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TARGET ARTICLE



The Ethical Defensibility of Harm Reduction and Eating Disorders

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ABSTRACT

Eating disorders are mental illnesses that can have a significant and persistent physical impact, especially for those who are not treated early in their disease trajectory. Although many persons with eating disorders may make a full recovery, some may not; this is especially the case when it comes to persons with severe and enduring anorexia nervosa (SEAN), namely, those who have had anorexia for between 6 and 12 years or more. Given that persons with SEAN are less likely to make a full recovery, a different treatment philosophy might be ethically warranted. One potential yet scarcely considered way to treat persons with SEAN is that of a harm reduction approach. A harm reduction philosophy is deemed widely defensible in certain contexts (e.g. in the substance use and addictions domain), and in this paper we argue that it may be similarly ethically defensible for treating persons with SEAN in some circumstances.

KEYWORDS



Disability; chronic conditions; and rehabilitation; health care delivery; mental health; mental illness; psychiatry/psychology; risk / benefit analysis

INTRODUCTION

Eating disorders are mental illnesses that can have a significant and persistent physical impact, especially for persons¹ who are not treated early in their disease trajectory (National Initiative for Eating Disorders 2016–2018a). From a bioethics perspective, many complex questions stem from the eating disorder domain, yet there is minimal consensus about how to respond. *How long should a person be involuntarily held in an eating disorder program if they cannot appreciate that they are at risk of dying from their illness? Is a person with an eating disorder capable of making their own healthcare and/or treatment decisions if they are at a less severe stage of their illness versus a stage when executive functioning is impaired due to illness? When is it ethically defensible to consider commencing enteral or parenteral nutrition or hydration? How many times should an eating disorder program consider admitting persons voluntarily?* Many of these questions are at the heart of considering the ethics of treating persons with eating disorders under

clinically complex and sometimes involuntary circumstances. Often, these questions are further complicated when there may be a relatively low chance of achieving an entirely symptom-free recovery, where a symptom-free recovery is often the goal of intensive eating disorder treatment programs.

Although many persons with eating disorders may make a full recovery such that they are entirely asymptomatic, some may not; this is especially the case when it comes to persons with severe and enduring anorexia nervosa (SEAN), namely, those who have had anorexia for 6 years or more. Given that persons with SEAN may be less likely to make a full recovery in comparison to others with eating disorder diagnoses, a different treatment philosophy might be ethically warranted.² One potential yet scarcely considered way to treat persons with SEAN is that of a harm reduction approach. A harm reduction approach is defensible in certain contexts³ (e.g. in the substance use and addictions domain), and considering this method for persons with SEAN might be similarly appropriate.

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¹Throughout this paper we will be using the term “person(s)” to describe persons with eating disorders. Thanks to our colleague, Ruby Shanker, for highlighting that the term “people” can denote homogeneity and a group agency, whereas the term ‘persons’ retains agency for individuals.

²However, some persons with SEAN may significantly improve with certain treatment approaches, as was demonstrated in a study on cognitive behavioural therapy for persons with SEAN (Calugi, El Ghoch, and Dalle Grave 2017).

³Although a harm reduction approach is deemed defensible in some circumstances and by some organizations/individuals, it is not an approach that is endorsed by all. For instance, Alcoholics Anonymous endorses an abstinence-only approach to alcoholism. Thanks to an anonymous referee for offering this example.

In the first section of this paper, we introduce eating disorders and justify our specific focus on persons with SEAN. We subsequently consider what a harm reduction approach for those with SEAN might look like. After exploring a harm reduction approach for persons with SEAN, we introduce some of the ethical strengths and potential vulnerabilities of this method. We conclude that a harm reduction methodology to treating persons with SEAN may be ethically defensible in certain contexts; we advocate for further research regarding the practical applicability of this approach to be done.

EATING DISORDERS

As previously mentioned, eating disorders are mental illnesses, and the symptoms associated with eating disorders have a physiological impact. Due to societal misperceptions and stigmatization, the idea that a person should “just eat” in order to recover from their illness is a common, oversimplified, and unhelpful response. All persons diagnosed with eating disorders are pre-occupied with food intake, body weight, and body image (American Psychiatric Association), however, there are different types of disorders that contribute to these experiences. Three of the most commonly cited eating disorders are: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED). Although not every person with the same eating disorder will necessarily have a similar experience, there are certain characteristics that contribute to each.

