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

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**Abstract**

Binge eating disorder (BED) is an autonomous DSM-5 mental health diagnosis with high lifetime prevalence rates and a complicated health sequalae that significantly impairs quality of life. Standard of care interventions for BED have low treatment success rates (38–44%), high recurrence rates (49–64%), and early discontinuation of care. Moreover, 93–97% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for formal treatment, and 56–87% never pursue or receive standard treatment, due in part to a variety of treatment barriers. Bray et al. (2024) provides an in-depth review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment access and engagement (stage 3) at the levels of the patient, healthcare providers/systems, and the general public. Here, we propose a multifaceted approach to comprehensively address these barriers. Our approach involves targeted campaigns directed at three distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. These campaigns should focus on dispelling stigma and raising awareness about BED prevalence, demographics, treatment options, and funding avenues. Incentivizing provider education through certifications, enhancing financial aid and insurance coverage, and establishing user-friendly online platforms that consolidate resources and multi-provider communication can further mitigate these barriers. Additionally, allocating research funding is imperative to develop and test new treatment modalities that are: 1) free or low-cost; 2) remote/virtually accessible or community based; 3) socio-demographically sensitive and inclusive; and 4) sensitive to the unique experiences of individuals with BED. Here, we suggest five major propositions and discuss current literature findings and public policy campaigns that support them. Overall, our proposals align with existing literature, endorsing collaborative efforts that involve healthcare, public policy, education, and research to combat BED barriers and improve BED detection and treatment-seeking, access, engagement, and success.

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# Introduction

# Binge Eating Disorder is a Prevalent Global Health Problem that Often Goes Undetected

Binge Eating Disorder (BED) is an autonomous DSM-5 mental health diagnosis defined by discrete, 2-hour episodes of rapidly eating objectively large amounts of food (more than most people would eat under similar circumstances and/or past being full) with a sense of loss of control, accompanied by distress, guilt, and shame that occur at least once weekly for at least three months (1). The disorder is linked to high lifetime prevalence rates (4.5–31% (2, 3)) and complex health sequelae (anxiety, depression, obesity, cardiovascular disease, diabetes) that significantly reduce quality of life (2, 4-8). Standard of care interventions for BED include cognitive behavioral therapy (CBT), behavioral weight loss, interpersonal therapy, and medications (9). However, these interventions have low treatment success rates (38.3–43.6% (2, 4)), high recurrence rates (49–64% (2, 10)), high treatment dissatisfaction (11), and high rates of early dropout (11). Furthermore, 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67.3% fail to recognize the need for formal treatment, and 56.4–86.8% never seek or receive standard treatment, due to a variety of treatment barriers (2, 12-15).

Bray et al. (2024) provides a critical review of barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment access and engagement (stage 3) at the levels of the individuals who experience BED, the healthcare providers/systems who care for individuals with BED, and the broader public sphere shaping the environment BED exists in (**Figure 1**)(15). These barriers encompass a wide spectrum, including denial/self-stigmatization, prioritization of physical complications over underlying psychological issues, miseducation about who can have BED, demographic disparities in healthcare utilization, stigmatization from healthcare providers, insufficient provider education and training on BED, insufficient BED screening, limited resources for finding, seeking, and coordinating care, eating disorder (ED) provider scarcity and wait lists, geographic access challenges, treatment costs, inadequate insurance coverage, and negative expectations/fears related to treatment outcomes.

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

### Barrers to Binge Eating Disorder Detection and Diagnosis

#### 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**)(15).

#### 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**)(15).

#### 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**)(15).

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

#### 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**)(15).

#### 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**)(15).

#### 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**)(15).

## Our Proposal for Hope

Here, we propose a multifaceted approach to comprehensively address existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment access and engagement (stage 3) at the levels of the patient, healthcare providers/systems, and the general public (**Figure 2**).

## Proposed Solutions to Treatment Barriers: Systems-Level Public Policy Interventions

The treatment barriers identified in Bray et al. (2024) and elsewhere emphasize the need for systems-level solutions to improve BED detection, screening, diagnosis, treatment-seeking, and treatment access and engagement. Our proposed emphasis on systems-level public policy solutions to overcome or minimize patient- and provider-level barriers aligns with findings from Bray et al., 2022 and others, in which several environmental factors identified as contributing to BED are also described as public policy issues (e.g., systematic oppression, marginalization, economic and food insecurity, stigmatization and its psychological impacts, social messaging and social media, and “predatory” food industry practices and environments (16)) (16-20). For example, in Bray et al., 2023, one BED expert noted:

*“…with tobacco, we were working on these treatments, and pharmacology, and all these sorts of things, and we really didn’t start to see drops in [tobacco use] until we changed the tobacco environment. … Leaning on a public health perspective ...if you can have a more optimal environment … that allows our individual treatments to have a better chance for success. Because if you’re trying to use … individual treatments to combat a [public policy issue], that’s a really tall order,” (16).*

In further support of the need for public health and public policy solutions to overcome BED treatment barriers – including detection, screening, diagnosis, treatment-seeking, and treatment access and engagement – we first point to literature identifying BED as a highly undetected disorder (e.g., 93.4–96.8% of individuals with BED are never formally diagnosed, 67.3% do not perceive the need for treatment, and 56.4–86.8% never pursue or receive treatment (2, 12, 13)). The lack of recognition/detection, diagnosis, treatment-seeking, and engagement can exist for a variety of complex reasons (**Figure 1**), most of which are systemic, occurring at the levels of healthcare providers/systems and the general public at large, often contributing to patient-level barriers in turn (15).

