How to address the treatment gap for patients with eating disorders and help with their recovery?

Word Count: 2017 Words excluding tables

Introduction

In an era characterised by the pursuit of an ideal body images, the prevalence of eating disorders (EDs) has caused a critical public health concern in the United Kingdom. It is estimated that around 725,000 people in the UK suffer from ED's, with subthreshold and unreported cases likely to increase this figure significantly.(1) Over 90% of individuals affected are women, with children and adolescents being particularly vulnerable.(2,3,4) ED's can present with many forms, but most commonly as Anorexia Nervosa (AN), Bulimia Nervosa (BN) or Binge Eating Disorder (BED).(1) AN, in particular, affects between 2-4% of women and carries the highest mortality rate of any psychiatric condition, with rates up to five times higher than those of the general population.(2,3,4,5) Compounding the severity of EDs is their association with high rates of psychiatric comorbidity, poor quality of life, and increased mortality, making them the 12th leading cause of disability in young females in high-income nations.(6,7,8,9)

Despite these worrying numbers, a significant treatment gap persists. This refers to the disparity between the number of people who require treatment for EDs and those who actually receive it.(10) Currently, it is estimated that as many as 80% of individuals with ED's are not receiving treatment, and even among those who do, many face long-term struggles with recovery.(11,12,13) It is also important to note that early intervention strategies, such as proactive screening and rapid evidence-based treatments, have been much slower to develop in the field of eating disorders compared to other areas of mental health. As such, addressing the disparity through timely action and improved access to care is more critical than ever. In response to these challenges, this essay will investigate the role of stigma, social media, and gaps in evidence-based treatment in perpetuating the treatment gap, while proposing targeted solutions to reduce these barriers and improve long-term recovery outcomes for individuals with eating disorders

Understanding the Scope of the Eating Disorder Crisis

The treatment gap for ED's is a multifaceted issue, with numerous barriers preventing individuals from accessing the care they need. While many individuals with EDs recognise their need for treatment, only 19-36% access treatment in any given year, compared to 35-41% of those with other mental health conditions. [14]This disparity is largely attributed to a range of personal, societal, and structural barriers. Allen and Dixon defined these obstacles as a combination of internal beliefs and external factors, such as the healthcare system's availability, accessibility, and affordability.(15) Stefl and Prosperi echoed this by identifying key attributes affecting service use, which include the acceptability of care and the individual's willingness to engage with it.(16)

Shame and Silence: How Stigma Prevents Help-Seeking in Eating Disorders

The stigma around ED’s remains one of the most significant deterrents to seeking treatment, which is more pronounced than that of other mental health conditions.(17) A literature review by Ali et al. identified 15 core barriers to care for EDs, with stigma, shame, and fear of losing control ranking among the most significant.(18) This stigma often manifests in feelings of embarrassment, reluctance to be judged, or fear of losing control over eating behaviours—particularly in individuals with AN.(19) For many individuals, ED’s may provide a sense of control over the lifestyle, which consequently complicates their willingness to relinquish that control in exchange for treatment. Interestingly, men with eating disorders highlighted the societal stigma attached to male body image and the perception that EDs primarily affect women.(18,20) This stigma extends beyond gender; stereotypes about who can have an eating disorder also play a significant role in preventing non-typical patients from seeking help. The stereotypical eating disorder patient is often thought to be young, cisgender, female, and emaciated. As a result, adolescents who are gender- or racially diverse, or those presenting at higher BMIs, are much less likely to be identified with an eating disorder or to access specialty treatment.(21, 22, 23, 24,25) These biases contribute to a significant portion of individuals with EDs being overlooked, further perpetuating the treatment gap.

