Restrictive intake self-harm in NHS settings: understanding relational dynamics and iatrogenic risk

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Summary Restrictive intake self-harm (RISH) describes a pattern of severe food and fluid restriction whose functions emerge primarily for reasons other than weight or shape psychopathology. RISH exhibits a distinct phenomenology from anorexia nervosa, rooted in conditional caregiving, attachment disruption and maladaptive internal working models that inhibit direct help-seeking. This paper draws on attachment theory and evidence on the functions of eating-disordered behaviour to argue that three relational configurations (boundary confusion, subjugation of needs and escalating distress signalling) create vulnerability to RISH and shape how individuals use restriction within relational contexts. It further proposes that risk-driven thresholds, hospital admissions and crisis-responsive models that characterise NHS care delivery may inadvertently reinforce these dynamics by validating the belief that suffering is required to access care. Highly restrictive and directive treatment plans for those with RISH can result in the escalation of dietary restriction, trauma and clinical deterioration. Medicalisation of care can also inadvertently reinforce care-seeking behaviour through restriction. A relational framework is therefore essential for understanding RISH, providing interventions that minimise iatrogenic harm and offering relational experiences in which needs can be expressed and met without bodily deterioration.

Keywords RISH; restrictive intake self-harm; anorexia nervosa; iatrogenic risk; affect regulation.

Severe restriction of food and fluid intake presenting in National Health Service (NHS) services is conventionally diagnosed as either anorexia nervosa or avoidant/restrictive food intake disorder (ARFID). Diagnostic criteria centre on weight and shape psychopathology in anorexia nervosa, with evidence supporting cognitive-behavioural approaches targeting fear of weight gain and body image distortion. National Institute for Health and Care Excellence guidelines[1] emphasise structured nutritional rehabilitation alongside psychological interventions addressing eating disorder cognitions. ARFID criteria encompass restriction driven by sensory sensitivities, fear of aversive consequences or lack of interest in eating. Treatment protocols derived from these frameworks show limited efficacy in reducing restriction and medical risk, and only where psychopathology aligns well with diagnostic criteria.[2,3]

Functional and relational understandings of restriction

Clinicians increasingly encounter patients presenting with severe restriction and associated medical emergency, yet showing minimal evidence of classical anorexia nervosa psychopathology. These individuals often lack the body image distortion characteristic of anorexia nervosa. Their restriction triggers clinical emergencies, hospital admissions and repeated cycles of deterioration and stabilisation. Once admitted, they may show greater capacity around eating and some physiological improvement compared with classical anorexia nervosa presentations, returning to severe restriction post-discharge.[2,4] Unlike anorexia nervosa, where resistance to eating is typically consistent and pervasive, restriction in restrictive intake self-harm (RISH) shows a more yo-yo pattern of rapid onset and partial remission in the context of care.[4]

These patterns do not map onto existing diagnostic categories. ARFID does not capture the relational and emotional drivers at play. Atypical anorexia nervosa still presupposes weight/shape psychopathology, which is often absent. Clinicians have begun using the term RISH to describe presentations where the primary function of restriction is emotional relief, interpersonal communication or self-harm rather than weight control.[2,3]

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A recent review highlighted the functional roles of restrictive eating, including as a form of self-harm, a regulatory strategy and for interpersonal influence.[5] These findings challenge assumptions that disordered eating can be understood primarily through weight/shape psychopathology and invite examination of how restriction may operate.

We draw on attachment theory to argue that RISH represents a relationally mediated coping strategy emerging when early caregiving experiences constrain capacity for direct help-seeking or self-regulation. We further argue that current NHS structures can inadvertently reinforce these developmental templates. A relationally informed approach is therefore essential to person-centred care and reducing iatrogenic harm.

RISH as a functionally distinct clinical phenomenon

What differentiates RISH from anorexia nervosa is not the absence of weight/shape concerns, but their reduced salience relative to the distinctive meaning and purpose of restriction. Individuals with RISH often restrict to communicate distress, relieve unbearable affect, elicit particular responses in others or create a sense of agency in invalidating or chaotic situations. Restriction in these cases functions in ways that overlap with self-harm and chronic suicidality.[4] The clinical recognition of these patterns has led to the development of RISH as a formulation-driven term, moving away from previous categorisations such as atypical anorexia nervosa or 'disordered eating', which many patients experience as invalidating and unhelpful for treatment engagement.[6]

A recent review by Ambler et al[5] found compelling empirical grounding for this conceptualisation. Affect regulation emerged as the most commonly endorsed function, with interpersonal influence, personal mastery and validation also prominent. These findings resonate with clinical observations of RISH, where restriction becomes an automatic response, making its rapid onset and offset comprehensible. When individuals are removed from the relational contexts that evoke restriction and placed into hospital environments with predictable routines, consistent attention and regular monitoring, the drive to restrict temporarily diminishes. This explains why swift medical stabilisation is often observed.

