What dosage?
4	**Have you ever used any other means of getting rid of calories, such as enemas, diet pills, or ipecac?** **(If yes)** What have you done? How many times in the past month? What dosage?

In addition, ask questions about the function of the behaviour and the person's readiness to change such as:

Are there other reasons that you x?	**How important is it for you to change x, from 0-10? Why? Why not zero? Lower/higher?**	**How important is it for others that you change x, from 0-10? Why? Why not zero? Lower/higher?**	**What might/does make it hard to change?**

When assessing purging behaviours keep in mind there is often a lot of shame associated, shame could impact upon disclosure and delay treatment.

It is yet to be empirically established whether interventions specifically targeting motivation to change provide additional benefit over and above established treatment approaches. However, more information about preliminary trials regarding Motivational Enhancement Therapy (MET) with individuals who have Eating Disorders can be found here: Pretreatment motivational enhancement therapy for eating disorders: A pilot study

Get to know the function of the person's purging 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	Purging behaviours are often driven by negative self-evaluation related to weight, body shape or appearance and fear of weight gain.	• **EXPLORE**: Consider the degree to which appearance standards may be important to the person's identity and feelings of belonging within particular groups. Explore the degree to which purging supports the person to manage body related distress and/or stigma and discrimination in regard to their appearance, gender or other aspects of identity. • **GENDER AFFIRMING CARE**: Consider how you might support people to affirm their gender in ways that support safety, through personal, social legal and medical spheres of affirmation. • **SUPPORT** the person to find other ways of affirming their body that are less harmful, such as seeking protective communities, spaces and health professionals.
Emotion & Sensory Regulation	Purging may provide temporary relief from painful emotional experiences.	• **EXPLORE**: To what extend might purging help the person to **regulate their emotional state** by relieving feelings of guilt/shame or disgust after eating disallowed food types or quantities? To what extent might it **distract the person from feeling emotionally out of control**? Or create a feeling of **numbness or temporary bodily disconnection**? • **SUPPORT**: Help the person identify their triggers, and to develop alternate coping skills such as sensory approaches and emotional and interpersonal skill development programs such as those in DBT.
Control of Physical Sensations	Purging may reduce sensory awareness of unpleasant stimuli.	• **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 purging assist them to avoid feeling full/reduce uncomfortable physical sensations? See CCI Link Gastrointestinal problems in eating disorders. • **CONSIDER**: People experiencing eating disorders are at **increased risk of having experienced trauma, domestic violence and emotional neglect**. To what extent might purging help the person to manage historical or current trauma? • **SUPPORT**: Practice trauma-informed care. Support safety. Assist the person in building alternate emotion regulation and distress tolerance skills. Support alternate ways of **managing challenging internal sensations**, (i.e., sensory approaches).
Deliberate Self-Harm/ Punishment	Some people purge as a deliberate act of self-harm. This may be compulsive, impulsive or ritualised.	• **EXPLORE**: To what extent might purging 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 purging 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 purging by examining other ways of expressing or tolerating distress. How might they act in the direction of self-tolerance as a precursor to self-acceptance?

Function	Overview	Tips for helping the person meet their needs in healthier ways
Trait Expression	Aspects of temperament may make one more susceptible to purging.	• **EXPLORE**: To what degree might the person's temperament traits, i.e., impulsivity, emotion sensitivity, emotion dysregulation & anxiety make them vulnerable to purging? • **SUPPORT**: Help the person to harness the strengths of their traits (such as creativity or capacity for emotional connection). Support them to take action to reduce harms associated with purging behaviour. See Hower et al., (2021)
Asceticism & Overcontrol	Asceticism is a severe form of self-discipline and avoidance of all forms of indulgence.	• **EXPLORE**: Does this persons purging occur in the context of cultural, religious or spiritual beliefs that encourage this? Does this occur in combination with perfectionism, or a more general tendency toward 'over control'? In what way may purging serve a function to regain control over perceived failures related to eating or physical activity? • **SUPPORT**: Consider the ways in which over control may be channelled into action and areas that are more adaptive (such as adherence to a meal plan, or work activity). Support the person to reduce harms of purging behaviour.

Purging and disordered eating: Possible physical harms & harm reduction approaches

Signs to seek medical attention immediately:

⚠ If someone is experiencing episodes of fainting, collapsing, dizziness, chest pain, heart palpitations, shortness of breath, severe abdominal pain, bleeding during purging behaviours (i.e., bleeding during vomiting or due to laxative use).

Support the person to improve nutrition and reduce harm alongside initial and ongoing medical assessment & monitoring of cardiac function, electrolytes and general observations in the presence of an eating disorder, especially with comorbid purging behaviour. Build in opportunities to support readiness for change.

Get to know the person's behaviours	Get clear & be direct about the consequence of the behaviour	Be clear, direct, and collaborate around what they can do to be safer
Behaviour	**Possible Physical Harms**	**Harm Reduction Approaches**
Self-induced vomiting (manually using fingers, objects or, less commonly, via substances such as ipecac).	**Acute:** Dehydration and Electrolyte (potassium, chloride and sodium) imbalance resulting in: • Dizziness, • Fainting, • Cardiac arrhythmias/arrest • Acute kidney injury • Death **Additional Harms:** • Salivary gland enlargement • Dental erosions • Tearing and bleeding of the upper gastrointestinal (GI) tract (Oesophagus) • Nose bleeds and haemorrhage in the eyes • GI disruption: reflux, heartburn, bloating • Calloused hands • Dysregulated digestive system / gastrointestinal problems • Brittle hair and nails, discoloured teeth • Not absorbing medications	**General Principles:** No amount of self-induced vomiting or purging behaviour is considered safe. However, reducing the behaviours reduce risk of adverse outcomes. Medical professionals and mental health professionals can work together to assess risk around purging, combining knowledge of current behaviour with medical assessment, in particular blood tests, to provide timely treatment. Oral potassium replacement is the most common treatment to replace potassium lost through purging. Involve families, carers and supports in harm reduction planning and activities. Harm reduction can also be a powerful act of self-care. **Support the person to reduce harms**: **Reduce risk of acute injury and/or physical harm:** • Know when to stop: e.g. feeling dizzy, abdominal pain • Know when to go to hospital: e.g. fainting, difficulty walking, and palpitations, and make sure others in the persons network of support know this too • Regular medical reviews, blood tests and ECGs • Avoid use of sharp objects to induce vomiting (e.g. toothbrushes), or ingesting and purging non-nutritive substances (e.g., blades, cotton balls, paper clips) **Reduce risk of dehydration and malnutrition:** • Replenish fluid intake, (electrolyte drinks/Gatorade chocolate milk, pho for hydration) • Continue meal/eating plan despite purging **Reduce risk to dental health and oral hygiene:** • Avoid brushing teeth vigorously after vomiting to reduce enamel erosion • Rinse mouth after vomiting with fluoride or water solution/baking soda (to help neutralise acid), leave toothpaste on tooth surfaces to strengthen tooth enamel • Consuming water before vomiting may be protective against dental erosion • Daily brushing with fluoride toothpaste & flossing. Encourage the person to speak with their the dentist about enamel building toothpastes or other helpful treatments