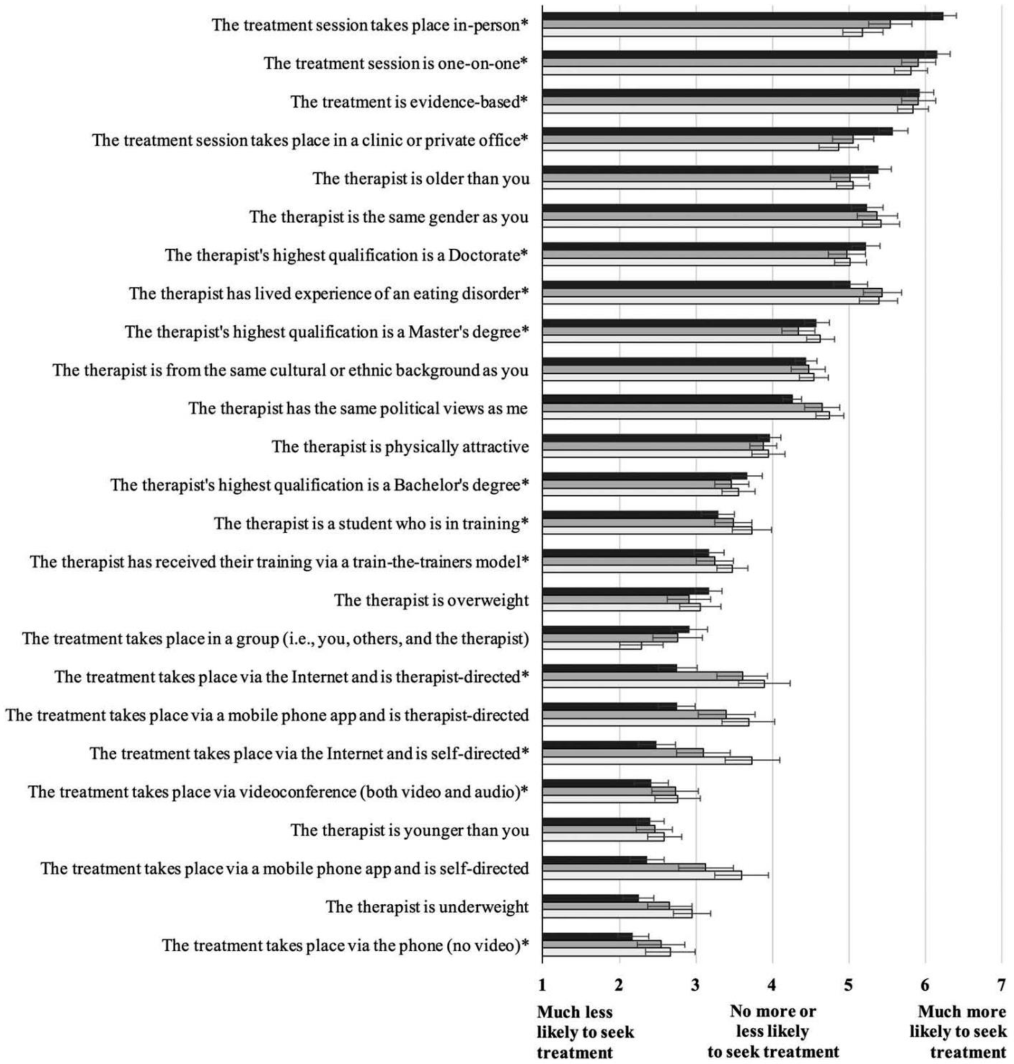

Figure 1Likelihood of seeking treatment for an eating disorder for participants who are currently diagnosed and in treatment (dark grey), currently diagnosed but not in treatment (middle grey), and undiagnosed and not in treatment (light grey).

