

Eating disorders can be difficult to treat but can be treated: what does the evidence tell us about what is effective in treating eating disorders, and how can we shape conversations with people living with eating disorders to reduce stigma?

Introduction:

Eating disorders occupy an unusual position in psychiatry. Few conditions attract such certainty about their nature and prognosis, yet are so poorly served by it. They are commonly imagined as a single illness, affecting young, thin, white, affluent women, driven by vanity, and either quickly cured or untreatable. Each element is at best partial and at worst harmful. NICE, the National Institute for Health and Care Excellence, defines eating disorders as conditions involving a persistent disturbance of eating that impairs health and psychosocial functioning.¹ Within that definition sit anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant/restrictive food intake disorder (ARFID), and a residual category of other feeding or eating disorders. Anorexia nervosa alone carries one of the highest mortality rates of any psychiatric disorder,² and Beat, the UK's eating disorder charity, estimates at least 1.25 million people in the UK are affected, around a quarter of them male.³

This essay will consider two themes: 1) Eating disorders are difficult to treat, and 2) they can be treated. As this essay will explain, the two roots are not independent. It will consider why "difficult to treat" remains accurate regardless, and closes with how conversation itself can be reshaped to help treatment reach those who need it.

Effective Treatment:

Anorexia nervosa

Anorexia nervosa has attracted more treatment research relative to its prevalence than any other eating disorder, yet remains notoriously difficult to study, partly because the illness is often ego-syntonic, meaning patients rarely experience symptoms as unwanted, which suppresses

¹National Institute for Health and Care Excellence. *Eating disorders: recognition and treatment*. NICE guideline NG69. 2017, updated 16 December 2020.

²Arcelus J, Mitchell AJ, Wales J, Nielsen S. Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of General Psychiatry*. 2011, 68(7), 724-731.

³Beat. How many people have an eating disorder in the UK? Beat Eating Disorders. Accessed 2026.

trial recruitment and inflates dropout. For adolescents, the strongest evidence favours family-based treatment (FBT), still known as the Maudsley approach. The original evaluation found family therapy outperformed individual therapy in adolescent-onset illness,⁴ a benefit a five-year follow-up found was sustained.⁵ A later trial found substantially higher remission with FBT than individual therapy,⁶ and a UK trial found multifamily therapy produced outcomes at least as good as single-family therapy.⁷ NICE recommends family therapy as first-line treatment for children and young people.⁸

For adults, no single therapy dominates as clearly, itself an important finding rather than an absence of evidence. NICE recommends a choice of broadly comparable approaches, including eating-disorder-focused cognitive behavioural therapy (CBT-E), the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), and Specialist Supportive Clinical Management (SSCM).⁹ The MOSAIC trial, comparing MANTRA and SSCM, found both produced meaningful improvement in body mass index and psychopathology at two years.^{10,11} The ANTOP trial similarly found psychodynamic therapy, CBT-E and treatment as usual all produced improvement, with only modest differences between them.¹² A 2021 network meta-analysis found structured therapies more acceptable to patients, shown by lower dropout, though none proved reliably superior on outcomes.¹³ Medication has not shown reliable benefit

⁴Russell GFM, Szmulker GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*. 1987, 44(12), 1047-1056.

⁵Eisler I, Simic M, Russell GFM, Dare C. A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: a five-year follow-up. *Journal of Child Psychology and Psychiatry*. 2007, 48(6), 552-560.

⁶Lock J, Le Grange D, Agras WS, Moye A, Bryson SW, Jo B. Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*. 2010, 67(10), 1025-1032.

⁷Eisler I, Simic M, Hodsoll J, et al. A pragmatic randomised multi-centre trial of multifamily and single family therapy for adolescent anorexia nervosa. *BMC Psychiatry*. 2016, 16, 422.

⁸NICE, NG69.

⁹NICE, NG69.

¹⁰Schmidt U, Magill N, Renwick B, et al. The Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC): comparison of the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) with Specialist Supportive Clinical Management (SSCM) in outpatients with broadly defined anorexia nervosa, a randomized controlled trial. *Journal of Consulting and Clinical Psychology*. 2015, 83(4), 796-807.