Behaviour	Possible Physical Harms	Harm Reduction Approaches
		• See EDGI interview with Dr Cynthia Bulik & Brittany Davis on EDs and dental health **Reduce skin damage and sores on the hands from vomiting using fingers** • Applying barrier cream to hands before and after vomiting to reduce skin damage **Address associated behaviours & build in other coping skills** • Psychoeducation & addressing binge/purge cycle. Ineffectiveness of purging • Distraction/ relaxation techniques to manage urges to induce vomiting **Reduce impact on medication absorption:** • Taking of prescribed medications or nutritional supplements when least likely to purge (i.e. at night time before bed) to avoid purging medications. **Psychoeducation:** CCI - Vomiting and Your Health | CCI - Gastrointestinal Problems | CCI - Regular Eating for Recovery | CEED – Physical Risk Indicators and Response Guide
Laxative and Diuretic use **Laxative substance names:** e.g. Senna, bisacodyl, coloxyl **Diuretic substance names:** e.g. Thiazide diuretics-hydrochlorothiazide Loop diuretics-furosemide Potassium sparing-spironolactone May be taken orally or as suppository	**The following risks have been associated with use:** • Diarrhoea (Laxative use) • Increased urine output (diuretics) • Dehydration and Electrolyte imbalance • Dizziness, fainting • Cardiac arrhythmias and death • Acute kidney injury • Constipation and faecal impaction Compensatory behaviours such as laxative and diuretic use are known to lead to a number of physical complications. The use of diet pills and laxatives has the potential for escalating weight control behaviours, de-regulating normal digestive functioning leading to an increase in more disordered eating. **Long term** • Disruption of bowel function, • Gas, pain, bloating • constipation, • Rectal prolapse • Dependence on laxatives	**Support the person to reduce harms**: **Reduce risk of acute injury and/or physical harm** • Maintain fluid intake • Know when to go to hospital: fainting, abdominal pain, severe diarrhoea • Stop use or have a planned withdrawal schedule if heavy use of laxatives/ diuretics • Dispose of supplies/ limit access **Long term** • Reduce frequency of use • If used as compensation for binges, reduce frequency of bingeing • Distraction/ relaxation techniques to manage urges to use diuretics/ laxatives • Regular medical reviews; may benefit from seeing gastroenterologist/ other specialists to manage complications of long term laxative use. • Individuals who frequently take laxatives or diuretic should follow a planned withdrawal schedule during which the drugs are gradually phased out. Inform the individual of likely weight gain from rebound fluid retention (Fairburn, 2008)

Behaviour	Possible Physical Harms	Harm Reduction Approaches
	Resource: The eating disorders medicine cabinet revisited: a clinician's guide to ipecac and laxatives (Steffen at al., 2007).	**Interventions to reduce risks to health through alternate coping** Identify and address causes for harmful laxative and diuretic use: Compensation for bingeing| Weight control | Mood regulation | Avoiding 'feeling full' |Desire to have an empty stomach | Habit Explore the impact of purging on physical health and areas of value and importance for the person. **Psychoeducation:** IOI - Physical Complication Associated With Laxatives CCI - Laxative Misuse CCI - Gastrointestinal Problems
Ipecac and Enema use **Ipecac Forms**: administered rectally **Enema substance names:** e.g. fleet microlax **Enema Forms:** administered rectally	**The following risks have been associated with use:** **Common to both enemas and ipecac:** Short term complications: • Dehydration • Electrolyte imbalance • Dizziness • Blackouts **Hyponatremia or water intoxication** Hyponatremia is an imbalance of electrolytes that occurs when the body does not have enough sodium; in severe cases it can cause confusion, seizures, and coma. Resource: Tabitha Farrar Coffee Enemas **Ipecac- oral, syrup** Short term complications of ipecac: • Seizures, Haemorrhages • Respiratory failure, Shock • Palpitations, Cardiac arrest • Sudden death Long term complications of ipecac: • Muscle wasting and weakness, Damage to heart muscles (cardiomyopathy, heart failure) • Tears in the GI tract due to repeated vomiting • Lethargy • Dangerous drop in core body temperature (hypothermia) • Impaired circulation, kidney and liver disease • Dental abnormalities • Sudden death	**General principles:** No amount of self-induced vomiting is considered safe. Support the person to reduce the behaviour where they can, and/or to seek alternatives that are less harmful. Regular early engagement with a medical professional who **understands the current level and combination of disordered eating behaviours** to identify and manage potential physical risk is required. Involve families, carers and supports in harm reduction planning and activities. Harm reduction can also be a powerful act of self-care. **Harm reduction approaches:** • Limit supplies at home • Reduce frequency of use • Use of supplements (K supplements if known to develop specific biochemical abnormalities) • Regular visits with GP for physical health, biochemical tests and ECG **Psychoeducation:** Bulimia and Ipecac Use

Behaviour	Possible Physical Harms	Harm Reduction Approaches
	Enemas- administered rectally **Short term complications** • Bloating, Cramping • Tissue damage in rectum/ colon if incorrectly administered **Long term complications** • Dependence on enemas to produce bowel movements • Damage to nerves, muscles and tissues of the colon • Rectal prolapse • Disruption of normal micro-organisms in the gut	
+ Pregnancy	During pregnancy, the body allocates extra resources to the growing foetus. As such, purging may impact on the health of mother and baby through dehydration, electrolyte imbalances and cardiac irregularities. See CCI resource: pregnancy and eating disorders; NEDC Resource: Pregnancy & Eating Disorders Professional Guide.	
Additional Considerations	**Risk and Professional Duty of Care** Consider the degree to which the person's behaviour could impact self and others including operating a motor vehicle, heavy equipment, caring for minors, and occupational duty of care. Consider your own professional duty of care in supporting approaches to minimise harm and duty of care should the person be unable/unwilling to behave safely in these areas.	

Harm reduction for Disordered Eating and Body Control Behaviours

Approaches for Harmful Physical Activity

Precisely what makes exercise harmful depends on an interaction between the person's daily activities, values, physical status, and the physical activity undertaken

Key features and considerations

Dysfunctional exercise:

- Is often one of the last eating disorder behaviours to remit
- Is associated with longer hospitalisation, greater relapse rates, and more chronic and severe eating disorder presentations
- Harms from exercise may be physical or psychosocial in nature, including reduced functioning in meaningful occupation or life activities due to an over-focus on exercise, or impact of injury.
- Engaging in physical activity can delay physical recovery from an eating disorder and prolong functional hypothalamic amenorrhoea which can have significant and sometimes irreversible long term health consequences

Physical activity can confer important benefits:

- Physical activity is recommended for bone health, cardiovascular health, and mental health.
- Emerging evidence suggests that nutritionally supported, medically supervised, and prescribed physical activity, particularly that which provides genuine enjoyment and pleasure, likely benefits both the physical and mental health of individuals experiencing an eating disorder, when safe to do so, and in balance with harms to bone health and hormone function due to malnutrition.
- Abstinence from physical activity has been associated with poorer treatment outcomes in some people with eating disorders
- Gentle physical activity is associated with improved interoceptive awareness which in turn promotes engagement with therapeutic interventions.