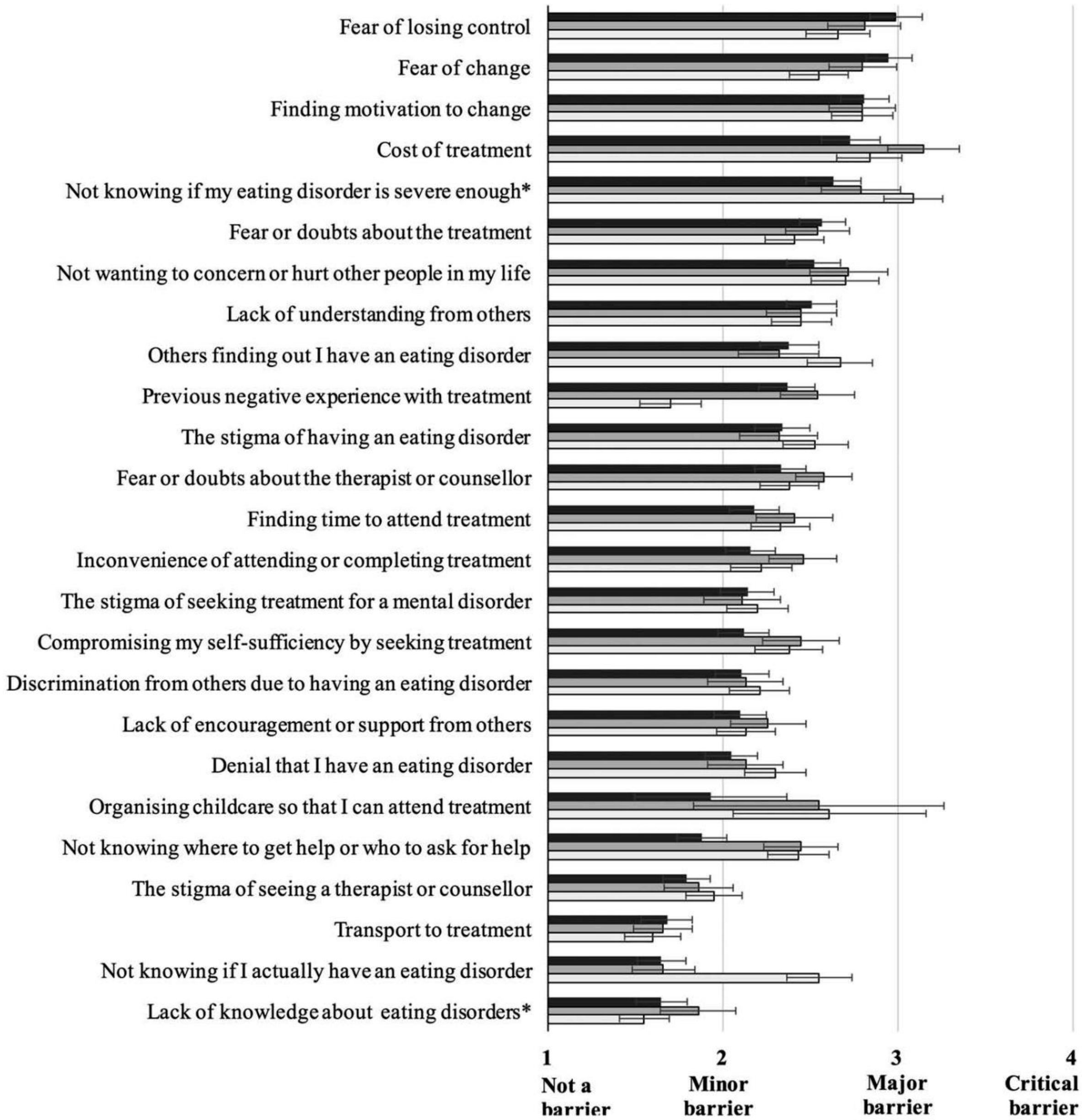

Figure 2Barriers to seeking to treatment for an eating disorder for participants who are currently diagnosed and in treatment (dark grey), currently diagnosed but not in treatment (middle grey), and undiagnosed and not in treatment (light grey).

One potential solution is to promote a broader understanding of the eating disorder spectrum, emphasising that these conditions can range from mild to severe. The oversaturation of information about the most extreme cases e.g. AN and BN, has led to a skewed perception of who can have an eating disorder. This has, in turn, caused many individuals with milder symptoms or those in the early stages of their disorder to dismiss their struggles as not serious enough to seek help.

Additionally, public awareness campaigns should aim to dismantle stereotypes and highlight the fact that anyone—regardless of gender, race, or body type—can develop an eating disorder. Campaigns that feature diverse representations of individuals with EDs can normalise the notion that eating disorders can affect any individual. Such campaigns could also provide educational resources for parents, caregivers, and general practitioners to increase awareness and challenge the misconception that eating disorders only appear in certain demographics.

Furthermore, increasing the availability of confidential online or telehealth-based treatment options for eating disorders could assist those who are hesitant to seek in-person help due to fear of judgment or shame. Digital platforms offer a discreet, private, and accessible alternative to traditional treatment, enabling people to receive care without the fear of being seen or judged by others.

Social Media: A Catalyst for Eating Disorders or a Platform for Recovery?

Social media has become an integral part of modern life, particularly for young people. Unfortunately, the constant exposure to curated images and unrealistic beauty standards on these platforms can have a significant impact on body image and self-esteem. According to a recent UK Government report, 95% of under-18s desire to change their appearance, and body image is a top three anxiety cause among Australian youths. (26, 27)

In 2020, social media use reached 49% of the global population, with 91% of UK and US adolescents using social media, and over 50% checking these at least once per hour. (28, 29) Although the minimum age requirement to create an account is set at 13 years old, most popular platforms lack robust age verification processes. As a result, up to 42% of children under the minimum age have social media profiles.(30) Consequently, there is a gap in media literacy and education around body image. This absence of early education leaves young users vulnerable to the harmful effects of social media trends, such as “fitspiration” and “thinspiration” content, which are commonly used as hashtags and captions on platforms like Instagram and TikTok.(31, 32, 33)

A concept referred to as the “Rodger’s framework self-perpetuating cycle of risk” can be used to further explain the relationship between social media use and eating disorders.(34) Appearance-focused platforms, the investment in photos, and the engagement with unhealthy trends contribute to body image concerns, disordered eating behaviours, and negative mental health outcomes. This relationship is mediated by factors such as internalising thin or fit ideals, engaging in appearance comparisons, and self-objectification. While research supports these findings, the direction of causality remains unclear: do social media platforms cause body dissatisfaction and disordered eating, or do individuals with pre-existing concerns gravitate toward such content, thus reinforcing harmful behaviours?

