Article

Treatment Access Barriers in Binge Eating Disorder: A Cross-Sectional Mixed-Methods Study of Binge Eating Disorder Experts’ Opinions

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**Abstract:** Binge Eating Disorder (BED) has high lifetime prevalence rates (4.5–31%) and low treatment success rates (38.3–43.6%). Moreover, ~95% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for treatment, and ~55–85% never receive or pursue standard treatment. This mixed-methods cross-sectional study collected information from 14 expert BED researchers and clinicians about barriers to accessing BED treatment. Experts were identified based on federal funding, PubMed-indexed publications, practice in the field, leadership in professional societies, and/or popular press distinction. Semi-structured interviews were anonymously recorded and analyzed by ≥2 investigators using reflexive thematic analysis and quantification. Nine participants (64%) spontaneously described 11 treatment barriers, including (1) stigmatization (from healthcare providers as well as internalized and systemic/sociocultural stigmatization); (2) healthcare inequity, avoidance, and under-use; (3) treatment costs and insurance coverage; (4) lack of education and awareness about BED (a) prevalence, (b) risk, and severity, (c) sociodemographic representation and who can have BED, (d) diagnostic criteria and (e) validity that impact individuals with BED, interpersonal relationships, healthcare providers/systems (e.g., BED stigma, screening, diagnosis, and referrals), and sociocultural environments; (5) insufficient provider screenings; (6) prioritizing physical complications over underlying psychopathology; (7) insufficient resources for finding/coordinating care, including time and transportation; (8) ED provider and treatment center scarcity and waitlists; (9) treatment time; (10) facing and enduring discomfort and hardships associated with treatment; and (11) fear of letting go of the coping/eating behaviors. Secondary reflexive thematic analysis yielded a conceptual 3x3 model that categorizes barriers across two dimensions: (1) source of the barrier and (2) stage in the treatment-access-process the barrier impedes. Barrier sources were found to exist at: (i) the individual/patient-level; (ii) the interpersonal/healthcare-provider/system-level; and (iii) the sociocultural environment/systemic/systems-level. The three discrete yet dependent stages that barriers can impede are: (i) detection and identification; (ii) treatment-seeking and planning; and (iii) treatment access and engagement. This model can be used to identify individual, interpersonal, and systemic program-, process-, and policy needs while also illuminating how these needs interact with one another. The model can also be used as a tool for conceptualizing possible solutions that individuals, healthcare providers/systems, and policy-makers can use to improve BED identification and treatment engagement. Addressing BED treatment barriers will require a collective effort from healthcare providers, policymakers, researchers, and social media influencers. This should include education and awareness campaigns on BED prevalence, demographics, stigmatization, scalable treatment options and benefits that target individuals who experience BED, social and healthcare providers who serve them, and the environments BED occurs in. Free, one-stop online resource platforms can streamline treatment-seeking and access, overcoming many barriers. Research funding is also needed to identify and test new treatment options that are: (a) free or low-cost; (b) community-based or accessible virtually; and (c-d) socio-culturally and socio-demographically sensitive, inclusive, and responsive.

**Keywords:** Binge eating; binge eating disorder; eating disorder; eating disorder treatment; treatment barriers; treatment costs; stigmatization; health equity; screening and diagnosis; public policy

1. Introduction

Binge eating disorder (BED) is an autonomous DSM-V diagnosis characterized by episodes of rapidly consuming objectively large amounts of food due to loss of control while associated with distress, guilt, and shame, and occurring at least once per week for at least three months [1]. The disorder is associated with high lifetime prevalence rates (e.g., 5–31% of U.S and global populations experience BED at some point in their lifetime)[2, 3]. It is also associated with a complicated health sequelae (e.g., anxiety, depression, obesity, cardiovascular disease, diabetes, and low self-esteem) that significantly impairs quality of life [2, 4-8]. Standard of care interventions for BED include psychological interventions (e.g., cognitive behavioral therapy (CBT), CBT-self-help, interpersonal therapy, and psychodynamic therapies), medications (antidepressants, anticonvulsants, and anti-obesity/weight loss medications), nutritional counseling, and behavioral weight loss [9]. A variety of additional evidence-based practices are gaining traction in the context of BED, including family-based therapy (FBT) and other psychodynamic therapies with guideline support [9, 10] as well as humanistic therapy [10], dialectical behavioral therapy (DBT), and DBT guided self-help [11, 12]. All of these interventions have low treatment success rates (38.3–43.6% [2, 4]), high recurrence rates (49–64% [2, 13]), high treatment dissatisfaction [14], and early discontinuation of care [14]. Moreover, studies find that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis [15, 16], 67.3% do not perceive the need for formal treatment [15], and 56.4–86.8% never receive or pursue standard treatment [2, 15] due to a variety of possible reasons.

Here, we conducted and recorded semi-structured interviews with 14 expert BED researchers, clinicians, and healthcare administrators. We used reflexive thematic analysis to collect information from experts in the field regarding current barriers to BED treatment intake. Identified themes included: **1) barriers to identifying BED; 2) barriers to treatment-seeking; and 3) barriers to accessing and engaging in treatment.** Within each theme, three subthemes were identified that included: **i) individual (patient-level) barriers** that originate and exist within the patient and are often within the patient’s control (e.g., under-reporting, fear of letting go); **ii) interpersonal (provider-level) barriers** that exist within the healthcare system and are often outside of the patient’s control (e.g., stigmatization from healthcare providers, insufficient provider screening); and **iii) systemic barriers** that originate and exist outside of the patient and outside of their control (e.g., stigmatization, treatment costs, inadequate insurance coverage, insufficient resources to find/coordinate care).

2. Materials and Methods

2.1. Participants and Recruitment

Researchers, clinicians, and healthcare administrators were identified as adult BED experts and recruited based on systematic eligibility criteria shown in **Table 1** and as previously published [17-19].

**Table 1: Participant eligibility criteria.**

|  |
| --- |
| *I. Eligibility criteria for researchers (18 recruited, 7 enrolled)* |
| Eligibility criteria for researchers required meeting one of the following four criteria (I.1–4): |
| 1. ≥1 active R01, T32, or P grant on binge eating or food addiction as identified on NIH RePORTER (<https://report.nih.gov>). |
| 1. Last author of ≥10 PubMed publications published 2010–2020 on adult BED AND ≥5 PubMed publications in 2015-2020 on the same topic.    1. Retrieved with the search term “binge eating disorder” in adults, young adults, and middle aged. |
| 1. Last author of ≥5 PubMed publications published in 2015-2020 relevant to food addiction.a |
| 1. Referral from someone who meets one of the qualifications above (I.1–3). |
| *II. Eligibility criteria for clinicians and healthcare administrators (18 recruited, 6 enrolled)* |
| Eligibility for clinicians and healthcare administrators required meeting ≥3 of the following 8 criteria: |
| 1. Association of Eating Disorders (AED) Award Winner or Honoree in 2010 – 2020 [20]. |
| 1. Castle Connolly Top Doctors Distinction in Psychiatry – Eating Disorders (2020/21) [21]. |
| 1. Executive position/board member for one of ten relevant societies:    1. Academy of Nutrition & Dietetics [22].    2. Academy of Eating Disorders (AED, FAED) [23].    3. American Society for Metabolic and Bariatric Surgery (ASMBS) [24].    4. Behavioral Health Nutrition Society [25].    5. Eating Disorder Research Society (EDRS) [26].    6. International Association of Eating Disorder Providers (IAEDP) [27].    7. Johns Hopkins 2020 Eating Disorders Conference [28].    8. National Center of Excellence for Eating Disorders (NCEED) [29].    9. National Eating Disorder Association (NEDA) [30].    10. Obesity Society [31]. |
| 1. Adult binge eating disorder provider listed in the Provider Directory for the National Eating Disorder Association (NEDA) [32] or the Alliance for Eating Disorders Awareness [33]. |
| 1. Association with an eating disorder program or treatment center with five or more locations listed in the NEDA Directory. |
| 1. Popular press distinction [34, 35]. |
| 1. Referral from an individual meeting ≥2 other qualifications above. |
| 1. Registered Dietician (RD) meeting 2 other criteria above. |
| *III. Additional Eligibility Criteria (2 recruited, 2 enrolledb)* |
| Individuals who met ≥1 academic/research criterion (I) and ≥1 clinical criteria (II) were also eligible. |
| **Table Legend:** BED: binge eating disorder. **a**This criterion required ≥ 5 publications in the past five years because of the relative newness of the concept of food addiction. **b**Both participants each met two academic/research criteria and two clinician/healthcare administrator criteria. Table reproduced from Bray et al., 2022-2024 [17-19, 36] with authors’ permissions. [17-36] refer to citations in References. |

2.2. Procedure

The study was approved by the National University of Natural Medicine IRB (# HZ12120) and was conducted as described previously [17-19]. BB sent eligible participants a scripted email study invitation. Consenting respondents were interviewed anonymously on Zoom (Zoom.com, last accessed 19 May 2022), with verbal consent obtained at the start of each interview. Interviews were recorded with participant consent. Recordings began after introductions to protect participant anonymity. Most interviews were scheduled for two hours, with abbreviated 30–60-minute interviews conducted as needed. Interview questions pertaining to BED treatment are shown in **Table 2** Demographic information was collected verbally or through a follow-up email survey at the end of each interview.

2.3. Data Analysis

Interview recordings were transcribed and de-identified. BB, MS, and HZ separately reviewed, qualitatively analyzed, and coded transcripts for themes, then discussed and finalized themes through reflexive engagement with the data (e.g., reflexive thematic analysis [37, 38]). BB and CB also quantified the number of participants expressing positive/supportive, neutral, or negative/skeptical perspectives on each theme [39-41], with HZ and CB consulted on quantification questions and tiebreakers.

**Table 2: Interview questions about barriers to adult BED identification and treatment- seeking, access, and engagement**

|  |  |
| --- | --- |
| ***Question n asked (n/14)*** | |
| 1. Please describe your perspective on (or knowledge of) literature and research findings, current clinical guidelines, and your own personal experiences that relate to binge eating disorder treatment. | 14 (100%) |
| 1. How important is it for treatment interventions to address the following possible aspects of BED (if at all)? | |
| * 1. Physical/Biological   2. Cognitive/mental   3. Emotional   4. Spiritual   5. Economic   6. Social   7. Cultural   8. Other | 14 (100%)  14 (100%)  14 (100%)  14 (100%)  11 (79%)  12 (86%)  12 (86%)  14 (100%) |
| 1. Please describe your view on the following health factors as they relate to adult BED treatment: | |
| * 1. Obesity   2. Weight Stigma   3. Other | 12 (86%)  12 (86%)  14 (100%) |
| 1. Are there any other aspects of BED treatment that you feel are important to address or discuss (that have not been addressed above)? | 12 (86%) |
| 1. Please describe your perspective on current research gaps that exist in the field of BED. | 4 (29%)\* |
| 1. Do you have any other suggestions that relate to future research on adult BED? | 8 (57%)\* |
| **Table Legend:** Results expressed as n (%). n = number participants asked. Percentages expressed as n/14 times 100. \*Indicates responses and response rates relevant to BED treatment access barriers. | | |

2.3. Secondary Data Analysis & Conceptual Modeling

The 15 treatment barriers most commonly identified by BED experts using the methods described in section 2.2 (outlined in section 3.1) were evaluated reflexively through a secondary thematic analysis and the evaluation yielded a conceptual model that categorized barriers across two dimensions: the **source** of the barrier and the **stage** in the treatment-access process (**Table 5**, **Figure 2**).

The model can be conceptualized as a 2-dimensional 3x3 matrix, in which one dimension (the three “rows”) represents three different levels of **possible source(s) of the barrier**. This theoretical model suggests that barriers to BED identification and treatment-seeking/initiation, access, and engagement can occur at three different levels, outlined below.

1. **The Individual (Patient) Level.** Individual/patient-level barriers generally originate and exist within the individual experiencing BED (e.g., the patient). Although the individual may not be responsible for these barriers, they often have an element of agency or control over them (e.g., barriers to self-recognition such as denial and self-stigmatization, fear of letting go).
2. **The Interpersonal (Healthcare Provider) Level**.Interpersonal barriers exist at the interpersonal level (e.g., at the level of the healthcare provider). These barriers are often outside of the individual/patient’s locus of agency/control (e.g., stigmatization in healthcare providers and insufficient provider detection and screening).
3. **The Systemic/Sociocultural (Systems/Sociocultural Factors) Level.** Systemic barriers often related to sociocultural norms or healthcare and policy standards. These barriers are generally out of the control of the patient and healthcare provider (e.g., stigmatization, lack of education about BED, treatment costs, and insurance coverage), though the patient and healthcare provider may participate in the system the barrier originates and exists in.

A second dimension (the three “columns” of the 3x3 matrix model) represent three **discrete yet dependent stages** that the 15 treatment access barriers identified in section 3.1 (using the methodology described in section 2.2) can occur in (and impede or encumber) in the process of BED identification, treatment-seeking/initiation, and treatment-access and engagement/entry. The three stages are outlined below.

1. **Stage 1: BED Detection & Identification.** This stageincludes BED detection, screening, diagnosis, and identification.
2. **Stage 2: Treatment-Seeking and Planning**. This stage includes exploring, contacting, assessing, planning, and coordinating viable treatment options and care.
3. **Stage 3: Accessing and Engaging in Treatment.** This stage often requires resources to access and engage in treatment and includes initiating ongoing treatment. This stage does not include ongoing treatment participation and maintenance, which is considered a separate (fourth) stage that is addressed in a separate publication.

Reflexive engagement with the data was used to map each of the fifteen treatment barriers identified in section 3.1 onto the model (of treatment stage and barrier level) and identify the number of participants who discussed the barrier in the context of each specific level and stage, as shown in **Table 5** and **Figure 2** .

Notably, many barriers were identified as existing at multiple source and stage levels (e.g., originating or existing at the individual/patient, interpersonal (healthcare provider) *and* sociocultural/systems levels and at more than one stage in the BED detection/identification, treatment initiation/seeking, and access/engagement process). For example, five participants (36%) discussed stigmatization from healthcare providers as being an individual/patient-level barrier that can result in healthcare avoidance or reluctance to discuss BED symptoms, thus preventing BED detection (36%) as well as treatment seeking and entry (36%). Stigmatization was also identified by 36% of experts as an interpersonal/provider-level barrier *and* a systemic/sociocultural barrier that in both sources/cases exist at all three stages. All three levels of stigmatization (systemic, interpersonal, and individual) can contribute to healthcare avoidance, in which stigmatized individuals choose to avoid the healthcare system in attempt to avoid the stigmatization they experience in the system. This can result in missed opportunities for BED detection, screening, diagnosis, and care. Thus, stigmatization poses a significant systemic, interpersonal, and individual barrier to healthcare.