¹¹Schmidt U, Ryan EG, Bartholdy S, et al. Two-year follow-up of the MOSAIC trial: a multicenter randomized controlled trial comparing two psychological treatments in adult outpatients with broadly defined anorexia nervosa. *International Journal of Eating Disorders*. 2016, 49(8), 793-800.

¹²Zipfel S, Wild B, Groß G, et al. Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial. *The Lancet*. 2014, 383(9912), 127-137.

¹³Solmi M, Wade TD, Byrne S, et al. Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: a systematic review and network meta-analysis. *The Lancet Psychiatry*. 2021, 8(3), 215-224.

for AN and should not be a sole treatment.¹⁴ Ultimately, it is clear that engagement matters just as much as the method of therapy used to manage the condition.

Even so, adult AN remains the diagnosis for which "difficult" is most literally true. A Cochrane review of "severe and enduring" anorexia nervosa, illness persisting for years despite treatment, found the evidence too limited to recommend one therapy over another,¹⁵ reflecting a smaller evidence base and a poor fit with any single cure-oriented model. There is more encouraging evidence that structured therapy can be integrated even into inpatient care, with one CBT-E model reporting shorter admissions and better outcomes at discharge.¹⁶

Bulimia nervosa & binge eating disorder

In contrast with AN, CBT for BN is thoroughly evaluated, and its transdiagnostic "enhanced" form, CBT-E, developed by Christopher Fairburn, is recommended by NICE as first-line treatment.^{17,18} In the pivotal trial testing CBT-E, 56% of patients who completed treatment achieved full remission from binge eating and compensatory behaviours, sustained over sixty weeks.¹⁹ A trial comparing CBT-E with psychoanalytic psychotherapy found CBT-E produced faster, greater symptom reduction.²⁰ NICE recommends guided self-help first, with individual CBT-E if this proves insufficient, and fluoxetine as an adjunct.²¹

Binge eating disorder, the most prevalent eating disorder in adulthood, has a comparably encouraging evidence base. A systematic review of 81 randomised trials found moderate to strong evidence for CBT and CBT-based guided self-help in achieving abstinence from binge eating,²² a finding echoed by a further meta-analysis with modest support for interpersonal

¹⁴NICE, NG69.

¹⁵Zhu J, Hay PJ, Yang Y, Le Grange D, Lacey JH, Lujic S, Smith C, Touyz S. Specific psychological therapies versus other therapies or no treatment for severe and enduring anorexia nervosa. *Cochrane Database of Systematic Reviews*. 2023, 8(8), CD011570.

¹⁶National Institute for Health and Care Excellence. *2024 exceptional surveillance of eating disorders: recognition and treatment* (NICE guideline NG69).

¹⁷NICE, NG69.

¹⁸Fairburn CG. *Cognitive Behavior Therapy and Eating Disorders*. New York, Guilford Press, 2008.

¹⁹Fairburn CG, Cooper Z, Doll HA, O'Connor ME, Bohn K, Hawker DM, Wales JA, Palmer RL. Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *American Journal of Psychiatry*. 2009, 166(3), 311-319.

²⁰Poulsen S, Lunn S, Daniel SI, et al. A randomized controlled trial of psychoanalytic psychotherapy or cognitive-behavioral therapy for bulimia nervosa. *American Journal of Psychiatry*. 2014, 171(1), 109-116.

²¹NICE, NG69.