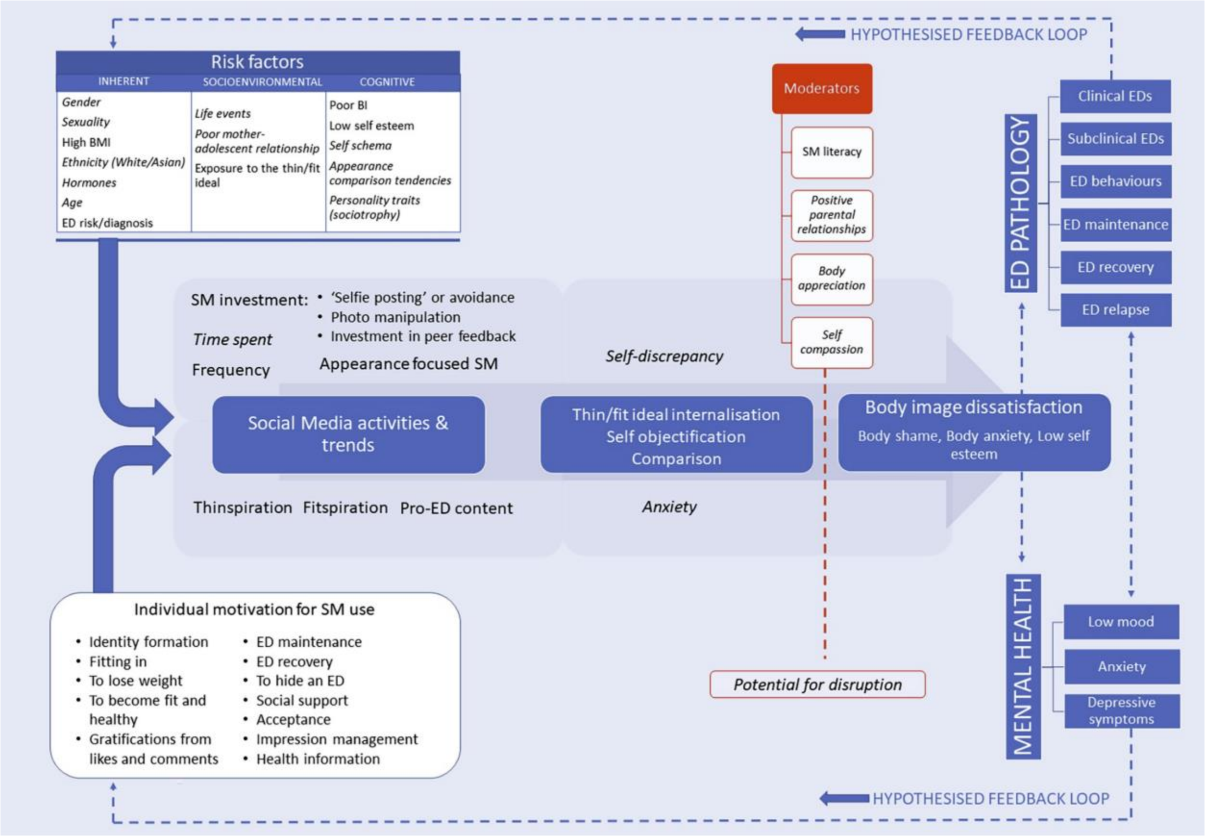

Figure 3: A self-perpetuating cycle of risk to show the relationship between social media usage, body image and eating disorder pathology.

In the UK, only 23% of young people report having received education on body image at school, even though 78% believe that such lessons would be beneficial.(35) This demonstrates a clear gap that needs to be filled. A well-structured programme would equip students with the skills to critically evaluate and question the unrealistic beauty standards perpetuated by social media. (36,37)

Furthermore, implementing a stricter age authentication processes, perhaps through requiring parental consent or identity verification, would be key in limiting access to children whose mental capacity has not yet developed to choose the correct content to interact with.(38) With this, it is important for the government to released campaigns to hold social media companies accountable for promoting harmful content like fitspiration and thinspiration, with clear guidelines on content moderation.

