Binge Eating Disorder: Breaking Down Patient-, Provider-, and Public Policy Barriers to Detection, Treatment Access, and Engagement

**Supplementary Material**

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**SUPPLEMENTARY MATERIAL**

## Supplemental Material S1

# S1 Patient-, Provider-, and Systemic Barriers to Binge Eating Disorder Detection, Treatment-Seeking, and Treatment Access and Engagement

# S1.1 Barrers to Binge Eating Disorder Detection and Diagnosis

#### S1.1.1 Patient-Level Barriers

Patient-level barriers to BED identification generally include deficient self-recognition (often due to miseducation about who can have BED and the validity of BED as an autonomous DSM mental health disorder as well as attending to weight gain, gastrointestinal issues, and other physical ailments associated with BED rather than the underlying psychopathology (e.g., emotion dysregulation, trauma history, negative affect and negative urgency, often likely related to self-denial)), deflecting/avoiding self-identification (often related to self-stigmatization about having an ED or mental health diagnosis), and missed opportunities for detection (often related to marginalization, racism, and stigmatization that can cause marginalized individuals to avoiding healthcare systems or avoid discussing binge eating behaviors with healthcare providers) (**Figure 1 (Also Figure S1 below)**)(1).

#### S1.1.2 Provider-Level Barriers

Provider-level barriers to BED identification generally relate to deficits in detection, screening, and diagnosis that stem from healthcare provider biases and deficient provider education and training on BED (**Figure 1/S1**)(1).

#### S1.1.3 Systemic Barriers

Systemic barriers to BED detection are generally similar to patient-level barriers and include stigmatization, lack of education and awareness about BED (specifically related to its overall prevalence, demographic prevalence, validity as a DSM-5 mental health diagnosis, potential severity, full prognosis, including symptoms and consequences, and low media representation), and prioritization of physical health and appearance over mental health (**Figure 1/S1**)(1).

### S1.2 Barriers to Seeking, Accessing, and Engaging in Binge Eating Disorder Treatment

#### S1.2.1 Patient-Level Barriers

Patient-level barriers to BED treatment-seeking, access, and engagement generally include insufficient resources to find, coordinate, and receive care, including deficiencies in: knowledge of treatment resources (e.g., treatment approaches, options, providers, centers, insurance coverage policies, and financial aid options/resources); time required to seek, access, engage in, and coordinate interdisciplinary care; financial aid options to help cover treatment costs; insurance coverage; transportation to- and from treatment; geographic access/proximity to treatment resources; ED provider specialists (and long waitlists); and resources to coordinate communication between multiple providers in a multidisciplinary team. Negative expectations about treatment can also hinder patient treatment-seeking and engagement by resulting in healthcare system avoidance due to perceived stigmatization, marginalization, healthcare inequity based on race, gender, and ethnicity; and due to shame, self-stigmatization and denial about having BED, an ED, and/or a mental health diagnosis. Fears about facing treatment hardships, letting go of the coping/eating behaviors (often associated with trauma/adversity), and “sticking with” treatment when it becomes difficult are also relevant patient-level barriers to treatment-seeking and engagement (**Figure 1/S1**)(1).

#### S1.2.2 Provider-Level Barriers

Provider-level barriers that can prevent an individual with BED from seeking, accessing, and engaging in treatment largely pertain to stigmatization from healthcare providers and insufficient resources to assist patients in finding/coordinating care, including deficiencies in provider education and training on BED treatment approaches and options, specialists and treatment centers, and financial aid resources as well as insufficient provider use of referrals for ED specialists, insufficient provider assistance in coordinating care, and insufficient compliance with empirical support for rapid response/behavior change within the first 3–4 treatment weeks (**Figure 1/S1**)(1).

#### S1.2.3 Systemic Barriers

Systemic barriers to BED detection are generally similar to patient-level barriers and usually include insufficient resources (and knowledge of resources) to find, coordinate, and receive care (as identified in section 1.3.1) and stigmatization occurring at the levels of the healthcare providers/systems and systemically (**Figure 1/S1**)(1).

## S1.3 Figure 1/S1

Figure 1/S1: Theoretical Model of Patient-, Provider-, and Systems-Level Barriers that can Impede BED Identification (Stage 1), Treatment-Seeking (Stage 2), and Treatment Engagement (Stage 3).

A screenshot of a diagram

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**Figure 1:** Theoretical model of where, when, and how patient-, provider-, and systems-level barriers that can impede BED identification (Stage 1), treatment-seeking (Stage 2), and treatment engagement (Stage 3), as spontaneously identified by 64% of BED experts (9/14**)**.

