# Toolkit for Dietitians Working with People with Personality Disorders

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# Index

# 1) Background

Working with people with a personality disorder (PD) can be very rewarding. It can also be quite challenging and can at times create a feeling of helplessness within the professionals involved. From the results of an in-house survey within a large NHS Trust, only 23% of qualified dietetic staff working in mental health felt 'somewhat confident' when working with people with PD. Three quarters of the dietetic staff working in mental health did not feel confident. Yet a high proportion of patients with a psychiatric diagnosis we see in clinical settings may have a comorbid PD (Zimmerman et al., 2008).

PDs are severe mental disorders that are characterized by inflexible, maladaptive, and pervasive patterns of cognition, affect, impulse regulation, and interpersonal behaviours (APA 2013) . There are different types of personality disorders recognised in major diagnostic manuals, including the ICD 11 (ICD-11 for Mortality and Morbidity Statistics) and DSM5-TR (Overview of Personality Disorders - Psychiatric Disorders - MSD Manual Professional Edition).

The means of classifying PD is moving towards systems such as the ICD 11. Unlike the previous ICD-10 and DSM-IV, the ICD-11 does not classify personality disorders into specific categories, for example, Antisocial, Borderline, or Narcissistic. Instead, it focuses on the core personality dysfunction and its severity, using five severity levels ranging from no impairment to severe. However in clinical practice, a historical diagnosis such as Emotionally Unstable Personality Disorder (EUPD), also known as Borderline Personality Disorder (BPD), can be often seen listed in the patient record along with other diagnoses. Some of these diagnoses may not be agreed between the team or patient. Fundamental to all personality disorders is that a person's difficulties are persistent, pervasive, and problematic, referred to as the 3 P's (Wood et al., 2014).

Dietetic staff included in the in-house survey were a range of Apprentices, Dietetic Assistants, and Dietitians (bands 5, 6, and 7). Some of the common challenges staff have raised include:

*What people with a PD say and what they do is not the same*

*Providing enough but not too much care*

*How to keep people safe without reinforcing behaviours*

*Maintaining boundaries and staying on topic in sessions*

*Difficulty of managing going from being idolised and then devalued as a clinician*

*I am unsure what are the most appropriate interventions with this patient group*

*I find people with a PD may either not engage or resist due to issues around feeling rejected*

*I think that with this population group you are more likely to feel that you have done something unprofessional and not stuck to your scope of practice.*

*I am an experienced clinician but can still be at risk of rescue behaviour and thinking I am the saviour, and I am the healthcare professional this time who can really help this patient*

*I sometimes feel I have to tip toe around patients for fear of provoking them*

The prevalence of PDs is estimated to be around 10-13% of the adult population, equally distributed between males and females (NIMHE, 2003) whilst in psychiatric hospital settings, the prevalence of PD ranges between 36-67% . Recently it has been suggested that PDs are developmental disorders and it is proposed that early diagnosis and treatment is important (Klinkby et al., 2024). The rates of BPD in adolescents are estimated at 1−3% in community samples, 11% in out-patient samples and greater than 40% for in-patient samples (RPsych 2018). A diagnosis of BPD in adolescence is associated with increased rates of hospitalisation and more severe symptoms of other mental health disorders, such as depression (RPsych 2018).

In clinical practice, it is often people with a BPD diagnosis who can appear the most complex, presenting in crisis with deliberate self-harm, anxiety, depression, and eating disturbances (NIMHE, 2003). This toolkit will predominantly focus on BPD / EUPD which tends to be the PD we come across most in our clinical practice as dietitians.

**An explanation of PD from people with lived experience:**

*"Healthy personality traits can include self-awareness, the ability to self-soothe and a resilience to cope with what life throws at you. On the other hand, many people with PD have personality traits which become rigid and maladaptive, to the point they start to impair functioning. We may have emotional needs that are unmet often stemming from childhood experiences, and present with an overwhelming fear of being abandoned".*

*"As a child I would walk into a room and have nobody lighting up their face for me. We all need someone to have their face lighting up for us. When core childhood needs are not met, that foundation can feel less stable, and those building foundations tend to be more prone to collapse".*

*"People with PD often struggle with a stable sense of self, experiencing a sense of threat. Growing up in an environment where our voice is unheard may lead to desperate means of being noticed. We can present with deliberate self-harm and other behaviours, for example taking overdoses, as a way of showing distress."*

Differing views can arise amongst patients, carers, and healthcare professionals regarding the use of the diagnostic label for PD (Why is personality disorder controversial? - Mind). Some patients and professionals feel the diagnosis is stigmatising and that it is upsetting to suggest the personality is 'disordered'. Others can find the diagnosis useful in understanding their difficulties.

Notably, some symptoms of PD can present similarly to traits or difficulties disproportionately experienced by people with autism (Gillett et al., 2023). In clinical practice, there can be conflicting opinions amongst teams around diagnosis of PD and neurodivergence. One study

suggests much less stigma attached to a diagnosis of autism than a personality disorder (Tamilson et al., 2025). Careful developmental assessment by the team is crucial during assessment to avoid misdiagnosis of either PD or autism which may prohibit or delay access to appropriate support (Gillett et al., 2023).

This toolkit has been developed alongside people with lived experience for dietetic staff working with people with a PD. It aims to build understanding about personality disorders and offer guidance on helpful and unhelpful ways of responding to people with PD.

## 2) Controversies Around PD

A constant in PD is controversy. This has been evident over recent years in relation to discussions about classification systems. The following section focuses on some of the common controversies encountered.

| Controversy | Alternative Interpretation |
|---|---|
| Manipulating | In some cases, people with PDs may be described as manipulative. This is often around eliciting care as a way of coping with intense distress and struggling to regulate their emotions. |
| Pushing boundaries | Part of our task is to provide appropriate limits and boundaries. As professionals, there can sometimes be a tendency to be overly rigid. Compassionate boundaries are important. |
| Attention seeking | This may be better reframed as eliciting care and attention to regulate emotions or as an attempt to have needs met where the person does not possess healthier means of communicating needs (Overview of Personality Disorders - Psychiatric Disorders - MSD Manual Professional Edition).<br><br>There will be a reason for the behaviour. Try to understand the mind of the person. In some cases, there will be a deep-seated fear of abandonment, and the person is experiencing intense emotions.<br><br>However, attention seeking is also a diagnostic criterion for certain PDs (DSM-5-TR). There are still debates within the research. |