²²Hilbert A, Petroff D, Herpertz S, et al. Meta-analysis of the efficacy of psychological and medical treatments for binge-eating disorder. *Journal of Consulting and Clinical Psychology*. 2019, 87(1), 91-105.

psychotherapy and medication.²³ Both reviews noted treatments are far more effective at reducing binge frequency and distress than at producing weight loss.²⁴²⁵²⁶ Lisdexamfetamine, a stimulant licensed specifically for moderate to severe BED, reduces binge frequency, though again should not be used alone.²⁷²⁸

ARFID

ARFID describes a heterogeneous group of presentations, including sensory sensitivity, low interest in food, and fear of choking, without the weight or shape concerns central to AN or BN.²⁹ Because the diagnosis is recent, its evidence lags behind the other disorders, and NICE's 2017 guideline does not cover it. The most developed intervention, CBT for ARFID, is a modular treatment matched to each presentation.³⁰ A 2024 scoping review found a growing but still largely uncontrolled evidence base, with a clear need for randomised trials.³¹ ARFID also involves no drive for thinness, so it sits furthest from the public stereotype of an eating disorder, and is often dismissed as fussy eating rather than referred for assessment, an evidence gap and a stigma gap from the same narrow picture.

Why are Eating Disorders ‘Difficult to Treat?’

A key finding is that earlier treatment predicts better outcomes. A review of the "duration of untreated eating disorder" found longer intervals between onset and treatment linked to poorer prognosis,³² the rationale behind early-intervention services such as FREED, which targets young people early in illness and has shown reduced waiting times and better recovery in its

²³Ghaderi A, Odeberg J, Gustafsson S, Råstam M, Brolund A, Pettersson A, Parling T. Psychological, pharmacological, and combined treatments for binge eating disorder: a systematic review and meta-analysis. *PeerJ*. 2018, 6, e51113.

²⁴Hilbert et al., 2019.

²⁵Ghaderi et al., 2018.

²⁶Brownley KA, Berkman ND, Peat CM, et al. Binge-eating disorder in adults: a systematic review and meta-analysis. *Annals of Internal Medicine*. 2016, 165(6), 409-420.

²⁷NICE, NG69.

²⁸Brownley et al., 2016.

²⁹Thomas JJ, Eddy KT. *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, and Adults*. Cambridge, Cambridge University Press, 2019.

³⁰Thomas and Eddy, 2019.

³¹Willmott E, Dickinson R, Hall C, et al. A scoping review of psychological interventions and outcomes for avoidant and restrictive food intake disorder (ARFID). *International Journal of Eating Disorders*. 2024, 57(1), 27-61.

³²Austin A, Flynn M, Richards K, et al. Duration of untreated eating disorder and relationship to outcomes: a systematic review of the literature. *European Eating Disorders Review*. 2020.

pilot evaluation.³³ Disorder-focused structured therapies also outperform generic treatment as usual, suggesting competent delivery matters as much as the therapy chosen.^{34,35} NHS England requires 95% of children and young people to start treatment within one to four weeks depending on urgency,³⁶ yet rising demand has strained that standard, while emergency department attendance for eating disorders has roughly tripled among under-nineteens.³⁷ This posits a crucial question - why are these conditions “difficult to treat”, even if there is a clear treatment?

One explanation is the ego-syntonic quality of restrictive eating disorders. Anorexia nervosa often recruits a person's own values, control, achievement, and discipline into the illness, so treatment can feel like an attack on identity rather than relief from suffering. This does not make recovery impossible, but it does make engagement itself a clinical task, part of why MANTRA builds motivational work into the treatment model rather than assuming motivation as a starting point.³⁸

Another reason is that time spent waiting is not a neutral delay but an active predictor of worse outcomes,³⁹ which makes strained NHS waiting times a clinical issue. A further barrier is diagnostic gatekeeping through body mass index, since many services have used BMI thresholds to decide eligibility despite NICE stating no single measure should determine access alone.⁴⁰ Many people with severe restrictive eating disorders are not underweight, so-called atypical anorexia nervosa, and a systematic review found this group experiences comparable severity and hospital admission rates to underweight patients while being far more likely to be judged "not sick enough" for referral.⁴¹

³³McClelland J, Hodsoll J, Brown A, et al. A pilot evaluation of a novel First Episode and Rapid Early Intervention service for Eating Disorders (FREED). *European Eating Disorders Review*. 2018, 26(2), 129-140.

³⁴Schmidt et al. (MOSAIC two-year follow-up), 2016.

³⁵Solmi et al., 2021.