Persons with AN do not have a normal body weight in accordance with their age and height. The threshold for AN is typically a body mass index (BMI) of 18.5 kg/m² or less (National Initiative for Eating Disorders 2016–2018b), where a healthy BMI is considered to be between 18.5 and 24.9 kg/m² (World Health Organization). Persons with AN may engage in restrictive behaviors by limiting their caloric intake and/or by bingeing/purging the food that they consume. Persons with AN will typically have an extreme and constant fear of gaining weight or becoming “fat” even though they are severely underweight and restricting their energy intake (National Eating Disorders Association 2018a). Approximately 0.9% of females and 0.3% of males suffer from AN (Hudson et al. 2007). Persons diagnosed with anorexia nervosa (AN) have the highest death rate of any mental health disorder; the mortality rate for AN is 5.6% per decade of illness (i.e. the risk of death increases the longer one has been ill) (Sullivan 1995). The standardized

mortality ratio is 5.86 (Arcelus et al. 2011). AN also has the highest suicide rate of any psychiatric illness, and according to the Academy of Eating Disorders, “[t]he risk of death [for people with AN] is three times higher than in depression, schizophrenia or alcoholism and 12 times higher than in the general population.”

In comparison to those with AN, individuals with BN engage in binge eating behaviors (i.e. eating more than 1,000 calories in one sitting) coupled with a feeling of being out of control/being unable to stop eating (which distinguishes it from mere overeating) (National Eating Disorders Association 2018b). They will typically follow episodes of binge eating with actions that are meant to “undo” the consequences (e.g. using laxatives, inducing vomiting, excessive exercise, fasting). A person with BN may have fluctuations in their weight, even though their weight is within the healthy range or higher. BN affects 1.5% of women and 0.5% of men (National Eating Disorders Association 2018b; Hudson et al. 2007).

Finally, persons with BED engage in binge eating behaviors and eat large quantities of food to the point of discomfort within a short period of time (National Eating Disorders Association 2018c). Persons with BED will typically eat alone and they will often feel immense guilt after a binge (National Eating Disorders Association 2018c). The primary difference between persons with BN and BED is that those with BED do not usually engage in unhealthy weight control measures immediately following a binge episode (e.g. laxatives, vomiting, excessive exercise, fasting). Although BED was captured in the fourth edition of the Diagnostic and Statistical Manual for Mental Illness (DSM-IV) under the heading “Eating Disorder-Not Otherwise Specified,” it is now recognized as an illness separate from other eating disorders and is the most recent eating disorder to be added to the DSM (National Initiative for Eating Disorders 2016–2018c). Furthermore, it is the most common eating disorder in the United States of America, affecting 3.5% of women and 2% of men (Hudson et al. 2007).

The cause of eating disorders is multifactorial. It is thought that a combination of predisposing factors (e.g. childhood experiences of adversity, family history, cultural factors), precipitating factors (e.g. separations and losses, disruptions of family homeostasis, new environmental demands, direct threats of loss of self-esteem, personal illness), and perpetuating factors (e.g. cognitive effects of starvation and the illness) can influence the development, type, and duration of an eating disorder (National Center for Eating

Disorders). Eating disorders do not discriminate based on a person's gender, sex, race, ethnicity, culture, religion, etc., however some individuals are at an increased risk of developing this illness, such as athletes who participate in sports that are weight and/or appearance focused (e.g. figure skating, gymnastics, bodybuilding) and people from Western societies that tend to glamorize perceptions of emaciated women (National Initiative for Eating Disorders 2016–2018d). Furthermore, while most of the eating disorder literature and relevant stereotypes focus on persons who identify as female, recent studies suggest that approximately 25% of eating disorder cases occur in persons who identify as male (Sheena's Place).

THE RELEVANCE OF SEVERE AND ENDURING ANOREXIA NERVOSA

Several ethically complex questions regarding the treatment of individuals with eating disorders exist in the literature and in practice, the most common of which tend to focus on influencing a person to participate in (what may be referred to as) clinically necessary treatment/therapy (Draper 2000; Geppert 2015; Lavis 2018). For instance, the question of whether and how often a person with anorexia ought to be re-fed in response to a decline in their weight is a relatively common conundrum. Although questions that consider the ethical permissibility of feeding and treatment options may apply to those with different eating disorder diagnoses, persons who have severe and enduring AN (SEAN), a sub-group of the AN population, are specifically pertinent.

Persons with SEAN have had their illness for between 6 and 12 years or more (Westmoreland and Mehler 2016; Touyz et al. 2013). During the course of their illness they are typically under- or unemployed and have multiple comorbidities related to their disorder, such as liver failure, cardiac failure, osteoporosis, etc. (Hay, Touyz, and Sud 2012); the extent of the physical comorbidities means that persons with SEAN often require medical interventions/medical management in addition to treating their eating disorder. In their review of treatment approaches for SEAN, Hay, Touyz, and Sud (2012) say that “[p]atients with severe and enduring anorexia nervosa have one of the most challenging disorders in mental health care.” Although people can recover from eating disorders, recovery is more likely if treatment commences early during one's illness trajectory since a person's symptoms are likely to worsen over time (National Initiative for Eating Disorders 2016–2018e).