Expanding Access to Care with Task Shifting and EBPIs

Improving recovery outcomes for individuals with eating disorders requires a holistic approach that puts the use of evidence-based psychosocial interventions (EBPIs) at a priority, and addresses both the research-practice gap and the treatment gap.(39) EBPIs, such as Family-Based Treatment (FBT) and Cognitive Behavioural Therapy (CBT), have been thoroughly tested and proven to be effective in controlled trials, yet many patients do not end up receiving these treatments due to the lack of widespread dissemination in clinical settings. (40, 41, 42)

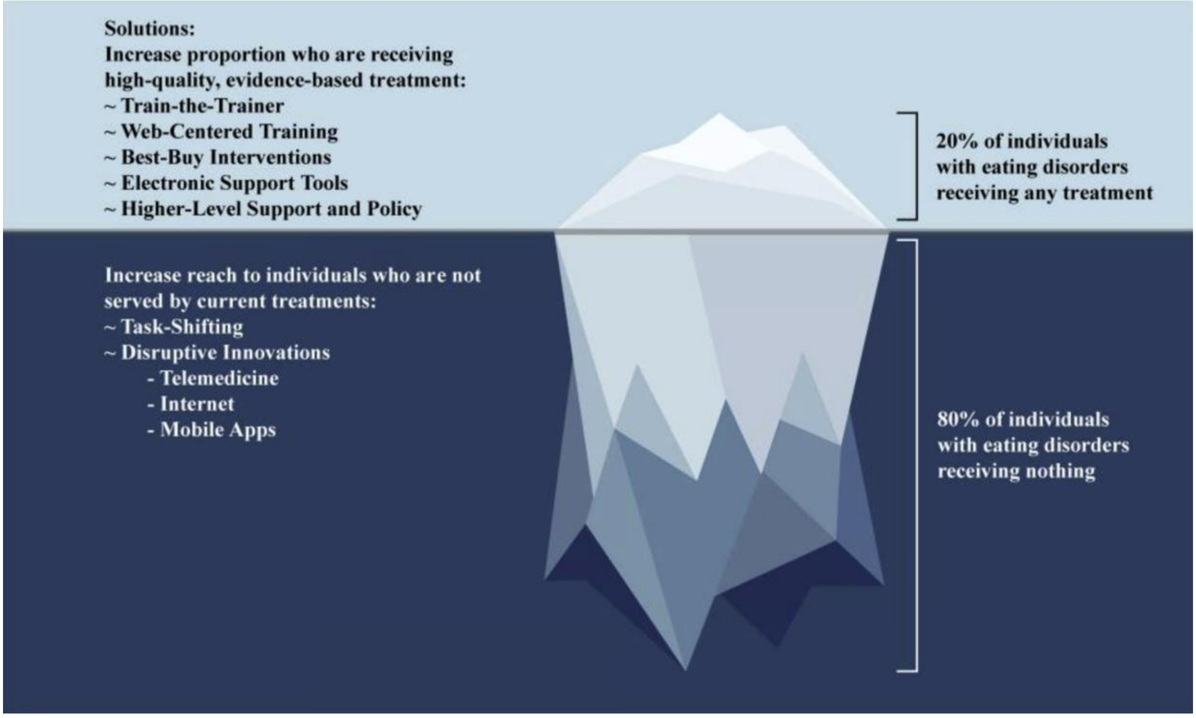

Figure 4 Depiction of the iceberg analogy: Ensuring that more people among the small minority who are receiving treatment obtain high-quality, evidence-based care and reaching the large number of individuals who are unserved by current treatments. https://doi.org/10.1002/eat.22670

The concept of Task Shifting has showed promising results in some areas in mental health, especially in regions with limited resources. It refers to a model that redistributes the responsibility of care from specialised clinicians to lay individuals and professionals with less concrete training. For example, a study in India used lay counsellors to administer psychoeducation and interpersonal therapy (IPT) for patients with anxiety and depression. The programme trained these counsellors, who had no prior health background, through a structured 2-month training course. The results were impressive: recovery rates at 6 and 12 months were significantly higher in the intervention group compared to the control group, which received care from a primary health worker.(43, 44)

This concept has also shown success in the field of eating disorders. For example, a study using cognitive-behavioural therapy guided self-help (CBTgsh) for binge eating demonstrated positive outcomes when graduate students with minimal experience administered the treatment under supervision.(45) Results from this study showed abstinence rates comparable to those achieved in more controlled, specialist-led interventions. Additionally, family-based treatment (FBT) for anorexia nervosa shifts the responsibility of re-feeding adolescents from inpatient hospital staff to parents, another form of task-shifting that has proven to be highly effective.(46,47)

Given the global shortage of specialists trained to treat eating disorders, adopting and expanding task-shifting strategies could significantly increase access to care, particularly for those who are positioned at the bottom of the iceberg. By leveraging trained lay counsellors or family members, this model addresses both the lack of specialised providers and the logistical barriers many patients face when seeking treatment.

