Treatment Barriers in Binge Eating Disorder: A Critical Review of Patient, Provider, and Systemic Barriers to Identification, Treatment-Seeking, Access, and Engagement in Adult Binge Eating Disorder

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**Abstract**

Binge eating disorder (BED) is a prevalent yet often undiagnosed and undertreated condition. Lifetime prevalence rates range from 4.5–31%, but treatment success rates linger between 38.3–43.6%. Alarmingly, approximately 95% of individuals meeting DSM criteria for BED never receive a formal diagnosis, while roughly 67% do not perceive the need for treatment. Moreover, 55–85% never pursue or receive standard treatment for multifaceted reasons. Here, we provide a narrative review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment accessing and engaging (stage 3), categorized as patient-level, provider-level, and systemic. These barriers encompass a wide spectrum, including denial/self-stigmatization, prioritization of physical complications over underlying psychological issues, miseducation about who can have BED, deficient healthcare access, demographic disparities in healthcare utilization, stigmatization from healthcare providers, insufficient provider education and training on BED, insufficient BED screenings, limited resources for finding, seeking, and coordinating care, ED provider scarcity and wait lists, geographic access challenges, treatment costs, inadequate insurance coverage, and negative expectations/fears related to treatment outcomes. Overall, support for these identified barriers resonates within the existing literature, emphasizing the need for systemic solutions encompassing public policy, public education, healthcare systems, research directives and media cooperation.

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# Introduction

Binge Eating Disorder (BED) is an autonomous DSM-5 diagnosis defined by discrete (2-hour) episodes of rapidly consuming objectively large amounts of food with a sense of loss of control, accompanied by distress, guilt, and shame, occurring at least once per week for at least three months (1). The disorder is linked to high lifetime prevalence rates (e.g., 4.5–31% of U.S and global populations experiencing BED at some point in their lifetime)(2, 3) and complex health sequelae (anxiety, depression, obesity, cardiovascular disease, diabetes) that significantly impair quality of life (2, 4-8). Standard of care interventions for BED include cognitive behavioral therapy (CBT), behavioral weight loss, interpersonal therapy, and medications (e.g., selective serotonin reuptake inhibitor (SSRI) antidepressants (escitalopram/citalopram, sertraline), anticonvulsants (topiramate), anti-obesity medications (orlistat), and amphetamine stimulants (Vyvanse/lisdexamphetamine))(9). A variety of additional evidence-based practices are also gaining traction in the context of BED, including family-based therapy and other psychodynamic therapies (FBT) (which do have some guideline support in the context of BED)(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)), and high rates of treatment dissatisfaction and early dropout (14). Furthermore, studies find that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67.3% do not recognize the need for formal treatment, and 56.4–86.8% never seek or receive standard treatment (2, 15, 16) due to a variety of possible reasons.

Recently, a theoretical framework has been proposed that categorizes BED treatment barriers as being (a) patient-level, (b) provider-level, and/or (c) systemic/systems-level and occurring at one of three stages in the pipeline from BED identification to treatment engagement: identifying BED (stage 1), *seeking* treatment (stage 2), and/or accessing and engaging in treatment once sought (stage 3) (**Figure 1**)(17). Within this framework, Bray et al., 2022 used thematic content analysis to identify 16 barriers to BED treatment-seeking, access, and engagement, as identified by 14 expert BED researchers, clinicians, and healthcare administrators during 2-hour recorded semi-structured interviews (17). Here, we provide an in-depth review of literature findings that support these and other barriers within the framework of the 3x3 treatment barrier model (17).

## Barriers to Binge Eating Disorder Detection, Recognition, Screening, and Diagnosis (Stage 1)

### Patient Level Barriers to Self-Recognition

Patient-level barriers to identifying BED pertain largely to self-recognition (**Figure 1**) and can be categorized broadly as follows:

1. **Deficient self-recognition** (e.g., due to miseducation about who can have BED (15, 17-23), lack of education about BED (15, 17-20, 22-26), and recognizing physical repercussions of BED (e.g., weight, gastrointestinal symptoms) vs. underlying psychopathology [e.g., emotion dysregulation, trauma history, negative affect, negative urgency (27, 28),1 also likely related to denial (15, 18, 19, 29-31)](15-18, 21, 22, 25, 28, 30, 32-34).
2. **Deflecting/avoiding self-identification** (often related to self-stigmatization about having an ED or mental health diagnosis (15, 17-19, 21-23, 26, 29-31, 35, 36)).
3. **Missed opportunities for detection** (e.g., avoiding healthcare systems to avoid marginalization (e.g., racism and stigmatization (17-19, 24, 29, 30, 33, 37)), not discussing binge eating behaviors with healthcare providers due to self-stigmatization, internalized stigmatization, and shame (15, 17-19, 22, 23, 29-31), and under-utilization of healthcare services among minority populations (17, 18, 23, 24, 32)).

These three categories of barriers are discussed further below.

### Deficient Self-Recognition

A variety of literature identifies BED as a highly undetected disorder (15, 16, 38, 39). For example, studies find that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis (15, 16, 40), and 67.3% do not perceive the need for formal treatment (15). These findings suggest many individuals who have BED do not recognize they have an ED. This possibility is supported by findings in the literature, in which limited self-recognition of BED is consistently recognized as a barrier to seeking and engaging in treatment (15, 17, 22, 26).