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| PDs are always the result of childhood trauma | It is often thought that abuse and trauma cause PD. However, some people suffer abuse and trauma and do not go on to develop PD, whilst some people with PD have not experienced significant abuse and trauma during childhood. More is detailed in the handbook "Meeting the challenge, making a difference" (Wood et al., 2014).<br><br>There tends to be a combination of genetic factors and biological vulnerability, together with early childhood experiences, wider environmental and social factors. Research suggests heritability rates of up to 50%. (Overview of Personality Disorders - Psychiatric Disorders - MSD Manual Professional Edition). |
| Untreatable | The evidence is strongest for treatment of BPD with evidence-based treatments such as Dialectical Behaviour Therapy (DBT) Mentalization-Based Therapy (MBT) (Rpsych, 2018). There is evidence that there can be significant recovery and remission from the symptoms of BPD over time (Rpsych, 2018). Specific symptoms such as emotional instability may decrease with age (Volkert et al 2018).<br><br>Some service users may prefer the term "Discovery" to recovery with reference to their journey with support services (Turner et al., 2011).<br><br>Joint working and trying to develop a comprehensive understanding of the experience of a person with PD is helpful. A formulation-based approach is common, using psychological theory to help understand how the person developed these problems, how they affect them, their current impact, what triggers them, and what implications this has for how we treat them now. (Wood et al., 2014). As a dietitian, being familiar with a patient's formulation (essentially a roadmap summarising the patient's difficulties to help make sense of them) can be used to guide your approach to treatment. See appendices for an example of a formulation. |
| Needing admission to hospital to stay safe | Each admission should carefully weigh up the risks and benefits as long-term hospital admission is likely to be harmful. |
| PD can only be diagnosed above an age of 18 | There is no longer a reference to age in PD diagnostic criteria. Whilst viewpoints amongst clinicians may still vary, a diagnosis can offer an explanatory framework for young people and those caring for |

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| | them. It may also support accessing effective therapeutic interventions (RCP, 2018). |
| Eating disorder vs disordered eating | One of the biggest controversies dietitians may be involved with is whether a patient has an eating disorder (ED) or disordered eating. It is important to note that disordered eating is not a diagnosis within diagnostic manuals, although it may be represented by other specified feeding or eating disorders. In clinical practice, disordered eating for people with a PD is often formulated as another form of self-harm and a description of maladaptive coping behaviours rather than a diagnosis. Quite often, disordered eating can raise more anxiety than cutting or overdosing, despite some behaviours such as swallowing batteries being just as lethal.<br><br>Targeted treatment focusing on deficits in emotional regulation may be indicated with co-occurring BPD and ED diagnoses (Dasineau et al., 2024). Emotion regulation is one of the four core skills that DBT teaches.<br><br>As with other mental health conditions, interventions should carefully consider the person's formulation and approaches to dietetic treatment will usually need to be different where the presenting problem is driven by eating disorder cognitions vs. a self harm or maladaptive coping presentation. |

# 3) Eating Problems and Personality Disorder

Co-morbidity of PDs and disordered eating is extremely common. Studies may need to be viewed with some caution as there appear to be varying diagnostic standards around what constitutes an eating disorder or disordered eating, for example, self-reporting an ED (De Paoli, 2020). The literature indicates that there is a high prevalence of co-morbidity, with studies reporting between 30-65% prevalence of eating disorders and PD (Martinussen, 2017; Vivarini et al., 2023; Khosravi, 2020).

The RCP guidelines (2018) suggest there are two types of presentation when considering eating problems in PD:

| **STABILITY**<br>*Patients craving stability* | **INSTABILITY** |
|---|---|
| • Relieve anxiety, anger, and guilt by means of avoidance and rituals of sameness.<br>• Often have obsessive compulsive symptoms.<br>• Tend to be patients with restrictive AN.<br>• Where there is a co-existent PD, this is often obsessive-compulsive PD. | • Other patients' find themselves unable to tolerate feelings such as anxiety, boredom, anger, and shame.<br>• Attempt to shift them by means of 'acting out' behaviours, risk-taking, self-harm, and substance misuse. These patients form strong but insecure attachments to other people and use their disorder to communicate their perceived needs.<br>• These symptoms may be described as impulsive or borderline. |

**Borderline Personality Disorder**

The literature suggests that issues with eating are common in people with BPD, contributing to their lack of treatment response and bad prognosis (Shaker et al., 2022; Miller et al., 2022). Vivarini et al. (2023) explored the prevalence of BPD in a sample of outpatients with eating disorders, and results indicated a 45% prevalence of BPD symptoms, which were associated with significantly higher eating disorder symptomology, psychological distress, and poorer psychosocial functioning.

People with BPD may be more sensitive to rejection and these fears of rejection may result in increased emotion and subsequent dysregulated eating behaviours (Selby et al., 2010). BPD is marked by self-damaging behaviour such as self-harm, substance misuse, and disordered eating behaviours which have been shown to regulate emotional experiences.

Treatment should be tailored to tackling these self-damaging behaviours in BPD (Dobbs, 2010). It has been suggested that interventions that address aspects of personality pathology may have better eating disorder treatment outcomes than traditional or usual eating disorder treatments (Simpson et al., 2022).

**Treating the Personality Disorder or Treating the Eating Disorder?**

It is not always clear which is the primary problem for the patient, and the first to occur is not necessarily the priority for treatment. As previously mentioned, there is often confusion when treating someone with PD as to whether problems around eating and drinking are self-harm or an eating disorder. Not everyone who presents with disordered eating has an eating disorder, and eating disorder focused treatment and inpatient admission can lead to an

escalation in the presentation and a worsening clinical picture (Disordered-Eating-Guidance-Document-September-22.pdf).

Vitally, it is important to consider the effects of starvation and other eating disorder behaviours on the brain. For underweight patients, even in the context of probable PD, refeeding is usually essential. In patients who binge and purge, rapid swings in blood levels of glucose and electrolytes act like drug highs and withdrawal. Attention to nutrition and freedom from purging behaviours can make the brain and mind more responsive to psychotherapy, prescribed medication, and healthy psychosocial rewards (RCP, 2018). For healthy weight patients who have both an eating disorder and PD, the priority may be to address the acquisition of new life skills (Danon et al., 2024).

The RCP (2018) offers the following guidelines around PD and eating problems:

- The consequences of starvation, purging and other eating disorder behaviours, may mimic symptoms of both ASD and BPD. For underweight patients, refeeding is a priority. This makes the brain and mind more responsive.
- When a patient is a normal weight, there may be higher priorities than addressing the eating disorder. Emotional regulation skills offered in several different therapy models help both eating disorder and PD features
- Families and other lay carers should be included in care plans.
- Care plans should be developed on an individual basis, using formulation rather than diagnosis alone to guide management.

**People with lived experience:**

*"Self-starvation or over filling can be used to fill up a hole where self should be".*

*"For someone with a PD, controlling feelings by putting something into the mouth or not can serve a similar purpose to using drink, drugs, or self-harm".*

*"Disordered eating can be present at either end of the spectrum i.e. overeating or undereating".*

# 4) Presentations we may see as Dietitians

## Food & Fluid Refusal vs Restrictive Intake Self-Harm

The term Restrictive Intake Self-harm (RISH) has been coined for a subset of patients. RISH is a formulation-driven term that aims to describe patients who present with restricted intake (of both foods and fluids) as a method of indirect self-harm (Ellison & Philpot, 2024).

A webinar is available (Webinar on Restrictive Intake Self Harm (RISH) and the Role of Nutrition | Sarah Elder ) which lists the similarities and differences between RISH and an ED. It highlights the extreme risks of giving the wrong treatment, citing the risk of death or institutionalism.