Maintaining Momentum: Essential Steps for Ongoing Recovery

Around 60% of patients with ED's reach full recovery, which is thought to be a result of early intervention and timely access to a full course of evidence-based treatment such as Family-Based Treatment for Anorexia Nervosa (FT-AN), MANTRA or CBT-E.(48) Moreover, as part of a comprehensive treatment plan, relapse prevention strategies should be implemented in the final stages of care, which would involve educating patients, parents and caregivers, to recognise relapse indicators, enabling early detection should symptoms re-emerge.(49)

In cases where patients experience a relapse, it is crucial that they have swift access to specialist treatment through a well-funded system, which can prevent deterioration and reduce the overall duration of illness.(50)

Conclusion

In conclusion, closing the treatment gap for eating disorders requires a comprehensive approach, emphasising early intervention, relapse prevention, and expanded access to specialised care through task-shifting. Adequate funding and stronger collaborations between primary care and specialist services are essential for sustainable, long-term recovery and improving patient outcomes.

References

[1] https://www.nice.org.uk/guidance/ng69/evidence

[2] https://cks.nice.org.uk/topics/eating-disorders/background-information/prevalence/

[3] Zipfel S, Giel KE, Bulik CM, Hay P, Schmidt U (2015) Anorexia nervosa: aetiology, assessment, and treatment. Lancet Psychiatry 12, 1099-1111

[4] Keski-Rahkonen A, Mustelin L (2016) Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors. Curr Opin Psychiatry 29(6), 340-345.

[5] https://cks.nice.org.uk/topics/eating-disorders/background-information/prognosis/

[6] Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. *Current Opinion in Psychiatry*. 2006;19(4):389-394. doi:https://doi.org/10.1097/01.yco.0000228759.95237.78

[7] de la Rie SM, Noordenbos G, van Furth EF. Quality of life and eating disorders. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation*. 2005;14(6):1511-1522. doi:https://doi.org/10.1007/s11136-005-0585-0

[8] Klump KL, Bulik CM, Kaye WH, Treasure J, Tyson E. Academy for eating disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders*. 2009;42(2):97-103. doi:https://doi.org/10.1002/eat.20589

---

[9] Agras WS. THE CONSEQUENCES AND COSTS OF THE EATING DISORDERS. *Psychiatric Clinics of North America*. 2001;24(2):371-379. doi:https://doi.org/10.1016/s0193-953x(05)70232-x

[10] Kazdin et al. (2017) identified the development and dissemination of non-dominant (i.e., novel) treatment models as one strategy to help close the treatment gap in eating disorders. In the context of mental health care, dominant treatment models refer to the most frequent ways that psychological interventions are provided to treatment-seeking individuals (Cooper & Bailey-Straebler, 2015; Kazdin et al., 2017)

[11] Devoe, D., Han, A., Anderson, S., Katzman, D., Patten, S., Soumbasis, A., Flanagan, J., Paslakis, G., Vyver, E., Marcoux, G., & Dimitropoulos, G. (2022). The impact of the COVID-19 pandemic on eating disorders: A systematic review. *International Journal of Eating Disorders*, *56*(1), 5–25. https://doi.org/10.1002/eat.23704

[12] Feldman, M., King, C., Vitale, S., Denhardt, B., Stroup, S., Reese, J., & Stromberg, S. (2022). The impact of COVID-19 on adolescents with eating disorders: Increased need for medical stabilization and decreased access to care. *International Journal of Eating Disorders*, *56*(1),257–262. https://doi.org/10.1002/eat.23788

[13] Otto, A., Jary, J., Sturza, J., Miller, C. A., Prohaska, N., Bravender, T., & Van Huysse, J. (2021).Medical admissions among adolescents with eating disorders during the COVID-19 pandemic. *Pediatrics*, *148*(4), e2021052201. https://doi.org/10.1542/peds.2021-052201

[14] Cachelin, F. M., & Striegel-Moore, R. H. (2006). Help seeking and barriers to treatment in a community sample of Mexican American and European American women with eating dis- orders. International Journal of Eating Disorders, 39, 154–161. doi:10.1002/(ISSN)1098-108X

[15] Allen, K., & Dixon, M. (1994). Psychometric assessment of the Allen barriers to treatment instrument. Substance Use & Misuse, 29, 545–563.