Additionally, many barriers that were described as barriers to treatment-seeking (stage 2) were also described as barriers to treatment access (stage 3). For example, an individual with (a) low income, (b) no health insurance, or insufficient (c) time, (d) transportation, or (e) childcare resources may decide not to engage in treatment or treatment-seeking before even assessing treatment options (e.g., at stage 2). Alternatively, the same individual may investigate treatment options (e.g., in stage 2) and then learn that available treatment options are not accessible to them, thus impeding stage 3 (treatment access and engagement). The barriers to treatment-seeking (stage 2) and treatment access (stage 3) are significantly different from one another to justify retaining these two stages as unique and distinct/separate from one another. However, because the barriers in these two stages are often quite similar, the two stages have been grouped together in **Table 5** and **Figure 2**, as well as in sections 3.2.2 and 4.2.2 below.

3. Results

3.0. Participant Response Rates and Characteristics

Thirty-eight participants met eligibility criteria and were invited to participate; 14 consented and participated (**Figure 1**). Six participants met the academic/research criteria (43%, 6/14), five met the clinical criteria (36%, 5/14), one met both the academic/research and clinical criteria (7%, 1/14), and two met a combination of criteria from the academic and clinical categories to qualify for inclusion in a mixed option (14%, 2/14) (**Table 1**). Thirteen of the fourteen participants provided demographic information, shown in Table 3.

Diagram

Description automatically generated**Figure 1.** Diagram of study flow, from participant identification to enrollment and follow-up. Thirty-eight experts met enrollment criteria and were invited to participate in the study. This included 18 experts who met the academic/research criteria (18/38, 47%), 18 experts who met the clinical criteria (18/38, 47%), and two who met the dual criteria (2/38, 5%; **Table 1**). Fourteen eligible experts consented, enrolled, and participated in the study (14/38, 37%), including six individuals who met the academic/research criteria (6/14, 43%), five who met the clinical criteria (5/14, 36%), one who met both the academic/research and clinical criteria (1/14, 7%), and two who met the dual criteria option (2/14, 14%). Thirteen participants (13/14, 93%) provided demographic information and were included in demographic analysis (**Table 3**). All 14 participant interviews were included in thematic analysis. Figure reproduced from [17, 19] with authors’ permissions.

**Table 3: Characteristics of study participants (N = 14)\***

|  |  |
| --- | --- |
| ***Eligibility criteria met:*** |  |
| Research/Academic | 6 (43%) |
| Clinical/Administrative | 5 (36%) |
| Both (Research/Academic AND Clinical/Administrative) | 1 (7%) |
| Combined (≥1 Research/Academic and ≥1 Clinical Administrative) | 2 (14%) |
|  | |
| ***Credentials*** | |
| Doctor of Philosophy (PhD) or Science (ScD) | 8 (62%) |
| Medical Doctor (MD) | 4 (31%) |
| Licensed or Registered Dietician (LD/RD) or RD Certified in Eating Disorders (CEDRD) | 4 (31%) |
| Bachelor of Medicine Chirurgical Doctor (Bachelor of Surgery) (BChB/MBChB) | 1 (8%) |
| Masters in Public Health (MPH) | 1 (8%) |
|  | |
| ***Additional Accreditations & Accolades*** | |
| Fellow of the Academy of Eating Disorders (FAED) | 8 (62%) |
| Healthcare Administrator | 2 (15%) |
| Certified Chef | 1 (8%) |
| Certified Intuitive Eating Specialist (CIES) | 1 (8%) |
| Fellow of the American College of Neuropsychopharmacology (FACNP) | 1 (8%) |
|  | |
| ***Sex assigned at birth*** | |
| Female | 8 (62%) |
| Male | 5 (38%) |
| Other | 0 (0%) |
|  |  |
| ***Sex/gender identity at time of study*** |  |
| This demographic information is highly relevant, given the disproportionately high risk and prevalence rates of BED among sex and gender minorities, including men and members of the LGBTQ2+ community [see discussion and citations in Bray et al., 2021[17]]. However, this demographic information was regretfully not collected for this study, as addressed in section 4.4 below. | |
|  |  |
| ***Age*** |  |
| 55 ± 10.2 years (range: 37 – 44 yrs., n = 13) |  |
|  |  |
| ***Ethnicity*** |  |
| Hispanic or Latino | 0 (0%) |
| Not Hispanic or Latino | 13 (100%) |
|  |  |
| ***Race*** |  |
| American Indian or Alaska Native | 0 (0%) |
| Asian | 1 (8%) |
| Black or African American | 0 (0%) |
| Native Hawaiian or Other Pacific Islander | 0 (0%) |
| White | 12 (92%) |
| More than one race | 0 (0%) |
|  |  |
| ***Geographical location of residence*** | ***7 reported*** |
| United States of America (USA) | 5 (71%)\*\* |
| United Kingdom (UK) | 1 (14%)\*\* |
| Australia (AU) | 1 (14%)\*\* |
| Canada (CA) | 1 (14%)\*\* |
| **Table Legend:** Results expressed as n (%) or mean ± SD. **Symbols: \***Percentages are expressed as n/13 times 100, as one participant did not provide demographic data. **\*\***Percentages are expressed as n/7 times 100, as only seven participants provided this data. **Abbreviations: AU,** Australia; **BED**, binge eating disorder; **CEDRD**, Registered Dietician Certified in Eating Disorders; **CIES**, Certified Intuitive Eating Specialist; **CIH**, complementary and integrative health; **CA**, Canada; **ED**, eating disorder; **FACNP**, Fellow of the American College of Neuropsychopharmacology; **FAED**, Fellow of the Academy of Eating Disorders; **LD**, Licensed Dietician; **LGBTQ2+**, lesbian, gay, bisexual, transgender, queer, two-soul/two-hearted, pansexual, and other; **MBChB**, Bachelor of Medicine Chirurgical Doctor/Bachelor of Surgery; **MD**, Medical doctor; **MPH**, Masters in Public Health; **PhD**, Doctor of Philosophy; **RD**, Registered Dietician; **ScD**, Doctor of Science; **UK**, United Kingdom; **USA**, United States of America. | |

3.1. Theme 1: Treatment Barriers (64%)

When asked to share their knowledge, opinions, and perspectives on various aspects of adult BED treatment (e.g., questions 2 – 6 in **Table 2**), 64% of BED experts (9/14, 64%) spontaneously described what the authors identified as 11 different thematic barriers to BED treatment access. The barriers and their respective expert endorsement rates (out of 14 and out of the 9 who described treatment access barriers) are outlined in **Table 4**.. Select quotes from participants regarding these treatment barrier themes are shown below and in **Table 4**.

*“The diagnosis is a difficult thing to study [and it] brings in other issues around access to health care, access to health insurance, and it brings in the issue of bias on the part of the people who give out [the] diagnosis. [P16, contd. below]*

*“There are probably millions of people in this country who avoid medical care because they don’t want to walk into the [doctor’s] office and have the doctor weigh them and say, ‘you know what, you have to lose weight and then we can talk about your XYZ conditions that are bothering you.’ …It’s a huge barrier to care.” (P16)*

*“We know that unfortunately eating disorders have been hampered by these old stereotypes about who’s affected, and that leaves millions of people undetected with an eating disorder. … The number of people that I’ve seen and done evaluations on who are really surprised to learn that the way that they’ve been eating is actually considered disordered and that they have an eating disorder and I think that that’s especially true for … any individuals who don’t fit that stereotypical mold of who has an eating disorder … [which is] a young, thin, cis-gendered, white woman…” (P75)*

*“I don’t think there’s enough facilities that are there for people, I don’t think insurance covers enough for higher level[s] of care and it needs to, and I think that … the stigma of their caregivers being in a smaller body and not understanding …I think that that needs to be addressed.” (P37)*

**Table 4: *Treatment Barriers Spontaneously Identified by BED Experts (n=9/14, 64%; adjusted to 100%) and in the literature***