Consequently, persons with SEAN will typically encounter greater challenges when it comes to being entirely asymptomatic upon receiving treatment (Yager 2020). In considering the relationship between quality of life and eating disorders for persons with chronic AN, Bamford et al. (2015) note that “[i]ndividuals with a longer duration of illness are less likely to recover, and suffer significant physical, social, and psychological sequelae as a result of their illness.” Similarly, R.A. Gordon (2000) says that, “one of the most intriguing puzzles of anorexia nervosa is the typical symptom of distorted body image, the perception that one is fat, an illusion that paradoxically tends to increase with worsening emaciation.” So, individuals who have had AN for a long period of time and have worsening emaciation are less likely to achieve and/or maintain a full weight restoration and symptom-free recovery. These and related articles describe the high likelihood that persons with AN will become sicker if they are not treated early, and that a symptom-free recovery will become progressively more challenging (Bamford et al. 2015; Geller, Williams, and Srikameswaran 2001; Noordenbos et al. 2002; Strober, Freeman, and Morrell 1997; Von Holle et al. 2008).

As a result of persistent symptoms, persons with SEAN who are engaged in treatment are often re-admitted to intensive eating disorder treatment programs at least once, and clinicians may experience challenges when it comes to providing treatment with the goal of an asymptomatic recovery as the number of admissions increase (Steinhausen, Seidel, and Winkler Metzke 2000; Strober 2004; Strober, Freeman, and Morrell 1997; Yager 2020). Involuntary hospital admissions and treatment (e.g. force-feeding) may be initially reasonable in particular circumstances for individuals with SEAN who are incapable of making their own treatment decisions, especially if this plan may result in a symptom-free recovery (and many persons with AN have subsequently said that they were appreciative for receiving care against their wishes) (Westmoreland and Mehler 2016; Guarda et al. 2007). However, a 2016 study suggests that “in the long term the outcome of patients treated on an involuntary basis may be worse than those treated on a voluntary basis” (Westmoreland and Mehler 2016). Furthermore, involuntary tube-feeding processes “may also contribute to a poor long-term prognosis” (Westmoreland and Mehler 2016), where the potential harms of a poor long-term prognosis that could result from tube-feeding may outweigh the desired benefits of enabling one to become symptom-free. Determining whether, when, and to what extent

someone with SEAN ought to receive treatment under involuntary circumstances is still up for debate (Draper 2000).

Another common challenge is when *clinically capable* persons with SEAN are open to receiving treatment so that they can live and maintain a certain quality of life, but perhaps not the *kind* of life that most clinicians would typically recommend and/or consider to be in the person's best interest. To be more specific, and while this may sound counterintuitive, many persons with SEAN may not want to and/or be able to stop engaging in all of their eating disorder symptoms, even though they may still want to live. For instance, a person with SEAN may want to receive enough treatment such that they can remain alert and participate in certain hobbies, but they may still want to and/or be unable to stop engaging in behaviors that are deemed clinically unsafe for them (e.g. bingeing/purging, severe food restriction, maintaining a BMI that is below the recommended healthy weight range, etc.). The idea that a person with SEAN may strive to achieve a better quality of life while continuing to engage in symptoms poses a challenge if eating disorder programs *only* treat individuals who are striving to achieve complete recovery and maintain an asymptomatic life, even after many unsuccessful attempts of trying to fully recover.

In cases involving a capable person with SEAN who does not want to and/or is unable to abide by certain eating disorder program requirements (which is more likely to be the case if a treatment program “has a clear emphasis of increased food intake and weight gain” [Elzakkers et al. 2014] and/or if it is unlikely that a person with SEAN can achieve certain treatment goals (e.g. to be completely symptom-free), then how should clinicians proceed? One option may be to try to convince the person to change their mind—to ask them to *try* to participate in treatment (again) with the goal of recovery, provide them with information about what their life could be like without any symptoms, etc.⁴ Another option may be to not treat them if they do not want to and/or are unable to strive for complete recovery in accordance with program requirements, which could result in death if they become increasingly ill. A third option, which would only be possible in certain circumstances (i.e. when a person is incapable of consenting to consent to a proposed treatment plan), may be to treat

the person on an involuntary basis. A final option may be to provide the person with pain and symptom management (sometimes referred to as palliative care), rather than actively treating them with a goal of recovery; this option is relatively rare for people with eating disorders and often framed as controversial (Lopez, Yager, and Feinstein 2010; Starzomska 2010).