Prevalence estimates suggest between 30-70% of people experiencing eating disorders engage in potentially harmful physical activity. Physical activity in the context of an eating disorder is particularly challenging as there may be substantial potential for harm alongside benefits to coping and wellbeing.

Definitions

All bodily movement is a form of physical activity whether it is incidental to daily occupation (e.g., gardening, vigorous housework, fidgeting, walking to the shops), or intentional (e.g., sport, or health and fitness regimes including gym work). An agreed definition of dysfunctional exercise is yet to be determined, however for the purpose of this resource, harmful physical activity is defined as an inability or unwillingness to cut down or stop exercising even though it is detrimental to health/wellbeing. This resource focuses mostly on harm reduction for physical health impacts.

Steps towards a harm reduction approach

Review and assess the person's physical activity-related behaviours

Collaboratively review the person's current physical activity alongside other ED related behaviours. Engage family, supports and community to add their perspectives where possible. Seek medical input regarding physical safety (see SEES) and consider involvement of an exercise physiologist

Consider:

Impact of exercise on the person's broader quality of life	**The important functional role physical activity may play for the person**	**Harms associated with physical activity in the context of an eating disorder**	**Potential harms of complete abstinence**

Dysfunctional physical activity warning signs:

- Exercise significantly interferes with important activities, occurs at inappropriate times or in inappropriate settings, or when the individual continues to exercise despite injury or other medical complications
- Exercise as permission to eat
- Exercising beyond prescription
- Intense anxiety, depression, irritability, feelings of guilt, and/or distress if unable to exercise or meet own standards and expectations around exercise
- Discomfort with rest or inactivity
- Exercise as a means of purging (needing to "get rid of" or "burn off" calories)
- Maintains excessive, rigid exercise regimen – despite weather, fatigue, illness, or injury
- Exercise used to manage emotions
- Withdrawal from friends and family
- Walking to shops multiple times per day
- Feeling not good enough, fast enough or not pushing hard enough during a period of exercise; overtraining
- Exercise that is secretive or hidden
- Jiggling leg, standing up when able to sit down

Assessment Tools

Exercise Dependence Scale (Hausenbias & Downs, 2002)	Compulsive Exercise Test (Taranis, Touyz, & Meter, 2011)	CET Exercise Profile [LEAP Manual p.25] (Taranis et al., 2011)	Assessment of physical activity form (CEED, 2021)

Collaboratively develop a specific and personally relevant harm reduction plan

Reducing physical activity can be really hard for the person and is challenging to monitor. A trusting collaborative therapeutic relationship in conjunction with harm reduction can help the person to shift in the direction of safety. For a comprehensive overview of exercise guidelines for people experiencing eating disorders, see Safe Exercise at Every Stage (SEES) Guideline and

Understand the interaction between harmful behaviours and risk for self-injury and suicide. One important function that eating disorder behaviours might play 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 exercise 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	Exercise may serve an important function in reducing body-related distress, by attempting to change shape or weight to meet cultural appearance ideals.	• **EXPLORE** the degree to which exercise supports the person to manage body related distress and/or stigma and discrimination in regard to their appearance, gender or other aspects of identity. • **Women** face particular pressures to live in a body that is slim/trim. People living in a larger body experience stigma & discrimination. **Sexual minority men** may be at greater risk of pressure for muscularity (Griffiths et al., 2018). **Aboriginal Australians** and **people living with disability** face unique body image & appearance pressures. • **GENDER AFFIRMING CARE** Trans and gender diverse people face considerable stigma and face greater risk of lack of access to appropriate health care. Consider how you might support people to affirm their gender in ways that support safety, through personal, social legal and medical spheres of affirmation. • **SUPPORT** the person to consider the degree to which certain appearance standards may be important to their identity and feelings of belonging within particular groups. Support the person to find other ways of affirming their body that are less harmful, such as seeking protective communities, spaces and health professionals.

Function	Overview	Tips for helping the person meet their needs in healthier ways
Emotion and Sensory Regulation	Exercise can become the primary way the person regulates their emotional state.	• **EXPLORE** with the person the degree to which exercise: Supports **avoidance of negative affect** such as feelings of guilt/shame after missing exercise and exercising primarily to avoid weight gain or loss of body 'tone', and/or **provides an anxiolytic benefit** through strenuous physical activity. • **SUPPORT** the person to build alternate emotion regulation and distress tolerance skills. Explore ways to move the body in ways that are less harmful/more supportive of recovery and regulating. Consider the use of **sensory approaches** to help the person to regulate the nervous system.
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 dangerous exercise for weight 'shredding'. Endurance athletes are at high risk. • **EXPLORE**: Is the athlete sticking to prescribed exercise? Is this value driven vs compulsive? Explore % of each. To what degree does the physical activity 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.
Trait Expression	Excessive exercise may be linked to the persons temperament.	• **EXPLORE** with the person the degree to which the following traits may underlie their physical activity: Obsessiveness, conscientiousness, perfectionism, high achievement, striving, relishing challenge. • **SUPPORT** the person to honour their characteristics and move toward more productive trait expression (e.g., Kaye et al., 2014; Hower et al., 2021).
Starvation & compulsivity	As starvation worsens, strong compulsions to be physically active can emerge.	• **EXPLORE:** Was there an increase in exercise as weight loss emerged? Compare pre & ED induced activity patterns. • **EDUCATE**: Starvation & the brain (CCI). Evolutionary theory suggests that as food became scarce (starvation) it was adaptive for the organism to move further beyond the usual physical space in search of food. • **SUPPORT:** Help the person to manage urges to reduce activity, use alternate sensory strategies, increase nutrition.

Physical activity and disordered eating: possible physical harms and harm reduction approaches

Signs to stop physical activity immediately:

- Chest pain or other pain that could indicate a heart attack, including pain in the neck and jaw, pain travelling down the arm or pain between the shoulder blades
- A very rapid or irregular heartbeat during exercise
- Discomfort or pain
- Extreme breathlessness (Better Health, 2024)

Symptoms that may contraindicate exercise:

- Ongoing, unstable or moderate to severe chest pain
- Near-syncope
- Dizziness
- Pallor (paleness)
- Cyanosis (bluish skin colour)
- Central nervous system dysfunction
- Intoxication from drugs or alcohol
- Ataxia
- Shortness of breath
- Light-headedness
- Confusion
- Nausea
- Cold/clammy skin
- Wheezing
- Leg cramps
- Claudication
- Fatigue
- Peripheral oedema

SEES Guidelines

Support the person to improve nutrition and weight restore alongside initial and ongoing medical assessment & monitoring of cardiac function and general observations in the presence of an eating disorder, especially with comorbid excessive exercise. Build in opportunities to support readiness for change.