### Deficient Education about Diagnostic Validity and Criteria of Binge Eating Disorder

Poor education about the diagnostic validity and criteria of BED (e.g., that it is an autonomous DSM-5 mental health diagnosis) has been identified as a potential barrier to BED detection in the literature (17-19, 21-23, 25, 30, 64). Emerging findings suggest the salience of this barrier may vary depending on sociocultural contexts. For example, the way in which eating, overeating, binge-type eating, excess body weight, and overweight/obesity status are viewed and normalized by a specific culture or community may serve to mask binge-type eating behaviors and prevent awareness that links the behvaior to an underyling eating disorder psychopathology (17-19, 21-23, 25, 30, 64). Bray et al’s., 2024 mixed-methods study of BED experts’ perceptions, observations, and experiences of BED treatment barriers quoted one BED expert as saying,*“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 [is astounding].Aand I think that’s especially true for … any individuals who don’t fit that* ***stereotypical mold of who has an ED*** *… [which is] a* ***young, thin, cis-gendered, white woman****…” (P75)*

### Misunderstanding About Sociodemographic Prevalence of Binge Eating Disorder

Miseducation about who can have an ED/BED is also identified in the literature as a barrier to BED recognition and detection (both at the patient- and provider levels)(15, 18-22, 41). This barrier is often linked in the literature to a growing recognition of old/outdated misconceptions that ascribe EDs exclusively to **s**kinny/thin, **w**hite, **a**ffluent, [cis-gendered, heterosexual] **g**irls/females (the “SWAG: skinny, white, affluent, girl” stereotype)(42)(18).

The literature reflects a growing understanding that thin white affluent cis-gendered females are more likely than their respective counterparts to perceive a need for treatment and/or receive a diagnosis and treatment for an eating disorder (15, 41, 43), thus resulting in saturation of this demographic in treatment-seeking populations that research studies traditionally recruit and orient from (18). However, this demographic does not exclusively represent all individuals who experience BED. For example, emerging literature demonstrates that black, indigenous, and people of color (BIPOC) have higher prevalence rates of BED than their white peers (44-46) but comprise <10% of participants in BED research studies (18, 47), are less likely to be screened by medical professionals for EDs (17, 48, 49), and 50% less likely to be diagnosed or receive care (17, 41, 43-45, 47, 48, 50, 51).

Individuals of minority sex- and gender orientation, such as members of lesbian, gay, bisexual, transexual and transgender, queer or questioning, two-souled, and other/ally (LGBTQ2+) communities, also have increased risks for developing an ED (52), with a nationally representative U.S.-based study finding a greater prevalence of adult BED in non-heterosexual participants (2.2%) than in heterosexuals (0.8%)(53). Literature on prevalence rates among agender, transgender, and gender non-binary individuals focus primarily on youth (54, 55) but also demonstrate transgender young adults have higher BED prevalence rates than their cis-gendered counterparts (28% in females, 64% in males, and 73% in non-binary respondents)(54), with transgender males having higher ED pathology scores than transgender females (55). Other overlooked, under-diagnosed, and under-represented individuals with high prevalence rates of undetected BED include males (15, 41), individuals in “normally” sized/weighted/shaped bodies (15), and low socioeconomic status (15, 55-58), especially those with food/nutrition insecurity (past or present) (55-63) or use of government assistance programs like Supplemental Nutrition Assistance Program (SNAP), food stamps, or welfare (55, 59, 61, 63)), as addressed in Bray et al., 2022 (18).

### Deflecting Self-Identification

### Denial, Shame, and Self-Stigmatization

A variety of literature identifies denial, shame, and self-stigmatization associated with having an ED, BED, and/or with having a mental health diagnosis more broadly as primary patient-level barriers to self-identiciation of binge eating disorder (15, 17-19, 21-23, 26, 29-32, 35, 36, 64, 73-75). For example, Bray et al’s 2024 mixed-methods study of BED experts perceptions and experiences related to BED treatment barriers quoted one expert as saying “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,” (P5, as cited in Bray et al., 2024). Another BED expert stated “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 as cited in Bray et al., 2024). A third BED expert stated, “…the stigma of their caregivers being in a smaller body and not understanding …I think that needs to be addressed… [P37 as cited in Bray et al., 2024).

In addition to the provider-level data identified above, a variety of patient-level data also identify denial, shame, and stigmatization as preventing detection. For example, Salvia et al’s 2023 qualitative study of women’s perceptions of weight stigma as it pertains to binge eating disorder identified a theme in which “participants described how experiencing weight stigma in medical settings resulted in perceptions of getting lower quality care and exacerbated healthcare avoidance,” {Salvia, 2023 #8326}. For example, one participant was quoted as stating, "To be honest I wasn’t bringing that [binge behaviors] up to my doctor either. I was not; nor to the nutritionist, I was not talking about it ... So, there would be many times when I did not have a good food log for her [the nutritionist] because I was refusing to write down how much I was eating, and it was fear. I just didn’t want to face it," (P16, Age 63). A third stated, "It’s embarrassing. And they [the physician] have already told me to lose weight, and if I tell them I’m binge eating, they’re going to be very disappointed in me," (P10, age 57). The denial, shame, and self-stigmatization are reported in the literature to contribute to delayed or deflected self-identification and healthcare delay and avoidance (17, 22){Salvia, 2023 #8326}. They are also suggested to contribute to prioritizing physical health outcomes associated with BED over the underlying mental health and ED psychopathology (17, 22), as addressed in section 2.1.2.2 below.

### Desire to Avoid Healthcare Provider Stigmatization

In additional to the patient-level barrier of self-stigmatazation (described in section 2.1.2.1 above), patient-and provider-level data also identify healthcare provider stigmatization as a patient- and provider-level barrier that prevents BED discussions and detection. For example, Salvia et al’s 2023 qualitative study of women’s perceptions of weight stigma as it pertains to BED identified a theme in which “participants described how experiencing weight stigma in medical settings resulted in perceptions of getting lower quality care and exacerbated healthcare avoidance,” {Salvia, 2023 #8326}. Participants were quoted as stating, “You know, how many times do you hear someone say ‘Ugh, I’ve got my physical coming up, I’m going to cancel it because I didn’t lose weight’? It’s that fear, it’s that judgment ... And it doesn’t work, it only makes us feel worse, and so we’re in a spiral. A spin. And so, we’ll just avoid you [the healthcare provider] because we don’t want to face your wrath," (P 18, age 63). While this barrier is one that can be overcome at the patient level, it is in fact a provider-level barrier that is more approviately addressed at the level of the healthcare provider and healthcare systems (as further discussed in section 2.2.2 below).