To exemplify, Johns et al.’s 2019 systematic review and thematic synthesis of current ED healthcare services found that “for individuals with EDs, the primary care service was described as an ‘obstacle’ or ‘barrier’ to care, rather than the first port of call or effective ‘gate-keepers’ to specialist services,” (21). Johns et al. also found that for family and friends of individuals with EDs, “help-seeking was initially sought in primary care or community settings” but were generally not effective/helpful and “self-help books, internet resources, support-based organizations [and/or] private treatment were where most of the ‘useful help’ was located.” Similarly, Bilic (2020) found that “lack of knowledge and experience among health professionals from outside the ED fieldmay contribute to delayed diagnosis and suboptimal treatment” (22).

Together, these and other findings emphasize two points. First, these findings suggest the need for primary care providers to receive more adequate education and training on EDs, including BED screening, detection, workup, and treatment options, as proposed in [Propositions #4](#Solution) and [5](#Solution ) below (sections 2.4 and 2.5). Second, these finding suggest individuals with BED and their friends and families are receiving information about BED from “self-help books, internet resources, support-based organizations, [and] private treatments,” rather than from their primary care providers. Therefore, efforts aiming to improve BED detection, identification, treatment-seeking, and treatment engagement should also focus on providing education on BED at the point of “consumer contact;” e.g., through direct-to-consumer marketing by providing BED education at the point where those with BED (and their friends and families) are looking for it (e.g., “self-help books, internet resources, support-based organizations, [and] private treatments,”), as proposed in [Propositions #1](#Solution) and [3](#Solution ) below (sections 2.1 and 2.3). Overall, these and other findings suggest the benefits of systemic public health/policy solutions that target the healthcare-, mass media-, and public policy systems that influence the BED environment, rather than targeting primary care providers or those with BED individually.

## Proposition #1: Public Campaign(s) to Increase Public Education About Binge Eating Disorder

Here, we propose the need for public campaign(s) to increase public education about BED.

### Aim 1: Reduce Stigmatization that Impedes BED Recognition, Treatment-Seeking, and Treatment Engagement

First (Proposition #1, Aim 1), the proposed campaigns should aim to reduce stigmatization and shame that are often cited as barriers to self-identification, disclosing symptoms to healthcare providers, seeking treatment, and engaging in treatment once sought (12, 14, 16, 23-26). This aim can be accomplished through four core educational sub-aims.

First (Proposition #1, Aim 1, Sub-aim 1), increasing public education and awareness of the high lifetime prevalence rates associated with BED (e.g., 4.5–31% (2, 3)) can help normalize the diagnosis and dismantle stigmatization and shame, thus facilitating self-identification, provider detection, treatment-seeking, and treatment engagement (12, 16, 23-26).

Second (Proposition #1, Aim 1, Sub-aim 2), increasing public awareness of demographic information about who can have BED can help dispel the “SWAG: skinny, white, affluent, girl” stereotype (27) that incorrectly ascribes EDs exclusively to thin, affluent, white, cis-gendered females (16). Demographic education campaigns can also help increase awareness of the high risk and prevalence rates of BED in minority socioeconomic, racial, ethnic, sex, gender, sexual orientation, body weight, and body size populations who are often underrepresented in research and overlooked clinically (16).

For example, literature supports the growing understanding that white affluent cis-gendered females are more likely than their respective counterparts to perceive a need for treatment and/or receive a diagnosis and treatment (12) and have thus traditionally saturated the treatment-seeking population (and research populations as a result) (16). However, this demographic does not exclusively represent all individuals who experience BED. Studies suggest that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis (12, 13); 67.3% do not perceive the need for treatment (12); and 56.4% – 86.8% never receive or pursue treatment (2, 12). These overlooked, under-diagnosed, and under-represented individuals often include males, individuals in “normally” sized/weighted/shaped bodies, and individuals with low socioeconomic status, especially those with past or present histories of food/nutrition insecurity or use of government assistance programs like the Supplemental Nutrition Assistance Program (SNAP), food stamps, or welfare (12, 28-31) (16, 28-36). Additionally, black, indigenous, and people of color have higher prevalence rates of BED than their white peers (37-39), but comprise <10% of participants in BED research studies (40), are less likely to be screened by medical professionals for EDs (41, 42), and are 50% less likely to be diagnosed or receive care (37, 38, 40, 41, 43, 44). Sexual minorities also have increased risks for developing an ED (45), with a nationally representative U.S. study finding greater prevalence of adult BED in non-heterosexual respondents than in their heterosexual counterparts (2.2% vs. 0.8%)(46). Literature on prevalence rates among agender, transgender, and non-binary individuals focuses primarily on youth (28, 47) but also demonstrates transgender young adults have higher prevalence rates of BED than their cis-gendered counterparts (28% in females, 64% in males, and 73% in non-binary respondents)(47), with transgender males having higher ED pathology scores than transgender females (28). Targeted public education campaigns aiming to increase awareness around these issues can help marginalized and under-represented individuals with- or at risk of BED more readily self-identify and self-screen.

Third (Proposition #1, Aim 1, Sub-aim 3), emphasizing inclusive language (e.g., identity-first language: “individuals with BED” vs. “BED patients/individuals”) can help reduce stigmatization by separating the person from the diagnosis/condition (48-53).