³⁶NHS England. *Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide*. 2015.

³⁷House of Commons Library. *Eating disorders*. Research briefing CBP-10497. 2026.

³⁸Schmidt U, Treasure J. Anorexia nervosa: valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology*. 2006, 45(3), 343-366.

³⁹Austin et al., 2020.

⁴⁰NICE, NG69.

⁴¹Harrop EN, Mensinger JL, Moore M, Lindhorst T. Restrictive eating disorders in higher weight persons: a systematic review of atypical anorexia nervosa prevalence and consecutive admission literature. *International Journal of Eating Disorders*. 2021, 54(8), 1328-1357.

Finally, recovery is rarely a single event. A meaningful minority of patients develop what has been termed a severe and enduring course, for which the evidence base remains thin and a purely cure-oriented model may not be the right target.⁴² Specialist clinicians also remain in short supply relative to demand across the UK, so even a well-designed pathway can be difficult to deliver at the speed evidence suggests matters most.

Social Stigma:

Public stigma around eating disorders has a distinctive content. A scoping review of 46 studies found people with eating disorders were consistently perceived as personally responsible for their condition, but the specific content differed by diagnosis. Anorexia nervosa attracted perceptions of vanity, bulimia nervosa attracted disgust, and binge eating disorder was frequently conflated with simple overeating, with weight itself treated as evidence of moral failing rather than a symptom.⁴³

Self-stigma follows a broadly established sequence, from awareness of negative public attitudes to application of the stereotype to oneself and harm to help-seeking.⁴⁴ Someone who has internalised the idea that restriction reflects admirable discipline, and who also fears being seen as attention-seeking if they ask for help, has two independent reasons to delay seeking help. Research synthesising lived-experience accounts of clinician stigma, meaning dismissive or weight-focused responses from healthcare professionals, found this contributed directly to treatment disengagement and, in some accounts, to worsening of eating-disorder behaviours as a means of being taken seriously.⁴⁵

There is also stigma within the medical profession. Interviews with adults with AN found weight stigma in medical settings, including clinicians praising weight loss and disbelieving restriction because a patient's weight was "normal," was present across the whole illness trajectory and directly contributed to healthcare avoidance.⁴⁶ A similar dynamic disadvantages other groups who depart from the stereotype of a young, thin, affluent woman. A major review

⁴²Zhu et al., 2023.

⁴³Brelet L, Flaudias V, Désert M, Guillaume S, Llorca P-M, Boirie Y. Stigmatization toward people with anorexia nervosa, bulimia nervosa, and binge eating disorder: a scoping review. *Nutrients*. 2021, 13(8), 2834.

⁴⁴Corrigan, Druss and Perlick, 2014.

⁴⁵Lubieniecki G, Fernando AN, Randhawa A, Cowlishaw S, Sharp G. Perceived clinician stigma and its impact on eating disorder treatment experiences: a systematic review of the lived experience literature. *Journal of Eating Disorders*. 2024, 12, 161.

⁴⁶Harrop EN, Hutcheson R, Harner V, Mensinger JL, Lindhorst T. "You don't look anorexic": atypical anorexia patient experiences of weight stigma in medical care. *Body Image*. 2023, 46, 48-61.

of eating disorders in boys and men found under-recognition by clinicians and by the men themselves, who often did not identify their own symptoms because the concept was so strongly gendered.⁴⁷ Beat estimates around a quarter of people with eating disorders in the UK are male,⁴⁸ a proportion public perception still underestimates. Stigma delays diagnosis and can undermine the therapeutic relationships every treatment depends on.

