EDITORIAL

Restricted intake self-harm (RISH)

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Summary Restricted intake self-harm (RISH) refers to intentionally limiting food or fluids as a form of self-harm rather than for weight or body image reasons. RISH is an emerging formulation-led construct, rather than a diagnosis, that was developed with lived-experience input. Experts by experience highlighted how existing labels like 'disordered eating' often misrepresent intent and lead to clinical misunderstandings. Individuals describe restriction to regulate emotions, express distress, seek care or commit suicide. Emerging evidence suggests this behaviour could be relatively common among young people yet is under-researched and frequently misclassified. Recognising RISH can help ensure appropriate adapted treatment approaches are created.

Keywords Feeding or eating disorders; self-harm; anorexia nervosa; anxiety- or fear-related disorders; trauma- and stressor-related disorders.

Restricted intake self-harm (RISH) is operationalised as the intentional restriction of food and/or fluids where the primary functions are the same as for other forms of self-harm, rather than for weight or shape control. Although the overlap between eating-related behaviours and self-harm has long been recognised, this specific functional presentation remains poorly defined, under-researched and frequently misclassified in clinical practice.

RISH is an emerging formulation-led construct, rather than a diagnosis. RISH emerged through a co-production process with two young people who identified their restrictive intake as serving the same function as other forms of self-harm. Both had previously received labels such as 'disordered eating', 'acute food refusal' or 'atypical anorexia', which they described as confusing, inaccurate and, at times, belittling. These terms failed to capture the intent underpinning their behaviour and led to clinical misunderstandings. We collaboratively developed the term restricted intake self-harm to more accurately reflect the function of the behaviour. This process represents an important epistemic shift to aligning clinical language with lived experience. To further analyse professionals', patients' and carers' thoughts on the potential self-harm-related functions of restricted intake, a survey was undertaken of health professionals working with young people in the UK, and patient and public involvement (PPI) with young people, families and an adult who identified as having RISH. We held PPI discussions in in-patient children and young people's mental health services units and community settings, including individual and group discussions with children and young people experiencing RISH symptoms, and informal conversations either by email or in person depending on their preference, with their parents and carers and an adult who identified as having experienced RISH. These sessions helped define RISH and shape how it should be researched. Katy, an adult who identifies as having RISH, described the impact of the function of her restriction through not being appropriately identified:

'None of these (diagnoses including atypical anorexia and ARFID [avoidant/restrictive food intake disorder]) "fitted" or felt quite right… they resulted in inaccurate assumptions by clinicians… I felt misunderstood… which ironically was the basis of development of restriction.'

Those who identified themselves as having RISH episodes described using restriction not to influence weight or shape but as a means of managing emotions, expressing unmet need and self-punishing by causing harm or uncomfortable sensations in their body. Others described attempting suicide through restrictive intake. In this context, restriction functioned analogously to other forms of self-harm, such as cutting or overdosing. The RISH construct seeks to acknowledge this and move away from vague or belittling terminology such as 'disordered eating' or 'acute food refusal' as a means of describing this population. Moving away from the term disordered eating has attracted the attention of clinicians both in the UK and internationally. The term RISH is now being increasingly adopted, and decision trees to aid clinicians differentiating RISH presentations from diagnosable eating disorders have been published.[1] This has led to some expressing concern that RISH could be used to restrict access to eating disorder specialist teams and that more research is required to determine whether, or when, restricted intake could be considered as a form of self-harm.[2]

Current evidence base

Studies conducted into restrictive eating have tended to focus mainly on Western Caucasian women; however, data are increasingly indicating that it impacts on all populations

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but may have a different aetiology and/or symptom profile.[3] Self-harm may be more prevalent among marginalised and under-researched groups, such as Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and Asexual+ (LGBTQIA+) youth and children in care.[4] There is a risk that current diagnostic frameworks and treatment models disproportionately mischaracterise these groups, reinforcing existing health inequalities. Wang et al[5] also expressed concern that the function of restricted intake needs to be considered, including in those with disordered eating who do not meet a diagnostic threshold. The empirical literature on restricted intake as a form of self-harm remains very limited. Only a small number of studies over the past 25 years have examined restrictive eating behaviours in relation to self-harm.[6–10]

These studies consistently indicate that both eating disorder behaviours and self-harm can function as maladaptive strategies for emotion regulation, often involving intentional physical harm or distress. Fox et al[7] identified associations between restrictive eating and self-harm intent, suggesting that, for some individuals, restriction is enacted with the explicit purpose of causing harm.