Fourth (Proposition #1, Aim 1, Sub-aim 4), increasing public awareness and education around stigmatization (16, 54-70) and discrimination (16, 68, 71-80) as they pertain to weight disorders (16, 54-57, 62), EDs (16, 56, 58-60, 64, 66, 67), and BED specifically (16, 66, 70) – at the levels of the patient/individuals with BED, institution(s) (e.g., healthcare systems), and society/the general public – can help reduce sociocultural stigmatization and discrimination in these conditions (81, 82). These initiatives should specifically focus on providing education about the forms of stigmatization and discrimination individuals with BED experience (e.g., those related to weight (16, 54-57, 62), having an ED (16, 70), having a mental health diagnosis (16), and perceived eating behavior (16, 70)), as well as the impacts stigmatization and discrimination can have on individuals with BED (16), including the often harmful and traumatic psychological impacts that contribute to the disorder (16) as well as unequal and unjust healthcare quality and treatment (16, 58, 61), unequal employment opportunities and security (16), and potential for marginalization and oppression (16, 64). The proposed campaigns should recognize the differences in stigmatization that may exist across gender (63, 65), race/ethnicity (64, 68), and sexual orientation (69). Overall, the goal of providing education around stigmatization and discrimination as it pertains to BED is to help reduce these problems, thus creating a safer environment in which individuals with BED can more readily self-identify, disclose their struggles, seek help, and engage in treatment.

### Aim 2: Enable Self-Identification

Second (Proposition 1, Aim 2), public health campaigns should aim to enable BED self-identification by increasing public awareness around four core topics related to BED (described below).

First (Proposition #1, Aim 2, Sub-aim 1), we suggest that providing education about the validity of BED as an autonomous DSM-5 ED and mental health diagnosis can help validate individuals with this condition and support access to care. Public campaigns that provide diagnostic education about BED can increase self-recognition and identification among the large percentage of individuals who do not recognize their binge eating behavior as disordered, often due to sociocultural norms, healthcare provider biases, and ignorance at the levels of the patient, healthcare providers, and general public (14, 16, 83). In support of the possible benefits of public education campaigns on BED validity, one BED expert stated, *“I have to say, Vyvanse [e.g., lisdexamfetamine demethylate, a stimulant medication for attention deficit hyperactive disorder, ADHD, that is the only FDA-approved medication for BED at the time of this publication], with all of the ads that they did, was incredibly helpful for [BED] research because people are self-identifying as having BED at much younger ages,” (P72 as quoted in Bray et al., 2024).*

Second (Proposition #1, Aim 2, Sub-aim 2), providing education about the signs, symptoms, and DSM diagnostic criteria associated with BED can help increase self-detection and identification, as described in [Proposition #1 (Aim 2, Sub-aim 1)](#Solution) and in [Proposition 4 (Aim 2, Sub-aim 3)](#Solution) (section 2.4.2).

Third (Proposition #1, Aim 2, Sub-aim 3), providing demographic information about who can have an ED can help dispel the “SWAG” stereotype (27) and increase awareness of the high risk and prevalence rates of BED in minority populations who are often underrepresented in research and overlooked clinically (16), as described above. This can help increase self-identification, regardless of demographic status.

Fourth (Proposition #1, Aim 2, Sub-aim 4), increasing public awareness of weight bias (12, 13, 16, 24, 83-86) and possible connections between weight changes, gastrointestinal issues, and other physical symptoms commonly associated with BED (83) and common underlying ED psychopathology (e.g., emotion dysregulation, trauma history, negative affect, negative urgency (83, 87)[[1]](#footnote-1)) can help individuals with BED link their perceived “weight problem(s)” (12, 13, 16, 24, 83-86) to possible ED(s). Use of slogans such as “we came for the vanity and stayed for the sanity,” popular in peer-led, mutual-help, community-based eating recovery programs (e.g., Overeaters Anonymous)(88, 89) may help link weight issues (“vanity”) to underlying ED psychopathology (“sanity”).

### Aim 3: Promote Treatment-Seeking and Engagement

Third (Proposition 1, Aim 3), public education campaigns should promote treatment-seeking and engagement through four core educational sub-aims.

First (Proposition #1, Aim 3, Sub-aim 1), public campaigns aiming to foster a demographically inclusive public education about who can seek and receive treatment for BED can help encourage treatment-seeking and access, particularly among minority populations. The rationale behind this proposal is that marginalized and minority individuals with BED may be inspired by campaigns that show individuals they identify with (e.g., of their socioeconomic status, race, ethnicity, sexual orientation/preference, pronouns, body weight/shape/size) seeking and receiving treatment for BED to believe BED treatment is possible and acceptable for them, too.

Second (Proposition #1, Aim 3, Sub-aim 2), advertising the benefits of treatment can help offset fears about treatment hardships and behavior change while also fostering positive attitudes about treatment-seeking and engagement. This possibility is supported by a variety of literature demonstrating direct-to-consumer advertising can positively influence patients’ awareness, knowledge, and communication with healthcare providers about advertised conditions and treatments (90, 91), as has been observed of BED in response to Vyvanse advertisements (14).

Third (Proposition #1, Aim 3, Sub-aim 3), championing the success of “treatment ambassadors” (e.g., successful treatment stories from individuals with BED of all demographics) can further help to dispel fears about treatment hardships and encourage demographically inclusive treatment-seeking and engagement. In support of this sub-aim, there is a precedence for championing the benefits of ED treatment and recovery (92-94). In the commercial sector, ED recovery programs advertise their success rates, positive treatment outcomes and often promote ambassadors (often public figures) who have had success in their particular program(s) (94, 95). However, empirical support for this tactic has not been published. Peer-led mutual support programs also often promote the benefits of recovery based on the experiences of those who have recovered or are recovering within the anonymity of their specific meetings and fellowships (88, 96, 97). In 12-Step programs, this is done through sponsorship and individual sharing guidelines that promote sharing “experience, strength, and hope” at meetings, and these tactics do have empirical support (88, 98, 99).

Fourth (Proposition #1, Aim 3, Sub-aim 4), campaigns designed to emphasize the importance of mental health can counterbalance the current sociocultural emphasis on external appearance (16, 100-102) and help reduce mental health stigmatization and weight over-valuation/bias that often prevent individuals with BED from recognizing BED and seeking and engaging in treatment (16). Thus, campaigns designed to create awareness around mental health relevance can: a) help dismantle mental health stigma (103, 104) and promote an environment where, b) identifying a mental health disorder like BED feels safer to individuals who experience these disorders, and c) where seeking and engaging in treatment for mental health disorders and EDs are more positively reinforced and more commonly associated with more positive (vs. negative) connotations.