Get to know the person's behaviours	Get clear & be direct about the consequence of the behaviour	Be clear, direct, and collaborate around what they can do to be safer
Behaviour	**Possible Physical Harms**	**Harm reduction Approaches**
High intensity (cardiovascular) activity	**The following risks have been associated with use:** **Musculoskeletal Injury/Impairment** **Acute**: Excessive exercise is associated with greater risk of musculoskeletal injury, poorer injury rehabilitation and poorer tissue healing (Smith, 2004). **Long term:** Depleted calcium resources which can cause irreversible bone damage (CCI – Calcium and Bone Health). Stress fractures, repetitive stress injuries, spinal fracture & kyphosis. Newer research is showing negative effects of excessive exercise on the hypothalamus, liver, and heart (da Rocha et al., 2019). ****Continuing with high intensity exercise increases stress on body and ongoing issues with hormone profiles and may lead to hypothalamic amenorrhoea**.	**Musculoskeletal Injury/Impairment** **Support the person to reduce harms**: **General principles**: • Reduce time, intensity, or repetition • Substitute strength-based training (under medical/physical guidance) • Decrease speed of exercise to reduce risk of injury • Build in other positive aspects of movement (Calogero & Pedrotty, 2007), such as: - Rejuvenating the body, not exhausting or depleting it - Enhancing mind–body connection - Alleviating mental and physical stress, not producing more. - Providing genuine enjoyment and pleasure, not pain and dread If unable to substitute or reduce yet: • Encourage the person to engage in adequate warm up and rest periods • Wear appropriate attire, footwear, and equipment **Long term** • Seek endocrinologist opinion RE reducing risk of injury. Support the person to discuss the usefulness of the oral contraceptive pill - recent guidelines suggest limited effectiveness • In context of previous fractures and disordered eating, support care team to consider a lower threshold for musculoskeletal injury treatment • Bone health may improve through adequate nutrition, + hormone function (maintaining adequate weight for individual biology + circumstance). Osteoporosis risk drops with returned menses. Some damage is irreversible. Monitor this with regular DEXA scans. • Consider supporting the person to access an exercise physiologist. **Psychoeducation**: CCI "Unhealthy Exercise"

Behaviour	Possible Physical Harms	Harm reduction Approaches
+ Rapid weight loss & Malnutrition/ Weight Suppression	**Organ Damage** If energy availability becomes extremely low (i.e., starvation) the body may move from generating energy by breaking down carbohydrates to breaking down proteins from muscles, bones and organs, including the heart. **Heart function** When a person rapidly loses weight, the size and strength of their heart substantially decreases. As a result, their heart is not able to pump blood around their body as efficiently as it should (CCI-Eating Disorders: What are the Risks?). Physical activity then places load on the heart which can result in **cardiac arrhythmia.** Excessive exercise has been implicated in the aetiology of **hypoglycaemia**. Those with a higher percentage fat-free mass and bigger muscles are more prone to this symptom. See here for information about the physical effects of hypoglycaemia. Hypoglycaemia can cause fatigue, loss of consciousness, fainting. The heart or breathing may stop, the person may become comatose, and/or suffer brain damage.	**Universal strategy** **This combination of behaviours can be extremely dangerous.** Make sure the person is aware of the risks involved in undertaking this behaviour & that there is a clear plan for medical admission if required. Support the person to improve nutrition and weight restore alongside initial and ongoing medical assessment & monitoring of cardiac function and general observations including random blood sugar testing. Build in opportunities to support readiness for change based on the person's values and motivations. **High Risk indictors** = Postural symptoms (dizzy, out of breath, low heart rate, any QTC abnormality, abnormal blood sugar levels). Consider need for higher intensity support to reduce immediate risks of physical activity in the context of rapid weight loss. Care team should discuss when exercise is safe to recommence under medical guidance (with adequate nutrition and hormone profile).
+Purging **+Inadequate hydration/ extreme heat**	**Dehydration** **Cardiac Function** - Frequent vomiting, use of laxatives or diuretics, dehydration and electrolyte loss during exercise can contribute to low potassium. Electrolyte fluctuations can cause an irregular heartbeat and **possible heart attack**.	**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) • See purging harm reduction resource for additional harm reductions to address vomiting, laxative and diuretic misuse, and disordered eating harm reduction resource to address food/fluid intake • Medical practitioner may consider prescribing potassium supplements • Consider the function of exercise under conditions of dehydration/heat and support person to address this • Body shame: Support the use of lighter fabrics if the person wishes to cover up during exercise • False beliefs about sweating out calories: Provide psychoeducation RE ineffectiveness and harms

Behaviour	Possible Physical Harms	Harm reduction Approaches
+Pregnancy	During pregnancy, the body allocates extra resources to the growing foetus. As such, exercise may impact on the health of mother and baby through dehydration, electrolyte imbalances and cardiac irregularities. See CCI resource: pregnancy and eating disorders; NEDC Resource: Pregnancy & Eating Disorders Professional Guide.	
Additional Considerations	**Risk and Professional Duty of Care** Consider the degree to which the person's behaviour could impact self and others including operating a motor vehicle, heavy equipment, caring for minors, and occupational duty of care. Consider your own professional duty of care in supporting approaches to minimise harm and duty of care should the person be unable/unwilling to behave safely in these areas.	

Additional resources

For a comprehensive overview of the health complications of unmodified exercise with an eating disorder see SEES Guidelines p.31-62), Resource: Safe Exercise at Every Stage Guidelines. This resource is designed to support clinicians in determining the level of exercise and education appropriate for individuals based upon their current level of physical and psychological wellbeing. See diagram p.29 for medical review recommendations.

Harm reduction for Disordered Eating and Body Control Behaviours

Approaches for Co-Occurring Harmful Substance Use

Psychoactive substances are often used to influence cognition or affect, whereas PIEDS are generally used to influence appearance and enhance sporting performance.

Key features and considerations

- Substance use among people experiencing eating disorders may include use of psychoactive substances or the use of performance and image enhancing drugs (PIEDS).
- Both eating disorders and substance use behaviour have been associated with short- and long-term consequences to most of the systems in the human body (See: health consequences of drug abuse; Mehler & Brown, 2015; Mehler & Rylander, 2015).
- The co-occurrence of substance use behaviours and disordered eating behaviours compounds physical risk.
- Individuals with eating disorders are up to five times more likely to abuse alcohol or illicit drugs than those without an eating disorder (The National Center on Addiction and Substance Abuse at Columbia University, 2003).
- Among individuals with eating disorders, lifetime prevalence of diet pill use may be as high as 32% (Reba-Harrelson et al. 2008), and anabolic steroid use is shown to have a close association with disordered eating behaviours in men, particularly in sexual minority men (Griffiths et al. 2017).