| **BED Treatment Access Barrier Spontaneously Identified by BED Experts | Expert Endorsement n (n/14; n/9) | [Empirical Support]** | | |
| --- | --- | --- |
| **Theme 1: Treatment Access Barriers Identified by BED Experts (n=9/14, 64%; adjusted to 9/9 endorsing experts, 100%) & in the Literature** | | |
| 1. **Stigmatization (1)** | **9 (64% / 100%)** | **[15, 17, 42-58]** |
| * 1. **From Healthcare Providers** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** |
| * + 1. Resulting in patient healthcare avoidance or nondisclosure | 6 (43% / 67%) | *[15, 17, 42, 46, 48-50, 55, 59-63, 66]* |
| * + 1. Resulting in missed provider detection, screening, discussion, diagnosis | *5 (36% / 55%)* | *[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]* |
| * + 1. Including stigma about body weight/shape/size | 6 (43% / 67%) | *[43-45, 48-53, 55, 57, 58, 67-73]* |
| * + 1. Including stigma about having an eating disorder/BED | *5 (36% / 55%)* | *[43-45, 48-53, 55, 57, 58, 67-73]* |
| * + 1. May prompt physical vs. psychopathological BED symptom attendance **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| * 1. **Self-Stigmatization** | **5 (36% / 55%)** | **[15, 17, 42-58]** |
| 1. About body weight/shape/size | 5 (36% / 55%) | [15, 17, 42-58] |
| 1. About having an eating disorder/BED | 5 (36% / 55%) | [15, 17, 42-58] |
| 1. About having any mental health or medical diagnosis | 5 (36% / 55%) | [15, 17, 42-58] |
| 1. Associated with Denial | *3 (21% / 33%)* | *[15, 17, 42-45]* |
| 1. Associated with Shame | *3 (21% / 33%)* | *[15, 17, 42, 43, 45-54]* |
| 1. Associated with healthcare avoidance and under-reporting BED | *3 (21% / 33%)* | [15, 17, 42-58] |
| 1. May prompt physical vs. psychopathological BED symptom attendance (2) | 3 (21% / 33%) | [15-19, 42, 43, 46, 50, 51, 55, 59, 62-65] |
| * 1. **Systemic/Sociocultural Stigmatization** | **8 (57% / 89%)** | **[15, 17, 42-58]** |
| 1. About body weight/shape/size | 8 (57% / 89%) | [15, 17, 42-58] |
| 1. About having an eating disorder/BED | 8 (57% / 89%) | [15, 17, 42-58] |
| 1. About having any mental health or medical diagnosis | 5 (36% / 55%) | [15, 17, 42-58] |
| 1. Associated with Denial | *3 (21% / 33%)* | *[15, 17, 42-45]* |
| 1. Associated with Shame | *3 (21% / 33%)* | *[15, 17, 42, 43, 45-54]* |
| 1. Associated with healthcare avoidance and under-reporting BED | *3 (21% / 33%)* | [15, 17, 42-58] |
| 1. Involves sociocultural prioritization of physical appearance vs mental wellness | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| 1. May prompt physical vs. psychopathological BED symptom attendance **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| 1. **Healthcare Inequity, Avoidance, & Under-Use (3)** | **7 (50% / 78%)** | **[17, 49, 55, 61, 74-80]** |
| * 1. Patient avoidance of stigmatization in healthcare systems and providers | 6 (43% / 67%) | *[15, 17, 42, 46, 48-50, 55, 59-63, 66]* |
| * 1. Demographically Characteristic Healthcare Under-Utilization **(3)** | **3 (21% / 33%)** | **[17, 49, 55, 61, 74-80]** |
| * 1. Associated with demographic/sociocultural beliefs about healthcare use | *3 (21% / 33%)* | *[17, 49, 55, 61, 74-80]* |
| * 1. Associated with undervaluation of BED symptoms and severity | *0 (0%)* | *[17, 49, 55, 61, 74-80]* |
| * 1. Associated with race/ethnic biases & inequity in healthcare systems and providers | *0 (0%)* | *[17, 49, 55, 61, 74-80]* |
| 1. **Treatment Costs & Insurance Coverage (4)** | **6 (43% / 67%)** | **[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]** |
| * 1. Treatment costs | 6 (43% / 67%) | [15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85] |
| * 1. Inadequate insurance coverage | 6 (43% / 67%) | [15, 42, 49, 85] |
| 1. Including all levels of care | *6 (43% / 67%)* | *[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]* |
| 1. Lack of access to health insurance | *6 (43% / 67%)* | *[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]* |
| 1. **Lack of Education and Awareness about BED (1)** | **6 (43% / 67%)** | **[17, 43, 46, 48, 49, 51-53, 63, 86]** |
| 1. **In individuals with BED** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** |
| 1. Lack of information on BED prevalence, risk, and severity | *4 (29% / 45%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86]* |
| 1. Misconceptions about who can have an ED **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 48, 49, 54, 80]* |
| 1. Preventing or impeding self-detection **(5)** | *3 (21% / 33%)* | *[15, 17, 43, 46, 48, 49, 55, 80, 86-88]* |
| 1. Poor education on BED diagnostic criteria and validity | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| E.g., that BED is a valid autonomous DSM-5 mental health diagnosis | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. **Among Healthcare Providers** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** |
| * + 1. Lack of information on BED prevalence, risk, and severity | *4 (29% / 45%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86]* |
| * + 1. Misconceptions about who can have an ED & BED sociodemographic representation **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 48, 49, 54, 80]* |
| * + 1. Resulting in unequal provider screening, esp. in minority populations **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* |
| * + 1. Poor education on BED diagnostic criteria and validity | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| * + 1. Resulting in unequal provider screening, diagnosis, & referral **(5)** | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| * + 1. Associated with insufficient provider education and training | *0 (0%)* | *[42, 43, 45, 46, 48, 51, 63, 73, 90, 91]* |
| 1. **Socioculturally** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** |
| 1. Lack of information on BED prevalence, risk, and severity | *4 (29% / 45%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86]* |
| 1. Misconceptions about who can have an ED **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 48, 49, 54, 80]* |
| 1. Preventing or impeding BED detection **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 48, 49, 55, 80, 86-88]* |
| 1. Contributing to individual, interpersonal, & provider miseducation **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* |
| 1. Linked to individual, interpersonal, healthcare & systemic stigmatization | *4 (29% / 45%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. Poor education on BED diagnostic criteria and validity | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| (E.g., that BED is a valid autonomous DSM-5 mental health diagnosis) | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. Linked to prioritization of physical appearance over mental wellness | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. **Insufficient Provider Screenings (5)** | **4 (29% / 45%)** | **[15, 17, 43, 46, 49, 55, 80, 88]** |
| * 1. Associated with misconceptions about who can have BED **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* |
| * 1. Resulting in unequal screening in non-“SWAG” minority populations **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* |
| * 1. Provider screening for physical symptoms but not underlying psychopathology **(2)** | *3 (21% / 33%)* | *[17-19, 43, 46, 49, 50, 55, 59, 62-65]* |
| * 1. Associated with insufficient provider education and training | *0 (0%)* | *[42, 43, 45, 46, 48, 51, 63, 73, 90, 91]* |
| * 1. May be related to insufficient time in an appointment to discuss eating behaviors | *0 (0%)* | *[46, 48, 49, 63]* |
| 1. **Prioritization of Physical BED Symptoms Over Underlying ED psychopathology (2)** | **3 (21% / 33%)** | **[15-19, 42, 43, 46, 49-51, 55, 59, 62-65]** |
| 1. **In individuals with BED** | **3 (21% / 33%)** | **[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]** |
| 1. Attending to/prioritizing physical comorbidities (e.g., weight, GI symptoms (sx’s)) vs. eating behaviors and underlying psychopathology **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| 1. Possible link to denial/self-stigma (re: body, ED, & mental health stigma) | *3 (36% / 55%)* | [15, 17, 42-58] |
| 1. Possible links to external stigmatization avoidance (e.g., avoiding interpersonal, healthcare, and sociocultural body-, ED-, and mental health stigma) | *3 (36% / 55%)* | [15, 17, 42-58] [15-19, 42, 43, 46, 50, 51, 55, 59, 62-65] |
| 1. Possible link to low education and awareness about BED **(1)** | *4 (29% / 45%)* | [17, 43, 46, 48, 49, 51-53, 63, 86] |
| 1. Possible link to interpersonal and sociocultural prioritization of physical appearance and symptoms over mental and holistic health | *3 (21% / 33%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86] [17-19, 43-46, 48-50, 52, 53, 55, 59, 62-65, 67-73]* |
| 1. **Among Healthcare Providers** | **3 (21% / 33%)** | **[15-19, 42, 43, 46, 49-51, 55, 59, 62-65]** |
| 1. Prioritizing-, attending to-, screening-, and diagnosing physical comorbidities (weight, GI, CDMB factors) vs. ED behaviors & psychopathology **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 49-51, 55, 59, 62-65]* |
| 1. Possible links to provider stigma re: body-, BED/ED-, and mental health | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| 1. Possible link to sociocultural prioritization of physical appearance and symptoms over mental and holistic health | *3 (21% / 33%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86] [17-19, 43-46, 48-50, 52, 53, 55, 59, 62-65, 67-73]* |
| 1. Possible link to insufficient provider education & training on EDs | 0 (0%) | *[46, 48, 49, 63]* |
| 1. Possible link to insufficient appointment time to discuss psychopathology | 0 (0%) | *[46, 48, 49, 63]* |
| 1. **Socioculturally** |  |  |
| * 1. Attending to physical comorbidities (e.g., weight/GI) vs. psychopathology **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| * 1. Screening for physical symptoms but not psychological ones | *3 (21% / 33%)* | *[17-19, 43, 46, 49, 50, 55, 59, 62-65]* |
| * 1. Including sociocultural prioritization of physical appearance over mental health | *3 (21% / 33%)* | *[17-19, 43-46, 48-50, 52, 53, 55, 59, 62-65, 67-73]* |
| * 1. May related to stigmatization (in patients, providers, and socioculturally) | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* |
| * 1. May be related to insufficient time in an appointment to discuss eating behaviors | *0 (0%)* | *[46, 48, 49, 63]* |
| 1. **Insufficient Resources to Find and/or Coordinate Care (6)** | **3 (21% / 33%)** | **[14, 15, 42, 43, 45, 46, 48, 49, 51, 63, 73, 89-94]** |
| * 1. **At the level of the individual/patient (6)** | ***3 (21% / 33%)*** | ***[42, 43, 45, 46, 49, 51, 63, 73, 89]*** |
| * + 1. Including time | *2 (14% / 22%)* | *[46, 48, 49, 63, 90, 95-104]* |
| * + 1. Including transportation | *1 (7% / 11%)* | *[42, 43, 49, 95-99]* |
| * + 1. Including coordinating communication between multiple providers | *3 (21% / 33%)* | *[42, 43, 45, 46, 49, 51, 63, 73, 89]* |
| * 1. **At the level of the healthcare provider** | ***1 (7% / 11%)*** | ***[14, 15, 42, 43, 45, 46, 48, 49, 51, 63, 73, 89-94]*** |
| * + 1. Insufficient provider education and training on BED treatment approaches and options, specialists and treatment centers, and financial aid resources | *0 (0%)* | *[42, 43, 45, 46, 48, 51, 63, 73, 90, 91]* |
| * + 1. Insufficient provider use of referrals for ED specialists | *1 (7% / 11%)* | *[63, 92, 93]* |
| * + 1. Insufficient provider assistance in coordinating care | *1 (7% / 11%)* | *[14, 15, 49, 63, 94]* |
| 1. **ED Provider- & Treatment Center Scarcity** | **3 (21% / 33%)** | **[17, 43, 63, 65, 105-108]** |
| * 1. ED provider scarcity and waitlists | 3 (21% / 33%) | [17, 43, 63, 65, 105-108] |
| * 1. ED treatment center scarcity (e.g., geographic access to treatment resources) | 3 (21% / 33%) | [17, 43, 49, 63, 109] |
| (E.g., Lack of specialists or treatment centers in certain geographic locations) | *3 (21% / 33%)* | *[17, 43, 49, 63, 109]* |
| * 1. Including access to transportation to and from treatment | *1 (7% / 11%)* | *[42, 43, 49, 95-99]* |
| 1. **Time Burden (7)** | **2 (14% / 22%)** | **[46, 48, 49, 63, 90, 95-104]** |
| * 1. Time burden to seek, coordinate, and initiate treatment | *2 (14% / 22%)* | *[46, 48, 49, 63, 90, 95-104]* |
| * 1. Time burden to access and engage in treatment | *2 (14% / 22%)* | *[46, 48, 49, 63, 90, 95-104]* |
| * 1. May be related to provider failing to push for rapid response/behavior change | *1 (7% / 11%)* | *[48, 63, 90, 100-104]* |
| E.g., behavior change in the first 3–4 treatment weeks | *1 (7% / 11%)* | *[48, 63, 90, 100-104]* |
| * 1. Insufficient time in a GP/PCP appointment to discuss eating behaviors | *0 (0%)* | *[46, 48, 49, 63]* |
| 1. **Facing Discomfort and Hardships Associated with Treatment (8)** | **2 (14% / 22%)** | **[36, 45, 52, 73, 110-113]** |
| * 1. Includes fear of facing treatment discomfort and hardships | *2 (14% / 22%)* | *[36, 45, 52, 73, 110-119]* |
| * 1. Tolerating/ “sticking with” treatment when it becomes difficult | *2 (14% / 22%)* | *[36, 114-119]* |
| * 1. E.g., “treatment is hard” | *2 (14% / 22%)* | *[36, 114-119]* |
| * 1. Negative attitudes about behavior change (e.g., ambivalence, low motivation) | *0 (0%)* | *[43, 45, 62, 110]* |
| * 1. Negative attitudes and beliefs about the feasibility of behavior change | *0 (0%)* | *[43, 45, 62, 110]* |
| * 1. Fear of weight gain and “breaking food rules”/facing “fear foods” (or fear of facing those fears) reported in literature on individuals with anorexia nervosa | *0 (0%)* | *[120, 121].* |
| 1. **Fear of letting go of the coping/eating behavior (9)** | **1 (7% / 11%)** | Direct support: [43, 45, 52, 53, 73, 110, 112, 113]  Indirect support: [122-126]  Reported in comorbid conditions: [127-130] |
| **Table Legend:** **Treatment Barriers Spontaneously Identified by BED Experts and supported in the literature. Column one** (left-hand column) identifies the 11 most commonly identified themes related to BED identification, treatment-seeking, and treatment access/engagement, as identified spontaneously (without prompting) in semi-structured interviews with 14 BED experts and reflexive engagement with interview transcripts for qualitative thematic analysis. In total, 9/14 BED experts (64%) spontaneously identified at least one of the 11 different themes. **Column two** (middle column) represents the number and percent of BED experts who spontaneously endorsed each theme (e.g., made unprompted/unsolicited statements that aligned with or supported the theme). Percentages are expressed as n/14 (depicting the percentage of all experts interviewed who endorsed each theme). An adjusted percentage is also shown (second percentage), which is expressed as n/9 (depicting the percentage of expert endorsement per theme out of the 9 experts who spontaneously addressed *any* of the fifteen identified themes and removing the five experts who did not address the topic of treatment barriers). **Column three** (right-hand column) identifies existing literature that supports each theme or sub-theme.  **Notes:** **(1)** E.g., that BED is in fact a valid autonomous DMS-5/DSM-5-TR mental health diagnosis that is separate from overweight and obesity, and that not all EDs present as AN or BN [1]. **(2)** The psychopathology thought to drive BED can vary according to the individual. Commonly endorsed models of conceptualizing BED psychopathology are addressed in Bray et al. 2022 and 2023 and Neyland, Shank, & Lavender 2020 [17-19, 50]. These include emotional dysregulation, childhood or lifetime adversity, negative affect and urgency, stigmatization from self or others, and self-denial. The prioritization or attendance to physical symptoms associated with BED (e.g., weight, gastrointestinal issues, cardiometabolic factors, and other physical ailments) but not underlying ED behaviors or psychopathology has been suggested to be linked to shame, stigmatization, and denial in some cases. This possibility is supported in qualitative literature that reports individuals with BED endorsing this possibility [15, 17, 42, 46-48]. **(3)** E.g., some racial, ethnic, sexual, and gender minorities are less likely to access and utilize healthcare [17, 49, 55, 61, 74-80]. **(4)** E.g., treatment cost prioritization and lack of information on financial assistance as well as insufficient health insurance information, coverage, and/or lack of health insurance altogether. **(5)** Although thin white affluent women (the “SWAG” demographic) have traditionally saturated eating disorder treatment-seeking and research populations and demographics, recent studies reveal that individuals who identify as BIPOC and/or LGBTQ2+: (a) have disproportionately higher BED risk, prevalence rates, and severity scores relative to their white, cis-gendered, heterosexual counterparts; (b) are under-represented in research (making up <10% of participants in BED research studies); (c) are less likely to be screened by medical professionals for EDs; (d) are ~50% less likely to be diagnosed or receive care; and (e) are more likely to experience one or more environmental factors that are associated with BED pathology and risk (e.g., economic precarity, food/nutrition scarcity, stigmatization, and discrimination). See Bray et al., 2022 and citations therein for references [17]. **(6)** Including time, transportation, and resources required to coordinate communication between multiple providers [42, 43, 45, 46, 48, 49, 51, 63, 73, 89, 95-99]. **(7)** E.g., having time to find and/or coordinate care and pursue/engage in treatment. **(8)** E.g., “treatment is hard.” To the authors' knowledge, this particular barrier has little empirical investigation in the context of BED. For example, the literature on “fear of facing treatment hardships” focuses more on populations with anorexia nervosa (e.g., facing fears of weight gain and “breaking food rules”/facing “fear foods”) [120, 121]. However, some support does exist for negative attitudes towards seeking help [43, 45] and patient ambivalence/low motivation to change in the context of BED [43, 45, 62, 110]. Additionally, studies on CIH intervention use in the context of BED treatment tend to identify a benefit of BED in supporting patients in tolerating and coping with treatment demands, indirectly supporting this barrier [114-119]. **(9)** Binge eating behavior is often viewed as a coping behavior associated with trauma/adversity both in BED [17-19, 122-126] and obesity [19, 126-131]. Trauma/adversity and obesity both have high comorbidity with BED [2, 5, 17-19, 132].  **Abbreviations: BED**, binge eating disorder; **BIPOC**, black, indigenous, and people of color; **CDMB**, cardiometabolic; **DSM-5**, Diagnostic Statistical Manual, 5th Edition (manual published by the American Psychiatric Association (APA) and used to diagnose psychiatric disorders); **DSM-5-TR**, Diagnostic Statistical Manual, 5th Edition Text Revision (current, most up-to-date version of the DSM-5); **ED**, eating disorder; **GI**, gastrointestinal; **GP**, general practitioner; **LGBTQ2+**, lesbian, gay, bisexual, transgender, queer, two-soul/two-hearted, pansexual, and other; **PCP**, primary care provider; **Sx/Sx’s,** symptom(s); **SWAG**, an outdated misconception that ascribes eating disorders to “thin (“skinny”), white, affluent, young women (“girls”),” typically with restrictive-type eating disorders. | | |

3.2. Theme 2: Theoretical Model of Treatment Barriers

The 11 treatment barrier themes identified by BED experts (outlined in section 3.1 above) were re-evaluated through a secondary reflexive thematic analysis. The evaluation yielded a conceptual 2-dimensional 3x3 model that categorizes barriers across two dimensions: the **stage** the barrier impedes in the treatment-access process and the **source** of the barrier (**Table 5**, **Figure 2**).

The dimension of **treatment-engagement process *stage*** includes three **discrete yet dependent stages** that treatment barriers can impede:

1. **Stage 1: BED Detection & Identification:** which includes BED recognition, screening, identification, and diagnosis (barriers in this stage were spontaneously identified by 50% of participants).
2. **Stage 2: Treatment-Seeking & Planning**, which includes exploring, contacting, assessing, planning, and coordinating viable treatment options and care (barriers pertaining to this stage were spontaneously addressed by 57% of participants).
3. **Stage 3: Treatment Access and Engagement**,which includes initiating ongoing treatment (barriers pertaining to this stage were spontaneously addressed by 57% of participants).

The dimension of treatment-engagement **barrier source(s)** also includes three levels:

1. The level of the **individual/patient**.
2. The **interpersonal/healthcare provider** level.
3. The **sociocultural/systemic/systems** level.

The barriers identified within each of the three levels for each of the two dimensions identified in the conceptual model are shown in **Table 5** and **Figure 2** and are described further below.

NOTE: Though stage two an stage 3 are significantly different stages in this model, they have been grouped together in **Table 5** and **Figure 2**

Many barriers that were described as impeding treatment-seeking (stage 2) were also described as impeding treatment access/engagement (stage 3). The way the barrier(s) were described as impeding the two stages was significantly at each stage, thus justifying the retention of these two stages as unique and distinct/separate from one another. However, because the barriers in these two stages are often quite similar, the two stages have been grouped together in **Table 5**, **Figure 2**, as well as in sections 3.2.2 and 4.2.2 below.