### Aim 4: Simplify Treatment-Seeking and Enable Treatment Access

Fourth (Proposition #1, Aim 4), the proposed campaigns should aim to simplify treatment-seeking and enable treatment access by increasing awareness of treatment resources in five core areas/sub-aims:

First (Proposition #1, Aim 4, Sub-aim 1), the proposed campaigns should aim to increase public education and awareness of current standard empirically supported treatment approaches for BED and their respective success rates. These include psychological interventions (e.g., CBT, CBT-guided-self-help, interpersonal therapy, and psychodynamic therapies), medications (e.g., antidepressants, anticonvulsants, and weight loss medications), nutritional counseling, and behavioral weight control (which combines nutritional and psychological counseling to promote healthy behavior change)(9, 105). Success rates associated with these standard interventions generally range from 38.3–43.6% (2, 4) and recurrence rates generally range from 49–64% (2, 10)). Increasing public awareness of these treatment approaches and their associated success rates can help alleviate the burden of treatment-seeking for individuals with BED who may not have information on what treatment options are available to them. Providing information on treatment success rates can also help individuals with BED make better-informed decisions about their treatment plan(s).

Second (Proposition #1, Aim 4, Sub-aim 2), public campaigns should aim to increase awareness of available directories for BED treatment providers and centers. For example, the Provider Directories provided by the National Eating Disorder Association (NEDA) and the Alliance for Eating Disorders Awareness (AEDA) could be of great benefit to treatment-seeking individuals with BED (106, 107).

Third (Proposition #1, Aim 4, Sub-aim 3), in order to enable and increase BED treatment-seeking, access, and engagement, public campaigns should also aim to increase awareness of scalable, equal-opportunity BED treatment options with empirical support that are:

1. Free or low-cost.
2. Remote/virtually accessible or community based.
3. Socio-demographically sensitive and inclusive.
4. Sensitive to the unique experiences of individuals with BED.

Examples include:

1. CBT self-help (CBTsh), which can be self-paced to minimize time burden, does not require a therapist or the associated economic and transportation burden(s), has been tested in ethnically diverse urban populations, and produces 33–85% reductions in binge eating and abstinence rates of 12.8–47% (108, 109).
2. CBT guided-self-help (CBTgsh), which does require the use of a therapist (and the associated costs) but is accessible virtually, thus beneficial for those without transportation resources or geographic limitations, and produces ~47–84% reductions in objective binge eating, abstinence rates of ~36–38%, and remission rates of ~30–50% (110-113).
3. Mindfulness meditation mobile applications (114, 115), which alleviate burdens associated with a therapist (e.g., cost, transportation) and can produce ~30% reductions in Binge Eating Scale (BES) scores (116) but can also have weak mindful eating-specific content if not empirically tested in the context of BED recovery (117).
4. Support group interventions that are free/donation-based, local/community-based, or remote/virtually accessible, and socio-demographically sensitive/inclusive.
   1. Many support groups are offered by ED foundations (e.g., the ED Foundation (EDF) (97) and the National Alliance for EDs (NAED) (96)).
   2. Additionally, Overeaters Anonymous (OA), a 12-Step mutual-support, peer-led, community-based intervention with empirical support (88, 118-125) has been found to produce ~70% rates of abstinence from disordered eating for between 30–360 days on average (119), with 46% of those who are abstinent for >30 days reporting never or rarely relapsing (119). There is also strong evidence supporting the efficacy and underlying mechanisms of 12-Step support programs (e.g., Alcoholics Anonymous,(AA)) in achieving long-term treatment engagement and thus delaying or preventing relapse (88, 99, 126-131) that includes minority populations (131-135).
   3. Moreover, free support groups are specifically optimized for individuals who do not have access to formal healthcare interventions (e.g., due to costs, insurance, time constraints, transportation/geography, provider scarcity, and healthcare avoidance (14))(14, 88, 136, 137) and are also optimized for long-term engagement when used independently or as a complement to formal treatment options.

Fourth (Proposition #1, Aim 4, Sub-aim 4), the proposed campaigns should seek to promote equal-opportunity treatment solutions such as those identified in sub-aim #3 above and should also include telehealth or online platforms for BED treatment, such as videoconferencing, telephone, text messaging, or mobile applications that can deliver evidence-based interventions or peer-led programs to individuals with BED who live in remote or underserved areas. Such platforms may also help reduce costs, travel time, and stigma associated with seeking treatment (14, 88, 96, 97, 99, 108-137).

Fifth (Proposition #1, Aim 4, Sub-aim 5), the proposed campaigns should also aim to increase public awareness of any financial aid options available for individuals with BED. This can help alleviate the burden of treatment-seeking for many with BED who have financial hardships.

### Aim 5: Provide Public Education on Provider-Level Treatment Barriers

Fifth (Proposition #1, Aim 5), the proposed campaigns should aim to provide public education on provider-level treatment barriers to minimize these barriers and the harms they can cause for individuals with BED (e.g., psychological impacts of stigmatization, including internalization, gaslighting, and healthcare avoidance)(12, 14, 16, 23-26, 85, 138). This aim should focus on increasing public awareness and education around the following provider-level barriers (14):

1. Stigmatization within healthcare systems (16, 23, 24, 26, 85, 138).
2. Unequal screening in minorities (12, 13, 16, 21, 24, 26, 84, 85, 139-141).
3. Weight bias within healthcare systems (12, 13, 16, 24, 83-86).
4. Poor education about BED within healthcare systems (12, 13, 16, 24, 83-85).
5. Poor education on treatment resources within healthcare systems (142).
6. The importance of rapid response for BED recovery (143).