## Supplemental Material S2

## S2 Free, One-Stop, Online Resource Platform for Individuals with Binge Eating Disorder (Section 2.3)

Here (and in section 2.3 of the main text), we propose the need for a free, one-stop, online resource platform that aligns with the aims proposed above (e.g., campaigns aiming to reduce stigmatization and promote BED education/awareness, self-identification, treatment-seeking, and treatment engagement). The primary rationale for this proposition is that individuals with BED, friends and family members acting on their behalf, and healthcare providers cite insufficient resources to find and coordinate care as a barrier to BED treatment-seeking, access, and engagement (1-3). Thus, it follows that a single/unified free, easily accessible, one-stop, online resource platform could simplify treatment-seeking and thus increase treatment access and engagement by providing all resources an individual with BED may need to navigate and manage their disorder. Additionally, this proposition recognizes the importance of early intervention and rapid recovery in BED treatment success (2, 4) and aims to provide resources in such a way that an individual who suspects s/he may have BED can easily learn more about BED, access diagnostic tools and screening resources, self-screen, and seamlessly access scalable resources on BED management and care. The resources for management and care could include resources for: a) a variety of scalable treatment options; b) addressing misconceptions, stigmatization, discrimination, and biases at the levels of the individual (self-stigmatization), healthcare providers and systems, and the general public; and c) coordinating care and communication across a multidisciplinary team of providers (which patients and providers identify as a barrier to treatment-seeking, access, engagement, and success)(1, 3). The overarching goals of this proposition are outlined below.

### S2.1 Companion Resources that Support Public Education Campaigns About Binge Eating Disorder

First, the online resource platform suggested above should contain informational resources that complement the aims of the BED public education campaign proposed in Section 2.1.

### S2.2 Screening Tools for Binge Eating Disorder Self-Identification

Individuals with BED may benefit from having access to an online platform that provides free online screening tools as well as other resources that enable self-screening and self-identification. The proposed screening tools may include the five outlined below; however, this is not an exhaustive list (5).

1. The ED Examination-Questionnaire (EDE-Q, full or brief) (6, 7).
2. The Binge Eating Scale (BES) (8-10).
3. The Eating Beliefs Questionnaire (EBQ, full or brief) (11, 12).
4. The Questionnaire on Eating and Weight Patterns-Revised (QEWP-R) (13).
5. The Yale Food Addiction Scale 2.0 (14-16).

It may also be beneficial to preface the screening tools with the diagnostic criteria for BED, as defined by the DSM-5 (17).

### S2.3 Scalable Treatment Resources

Given the importance of early intervention and rapid recovery to BED treatment success (2, 4), individuals with BED may also benefit from having access to a resource platform that can facilitate a seamless transition from engagement with screening resources to scalable treatment resources, particularly for individuals who screen positive for BED (thus helping to facilitate rapid intervention and recovery). It may be beneficial for such a platform to provide a variety of scalable treatment options and resources, including information on the importance of early intervention and rapid recovery (2, 4). Such a platform may also do well to include the information outlined below.

1. Financial aid options.
2. Insurance provider policies and coverage.
3. Navigating insurance.
4. Provider and Treatment resources (described in Proposition #1, Aim 4 above).
5. Treatment options that do not require financial aid or insurance coverage. This may include resources that are:
   1. Free or low-cost.
   2. Overcome transportation limitations (e.g., accessible remotely, virtually accessible, or local/community-based treatment options).
   3. Offer flexible , self-guided time and pace options.
   4. Socioculturally and sociodemographically sensitive and inclusive (e.g., through community-based approaches that honor patient narratives and emphasize the importance of justice, equity, diversity, and inclusion as well as validation and non-oppression).
   5. Sensitive to the specific needs of individuals with BED.

### S2.4 Resources for Coordinating Communication and Care Across Multidisciplinary Providers

Here, we suggest individuals with BED may benefit from having easy access to a resource platform that can help alleviate the patient burden of coordinating communication and care across multiple providers in multiple fields and levels of care. This burden is cited as a barrier to treatment-seeking and engagement in Bray et al., 2024a, b, and other literature sources identified therein (1){Bray, 2024 #7963}. This aim can be accomplished through the use of secure login pages that patients and providers can access, enabling providers to document and communicate specific care notations to the patient and other providers on the care team. The ability to access and comply with a variety of free/low-cost self-paced treatment options (e.g., BED-specific mobile applications) can also be beneficial. This possibility can be particularly helpful for patients who receive care from multiple providers working within different networks or facilities (e.g., a patient who utilizes the help of a primary care provider through his or her insurance coverage/network, an out-of-network/out-of-pocket therapist, a responsive mobile application to track his/her food/eating thoughts and behaviors, and separate mobile application to manage his/her diet/nutrition, weight, and health goals) and is responsible for coordinating communication and care between these various provider modalities.