[16] Stefl ME, Prosperi DC. Barriers to mental health service utilization. *Community Mental Health Journal*. 1985;21(3):167-178. doi:https://doi.org/10.1007/bf00754732

[17] Roehrig, J., & McLean, C. (2010). A comparison of stigma towards eating disorders versus depression. *International Journal of Eating Disorders*, *43*(9), 671–674. https://doi.org/10.1002/eat.20760

[18] Scott Griffiths, Susan L Rossell, Deborah Mitchison, Stuart B Murray & Jonathan M Mond (2018) Pathways into treatment for eating disorders: A quantitative examination of treatment barriers and treatment attitudes, Eating Disorders, 26:6, 556-574, DOI:10.1080/10640266.2018.1518086

[19] Bardone-Cone, A.M., Hunt, R.A. & Watson, H.J. An Overview of Conceptualizations of Eating Disorder Recovery, Recent Findings, and Future Directions. *Curr Psychiatry Rep* **20**, 79 (2018). https://doi.org/10.1007/s11920-018-0932-9

[20] Griffiths, S., Murray, S. B., & Touyz, S. (2015). Extending the masculinity hypothesis: An investigation of gender role conformity, body dissatisfaction, and disordered eating in young heterosexual men. *Psychology of Men & Masculinity*, *16*(1), 108–114. https://doi.org/10. 1037/a0035958

[21] Hamilton, A., Mitchison, D., & Touyz, S. (2021). Understanding treatment delay: Perceived barriers preventing treatment-seeking for eating disorders. *The Australian and New Zealand Journal of Psychiatry*, *56*(3), 248–259. https://doi.org/10.1177/00048674211020102

---

[22] Goldstein, M., Alinsky, R., & Medeiros, C. (2016). Males with restrictive eating disorders: Barriers to their care. *Journal of Adolescent Health*, *59*(4), 371–372. https://doi.org/10.1016/j.jadohealth.2016.07.022

[23] Lebow, J., Sim, L., & Kransdorf, L. (2015). Prevalence of a history of overweight and obesity in adolescents with restrictive eating disorders. *Journal of Adolescent Health*, *56*(1), 19–24. https://doi.org/10.1016/j.jadohealth.2014.06.005

[24] Rodgers, R., Berry, R., & Franko, D. (2018). Eating disorders in ethnic minorities: An update. *Current Psychiatric Reports*, *20*(90), 1–11. https://doi.org/10.1007/s11920-018-0938-3

[25] Sonneville, K., & Lipson, S. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders*, *51*(6), 518–526. https://doi.org/10.1002/eat.22846

[26] House of Commons. Changing the perfect picture: an inquiry into body image. London: UK Parliament; 2020 [cited 2021 1 June]. Available from: https://committees.parliament.uk/publications/5357/documents/53751/default/.

[27] Tiller E, Fildes J, Hall S, Hicking V, Greenland N, Liyanarachchi D, et al. Youth survey report 2020. Mission Australia. 2021.

[28] Tankovska H. Social Media 2021. Available from: https://www.statista.com/topics/1164/socialnetworks/.

[29] Common Sense Media. Social media, social life- teens reveal their experiences. 2018 [cited 2021 11 June]. Available from: https://www.commonsensemedia.org/sites/default/files/uploads/research/2018_cs_socialmediasociallife_fullreport-final-release_2_lowres.pdf.

[30] BBC News. Under-age social media use 'on the rise', says Ofcom. BBC [Internet]. 2017 [cited 2022 1 July]. Available from: https://www.bbc.co.uk/news/technology-42153694.

[31] Dignard NAL, Jarry JL. The "Little Red Riding Hood effect:" Fitspiration is just as bad as thinspiration for women's body satisfaction. Body Image. 2021; 36:201–13. https://doi.org/10.1016/j.bodyim.2020. 11.012 PMID: 33360477

[32] Prichard I, Kavanagh E, Mulgrew KE, Lim MSC, Tiggemann M. The effect of Instagram #fitspiration images on young women's mood, body image, and exercise behaviour. Body Image. 2020; 33:1–6. https://doi.org/10.1016/j.bodyim.2020.02.002 PMID: 32062021

[33] Tiggemann M, Anderberg I. Muscles and bare chests on Instagram: The effect of Influencers' fashion and fitspiration images on men's body image. Body Image. 2020; 35:237–44. https://doi.org/10.1016/j.bodyim.2020.10.001 PMID: 33157398

[34] Rodgers RF. The Relationship Between Body Image Concerns, Eating Disorders and Internet Use, Part II: An Integrated Theoretical Model. Adolescent Res Rev. 2016; 1(2):121–37. https://doi.org/10.1007/s40894-015-0017-5

[35] House of Commons. Changing the perfect picture: an inquiry into body image. London: UK Parliament; 2020 [cited 2021 1 June]. Available from: https://committees.parliament.uk/publications/5357/documents/53751/default/.