As in all complex cases with multiple options to consider, the most ethically defensible decision will vary depending on relevant contextual factors. If it turns out, however, that a person with SEAN: (1) does not want to and/or is unable to achieve a recovery that is entirely symptom-free, (2) is capable of making their own treatment decisions, *and* (3) wants to live and improve their current condition to achieve a certain quality of life (from which end-of-life care may be inappropriate and unjustifiable) then perhaps an additional option could be considered. One option that is seldom explicitly explored from an ethics perspective in the eating disorder domain is that of harm reduction.

HARM REDUCTION

Harm reduction is a term that is typically used in discussions regarding persons with substance use disorders (SUDs). It is defined as “a philosophy and an approach to policy, programs, and practices that aims to reduce the health, social, and economic harms associated with the use of psychoactive substances in people unwilling or unable to stop” (Buchman and Lynch 2018). Harm reduction has gained recent widespread attention across North America as a result of the opioid epidemic (Global Commission on Drug Policy 2017). Instead of reprimanding persons who use drugs and demanding them to abstain from using illicit substances, some cities have instead started to open supervised injection sites, provide education around safe drug use, etc. (Warnica and Hauen 2017).⁵ The purpose of a harm reduction approach is not to completely “extinguish the problematic health behaviors completely or permanently” (Hawk et al. 2017), but

⁴It is important to highlight that a fine and important line exists between trying to encourage or convince someone to change their mind about a treatment plan versus coercing them to do so.

⁵While supervised injection sites are a recent example of a harm reduction initiative, the practice of harm reduction has a much longer history. The concept of harm reduction originated in England in the 1980s in response to growing rates of Human Immunodeficiency Virus (HIV) amongst people who use drugs (Bridgeman, Fish, and Mackinnon 2017). In order to respond to the increase of HIV (and, correspondingly, Hepatitis C), needle exchanges and other harm reduction initiatives were introduced. Harm reduction initiatives were primarily started and supported by public activists and were only later implemented by some mainstream governmental and healthcare systems (Des Jarlais 2017).

rather to mitigate the possibility and severity of the potential harm(s).⁶

Harm reduction approaches are considered “inexpensive, easy to implement and have a high impact on individual and community health” (Harm Reduction International). At least part of the reason that these approaches are effective is because harm reduction practitioners are trained to be non-judgmental and to meet their clients/patients wherever they are in their substance use journey.⁷ The goal of harm reduction is *not* to persuade particular individuals to pursue clinically recommended treatment in certain contexts. For instance, rather than saying that a person who uses substances must abstain, a harm reduction practitioner might educate the individual on the benefits of using sterile injecting equipment, which may ultimately save or prolong their life.

Harm reduction may not be a concept that everyone easily identifies with since it is often specifically linked to SUDs; however, it is a practice that clinicians (and society in general) implement on a regular basis. For instance, upon recognizing that their patient with diabetes is unlikely to completely abstain from eating foods with added sugars or refined carbohydrates (e.g. white bread, potato chips, instant rice, etc.), a clinician may suggest that their patient consume less of each item to mitigate the potential harms. Similarly, people may choose to use condoms to reduce their risk of getting a sexually transmitted infection or take medication for pre-exposure prophylaxis to reduce the chance of contracting HIV. As highlighted in these examples, harm reduction is something that is regularly practiced yet rarely labeled as such.

Implementing a harm reduction approach for persons with eating disorders has been scarcely considered. One of the most prominent resources that considers it, however, is the *Clinical Practice Guidelines for the British Columbia Continuum of Services* established by Geller et al. The guidelines suggest that a harm reduction approach may be beneficial

for those with chronic eating disorders (not just people with AN), where the goal would be to improve one’s quality of life. In support of this model of care, the authors refer to patient accounts, where patients with chronic eating disorders “suggested that although they were not willing to consider working toward full recovery, they were nevertheless interested in pursuing goals that were meaningful to them and which improved their quality of life.” (Geller et al. n.d.). In addition to this resource, Westmoreland and Mehler (2016) also consider what a harm reduction approach for persons with chronic anorexia might look like. They say that a harm reduction model may allow patients to maintain an agreed upon weight that is below average (and not clinically recommended), yet one that still allows them to have a quality of life “even if they cannot work or be fully independent.” And similar to a harm reduction approach, Yager (2020) practices in a manner referred to as “compassionate witnessing”, in which he supports patients with SEAN by validating their experiences, pursuing motivational interviewing, offering hope and encouragement, and providing resources and new treatment options for their consideration.