### Recognizing and/or Prioritizing Physical Repurcussions of Binge Eating Disorder Over Psychological Underpinnings

Literature suggests many individuals with BED recognize, prioritize, and/or focus on physical issues often associated with BED (e.g., weight, cardiometabolic markers, gastrointestinal issues) but overlook, undervalue/prioritize, or deflect/reject the underlying mental health issues and ED psychopathology [e.g., emotion dysregulation, trauma history, negative affect, negative urgency, food/eating/substance addiction (27, 28, 65)[[1]](#footnote-1)](17, 18, 22, 25, 26, 28, 30, 32, 33, 38, 66). Weight overvaluation is thought to be a central feature of the underlying psychopathology for many individuals with BED (28, 39, 67-72), possibly contributing to this phenomenon. The valuation of body weight/shape/size and physical health over mental health underpinnings may also be related to weight vs. mental health “taboos” held by patients and society at large (21, 22, 66). This can result in a situation in which help-seeking for weight may be viewed as less taboo than help-seeking for disordered eating.

### Missed Opportunities for Detection: Often Related to Systemic Sociocultural Barriers

### Sociocultural Disparities in Healthcare Quality and Use

Many patient-level self-detection barriers involve sociocultural norms around weight and eating behaviors, as well as sociocultural views around physical and mental healthcare prioritization and use (17, 23). For example, in Becker et al.’s 2010 qualitative study of perceived social barriers to care for EDs among ethnically diverse health consumers (21), a Puerto Rican male participant expressed a view that seeking help was “silly” and that “eating issues were ‘something I should deal with in myself,’ and ‘more of a personal thing than anybody else helping me with it.’” These sentiments have been echoed in other studies of race and ethnic minority populations in the U.S., including studies of other Latina and African American populations (21, 23), and are often related to sociodemographic disparities in healthcare utilization and treatment more broadly, as identified in the literature (17, 18, 20, 21, 23, 24, 32, 76-81).

Sociodemographic disparities in healthcare experience and use can contribute to disproportionately high healthcare avoidance in some racial, ethnic, and sociodemographic populations. These can be driven by sociocultural beliefs about healthcare utilization, marginalization from healthcare providers (e.g., racism and stigmatization), and disparities in treatment quality receipt based on race, ethnicity, or other sociodemographic factors (18, 20, 21, 24, 32, 76-81) (23). For example, a 2022 review on racism in healthcare reported that racialized minorities experience inadequate healthcare and feeling dismissed in healthcare interactions associated with lack of trust and delay in seeking healthcare (24). Notably, the patient-level barrier of sociodemographic disparity in healthcare use is intertwined with additional provider-level barriers related to racism and marginalization that can result in patient healthcare avoidance and inferior patient care that can prevent BED detection, referral, and treatment engagement in turn (as addressed in section 2.2.1 below)(15, 17-21, 24, 25, 29, 30, 32, 33, 37, 66, 73, 76-81).

### Sociodemograhic Disparities in Healthcare Access

Outside of ethnic and racial disparities in healthcare quality and use, socioeconomic status can also present a barrier to healthcare access (15, 17, 18, 21, 29, 82). For example, Sonneville & Lipson (2018) find that approximately 85% of college students lack health insurance or resources to access a primary care provider (15). This can result in these indivdiuals missing the opportunity for BED recognition or screening.

### Provider-Level Barriers to BED Detection

Provider-level barriers to BED identification generally relate to deficits in detection, screening, and diagnosis and are supported in the literature (17). For example, a 2017 randomized clinical trial found that among 100 women who qualified as having a DSM-diagnosed ED and enrolled in a BED intervention study (suggestion self-identification and high motivation for treatment-seeking), 99% had received health-related services in the past year, yet only 42% received services related to weight or EDs and only 4% had received an ED diagnosis in that time, as verified by insurance claim codes (40). These findings suggest that in an insured population of women who meet gender stereotypes for having an ED (and so are more likely to be detected for an ED based on gender), express motivation for treatment (suggesting a higher likelihood of discussing eating behaviors with the provider), and have had at least one service contact with their health care provider (and thus at least one opportunity for their ED to be detected), only 4% received an ED diagnosis (40). Moreover, findings suggest that missed provider screenings are more prevalent among minorities, as addressed above (15, 17, 18, 48, 49, 55-59, 61, 63).

Overall, deficiencies in provider detection, screening, and diagnosis can occur for a variety of different reasons but generally relate to:

* Negative healthcare provided biases based on race and ethnicity (24).
* Stigmatization (15, 17, 27, 28, 30, 32, 60-62, 67, 75-77).
* Misconceptions about who can have an eating disorder.
* Miseducation about BED.

### Racialized Biases and Discrimination Among Healthcare Workers and Systems

Implicit healthcare provider biases can compromise healthcare quality and equity, resulting in deficient BED screening and causing individuals with BED to avoid healthcare use (15, 17-21, 24, 25, 29, 30, 32, 33, 37, 66, 73, 76-81). For example, Hamed et al.’s 2022 review on healthcare staff’s racial attitudes, beliefs, and implicit racial biases revealed a range of negative stereotypes regarding racialized minority healthcare users who were viewed as “difficult” and racial biases that negatively influence medical decisions (24). Similarly, a “multi-ethnic (including African American)” female participant in Becker et al. (2010) reported her psychologist “did not believe she had an ED because she was Black” and “didn’t fit the stereotype,” further reporting “when … I explained to her things that had happened… [she] said she didn’t know how she would be able to help any further because she didn’t feel that I fit the stereotype or the protocol [of] someone with an ED,” (21).

### Healthcare Provider Stigmatization Based on Body Weight/Shape/Size

Healthcare provider biases, stigmatization, and descrimination based on patient body weight/shape/size can also significantly compromise healthcare quality and equity, result in deficient BED screening, and cause individuals with BED to avoid discussing BED symptoms with healthcare providers, and/or avoid or delay healthcare use altogether (15, 17-21, 24, 25, 29, 30, 32, 33, 37, 66, 73, 76-81). For example, in Bray et al.’s 2024 mixed-methods study of BED experts’ perceptions, experiences, and observations of healthcare provider stigmatization based on body weight/shape/size as a barrier to BED treatment both in the literature and clinically, one BED expert was quoted as saying,*“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* as quited in Bray et al., 2024). Another expert was quoted as saying,*“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* as cited in Bray et al., 2024).