To learn more about drug addiction:

Johann Hari's Ted Talk "Everything you think you Know about Addiction is Wrong"

Language matters:

See this resource for respectful, person-centred language and substance use

Substances covered in this resource

Psychoactive substances

- **Depressants**: (Alcohol, Kava, Benzodiazepines, GHB)
- **Cannabinoids**: (Cannabis, Synthetic Cannabis, Hemp, Medicinal Cannabinoids, Butane Hash Oil)
- **Stimulants & Empathogens** (Nicotine, Caffeine, Amphetamine, MDMA, Cocaine, Ice, Khat, Betel Nut, PMA, Mephedrone, Synthetic Cathinones)
- **Dissociatives & Psychedelics** (Ketamine, Ayahuasca, LSD, NBOMes, Psilocybin, PCP, DXM, Nitrous Oxide)
- **Opioids** (Heroin, Codeine, Oxycodone, Buprenorphine, Methadone, Opium, Fentanyl)

Performance & Image Enhancing Drugs + Other

- **Anabolic Steroids, Peptides & Hormones**
- **Anorectics** (Diet pills, appetite suppressants, i.e., Topiramate, Lisdexamfetamine, Phentamine)
- **Antidiabetics**

See the Alcohol and Drug Foundation's Drug Wheel for an overview of the effects of different drugs

Steps towards a harm reduction approach

Review and Assess the person's substance use behaviours

Collaboratively review the person's current substance use 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 an AOD specialist.

With any co-occurring substance use and disordered eating behaviour:

- Ensure a thorough assessment of the risks associated with the behaviours
- Ensure the person experiencing the eating disorder is informed of the risks
- Eating regular meals and consuming fluid regularly in addition to regular engagement with a medical professional are some of the fundamental safeguards against harm.

Factors influencing harm associated with eating disorders & substance use:

Actual harms may be difficult to estimate due to individual needs and concerns, and inconsistent content and concentration of substances. Licit and illicit substances affect everyone differently, based on:

- Height, weight and health
- Route of administration
- Whether the person is used to taking the substance
- The amount taken
- The strength of the drug
- Whether other drugs are taken around the same time

Physical risk is likely to be increased with:

Increased frequency of substance use, increased substance dose	Ongoing engagement in substance use behaviour or disordered eating	Engagement in substance use or disordered eating behaviour whilst pregnant

Assessment Tools

NIDA Drug Use Screening Tool (ASSIST)	Tobacco, Alcohol, Prescription medication and other Substance use (TAPS)	Alcohol Screening and Brief Intervention for Youth (NIAAA)

Collaboratively develop a specific and personally relevant harm reduction plan

No level of substance use is without risk. And, reducing substance use can be really hard for the person. A trusting collaborative therapeutic relationship in conjunction with harm reduction can help the person to shift in the direction of safety.

⚠ Understand the interaction between harmful behaviours and risk for self-injury and suicide. One important function that eating disorder behaviours might play 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 substance use 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	Substance use may serve an important function in reducing body-related distress, by attempting to change shape or weight to meet cultural appearance ideals.	• **EXPLORE** the degree to which their substance use supports the person to manage body related distress and/or stigma and discrimination in regard to their appearance, gender or other aspects of identity. • **Stimulants** (caffeine, nicotine, diet pills) suppress appetite & may be used to reduce food intake to alter weight/shape. • **Steroids & hormones** may serve a function of meeting gendered body norms by masculinising/feminising the body. This may be particularly relevant for transgender individuals and sexual minority men and women. • **PIEDs** may also support the approximation of internalized cultural body ideals related to thinness, muscularity, body fat. • **GENDER AFFIRMING CARE** Trans and gender diverse people face considerable stigma and face greater risk of lack of access to appropriate health care. Consider how you might support people to affirm their gender in ways that support safety, through personal, social legal and medical spheres of affirmation. • **SUPPORT** the person to consider the degree to which certain appearance standards may be important to their identity and feelings of belonging within particular groups. Support the person to find other ways of affirming their body that are less harmful, such as seeking protective communities, spaces and health professionals.
Emotion and Sensory Regulation	Psychoactive substances may be used to manage mood and as an attempt to regulate emotional state.	• **EXPLORE** the degree to which the person's substance use supports them to manage difficult emotional states through reducing anxiety, increasing euphoria, avoiding distress and challenges or to reduce body-related distress. • **Depressants, cannabinoids & opioids** can function to reduce anxiety or intrusive thoughts | **Stimulants & empathogens** can temporarily increase positive mood states & perceived social connectedness (Boys, Marsden & Strang, 2001) | **Heroin** use is linked to escape and avoidance (passing out/forgetting, going 'on the nod'/sleeping) | **PIEDs** may alter mood by reducing distress related to weight gain or body appearance. • **SUPPORT** the person to build alternate emotion regulation and distress tolerance skills. Consider the use of **sensory approaches** to help the person to regulate their nervous system.

Function	Overview	Tips for helping the person meet their needs in healthier ways
Athletic Performance & Aesthetics		• **EXPLORE** the degree to which the person's substance use is related to sports or physical performance or appearance. • **Anabolic steroids** are used to build muscle and improve athletic performance (See Drugs in Sports). • "Pre-workout" **supplements or stimulants** may be used to improve performance in physical activity. • **Appetite suppressants**, other stimulants and antidiabetics may be used to adhere to sport & art-based weight requirements/body ideals, such as combat sports with weight divisions, jockeys & dancers. • **SUPPORT** the person to consider ways in which they may maintain positive aspects of their chosen field whilst reducing harms associated with disordered eating and substance use.
Social Lubrication, Belonging & Connection	Psychoactive substances may be used by individuals to manage social anxiety & to fit in.	• **EXPLORE**: To what degree does the use of substances assist the person in feeling connected to a peer group, and reducing isolation from others? Common substances used in this regard include depressants, cannabinoids and opioids. • Pressure to use **PIEDs** may be experienced within some settings such as in gyms/body building groups. • **SUPPORT**: Support the person develop meaningful connections, a sense of purpose and relationships to tend to needs of belonging. Support the person through unconditional positive regard. See Johann Hari Ted Talk - drug addiction and social bonds.

PIED substance use and disordered eating: Possible physical harms & harm reduction approaches

Signs to stop use immediately:

- High blood pressure
- Blood clots
- Stroke
- Heart attack
- Liver problems
- Heart problems

Support the person to improve nutrition and weight restore alongside initial and ongoing medical assessment & monitoring of cardiac function and general obs in the presence of an eating disorder, especially with comorbid substance use. Build in opportunities to support readiness for change.