**Table 5: *Classification of BED Treatment Access Barriers by Source and Stage as Identified by BED Experts***

| **BED Treatment Access Barrier Source, Stage, & Individual Barrier(s) | Expert Endorsement n (n/14 // n/9) | [Supporting Literature]** | | | |
| --- | --- | --- | --- |
| ***Subtheme 1: Barriers to BED Recognition, Detection, Screening & Diagnosis*** | ***9 (64%/100%)*** |  | |
| 1. **Individual/Patient-Level Barriers (Section 3.2.1.1)** | **9 (64%*/100%*)** |  | |
| 1. **Healthcare Avoidance and Under-Reporting due to Stigmatization** | **9 (64%/100%)** | **[15, 17, 42, 46, 48-50, 55, 59-63, 66]** | |
| * 1. Avoidance of healthcare provider/system stigmatization | 6 (43%/ 67%) | *[15, 17, 42, 46, 48-50, 55, 59-63]* | |
| * 1. Linked to self-stigmatization (diagnosis avoidance) | 5 (36% / 55%) | *[43, 44, 48-50, 55-58]* | |
| * 1. Barrier to clinical detection, screening, diagnosis, & support | *6 (43% / 67%)* | *[15, 17, 42, 46, 48-50, 55, 59-63, 66]* | |
| * 1. Avoidance of system/sociocultural stigmatization | *3 (21% / 33%)* | *[17, 49, 55, 61, 74-80] [15, 17, 42-58]* | |
| * 1. Linked to body/weight/shape size and/or ED/mental health stigma | 5 (36% / 55%) | *[15, 17, 42-58]* | |
| * 1. Linked to denial, guilt, and shame | 3 (21% / 33%) | *[15, 17, 42-54]* | |
| * 1. Linked to physical (vs psychopathological) BED symptom attendance **(2)** | 3 (21% / 33%) | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* | |
| * 1. Linked to fear of facing treatment hardships **(8)** | 2 (14% / 22%) | *[36, 45, 52, 73, 110-119]* | |
| * 1. Linked to fear of facing the underlying ED psychopathology (e.g., “letting go of the coping/eating behavior) **(9)** | 1 (7% / 11%) | *Direct support: [43, 45, 52, 53, 73, 110, 112, 113]*  *Indirect support: [122-126]*  *Reported in comorbid conditions: [127-130]* | |
| 1. **Denial/Self-Stigmatization Impeding Self-Detection/Recognition** | **5 (36% / 55%)** | **[15, 17, 42-58]** | |
| * 1. Separate from healthcare avoidance and under-reporting | 5 (36% / 55%) | *[15, 17, 42-58]* | |
| * 1. Linked to self-stigmatization | 5 (36% / 55%) | *[43, 44, 48-50, 55-58]* | |
| * 1. Linked to shame | 3 (21% / 33%) | *[15, 17, 42, 43, 45-54]* | |
| * 1. Linked to denial | 3 (21% / 33%) | *[15, 17, 42-45]* | |
| * 1. Linked to physical (vs psychopathological) BED symptom attendance **(2)** | 3 (21% / 33%) | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* | |
| * 1. Linked to fear of facing treatment hardships **(8)** | 2 (14% / 22%) | *[36, 45, 52, 73, 110-119]* | |
| * 1. Linked to fear of facing the underlying ED psychopathology (e.g., “letting go of the coping/eating behavior) **(9)** | 1 (7% / 11%) | *Direct support: [43, 45, 52, 53, 73, 110, 112, 113]*  *Indirect support: [122-126]*  *Reported in comorbid conditions: [127-130]* | |
| 1. **Healthcare Under-Utilization (3)** | **5 (36%/ 55%)** | **[17, 49, 55, 61, 74-80]** | |
| * 1. Barrier to clinical detection, screening, diagnosis, & support | 3 (21%/ 33%) | *[17, 49, 55, 61, 74-80]* | |
| * 1. Demographically characteristic healthcare under-utilization **(3)** | 3 (21%/ 33%) | *[17, 49, 55, 61, 74-80]* | |
| * 1. Associated with demographic/sociocultural beliefs about healthcare use | *3 (21% / 33%)* | *[17, 49, 55, 61, 74-80]* | |
| * 1. Associated with undervaluation of BED symptoms and severity | *3 (21% / 33%)* | *[17, 49, 55, 61, 74-80]* | |
| * 1. Avoidance of race/ethnic biases & inequity in healthcare systems | 1 (7% / 11%) | *[17, 49, 55, 61, 74-80]* | |
| 1. **Low Education and Awareness about BED (1, 5)** | **4 (29% / 45%)** | **[15, 17-19, 42, 43, 46, 48-53, 55, 59-66, 80, 86-88]** | |
| * 1. Low information on BED prevalence, risk, and severity | *4 (29% / 45%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86]* | |
| * 1. Misconceptions about BED demographics and who can have an ED**(5)** | *4 (29% / 45%)* | *[15, 17, 43, 48, 49, 54, 80]* | |
| * 1. Poor education on BED diagnostic criteria and validity | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| E.g., that BED is a valid autonomous DSM-5 mental health diagnosis | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| * 1. Linked to healthcare & sociocultural lack or mis-information about BED | *3 (21% / 33%)* | *[15, 17, 43, 46, 48, 49, 55, 80, 86-88]* | |
| * 1. Linked to prioritization of physical appearance and symptoms over mental health/underlying BED/ED psychopathology **(2)** | *2 (14% / 22%)* | *[17-19, 43, 46, 48-53, 55, 59, 62-65, 89]* | |
| 1. **Attendance to Physical BED Symptoms vs. Underlying ED Psychopathology (2)** | **3 (21% / 33%)** | **[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]** | |
| * 1. Attending to/prioritizing physical comorbidities (e.g., weight/GI symptoms) vs. eating behaviors and underlying psychopathology (2) | 3 (21% / 33%) | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* | |
| 1. Possible link to denial/self-stigma (re: body, ED, & mental health stigma) | 3 (36% / 55%) | [15, 17, 42-58] | |
| 1. Possible links to external stigmatization avoidance (e.g., avoiding interpersonal, healthcare, and sociocultural body-, ED-, and mental health stigma) | 3 (36% / 55%) | [15, 17, 42-58][15-19, 42, 43, 46, 50, 51, 55, 59, 62-65] | |
| 1. Possible link to low education and awareness about BED **(1)** | 4 (29% / 45%) | [17, 43, 46, 48, 49, 51-53, 63, 86] | |
| * 1. Possible link to interpersonal and sociocultural prioritization of physical appearance and symptoms over mental and holistic health | *3 (21% / 33%)* | *[17, 43, 46, 48, 49, 51-53, 63, 86][17-19, 43-46, 48-50, 52, 53, 55, 59, 62-65, 67-73]* | |
| 1. **Fear of Facing Underlying ED Psychopathology &/or Treatment Hardships (8,9)** | **3 (21% / 33%)** | **[36, 45, 52, 73, 110-113]** | |
| 1. Fear of facing treatment hardships **(8)** | 2 (14% / 22%) | *[36, 45, 52, 73, 110-119]* | |
| 1. Fear of facing the underlying ED psychopathology (e.g., “letting go of the coping/eating behavior) **(9)** | 1 (7% / 11%) | *Direct support: [43, 45, 52, 53, 73, 110, 112, 113]*  *Indirect support: [122-126]*  *Reported in comorbid conditions: [127-130]* | |
| 1. Linked to healthcare avoidance, stigmatization, and attending to physical (vs psychopathological) symptoms **(2)** | 2 (14% / 22%) | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65][36, 43, 45, 52, 53, 73, 110-119]* | |
| 1. **Interpersonal/Provider-Level Barriers (Section 3.2.1.2)** | **7 (50% */ 78%*)** |  | |
| 1. **Stigmatization & Weight Bias from Healthcare Providers** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** | |
| * 1. Including weight, B/ED, mental health, & medical diagnosis stigmatization | *6 (43% / 67%)* | *[43-45, 48-53, 55, 57, 58, 67-73]* | |
| * 1. Linked to patient healthcare avoidance or nondisclosure | 6 (43% / 67%) | *[15, 17, 42, 46, 48-50, 55, 59-63, 66]* | |
| * 1. Linked to missed provider detection, screening, discussion, diagnosis | *5 (36% / 55%)* | *[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]* | |
| * 1. Linked to physical vs psychopathological BED symptom attendance **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* | |
| * 1. Possible link to low education on BED (including prevalence and risk, underlying psychopathology, demographic prevalence rates and who can have BED, and screening and diagnostic criteria and processes)**(1,5)** | *5 (36% / 55%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* | |
| 1. **Low/Insufficient Information, Education, and Awareness About BED (1)** | **6 (43% / 67%)** | **[15, 17-19, 42, 43, 46, 48-51, 55, 59-66]** | |
| **Including:** |  |  | |
| 1. Lack of information on BED prevalence, risk, and severity | *4 (29% / 45%)* | [15, 17, 43, 46, 49, 55, 80, 87, 88] | |
| 1. Misconceptions about BED sociodemographics & who can have an ED (E.g., the S.W.A.G. stereotype) **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 48, 49, 51-53, 55, 63, 80, 86, 88]* | |
| 1. Poor education on BED diagnostic criteria and validity | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| (E.g., lack of familiarity with diagnostic criteria) | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| **Associated with:** |  |  | |
| 1. Insufficient provider education and training | *0 (0%)* | *[42, 43, 45, 46, 48, 51, 63, 73, 90, 91]* | |
| **Resulting in:** |  |  | |
| 1. Provider stigmatization and weight bias | *5 (36% / 55%)* | *[15, 17, 43, 46, 48, 49, 51-53, 55, 63, 80, 88, 89]* | |
| 1. Unequal provider detection, screening, & diagnosis (Broadly) **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 48, 49, 51-53, 55, 63, 80, 88, 89]* | |
| Especially among marginalized and minority populations **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* | |
| 1. Prioritizing/attending physical sx’s (weight/GI) vs ED psychopathology **(2)** | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| 1. Under-screening | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* | |
| 1. **Insufficient provider screenings (5)** | **4 (29% / 45%)** | **[15, 17, 43, 46, 49, 55, 80, 88]** | |
| * 1. Associated with misconceptions about who can have BED **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* | |
| * 1. Resulting in unequal screening in non-“SWAG” minority populations **(5)** | *4 (29% / 45%)* | *[15, 17, 43, 46, 49, 55, 80, 88]* | |
| E.g., racial, ethnic, sex, gender, and sexual orientation minorities **(5)** | 4 (29% / 45%) | [15, 17, 43, 46, 49, 55, 80, 88] | |
| * 1. Screening for physical symptoms but not underlying psychopathology | *3 (21% / 33%)* | *[17-19, 43, 46, 49, 50, 55, 59, 62-65]* | |
| * 1. Associated with insufficient provider education and training | *0 (0%)* | *[42, 43, 45, 46, 48, 51, 63, 73, 90, 91]* | |
| * 1. Associated with insufficient time in GP/PCP appointment to discuss eating behaviors and psychopathology | *0 (0%)* | *[46, 48, 49, 63]* | |
| 1. **Attending to Physical vs. Psychological Symptoms/Comorbidities/Pathology (2)** | **3 (21% / 33%)** | **[15-19, 42, 43, 46, 49-51, 55, 59, 62-65]** | |
| (E.g., Prioritizing-, attending to-, screening-, and diagnosing weight, GI, & cardiometabolic factors vs. ED behavior and psychopathology) **(2)** | *3 (21% / 33%)* | *[15-19, 42, 43, 46, 49-51, 55, 59, 62-65]* | |
| **Possible links to:** |  |  | |
| * 1. Provider stigma re: body-, BED/ED-, and mental health | 3 (21% / 33%) | *[15-19, 42, 43, 46, 50, 51, 55, 59, 62-65]* | |
| * 1. Insufficient provider education & training on EDs | 0 (0%) | *[46, 48, 49, 63]* | |
| * 1. Insufficient appointment time to discuss psychopathology | 0 (0%) | *[46, 48, 49, 63]* | |
| 1. **Healthcare Inequity (3)** | **1 (7% / 11%)** | **[17, 49, 55, 61, 74-80]** |
| **Associated with:** | **1 (7% / 11%)** | ***[17, 49, 55, 61, 74-80]*** |
| 1. Race, ethnicity, & other marginalized status’ (3) | 1 (7% / 11%) | [17, 49, 55, 61, 74-80] | |
| 1. Healthcare avoidance (3) | 1 (7% / 11%) | [17, 49, 55, 61, 74-80] | |
| 1. Missed opportunities for detection, screening, & diagnosis (3) | 1 (7% / 11%) | [17, 49, 55, 61, 74-80] | |
| 1. **Systems-Level Barriers (Section 3.2.1.3)** | **7 (50% */ 78%*)** |  | |
| 1. **Sociocultural stigmatization around weight, B/ED, and mental health issues** | **5 (36%/ 55%)** | **[43-45, 48-53, 55, 57, 58, 67-73]** | |
| 1. **Lack of education and awareness about BED (1)** | **4 (29% / 45%)** | **[17, 43, 46, 48, 49, 51-53, 63, 86]** |
| **Including:** |  |  |
| 1. Misconceptions about who can have an ED **(5)** | 3 (21% / 33%) | [15, 17, 43, 48, 49, 80, 86] |
| (Which can prevent detection and identification) **(5)** | 3 (21% / 33%) | [15, 17, 43, 48, 49, 80, 86] |
| 1. Poor sociocultural education on BED diagnostic criteria & validity | 2 (14% / 22%) | [17, 43, 46, 48, 49, 51-53, 63] |
| (E.g., that BED is an autonomous DSM-5 mental health diagnosis) | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| **Resulting in:** |  |  |
| 1. Stigmatization (re body weight/shape/size, ED/mental health diagnosis) | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. Prioritization of physical sx’s (e.g., weight) vs, psychopathological underpinnings, and under-screening | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. Missed detection and under-screening | *2 (14% / 22%)* | *[17, 43, 46, 48, 49, 51-53, 63, 89]* |
| 1. **Sociocultural prioritization of physical appearance over mental health** | **3 (21% / 33%)** | **[17-19, 43, 46, 49, 50, 55, 59, 62-65]** | |
| ***Subthemes 2 and 3: Barriers to BED Treatment Seeking, Access, & Engagement*** | ***8 (57% / 89%)*** |  | |
| 1. **Individual/Patient-Level Barriers (Section 3.2.2.1)** | ***8 (57% / 89%)*** |  | |
| 1. **Treatment Costs & Insurance Coverage (4)** | **6 (43% / 67%)** | **[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]** | |
| * 1. Treatment costs | 6 (43% / 67%) | [15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85] | |
| * 1. At all levels of care | *6 (43% / 67%)* | *[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]* | |
| * 1. Insufficient insurance coverage | 6 (43% / 67%) | [15, 42, 49, 85] | |
| * 1. Lack of access to health insurance | *6 (43% / 67%)* | *[15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85]* | |
| 1. **Healthcare Avoidance** | **5 (36%/ 55%)** | **[15, 17, 42, 46, 48-50, 55, 59-63]** | |
| * 1. Due to healthcare provider stigmatization | *5 (36%/ 55%)* | *[15, 17, 42, 46, 48-50, 55, 59-63]* | |
| * 1. Associated with demographic/sociocultural beliefs about healthcare use | *3 (21% / 33%)* | *[17, 49, 55, 61, 74-80]* | |
| * 1. Avoidance of race/ethnic biases & inequity in healthcare systems | *0 (0%)* | *[17, 49, 55, 61, 74-80]* | |
| 1. **Denial/self-stigma re: ED/mental health diagnosis** | **3 (21% / 33%)** | **[15, 17, 42-58]** | |
| 1. Denial | *3 (21% / 33%)* | *[15, 17, 42-45]* | |
| 1. Self-stigmatization | *3 (21% / 33%)* | *[43, 44, 48-50, 55-58]* | |
| 1. Shame | *3 (21% / 33%)* | *[15, 17, 42, 43, 45-54]* | |
| 1. **Insufficient resources for finding/coordinating care (6)** | **3 (21% / 33%)** | **[42, 43, 45, 46, 49, 51, 63, 73, 89]** | |
| * 1. Including time **(7)** | *2 (14% / 22%)* | *[46, 48, 49, 63, 90, 95-104]* | |
| * 1. Including transportation | *1 (7% / 11%)* | *[42, 43, 49, 95-99]* | |
| * 1. Including coordinating communication between multiple providers | *3 (21% / 33%)* | *[42, 43, 45, 46, 49, 51, 63, 73, 89]* | |
| 1. ***\*\*Insufficient resources for accessing/engaging in care (6)\*\**** | ***3 (21% / 33%)*** | ***[42, 43, 45, 46, 49, 51, 63, 73, 89]*** | |
| * 1. Including time **(7)** | *2 (14% / 22%)* | *[46, 48, 49, 63, 90, 95-104]* | |
| * 1. Including transportation | *1 (7% / 11%)* | *[42, 43, 49, 95-99]* | |
| * 1. Including coordinating communication between multiple providers | *3 (21% / 33%)* | *[42, 43, 45, 46, 49, 51, 63, 73, 89]* | |
| 1. ***\*\*Geographic access to treatment resources \*\**** | ***3 (21% / 33%)*** | ***[17, 43, 49, 63, 109]*** | |
| 1. E.g., Lack of specialists or treatment centers in certain geographic locations | *3 (21% / 33%)* | *[17, 43, 49, 63, 109]* | |
| 1. Including access to transportation to and from treatment | *1 (7% / 11%)* | *[42, 43, 49, 95-99]* | |
| 1. ***\*\*Eating disorder provider scarcity and wait lists \*\**** | ***3 (21% / 33%)*** | ***[17, 43, 63, 65, 105-108]*** | |
| 1. **Facing discomfort and hardships associated with treatment (8)** | **1 (7% / 11%)** | **[36, 45, 52, 73, 110-113]** | |
| 1. E.g., “treatment is hard” | 1 (7% / 11%) |  | |
| 1. Negative attitudes about behavior change (e.g., ambivalence, low motivation) | 0 (0%) | [43, 45, 62, 110] | |
| 1. Negative attitudes and beliefs about the *feasibility* of behavior change | 0 (0%) | [43, 45, 62, 110] | |
| 1. Fear of weight gain and “breaking food rules”/facing “fear foods” (or fear of facing those fears) reported in literature on individuals with anorexia nervosa | 0 (0%) | [120, 121]. | |
| 1. **Letting go of the coping/eating behavior (9)** | **1 (7% / 11%)** | **Direct support: [43, 45, 52, 53, 73, 110, 112, 113]**  **Indirect support: [122-126]**  **Reported in comorbid conditions: [127-130]¶** | |
| 1. **Poor** education and awareness about BED severity and need for treatment **(1)** | 0 (0%) | [17, 43, 46, 48, 49, 51-53, 63, 86] | |
| 1. **Interpersonal/Provider-Level Barriers (Section 3.2.2.2)** | ***8 (57% / 89%)*** |  | |
| 1. Stigmatization from healthcare providers | 5 (36%/ 55%) | [15, 17, 42, 46, 48-50, 55, 59-63, 66] | |
| 1. Insufficient resources for finding and coordinating care **(6)** | 3 (21% / 33%) | [14, 15, 42, 43, 45, 46, 48, 49, 51, 63, 73, 89-94] | |
| * 1. Insufficient provider education and training on BED treatment approaches and options, specialists and treatment centers, and financial aid resources |  | [42, 43, 45, 46, 48, 51, 63, 73, 90, 91] | |
| * 1. Insufficient provider use of referrals for ED specialists |  | [63, 92, 93] | |
| * 1. Insufficient provider assistance in coordinating care |  | [14, 15, 49, 63, 94] | |
| 1. Time associated with treatment engagement | 2 (14% / 22%) | [46, 48, 49, 63, 90, 100-104] | |
| * 1. Insufficient time in a GP/PCP appointment to discuss eating behaviors | 2 (14% / 22%) | [46, 48, 49, 63] | |
| * 1. Not pushing for rapid response/behavior change in the first 3–4 treatment weeks | 1 (7% / 11%) | [48, 63, 90, 100-104] | |
| 1. **Systems-Level Barriers (Section 3.2.2.3)** | **8 (57% / 89%)** |  | |
| 1. Treatment costs **(4)** | 6 (43% / 67%) | [15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85] | |
| 1. Insufficient insurance coverage **(4)** | 5 (36%/ 55%) | [15, 42, 49, 85] | |
| 1. Systemic/societal stigmatization | 5 (36%/ 55%) | [43-45, 48-50, 52, 53, 55, 67-73] | |
| 1. Insufficient resources for finding/coordinating care **(6)** | 3 (21% / 33%) | [46, 49], [42, 43, 45, 46, 51, 63, 73, 89] | |
| 1. ***\*\*Geographic access to treatment resources \*\**** | ***3 (21% / 33%)*** | ***[17, 43, 49, 63, 109]*** | |
| 1. ***\*\*Provider/treatment center scarcity and wait lists \*\**** | ***3 (21% / 33%)*** | ***[17, 43, 63, 65, 105-108]*** | |
| 1. Sociocultural prioritization of physical health outcomes over mental health | 3 (21% / 33%) | [17-19, 43-46, 48-50, 52, 53, 55, 59, 62-65, 67-73] | |
| 1. Time required for treatment | 2 (14% / 22%) | [48, 49, 95-99] | |
| 1. ***\*\*Transportation to and from treatment\*\**** | ***1 (7% / 11%)*** | ***[42, 43, 49, 95-99]*** | |
| **Table Legend:** **Tabular Depiction of the Theoretical Model displayed in Figure 2 that Categorizes BED Treatment Access Barriers by Source (e.g., as (1) Individual, (2) Interpersonal, or (3) Systems-Level Barriers) and Stage (e.g., as barriers to BED Identification (Stage 1), Treatment-Seeking (Stage 2), and Treatment Access (Stage 3)),** as Identified by BED Experts. Results expressed as n (%). Percentages: n/14 times 100, in which n represents the number of participants who spontaneously endorsed a particular theme.  **Notes:** **(1)** E.g., that BED is in fact a valid autonomous DMS-5/DSM-5-TR mental health diagnosis that is separate from overweight and obesity, and that not all EDs present as AN or BN [1]. **(2)** The psychopathology thought to drive BED can vary according to the individual. Commonly endorsed models of conceptualizing BED psychopathology are addressed in Bray et al. 2022 and 2023 and Neyland, Shank, & Lavender 2020 [17-19, 50]. These include emotional dysregulation, childhood or lifetime adversity, negative affect and urgency, stigmatization from self or others, and self-denial. The prioritization or attendance to physical symptoms associated with BED (e.g., weight, GI issues, and other physical ailments) but not underlying ED behaviors or psychopathology has been suggested to be linked to shame, stigmatization, and denial in some cases. This possibility is supported in qualitative literature that reports individuals with BED endorsing this possibility [15, 17, 42, 46-48]. **(3)** E.g., some racial, ethnic, sexual, and gender minorities are less likely to access and utilize healthcare [17, 49, 55, 61, 74-80]. **(4)** E.g., treatment cost prioritization and lack of information on financial assistance as well as insufficient health insurance information, coverage, and/or lack of health insurance altogether. **(5)** Although thin white affluent women (the “SWAG” demographic) have traditionally saturated eating disorder treatment-seeking and research populations and demographics, recent studies reveal that individuals who identify as BIPOC and/or LGBTQ2+: (a) have disproportionately higher BED risk, prevalence rates, and severity scores relative to their white, cis-gendered, heterosexual counterparts; (b) are under-represented in research (making up <10% of participants in BED research studies); (c) are less likely to be screened by medical professionals for EDs; (d) are ~50% less likely to be diagnosed or receive care; and (e) are more likely to experience one or more environmental factors that are associated with BED pathology and risk (e.g., economic precarity, food/nutrition scarcity, stigmatization, and discrimination). See Bray et al., 2022 and citations therein for references [17]. **(6)** Including time, transportation, and resources required to coordinate communication between multiple providers [42, 43, 45, 46, 48, 49, 51, 63, 73, 89, 95-99]. **(7)** E.g., having time to find and/or coordinate care and pursue/engage in treatment. **(8)** E.g., “treatment is hard.” To the authors' knowledge, this particular barrier has little empirical investigation in the context of BED. For example, the literature on “fear of facing treatment hardships” focuses more on populations with anorexia nervosa (e.g., facing fears of weight gain and “breaking food rules”/facing “fear foods”) [120, 121]. However, some support does exist for negative attitudes towards seeking help [43, 45] and patient ambivalence/low motivation to change in the context of BED [43, 45, 62, 110]. Additionally, studies on CIH intervention use in the context of BED treatment tend to identify a benefit of BED in supporting patients in tolerating and coping with treatment demands, indirectly supporting this barrier [114-119]. **(9)** Binge eating behavior is often viewed as a coping behavior associated with trauma/adversity both in BED [17-19, 122-126] and obesity [19, 126-131]. Trauma/adversity and obesity both have high comorbidity with BED [2, 5, 17-19, 132].  **Symbols: ¢** Thought to be linked to trauma/adversity and fear often. **\*\***Proposed barriers presented in bold and italicized text with double asterisk (**\*\***) pertain more to treatment access/entry (stage 3) than to treatment-seeking (stage 2). **¶** E.g., obesity**.**  **Abbreviations: BED**, binge eating disorder; **BIPOC**, black, indigenous, and people of color; **DSM-5**, Diagnostic Statistical Manual, 5th Edition (manual published by the American Psychiatric Association (APA) and used to diagnose psychiatric disorders); **DSM-5-TR**, Diagnostic Statistical Manual, 5th Edition Text Revision (current, most up-to-date version of the DSM-5); **ED**, eating disorder; **GI**, gastrointestinal; **GP**, general practitioner; **LGBTQ2+**, lesbian, gay, bisexual, transgender, queer, two-soul/two-hearted, pansexual, and other; **PCP**, primary care provider; **SWAG**, an outdated misconception that ascribes eating disorders to “thin (“skinny”), white, affluent, young women (“girls”),” typically with restrictive-type eating disorders.. | | | |