### Misconceptions Among Healthcare Providers About Who Can Have an Eating Disorder

Provider stereotypes about who can have an ED (similar to those addressed in section 2.1.1.1 above) can also lead to insufficient BED detection and screenings that are amplified in minoritized populations (15, 18-22, 30, 32, 83).

Recognizing, screening for-, prioritizing, and treating physical issues often associated with BED (e.g., weight, cardiometabolic markers, gastrointestinal issues) but overlooking or ignoring underlying mental health issues and ED psychopathology (as discussed above) has also been identified in the literature (15, 17-19, 21, 24, 25, 29, 30, 32, 33, 37, 66, 73) and can prevent or delay BED detection until associated physical symptoms are “severe and pronounced” (25).

Overall, these provider biases and deficiencies can result in missed opportunities for recognition and detection, both through deficient provider screenings and through breaches in the patient-provider relationship and communication, which can drive patients with BED to withhold information about their eating behaviors to avoid marginalization, stigmatization, and shame.

### Deficient Provider Education and Training on BED

Deficient provider education and training on BED can also result in deficient screening and diagnosis (17, 22, 83-86). In the literature, providers express a perceived lack of standardized or validated assessment tools for BED, a perceived lack of unified guidelines on using existing standardized or validated assessment tools, a lack of education and training on standardized assessment tools and guidelines, and a subsequent lack of confidence in their ability to detect, screen, and diagnose BED as barriers to screening and diagnosis (22, 84-87). A lack of routine screening for BED in primary care or other settings has also been identified in the literature as a source of deficient BED detection and an area for clinical improvement (15, 16, 18, 30, 32, 33). Deficient provider education on the diagnostic validity and criteria of BED (e.g., that it is a valid autonomous DSM-5 mental health diagnosis) has also been identified as a provider-level barrier (17, 19, 21, 22, 25, 28, 30, 64). For example, a recent study including 405 healthcare providers from the U.S. found that 93% of general healthcare providers and 89% of psychiatrists among the survey respondents were not able to correctly identify the diagnostic criteria for BED (Cao et al., 2019 as cited in Bilic et al., 2020 (22, 83)). Literature also suggests deficient provider education and training on diagnosing and treating BED can impede screening and detection (22, 25, 29, 30, 87). Similarly, provider de-prioritization or avoidance of screening for-, diagnosing, and treating BED is identified as a detection barrier in the literature often linked to BED stigmatization, lack of education and training, low treatment success rates, perceived financial concerns, and overall negative views about EDs/BED (19, 22, 25, 87).

In support of this possibility, Johns et al.’s 2019 systematic review and thematic synthesis of healthcare professionals’ perspective of barriers to care and unhelpful experiences in current eating disorder healthcare services stated:

*“Professionals in primary care settings … described …[facing] challenges and difficulties with individuals with eating disorders, their families and the eating disorder healthcare interface itself. Primary care professionals argued that individuals with eating disorders are difficult and challenging and create tension between all parties (88). They felt that people with eating disorders often lack motivation and adherence with treatment … (88-93). Therefore, some primary care professionals were reluctant to work with eating disorders (94), with expressions of ‘frustration’ (90, 92), ‘resentment’ (95), and ‘irritability and disgust’ in the physical comorbidities (91, 95), considering eating disorders as being ‘low prestige’ compared with other illnesses (95), with some stating they ‘don’t like’ or ‘don’t want to work with them’ (92, 96). Other primary care professionals indicated that they just ‘don’t’, or ‘don’t want’ to screen for eating disorders (89, 92, 97, 98), as they find them time consuming or too complex (89, 91-94, 99)…” (25).*

Johns’ conclusions are reflected in a variety of additional literature. For example, a 2017 qualitative study on the experiences of ED treatment in men (Thapliyal et al., 2017 (19)) identified lack of expertise in treating EDs and perceived incompetence of therapists, ignorance of EDs in men, and money-mindedness of therapists as important and critical themes and issues identified in at least half of the autobiographies included in the study. An exemplary passage was provided quoting a male with BED describing his treatment experience, as published in Henning & Woods 2004 (100): *“Until this stay, I had seen eight different professionals who tried to help me and at the same time only two knew how to work with someone who suffered from an eating disorder,” (Henning & Woods 2004, p. 67*, as cited in Thapliyal et al., 2017).

Becker et al.’s 2010 qualitative study of perceived social barriers to care for EDs based on perspectives from ethnically diverse health care consumers (21) similarly quoted a “multi-ethnic (including African-American)” female participant who stated: *“I felt like basically what I was saying [to my psychologist] … was … going in one ear and out the other, she wasn’t paying any attention to me or taking her job seriously,” (21)*.

Overall, Johns et al. (2019) concluded: “for individuals with eating disorders, the primary care service was described as an ‘obstacle’ or ‘barrier’ to care, rather than the first port of call or effective ‘gate-keepers’ to specialist services” (25).

### Systemic Barriers to BED Detection

Systemic barriers to BED detection are generally similar to patient-level barriers and so will not be discussed at length here. These generally include:

1. Stigmatization (17, 19, 21, 22, 26, 32, 35, 64, 73, 101-120)(30, 35, 61-74).
2. Lack of education and awareness about BED, specifically related to:
   1. Overall prevalence (15, 18-20, 22).
   2. Demographic prevalence (15, 17-22).
   3. Validity as a DSM-5 mental health diagnosis (17-19, 21, 22, 25, 28, 30, 64).
   4. Symptoms, severity, and consequences of BED (15-18, 21, 22, 26, 29, 30, 32, 33, 35, 64).
   5. Low media representation of BED (30).
3. Prioritization of physical health outcomes over mental health (17, 18, 22, 40, 121-127).