Patterns that indicate behaviours are more linked to RISH include:

- Previous intake has involved a range of food, textures, including high calorie foods such as takeaways
- Sudden restriction of both food and fluid
- Aiming to lose weight (often can present at a healthy BMI)
- Open about level of restriction (may underreport food and fluid intake e.g. 200kcal/day)
- Eating problems co-exist with high expressed emotion
- Alternating patterns of eating behaviours, other self-harm, and impulsive behaviours
- Often wants to be in hospital/Requests for nasogastric feeding/a number of hospital admissions which do not appear to resolve the problems

Whilst self-harm can sometimes result in accidental death, usually self-harm is used as a coping strategy e.g., to get the bad feelings out, help the person feel in control, or punish themselves (Wood et al., 2014). Food is used as control and a maladaptive coping strategy. There may be a drive to be thinner, a need to be in control, or display distress. These patients can exhibit total food and fluid refusal quite suddenly and may be the patients who are tube fed under restraint.

They can also be the people who have built a relationship with their medication or disordered eating, and these can become part of their identity. So, if we remove either, there can be a sudden sense of loss and feeling that there is “nothing wrong with me”.

## Anorexia Nervosa and Binge Eating Disorder

A systematic review and meta-analysis indicates that avoidant and obsessive-compulsive PDs are among the most frequently diagnosed PDs in restricting Anorexia Nervosa (AN) and binge-eating disorder (BED), whereas borderline and paranoid PDs are commonly diagnosed with binge eating/purging (Farstad et al., 2016). This is reinforced by another study which indicates that restrictive personality disorders are associated with restrictive eating pathology, whereas impulsive personality disorders are associated with impulsive eating pathology e.g. binge eating disorder (Sansone & Sansone, 2013).

In a systematic review, BED diagnosis has been shown to have a 28% probability of being accompanied by a comorbid PD (Senra et al., 2024).

Binge eating has been identified as a form of impulsivity commonly seen in BPD, with research showing that feelings of emotional emptiness increase pre- and post-bingeing. The authors recommend distress tolerance skills training to treat binge eating within BPD (Hein et al., 2024). Binge eating can also act as self-soothing or a coping strategy to regulate emotions.

**People with lived experience:**

*"Self-harm can be visual. Binge eating can be a hidden self-harm behaviour or coping mechanism.*

*If I feel rubbish I am going to eat and punish myself. If I had an emotionally difficult day I would go home, and binge eat in bed".*

## Purging

Individuals with BPD often engage in dysregulated eating behaviours, such as binge-eating and purging. The tendency to worry about, and expect rejection in most situations, may be involved in this relationship by increasing the intensity and frequency of emotion dysregulation (Selby et al., 2010).

Greater impulsivity is shown among those with bulimia nervosa than those with AN (Farstad et al., 2016).

Using the four core skills of DBT – mindfulness, interpersonal effectiveness, emotion regulation & distress tolerance – has been associated with a reduction in binge-purge behaviours (Safer et al., 2001).

**People with lived experience:**

"There is an emotional hole which needs to be filled physically. It tends to be emotionally driven rather than compulsion driven.

Something inside me can be filled, then emptied. When I eat and eat, I am filled with so much pain that I need to get something out".

## Obesity

There is an association between BPD and obesity, with 27% of obese individuals studied also diagnosed with BPD (Sansone & Sansone, 2013). A 2016 systematic review of PD and obesity shows that having a PD is associated with an increased risk of obesity, with higher risks of severe obesity being seen in those with avoidant or antisocial PD in females (Gerlach et al., 2016). The paper also showed that conservative treatments for obesity tend to be less successful in those of either gender with PD.

It is worth noting that whilst antipsychotics should not be used in the medium or long term treatment of BPD (as per NICE guidance), many patients we support with a PD diagnosis will have current or previous antipsychotic use which can be associated with significant weight gain.

People with PD may struggle with emotional eating and impulsivity around highly palatable foods, leading to erratic eating patterns and poor meal planning skills. Fear of judgement, distrust and a need for validation or approval may lead to dishonesty and selective disclosure of dietary intake. If they are in DBT or have been in the past, using some that language can be helpful: for example, mentioning *distress tolerance* or *emotion regulation* skills alongside emotional eating, or encouraging *mindfulness* when discussing hunger/fullness cues.

Professional input around weight management can act as a way to elicit care, attention and concern for individuals. People may receive support and social contact that they would not otherwise have. This may result in a person with a PD actually creating barriers to weight loss for fear of losing the care as they progress (Felitti et al., 2010).

Keeping in mind trauma history (e.g. food insecurity, bullying around weight or shape) can help professionals see the bigger picture. Motivational interviewing, DBT skills and keeping a trauma-informed perspective on their behaviours can improve engagement and outcomes (McMurran et al., 2013; Gerlach et al., 2016).

**People with lived experience:**

"Be mindful of what it might cost us to give up that behaviour. There is a fragility associated with having either an obese body or a thinner body and it can be a strategy to manage distress. What is behind it?"

## Nasogastric Tube Feeding

Without a clear endpoint, patients can end up for months and even years on nasogastric (NG) feeding, often being fed under restraint. Long term admissions and the use of physical restraint are unhelpful (NIMHE, 2003).

A series of papers have looked at ethical and clinical justifications for how and when NG feeding under restraint is used (Fuller et al., 2024a); NG feeding should only be used in extremis where other less aversive and intrusive options are not feasible or have failed, and even then, employed as little and as briefly as possible (Fuller et al., 2024b). Starting NG feeding under restraint may result in inadvertent worsening of the dynamics, reinforcing the refusal of nutrition, leaving no clear 'exit strategy' to discontinue the intervention.

In clinical practice, it can often be the younger patients in their 20s and below that may be NG fed. One paper highlights that interventions during childhood and adolescence are increasingly shown to be cost effective (Coid et al., 2006). It is likely that we need to be focusing on preventative interventions which may decrease this very restrictive practice.

**People with lived experience:**

"It can often be like I am in competition to be the sickest person. Having a nasogastric tube can be my way of demonstrating how poorly I am. If I need restraining to be fed, this can also be an escalation of my self-harm with the healthcare professionals helping me to self-harm and getting my unmet needs met".

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"At my worst, I am truly in child mode. The feeding tube could be seen as the preverbal stage of child development, with staff holding me as the baby with the bottle".

### Eating Habits

People with PD have often had unstable childhoods which can have a huge impact on eating habits in later life. As health professionals, we need to be mindful of this history and the family narratives when growing up.

**People with lived experience:**

*"I am more focused on my own and other's eating habits than people without PD. I am worried about food poisoning, worried about other people's cooking. I have rules for living around food. My own personal rules. I won't drink milk if it has not been opened that day. People need to have clean souls if I am going to eat the food they have cooked. I know the exact use by dates of not only my own fridge but also my parents' fridge".*

*"We never sat at the table to eat. Education can be quite important. We were raised on Iceland frozen food. There were definite rules about good foods and bad foods. And rules about being thin. If you are thin it is okay, if you are in a bigger body, you are worthless".*

*"If a shop stops selling normal cola, I will go to the next shop and beyond rather than buy a diet cola. These are my antisocial traits coming through as I don't mind diet cola, but nobody is going to make me do something I don't want to do".*

*"If you told me to eat my broccoli and I wasn't going to get up from the table until I did, I would sit there and I would win and not eat the broccoli".*

### Other Presentations

**People with lived experience:**

*"I have diabetic neuropathy. If I eat too much sugar, it causes me pain so sometimes to punish myself, I will eat lots of sugar".*

# 5) The Role of the Dietitian in PD Within the MDT and Suggested Good Practice

Working in a team of at least three people has been suggested as good practice for working with people with complex psychological, social and behavioural difficulties (Wood et al., 2014). People with complex needs are often experiencing confusion themselves, and it becomes particularly important that teams convey consistent messages to service users. Teamwork is vital, not only in being clear about the primary task but also to share responsibility for difficult decisions (Davison, 2002).