Although these resources are helpful in bringing forward the idea of harm reduction for persons with SEAN, the approach has not to our knowledge been specifically outlined and thoroughly contemplated for persons with SEAN from an ethics perspective (which is what we do in the subsequent section). To be more forthright about what we mean by a harm reduction approach for persons with SEAN, we suggest that it may involve acknowledging and accepting that the person will continue to binge, purge, exercise, etc. and try to mitigate the potential harms that can result from this behavior(s). Based on this approach, a clinician and their patient with SEAN may agree, for example, that a person *can* (though not necessarily *should*) maintain a BMI of 14 kg/m² (i.e. a BMI that comes with inherent risks to their health), consume low-calorie foods, *and* live, only insofar as they also take vitamins, do not allow their BMI to go under a mutually agreed upon weight, consume a certain number of calories per day, etc. While a harm reduction approach would not necessarily involve any kind of enforcement (if, for instance, a patient’s BMI went under a mutually agreed upon weight), it would involve encouraging the person to maintain certain behaviors in order to reduce physical harms and/or to achieve their goal of improving their quality of life. All of the maintained eating disorder behaviors and

⁶In addition to being separate diagnostic categories, SUDs and SEAN are distinct when it comes to thinking about how they are stigmatized and why a harm reduction methodology may be helpful. People with SUDs may experience particular harms from drugs (e.g. overdoses, HIV, Hepatitis C) at least in part because of the stigmatizing and prohibitive laws and policies that exist, which often result in people using drugs in an unsafe manner (e.g. without sanitary injecting equipment). Although people with SEAN may also be stigmatized such that society may fail to comprehend and/or sympathize with those who are diagnosed, the nature of the stigma is different. The harms that people with SEAN experience are not caused by stigmatizing and prohibitive laws/policies in relation to their eating disorder behaviors, whereas the harms that people with SUDs experience are often related to this kind of stigmatization.

⁷In the substance use domain, harm reduction occurs on a spectrum that ranges from abstinence to no changes in one’s using.

any relevant consequences would be openly discussed between the clinician and the patient.

A harm reduction approach would ultimately enable a person with SEAN to continue to pursue certain behaviors while at the same time decreasing the potentially significant harms that these behaviors could cause. Moreover, a harm reduction approach for eating disorder programs may provide persons with the opportunity to receive respite from their behaviors (e.g. bingeing and purging) by being an inpatient for a few weeks without receiving intensive treatment with the goal of sustained behavioral change. While a patient's goal in this kind of situation may be to have temporary medical stabilization, it is possible that a hospital admission may also provide them with the opportunity to connect with additional supports that improve their quality of life (e.g. housing support, financial assistance, and community services). Given that many persons with SEAN have a history of post-traumatic stress disorder (PTSD) and other psychiatric co-morbidities, having access to these supports may be of significant benefit; these supports may not have been considered had they not felt comfortable being admitted to an acute care unit for temporary respite care.

Harm reduction may be a counterintuitive approach to many eating disorder programs and philosophies, which typically try to normalize eating patterns, encourage patients to consume various foods, help patients achieve a healthy BMI, and require them to be asymptomatic.⁸ In many, if not most, contexts, clinicians would typically not allow or enable a person with SEAN to eat low-or-no-calorie products, whereas a harm reduction approach may recognize that this behavior can be maintained to a certain extent while also pursuing other acts that will minimize potential harms. The goals for a person with SEAN may need to be different than a person without SEAN, and so considering the potential benefits of harm reduction may be warranted. A harm reduction approach responds to the suggestion that “it can be ethical for clinicians to accept treatment refusal [for patients with eating disorders], especially against a background of prior treatment failure” (Lavis 2018; Matusek and Wright 2010; Draper 2000) while at the same time

recognizing that eating disorders are not necessarily fatal illnesses (Melamed et al. 2003). Given that SEAN is not necessarily fatal and since one's quality of life may improve, a palliative approach to care may not be appropriate, and it ought to be distinguished from that of harm reduction (or at least the harm reduction approach that we put forward in this paper). Harm reduction differs from a palliative approach since it does not simply focus on pain and symptom management and/or fail to modify the person's disease in its current state. In their discussion of palliative psychiatry, Trachsel et al. (2016) state that “[s]everal clinical approaches in modern psychiatry can already be considered palliative, as they aim at promoting quality of life rather than achieving disease-remission or disease-modification.” While a harm reduction approach to SEAN also aims to promote one's quality of life, it may also involve modifying one's disease in order to ensure that one survives and/or achieves the quality of life that one wants. Additionally, palliative psychiatry (and palliative approaches more generally) tend to be put forward when treatment has been considered futile. As indicated at the end of Section III, however, our proposed harm reduction approach to SEAN may be implemented both when one is unable to achieve a recovery that is entirely symptom-free (i.e. when treatment is futile) and/or when one a person with SEAN does not want to achieve an entirely symptom-free recovery. Enabling a person with SEAN to pursue harm reduction even when treatment is not futile differs from typical palliative psychiatry approaches.