Changing The Conversation:

Because eating disorders present so variably, assuming what someone's experience must be, based on their appearance, is precisely how atypical presentations go unrecognised.⁴⁹⁵⁰ Education that combats weight-based assumptions, alongside screening that does not rely on visible thinness as the trigger for concern, is a direct response to the clinician-stigma findings above.⁵¹⁵²

Another principle is to keep everyday conversation away from weight, food and appearance, including well-intentioned compliments. Remarks such as "you look so well" can function as reinforcement regardless of intent, since eating disorders often recruit external validation into their own maintenance. This is central to the "New Maudsley" model of carer support, which reframes the carer's role toward calm, curious, non-judgemental communication, stepping back from patterns the model terms "accommodating" and "enabling."⁵³ NICE places the same emphasis on family members as active participants in treatment.⁵⁴

Conversation beyond the individual matters too. Lauren Greenfield's 2006 documentary *Thin* depicted the tedium and relapse of treatment rather than a redemptive arc. However, its cast, too, was largely young, female and underweight. This is an example of the difficulty for even sympathetic representation to escape the stereotype it complicates.⁵⁵ A useful counterpoint is

⁴⁷Brown TA, Keel PK. Eating disorders in boys and men. *Annual Review of Clinical Psychology*. 2023, 19(1), 177-205.

⁴⁸Beat, 'How Many People Have an Eating Disorder in the UK?'

⁴⁹Harrop et al., 'You Don't Look Anorexic', 2023.

⁵⁰Brown and Keel, 2023.

⁵¹Lubieniecki et al., 2024.

⁵²McEntee ML, Philip SR, Phelan SM. Dismantling weight stigma in eating disorder treatment: next steps for the field. *Frontiers in Psychiatry*. 2023, 14, 1157594.

⁵³Treasure J, Smith G, Crane A. *Skills-based Caring for a Loved One with an Eating Disorder: The New Maudsley Method*. 2nd ed. Abingdon, Routledge, 2016.

⁵⁴NICE, NG69.

⁵⁵Greenfield L (director). *Thin*. HBO documentary film, 2006.

the BBC documentary *Freddie Flintoff, Living with Bulimia*, in which the cricketer disclosed a twenty-year history of bulimia concealed throughout a hyper-masculine sporting career.⁵⁶ Disclosure by figures furthest from the stereotype is precisely the mechanism contact-based stigma-reduction predicts should work best, since it contradicts the stereotype rather than simply asserting its falsity.⁵⁷⁵⁸

NICE's guidance against using BMI alone to gate access to treatment is itself institutional conversation-shaping, still unevenly implemented.⁵⁹⁶⁰ A primary-care culture that asks only about weight loss will, by design, keep missing binge eating disorder, ARFID and atypical presentations, however sensitively any clinician communicates.⁶¹⁶² Beat's public messaging that eating disorders can affect anyone, regardless of age, gender, weight or background, targets this public stigma directly, and current NHS efforts to train teachers, school nurses and GPs to spot a wider range of presentations show that message reaching institutional practice.⁶³⁶⁴

Conclusion:

Taken together, the evidence above and the conversational shifts described point towards the conclusion that eating disorders can be treated. The evidence for structured, disorder-focused therapies, family-based treatment for adolescent AN, a plurality of options for adult AN, CBT-E for bulimia nervosa and binge eating disorder, and an emerging base for ARFID, is reasonably substantial. Eating disorders are also difficult to treat, not because the treatments fail, but because the illnesses are often ego-syntonic, because services stay organised around a narrow, stigma-inflected picture of who becomes unwell, and because a meaningful minority develop illness the evidence base cannot yet adequately answer.

⁵⁶*Freddie Flintoff: Living with Bulimia*. BBC One/BBC Four documentary, first broadcast 28 September 2020.

⁵⁷Corrigan, Druss and Perlick, 2014.

⁵⁸Brown and Keel, 2023.

⁵⁹NICE, NG69.

⁶⁰Harrop et al., 2021.

⁶¹Pearl et al., 2023.

⁶²McEntee, Philip and Phelan, 2023.

⁶³Beat, 'How Many People Have an Eating Disorder in the UK?'

⁶⁴NHS England. *NHS staff to train teachers, school nurses, and GPs to spot eating disorders*. Press release, January 2026.

Ultimately, a diagnostic and service system built, often unconsciously, around one stereotyped presentation will systematically under-recognise everyone who does not fit it. Reshaping conversation is not separate from evidence-based treatment, but is a condition of its success.

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