This aim can align with those identified in [Proposition #4](#Solution) (section 2.4) below.

### Feasibility and Other Relevant Considerations for Proposition #1

In support of the feasibility of the education campaigns proposed in Proposition #1, we call attention 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)), which set a precedent by calling for National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) funds to be used to train healthcare professionals and school personnel to identify EDs and intervene early (144).

Further, Aims 2 (Sub-aim 4) and 3 (Sub-aim 4) presented in sections 2.1.2 and 2.1.3 here align with the overarching goals of previous policy recommendations for prevention of EDs, weight stigmatization, and disordered weight control behaviors that focus on regulating dietary supplements marketed for weight loss and muscle enhancement (17, 19). For example, Aim 2, Sub-aim 4 proposed here (Proposition #1, section 2.1.2) advocates for increasing public awareness and distinction between physical appearance (and health) and mental health, which aligns with Aim 3, Sub-aim 4 also presented here (Proposition #1 , section 2.1.3), which advocates for campaigns designed to emphasize the importance of mental health, counterbalance the current sociocultural emphasis on external appearance (16, 100-102), and help reduce mental health stigmatization and weight over-valuation/bias that often prevent individuals with BED from recognizing BED and seeking and engaging in treatment (16). Austin et al.’s 2017 call for public health policy regulations around dietary supplement marketing, specifically those that advertise weight loss and market youth, share a goal to prevent or reduce BED by targeting the macro-environment that BED exists in through academic-community-government partnership (19).

Overall, we advocate public policy changes that provide funding to educate the public on adult BED and barriers to treatment. Additionally, we suggest the proposed campaigns leverage multi-media advertising via social media, internet, television, radio, and billboards. This suggestion is based findings that direct-to-consumer advertising can positively influence patients’ awareness, knowledge, and communication with healthcare providers about the advertised conditions and treatments (14, 90, 91).

## Proposition #2: Public Campaign(s) to Increase Resources for Equal-Opportunity Treatment Engagement

Second (Proposition #2), we propose the need for public policy changes that increase equal opportunity treatment resources.

### Aims 1 – 3: Increase Financial Aid Options, Insurance Coverage, and Federal Funding for Research Opportunities

First (Proposition #2, Aims 1–2), the proposed campaigns should aim to increase financial aid options and insurance coverage for BED treatments. This can reduce the costs that often prevent many individuals with BED from seeking or engaging in treatment (14, 15, 23, 24, 43, 145-148).

The proposed campaigns should also seek to increase federal funding for BED research (Proposition #2, Aim 3), with specific calls to action for research that can empirically test and support new treatment options that are: 1) free or low-cost; 2) remote/virtually accessible or community-based; 3) socio-demographically sensitive and inclusive; and 4) sensitive to the specific needs of individuals with BED, as described in [Proposition #1, Aim 4, Sub-aim 3](#Solution) (section 2.1.4) above.

### Feasibility and Other Relevant Considerations for Proposition #2

In support of the feasibility of this proposition, 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)), which also improved health insurance coverage for EDs by clarifying the intent of the [Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (the Parity Law, which required insurance providers to cover individuals with mental illness equally as those with other health issues) to include residential treatment services for EDs (144). Since then, insurance coverage for EDs has improved, though it remains a barrier to treatment (15). Tamargo et al. (2022) discuss healthcare policies that drive insurance coverage decisions (e.g., “medical necessity”), the roles of insurance companies in determining insurance coverage provisions, current limitations in insurance coverage, reasons for denial, the ethical implications of current insurance practices, and directives for improvement in their 2022 publication (148).

In further support of the feasibility of this proposition, we also point to the Federal 21st Century Cures Act ([Public Law 114-225, S. 1033](https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf))(20, 149-151), which was passed into law in 2016 with the primary aim to “accelerate the discovery, development, and delivery of 21st century cures,” (150). This aim was primarily achieved by providing the National Institute of Health (NIH) with “critical tools and resources to advance biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials of promising new therapies,” (151). The enacted policies focused on providing the NIH with funding and other resources to accelerate research (e.g., by alleviating administrative burdens that can prolong the start of clinical trials, allowing researchers to more easily attend scientific conferences in person, where collaboration can often lead to scientific breakthroughs, enhancing data sharing among NIH-supported researchers, improving privacy protections for researchers, and – in alignment with the aims we call for here – encouraging inclusion of diverse populations represented in clinical research and opening up new NIH funding opportunities for young investigators) and amplify research in four core areas specifically designated to receive multiyear funding (including the *All of Us* Research Program aiming to increase diversity, equity, and inclusion in research)(151).

Similar policy advocating secured multiyear funding for BED research specifically dedicated to developing and testing new treatment options that are: 1) free or low-cost; 2) remote/virtually accessible or community-based; 3) socio-demographically sensitive and inclusive; and 4) sensitive to the specific needs of individuals with BED could have great public benefit both qualitatively and economically.

## Proposition #3: Free, One-Stop, Online Resource Platform for Individuals with BED

Third (Proposition #3), we propose the need for a free, one-stop, online resource platform that aligns with the aims proposed in Proposition #1 (e.g., 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 (14, 15, 142). 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 (142, 152) 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)(14, 15). The overarching goals of this proposition can be addressed as follows.

### Aim 1: Companion Resources to Parallel Proposition #1 Aims

First (Proposition #3, Aim 1), the proposed online resource platform should contain informational resources that complement the aims of the BED public education campaign proposed in [Proposition #1](#Solution) (Section 2.1).