Get to know the person's behaviours	Get clear & be direct about the consequence of the behaviour	Be clear, direct, and collaborate around what they can do to be safer
Substance	**Possible Physical Harms**	**Harm Reduction Approaches**
Anabolic Steroids, Peptides and Hormones (non-prescribed/ misused) **Street names**: Gear, arnolds, gym candy, pumpers, roids, stackers, weight trainers, and juice May be taken orally or injected	**The following risks have been associated with use**: • High blood pressure, artery damage, blood clots, stroke & heart attack • Liver tumours, peliosis hepatis • Increased aggression and irritability • Depression, psychosis, and suicidal ideation and behaviour • Sleeping difficulties, loss or increase of sexual drive **Biological Male-specific risks** • Atrophy (wasting away of tissues or organs) of the testicles • Loss of sexual drive • Diminished or decreased sperm production, sterility • Breast and prostate enlargement, prostate problems • Decreased hormone levels **Biological Female-specific risks** • Menstrual irregularities, infertility • Masculinising effects such as facial hair, diminished breast size, permanently deepened voice, and enlargement of the clitoris and baldness are not reversible • Steroids can affect foetal development during pregnancy Note: In the absence of supportive health professionals and access to appropriate treatment, trans individuals are at risk of non-prescribed gender-affirming hormone use and body-transformation practices (Rotondi et al., 2013). **Heart Function** Cardiovascular complications in eating disorders are common, such as bradycardia due to malnutrition, or arrhythmia due to electrolyte abnormality. Use of anabolic steroids, peptides, and hormones in combination with other disordered eating behaviours place people at increased risk of heart complications such as arrhythmia and heart attack.	**General principles**: Regular engagement with a medical professional who understands the **current level of use and disordered eating behaviour** to identify and manage potential physical risk early. Medical professional to consider monthly ECGs in combination with regular heart rate monitoring. Neither oral steroid use nor injected steroid use are considered safe. However, as research has linked oral use with increased risk to the liver, injectable Anabolic Steroids, Peptides and Hormones may be more safe, so long as an individual is informed about safe injecting practices: Touchbase Toolkit: Injecting – Touchbase For **transgender individuals** using non-prescribed hormonal substances– encourage prescribed gender-affirming hormones monitored in a primary care/medical setting. Support the person to access accurate information, weigh benefits and harms and consider reducing their use. **NOTE: Suicide risk escalates in the context of stopping steroid use** For more information on reducing harms from PIED use: • Alcohol and Drug Foundation • Looking Beyond the Provision of Injecting Equipment to People Who Use Anabolic Androgenic Steroids: Harm Reduction and Behavior Change Goals for UK Policy (Bates, G., 2021) For medical guidance on assessing and reducing risk of PIEDs see: • Harm Reduction in Male Patients Actively Using Anabolic Androgenic Steroids (AAS) and Performance-Enhancing Drugs (PEDs): a Review (Bonnecaze, A., 2021) See also Eating Disorders in male athletes. Support the person to understand common withdrawal symptoms.

Substance	Possible Physical Harms	Harm Reduction Approaches
	If substances are injected, there is an increased risk of: • Tetanus • Infection, vein, skin, or bone damage • Blood-borne viruses including HIV and hepatitis	
Anorectics (Diet Pills, appetite suppressants) i.e. **Topiramate** (Topamax), **Dexamfetamine** (Vyvanse, Ritalin), **Phentermine** (Duromine, Ionamin) *Some indicated for use with EDs however need to be used with caution **The risks and functions and harm reduction approaches for these substances overlap with Stimulants and empathogens, please refer to this section for additional information	Phentermine and Lisdexamfetamine are appetite suppressants and they work to reduce the perception of hunger in the brain. These substances (Phentermine in particular) can have gastrointestinal side-effects like vomiting or diarrhoea. **The following risks have been associated with use:** • Nausea, vomiting & diarrhoea • Sleeplessness, insomnia • Kidney problems & liver damage • Changes to heart rate & increased blood pressure **Dehydration** Individuals who are purging or restricting fluid intake alongside use of anorectics are at increased risk of complications due to dehydration including low potassium. Electrolyte fluctuations can cause an irregular heartbeat and **possible heart attack**. **Heart problems** Amphetamine based anorectics place a higher load on the sympathetic nervous system. This increases risk of arrhythmias and tachycardia's due to increased heart rate, which can be particularly dangerous where the heart is small/malnourished (due to cardiac myopathy). **Psychiatric** Increased anxiety, suicidal ideation, psychosis/psychotic symptoms Dexamfetamine (Vyvanse, Ritalin) and phentermine (Duromine, Ionamin) can cause constipation for some, diarrhoea for others. There is some evidence that these substances may delay gastric emptying, some evidence suggests they increase absorption. Assessment of gastric functioning in the context of use is recommended.	**General principles:** Regular engagement with a medical professional who understands the **current level of use and disordered eating behaviour** to identify and manage potential physical risk early. Where anorectics have been prescribed – consider whether prescription indicated and correct. Consider contraindications. Provide education about risks and harms of anorectics. Consider function of anorectic use and alternative coping strategies. Utilise motivational approaches to support readiness to reduce use. **Note: Sudden cessation has been linked with depression. Ensure appropriate medical supervision (relevant to dose) and psychiatric support.** Consider anticipatory distress due to return of hunger cues/sensations, fear of binge eating/triggers for binge eating. If the person is prescribed short-acting dexamphetamine (i.e., Ritalin) and is struggling to take this as required, support them to speak with their medical practitioner about switching to a long-acting option (i.e., Vyvanse) to better support their needs/lifestyle. For an overview of diet pills/diet related substances in Australia, See Choice 2020 and NIH 2020 .

Substance	Possible Physical Harms	Harm Reduction Approaches
Antidiabetics	**Using metformin for weight loss** Liaise with prescriber. Consider contraindications of weight loss substances in the context of treatment for an eating disorder. **Insulin Omission** Some individuals with Type 1 diabetes intentionally omit or reduce their prescribed insulin, inducing a hyperglycaemic state resulting in polyuria and caloric reduction for the purpose of preventing weight gain. **Acute Risks** • Diabetic ketoacidosis • Slow wound healing, infections, muscle atrophy • Menstrual disruption • Dehydration & electrolyte imbalance **especially when combined with vomiting **Diabetic ketoacidosis (DKA)** The body cells (muscle and lipid cells) may be starved for glucose due to absence or improper function of insulin and/or in the presence of inadequate nutrition. If not managed, this condition can progress to **coma** and even **death**. **Hyperosmolar Hyperglycaemic Nonketotic Syndrome (HHNS)** High blood glucose level triggers increased urination. If liquids are not replaced, the individual can become severely dehydrated. High blood glucose levels can lead to altered mental states, confusion, seizures, coma, and even death (PDB101). **Hypoglycaemia** – Low blood sugar – risk of reduced consciousness/coma: Some individuals may desire feeling uninhibited as a result of Hypoglycaemia. **Hyperglycaemia** – High blood sugar – risk of DKA: Some may misuse insulin to avoid hypoglycaemia which can be accompanied by intense hunger which may trigger binge eating. **Longer term risks** • **Prolonged hyperglycaemia** • Early onset microvascular complications of diabetes i.e., retinopathy, nephropathy, and neuropathy (U.S Pharmacist) • Gastroparesis, chronic diarrhoea • Coma, stroke, and death	**Diabetes Management** Support good care team communication and collaboration (including endocrinology, psychiatry & diabetes specialists). While dietary restraint and physical activity are components of the comprehensive treatment of Type 1 Diabetes Mellitus, clinicians must recognize that these behaviours also occur in eating disorders. Problem-solve diabetes management challenges: • Calorie counting and dietary restriction as part of diabetes management, person learns energy requirements of food • Use of supports to manage this, family & care providers • Consider the role of insulin use and diabetes-related behaviours as possible triggers or maintaining factors for the eating disorder See Eating Disorders in Adolescents with Type 1 Diabetes See NEDA Resource: Diabulimia **Masked eating disorder severity** Intensive insulin therapy may result in higher BMI and 'expected' body weight. As with all eating disorder assessments it is important to determine severity based on behavioural and psychological indicators, not based on body weight, size or shape.