FOR OR AGAINST A PRACTICE OF HARM REDUCTION?

There are a few reasons that harm reduction approaches for persons with SUDs are often seen as ethically defensible, and these same reasons may apply to persons with SEAN. One of the primary reasons is because of the importance of respecting and enabling autonomy, namely, the idea that persons ought to be given the opportunity to make their own decisions when it comes to their quality of life and treatment plans.⁹ A harm reduction approach allows individuals to “direct their own treatment goals based on what matters to them [at a particular point in time]” (Buchman and Lynch 2018), thereby enabling

⁸Because harm reduction is a different type of treatment approach, it may influence conflicting individual perspectives on clinical teams. Exploring the complex team dynamics that may result from implementing a harm reduction approach is outside the scope of this paper, but we would suggest as a starting point that all team members have an opportunity to voice their perspectives and concerns in a safe environment. Consulting external services (e.g. bioethics, mediation services, etc.) may also be beneficial when it comes to exploring and/or making changes to the way that a unit operates.

⁹While it is typically argued that the autonomous decisions made by capable individuals ought to be respected, it should also be noted that capacity and autonomy are not synonymous. Because of this, it may also be the case that people who are deemed ‘incapable’ may be able to make autonomous decisions, and, if so, then these decisions would also need to be considered from the perspective of autonomy.

time-specific autonomous decision-making to occur. In their discussion about how healthcare practitioners can enable autonomous decision-making through a practice of harm reduction, Hawk et al. (2017) say that “providers [can] offer suggestions and education regarding patients’ medications and treatment options, [and] individuals ultimately make their own choices about medications, treatment, and health.” This model moves away from traditional paternalistic approaches to medicine and toward a practice of person-centered and autonomy-promoting care (which is of particular importance in Western liberal societies). It is important to highlight that persons who are considered to be making “bad” decisions are often seen as non-autonomous; harm reduction clinicians ought to be cognizant of this possible assumption and try to mitigate judgments and biases when trying to enable autonomy.

Autonomy was historically (and is still frequently) regarded as a principle that promotes complete self-governance (i.e. individuals are and ought to be the sole authors of their decisions). This conception of autonomy was reconceptualized by feminist philosophers, however, who recognized that individuals make decisions as influenced by others and their social contexts (Mackenzie and Stoljar 2000; Stoljar 2018); this conception of autonomy is typically referred to as relational autonomy, which operates under the foundational assumption that individual decisions will inevitably influence and be influenced by others because of the social constructs in which we live (Russell 2007). In the context of implementing a harm reduction approach for persons with SEAN, it seems that a relational approach to autonomy, rather than an individualistic conception, would be most appropriate. A relational approach would be the most appropriate to consider for a harm reduction approach to SEAN because the person with SEAN would likely be making decisions with the support of those around them (e.g. healthcare practitioners, family members, etc.) and those around them would plausibly be influenced by their decision to pursue a harm reduction approach (in addition to their success or failure to maintain it). This latter point is highlighted in Russell’s (2007) analysis of persons with AN and the challenges that family members often encounter when it comes to accepting that their loved one may not pursue the most recommended course of treatment to remedy their illness.

One of the challenges that may be posed in response to the autonomy argument is the fact that persons with SEAN often are in denial about the

seriousness of their own illness; i.e. part of the psychopathology of AN (and this is reflected in the diagnostic criteria for AN) is that a person’s recognition of the seriousness of their low body weight is impaired. Consequently, in discussions about treatment goals, it may be hard for clinicians to ascertain if the person with SEAN is being realistic about having limited treatment goals, and/or whether their limited treatment goals are being influenced by the cognitive distortions that are a part of their illness. This aspect of SEAN makes it 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. Because of this complicated factor, perhaps a harm reduction approach would be most defensible to pursue insofar as a clinician can reasonably gauge if a person with SEAN is making an autonomous choice based on their current circumstances (assuming, of course, that autonomy is ethically significant). If a person with SEAN is not making an autonomous choice, then a patient-led approach to treatment may be deemed unwarranted. In order to determine if a person is making an autonomous choice that is not primarily based on denial, clinicians may want to consider factors such as a person’s understanding and appreciation of their illness (i.e. the criteria that is used to determine capacity), the number of attempts in which a person has tried to make a full recovery (which may make them more informed/better able to make an autonomous decision about not striving to be entirely asymptomatic), the consistency with which they express their goals, etc. While it may take some time and effort to be able to determine if a person is making an autonomous choice, it will be important for clinicians to ensure that patients are provided with the opportunity to make autonomous decisions even if they differ from clinical recommendations. Ultimately, if autonomy can be enabled and gauged accordingly, then a harm reduction approach may be worth pursuing.¹⁰