### Aim 2: Screening Tools for Self-Identification

Second (Proposition #3, Aim 2), the proposed resource platform should provide free online screening tools for individuals with BED to self-screen and self-identify. The proposed screening tools may include (153):

1. The ED Examination-Questionnaire (EDE-Q, full or brief) (154, 155).
2. The Binge Eating Scale (BES) (156-158).
3. The Eating Beliefs Questionnaire (EBQ, full or brief) (159, 160).
4. The Questionnaire on Eating and Weight Patterns-Revised (QEWP-R) (161).
5. The Yale Food Addiction Scale 2.0 (162-164).

It may also be beneficial to preface the screening tools with the diagnostic criteria for BED, as defined by the DSM-5 (1).

### Aim 3: Scalable Treatment Resources

Third (Proposition #3, Aim 3), given the importance of early intervention and rapid recovery to BED treatment success (142, 152), the proposed resource platform should seek to facilitate a seamless transition from screening resources (Proposition #3, Aim 2) to scalable treatment resources, particularly for individuals who screen positive for BED (thus helping to facilitate rapid intervention and recovery). The platform should provide a variety of scalable treatment options and resources, including information on the importance of early intervention and rapid recovery (142, 152) as well as information on:

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 (e.g., free or low-cost treatment options), access to transportation (e.g., remote, virtually accessible, or local/community-based treatment options), daytime commitments or rigid schedules (e.g., self-paced options), or sociodemographic conformity (e.g., sociocultural and demographically sensitive and inclusive treatment options that are sensitive to the specific needs of individuals with BED), as described in Proposition #1 (Aim 4) and Proposition #2 (Aim 3) above.

### Aim 4: Resources for Coordinating Communication and Care Across Multidisciplinary Providers

Fourth (Proposition #3, Aim 4), the proposed resource platform should help alleviate the patient burden of coordinating communication and care across multiple multidisciplinary providers. This burden is cited as a barrier to treatment-seeking and engagement. This aim may 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) could also be beneficial. This aim could 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.

### Aim 5: Resources for Individuals with BED who Experience Stigmatization

Fifth (Proposition #3, Aim 5), the proposed resource platform should provide free online resources for individuals with BED who experience misconceptions, stigmatization, discrimination, and/or biases based on their ED, BED, or mental health diagnosis, eating thoughts and behaviors (perceived or real), or body weight, shape, or size – either within him or herself (e.g., self-stigmatization, guilt, and shame) or at the levels of healthcare systems and providers or the mass media and general public (14-16). In addition to providing information on stigmatization and its impacts on individuals with BED (proposed in Proposition #1, Aims 1 and 5 above), this aim should also include resources for healing and reducing stigmatization at the levels of the individual/self, healthcare systems and other instructions, and mass media and general public (81, 82).

### Aim 6: Resources for Healthcare Providers

Sixth (Proposition #3, Aim 6), the proposed resource platform should also provide free online resources for healthcare providers that align with the aims proposed in [Proposition #4](#Solution) (section 2.4) and [Proposition #5](#Solution) (section 2.4.1) below. The goal of this aim (as in Propositions 4 and 5) would be to reduce provider-level treatment barriers and their impacts on individuals with BED. In addition to the resources endorsed in Propositions #4 and 5 below, we also suggest including the following resources in the free, one-stop, online platform proposed here:

1. Information on stigmatization (16, 23, 24, 26, 85, 138), weight bias (12, 13, 16, 24, 83-86), and under-screening (12, 13, 16, 24, 26, 84, 85, 139, 141) 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 (9, 142, 165-168)).

These resources should also be accessible to individuals with BED, should they wish to share them with their healthcare provider(s).

### Feasibility and Other Relevant Considerations for Proposition #3

Importantly, several online resource platforms exist that are similar to the one-stop platform we propose her:

* The NEDA website (169) 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 ED Coalition website (170) 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 ED Foundation website (171) 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 (172) 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 (144). Similar policy to provide funding for a free, easy-access, one-stop, online resource platform for BED could have great public benefit.

## Proposition #4: Public Health Campaign(s) to Increase Education About BED within Healthcare Systems

Here, we highlight the need for public campaign(s) to increase education about BED within healthcare systems. We suggest these campaigns should focus on five specific aims discussed below.

### Aim 1: Reduce Stigmatization within the Healthcare System

First (Proposition #4, Aim 1), the proposed campaigns should aim to reduce stigmatization that individuals with BED: 1) often face from within healthcare systems, and 2) site as barriers to BED self-identification, symptom disclosure within healthcare systems and to healthcare providers, treatment-seeking, and treatment engagement (12, 14-16, 23-26), as also addressed in Proposition #1 (Aim 1, Sub-aim 4). This aim can be accomplished through three core educational sub-aims that are also addressed in Proposition #1.

1. Providing education about stigmatization related to BED within healthcare systems.
2. Emphasizing inclusive “identity-first” language.
3. Providing education on weight bias within healthcare systems (12, 13, 16, 24, 83-86) and increasing provider awareness of possible connections between weight changes, gastrointestinal issues, and other physical ailments commonly associated with BED (83) and common underlying ED/BED psychopathology.