**A screenshot of a diagram

Description automatically generatedFigure 2. Theoretical model of patient-, provider-, and systems-level barriers that can impede binge eating disorder (BED) identification (Stage 1), treatment-seeking (Stage 2), and treatment engagement (Stage 3),** as spontaneously identified by 64% of BED experts in this study (n=9/14). Eleven (11) barriers to BED treatment were identified through reflexive thematic analysis as common themes among BED expert interview transcripts (n=9/14). Secondary reflexive thematic analysis of the themes yielded a conceptual model that categorized barriers across two dimensions: the **source of the barrier** and the **stage in the treatment-access process**. The model can be conceptualized as a 3x3 matrix, in which the three “rows” represent the source(s) of the barrier (e.g., whether the barrier occurs at the **level of the** **individual (patient)**, the **interpersonal level** (e.g., at the level of the healthcare provider), or the **systemic level** (i.e., sociocultural factors)). The “columns” (which are collapsed here to two columns as described further below) represent the stage in the treatment-access process the barrier occurs in (e.g., whether the barrier impedes **BED detection (Stage 1**, which includes BED screening, diagnosis, and identification), the **initiation of treatment-seeking (Stage 2)**, or **access to ongoing treatment (Stage 3)**). By categorizing barriers in this manner, the model aims to provide a comprehensive framework for understanding the multifaceted challenges faced by individuals with BED. This framework can help in identifying targeted interventions at each stage and level, ultimately improving outcomes related to BED detection, screening, diagnosis, referral, treatment access, treatment engagement, and treatment outcomes in turn. Notably eight patient-level- and five systemic barriers that were described as impeding the treatment-seeking stage (Stage 2) were also described as barriers to treatment access and engagement (stage 3). The way the barriers were described as interacting with the different stages of the treatment-seeking and access process (e.g., Stage 2 and Stage 3) differed significantly from one another enough to justify Stage 2 and Stage 3 as two unique stages in the treatment access//engagement process that are distinct from one another. The two stages (Stage 2 and Stage 3) have been grouped together in this visual representation of the conceptual model to conserve space. The eight patient-level barriers and five systemic barriers that were identified as impeding both the treatment-seeking (Stage 2) and the treatment access/entry stage (Stage 3) are shown in normal font in the right-side column/bubble. Two additional patient-level and systemic barriers were described by experts as pertaining more to treatment access/engagement than to treatment-seeking. These barriers (four total) are shown in bold-type font and earmarked with an asterisk. **Abbreviations: BED**, binge eating disorder; **ED**, eating disorder; **GI**, gastrointestinal; **MH**, mental health.

3.2.1. Theme 2, Subtheme 1: Barriers to Identifying Binge Eating Disorder (50%)

Seven participants (7/14, 50%) spontaneously identified barriers that were related to identifying BED (**Table 5, Figure 2**).

3.2.1.1. Theme 2, Subtheme 1, Foci i: Individual (Patient-Level) Barriers to Identifying Binge Eating Disorder

Seven participants (7/14, 50%) spontaneously described six barriers to identifying BED (**stage 1**) that were described as being **individual (patient-level) barriers** (as defined in section 2.4). These barriers are outlined below.

1. Desire to avoid stigmatization from healthcare providers (36% spontaneous endorsement, 5/14).
2. Demographically characteristic healthcare under-utilization (e.g., that some racial, ethnic, sexual, and gender minorities are less likely to access and utilize healthcare) (21% spontaneous endorsement, 3/14).
3. Denial/self-stigmatization about having an ED- and/or mental health diagnosis (21%).
4. Miseducation about who can have BED (which prevents self-detection) (21%).
5. Recognizing physical repercussions of BED (e.g., weight, gastrointestinal symptoms) vs. psychological pathology (21%).
6. Poor education about BED as a diagnosis (e.g., that BED is an ED and that not all EDs present as anorexia nervosa or bulimia nervosa) prevents self-detection (14%, 2/14).

Select quotes from participants regarding patient-level barriers to identifying BED (**Figure 2**) are shown below and in **Table 5**.

Notable, some of the barriers above exist at multiple levels (e.g., patient, provider, and systemic levels). For example, “miseducation about who can have an ED" is a barrier that can exist in individuals with BED (e.g., at the **patient-level**) as well as at the **interpersonal level** (e.g., **at the level of healthcare providers** who under-screen minorities (see section 3.2.1.2 below) and systemically (at the **systems-level**; see section 3.2.1.3 below).