In addition to autonomy, considering a harm reduction approach for persons with SEAN may be defensible from a virtue ethics perspective. In their article on harm reduction and substance use, Christie, Groarke, and Sweet (2008) consider how harm reduction may be ethically justified. Rather than reflecting upon harm reduction through the lenses of autonomy,

¹⁰As stated by Geller et al., “the values of patient autonomy and the right to refuse treatment come in conflict with care provider nonmaleficence and the intent to avoid harm to the patient.” We recognize that this same conflict may arise even when a patient decides to pursue a harm reduction approach since some types of harm will inevitably occur.

beneficence, non-maleficence, and justice (i.e. principlism), the authors consider it from the perspectives of utilitarianism, deontology, and virtue ethics; they suggest that virtue ethics is often seen as a more balanced alternative than the other two theories. As described by the authors, virtue ethics “does not focus on isolated acts but on the character of the agent—e.g. honesty, loyalty, courage, compassion, kindness, fairness, etc.” (Christie, Groarke, and Sweet 2008). More specifically, virtue ethics is based on promoting virtuous character traits, i.e. those that are understood as a mean between two extremes. For instance, assertiveness may be seen as a virtuous character trait since it exists between the extremes of aggressiveness and passiveness. In contemplating the defensibility of harm reduction from a virtue ethics standpoint, the authors suggest that a character trait of compassion may be that which motivates harm reduction workers and programs to be ethically defensible. Compassion involves having “the correct ratio between removing and not removing suffering or pain or misery from others” or “the right measure of sensitivity or solitude for suffering” (Christie, Groarke, and Sweet 2008). Abstinence-based programs for people with SUDs (and SEAN) may, at times, be too extreme such that they do not result in positive consequences and cause harm. Alternatively, doing nothing (i.e. the other extreme) for a person with a SUD and/or SEAN may also result in harm since no support is offered. A moderate compromise that exists between these options is that of harm reduction. Harm reduction does not involve “aiding and abetting” (Christie, Groarke, and Sweet 2008) the harmful behavior(s), but rather on providing compassionate care so that their quality of life can improve by mitigating possible harms.

A harm reduction approach may also be defensible from the perspective of trust insofar a harm reduction method may help clinicians demonstrate trustworthiness to people with SEAN. Persons with SEAN (and SUDs) are frequently stigmatized, judged for engaging in “bad” behaviors, and likely to encounter challenging experiences within the healthcare system (e.g. health providers failing to understand their diagnosis, considering them to be challenging patients, etc.). These experiences may influence individuals’ trust of clinicians and their willingness to seek medical attention. As argued by Onora O’Neill (2002), “the most common explanation for refusal to place trust is that it is a reasonable response to prior untrustworthiness or unreliability, and correspondingly that trust is a proper response to prior trustworthiness or

reliability.” Similarly, in their article about trust and gender in medicine, Rogers and Ballantyne (2008) say that “[i]f doctors are trustworthy, [then people] are able to access health care, confident in the skills and knowledge of the practitioners and comfortable in the intimacy of the consultation”. Given that many patients with SEAN have likely experienced stigmatization, judgment, and/or unhelpful responses from healthcare providers, it is plausible that clinicians (and even those who specialize in eating disorders) may be regarded as untrustworthy.

Another reason that clinicians may be seen as untrustworthy by people with SEAN is because trust can amplify existing vulnerabilities, where a “[v]ulnerability can be defined as the inability to protect one’s interests” (Rogers and Ballantyne 2008). And since someone with SEAN may have an interest to protect aspects of their eating disorder, which many eating disorder programs would prohibit, then it is likely that an eating disorder program and clinicians would not easily gain the trust of a patient with SEAN.

A harm reduction approach may help clinicians’ trustworthiness from people with SEAN since the approach is inherently non-judgmental. Because of this characteristic of harm reduction, it is likely that patients who previously experienced negativity or challenges within the health care system may still be open to receiving care from a harm reduction practitioner. As stated by Hawk et al. (2017), harm reduction methods will enable patients to “remain engaged in care and have access to trusted providers in times of crisis or acute illness”; this is important for persons with SEAN who may need to be medically managed and/or stabilized during the course of their illness. Ultimately, people with SEAN are more likely to trust treatment providers and be willing to seek care if they feel that their personal goals, wishes, and perspectives are respected via a harm reduction approach. So, insofar as it is incumbent on clinicians to show that they deserve to be trusted, then harm reduction may be a suitable approach to consider.