Substance	Possible Physical Harms	Harm Reduction Approaches
Additional Considerations	**Risk and professional duty of care** Substance use behaviours are associated with increased risk of workplace injury, domestic violence, motor vehicle accidents and violent offences (See: Impacts of illicit drug use). Therefore, it is recommended that the potential risk harm to self and others is assessed and considered carefully.	

Additional resources that focus on harm reduction for PIEDs use:

There is a substantial body of literature on harm reduction approaches for individuals who use PIEDs. For a more detailed overview, please see: Bates, McVeigh & Leavey (2021); Bates , Shepherd & McVeigh (2021) ; Bonnecaze, O'Connor & Burns (2021)

PSYCHOACTIVE substance use and disordered eating: Possible physical harms & harm reduction

Signs to seek emergency medical attention:

Loss of Consciousness, seizures, suspected overdose, overheating. If you are unsure if someone's breathing or heart rate is abnormally fast or slow, it is recommended to be cautious and seek medical advice.

The use of more than one substance in conjunction with one another can be unpredictable and risky, it is recommended to avoid this where possible, and provide information on specific drug interactions where possible. Attend regular medical review of the physical aspects of substance use and eating behaviour, and ensure the care team is informed of the nature of both of these behaviours.

Get to know the person's behaviours	Get clear & be direct about the consequence of the behaviour	Be clear, direct, and collaborate around what they can do to be safer
Substance	**Possible Physical Harms**	**Harm Reduction Approaches**
Depressants (Alcohol, Kava, Benzodiazepines, BHB)	**Depressants have been linked to the following effects**: • increased risk of accident or injury • impaired judgement and coordination • vomiting, slowed, irregular or shallow breathing • blackouts and memory loss • unconsciousness & death • dependency (especially alcohol & benzodiazepines) **Heart function** Cardiomyopathy is linked to both eating disorders and alcohol use. Individuals with comorbid disordered eating and alcohol use may be at increased risk of arrhythmia and/or heart failure. Malnourished individuals are at risk of more severe consequences of alcohol consumption.	**General principles**: If unable to reduce or cease, encourage the person to use depressants around other trusted individuals, inform others of depressant use and the signs to seek emergency medical attention. Encourage the person to consume food prior to engaging in use of depressants. Alcohol is a diuretic which can increase risk of renal impairment. Support regular hydration. Extent of malnourishment may be masked (higher weight than expected for food intake due to calories in alcohol). Introduce regular eating alongside alcohol use. Frequent alcohol use has multiple effects on Thiamine (i.e., uses up in breakdown of alcohol. Malnutrition, **impacts absorption of thiamine**). The care team may consider prophylactic thiamine alongside medical oversight.

Substance	Possible Physical Harms	Harm Reduction Approaches
	Refeeding syndrome Alcohol use and detoxification has been associated with increased risk of refeeding syndrome among individuals presenting with malnutrition (Rutten et al., 2017). **Wernicke encephalopathy** Alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, and/or the effects of chemotherapy increase the risk of this degenerative brain disorder caused by the lack of thiamine (vitamin B1).	Support the person not to count alcohol calories when attempting to improve eating and nutrition. Introduce regular eating alongside alcohol use. **Note: Abrupt cessation of depressant intake after prolonged heavy use may trigger withdrawal seizures** (See: Rogawski, 2005(alcohol), Hu, 2011 (benzodiazepines)) Resource: Alcoholism warning signs **Psychoeducation** Harm Reduction Victoria Resources
Cannabinoids (Cannabis, Synthetic Cannabis, Hemp, Medicinal cannabinoids, Butane Hash Oil	**Risks in using cannabinoids** **Seizure** May be increased if at risk of electrolyte disturbance **Cardiac risks** Cannabinoids can cause heart palpitations, tachycardia (leading to arrhythmias) and hypotension (or sometimes hypertension). **Cannabinoid Hyperemesis Syndrome** • Marked by recurrent bouts of severe nausea, vomiting, and dehydration. • Risk of electrolyte disturbance in people with eating disorders, especially where there is vomiting, excessive exercise and/or inappropriate fluid intake. This may place people at risk of cardiac arrhythmia and death. **Synthetic cannabinoids** Harmful side effects of using synthetic cannabinoids can include: • Fast and irregular heartbeat • Racing thoughts, agitation, anxiety and paranoia • Aggressive and violent behaviour • Chest pain, stroke • Vomiting • Acute kidney injury • Seizures, psychosis • Death	**General principles:** Encourage the person to maintain hydration. Activities like driving, swimming and operating machinery while under the influence should be avoided. Using Cannabinoids around other trusted individuals, informing others of use and of the signs to seek emergency medical attention is recommended. Provide information about cannabis and cannabis withdrawal (see NSW health info). It can be dangerous to mix cannabis with other drugs such as alcohol or prescription drugs. This is because the effects of cannabis and the other drug can become stronger and produce more unpredictable effects than if they were used separately. **Synthetic cannabinoids** are chemical compounds that attempt to mimic the effects of the psychoactive ingredient in cannabis. Most synthetic cannabinoids have had no human research conducted on them and some can cause more severe health risks than others. It is recommended that alcohol and other drug workers strongly discourage their clients from taking synthetic cannabinoids for extended periods of time or in high doses (ADF, 2025).