It is useful to remind ourselves that we are dietitians and not therapists. Whilst it is important that we understand what factors inform a patient's presentation, our remit is to get the

headline and not the story. For example, if there has been trauma, we don't need to understand the intimate details as to what the trauma might be. Being clear about the purpose of our care is crucial for each episode of care. Using outcome measures such as Therapeutic Outcome Measures (TOMs) at the beginning and end of treatment (BDA, 2021) can be helpful.

People with PD often have complex difficulties and no single treatment intervention is likely to meet their diverse needs. A management plan will usually need to be multi-agency and multi-disciplinary. Features of a successful management plan include a consistent approach with both clear and realistic goals. Having a long-term time frame is also crucial (Davison, 2002).

| **Guidance on Working with Some Common Presentations** | |
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| **Attachment**<br>• Overreliance on the dietitian<br>• Fear of abandonment<br>• Passive engagement<br>• Meltdown, regression or relapse on withdrawal of care | Professional boundaries – establish a relationship that is warm, friendly, compassionate, and non-judgemental.<br><br>You need a purpose to the relationship and a time frame (Wood et al., 2014).<br><br>Plan the ending as you begin. Patients with PD often struggle with transitions and endings, so it can be helpful to agree a structured and phased plan to treatment. NICE has specific recommendations for treatment transitions for BPD (NICE, 2009). Aim to stick to the boundaries agreed at the outset of treatment e.g., four sessions. However, also avoid being overly rigid and if you both agree that one more session would be appropriate, offer some flexibility too.<br><br>Therapeutic contracts. A formal, written contract between the patients and the treatment team can be useful enabling patients to be actively involved in their treatment and responsible for their actions. This can be as simple as the dietitian and patient sitting together at the start of treatment with a blank sheet of paper and agreeing on the principles, goals, and expectations of treatment. Patients need to buy into the contract, and it needs to be based on truth. |

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| | Do what you say you are going to do.<br><br>Take a curious and compassionate approach e.g., “holding the hope”.<br><br>Use behaviour change tools such as motivational interviewing, active listening, and different types of reflections to demonstrate empathy. |
| **Need for validation/attention**<br><br>• Excessive need for validation<br>• Not implementing any changes despite consistent engagement to elicit ongoing care<br>• Flattery as avoidance of responsibility<br>• Shifting focus away from key issues<br>• Can elicit rescue/saviour behaviour in the practitioner<br><br>**Dietitian quote:**<br><br>*“I find there can be an overinflated sense of responsibility which can occur as a clinician when working with patients with PD.*<br><br>*It helps to know that other professionals, and even therapists, can find them a very complex group to work with and don’t always get it right”.* | Be neither overly supportive nor overly demanding i.e. not too close and not too distant.<br><br>Use outcome measures before and after treatment to evaluate your effectiveness.<br><br>Use supervision to explore themes around patients using skills to make abandonment less likely to happen “you are the only one who has ever understood me”. Be aware of the Rescue seesaw Skills and Concepts<br><br>Joint team approach using the formulation.<br><br>If in hospital, consider a less is more approach such as leaving food, drinks in bedroom without staff supervising, patient to keep food in room e.g., biscuits.<br><br>There may be lots of confusion created by a patient which can raise anxiety amongst the team. It can be that you feel as if you are second guessing what the best way forward is. If the team is firmer about boundaries at the end of treatment, it might be that the patient suddenly does really well in an effort to make the team think they should keep them longer. |
| **Avoidance**<br><br>• Missing sessions when overwhelmed or stressed<br>• Deflecting focus from problematic areas<br>• Minimising issues<br>• Emotional withdrawal | Consider different approaches. It may be that you don’t see the patient directly but that you work through the existing clinician involved in their care rather than being “parachuted in” for an ad hoc session. |

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| | Note increased restrictive practice can lead to restrictive intake and prolonged admissions.<br><br>NICE guidelines for BPD (NICE, 2009) highlight developing an optimistic and trusting relationship as a key priority, being hopeful and optimistic about recovery, being consistent, open, and reliable whilst bearing in mind that many people will have experienced rejection/abuse/trauma. |
| **Other Common Presentations**<br><br>• Self-sabotage<br>• Idealisation & devaluation<br>• Interpersonal issues<br>• Emotional dysregulation<br>• Impulsivity<br>• Fleeting commitment | Often service users can feel frustrated and misunderstood. By offering care in a curious and compassionate way, the authenticity of the relationship can come through.<br><br>We need to accept sometimes that people are not ready for recovery or engaged in the most effective psychological intervention, which will limit the capacity for effective dietetic intervention.<br><br>Formulation - People may be unlikely to see things now, but having something written in their formulation created by the team can help for the future. Identifying consistent patterns of distress can enable people to become more conscious and aware about those patterns which need to be broken. Working within the multidisciplinary team, the dietitian can help to support a consistent team approach from the formulation.<br><br>People with BPD and substance use disorders (SUDs) often display fleeting commitment or "butterfly" attachment, characterised by a lack of perseverance with changes and minimal attachment to the practitioner. This is thought to be because social encounters are less reinforcing than substance use for the individual. Putting more emphasis on validation and building rapport – a strategy in DBT – can be effective in the early stages of working with these individuals, before moving onto discussing change (McMain et al., 2007). |

# 6) Guidance on Dietetic Interventions

**Pre-Session / Start of Dietetic Intervention**

Develop an understanding

Joint working with the multidisciplinary team (MDT) should give both the patient and team an understanding around the formulation and clarify what targeted care will look like to tackle the maladaptive behaviours identified. What else is going on for the patient? Is the restriction of food or drink in response to a crisis? Is it reactive or chronic?

Identify goals

Does the person want to change? Why would they want to change? We need as professionals to take on different roles based on the stage of change that the patient presents ( Raihan & Cogburn, 2023). We are trying to get people to identify maladaptive coping mechanisms. If we remove the maladaptive strategy, we need to be mindful how they then replace it. Working with the team to identify DBT strategies can be very helpful to manage distress, emotion regulation, and interpersonal difficulties.

We need to be specific about what treatment we can offer. What are the specific changes/goals/weight restoration we expect? Present this information clearly. People with PD can still be appropriate. Ask the patient what is helpful from their perspective. It may be that goal-based treatment is more helpful than giving a set meal plan.

**During Dietetic Intervention**

Assessment

Try and conduct your assessment with the help of other people involved in the patient's care to gain a broader understanding.

Advice

An individualised approach can help. Some things will work, whereas other things may not. For example, some people might eat more if not observed. The RAVES model can be useful when working with people to develop positive relationships with food. RAVES A4.pdf - Google Drive

It may be that your intervention is simply around reintroducing structure and adequacy. Validating their distress around eating whilst gently cheerleading and promoting problem solving can be a helpful approach.