Many of the multi-level barriers experts described also interact with one another. For example, the P5 quotation below describes patient-level barriers of under-reporting BED symptoms and reduced healthcare utilization among certain demographic populations (e.g., men) that are attributed by experts and in the literature as being related to **individual (patient-level) barriers** (e.g., desire to avoid stigmatization and healthcare stigmatization and denial/internalized stigmatization and shame) as well as **interpersonal (provider-level) barriers** (healthcare provider stigmatization and bias related to body weight/shape/size and physical health outcomes *and* healthcare inequity resulting in under-reporting BED symptoms and healthcare avoidance) and **systems-level barriers** (e.g., systemic stigmatization around body weight/shape/size, prioritization of physical health outcomes over mental health, stigmatization about having an eating disorder or mental health diagnosis, attitudes about healthcare use, and systemic healthcare inequity (e.g., in marginalized and minority populations that often leads these populations to avoid healthcare systems)).

*See P75 and P16 statement in section 3.1.*

*“It remains true that [with few exceptions] …you will see far more women than men in [ED treatment programs] ... And … it appears that for probably a bunch of obvious or easily understandable reasons, case finding for men who have EDs is not very good. You know, there is* ***stigma****,* ***people are not so likely to report****, and that’s true across the board. … [and] in these kinds of illnesses [those barriers to treatment-seeking and case findings probably affect] men even more than women. And certainly,* ***providers don’t think to ask****, and …I think it’s generally true that* ***health care utilization*** *in young men is sort of non-existent for the most part, and so there aren’t as many chances for case finding [which] means that there are mostly women in the treatment programs.” (P5)*

*“People with EDs, they struggle with* ***mental health stigma****, they struggle with* ***ED stigma****, and they struggle with* ***weight stigma****. [So those are] three [forms of stigmatization that] obviously can impact [individuals with BED] in very severe ways.” (P93)*

*See P7 and P72 statement in* ***section 3.2.1.2 below****.*

3.2.1.2. Theme 2, Subtheme 1, Foci ii: Interpersonal (Provider-Level) Barriers to Identifying Binge Eating Disorder

Seven participants (7/14, 50%) spontaneously described six barriers to identifying BED that were described as provider-level barriers (as defined in section 2.4). These included:

1. Stigmatization from healthcare providers (36% spontaneous endorsement, 5/14).
2. Unequal screening in racial, ethnic, sex, gender, and sexual orientation minorities (29%, 4/14).
3. Screening for physical issues associated with BED (e.g., weight/gastrointestinal issues) but not for psychological issues (e.g., EDs, BED) (21%, 3/14).
4. Miseducation about who can have BED (21%).
5. Recognizing physical repercussions of BED (e.g., weight, gastrointestinal symptoms) vs. psychological pathology (21%).
6. Poor education about BED as a diagnosis (e.g., that BED is an ED and that not all EDs present as anorexia nervosa or bulimia nervosa) (14%, 2/14).

Select quotes from participants regarding provider-level barriers to identifying BED (**Figure 2**) are shown below and in **Table 5**.

*“I have a patient with BED whose doctor told her,* ***‘you’re fat every day, so you should exercise every day.’*** *That’s from a health care practitioner.” (P7)*

*“The* ***police are to black men as the medical establishment is to black women****.” (P72)*

*“…if you are a BIPOC [Black, Indigenous, or Person of Color community member] you are very unlikely to get detected with an ED, and that means you could struggle for a long time.” (P75)*

*See also quotations from P16 in theme 1 (section 3.1) and P5 in theme 2, sub-theme 1, foci 1 (section 3.2.1.1 above).*

3.2.1.3. Theme 2, Subtheme 1, Foci iii: Systems-Level Barriers to Identifying Binge Eating Disorder

Seven participants (7/14, 50%) spontaneously described three barriers (including two sub-barriers) to identifying BED that were classified as systemic barriers (as defined in section 2.4). These are outlined below.

1. Stigmatization socioculturally (36% spontaneous endorsement, 5/14).
2. Lack of education and awareness about BED (21% spontaneous endorsement, 3/14), including:
   1. Miseducation about who can have BED (21%).
   2. Poor education about BED as a valid DSM-5 mental health diagnosis (e.g., that BED is – separate from overweight and obesity – and that not all EDs present as anorexia or bulimia nervosa) (14%, 2/14).
3. Prioritization of physical health outcomes over mental health (21% spontaneous endorsement, 3/21).

Select quotes from participants regarding systemic barriers to identifying BED (**Figure 2**) are shown below and in **Table 5**.

*“… the stereotypical [judgement is] that someone in a larger body is a failure, is lazy, is all these negative things…” (P37)*

*“Anytime you’re given the message overt or covert, that something is… wrong with you, like you’re bad, you’re too much, you’re big, you’re repulsive, you’re gluttonous, whatever, … that’s really the message that people internalize through a lot of experiences with healthcare practice, practitioners, families, schools, etc.” (P7)*

*“If you’re a black woman, if you are somebody who lives in a larger body, if you are an older male, people aren’t going to think that your eating habits [constitute] an ED because you aren’t … a young, thin, cis-gendered, white woman, and so I think that even just recognizing that BED is ‘a thing’ is one of those things that gets in the way… …So knowing, for example, … that if you are a BIPOC [community member] you are very unlikely to get detected with an ED, and that means you could struggle for a long time, and what do we do then to reach these communities in a way that’s meaningful?” (P75)*

*“We are living in a society that’s so weight-focused and oppressive towards individuals living in larger bodies…” (P7)*

*See also P75 quotation in sections3.2.1.1 and 3.2.1.2 above.*

3.2.2. Theme 2, Subthemes 2 & 3: Barriers to Treatment-Seeking (Subtheme 2) and Treatment Access/Engagement (Subtheme 3) (57%)

Eight participants (8/14, 57%) spontaneously identified barriers related to seeking and/or accessing/entering treatment for BED (**Table 5, Figure 2**). The identified barriers associated with treatment-seeking and access are very similar and have thus been grouped together here (below) and in **Figure 2**.

3.2.2.1. Theme 2, Subtheme 2-3, Foci i: Individual (Patient-Level) Barriers to Seeking and Accessing Treatment (57%)

Eight participants (8/14, 57%) spontaneously described eight barriers to treatment-seeking and ten barriers to treatment access/entry that were described as being patient-level barriers (as defined in section 2.4). The eight barriers to treatment-seeking were also identified as barriers to treatment access/entry; the two additional barriers to treatment access/entry are indicated bold and italicized font and an asterisk. These barriers are shown below.

1. Treatment cost (e.g., treatment cost prioritization and lack of information on financial assistance) and insurance coverage (e.g., insufficient coverage or lack of insurance) (43% spontaneous endorsement, 6/14).
2. Desire to avoid healthcare provider stigmatization (36%, 5/14).
3. Demographically characteristic healthcare utilization (e.g., being reduced in specific subsets of racial, ethnic, sex, gender, and sexual orientation minorities) (21%, 3/14).
4. Denial/self-stigmatization about having an ED and/or mental health diagnosis (21%).
5. Insufficient resources for finding/coordinating care (21%).
6. ***Geographic access to treatment resources (21%).\****
7. ***ED provider scarcity and waitlists (21%).\****
8. Having/prioritizing/taking the time required to seek, access, coordinate, and engage in treatment (7%).
9. Fear of facing the discomfort and hardships associated with treatment (e.g., “treatment is hard”)(7%, 1/14).
10. Fear of letting go of the coping/eating behavior (often linked to trauma/adversity) (7%).

Select quotes from participants regarding patient-level barriers to seeking and receiving treatment (**Figure 2**) are shown below and in **Table 5**.

*“For, [the provider, a large part of treatment is] just trying to understand where the eating patterns have developed from, what are the barriers to get them from [binge] eating, [and] what are they coping with… And then from my perspective, is just trying to help with consistency of eating and bringing down those fears, a lot of body image stuff as well, that tends to come up, so [for example], the fear of gaining more weight from eating… [P37, Contd. below]*

*“…[Early on in my practice as a registered dietician certified in ED treatment], I picked up on the* ***fear of what’s going to come up*** *[as a barrier to treatment], and then also once it does come up [it can have a snowballing effect of bringing up more and more emotion], [and clients] can backtrack a little bit because of that experience.” (P37)*

*“Any level of treatment brings distress, and in some ways,… I think that a hugely* ***important part of treatment is trying to help people tolerate what they need to do treatment-wise****. … Most of the time, we really have to work to help people tolerate treatment.” (P5)*

*See quote from patient P5 above in section 3.2.1.1 above.*

3.2.2.2. Theme 2, Subtheme 2-3, Foci ii: Interpersonal (Provider-Level) Barriers to Seeking and Accessing Treatment (57%)

Eight participants (8/14, 57%) spontaneously described three barriers to seeking and accessing/entering BED treatment that were categorized as provider-level barriers (as defined in section 2.4), as outlined below.

1. Stigmatization from healthcare providers (36%, 5/14).
2. Insufficient resources for finding/coordinating care (21%, 3/14).
3. Time for treatment (14%).

Select quotes from participants regarding provider-level barriers to seeking and receiving treatment (**Figure 2**) are shown below and in **Table 5**.

*“…the* ***stigma of their caregivers being in a smaller body and not understanding*** *…I think that needs to be addressed… [P37 Contd. below]*

*“[Also], there needs to be a holistic approach [for BED treatment], meaning that we [need to] have more [of] the entire treatment team on board. I think that a lot of times we're working in silos. So definitely having the therapist and the dietician and the physician all on the same page – and the psychiatrist, if that’s appropriate, as well.” (P37)*

*“The only thing that makes a really good prediction about whether someone will do well [in treatment] is how well they do in the first few sessions. If we can really push people at that point, then we can do well. So, if I were going to look for anything as a research topic, I’d look [to understand] why some therapists push [for behavior] change early, but others don't.” (P84).*

*See quotes from participants P75 and P7 in section 3.1, P16 in section 3.1.1.1, and P5 in section 3.2.2.3.*

3.2.2.3. Theme 2, Subtheme 2-3, Foci iii: Systems-Level) Barriers to Seeking and Accessing Treatment (57%)

Eight participants (8/14, 57%) spontaneously described five barriers to treatment-seeking and six barriers to engaging in treatment that were classified as systemic barriers (as defined in section 2.4). The five barriers to treatment-seeking were also identified as barriers to treatment access/entry. The additional barriers to treatment access/entry are indicated with bold and italicized font and an asterisk. These barriers are shown below.

1. Treatment costs and insufficient insurance coverage (43% spontaneous endorsement, 6/14).
2. Systemic/societal stigmatization (36%, 5/14).
3. Insufficient resources for finding/coordinating care (21%).
4. ***Geographic access to treatment resources (21%).\****
5. ***Provider/treatment center scarcity and waitlists (21%).\****
6. Sociocultural prioritization of physical health outcomes over mental health (21%, 3/21).
7. Time required for treatment (14%).

Select quotes from participants regarding systemic barriers to seeking and accessing treatment (**Figure 2**) are shown below and in **Table 5**.

*“In [some countries], there is no public funding for people who have BED. …they’re just sort of on their own when it comes to treatment.” (P38)*

*“I don't think there's enough facilities that are there for people, I don't think insurance covers enough for higher level[s] of care and it needs to, and I think that … needs to be addressed.” (P37)*

*“It is, it is true in a lot of settings – and certainly, I think it's going to be true post-COVID, at least for a while – that there's a* ***relative shortage of treatment resources****. So, in certain levels of care, it’s going to be the case that people with any ED diagnosis are going to be competing for a* ***scarce resource****. You know, there are* ***waitlists*** *at many places, treatment programs are very busy and will be more and more so.” (P5)*

*See also quotes from participants P75 and P7 in section 3.1, P16 in section 3.1.1.1, and P37 and P84 in section 3.2.2.2.*

3.3. Theme 3: Research Gaps Related to Binge Eating Disorder Treatment Barriers

When asked to describe their perspective(s) on current research gaps that exist in the field of BED and share any other suggestions that relate to future research objectives (questions 7 and 8 in **Table 2**), six participants (6/14, 43%) gave responses that pertained to current barriers to treatment of adult BED (**Table 6**). These responses were categorized into six themes, described below.

First (theme 1), four participants (4/14, 29%) spontaneously identified a need for a better understanding of the experiences of individuals with BED (both in general and in relation to treatment), including research on the topics of: a) how to best learn and listen to the experiences of individuals with BED; b) understanding how underrepresented groups struggle with experiences unique to them; c) understanding larger systemic issues that may increase vulnerability for binge eating and hamper treatment engagement and responses; d) identifying how to best reach under-represented communities in a way that’s meaningful to them; and e) understanding weight stigma and discrimination. Three additional themes that were spontaneously endorsed by two expert participants each (2/14, 14% each) included: 2) a need to identify how to best integrate multi-disciplinary approaches and treatments; 3) a need for better indicators of who does and does not do well in treatment and why; and 4) a need for greater availability in funding for BED research (both in general and as it pertains to treatment barriers). Two additional themes spontaneously endorsed by one BED expert each (7% each) included: 5) empirical investigation of peer mentorship programs and 6) understanding that individuals in smaller and larger bodies can have BED. Select quotes from participants regarding treatment barriers are shown below and in **Table 6**.