RISH thus sits conceptually at the intersection of eating disorder and self-harm. Like self-harm, it may serve as a means of coping, communicating or regaining agency. Like eating disorders, it involves the body as the primary site of meaning-making and self-regulation. Understanding RISH therefore requires a framework capable of integrating these domains.

Relational dynamics and the development of RISH

Attachment theory provides a useful foundation for understanding why some individuals resort to restriction for regulation. Bowlby[7] argued that early caregiving experiences shape internal working models that govern how individuals perceive their own needs and the responsiveness of others. When caregiving is inconsistent, intrusive, or conditional, the development of self-regulation and help-seeking may be compromised.[8] From our clinical observations, three relational patterns appear particularly relevant to RISH.

Boundary confusion develops when caregivers override bodily cues, impose their emotional states on the child, or fail to support the development of autonomy. Children learn that internal signals (e.g. hunger, distress, curiosity) are unreliable. Restriction becomes a means of reclaiming control and asserting autonomy. Individuals who describe restricting for self-protection (e.g. to avoid demands, maintain distance, or create interpersonal barriers[4]) are reflecting this dynamic.

Subjugation arises when children learn that expressing needs leads to rejection, conflict, or punishment. Restriction becomes a paradoxical means of communicating need while simultaneously denying it. This is consistent with restriction as interpersonal influence.[4] Risk-based access criteria within the NHS can inadvertently confirm the internalised belief that needs are legitimate only when distress is extreme. Individuals may therefore escalate restriction to reach a level of medical compromise that warrants intervention, consistent with documented avoidant personality traits in eating disorder populations, including fear of rejection and interpersonal avoidance as both risk and maintaining factors.[9]

In unpredictable caregiving environments, children may learn that only extreme distress elicits care. Restriction in RISH often echoes this relational pattern; individuals deteriorate rapidly when they feel abandoned or unheard, yet stabilise quickly when admitted to hospital. Understanding these mechanisms is essential for reducing iatrogenic harm.

Iatrogenic reinforcement within NHS structures

Risk-driven thresholds communicate that care is contingent upon measurable physiological risk. This reinforces the belief that deterioration is necessary to be taken seriously. Similarly, crisis-responsive models re-enact relational patterns where help is available only when distress reaches its peak. This can make verbal help-seeking feel futile, and encourage reliance on restriction as the most reliable means of eliciting intervention. Standard eating disorder pathways may thereby inadvertently reinforce restrictive behaviours.[10]

Time-limited admissions may mirror experiences of inconsistent caregiving, with abrupt transitions potentially contributing to feelings of abandonment and renewed restriction.[11] Lengthy psychiatric or specialist in-patient admissions can reinforce the reliance on illness as a means of securing relational connection.[4]

From our clinical observation, staff countertransference can lead to responses that replicate conditional care, such as withdrawing support in response to perceived manipulation or escalating control in response to deterioration. Collectively, these structural features risk further entrenching RISH cycles while attempting to mitigate risk.

Clinical and service-level implications

Addressing RISH requires both relationally informed clinical interventions and structural adjustments. Clinically, the

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cornerstone of effective intervention is a comprehensive functional assessment.[4] Clinicians must explore what restriction accomplishes, what states it regulates, what relational meanings it holds, and anticipated fears if restriction were reduced or abandoned. Primary care decision-making tools such as those developed by Ellison and Philpot[6] can assist in accurate initial identification of RISH presentations, supporting appropriate referral pathways from the outset. Further, interventions targeting personality and emotional regulation processes have been associated with improved eating disorder outcomes, supporting a functionally informed approach.[9] Interventions may subsequently focus on developing alternative emotion-regulation strategies, practising direct help-seeking, establishing boundaries or fostering agency, depending on the primary function of restriction.

Organisationally, reducing iatrogenic reinforcement requires rethinking service access, continuity of care, and transitions. Creating pathways that recognise psychological distress irrespective of body mass index, providing continuity during periods of lower acuity, and managing transitions gradually may reduce the need for escalation. Multidisciplinary teams should explicitly discuss how service structures may inadvertently reinforce restriction with each other and with patients.

Supporting staff through training and supervision is equally critical. Understanding RISH as relationally mediated helps staff interpret countertransference reactions in a more contextualised way. Reflective supervision enables consistent responses that offer relational experiences differing from those that shaped reliance on restriction.