The lack of education and awareness about BED, specifically in relation to its sociodmograpihc prevalence rates, poses a particular barrier to sociodemographic minority populations (e.g., Black Indigenous, and People of Color (BIPOC) and lesbian, gay, bisexual, transexual and/or transgender, queer or questioning, two-souled, and other/ally (LGBTQ2+) populations) who have disporporately high rates of BED in relation to their white cis-gendered counterparts but low awareness of this issue (as addressed in Bray et al., 2022). This issue may be related to the outdated “SWAG” stereortype that ascribes eating disorders exclusively to “skinny/[thin], white, affluent, [heterosexual, cis-genedered] girls/[young woman],” as addressed in section 2.1.1 above (18, 42). For example, Becker et al.’s 2010 qualitative study of perceived social barriers to eating disorder care in ethnically diverse health care consumers quoted an African American female participant is stating, “I’ve had a lot of black women tell me that black women don’t really have EDs, eating problems, however, it’s phrased…. in a lot of people’s minds, it’s a white person’s problem,” and “no one ever looked at me [as possibly having an ED] because, you know, white girls [have EDs], not black girls,” (21). This particular barrier can prevent BED identification at both the patient, provider, and systemic levels.

## Barriers to Treatment-Seeking (Stage 2), Access, and Engagement (Stage 3)

Treatment-seeking (stage 2; **Figure 1**) can be viewed as a contemplation/planning stage that is dependent on identifying the presence of BED (stage 1) and often required for an individual with BED to access and receive treatment (stage 3). Similarly, accessing and receiving treatment (**Figure 1**) is dependent on identifying BED (stage 1) and is often also dependent on treatment-seeking behaviors such as investigating treatment options and coordinating care and financial aid (stage 2). Thus, treatment-seeking (stage 2) and treatment access/engagement (stage 3) are discrete yet dependent steps in achieving treatment outcomes associated with recovery and remission. Because the barriers and proposed solutions to treatment-seeking and treatment access/engagement are very similar, we have grouped them together here.

## Patient-Level Barriers to Treatment-Seeking and Engagement

## Insufficient Resources to Find, Coordinate, and Receive Care

Patient-level barriers that can prevent or delay an individual with BED from seeking, accessing, and/or engaging in treatment largely pertain to insufficient resources to find, coordinate, and receive care (**Figure 1**), including (17):

1. Knowledge of treatment resources (e.g., insufficient information on treatment approaches, options, providers, centers, and financial aid) (19, 22, 25, 26, 29, 30, 35, 64).
2. Financial aid options to help cover treatment costs (at all levels of care)(15, 21, 22, 26, 29, 30, 36, 66, 73, 75, 82, 128, 129) and awareness of financial aid resources (22, 25, 29, 30, 64).
3. Insurance coverage (15, 21, 29, 82).
4. Transportationto and from treatment (29, 87, 127, 130-132).
5. Time required to seek, access, engage in, and coordinate interdisciplinary care (21, 30, 87, 127, 130, 131).
6. Geographic access/proximity to treatment resources (18, 21, 22, 25, 36, 133).[[2]](#footnote-2)
7. ED provider scarcity and waitlists (18, 22, 25, 36, 134).2
8. Lack of Sociocultural Sensitivity and Inclusion (18, 23).
9. Insufficient resources to coordinate communication between multiple providers in a multidisciplinary team (21, 30).
10. Deficient or deflected self-recogtnition/identification (associated with feelings of fear, stigma, and shame, and/or low mental health literacy/perception of need for treatment)(23, 75), as addressed in section 2.1 above and 3.1.2 below.
11. Negative treatment beliefs, pereptions, expectations, and experiences (23, 75), as addressed in section 2.1 above and 3.1.2 below.

Each of these barriers are discussed individually below.

## Insufficient Knowledge of Treatment Resources[[3]](#footnote-3)

Various literature identifies insufficient knowledge of treatment resources as a barrier to treatment-seeking and -engagement (17, 19, 22, 25, 26, 29, 30, 35, 64). Examples include insufficient information on treatment approaches, treatment options, providers, treatment centers, and financial aid. Additional examples of this barrier existing at a provider level are provided in section 3.2 below.

## Treatment Costs and Insurance Coverage3

A variety of iterature identifies treatment costs and insurance coverage issues as barriers to BED treatment seeking and access (17, 22, 26, 30, 35, 36). In support of this possibility, a study estimating one-year healthcare costs and utilization of adults with BED based on clinical notes in the Department of Veterans Affairs electronic health record database from 2000–2011 found the mean total unadjusted one-year healthcare costs for individuals with BED in 2011 (including total healthcare, inpatient, outpatient, and pharmacy costs) were $33,716 ± $38,928 (N=257), which was estimated to be $18,152 higher than those associated with matched VA patients without an ED (p<0.001)(135). Recent findings also suggest BED has high prevalence rates among individuals of low socioeconomic status (15, 55-58) who often require government assistance (18, 55, 59, 61, 63), suggesting reduced feasibility of funding the $18,152 annual treatment costs in these individuals. A 2019 study that used data from the 2012-2013 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III) also reported 25% of adults with DSM-5-defined BED reported an annual income of <$20,000 (thus less than the estimated annual costs associated with BED healthcare use (135))(67) and 44% reported an annual income of <$35,000 (less than the total unadjusted annual costs of healthcare use for individuals with BED)(135))(67).

Individuals with BED also consistently report treatment costs (15, 21, 26, 29, 30, 35, 36, 66, 73) and inadequate insurance coverage (15, 21, 29, 82) as barriers to care. A 2010 cross-sectional qualitative study of perceived social barriers to care for EDs found that although 94% of participants reported having healthcare at the time of the survey, economic or health insurance constraints were still consistently identified as a barrier to treatment (21). One participant reported prematurely discontinuing treatment due to discontinued insurance coverage; another reported attending a treatment facility 2.5 hours away from home while continuing to see their primary care provider (2.5 hours away) due to coverage rules within their HMO (21). A third participant reported their insurance did not cover all their treatment needs (21). Tamargo et al. (2022) discuss healthcare policies that drive insurance coverage decisions (e.g., “medical necessity”), the roles of insurance companies in determining insurance coverage provisions, current limitations in insurance coverage, reasons for denial, the ethical implications of current insurance practices, and directives for improvement at length (82).