*“…There’s a lot of emphasis these days on making sure that we’re meeting the needs of underrepresented groups and so a lot of people are talking about how* ***EDs don’t discriminate****, and that’s certainly true and* ***I think it also makes sense to talk about the specific ways in which underrepresented groups might be struggling that are unique to them and their experiences versus just saying ‘anyone can be affected****” (P75)*

*“[When thinking about] how to help people … [I] think …we should be* ***taking account of people’s narrative and life experiences*** *and that should be informing our therapy and our therapeutic approaches.” (P93)*

*“I think our assessment with individuals who seek care [for BED] needs to be comprehensive to understand their experience[s]. …****I think we need to be having those conversations with individuals [with BED] to say, ‘tell me about your experience,’ and then allow that to help us guide our line of questioning with clients, and to see where there might be gaps*** *in what we have in our assessments [and treatment options] [vs.] what they've said* ***… I think it's more [about] the [question of] ‘how do we listen for what people are telling us about their experience?’****.” (P60)*

*See quotation from P84 in section 3.2.2.2.*

**Table 6: *Research Gaps and Future Research Directives that were Spontaneously Identified by BED Experts and Pertain to Treatment Barriers (29%)***

|  |  |
| --- | --- |
| ***Research Gaps and Future Research Directives Pertaining to Treatment Barriers*** | ***n (n/14)*** |
| 1. Need for a better understanding of the experiences of individuals with BED (both in general and in relation to treatment). | 4 (29%) |
| * 1. How to best learn and listen to the experiences of individuals with BED. | *1 (7%)* |
| * 1. Understanding how underrepresented groups struggle with experiences unique to them. | *1 (7%)* |
| * 1. Understanding larger systemic issues that may increase vulnerability for binge eating and hamper treatment engagement and responses. | *1 (7%)* |
| * 1. Identifying how to best reach under-represented communities in a way that’s meaningful to them. | *1 (7%)* |
| * 1. Understanding weight stigma and discrimination. | *1 (7%)* |
| 1. Identifying how to best integrate multi-disciplinary approaches and teams. | 7 (50%) |
| 1. Need for greater funding for research on BED (both in general and in relation to treatment barriers). | 7 (50%) |
| 1. Understanding that individuals in smaller and larger bodies can have BED. | 8 (57%) |
| 1. Peer Mentorship Programs. | 8 (57%) |
| ***Additional Participant Statements Related to Treatment Barriers*** | |
| *“I think we’re very underfunded in terms of treatment trials, and …woefully underfunded when we compare ourselves with high weight disorders. … …and just generally, across the board, we need …more funding for research…” (P93)*  *“[I am] constantly surprised at how easy it is to get money for [weight disorders in comparison to eating disorders]. The weight loss trial: not hard at all [to get funded]. If you think you’ve got the diet that works, it’s not hard to persuade governments or philanthropists or people to fund you. It’s very hard to persuade governments or philanthropists to fund if we think we’ve got some new eating disorder treatment, or some enhancement of initial treatment****. We find it much harder to get [funding for research on BED] than [it is to get funding for] yet another diet.****” (P93)*  *“We* ***really need more literature on an integrated approach to [treating]*** *BED because you see the binge eating psychotherapy literature and then you see the BED interventions that are more nutritionally related and we need to do this in each [ED] diagnosis but with BED, we need to bring those two things together because they've been existing sort of separately and* ***multidisciplinary team treatment is so often the case that we really need to also have our research echo that****. …I think that's the other piece, that there are interesting [findings] on both of those perspectives [but] how do we bring them together? … I'd really like to see the literature progress in that sense of [asking]: ‘what does a multidisciplinary intervention for BED look like, and let's study that,’.” (P60)* | |
| **Table Legend:** Research Gaps and Future Research Directives that were Spontaneously Identified by BED Experts and Pertain to Treatment Barriers (29%) Results expressed as n (%). Percentages: n/14 times 100, in which n represents the number of participants who spontaneously endorsed a particular theme. **Abbreviations: BED**, binge eating disorder; **ED**, eating disorder; **P**, participant (e.g., “P93” references participant number 93. Numbers were assigned to the fourteen participants randomly using a random number generator). | |

4. Discussion

This study aimed to explore the barriers to treatment access for adult BED from the perspectives of expert researchers, clinicians, and administrators in the field. We conducted semi-structured interviews with 14 BED experts and identified three areas where these barriers manifest (**Table 2**): 1) identifying BED, 2) seeking treatment, and 3) accessing and engaging in treatment. Each of these stages is influenced by individual/patient-level, interpersonal/provider-level, and sociocultural/systemic/systems-level barriers, highlighting the multifaceted nature of this issue. We developed a model of how these barriers can interact and influence each other at different stages of the treatment process (**Table 2**). This conceptual model can be used to conceptualize, operationalize, and construct possible solutions to overcome the individual/patient, interpersonal/provider, and sociocultural/systems-level barriers at each stage in the treatment access process, as discussed further below and elsewhere [133].

Overall, we suggest that more education and awareness campaigns, more tools and guidelines that can simplify screening, treatment-seeking and access for patients and providers, and more accessible and affordable treatment options, that are: a) free or low-cost; b) made accessible through virtual/remote delivery or localized community resources; and c) culturally and demographically sensitive and (d) inclusive, and more supportive, empathic, and narrative-based care are needed to improve the identification, referral, treatment-seeking, treatment access, and subsequent engagement of individuals with BED. These findings have important implications for research, practice, and policy in the growing BED field.

4.1. Novelty & Innovation

To our knowledge, this is the first study to systematically collect and analyze the views of BED experts on barriers to BED detection, recognition, identification, and diagnosis (stage 1), treatment initiation (stage 2), and treatment access and engagement (stage 3) in adult BED. Previous studies have mostly focused on the perspectives of patient focus groups [15, 42, 46, 59, 80, 105], studies, systematic reviews, and meta-analyses of existing research on treatment outcomes [43, 134, 135] or narrative reviews/commentaries [14]. Moreover, most studies have used quantitative methods such as surveys or questionnaires [43, 134, 135], which may limit the depth and richness of the data [37, 38, 136, 137]. By using qualitative methods such as semi-structured interviews and reflexive thematic analysis, we were able to capture the nuances and complexities of the experts’ experiences and opinions on BED detection and treatment access barriers. We also included experts from different backgrounds and roles, such as researchers, clinicians, and healthcare administrators. This allowed us to gain a more comprehensive and diverse understanding of contemporary challenges and opportunities in BED treatment.

The conceptual/theoretical 3x3 model of treatment barriers shows in **Table 5** and **Figure 2** is also novel and can help innovate the field by identifying individual, interpersonal, and systemic program, process, and policy needs related to BED identification, treatment initiation, treatment access, and treatment engagement (and to the lived experience of BED as a whole). The model’s conceptual framework can also be used as a tool for conceptualizing, operationalizing, and constructing possible solutions for each of the different barriers identified at each of the different source- and stage levels in the model. Thus, the model can be used to offer solutions that policy-makers, healthcare providers, and individuals with BED can use to overcome BED identification and treatment access and initiation barriers.

Overall, our findings suggest that increasing education about BED – both in the general public and in healthcare systems – can help increase BED recognition, diagnosis, treatment seeking, and engagement. This includes education on BED’s high prevalence rates, diagnostic validity and criteria, demographic information, possible connections with physical ailments, and associated stigmatization at the individual/patient, interpersonal/provider, and systems levels. Educating providers on stigma, fostering safe spaces for individuals with BED within the healthcare setting, and championing the benefits of binge eating treatment and recovery can also help facilitate detection and diagnosis.

Our findings also suggest that interventions that are: a) free or low-cost; b) made accessible through virtual delivery or localized community resources; and c) culturally and demographically sensitive and inclusive to individuals from marginalized racial, ethnic, and socioeconomic backgrounds may have considerable potential to improve BED treatment uptake and response rates, warranting research funding. Examples include CBT self-help [138, 139], CBT guided-self-help [140-143], remotely-delivered mindfulness meditation mobile applications [144, 145] facilitated support groups [146, 147], and peer-led, mutual-help, community-based 12-Step interventions [148-150] or 12-Step facilitation [151-153], as addressed in section 4.4.1.1.4 below.

Importantly, our findings also indicate potential benefits from conducting *qualitative* needs assessments, process evaluations, and satisfaction estimates *in individuals who have BED* (and especially those who do *not* have a formal BED diagnosis or access to/engagement in formal BED treatment or support). Needs assessments are commonly used in clinical research and program evaluation to identify normative, expressed, felt and comparative needs related to resources, policy changes, program/systems processes, service improvements, and partnerships, as identified by healthcare patients, providers, administrators, and policy-makers [154]. Satisfaction estimates are similarly used to collect information on interpersonal, administrative, and technical/clinical experiences (e.g., patient satisfaction with relational quality between patient and provider, administrative processes like scheduling, wait times, and registration/enrollment, and perception of patient/provider experience and progress) [154]. These types of assessments are typically administered through quantitative surveys, which may limit the depth and richness of the data [37, 38, 136, 137].

Conducting *qualitative* needs assessments, process evaluations, and satisfaction estimates can enable identification and collection of more nuanced, complex, and novel/not-yet-identified experiences and needs *from the individuals who experience them.* Qualitative methods can also be used to collect input/suggestions for possible solutions that can overcome the needs and treatment access barriers identified here. Solutions for BED identification and treatment access barriers and needs may be more innovative *and feasible* *if proposed* *by the individuals who experience them*, especially if paired with data collected from researchers, clinicians, healthcare administrators, social workers, and community/group leaders.

4.2. Relationship of Findings to Existing Literature

The barriers that impede adult BED detection, treatment-seeking, and treatment access continue to change and evolve, as does our awareness of them as a field. The themes identified here represent new and emerging areas of recognition pertaining to possible barriers that obstruct adult BED detection, diagnosis, treatment-seeking, and treatment access and engagement. Our findings are consistent with previous literature on treatment barriers for BED, including:

1. Treatment costs [15, 42, 43, 45, 46, 49, 50, 52, 53, 62, 73, 81-85].
2. Inadequate insurance coverage [15, 42, 49, 85].
3. Stigmatization (systemically[43-45, 48-50, 52, 53, 55, 67-73] and specifically in healthcare systems and from healthcare providers[15, 17, 42, 46, 48-50, 55, 59-63]).
4. Insufficient provider screenings, both in general [15, 16, 42, 43, 46, 51, 55, 63] and in minorities in particular [15, 17, 43, 46, 49, 55, 80].
5. Sociodemographic disparities in healthcare utilization and treatment (e.g., healthcare avoidance in some racial, ethnic, and sociodemographic populations, often due to marginalization – e.g., racism and stigmatization from healthcare providers – but also related to sociocultural beliefs about healthcare utilization as well as disparities in treatment quality receipt based on race, ethnicity, or other sociodemographic factors)[17, 49, 55, 61, 74-80].
6. Denial [15, 17, 42-45], self-stigmatization [43, 44, 48-50, 55], and shame [15, 17, 42, 43, 45-53] about having an ED, mental health diagnosis, or medical diagnosis.
7. Miseducation about who can have an ED/BED [15, 17, 43, 48, 49, 80].

This particular barrier is often described by experts here and in the literature as being related to old misconceptions that ascribe EDs exclusively to thin, white, affluent, cis-gendered females (the “SWAG: skinny, white, affluent, girl” stereotype[17, 155])[17]. This misconception likely exists because white affluent cis-gendered females are more likely than their respective counterparts to perceive a need for-, seek-, and/or receive a diagnosis and treatment for an ED [15, 42, 156, 157], and have thus traditionally saturated the treatment-seeking population (and thus research populations in turn) [17] – both for ED treatment and for physical and mental health more broadly [17, 158-161]. However, there is a growing recognition in the literature that this demographic represents a minority of all individuals who experience BED [17]. For example, recent studies suggest that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis [15, 16]; 67.3% do not perceive the need for treatment [15]; and 56.4% – 86.8% never receive or pursue treatment [2, 15]. These overlooked, under-diagnosed, and under-represented individuals often include males [15], individuals in “normally” sized/weighted/shaped bodies [15], and individuals with low socioeconomic status [15, 162-165], especially those with past or present histories of food/nutrition insecurity [162-170] or use of government assistance programs like SNAP, food stamps, or welfare [162, 166, 168, 170], as addressed in Bray et al., 2022 [17]. Additionally, black, indigenous, and people of color have higher BED prevalence rates than their white peers [54, 171, 172], but comprise <10% of participants in BED research studies [86], are less likely to be screened by medical professionals for EDs [87, 88], and are 50% less likely to be diagnosed or receive care [54, 83, 86, 88, 171, 173]. Sexual minorities also have increased risks for developing an ED [174], with a nationally representative US-based study finding a greater prevalence of adult BED in non-heterosexual participants (2.2%) than in heterosexual participants (0.8%)[175]. Literature on prevalence rates among agender, transgender, and non-binary individuals focuses primarily on youth [162, 176] 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)[176], with transgender males having higher ED pathology scores than transgender females [162].

Overall, these data suggest that the outdated misconception that ascribes eating disorders to the SWAG demographic leaves many cases of adult BED undetected. This seems to be especially true for individuals who identify as BIPOC and/or LGBTQ2+, who have disproportionately higher BED risk, prevalence rates, and severity scores relative to their white, cis-gendered, heterosexual counterparts; (b) are under-represented in research (making up <10% of participants in BED research studies); (c) are less likely to be screened by medical professionals for EDs; (d) are ~50% less likely to be diagnosed or receive care; and (e) are more likely to experience one or more environmental factors that are associated with BED pathology and risk (e.g., economic precarity, food/nutrition scarcity, stigmatization, and discrimination)(as addressed in Bray et al., 2022 [17]).

1. Recognizing, screening for, and prioritizing physical issues often associated with BED (e.g., weight, cardiometabolic markers, gastrointestinal issues)[19] vs. underlying mental health issues and ED psychopathology [e.g., emotion dysregulation, trauma history, negative affect, negative urgency, as outlined in section 3.1 (8a) above and elsewhere][17-19, 43, 46, 50, 55, 59, 62-65].

This barrier (and the prioritization it describes) is thought to be related to (i) sociocultural “taboos” and (ii) patient shame and denial [15, 17, 42, 46-48] related to weight, mental health, and eating disorders, that stem from (iii) patient [43, 62], provider [46, 63], and societal [49] prioritization of physical health and weight over mental health and wellness [43, 46, 49, 62, 63].

1. Insufficient resources to find and coordinate care, including:
   1. Insufficient patient and provider education on BED treatment options [42, 43, 45, 46, 51, 63, 89],[73].
   2. Insufficient resources to coordinate communication between multiple providers on a multidisciplinary team [46, 49].
   3. Time required to seek, coordinate, and engage in treatment [48, 49, 95-99] [see note for 9.d directly below].
   4. Transportation to and from treatment [42, 43, 49, 95-99].

NOTE: Existing literature does not tend to recognize transportation as a barrier to treatment access *directly* (to the authors’ awareness). However, transportation *is* cited as a barrier for BED research participation and a reason for research participation dropout in a variety of literature in the field. For example, Striegel-Moore et al (2001) reported 20.8% of participants in their comparison of binge eating disorder and bulimia nervosa in a community sample (44/157) were interviewed by phone due to scheduling constraints or lack of access to transportation [97]. Wilfley et al (2000) reported 53/543 (9.8%) participants who were screened by phone to participate in their study on comorbid psychopathology in binge eating disorder did not participate because of time conflicts or lack of time and 15/543 (2.8%) did not participate due to transportation limitations or being too far from the clinic [96]. Thompson-Brenner et al. (2013) recognize transportation and time constraints as possible contributors to the observed disparity in dropout rates between individual vs. group self-help/guided self-help treatment (26.1% [95% CI: 25.8%, 26.4%] vs. 40.3% [95% CI: 39.4%, 41.2%]) and between different ethnicities [99]. In their estimate of the true costs of BED treatment,Jenkins et al. (2022) identified “out-of-pocket expenses” as an important contribution to BED treatment costs, which, “focused largely on transportation,” [98]. Additionally, Goode et al. (2023) report “several” eligible participants in their pilot open trial of an appetite awareness and lifestyle modification intervention for black women at risk for BED being unable to participate “due to work or transportation challenges,” [95].

1. ED provider scarcity and wait lists [17, 43, 63, 65, 105-108].
2. Geographic access to treatment resources [17, 43, 49, 63, 109].
3. Poor education on BED diagnostic criteria and validity (e.g., that BED is in fact an autonomous DSM-5 mental health diagnosis) [17, 43, 46, 48, 49, 51-53, 63].
4. Fear of letting go of the coping/eating behavior (often associated with trauma/adversity),”[43, 52, 53, 110].