Challenging behaviour during a crisis can be particularly difficult to manage; it is important to keep in mind what we know about a person's personality traits e.g., fear of abandonment and how this may be informing their behaviour. The aforementioned NICE guidelines are also helpful when dealing with a crisis (NICE, 2009).

**People with lived experience:**

*"In a crisis, you won't be dealing with the 39-year-old patient in front of you, for example, but actually a small child fearing they are being abandoned".*

*"We can be horrible, but we are wanting care. What can help: listening, being calm, try to find out what has set off the behaviour".*

*"Not everyone will act out, others will withdraw. We are all human beings and personality will also come through".*

**Nasogastric Feeding**

Tube feeding should be only considered as a lifesaving intervention. A least restrictive approach should be used e.g. consider bolus feeding as top up feeds, alternate days or limit to one feed daily. If a nasogastric feed is being considered, have an exit strategy pre-agreed with the team and patient e.g. remove tube after one week. Present the weaning off the nasogastric tube plan as an individualised plan. It can help to give it to the patient for them to take away, make their own suggestions and have some say in their treatment.

If there is a need for an advance care plan in place for when someone is in crisis and may need admitting to hospital, the team should develop one with patients when they are not in crisis. If it is a good crisis plan, the patient and team know what they are doing, and this may help to avoid NG feeding in the first place.

**End of Treatment**

For ward-based patients, be mindful of your purpose of treatment. It may be more appropriate to not see the patient for the duration of their stay, by having a time-based episode of care for example.

Try and aim for ending well. Despite good intentions, it may be that a good ending is tricky. People with PD in crisis may want the healthcare professional to fix them and have idealistic expectations, which when not met can lead them to dismiss people.

## 7) Advice from People with Lived Experience

*Prepare your ending from the beginning.*

*I am a man with a PD, not a PD.*

*There can be competition in my head, particularly with others who are mentally ill. Who can self-harm the best? I might engineer things to get my needs met. There can be a degree of one-upmanship. For example, I could learn what I need to do to from a person with an eating disorder and present with these symptoms.*

*Don't always believe me. You may need to take me with a pinch of salt. Approach me with curiosity.*

*I like getting another diagnosis. Collecting another diagnosis gives me validation.*

*We are trying to get our needs met.*

*The intensity of our emotions is f***** big, it's life ending.*

*Be honest with me about what you are feeling at present.*

*I want to build relationship with someone authentic. Be you/be real/be with us. Most important: listen and be alongside me.*

*Engage your curiosity.*

*Goals can be really helpful in agreeing what we are going to aim for. Celebrate every baby step.*

*You can't go back and change the beginning, but you can start where you are now and change the ending.*

*PD is treatable, but it does take time. I prefer discovery rather than recovery.*

# 8) Supervision

Supervision is vitally important. Without access to regular supervision when working with people with PD, there is likely to be a high degree of staff burn out. The use of reflective practice is crucial as is support around managing anxiety and dealing with conflict (NIMHE, 2003). When treating people with a PD, it can often feel as if we are not good enough and supervision can help us not take things personally.

**Dietitian quotes:**

*"A supervisor once told me that patients disclose risk to dietitians because we are empathetic. However, we don't normally have the skills to manage risk independently. I felt I was doing something wrong all the time this happened. Supervision helped me learn better how to hold my own boundaries in session".*

***

*"My first job in mental health was working in a CAMHS unit. I increased the meal plan of one of the young people and they went and sat in their wardrobe and refused to come out. I felt both patients and staff knew I was hopeless at the job, and I felt both anxious and angry towards the patient. Taking this case to supervision really helped me explore my own feelings, to be more curious rather than judgemental and more able to respond in the interest of the patient".*

Try using an emotional thermometer – where do we feel we are with patients (Skills and Concepts)?

Working with adults with unmet emotional needs can often trigger strong emotions such as anger when we encounter a push me, pull me approach. If people are frightened and chaotic inside, getting attention for what they need may feel imperative. As adults we would expect this in emotionally appropriate ways so if other adults are acting in inappropriate ways, it can make us feel frustrated.

Be alive to endings as mentioned above. There may be some negativity experienced at endings which may be the patient laying the groundwork for why they have failed; "look at what you made me do". Alternatively, people with PD can evoke strong reactions such as rescuing, giving us an over-inflated sense of responsibility, which is not helpful when we are trying to help them build autonomy. The rescue blame seesaw is helpful to be aware of (Skills and Concepts).

**Dietitian quote:**

*"As soon as I knew a patient had a PD diagnosis it was feeling like a thorn in my side trying to support them, we then went back to the formulation they had in supervision, and I was able to depersonalise".*

# 9) Conclusion

Hold the hope, be curious, and be compassionate. Be realistic about change and how long it may take. Try and understand what the person with PD is experiencing and what is affecting their present feelings and behaviour.

Be familiar with your patient's formulation of their particular situation. This should be linked to a shared treatment plan with short and longer-term goals. There should be consistency in the team messages e.g., treatment time length, type of treatment.

And finally, look after yourself. Use supervision to take time out to reflect as well as celebrating progress.