### Aim 2: Increase BED Recognition, Screening, and Detection

Second (Proposition #4, Aim 2), the proposed campaigns should aim to increase BED recognition, screening, and detection by targeting provider-level barriers to BED identification (see sections 1.2.1.2, 1.2.1.1, and 2.1.1). This aim can be accomplished by providing education focused on three core areas:

1. BED demographics and demographically biased under-screening (12, 13, 16, 24, 26, 84, 85, 139, 141). Education related to this sub-aim should focus on dispelling the “SWAG” (skinny, white, affluent, girl) stereotype about who can have an ED (16, 27) and increasing recognition of populations of individuals with BED who have been historically overlooked in the field (16), as addressed in Proposition #1 ([Aim 1, Sub-Aim 2](#_Aim_1_) and [Aim 2, Sub-Aim 3](#_Aim_2:_Enable)).
2. Weight bias within healthcare systems (12, 13, 16, 24, 83-86), including possible connections between physical symptoms commonly associated with BED (e.g., weight changes, gastrointestinal issues (83)) and common underlying psychopathology of BED, as addressed in Proposition #1 (Aim 2, Sub-aim 4) and Proposition #4 (Aim 1, Sub-aim 3) above. The overall goal of this sub-aim is to reduce the potentially harmful focus on weight loss that exists in BED and instead increase focus on the underlying ED pathology when applicable, thus increasing BED screening and detection.
3. Diagnostic criteria for BED and recognition of BED as a valid DSM-5 mental health and ED diagnosis that is separate from overweight and obesity (1, 83), as addressed in Proposition #1 ([Aim 2, Sub-aim 1](#_Aim_2:_Enable)). The overall goal of this sub-aim is to reduce the miseducation that exists within healthcare systems about the validity of BED and its distinction from overweight and obesity that often impedes BED recognition, screening, detection, and diagnosis (12, 16, 21, 26, 83, 139, 141).

### Aim 3: Promote Narrative-Based Medicine

Third (Proposition #4, Aim 3), the proposed campaigns should promote narrative-based medicine (e.g., taking and accounting for patient narratives and lived experiences in the clinical setting and using patient narratives to inform care, including unbiased screening and scalable treatment resources and solutions) (173-176). The potential for narrative-based medicine to better inform our current understanding of BED and the barriers that prevent its identification and treatment are well-described (16, 28, 29, 34, 38, 40, 44, 173-176). Furthermore, the themes identified herein emphasize the need for clinical tactics and open-ended research that can access and include the ~70% of individuals who experience BED symptoms but may not recognize their need for treatment (12) as well as the ~95% of individuals with BED who never receive a formal diagnosis (12, 13) and the ~56-87% who never pursue or receive treatment (2, 12). It is equally important to identify screening, treatment engagement, and research recruitment and dissemination tactics and treatment options that include minority and marginalized populations and receive and account for the unique treatment barriers these populations face.

### Aim 4: Increase Provider Education and training on BED Treatment Options and Resources

Fourth (Proposition #4, Aim 4) the proposed campaigns should aim to increase provider education and training on BED screening, diagnosis, referrals, treatment options and resources, and the empirical support for rapid treatment response as an important treatment outcome (143, 152), as described in [Proposition #1 (Aims 4](#Solution ) and 5[)](#Solution ) and [Proposition #3 (Aim 3](#Solution ))(sections 2.1.4, 2.1.5, and 2.3.3). These campaigns can include online courses, workshops, or webinars that can enhance the knowledge and skills of primary care providers/general health practitioners, internists, and any healthcare providers treating BED (including specialists). These campaigns should also make use of the following relevant clinical practice guidelines for BED:

* The American Psychiatric Association (APA)’s 2023 practice guidelines for treating patients with EDs, including BED (177, 178).
* Ralph et al.’s 2022 clinical practice guidelines for managing EDs in people with higher weight (167).
* The United Kingdom National Institute for Health and Care Excellence (NICE)’s 2020 clinical guidelines for recognizing and treating EDs, including BED (168).
* The Australia & New Zealand Academy for EDs (ANZAED) 2020 principles on ED treatment and general clinical practice and training standards (142).
* The Australian National EDs Collaboration (NEDC)’s 2018 National Practice Standards for EDs (166).
* Hilbert et al.’s 2017 evidence-based clinical guidelines for EDs: international comparison (9).

Providing certification or accreditation (e.g., continuing medical education (CME) credits or continuing education units (CEU)) for such courses may also help incentivize healthcare providers to engage in the proposed training initiatives and enable them to signal their expertise and competence in BED treatment, as addressed in [Proposition #5](#Solution ) (section 3.5) below.

### Aim 5: Streamline Interdisciplinary Treatment Processes and Communication

Fifth (Proposition #4, Aim 5), the proposed campaigns should streamline interdisciplinary treatment processes and communication to reduce patient burden of coordinating communication and care across multiple providers, which has been identified as a patient-level barrier to treatment-seeking and engagement (see [Proposition #3, Aim 4](#_Aim_4:_Resources)).

### Feasibility and Other Relevant Considerations for Proposition #4

As addressed in Section 2.3.7 (“[Relevant Considerations for Proposition #4](#Relevant Considerations for Solution )”), several existing online resources do already exist that are similar to our proposed solution:

* The NEDA website (169) contains information about a variety of different EDs (including BED), including free and low-cost treatment options (including social support group directories) and professional development courses and resources for providers.
* The Mayo Clinic (172) offers patient and provider resources specific to BED, including diagnostic resources (including relevant laboratory workup) and 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 all or some of this information. We propose that BED providers may benefit from having one definitive unified/streamlined resource platform that combines the aims identified here rather than several unvetted piecemeal resource options. Accordingly, we also suggest that the information in the campaign proposed here be made available in the online resource platform proposed in [Proposition #3, Aim 6](#Solution ) (section 3.3.6 [above](#Solution )).

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)), which set a precedent by calling for federal funds to be allocated to training healthcare professionals in early ED detection and intervention (144). Similar policy to provide funding for a public health campaign for BED providers could have great public benefit.

Lastly, supporting the feasibility of requiring healthcare provider education and trainings on the empirical support for rapid treatment response as an important treatment outcome (143, 152), as advocated in Aim 4 here (Proposition #4, section 2.4.4), we point to the Medicaid Early and Periodic Screening, Diagnosis, and Treatment benefit/program (179), which requires Medicaid providers to assess concerning mental health symptoms in children and adolescents, including concerning symptoms related to disordered eating or weight control (20). Here, we advocate for similar policy that requires providers to screen for BED in an unbiassed fashion, incentivizes providers to push for rapid treatment response (e.g., by emphasizing and encouraging behavior change within the first 3–4 treatment weeks (143, 152) and/or – for primary care providers – providing referrals and assisting patients in accessing specialized care within one week of screening and diagnosis.