## Transportation

Literature on transportation as a treatment barrier (e.g., having access to transportation to and from treatment) is less direct, though it does exist (17). Cachelin et al.’s 2001 study examining treatment barriers in an ethnically diverse community sample (61 women with EDs, 33 with BED, recruited through community flyer) found 10.3% of participants endorsed lack of transportation as a reason for not seeking treatment (29). Additional evidence of transportation as a treatment barrier can be found in reasons for research dropout. Striegel-Moore et al. (2001) reported 20.8% of participants in their comparison of BED and bulimia nervosa in a community sample were interviewed by phone due to scheduling constraints or lack of access to transportation (127). Wilfley et al. (2000) reported 9.8% of participants who were screened by phone to participate in their study on comorbid psychopathology in BED did not participate because of time conflicts or deficiencies and 2.8% did not participate due to transportation limitations or being too far from the clinic (131). Thompson-Brenner et al. (2013) recognized transportation and time constraints as possible contributors to the observed disparity in dropout rates between individual vs. group self-help/guided self-help treatment (mean 26.1% vs. 40.3%) and between different ethnicities (87). In their estimate of the true costs of BED treatment, Jenkins et al. (2022) identified “out-of-pocket expenses” as an important factor, which “focused largely on transportation.” Lastly, 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” (130).

## Time Burden

Literature identifying the time burden required to seek, access, engage in, and coordinate interdisciplinary care as a barrier to treatment-seeking and -engagement is also less prevalent and direct, though it does exist (17, 21, 30, 87, 127, 130, 131). For example, individuals with BED commonly cite time as a reason for research dropout, as identified above (87, 127, 130, 131). In further support of the time burden associated with coordinating care and engaging in treatment, one participant in Herman et al.’s 2014 mixed-methods study on patient experience with DSM-5-defined BED reported seeing a variety of specialists, “my rheumatologist, …my gynecologist, the endocrinologist, …the nutritionist,” (30). Additionally, multiple patients report on time burdens identified as barriers to care in Becker et al.’s 2010 cross-sectional qualitative study of perceived social barriers to care for EDs (“it was a hassle to switch around the doctors, and things”) (21).

## Geographic Proximity

Similarly, the literature consistently identifies geographic access/proximity to treatment resources (17, 18, 21, 22, 25, 36, 133) and ED provider scarcity and waitlists (17, 18, 22, 25, 36, 134) as barriers to treatment entry and engagement. In Becker et al.’s 2010 cross-sectional qualitative study of perceived social barriers to care for EDs, one patient reported: ‘‘I think access to care can be a big problem. Even if it’s not just a factor of, ‘I don’t have insurance, I don’t have money,’ finding places at least here where I live that treat eating problems is hard. There are not a lot of places here” (21).

## Provider Specialist Scarcity and Wait Times

Patients and providers also consistently identify “long waiting lists and a lack of [ED treatment providers and] resources with no guarantee of admission and treatment by more specialized services for EDs” (25) as major treatment barriers (17, 18, 22, 25, 134, 136-142). Johns et al.’s 2019 systematic review and thematic synthesis of patient, family, and provider experiences of current ED healthcare services found that “‘referring on’ [often occurred] to under-resourced specialist service struggling to respond to demand (93, 136, 141, 143) [and] ED service [scarcity] created limited access (140, 142, 144), geographical barriers (140), long waiting lists and delays (136, 139, 140, 142) rigid admission rules based on single treatment modalities and ED physical traits (140, 142, 144). Lower BMI took priority (142, 145); referrals were only accepted for serious cases (139-142, 146). Furthermore, specialist ED care provided no guarantee of treatment even after gaining access (142), with the risk of losing a place if another patient took priority (141, 142) and immediate discharge occurring after weight restoration, with little if any aftercare (142)” (25).

While most of the research on provider scarcity and wait times is in the context of anorexia and bulimia nervosa, empirical support does exist in the context of BED (17). For example, Bell et al.’s 2004 prospective observational study of 125 patients with BED (N=27) or BN (N=98) referred to a supervised self-help program over a 2-year period and attended the initial mental health screening (demonstrating some interest in change) found that patient wait times ranged from 1–22 weeks; patients engaging treatment had significantly shorter wait times than those who never attended a single appointment (median 4 weeks in patients who engaged [68%] and 6 weeks in patients who failed to engage [32%]; p=0.445) (134). When wait times were stratified as short (≤ 4 weeks) or long (≥5 weeks), the odds ratio (OR) of attending a treatment appointment was 2.4 times greater for those with “short” wait times (134). A fitted regression model further suggested the odds of appointment attendance and treatment engagement reduced by 15% per week of wait time (OR =0.85, *p* = 0.002) (134), suggested clients should start treatment within 4 weeks of their assessment and no later than 10 weeks to ensure greatest likelihood of attendance.

Regarding treatment time courses, Grilo et al. (2006, 2007, 2012) found that rapid response to treatment (e.g., ≥65–70% reduction in binge eating by week four of treatment (147-149)) characterizes ~44–67% of participants across different treatment modalities (e.g., fluoxetine (148), CBT (147, 148), fluoxetine and CBT (148), CBT guided self-help (149), and behavioral weight loss (147)) and predicts binge eating remission and reductions in binge eating frequency, ED psychopathology, and weight loss (147-149). While rapid response was found to be unrelated to baseline variables, a possible relationship between treatment wait times and rapid response remains to be tested. Moreover, in addition to risking the potential to miss out on rapid treatment response and its associations with positive treatment outcomes (147-149), longer treatment times also threaten to pose a barrier to treatment access and engagement by amplifying a variety of barriers already addressed here. For example, longer treatment times are associated with greater treatment costs, greater insurance coverage needs, greater transportation needs, and exacerbated time burdens. Together, these barriers may render treatment inaccessible to some individuals for whom shorter treatment options may be possible. Alternatively, these amplified barriers may cause some individuals to prematurely terminate or discontinue longer treatment courses (21), thus compromising treatment success rates.