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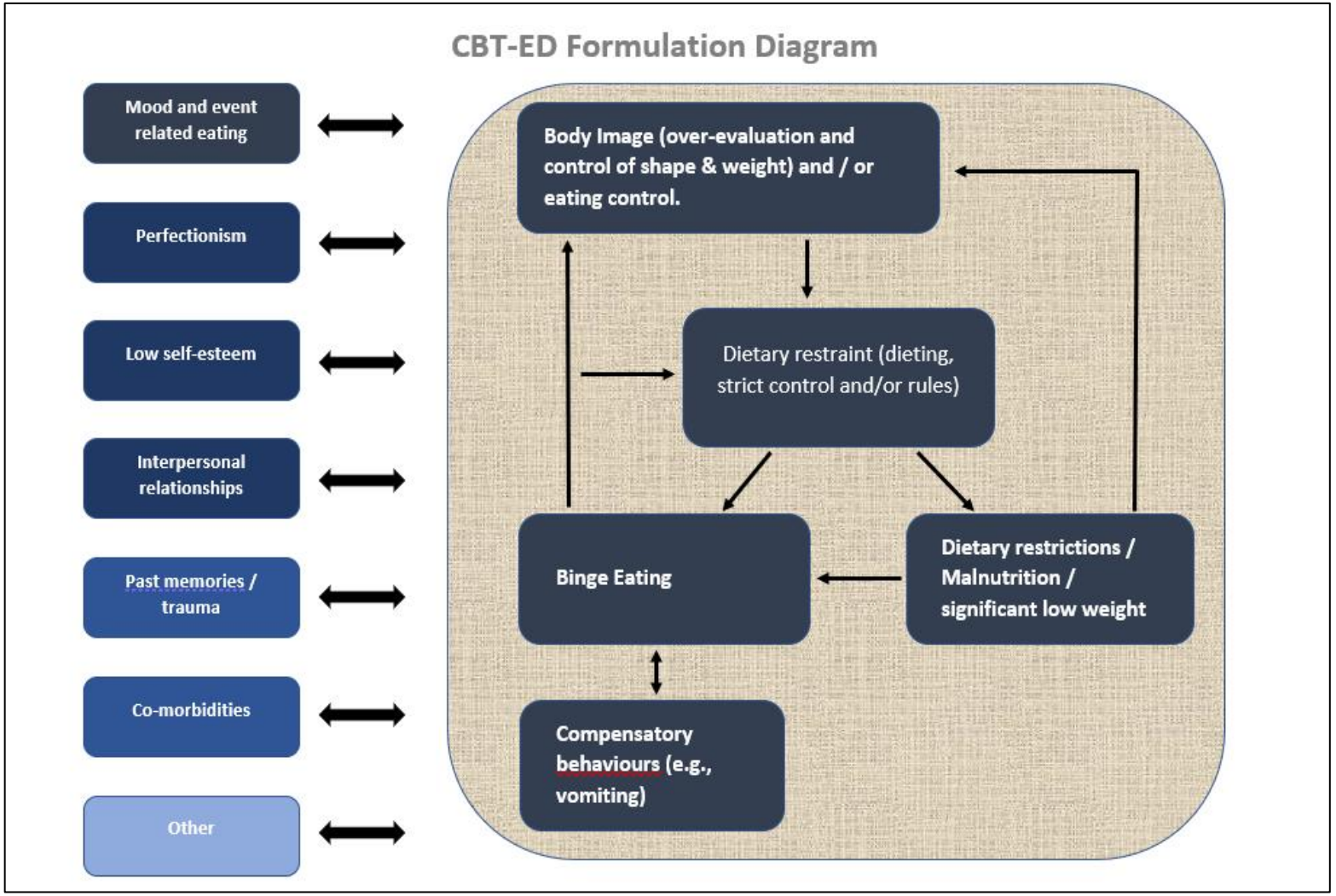
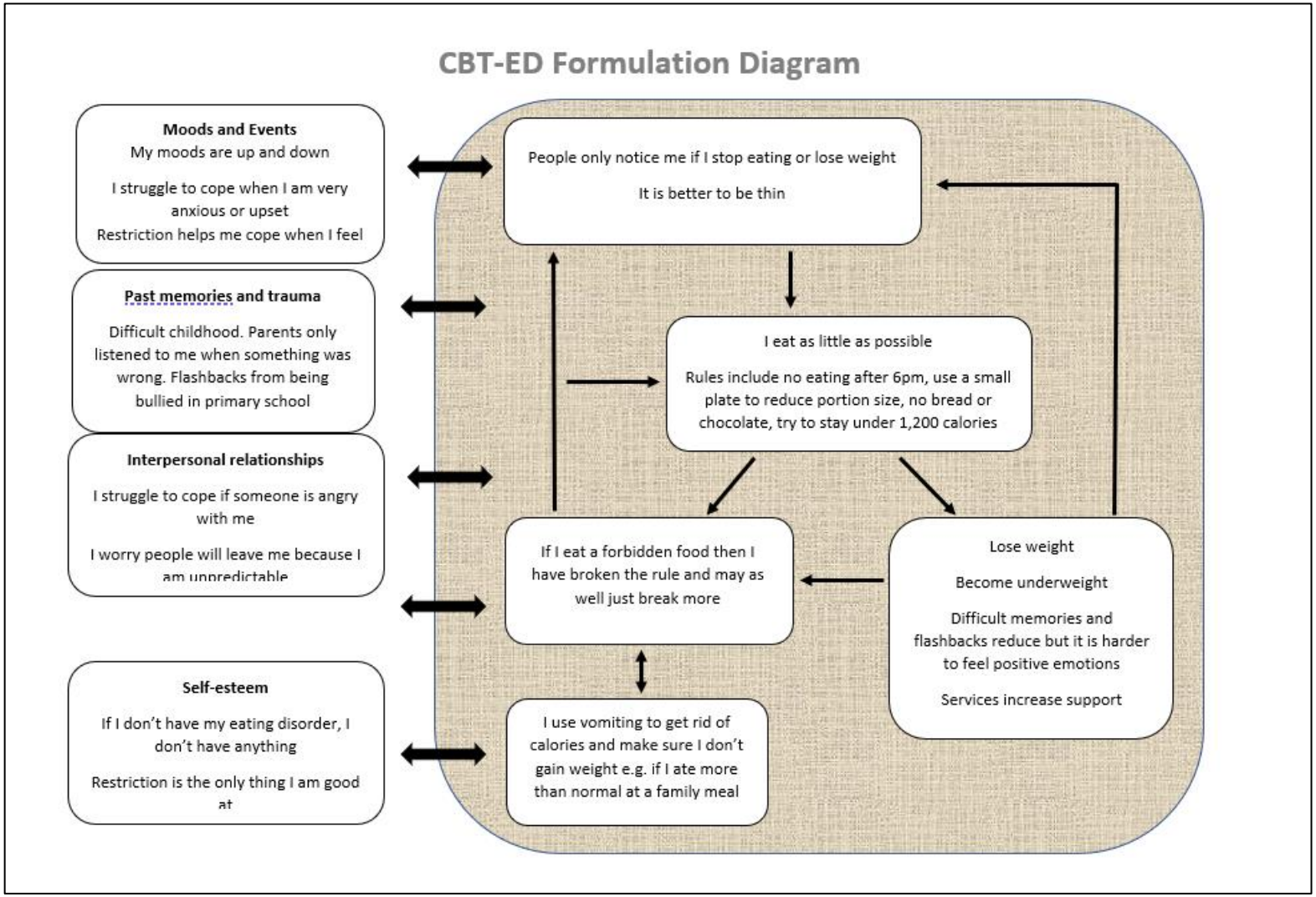
## Appendix A: Formulation Examples

*PD Formulation Template*



*PD Formulation Example*



# Appendix A: Case Studies

**Case Study 1** – *Alan*

**Background**

- 51 yr old male EUPD, Bulimia Nervosa.
- History of sexual abuse. Socially isolated.
- Referred to eating disorder service for support with eating.
- Struggled for many years with eating problems since age 12. Overweight as a child, tried to lose weight which turned into bingeing and purging. BMI 22.4kg/$m^2$.
- Bingeing and purging two-three times a week at referral. Not eating during the day, only drinking coffee then bingeing on crisps, bread, chocolate and ice cream in the evening.

**Dietetic Intervention**

*Purpose of Dietetic Intervention: Regular Eating*

Before Alan started Enhanced Cognitive Behavioural Therapy (CBT-E) it was agreed that we offer four sessions of joint dietitian and Occupational Therapy (OT) input to help him start to introduce a regular meal pattern. This would reduce the chance of binges occurring in the evening.

The focus was on how to do this practically; including planning his food shop, where to eat in his flat, and how to manage ED urges afterwards.

**Outcome**

Alan had some setbacks, including a chest infection, but began to make changes. He was able to have a regular evening meal and began to introduce lunch. Binge and purge frequency reduced. He then moved on to start CBT-E therapy.

**Professional Reflection**

I was aware that Alan wanted to use the full time for our appointments. Some sessions we would agree the goals quickly, but as health professionals we got the sense that using the full time felt important to him. He would often bring up things from his past and seek validation that life had been difficult for him.