Implications, limitations and future directions

RISH represents an emerging and clinically pressing challenge – recognised across both child and adult mental health settings, including in survey data from child mental health professionals.[4] It cannot be fully understood through the lens of classical anorexia nervosa. Its roots lie in relational trauma, emotion dysregulation, and internal working models that make direct help-seeking feel dangerous or ineffectual. Empirical research has identified overlapping personality profiles in eating disorder populations – including constricted/overcontrolled and emotionally dysregulated subtypes – which share features with the relational patterns observed in RISH.[9,12] Restriction encompasses a range of functions and its rapid escalation and de-escalation reflect its relational embeddedness.

Current NHS structures may reinforce the very dynamics they seek to manage by inadvertently creating cycles of deterioration and crisis. It should be acknowledged that the evidence base for RISH as a distinct clinical entity remains emergent, resting primarily on clinical observation and conceptual literature; empirical research including case series and prospective studies is urgently needed. Relational and functional formulation offers crucial insights into clinical and systemic interventions for RISH. Attending to the functions restriction serves, making services more responsive to need rather than exclusively to risk, and supporting staff to work relationally are essential components of creating therapeutic environments in which needs can be expressed and met without resorting to restriction. Services can therefore begin to interrupt the cycles of iatrogenic reinforcement that sustain RISH and foster healthier engagement and recovery. Such responses have been described in emerging clinical reports of RISH presentations.[4]

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Author contributions

S.S. and K.G. were involved in the initial literature review and the writing and the discussion of the paper. S.S. and K.G. contributed equally to writing the paper.

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Declaration of interest

None.

References

1 National Institute for Health and Care Excellence (NICE). *Eating Disorders: Recognition and Treatment. NICE Guideline [NG69]*. NICE, 2017 (https://www.nice.org.uk/guidance/ng69 [accessed 1 Jan 2024]).

2 Frostad S, Bentz M. Anorexia nervosa: outpatient treatment and medical management. *World J Psychiatry* 2022; **12**: 558–79.

3 Solmi M, Wade T, Byrne S, del Giovane C, Fairburn C, Ostinelli EG, et al. Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: a systematic review and network meta-analysis. *Lancet Psychiatry* 2021; **8**: 215–24.

4 Fenton C, Ellison C, Philpot U, Adedeji A, Cruickshank K, Goldup H, et al. Restricted intake self-harm (RISH): a composite case example and guidance for management. *Frontline Gastroenterol* [Epub ahead of print] 19 Sep 2025. Available from: https://doi.org/10.1136/flgastro-2024-102823.

5 Ambler F, Hill AJ, Willis TA, Gregory B, Mujahid S, Romeu D, Brennan C. How do the psychological functions of eating disorder behaviours compare with self-harm? A systematic qualitative evidence synthesis. *Healthcare* 2025; **13**: 1914.

6 Ellison C, Philpot U. Confusion between avoidant restrictive food intake disorder, restricted intake self-harm, and anorexia nervosa: developing a primary care decision tree. *Br J Gen Pract* 2024; **74**: 559.

7 Bowlby J. *A Secure Base: Clinical Applications of Attachment Theory*. Routledge, 1988.

8 Ringer F, Crittenden PM. Eating disorders and attachment: the effects of hidden family processes on eating disorders. *Eur Eat Disord* 2007; **15**: 119–30.

9 Simpson S, Azam F, Brown S, Hronis A, Brockman R. The impact of personality disorders and personality traits on psychotherapy treatment

https://doi.org/10.1192/bjb.2026.10242 Published online by Cambridge University Press

outcome of eating disorders: a systematic review. *Personal Ment Health* 2022; **16**: 217–34.

10 Ellison C, Philpot U, Fenton C, Fuller SJ, Leighton C, Ecclestone L, et al. Restrictive Intake Self-Harm (RISH): Practice Considerations for the Management of RISH across Care Settings and Age. Insight Eating, 2025 (https://insighteating.co.uk/rish/ [accessed 21 Jan 2026]).

11 Day S, Mitchison D, Mannan H, Tannous WK, Conti J, Dearden A, et al. Residential versus day program treatment for eating disorders: a comparison of post-treatment outcomes and predictors. *J Affect Disord* 2025; **371**: 177–86.

12 Westen D, Harnden-Fischer J. Personality profiles in eating disorders: rethinking the distinction between Axis I and Axis II. *Am J Psychiatry* 2001; **158**: 547–62.

https://doi.org/10.1192/bjb.2026.10242 Published online by Cambridge University Press