A practice of harm reduction may also be defensible insofar as it can save/prolong lives and/or improve a person’s quality of life. From one perspective, bioethical principles of beneficence and non-maleficence could be used to defend the idea that ideal (“gold standard”) clinical practices should always be pursued, irrespective of whether a patient wants to and/or will be able to adhere to clinical recommendations. Many clinicians practice in a way that honors the Hippocratic tradition’s precept of “first, do no harm”; the application of this precept could be

interpreted in a way that opposes harm reduction insofar as harm reduction may, indeed, enable some clinically harmful (or, at least, less than ideal) practices to occur. If a person with an eating disorder is ultimately allowed to maintain a weight that could lead to medical instability and harm, then this may be interpreted as going against a primary principle in medicine.

In response, however, we would argue that a person-centered approach (i.e. focusing on the person as a whole as opposed to solely considering them as a patient) to care in combination with the principles of beneficence and non-maleficence would seek to enable patients to determine what is helpful and harmful when it comes to their quality of life. This approach would encourage clinicians to mitigate potential harms in accordance with their clinical expertise *and* the views of patients. If a person with SEAN may be able to live for a longer period of time and/or to achieve an improved quality of life (based on their perspective of what a good quality of life looks like) by making lifestyle modifications while maintaining certain symptoms, then a harm reduction approach may be worth considering. Although harm reduction may not always align with clinically ideal recommendations, it is a person-centered method that can offer help and prevent harm based on individual patient circumstances. Furthermore, while a harm reduction approach may involve the acceptance of certain harmful behaviors (which may be interpreted as passively causing harm), it is not encouraging clinicians to actively do harm to patients. Finally, it should be highlighted that our argument to consider a harm reduction approach is primarily for persons with SEAN who have previously been treated in other ways (i.e. in ways that are not focused on reducing harm but rather on achieving a symptom-free recovery) for a period of time. Eliminating all clinically harmful behaviors and striving for complete recovery would be the method that is utilized early in one's illness trajectory (i.e. for persons without SEAN). Our argument in support of harm reduction is meant to apply to specific situations where a symptom-free recovery may not be realistic, which is more likely to be the case for persons with SEAN.

Although harm reduction is being increasingly used for individuals with SUDs and is typically considered to be ethically defensible, it still receives some criticism. Two of the primary critiques of harm reduction are: (1) the idea that harm reduction keeps persons with addictions “stuck” in the addiction cycle and (2) the idea that harm reduction encourages/endorses

“bad” behaviors. While a full defense of harm reduction in response to these two arguments for persons with SUDs is beyond the scope of this paper, there is evidence available that responds to and rejects each possibility (Hunt et al. 2003). The responses offered in response to such objections are compatible with those that we raise above, specifically regarding the importance and potential benefits of autonomy, trust, person-centeredness, and quality of life. Furthermore, it should be noted that a harm reduction approach may not be suitable for all patients nor should it necessarily be practiced without trying alternate approaches. It may be apt for persons with SEAN in some circumstances though, specifically where the ethical benefits outweigh the potentially detrimental clinical consequences. Given the supporting evidence available for persons with SUDs, we suggest that considering a harm reduction approach for persons with SEAN ought to be further explored at the very least.

CONCLUSION

In conclusion, the purpose of this article is to introduce a case for implementing a harm reduction approach for persons with SEAN. A harm reduction method acknowledges that persons with SEAN may maintain certain eating disorder symptoms and try to mitigate the potential harms that may result as a consequence. This approach does not strive to achieve full weight restoration during a patient's treatment, but instead focuses on achieving medical stability and an improved quality of life based on what seems reasonable to the patient and clinical team. This approach may not only apply in intensive treatment programs, but also in outpatient treatment/management.

Although a harm reduction approach for persons with SEAN may be seen as a counterintuitive method to treating persons with eating disorders, there is at least some reason to consider implementing it in certain contexts in order to enable autonomy, promote person-centered care, and build/maintain trust. We recognize that harm reduction is not appropriate for every patient in every context, but suggest that it may be suitable for persons with SEAN who want to live and maintain a certain quality of life. Ultimately, we posit that further research needs to be pursued on the potential defensibility of harm reduction approaches for persons with SEAN, and we offer this introduction as a motivation to complete this task.

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