

## INTRODUCTION

Binge Eating Disorder (BED) was introduced as a separate eating disorder (ED) in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013). It is widely recognised that a low proportion of individuals with ED receive treatment and that there is a large unmet need within the community (Hart, Granillo, Jorm & Paxton, 2013), this delay in receiving ED treatment has been reported to be approximately five years (Rosenvinge & Klusmeier, 2000). Whilst BED has been estimated to be the most prevalent of the ED, it is not as widely recognised (Turner, 2013).

Barriers to treatment seeking for ED include; shame and denial of illness; concerns about negative judgements from others; poor symptom knowledge; fear of stigma (Hepworth & Paxton, 2007; Goodwin & Fitzgibbon, 2000).

Facilitating factors have included; increased psychological distress; increased perceived symptom severity; increased awareness; others initiating the process; interference with everyday activities and when self management is no longer effective (Gilbert et al. 2012; Schoen et al. 2012; Hepworth & Paxton, 2007).

Qualitative studies have explored the process of accessing treatment for individuals with anorexia nervosa (AN) and ED (Gulliksen et al. 2015; Schoen et al. 2012) however there is a paucity in the literature pertaining specifically to BED and to date, no studies have considered the treatment seeking experience for BED specifically.

**Research aim:** to explore individuals' lived experiences of seeking treatment for BED.

## METHODOLOGY AND RESULTS

Table 1: Demographic Information

Gender	Female	8
	Male	0
Body Mass Index (BMI)	Mean	36.9
	Range	26 – 48.4
Time since diagnosis	Mean	2 years
	Range	7 days – 10 years
Ethnicity	White British	8
Marital status	Married	3
	Single	4
	Separated	1
Occupation	Full time	4
	Part time	2
	Unemployed	1
	Student	1

Eight participants were recruited from a specialist NHS outpatient ED Service. Participants were interviewed using a semi-structured interview, which was developed using service-user consultation. Interviews ranged between 32 – 68 minutes in duration. The data was analysed using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). This led to the development of four super-ordinate themes and 11 sub-ordinate themes (Figure 1).