### S2.5 Resources for Individuals with BED who Experience Stigmatization

Individuals with BED may also benefit from having access to free online resources that they can use to navigate experiences of stigmatization, discrimination, misunderstanding/misconceptions, and/or biases based on their ED, BED, or mental health diagnosis, eating thoughts and behaviors (perceived or real), and/or body weight, shape, or size – either within themselves (e.g., self-stigmatization, guilt, and shame) or through engagement with healthcare systems and providers, mass media, and general public exposure and interpersonal relationships and encounters (1, 3, 18). In addition to providing information on stigmatization and its impacts on individuals with BED, a one-stop resource platform may also include resources for healing and reducing stigmatization at the levels of the individual/self, interpersonal relationships, healthcare systems and other instructions, and mass media and general public (19, 20).

### S2.6 Resources for Healthcare Providers

Individuals with BED can also benefit from the creation of free online resources for healthcare providers that address treatment barriers that exit at the level of healthcare providers and systems but have impacts at the patient level. These issues include those related to BED stigmatization and disparities in BED recognition, screening, and detection at the level of healthcare providers and systems (addressed in sections 2.4 and 2.4.1 in the main text). This possibility can help reduce provider-level treatment barriers and their impacts on individuals with BED, and may also reduce the patient-level avoidance of healthcare systems that occurs in response to the stigmatization and inequity in these systems.

Healthcare provider education resources should also include the following resources, in one free, one-stop, online platform:

1. Information on stigmatization (18, 21-25), weight bias (18, 21, 22, 26-30), under-screening (18, 21, 22, 25-28, 31, 32), and inequities in detection and screening within healthcare systems.
2. Information on treating BED (e.g., laboratory work that might be helpful, referrals, and follow-up for individuals with BED to appropriate care options)(2, 33-37).

These resources should also be accessible to individuals with BED, should they wish to share them with their healthcare provider(s), though should be offered with an acknowledgement that healthcare education around these issues is not the responsibility of the individuals/patients.

### S2.7 Feasibility and Other Relevant Considerations

Importantly, several online resource platforms do exist that are similar to the one-stop platform we propose here. We have outlined four (4) below; however, this is not an exhaustive list.

* The National Eating Disorder Association (NEDA) website (38) contains information about a variety of different EDs (including BED), including information on signs and symptoms of BED, screening tools, insurance and legal information/resources, a treatment/provider directory, free and low-cost treatment options (including social support group directories), information on identity and EDs that pertains to socio-demographic minorities and marginalized populations, information on weight stigma and its impacts on mental health, an ambassador program (to champion treatment successes) and professional development courses and resources for providers.
* The Eating Disorder Coalition website (39) has information on EDs, including their prevalence in minority and marginalized populations as well as an ambassador program and a variety of resources on parity and insurance, including Medicare and the Anna Westin Act. However, this site caters more to research and policy than to individuals who experience EDs.
* The Eating Disorder Foundation website (40) offers information on EDs (including BED) that includes signs and symptoms, treatment options, including free and low-cost options and support groups, and mentorship programs.
* The Mayo Clinic (41) offers patient and provider resources specific to BED, including information on symptoms, causes, risk factors, complications, diagnosis (including relevant laboratory workup), treatment approaches/options (including standard treatment options as well as “lifestyle and home remedies,” “alternative medicine” approaches, coping and support, and Mayo Clinic providers).

Various commercial treatment centers also offer websites with all or some of the information we suggest including. Here, we propose that individuals with BED may benefit from having one definitive unified and streamlined resource platform that combines the aims identified here, rather than having several unvetted piecemeal resource options. Importantly, we do not suggest a consensus on how BED should be conceptualized or treated. Rather, we suggest that individuals with BED could benefit from having a one-stop online resource platform within which they can learn about the various existing conceptualizations of BED and use that information to explore treatment options suitable to their needs and circumstances.

In support of the feasibility of the online resource platform proposed here, we again point to the Anna Westin Act of 2015 ([H.R. 2515](https://www.congress.gov/bill/114th-congress/house-bill/2515), [S. 1865](https://www.congress.gov/bill/114th-congress/senate-bill/1865)) and its precedential call for NIMH and SAMHSA funds to be used to train healthcare professionals and school personnel to identify EDs and intervene early (42). Similar policy to provide funding for a free, easy-access, one-stop, online resource platform for BED could have great public benefit.

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