I could not attend one of the four sessions with the Occupational Therapist. I let him know in advance, and I decided to let him know why I could not attend (a work event) and personalised it by letting him know that I was a bit nervous about it. The rationale for this, was to challenge the idea he might have that the health professionals have 'perfect' lives, we only ever feel happy, and we do not care about him. This helped to maintain rapport.

Setting a boundary of four sessions was extremely helpful, each week we would reiterate which

session it was and how many were left. He was not having a full regular meal pattern when we finished but he had made progress.

**Case Study 2** – *Amina*

**Background**

- 20-year-old female with EUPD.
- Weight one year ago: 86kg which decreased to 45kg over a year, BMI: 16. Wanting to be skinnier and below 40kg.
- Admitted to inpatient mental health ward for five days stay crisis admission planned by Adult Mental Health Team to help get back on track further to suicidal thoughts and severely restricting food intake. Multiple adult and CAMHS hospital admissions previously with headbanging and self-harm.
- Already on sip feeds at home (two a day), eating cereal bars and consuming +++ fizzy drinks.
- Walking 34, 000 steps/daily.
- The ward referred to adult eating disorders service who agreed to help jointly manage her inpatient admission.
- Parents went on holiday during Amina's admission and asked if daughter's admission could be extended whilst they were away.

**Dietetic Intervention**

*Purpose of Dietetic Intervention: To Facilitate Regular Intake & Reversal of Weight Loss*

Amina and the dietitian made a plan together around regular eating. This included her sip feeds, which the ward had asked her to bring in from home as she was familiar with them.

**Outcome**

Amina was discharged from hospital after a nine-week admission at a BMI of 16, eating and drinking normally. Step count 15,000/day.

On discharge, a meal plan for the community was given to Amina of 2200kcal/d to aim towards. A request for sip feeds was made to the GP of one further month only.

**Professional reflection**

On admission, there was a push from the ward for Amina to be admitted to a specialist eating disorder unit. However, the eating disorder team felt that her presentation was more disordered eating as a result of EUPD rather than an eating disorder. Amina has since been referred to the Trust's specialist PD service.

In hospital it seemed as if she regressed. BMI during admission decreased to 14. She asked to be tube fed (appeared to be means to validate her distress).

Drinking decreased on the ward and the team felt prolonged admission would be unhelpful. Glucagon injection to treat severe hypoglycaemia needed to be administered but Amina started

refusing glucagon so was taken to the acute hospital. She started eating and drinking again, then started tying ligatures and was put on constant observations

Whilst the aim was to avoid a prolonged admission in a restrictive environment, we acknowledged the escalation of risks in hospital since admission. Amina had limited capacity for dietetic input as she was not able to engage in any work whilst in crisis.

The formulation was discussed with the team. Her needs were being met despite being dysfunctional, presenting as a frail little girl who needs to be cared for and eliciting care. Having an eating disorder seemed much more acceptable to this patient than EUPD.

We did manage to avoid nasogastric feeding despite the downwards weight trend, noting some of this would be fluid loss. Part of the dietitian role was to take a backseat in treatment as Amina was not engaging but she did enjoy being seen by the dietitian so a less is more approach was taken, checking in instead with the ward and supporting the MDT who were working hard on supporting Amina to reconnect with her interests outside.

There is very little community dietetic support available where Amina lives but this was also decided not to be the right service for her and instead the emphasis was on DBT strategies. The AMHT were given a copy of the meal plan made with Amina to support her getting back on track and she has since been regaining weight in community, awaiting assessment from our complex needs team.

**Case Study 3** – Kayleigh

**Background**

- 27-year-old female on an enhanced low-secure forensic ward.
- Admission BMI of 64.7 kg/m². Detailed weight history shows BMI of 34.2kg/m² from age 18, 10 years prior.
- Mental health diagnosis of EUPD. Prescribed clozapine, sertraline, and lithium for mental health.
- Diagnosed with T2DM (HbA1c of 51mmol/mol), managed with metformin and (soon after admission to our service) tirzepatide.
- Transferred to high-secure unit due to challenging behaviours including the increasing risk of assaults and violence, continuous self-harm, making improvised weapons, mood instability, manipulation, and attention-seeking behaviours.
- Following this was stepped down to medium-secure for a year, leading up to current admission. She had been much more settled but still avoidant, with poor engagement with many staff including the dietitian psychologist & OT.

**Dietary Intervention**

*Purpose of Dietetic Intervention: Weight Management*

I worked with Kayleigh over a 6-month period. In the early stages I arranged meetings with our clinical psychologist, physical fitness practitioner, OT lead, and ward doctor to discuss how we should approach a weight management intervention. We had never had a patient with such a high BMI on our caseload before. We concluded that a combination of 1:1 dietetic work, psychological support around weight management, and ward-level health promotion strategies / targeting the '*ward culture of unhealthy eating'* was the best option.

The initial aims of the dietetic intervention were to build trust and rapport in a deliberate way using ice breakers at the beginning of each session, and to emphasise a patient-centred approach that shifts focus towards using non-weight measures of progress. Nutrition education was also part of our sessions, followed by the exploration of potential dietary changes.

Kayleigh was prescribed tirzepatide soon after our first session, primarily for glycaemic control with a secondary aim of weight management.

**Outcome**

Kayleigh attended our first three sessions, but engagement was felt to be superficial. She was avoidant and dismissive of conversations relating to the relationship between mood, emotions, and her eating behaviours. Things progressed to avoidance with her signing herself out for planned sessions, which became a theme for both psychology and most of the MDT.

On a surface level, we had someone who is presenting with challenging and oppositional behaviours choosing not to engage in treatment that can help her with her goals and physical

health. On a deeper level however, it was likely that food, obesity, and the attention/support that these bring are serving some underlying function for Kayleigh. She reported getting a lot of attention from peers and staff in the few weeks after starting tripeptide and commented that she wondered if her family would notice.

Kayleigh still achieved significant weight loss. 20kg / 11.9% weight loss in 3 months, with BMI reducing from 64.7 to 57.0kg/$m^2$. She also reported improved stamina, mobility, and confidence, as well as improved HbA1c & sleep quality. However, her engagement with dietetics never improved despite support from her parents.

Some observations:

- During a previous placement, Kayleigh reported being raped as a teenager. Sexual assault during childhood or adolescence can be associated with later obesity (Felitti et al., 1991). There is the potential that obesity for her is both physically protective ("*people leave you alone*") and sexually protective ("*men won't bother you*").
- There are reports of Kayleigh foraging for food in bins in the streets with her sister when she was a young child. This suggests she experienced food insecurity, which has been shown to be strongly associated with obesity, disordered eating, and binge-eating (Carvajal-Aldaz et al., 2022; Hazzard et al., 2022).

**Reflections**

I think the biggest learning point was the importance of getting to know the psychological functions of obesity, weight gain, and eating behaviours. Right from admission Kayleigh was getting a lot of attention because of her weight. Her disengagement may have been a way of her expressing that she did not feel ready for the withdrawal of care associated with successful weight loss.

Having an empathic and non-judgemental approach does not automatically equate to ongoing engagement – understanding behaviour is essential. Resistance or lack of progress is an invitation to explore new strategies or perspectives rather than a reason to feel discouraged.