## Lack of Sociocultural Sensitivity & Inclusion

A growing area of investigation seeks to better understand the experiences of individuals with BED who are members of marginalized and minotrity populations, and the treatment barriers that pertain specifically to them and their communities (18). For example, Reyes-Rodríguez, et al.’s 2013 qualitative analysis of eating disorder treatment barriers among adult Latinas in the US identified several thematic issues related to language barriers, interpretation, and privacy (23). Lack of bilingual treatment services and use of interpreters to overcome language barriers were both identified as themes that prevented treatment pursuit. The issues surrounding language barriers and interpreter use are ones not recognized in other literature, to the authros’ knowledge. Reyes-Rodriguez found that all participants “stressed the necessity of bilingual services,” both in eating disorder assessment and treatment and in mental health care more broadly (23). “Patients with previous experience using an interpreter in health/mental care reported discomfort during treatment sessions due to the lack of privacy and frequent misunderstanding regarding symptoms among themselves, interpreters, and clinicians,” Reyes-Rodriguez et. al. notes (2013). One patient also reporteded “an experience in which an interpreter added their understanding of a situation and personal advice to the information exchanged between the patient and her doctor, [stating], ‘the interpreter would tell me what she [the therapist] was saying to me but would also tell me what she [the interpreter] thought about what I was saying so it was... difficult...not only having to tell my issues to the psychologist...but also with an interpreter as well, that had nothing to do with it,’,” (23). These and other sociocultural/demographic-specific barriers highlight the need for greater research and treatment options that are socioculturually sensitive, inclusive, and responsive, as advocated in the literature (17, 18, 150).

## Negative Expectations About Treatment

A cluster of patient-level barriers has also been identified in the literature that can lead to healthcare avoidance and prevent an individual with BED from seeking and/or accessing/receiving treatment if sought (**Figure 1**) and that generally pertain to negative expectations about treatment (17, 23, 26, 35, 75). These barriers generally relate to stigmatization and treatment fears, addressed below.

Barriers related to stigmatization identified in the literature include (17):

1. Healthcare system avoidance due to provider stigmatization (see section 2).
2. Sociodemographic disparities in healthcare utilization, often driven by marginalization and disparities in healthcare quality within healthcare systems and sociocultural norms about healthcare use (see sections 2.1.3 and 2.2.1).
3. Healthcare avoidance due to shame, self-stigmatization, and denial about having BED, an ED, and/or a mental health diagnosis (see section 2.1.2).

Barriers related to treatment fears include (17):

1. Fear of letting go of the coping/eating behavior (often associated with trauma/adversity)(22, 23, 26, 35, 36, 75, 151, 152).
2. Fear of facing treatment hardships (23, 26, 35, 75, 152).
3. Tolerating (“sticking with”) treatment when it becomes difficult (152).

“Fear of letting go of the coping/eating behavior (often associated with trauma/adversity)” has some direct empirical support in the context of BED (e.g., patient report (23, 26, 35, 75, 151) and expert endorsement (17, 26, 35, 75)).

This treatment barrier also has some indirect support (17). 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 (153-157). Similar associations have been observed in obesity (157-159), which has high comorbidity with BED (2, 5, 68). For example, Vincent Felitti’s hallmark ACEs Study (160) found that individuals with obesity and comorbid ACEs perceived excess body weight to feel “safe;” whereas major weight loss was perceived as “threatening” (161) and associated with high attrition rates (>50%) (158, 160-162). Felitti concluded that “obesity … from the involved patient’s standpoint [was] often an unconsciously chosen solution to unrecognized traumatic life experiences that were lost in time and further protected by shame, secrecy, and social taboos against exploring certain realms of human experience,” (161). Although Felitti and colleagues did not assess patients for EDs or BED, it is possible (and probable) that Felitti’s conclusion about obesity could pertain more accurately to an underlying BED or disordered eating behaviors (e.g., binge eating, food/eating addiction) that contribute to obesity. This possibility – although not yet tested – is supported by a variety of literature demonstrating associations between trauma history or adversity and BED (including ACEs, ALEs, family-related non-abuse ALEs, and PTSD) (18, 28, 153-157, 163-174). It is similarly possible that what Felitti perceived to be a fear of major weight loss (wherein excess weight was perceived to be an unconscious coping mechanism to childhood trauma or adversity) was actually a fear of letting go of the underlying BED or disordered eating behavior that caused the weight loss. It is also possible that some individuals with BED and comorbid overweight or obesity perceive their excess weight to feel “safe,” as Felitti and colleagues observed (161), and thus perceive weight loss as “threatening (161),” contributing to the high rates of early dropout associated with BED treatment (14) or serving as a barrier to treatment seeking or engagement altogether. However, these possibilities remain to be tested.

More recently, a 2020 review shed light on several limitations of the "protective measure" theory that purports individuals exposed to sexual abuse will deliberately or subconsciously gain weight as a “protective measure” that serves to prevent future victimization (175). The review adopts a biopsychosocial approach to explore connections between childhood sexual abuse and conditions like eating disorders, food addiction, drug addiction, and obesity throughout life. The various pathways that can become activated by the biological embedding of abuse are explored, including inflammation, stress response, brain changes, and epigenetics. These pathways can contribute to conditions like food addiction and substance use disorder, which can ultimately lead to obesity. The review questions the traditional “protective measure” theory and endorses “a more comprehensive understanding of the mechanisms by which childhood sexual abuse become biologically embedded,” suggesting that this greater understanding “may help clinicians and survivors normalize and/or address disordered eating and weight-related outcomes, as well as identify intervention strategies.”

To the authors’ knowledge the two additional treatment barriers identified here (fear of facing treatment hardships and tolerating/”sticking with” treatment when it becomes difficult) have less direct empirical investigation in the context of BED. For example, the literature base 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”) (176, 177). However, some support does exist for patient ambivalence/low motivation to change in the context of BED (17, 22, 26, 35, 66).

