

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?

By Dr Mamoor Waheed

The weight chart on the screen had barely moved in eight weeks. I remember scrolling back, hoping I'd misread the trend, and feeling something tighten in my chest I didn't yet have a name for. My patient noticed first. "I'm getting nowhere" she said, flatly. I would have liked to say something similar myself.

It took supervision, weeks later, for me to recognise what had happened. My frustration was not simply a reaction to slow progress; it was, in miniature, an echo of hers. She had lived inside that stalled trajectory for months. I had felt it for eight weeks and already wanted out of the feeling. This is not something unique: clinicians treating eating disorders report frustration, hopelessness, and a sense of incompetence, reactions that are more pronounced in less experienced staff and correlate with perceived lack of patient improvement.^{1,2} What struck me was how easily that frustration, unexamined, could have curdled into something else: the quiet reclassification of my patient from 'unwell' to 'difficult'. This essay argues that examining that frustration rather than acting it out is not a separate skill from evidence-based care. Rather, it is part of evidence-based care, because the evidence for what works in eating disorders and the evidence for what reduces stigma both run through it.

Difficult to treat is not untreatable

There were two clocks running in that consultation, and I was only reading one of them: mine - the service measured in sessions and rotation months. The illness keeps a different clock, and the outcome literature is unambiguous about how slowly it turns. At nine-year follow-up, fewer than a third of people with anorexia nervosa were recovered. At twenty-two years, nearly two-thirds were.³ Bulimia nervosa recovers faster still, with roughly two-thirds recovered by the same mark.³ Anorexia nervosa is chronic on the timescale of a training rotation. It is treatable on the timescale of a life. Much of what we call "difficult to treat" lives in the gap between those two clocks and so does, I will argue, much of our stigma.

Around a fifth of patients do go on to a severe and enduring course, and NICE currently offers no specific recommendations for this group; an honest gap, not a footnote to bury.⁴ Holding both truths together is, I believe, the right clinical posture: recovery is the modal outcome over a long enough horizon, and a meaningful minority will not follow that curve on any timescale we can promise. That uncertainty should make us more careful, not more fatalistic: it argues for persistence, review, and adaptation, rather than prematurely translating chronicity into hopelessness.

What the evidence says works

NICE guideline NG69 remains the organising framework, and I won't rehearse it exhaustively.⁵ Two features matter more than the algorithm itself. First, for adolescents with anorexia nervosa, family therapy is first-line, and in the Lock and Le Grange trial tradition it roughly doubled remission compared

with individual therapy - around fifty per cent versus twenty-five per cent.⁶ Its core stance, externalising the illness from the young person rather than locating pathology within the family, is itself an anti-stigma intervention embedded inside a treatment protocol, not an add-on.⁷

Second, for adults with anorexia nervosa, CBT-ED, MANTRA, and specialist supportive clinical management are all first-line, and none has demonstrated clear superiority.⁴ The honest reading is not that we lack good therapies; it's that engagement and alliance are doing much of the work regardless of the manual. NICE's own emphasis on shared decision-making and tailoring information to the person's needs supports that reading: treatment is not simply delivered to a passive patient but negotiated with someone whose fear and ambivalence are part of the disorder being treated. That null result underwrites this essay's thesis: if alliance is one active ingredient, how a clinician holds the relationship matters as much as whichever treatment they ultimately deliver.

This is not only an anorexia nervosa story. Bulimia nervosa and binge eating disorder - the most prevalent eating disorders in the population; respond well to guided self-help and CBT-ED, often with faster symptomatic change than anorexia nervosa, and ARFID, though evidence is younger, is increasingly managed with adapted family and behavioural approaches rather than borrowed anorexia protocols. I focus on anorexia nervosa below because it carries the heaviest stigma and the longest recovery curve, not because the rest of the diagnostic spectrum is an afterthought.

The strongest UK evidence that early treatment changes trajectories come from FREED, the pathway for sixteen- to twenty-five-year-olds within three years of onset. FREED shortens the duration of untreated illness and improves treatment uptake compared with usual care,⁸ and the FREED-Upscaled study found significantly more patients reached a healthy weight and needed less inpatient or day-patient care.⁹ Recent functional-outcome data from the same cohort show significant improvements in work, education, and social functioning alongside clinical gains.¹⁰ This lets me evidence, rather than merely assert, the social leg of a biopsychosocial formulation: medical stabilisation, psychological therapy, and social reintegration all move together when treatment lands early. As with many conditions in our beloved field of Psychiatry, there is no pharmacological shortcut; no medication is recommended as sole treatment for anorexia nervosa - so the 'journey' framing I defend below is not sentimental packaging. It is the evidence.

From frustration to conversation

This is where the two halves of the title meet, and where the written piece's real work happens.

I don't think it's controversial to say that clinicians are not immune to the stereotypes circulating in wider culture. In this context, it is no different; eating disorder patients are frequently perceived, even by professionals, as manipulative or wilfully non-compliant, and anorexia nervosa attracts a particular bias toward being seen as intractable - strongest among less experienced staff.^{2,11} Patients notice. A 2024 systematic review of lived-experience literature found that perceived clinician stigma reduces engagement, damages therapeutic alliance, and is a direct barrier to accessing and remaining in care.¹² Its themes: reduced treatment engagement, damaged therapeutic alliance, barriers to care, and weight stigma all map almost exactly onto the points at which eating-disorder treatment most depends on trust.

Weight-focused conversations in primary care can even redirect people toward weight-management advice instead of eating disorder assessment.