## Proposition #5: Certification and Accreditation for Provider Training in BED

Lastly (Proposition #5), we propose developing and incentivizing education and training courses on BED for healthcare providers and systems through certifications and accreditations (e.g., CME or CEU). Proposed course content should include BED stigmatization (16, 23, 24, 26, 85, 138), patient experience (16, 23, 24, 26, 85, 138), screening, and standard treatment approaches, resources for referral directories, and scalable treatment options. The proposed certifications and accreditations could be helpful both in incentivizing healthcare providers to engage in these educational initiatives and in enabling providers to signal “safe spaces” for those with BED (e.g., by advertising or displaying their credentials), as outlined in the two aims below.

1. **Aim 1:** Educate healthcare providers on BED management and care in various settings (including primary care).
   1. Course content can focus on Aims 1–5 in [Proposition #4](#Solution ) (section 2.4) above.
   2. Course content should incorporate the relevant clinical practice guidelines identified in [Proposition #4, Aim 4](#_Aim_4:_Increase) (section 2.4.4) above (9, 142, 166-168, 177, 178).
   3. Courses and trainings should be included into medical school curriculum and offered for CME accreditation and specialized certification.
   4. Course content should specifically incorporate the training standards suggested in the ANZAED 2020 principles on ED treatment and general clinical practice training standards (142).
2. **Aim 2:** Signal safe treatment/healthcare spaces for individuals with BED.
   1. Course certificates and accreditations can be displayed and leveraged to signal safe and informed treatment/healthcare spaces for individuals with BED.
   2. Accreditations and certifications can specifically signal education on stigmatization and weight bias.

As addressed in Proposition #4 (section 2.4.6) and elsewhere above, 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)) provides a precedent for directing federal funds to train healthcare professionals and school personnel in ED treatment (144), thus supporting the potential feasibility of this Proposition.

## Conclusions

Bray et al. (2024) provides an in-depth review of literature pertaining to patient-, provider-, and systemic barriers that can hinder BED identification, treatment-seeking, and treatment accessing and engaging. Their findings emphasize the need for a variety of systems-level public policy solutions to improve BED detection, screening, diagnosis, treatment-seeking, and treatment access, and engagement. These solutions require a collective effort from healthcare providers, policymakers, and researchers. Here, we propose a multifaceted approach involving targeted campaigns directed at three distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. We propose these campaigns focus on dispelling a variety of misconceptions, biases, and stigmatization that surround BED and providing information on BED prognosis, prevalence, demographics, stigmatization, suggested standards for screening, standard treatment approaches, scalable treatment and funding options, resources for directories of treatment providers, navigating insurance policies, and scalable treatment options, as well as treatment benefits and champions. We suggest offering certifications and accreditations (e.g., CME, CEU) to help incentivize provider education and training on these topics. Financial aid and insurance coverage for treatment have improved but further improvements are still needed. Free, one-stop, online platforms with resources on BED risks, prevalence, demographics, detection, screening, treatment and financial aid options, and insurance information can further reduce many barriers and streamline treatment-seeking and access. Research funding is also needed to identify and test new treatment options that are: a) free or low-cost; b) community-based or virtually accessible; c-d) culturally and demographically sensitive and inclusive; and e) sensitive to the unique needs and experiences of individuals with BED. Lastly, we discuss current literature findings and public policy campaigns that support the solutions we propose here (e.g., 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)), which set a precedent by calling for National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) funds to be used to train healthcare professionals and school personnel to identify EDs and intervene early and improved health insurance coverage for EDs by clarifying the intent of the [Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (the Parity Law, which required insurance providers to cover individuals with mental illness equally as those with other health issues) to include residential treatment services for EDs (220))(17-20, 149-151, 179). Overall, our proposal aligns with existing literature, endorsing collaborative efforts that involve healthcare, public policy, education, and research to combat BED barriers and improve BED detection, treatment-seeking, treatment access, engagement, and overall success (14-17, 19, 20).

## Conflict of Interest

*The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest*.

## Author Contributions

Conceptualization, B.B. and H.Z.; methodology, B.B. and H.Z.; formal analysis, B.B., and H.Z.; investigation, B.B. and H.Z.; resources, B.B.; data curation, B.B.; writing—original draft preparation, B.B.; writing—review and editing, B.B., D.W., A.S., A.J.S., C.B., and H.Z.; supervision, H.Z.; project administration, B.B. and H.Z. Online artificial intelligence (e.g., BING chat (bing.com) and [ChatGPT (openai.com)](https://openai.com/chatgpt)) was used as an editorial tool for manuscript preparation. All authors have read and agreed to the published version of the manuscript. All authors agree to be accountable for the content of the work.

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## Tables and Figures

## Figure 1

Figure 1: 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

Description automatically generated

**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**)**.

## Figure 2: Proposed Solutions to Treatment Barriers: Systems-Level Public Policy Interventions.

A black and white screen with text

Description automatically generated with medium confidence

**Figure 2:** Proposed Solutions to Treatment Barriers: Systems-Level Public Policy Interventions. Theoretical model of possible solutions that can be enacted to overcome or minimize the barriers identified in **Figure 1.**

1. The psychopathology thought to drive BED most likely varies according to the individual. Commonly endorsed models of conceptualizing BED psychopathology are presented in Bray et al., 2023 and Neyland, Shank, & Lavender 2020. [↑](#footnote-ref-1)