Additionally, the possible barrier of insufficient willingness or ability to tolerate/“stick with” treatment hardships surprisingly lacks direct empirical support in the context of BED, to our knowledge, outside of Bray et al., 2024 (17). However, retention rates for BED treatment are generally low (178), ranging from 42–88% (46, 179-183), and early discontinuation of care is a common quandary (14, 178, 184). Whether low retention and early discontinuation of care are related to tolerating treatment hardships warrants further testing.

Additionally, several other patient-level barriers to treatment-seeking, access, and engagement are consistently identified in the literature. These include:

1. The belief that BED is “not that big of a deal,” or “I should be able to do it myself” and consequently deprioritizing treatment (15, 21, 22, 26, 29, 35, 64) both at the patient (15, 22, 26, 29, 35) and public levels (21, 22, 64).
2. Patient ambivalence/low motivation to change (22, 23, 26, 66).
3. The fear/belief that “others can’t help” (19, 21, 29), low confidence in ability to change (22, 151), or sociocultural beliefs related to fatalism (e.g., permance of “fate”)(23).
4. Lack of social support (21-23, 26).
5. 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).

## Provider-Level Barriers to Treatment-Seeking and Engagement

Provider-level barriers that can prevent an individual with BED from seeking treatment and/or from accessing/receiving treatment if sought (**Figure 1**) largely pertain to stigmatization from healthcare providers (see sections 2.1.3 and 2.2.1)(15, 17-19, 21, 23-25, 29, 30, 32, 33, 37, 66, 73) and insufficient resources to assist patients in finding/coordinating care (17, 21-23, 25, 29, 30, 64). This includes insufficient provider education and training on BED treatment approaches and options, specialists and treatment centers, and financial aid resources (22, 23, 25, 29, 30, 64) as well as insufficient provider use of referrals for ED specialists (25, 142, 145) and insufficient provider assistance in coordinating care (14, 15, 21, 25, 185). For example, in Becker et al.’s 2010 qualitative study of perceived social barriers to ED care among ethnically diverse health consumers, a female participant of Polish, Hungarian, and Italian heritage stated, “I was pretty much the one that got my own help” (21).

## Insufficient Knowledge of Treatment Resources

Various literature identifies insufficient knowledge of treatment resources as a barrier to treatment-seeking and -engagement (17, 19, 22, 25, 26, 29, 30, 64). Examples include insufficient information on treatment approaches, treatment options, providers, treatment centers, and financial aid. For example, Johns et al.’s thematic synthesis of literature on current ED healthcare services identified “lack of ED experience, understanding, and knowledge among primary care professionals, particularly among general practitioners, practice nurses, and social workers” as a primary unhelpful experience and barrier to the help-seeking process (25). Johns et al. also reported that “primary care professionals saw the lack of training and resources in EDs as a barrier,” (citing Grange and Gelman, 1998 (25, 93)), though this barrier was more commonly associated with a lack of confidence in screening for EDs in the primary care setting due to a commonly perceived lack of well-validated universal screening protocols for EDs (25).

Additional, provider-level barriers to treatment-seeking and engagement include not pushing for rapid response/behavior change within the first 3–4 treatment weeks (17, 19, 25, 147-149, 186, 187), as addressed in section [3.1.1.4](#_4.2.2.1.1.4_Time_Burden).

## Systemic Barriers to Treatment-Seeking and Engagement

Systemic barriers to BED detection are generally similar to patient-level barriers (17) and will not be discussed at length here. These generally include the insufficiency of resources (as identified in section 3.1.1) and stigmatization occurring at the levels of the healthcare providers/systems and systemically (as addressed in sections 2.2.1, 2.1.3, and 2.1.1).

## Summary

Overall, the barriers that impede adult BED detection (stage 1), treatment-seeking (stage 2), and treatment access (stage 3) continue to change and evolve, as does our awareness of them as a field. The themes identified here represent new and emerging barriers identified in the literature that can obstruct adult BED detection, diagnosis, treatment-seeking, and treatment access and engagement.

Here, we extend the existing literature by providing a theoretical model of how these barriers can interact and influence each other at different stages of the treatment-seeking and engagement process (**Figure 1**). Our model suggests that individuals with BED may face patient-level, provider-level, and systemic barriers at three stages in the process of treatment-seeking and access: identifying BED (stage 1); seeking BED treatment (stage 2); and accessing, engaging in, and receiving BED treatment once sought (stage 3). These barriers may prevent individuals with BED from recognizing their condition, seeking help, finding appropriate care, and engaging in treatment. Our model also implies that some barriers may be more prevalent or salient at certain stages 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 (2 and 3).

## Conclusions

In conclusion, existing literature identifies a variety of 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 patient-, provider- and systems-level barriers, 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.

This review also explores and uses a theoretical model of how BED treatment barriers can interact and influence each other at different stages of treatment. Our findings have implications for research, practice, and policy in BED. Overall, we suggest that more education and awareness campaigns, tools that can simplify screening, treatment-seeking/access, accessible and affordable treatment options, and 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 team approaches, 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 virtually available) is warranted. These solutions are further explored in Bray et al., 2024 (150).

## Conflict of Interest

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

## Author Contributions

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

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## Tables and Figures

## Figure 1

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

A screenshot of a diagram

Description automatically generated

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

1. The psychopathology thought to drive BED most likely varies according to the individual. Commonly endorsed models of conceptualizing BED psychopathology are presented in Bray et al., 2023 and Neyland, Shank, & Lavender 2020 while mental health factors and comorbidities empirically associated with BED are presented in Bray et al., 2022. [↑](#footnote-ref-1)
2. Geographic access to treatment resources and provider/treatment center scarcity and wait lists are treatment barriers that pertain more to treatment access/entry (stage 3) than to treatment-seeking (stage 2). [↑](#footnote-ref-2)
3. Note: The barreirs of insufficient knowledge of treatment resources (3.1.1.1), treatment costs and insurance coverage (3.1.1.2), geographic proximity (3.1.1.5), provider specialist scarcity & wait times (3.1.1.6), and negative expetations about treatment (3.1.2) are listed here as patient-level barriers though they are more appropriately listed as patient- and systems-level barriers. [↑](#footnote-ref-3)