Substance	Possible Physical Harms	Harm Reduction Approaches
	Interactions with mental health and ED behaviours Use of cannabinoids may exacerbate depressive or anxiety symptoms which are often comorbid with eating disorders. People may be at risk of disordered eating symptom exacerbation. Cannabinoids have been associated with increased Psychotic symptoms and Schizophrenia. The use of some Cannabinoids increases appetite. This may be triggering for those who engage in binge eating and/or find hunger cues particularly triggering. This may lead to worsened compensatory behaviour. Consider increased risk of refeeding if underweight for genetics/recent rapid weight loss and major change to caloric intake in context of cannabis use.	Harm reduction approaches include: • Call triple zero (000) immediately if someone is experiencing negative effects and looks like they are in trouble • Use only a small amount. Taking a low dose first can help determine the effects and the strength of the drug • Take breaks and eat food and drink water often. • Taking deep, regular breaths while sitting down can help with anxiety. • Keep the supply packet and provide it to medical professionals if a person experiences adverse effects. This information may make treatment quicker and more effective. If the person has used the drug with somebody else, they could also advise exactly what has been taken or write it down. Provide information to the person so they understand the risks associated with synthetic cannabinoids and what they can do to be safe (see ADF information)
Stimulants & Empathogens (Nicotine, Caffeine, Amphetamine, MDMA, Cocaine, Ice Khat, Betel Nut, PMA, Mephedrone, Synthetic Cathinones) **The risks, functions and harm reduction approaches for these substances overlap with PIEDs, please refer to this section for additional information	**The following effects may be experienced**: • Increased heart rate and blood pressure • Reduced appetite, nausea • Increased body temperature • Seizures, overdose • Coma & death Use of Stimulants & Empathogens including tobacco is likely to be more dangerous when the person has an existing heart problem, which puts those individuals with an eating disorder at increased risk due to the risk of cardiovascular concerns among those with eating disorders. **Using Stimulants & Empathogens may exacerbate an existing mental health condition.** **Serotonin syndrome**. This is a serious condition with symptoms such as confusion, agitation, sweating, increased heart rate and muscle spasms, and can be fatal. Using empathogens (i.e., MDMA) with other drugs such as antidepressants can be dangerous, increasing the risk of serotonin syndrome.	**General principles**: Set up treatment non-negotiables regarding medical care and physical health checks, including regular ECGs Encourage the person to maintain hydration and to consume regular small meals, in line with current food/eating goals, even if the person does not feel like it. Consuming something salty whilst using stimulants & empathogens can assist in maintaining electrolyte balance. Many of the problematic side effects associated with Stimulants & Empathogens are a result of insomnia, so encourage the person to sleep where possible. Using Stimulants & Empathogens around other trusted individuals and informing others of use and the signs to seek emergency medical attention is recommended. If using Phentermine (Duramine) or Lisdexamfetamine: Check prescribing doctor knows the person has an eating disorder and that they are prescribing within guidelines

Substance	Possible Physical Harms	Harm Reduction Approaches
	Gastrointestinal problems Cocaine use can cause abdominal pain and bowel tissue decay, which may be problematic to individuals with eating disorders due to an increased risk of constipation + other GI problems	Harm Reduction Victoria provides Substance Specific Brochures that outline the risk of harm and harm reduction strategies associated with specific substances.
Dissociatives & Psychedelics (Ketamine, Ayahuasca, LSD, NBOMes, Psilocybin, PCP, DXM, Nitrous Oxide)	**The following effects may be experienced**: • Unconsciousness, dizziness • Blurred vision, clumsiness • Fast or irregular heartbeat • Breathing quickly, or slow ineffective breathing • Vomiting, sweating and chills • Numbness **Nerve damage and some types of anaemia** Those with eating disorders and regular long-term inhalation of nitrous oxide are at increased risk of nerve damage and anaemia due to deficiency of vitamin B12 **Cardiovascular complications** Individuals with eating disorders may be at increased risk of cardiovascular complications when using substances that are associated with a fast or irregular heartbeat, such as Dissociatives & Psychedelics	**General principles**: Encourage the person to maintain hydration and to avoid driving as this is illegal and dangerous. Encourage eating a decent meal well prior to use of Dissociatives & Psychedelics to avoid nausea, and to consider spreading out food intake and maintain hydration throughout the period of use. Using Dissociatives & Psychedelics around other trusted individuals and informing others of use and the signs of seeking emergency medical attention is recommended. Regular ECGs and physical health checks by GP. Prophylactic B12 may be indicated in the case of nitrous oxide use. Harm Reduction Victoria provides Substance Specific Brochures that outline the risk of harm and harm reduction strategies associated with specific substances.
Opioids (Heroin, Codeine, Oxycodone, Buprenorphine, Methadone, Opium, Fentanyl)	**The following effects may be experienced**: • Extreme relaxation, drowsiness, and clumsiness • Confusion, slurred speech, • Slow breathing and heartbeat. **If a large dose is consumed** someone may develop: • Cold, clammy skin, slow breathing • Blue lips and fingertips, falling asleep ('going on the nod') • Death by respiratory depression. **Long-term effects include**: • Increased tolerance, dependence • Constipation • Damage to vital organs such as the lungs, brain and heart	**General principles**: Encourage the person to maintain hydration and to avoid driving as this is illegal and dangerous. Using Opioids around other trusted individuals and informing others of use and the signs to seek emergency medical attention is recommended. It is important that safe injecting guidelines are followed if Opioids are injected (See National Harm Reduction Coalition Safe Injecting Guidelines). Naloxone: For people at risk of overdose (i.e., those prescribed high dose opioids or misusing opioids), consider whether their medical practitioner can offer take-home naloxone. Naloxone acts to reverse overdoses and may be administered via nasal spray, ampoules or injection (See Department of Health information: How to administer Naloxone).

Substance	Possible Physical Harms	Harm Reduction Approaches
	Cardiovascular complications Slowed heartbeat is a common experience of using opioids. This may mask underlying/co-occurring heart conditions related to malnutrition and electrolyte disturbance. **Digestive complications** May be compounded with co-occurring eating disorder and long-term effects of opioid use. Slow gut transit may worsen constipation, generate challenging physical sensations associated with eating, and or contribute to artificially high scale weight.	Consider supporting the person to discuss **opioid replacement therapy** with their prescriber. Opioid pharmacotherapy treatments (such as methadone or buprenorphine) can: • reduce drug cravings and withdrawal symptoms • improve the physical and mental health of opioid dependent people • decrease substance-related criminal activity • increase patients' ability to gain and maintain employment If malnourished the person may experience low blood sugar levels due to **unintentional fasting**. Monitor regularly with GP (unintentional fasting). The person might miss meals due to sleeping for long periods of time. Consider a meal plan that builds this in, seek to increase food intake before/after using. If at lower weight, the person is at greater risk of overdose. Support the person to understand the risks and consider pros & cons of use and low weight. Harm Reduction Victoria provides Substance Specific Brochures that outline the risk of harm and harm reduction strategies associated with specific substances.
Additional Considerations	**Risk and professional duty of care** Substance use behaviours are associated with increased risk of workplace injury, domestic violence, motor vehicle accidents and violent offences (Health Consequences of Drug Misuse; NIH, 2017). Therefore, it is recommended that the potential risk of harm to self and others is assessed and considered carefully.	

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