**Case Study 4** – *Ana*

**Background**

- 40-year old female referred to community eating disorder intensive services following weight loss from 111kg to 55kg over six months and continued weight loss. Referral BMI 19 and irregular menstruation
- Trying to limit self to 300-500kcal/day, however bingeing and purging most evenings. History of self-induced vomiting and use of laxatives. Self-harm/purging decreases when intake decreases. History of domestic abuse and complex trauma and diagnosis of EUPD.
- Single parent with a daughter with profound needs.
- Reporting she wants to stay out of hospital as reason for input.

**Dietetic Intervention**

*Purpose of Dietetic Intervention: Reverse Weight Loss, Reduce Purging & Establish "Normal Eating"*

As part of a multidisciplinary approach, Ana was offered dietetic support. A goals-based approach was taken. Ana at first did not want a meal plan saying to the dietitian it had not worked in the past. However, she then told other people from the team that she did want a meal plan. A very general meal plan was drafted together with Ana.

Her goals initially were to eat more normally. e.g., be able to eat with her daughter and have food freedom including be able to eat food spontaneously.

Weight and BMI were discussed each session, using a weight graph, with the aim being to stop any further weight loss. Ana was able to have discussions about being a healthier weight to enable her to be both biologically and mentally healthy.

Self-monitoring records were discussed at each appointment and Ana found these really useful to look back on and acknowledge her progress as well as working on writing rational thoughts to help bat the eating disorder thought away. Towards the end of treatment, Ana started reporting her intake was drastically reduced, asking for more intensive input from the team, including extra appointments and more meal support. This coincided with the school holidays and various date anniversaries.

**Outcome**

Ana decreased the purging, although near discharge from treatment, this started to increase.

Weight was stabilised and Ana was a BMI of 20 on discharge. In the last week of treatment, Ana gained 1.5kg within the week. Ana was discharged from the eating disorder team and has since started mentalisation based therapy.

**Reflection**

Ana could be very reflective in sessions, acknowledging she put emotions on her food which ended up in having a plate of fear that she needed to eat.

As a team, we were mindful of Ana becoming more dependent on us and at one stage it appeared that we were making her worse as she started asking for more meal support, went on sick leave from her job and was keen to have a treatment extension. Sticking to the boundaries agreed at the start of treatment, we worked together to give a kind but clear message and end well with Ana back at work, weight stabilised and meeting the goal of avoiding a hospital admission.

**Case Study 5** – *Milly*

**Background**

- Milly has had several diagnoses on her patient records including emotional dysregulation, eating disorder, disordered eating, depression, emotionally unstable personality disorder, and autistic spectrum disorder.
- The team's current working diagnosis is EUPD avoidant and anxious traits. She reports to having autism and does not want to have a PD. Eating disorder symptoms have been conceptualised as a form of deliberate self-harm.
- Currently aged 27. First presentation to the CAMHS ward aged 17 with an overdose. Nasogastric tubes since inserted over the years following a refusal to eat and drink, with a mix of admission to general hospital, general mental health wards and specialist eating disorder units.
- Milly had been referred to the Complex Needs personality disorder team and is due to start PD treatment within a therapeutic community.
- Current presentation: overdose and complete refusal to eat with minimal fluid intake. Presented in crisis with deterioration of mental and physical state due to restricting oral intake. This required admission into the general hospital and nasogastric feeding commenced. Informal transfer onto general mental health ward with Milly consenting to admission and treatment, including NG feeding. BMI was 19 on admission. Milly has since refused for any further weights to be taken.

**Dietetic intervention**

*Purpose of Dietetic Intervention: To Wean off NG Feeding*

On admission to the mental health ward, Milly was changed from pump feeding to bolus feeds. It was agreed with the team to facilitate a bolus feed of a 2kcal/ml sip feed twice daily. Additional fluid was given by the NGT. No restraint was needed.

The dietitian met Milly and discussed three options:

- staying on the NG tube and being discharged back into the community,
- taking the plunge and starting to eat that day or
- working with the dietitian to transition onto oral sip feeds.

Milly was given some time to think about this and chose the transition to oral sip feed route. The dietitian gave Milly a suggested plan to look through overnight and make any changes with a view to starting the next day. The dietitian suggested a timeline of a week and in the end, it took 10 days, with a few delays caused by the wrong flavour of sip feed being available and Milly feeling she was not getting the right amount of support from the nursing staff. This was quickly managed.

All sessions with the dietitian were planned and booked in advance with Milly and the nursing team.

**Outcome**

Milly was successfully weaned off the nasogastric tube to drinking the sip feed orally. She increased fluid intake and was discharged on oral sip feeds with a request to the GP for a month prescription only of sip feeds.

The dietitian encouraged Milly to do problem solving e.g. increasing fluid intake – Milly suggested her relatives bring in her water bottle and increased her fluid intake.

Prior to discharge, a plan was made with Milly around the transition to eating solid food in the community.

**Professional reflection**

The team were keen to have a quick admission and transfer Milly back into the community on NG feeding. This would have presented all sorts of problems, with community teams unwilling to take on the management of the NG tube and feeding plan.

Working together with joint sessions to wean onto oral intake between Milly, the inpatient dietitian and nursing team, giving consistent messages, being boundaried but giving Milly options seemed a better approach. Initially the ward team were checking bloods daily and the dietitian was able to advise on reducing this frequency, particularly as this was overly medicalising Milly's presentation.

Milly was offered a choice by the dietitian of when she would have the NG tube removed (either after the last feed on the oral transition plan or the next day, she chose the latter).

Milly's behaviours escalated towards the end of admission with the team informing her of a discharge date which she felt was too soon and her behaviour escalated, refusing oral intake, tying a ligature and being put under section. This resulted in the discharge date being postponed by five days.

The dietitian had planned five sessions with Milly. However, after our last session, where we focused on ending well and next steps towards normal eating in the community, Milly sent the dietitian an email saying she needed to reveal something. The dietitian discussed with the nursing team who felt it would be useful to know, and they felt Milly had engaged well with the dietitian. We decided to meet Milly to see what she wanted to reveal. She had been buying weight loss drugs on the internet and had a large supply of them at home. The dietitian supported Milly making a plan around what to do with the medication which Milly then communicated to the team and her family. It is probably worth noting that even as an experienced dietitian, there is a certain amount of satisfaction in being given the saviour role by patients with PD.

Although the nutrition given was below Milly's energy requirements at 1600kcal/d, we felt as a team that in terms of least restrictive practice, the purpose of the dietetic intervention was to wean her off the nasogastric feed, ensuring adequate energy and fluid intake.

For this case, it was very much "choose your battles". Transitioning onto sip feeds in hospital was a good enough outcome. Transitioning onto solid food could have taken at least another two weeks and the team were united in the belief that staying even longer in hospital was not helpful. Also, ideally we would have had weekly weights. Sometimes patients will agree to MUAC measurements if they refuse being weighed. In this case, we took a low-key approach as knowing Milly's weight was not going to change our treatment plan and based on past weight pattern, Milly's BMI tends to go back to a healthy range in community when she is not in crisis.

This felt like a very satisfactory episode of care although I did need to rein myself in from the saviour role. What seemed to work was the clear timeframe, involving Milly in treatment decisions. It seemed at times as if she had dug herself into a hole and this approach appeared to help her get back on track.