In addition to direct empirical support/patient report [110], this treatment barrier also has some indirect support beyond expert endorsement here. For example, systematic reviews and meta-analyses collectively demonstrate strong associations between trauma history (including adverse childhood experiences (ACEs), adverse life experiences (ALEs), family-related non-abuse ALEs, and post-traumatic stress disorder (PTSD)) and BED [122-126]. Similar associations have been observed in obesity [126, 129, 131], which has high comorbidity with BED [2, 5, 132]. For example, Vincent Felitti’s hallmark ACEs Study [130] found that individuals with obesity and comorbid ACEs perceived excess body weight to feel “safe;” whereas major weight loss was perceived as “threatening”[128] and associated with high attrition rates (>50%)[127-130]. However, it remains to be tested whether a similar fear of weight loss may exist among individuals with BED and comorbid experiences of adversity.

To the authors' knowledge, two possible treatment barriers identified here have little empirical investigation in the context of BED. For example, the literature on “fear of facing treatment hardships” focuses more on populations with anorexia nervosa (e.g., facing fears of weight gain and “breaking food rules”/facing “fear foods”) [120, 121]. However, some support does exist for negative attitudes towards seeking help [43, 45] and patient ambivalence/low motivation to change in the context of BED [43, 45, 62, 110].

The possible barrier of insufficient willingness or ability to tolerate or “stick with” treatment hardships surprisingly lack direct empirical support in the context of BED, to the authors’ knowledge. However, retention rates for BED treatments can range from 42–88% [172, 177-181] but are generally low [182] and early discontinuation of care is a common quandary in the field [14, 182, 183]. Whether low retention and early discontinuation of care are related to tolerating treatment hardships warrants further investigation.

Additionally, several treatment barriers are consistently identified in the literature that were not identified here. These included:

1. Limited self-recognition [15, 43].

Note: Although limited self-recognition was identified by experts here, it was not identified as a theme in sections 3.1 or 3.2.1.1 because it was instead identified more specifically as “miseducation about who can have an ED/BED,” “recognizing, screening for, and prioritizing physical ailments often associated with BED (e.g., weight, cardiometabolic markers, gastrointestinal issues) vs. underlying mental health issues and ED psychopathology,” and “poor education on BED diagnostic criteria and validity,” which can lead to limited self-recognition at the individual (patient) level but can also lead to deficient detection, screening, and diagnosis at the interpersonal (provider) level and limited detection at the systems-level.

1. Insufficient time in a general practitioner/primary care appointment to discuss eating behaviors [46, 48, 49, 63].
2. Lack of healthcare provider education and training on screening, diagnosing and treating BED [42, 43, 46, 63, 89, 184].
3. Belief that BED is “not that big of a deal,” or “I should be able to do it myself” and consequently de-prioritizing treatment [15, 42, 43, 49, 51] both at the individual (patient) level [15, 42, 43, 45] and public (systems) level [43, 49, 51].
4. Provider de-prioritization or avoidance of addressing and treating BED is often related to stigmatization, lack of education and training (as addressed above), low treatment success rates, and perceived financial concerns [43, 48, 63].
5. Patient ambivalence/low motivation to change [43, 62].
6. The fear/belief that “others can’t help,” [42, 48, 49] or low confidence in ability to change [43].
7. Lack of social support or encouragement from others to seek help [43, 45, 49].
8. Aversion to being treated alongside individuals with low-weight EDs, such as anorexia nervosa (a distinctly different ED associated with different underlying psychopathology), which can worsen weight stigma and shame [15].

Our findings extend the existing literature by providing a possible model/framework of how these barriers can interact and influence each other at different stages of the treatment-seeking and engagement process (**Table 5; Figure 2**).

Our proposed model/framework suggests individuals with BED may face barriers to BED treatment engagement in at least three different stages in the process of treatment-seeking and access:

1. **BED detection (Stage 1),** which includes BED screening, diagnosis, and identification (barriers pertaining to this stage were spontaneously identified by 50% of participants).
2. **Seeking treatment for BED (Stage 2)** (barriers pertaining to this stage were spontaneously addressed by 57% of participants).
3. **Access to ongoing treatment (Stage 3)** (barriers pertaining to this stage were spontaneously addressed by 57% of participants).

These barriers may prevent individuals from recognizing their condition, reaching out for help, finding appropriate care, and engaging in treatment.

Our proposed model/framework also suggests that within each of these three stages, individuals with BED may encounter treatment barriers originating from at least three **possible source(s)**:

1. Themselves (e.g., **individual/patient-level barriers**).
2. Healthcare providers and interpersonal interactions (e.g., **interpersonal/provider-level barriers**).
3. Sociocultural factors (e.g., **sociocultural/systemic/systems-level barriers**).

\*\*\*The barriers identified within each of the three levels for each of the two dimensions identified in the model are shown in **Table 5** and **Figure 2**.

Our model implies that some barriers may be more prevalent or salient at certain stages of the treatment-seeking//access process than others. For example, denial and self-stigmatization may be more problematic in identifying and detecting BED (stage 1), while costs and insurance coverage may be more relevant at the treatment-seeking and engagement stages (stages 2 and 3).

Our model’s recognition of three separate/discrete stages and sources of treatment access barriers also helps provide an insightful framework that can be useful in considering solutions to treatment access barriers (in BED and in eating disorders and other physical and mental health illnesses more broadly), and in recognizing that treatment access solutions must include multi-dimensional approaches that can target barriers at all three levels and in all three stages of the treatment access process. Figure 3 provides an example of how our theoretical model/framework can be used to conceptualize, operationalize, and construct possible solutions to the BED treatment access barriers identified here. The solutions proposed therein are addressed further in a separate forthcoming manuscript .

4.3. Clinical Implications

Our findings have several implications for clinical practice and service delivery for BED. First, our findings highlight the need for public policy education and awareness campaigns to increase the recognition and understanding of BED among the general public, healthcare providers, and policymakers. These campaigns should focus on raising awareness about BED as a valid and prevalent ED, particularly among marginalized populations. Such campaigns should aim to dispel myths and stereotypes about who can have an ED (e.g., the “SWAG: skinny, white, affluent, girl” stereotype [17, 155]) as well as what the signs and symptoms of BED are, what the health consequences of BED are (and how to differentiate physical ailments from underlying psychopathology), and what the available treatment options are.

Second, our findings suggest the need for more self-screening and treatment-seeking tools that can be used to help identify and self-identify individuals with BED in various settings, such as primary care, mental health care, weight management programs, or community-based organizations. Such tools could include brief self-report questionnaires administered by trained professionals or online platforms. Free, online, one-stop platforms that can assist individuals with eating or weight concerns in self-screening and coordinating treatment options that work would be extremely beneficial and warrant feasibility testing and funding.

Third, our findings indicate the need for more accessible and affordable treatment options for BED that can meet the diverse needs and preferences of individuals with this condition, as reflected in the literature [15, 148]. Such options could include evidence-based interventions delivered in various formats (e.g., individual or group therapy), modalities (e.g., face-to-face or online), intensities (e.g., outpatient or inpatient), durations (e.g., short- or long-term), or approaches (e.g., cognitive-behavioral therapy or interpersonal therapy). There is also a need for research funding and findings on new or alternative treatment options that are free or low-cost, can be delivered virtually, and are both sensitive and inclusive to individuals of all demographics (including body weight and shape, race, ethnicity, sex and gender preferences and alignments, religion, socioeconomic and sociocultural status) [148, 150].

Fourth, our findings emphasize the need for more supportive and empathic care for individuals with BED that can address their psychological and emotional needs as well as their physical health needs. Such care could involve building rapport and trust with patients, providing psychoeducation and feedback on their condition and progress, validating their feelings and experiences, addressing their fears and concerns about treatment, helping them cope with stigma and discrimination from others or themselves, encouraging them to seek social support from family or friends or peers with similar issues, and empowering them to take charge of their recovery.

Peer-led, mutual-support, community-based programs hold promise [148, 150], as they have a track record of achieving long-term treatment engagement and success in other mental health illnesses (e.g., anorexia nervosa [185] and alcohol dependence and misuse [148, 152, 153, 186-190]) that include minority populations [151, 190-193]. They are also led by individuals who have the experience of binge eating and understand the nuanced challenges that other individuals with BED face [148, 150]. Such programs also have the benefit that they are typically free, easily accessible with virtual delivery options, and all-inclusive and welcoming [148, 150]. These programs do have some empirical support [148, 149, 185, 194-198]. They are also not without limitations [148] and require research funding for empirical testing and manualized clinical delivery or involvement [148, 194], as has been done in similar programs for other mental health problems (e.g., 12-Step Facilitation) [148, 152, 153, 186-190].

Fifth, our findings underscore the importance of taking and voicing/circulating/increasing awareness of the patient narrative – both clinically and publicly – to increase awareness and understanding of who BED can affect, what the experience of BED is, what barriers individuals with BED face, and how those barriers can be minimized or overcome. To achieve this objective, qualitative research should also include individuals with BED to better understand barriers to receiving a diagnosis and treatment, as has also been discussed elsewhere in the literature and by experts in this study [17]. Peer-led, mutual help, community-based programs also offer opportunities for individuals with BED to share their experiences and be heard in a safe setting [148]. However, education and training also needs to be implemented within the healthcare system so that healthcare providers can better understand patient challenges and ultimately help direct patients to the care they need.

4.4. Study Limitations and Strengths

This study has some limitations that should be acknowledged. First, the study’s sample size (n = 14) is appropriate for a mixed-methods analysis of this nature [17-19, 37-41] but limits the ability to generalize the data’s themes and conclusions to the field of BED researchers and clinicians at large. Thus, findings from this study are not necessarily generalizable.

Second, our data collection and analysis methods were qualitative and subjective, which may introduce biases or errors in interpreting or presenting the data. Therefore, our findings may not be replicable or verifiable by other researchers or methods.

Third, our study design was cross-sectional and exploratory, which did not allow us to establish causal relationships or test hypotheses. Therefore, our findings may not be conclusive or definitive about the nature or mechanisms of treatment barriers for BED.

Fourth, we did not directly ask participants about their views on treatment access barriers, and the themes identified in this work have not been verified by the experts themselves. A follow-up questionnaire or Delphi Panel is warranted to gather their direct responses.

Fifth, we only present data here that pertains to treatment access barriers. Barriers that affect later stages of treatment, including treatment retention, completion, and long-term follow-up, are not addressed here but should be addressed in future publications, as these stages of treatment certainly have discrete unique patient-, provider-, and systems-level barriers.

Sixth, there are several limitations in the demographics of the experts interviewed in this study. First, although this study’s sample provides an accurate demographic representation of ED experts (92% White, 100% not Hispanic or Latino), it does not accurately represent the demographic profile of individuals who experience adult BED, which has higher rates of Hispanics, Latinos and Blacks, Indigenous, and Peoples of Color [54, 171, 199]. The demographic discrepancies between those who study and treat adult BED and those who experience it are not insignificant. These discrepancies highlight the importance of including marginalized populations in academic and clinical training opportunities for adult BED research and care, and of emphasizing community- and narrative-based approaches to research. Additionally, one of the study’s four possible eligibility criteria for researchers (NIH R01 grant funding; see **Table 1**) presents a bias for including participants from the US. There were three other eligibility criteria researchers could meet to be included that were not dependent on any nationality and the final study sample does include participants from the UK, AU, and CA as well as from the US. Nevertheless, it would have been optimal to include criteria for funding from other federal agencies. Treatment access barriers may vary regionally, and it is possible our findings are skewed to place greater emphasis on the treatment barriers specific to the geographic locations of the experts we interviewed. Finally, this study collected demographic data on sex assigned at birth but not gender. This oversight is important because gender is demographically relevant, whereas sex assigned at birth is not relevant to this study question. Further, asking for sex assigned at birth follows an old convention that fails to account for equity and diversity inclusion.

Despite these limitations, this study has some strengths that should be recognized. First, our study addressed a novel and important topic that has received little attention in the literature: treatment access barriers for BED from the perspectives of experts. Therefore, our study contributes to filling a gap in the knowledge base and advancing the field of BED research.

Additionally, our study used rigorous and transparent methods to collect and analyze the data. For example, this study’s systematic inclusion criteria (**Table 1)** provide a strong population representation of experts who drive the field. This includes researchers with the greatest funding and publication output (recently and historically) and clinicians with high clinical and academic affiliations, as well as those most likely to be accessed by individuals with BED themselves (e.g., most commonly identified through a Google search or popular press books on BED). As a result, the study sample includes a well-rounded balance of BED experts, including researchers, medical doctors, licensed therapists, and dietitians, as well as intuitive eating specialists, healthcare administrators, and public health advocates (**Table 3**). Although one of the four possible inclusion criteria for researchers involves NIH funding, this criterion was not required (researchers were required to meet one of the four possible criteria). Thus, while this criterion presents a bias for the inclusion of academics within the US, the study sample does include a balanced geographic representation, with individuals across the US as well as in the UK, AU, and CA. The study’s use of semi-structured interviews (**Table 2**), reflexive thematic analysis, and peer debriefing further ensure the rigor and transparency of our methodological approach, thus validating the quality and credibility of the data and findings. Finally, our study generated rich and detailed data that captured the complexity and diversity of the experts’ experiences and opinions on treatment barriers. Therefore, our study provides a comprehensive and nuanced understanding of current challenges and opportunities in BED treatment.

5. Conclusions

In conclusion, this study explored the current barriers to treatment access for adult BED from the perspectives of expert researchers, clinicians, and healthcare administrators. We identified several patient-, provider-, and systems-level barriers that can prevent BED detection, diagnosis, treatment-seeking, and treatment engagement. Addressing these barriers requires a concerted effort from healthcare providers, policymakers, and researchers. By reducing internal and external obstacles, improving education, and expanding affordable treatment options, we can enhance the prospects for individuals affected by BED to receive the care they need and improve their mental health outcomes.

We also developed a theoretical model of how these barriers can interact and influence each other at different stages of the treatment process. Our findings have implications for research, practice, and policy in the BED field. We suggest that more education and awareness campaigns, more tools that can simplify screening, treatment-seeking and access, more accessible and affordable treatment options, and more supportive and empathic care are needed to improve the identification, referral, and treatment engagement of individuals with BED. We also recommend that future studies further investigate the experiences of individuals with BED (in general and in relation to treatment barriers), identify how to best integrate multi-disciplinary approaches and teams, examine the effectiveness of peer mentorship programs, and secure more funding for BED research.

Funding for research that can test new treatment options that are: 1) free or low cost; 2) sensitive to the unique experiences of individuals with BED; 3) inclusive to individuals of all demographics; and 4) easily accessible (e.g., community-based and/or available virtually) is warranted.

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