The countertransference insight closes the loop from my opening. A clinician's frustration at slow progress, unexamined, does not stay contained. It leaks into tone, into whether a plateau gets framed as 'not engaging' rather than 'still recovering'. A 2025 scoping review of countertransference in eating disorder treatment found that negative reactions such as helplessness, anger, and hopelessness are common, particularly with anorexia nervosa, and are more pronounced in less experienced therapists and it recommends training clinicians specifically to recognise and mentalise these reactions rather than to act them out.² Supervision and reflective practice are therefore not just staff wellbeing initiatives. They are anti-stigma interventions, upstream of every conversation a patient has with us and ultimately benefitting both the clinician and the patient which can't be a bad thing surely.

What does this look like in the room? Externalise the illness from the person, borrowing family therapy's core stance even outside formal FBT.⁶ Validate the fear and ambivalence a patient brings rather than confronting it head-on. Ambivalence is a feature of the illness, not a character flaw. Use language that preserves agency without implying blame. Mark the progress a patient cannot see themselves: function, flexibility, relationships restarting, exactly the kind of change FREED's functional data shows moving even when weight change is slow.¹⁰ And, when honest, share the long-term recovery figures directly and not as false reassurance, but as an evidenced instrument of hope, because the twenty-two-year data is real and patients are entitled to it too.³

The same discipline extends to what we write. Frustration that escapes the consulting room subsequently tends to resurface in our vocabulary: 'non-compliant', 'failed treatment', 'revolving door', 'difficult patient'; and each phrase quietly relocates the deficiency from the illness, or from the service's timing, into the patient's character. The corrective is not euphemism but accuracy: the treatment failed her is, in most cases, simply the truer sentence. Patients read their clinic letters now, they can see every consultation with their GP on their NHS app on their phone; every letter is itself a conversation that either reduces stigma or rehearses it. That makes written language part of clinical risk management as well as kindness: it can either keep a patient close to care or confirm their expectation and make them feel that care is not for people like them.

None of this is soft padding around the "real" treatment. A hopeful, validating clinical stance is associated with better engagement, and engagement is the rate-limiting step for every therapy named above. The conversation is not adjacent to the treatment. For this population, it is part of the treatment.

The room, again

I think about that consultation often. The weight chart hadn't moved, but something else had, quietly, either side of it. She had gone back to college part-time; she had eaten a meal with her sister without leaving the table. I hadn't been looking for those things, because I was still reading the wrong clock, and still, if I'm honest, half-measuring my own patience against hers.

Eating disorders are difficult to treat on any timescale, whether it be a training rotation, a service contract, or a clinician's own tolerance for uncertainty can comfortably hold. They are, the evidence tells us clearly, treatable on the timescale that matters. The question this title poses is not whether we can make eating disorders quick to treat, and alas we cannot, not yet, and pretending otherwise is its own quiet form of stigma. The question is whether we can become the kind of clinicians willing to stay curious about our own frustration for exactly as long as recovery takes. That, more than any manual, is the conversation that reduces stigma because it starts with the one we're willing to have with ourselves.

Endnotes

1. Thompson-Brenner H, Satir DA, Franko DL, Herzog DB. Clinician reactions to patients with eating disorders: a review of the literature. *Psychiatr Serv*. 2012;63(1):73–78.
2. Zeeck A, Gruteser V, Lau I, Egenolf M, Klose C, Lienhart S, Hartmann A. Countertransference in the treatment of patients with eating disorders. *J Eat Disord*. 2025;13:240. doi:10.1186/s40337-025-01439-z.
3. Eddy KT, Tabri N, Thomas JJ, et al. Recovery from anorexia nervosa and bulimia nervosa at 22-year follow-up. *J Clin Psychiatry*. 2017;78(2):184–189.
4. National Institute for Health and Care Excellence. 2024 exceptional surveillance of eating disorders (NG69). NICE, 2024.
5. National Institute for Health and Care Excellence. Eating disorders: recognition and treatment. NICE guideline NG69. 2017 (updated 2020).
6. Lock J, Le Grange D, Agras WS, et al. Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Arch Gen Psychiatry*. 2010;67(10):1025–1032.
7. Lock J, Le Grange D. Family-based treatment: where are we and where should we be going to improve recovery in child and adolescent eating disorders. *Int J Eat Disord*. 2019;52(4):481–487.
8. Flynn M, Austin A, Lang K, Allen K, Bassi R, Brady G, Brown A, Connan F, Franklin-Smith M, Glennon D, Grant N, Jones WR, Kali K, Koskina A, Mahony K, Mountford V, Nunes N, Schelhase M, Serpell L, Schmidt U. Assessing the impact of First Episode Rapid Early Intervention for Eating Disorders on duration of untreated eating disorder: a multi-centre quasi-experimental study. *Eur Eat Disord Rev*. 2021;29(3):458–471.
9. Austin A, Flynn M, Shearer J, Long M, Allen K, Mountford VA, et al. The First Episode Rapid Early Intervention for Eating Disorders–Upscaled study: clinical outcomes. *Early Interv Psychiatry*. 2022;16(1):97–105.
10. Gallagher L, Allen KL, Schmidt U. Evaluating the impact of eating disorder early intervention on young people's work, education and social functioning. *Eur Eat Disord Rev*. 2025. doi:10.1002/erv.70029.
11. Bannatyne A, Stapleton P. Educational interventions in reducing negative attitudes and stigmatisation toward patients with anorexia nervosa. *J Eat Disord*. 2013;1(Suppl 1):O38.
12. Lubieniecki G, Fernando AN, Randhawa A, Cowlshaw S, Sharp G. Perceived clinician stigma and its impact on eating disorder treatment experiences: a systematic review of the lived experience literature. *J Eat Disord*. 2024;12(1):161. doi:10.1186/s40337-024-01128-3.