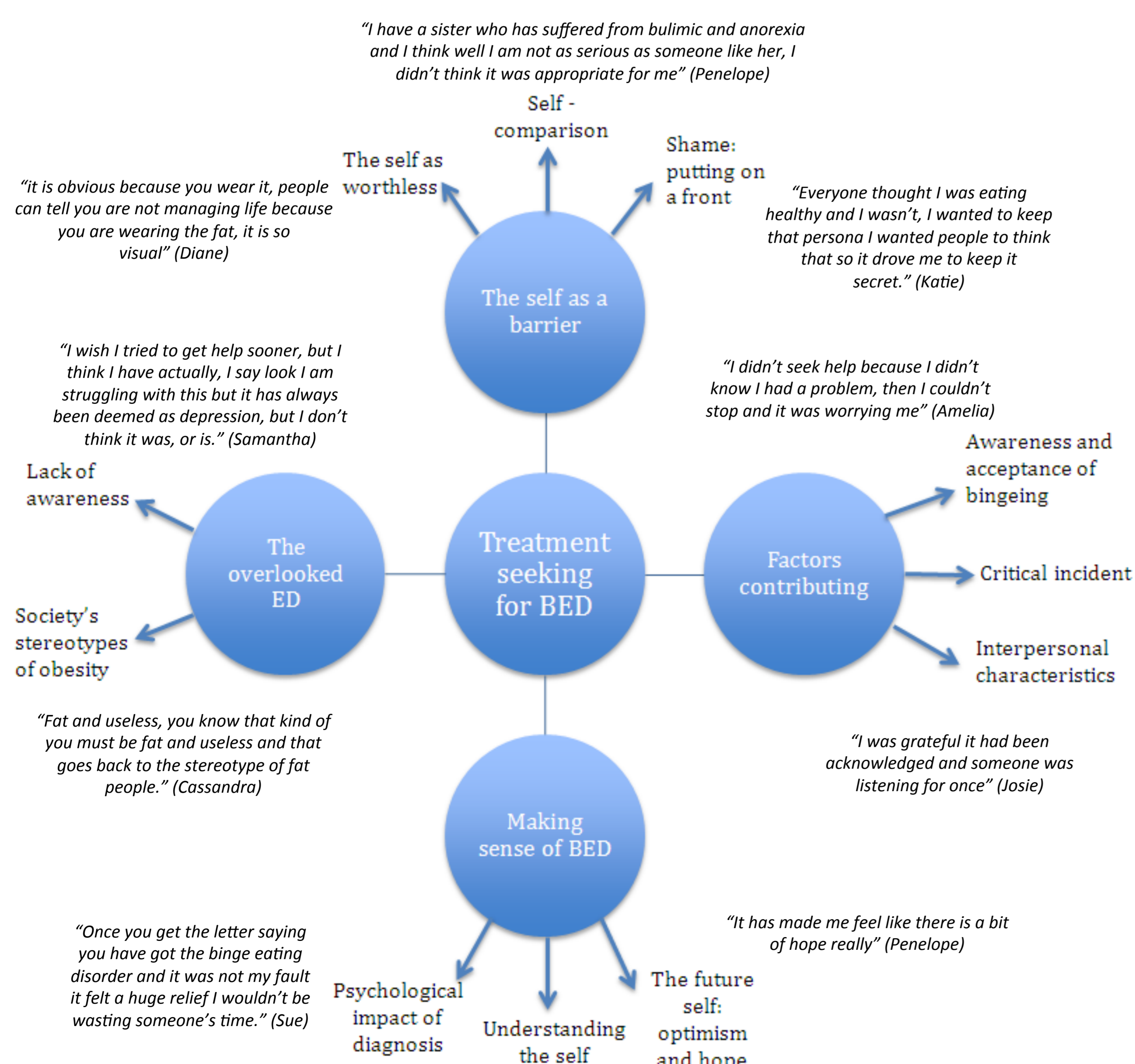


Figure 1: Super-ordinate and sub-ordinate themes

## RESULTS AND DISCUSSION

All participants experienced difficulties in their journeys to access specialist treatment. They had all attempted several times without success before receiving specialist help for their eating difficulties.

Specific difficulties in accessing treatment included identification of the self as not worthy of treatment, social comparison and shame attached to eating difficulties (*'the self as a barrier'*). Participants experienced incongruence between their internal and external world and shame related to bingeing. Shame has been accepted as a central phenomenon in ED, shame has been found in to be related to bingeing and purging behaviour in bulimia nervosa (BN).

This was reinforced by contextual factors, which appeared to further impede access to treatment, described in the *'overlooked eating disorder'* theme. Emotional overeating and over eating are different to BED and this is not widely recognised and indeed was experienced by participants. Information relating to binge eating disseminated in the public domain is frequently discussed in the context of obesity (Turner, 2013).

Facilitating factors, included interpersonal factors, which contributed to feeling understood, the process of awareness and critical incidents (*factors contributing to accessing treatment*), this led participants to feel able to initiate the treatment seeking process and to disclose their difficulties.

Finally, *'making sense of BED'* as a consequence of accessing treatment was considered; this was encompassed within the themes of the psychological impact of receiving diagnosis, understanding the self, and the future self.

## CLINICAL IMPLICATIONS

- This is the first study to have used qualitative methods to explore the experience of seeking treatment and to have identified shame as a barrier to accessing treatment for BED and indeed for sharing difficulties with professionals. This is important for clinicians in both primary and secondary care services to be aware of when individuals present in their clinics.
- Participants described initially seeking treatment for physical and/or psychological difficulties other than their eating concerns. In addition to interpersonal characteristics in professionals participants valued being asked direct questions about their eating patterns. This is an important opportunity for clinicians to ask questions about eating and to assess for BED given that individuals may not initiate dialogue regarding eating patterns.
- Insight into the treatment seeking experience from participants who have successfully accessed treatment allows information regarding the facilitating factors in addition to barriers to be explored, and to consider how these can be applied within primary care and community settings.
- The experiences of shame and self criticism described in this study suggest that compassion focused therapy (CFT) (Gilbert, 2010) might be of clinical benefit for this client group, as this particular therapy aims to evoke self compassion in individuals.
- The lack of awareness from both professionals and individuals about BED symptoms suggests that there is a need for educating both individuals and professionals about the criteria and characteristics of BED.

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### Key references:

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