[36] Burnette CB, Kwitowski MA, Mazzeo SE. "I don't need people to tell me I'm pretty on social media:" A qualitative study of social media and body image in early adolescent girls. Body Image. 2017; 23:114– 25. https://doi.org/10.1016/j.bodyim.2017.09.001 PMID: 28965052

---

[37] McLean SA, Wertheim EH, Masters J, Paxton SJ. A pilot evaluation of a social media literacy intervention to reduce risk factors for eating disorders. Int J Eat Disord. 2017; 50(7):847–51. https://doi.org/10.1002/eat.22708 PMID: 28370321

[38] Lenza C. Eating Disorders in ‘Millennials’: Risk Factors and Treatment Strategies in the Digital Age. Clinical Social Work Journal. 2020; 48(1):46–53. https://doi.org/10.1007/s10615-019-00733-z

[39] Kazdin AE, Fitzsimmons-Craft EE, Wilfley DE. Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders*. 2017;50(3):170-189. doi:https://doi.org/10.1002/eat.22670

[40] Cooper Z, Bailey-Straebler S. Disseminating Evidence-Based Psychological Treatments for Eating Disorders. *Current Psychiatry Reports*. 2015;17(3). doi:https://doi.org/10.1007/s11920-015-0551-7

[41] Fairburn CG, Wilson GT. The dissemination and implementation of psychological treatments: Problems and solutions. *International Journal of Eating Disorders*. 2013;46(5):516-521. doi:https://doi.org/10.1002/eat.22110

[42] Lilienfeld SO, Ritschel LA, Lynn SJ, Brown AP, Cautin RL, Latzman RD. The research-practice Gap: Bridging the schism between eating disorder researchers and practitioners. *International Journal of Eating Disorders*. 2013;46(5):386-394. doi:https://doi.org/10.1002/eat.22090

[43] Patel V, Weiss HA, Chowdhary N, et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *The Lancet*. 2010;376(9758):2086-2095. doi:https://doi.org/10.1016/s0140-6736(10)61508-5

[44] Patel V, Weiss HA, Chowdhary N, et al. Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months. *British Journal of Psychiatry*. 2011;199(6):459-466. doi:https://doi.org/10.1192/bjp.bp.111.092155

[45] Striegel-Moore RH, Wilson GT, DeBar L, et al. Cognitive behavioral guided self-help for the treatment of recurrent binge eating. *Journal of Consulting and Clinical Psychology*. 2010;78(3):312-321. doi:https://doi.org/10.1037/a0018915

[46] Grilo CM, Masheb RM. A randomized controlled comparison of guided self-help cognitive behavioral therapy and behavioral weight loss for binge eating disorder. *Behaviour Research and Therapy*. 2005;43(11):1509-1525. doi:https://doi.org/10.1016/j.brat.2004.11.010

[47] Mitchell JE, Agras S, Crow S, et al. Stepped care and cognitive–behavioural therapy for bulimia nervosa: randomised trial. *British Journal of Psychiatry*. 2011;198(5):391-397. doi:https://doi.org/10.1192/bjp.bp.110.082172

[48] Dane A, Bhatia K (2023) The social media diet: A scoping review to investigate the association between social media, body image and eating disorders amongst young people. PLOS Glob Public Health 3(3): e0001091. https://doi.org/ 10.1371/journal.pgph.0001091

[49] Vanderlinden J, Buis H, Pieters G, Probst M. Which elements in the treatment of eating disorders are necessary “ingredients” in the recovery process?—A comparison between the patient’s and therapist’s view. *European Eating Disorders Review*. 2007;15(5):357-365. doi:https://doi.org/10.1002/erv.768

[50] Bardone-Cone, A.M., Hunt, R.A. & Watson, H.J. An Overview of Conceptualizations of Eating Disorder Recovery, Recent Findings, and Future Directions. *Curr Psychiatry Rep* **20**, 79 (2018). https://doi.org/10.1007/s11920-018-0932-9