Emerging quantitative evidence supports the clinical relevance of this phenomenon. Washburn et al[10] identified that 29.5% of adolescents and young adults in psychiatric care reported engaging in eating-related behaviours with self-injurious intent, conceptualised as self-injurious disordered eating symptoms. This group demonstrated greater psychopathology, poorer quality of life and increased functional impairment compared with those engaging in non-suicidal self-injury alone.

Similarly, Mahl et al[8] found that approximately 20% of high school students reported restrictive eating as a form of self-harm at some point. Together, these findings suggest that RISH behaviours could be relatively common among young people. However, the evidence base lacks qualitative exploration of lived experience and does not explicitly differentiate the function (self-harm versus weight/shape control) described in RISH.

Together, these studies[6–10] and the PPI conducted by this author have framed restricted intake as serving different functions, including as a way of regulating overwhelming emotional experiences, as a form of self-punishment in response to negative thoughts or as a means of communicating distress, eliciting care or creating safety from those around them. In PPI sessions, Katy, an adult who identifies as having struggled with RISH episodes, stated: 'My underlying need was for it to be understood I wasn't OK, and restriction resulted in support and care.' One young person with RISH discussed how they would acutely restrict their intake to avoid contact with a relative whom they described as emotionally abusive.

Conceptual clarification: RISH and anorexia nervosa

A key contribution of the RISH construct is the clarification of functional intent. Anorexia nervosa is primarily characterised by restricted intake due to weight and shape concerns, with ICD-11 stating that 'body weight or shape is central to the person's self-evaluation'.[11] By contrast, RISH is not characterised by the primary aim of the restriction being weight or shape concern, but by the intent to self-harm through restriction of food and/or fluids. In ARFID, restriction is typically related to sensory sensitivities, fear of aversive consequences or limited interest in eating, rather than a desire to inflict harm. Importantly, RISH is not mutually exclusive with eating disorders and may co-occur. Likewise, RISH can occur in anxiety disorders, depression or psychosis, but these presentations may also involve other forms of reduced eating or drinking secondary to overwhelming affect, dissociation or other functions rather than as a form of self-harm. As with other forms of self-harm, careful assessment of intent, function and associated risk remains essential to differentiate these overlapping clinical presentations. In such cases, where there is a co-occurrence of RISH with a diagnosed mental health condition, clinicians should continue to follow the appropriate treatment guidelines for the diagnosed disorder while also recognising and addressing the self-harm function of restrictive intake, because this may require adapted risk management strategies and therapeutic approaches.

Misclassification of RISH could have iatrogenic consequences when treated solely within either an eating disorder or self-harm framework, as described in Simpson's article on RISH in National Health Service (NHS) settings.[12] In an eating disorder framework, the strong focus on nutrition and weight restoration may inadvertently reinforce the behaviour, particularly if care becomes contingent on restriction. Conversely, a self-harm framework rarely involves input from dietetics and physical health monitoring, as described in the National Institute for Health and Care Excellence (NICE) eating disorder guidance,[13] which is required to ensure safety during a RISH episode.

Clinical and research implications

The RISH construct raises several critical clinical and research questions. First, there is a need for improved identification. Current terminology such as disordered eating lacks specificity and may obscure risk.[14] Young people involved in this work explicitly described such terms as invalidating. Second, treatment models require adaptation. Interventions developed for anorexia nervosa may be insufficient or even counterproductive when applied to RISH episodes without adaptation. NICE[15] recommends interventions for self-harming behaviours but does not describe a treatment approach for RISH specifically. Although following NICE guidance for self-harm would be important in RISH, this population also often requires input from dietetics and those with expertise in monitoring and managing restricted intake.

Key points

Restricted intake self-harm represents a clinically meaningful, co-produced construct that defines a subgroup of people often labelled with having disordered eating. It foregrounds function over form and aligns psychiatric understanding with lived experience.

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The current evidence base, while limited, supports the probable clinical importance of this construct. However, substantial gaps remain, particularly regarding patient experience and treatment. Failure to research RISH risks clinicians utilising treatments that were not developed for this difficulty and that could result in ineffective care. By contrast, adopting this construct for further research offers an opportunity for the development of effective, trauma-informed and developmentally appropriate interventions.

About the author

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Declaration of interest

None.

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