

Perceived Barriers and Facilitators Towards Help-Seeking for Eating Disorders: A Systematic Review

Kathina Ali, MSc^{1*}
 Louise Farrer, PhD¹
 Daniel B. Fassnacht, PhD²
 Amelia Gulliver, PhD¹
 Stephanie Bauer, PhD³
 Kathleen M. Griffiths, PhD¹

ABSTRACT

Objective: To systematically review the literature on perceived barriers and facilitators of help-seeking for eating disorders.

Method: Three databases (PubMed, PsychInfo, Cochrane) were searched using keywords and Medical Subject Headings (MeSH) terms. Retrieved abstracts ($N = 3493$) were double screened and relevant papers ($n = 13$) were double coded. Qualitative and quantitative studies were included if they reported perceived barriers and facilitators towards seeking help for eating disorders. Barriers and facilitators were extracted from the included papers and coded under themes. The most prominent barriers and facilitators were determined by the number of studies reporting each theme.

Results: Eight qualitative, three quantitative, and two mixed-methods studies met the inclusion criteria for the current review. The most prominent perceived

barriers to help-seeking were stigma and shame, denial of and failure to perceive the severity of the illness, practical barriers (e.g., cost of treatment), low motivation to change, negative attitudes towards seeking help, lack of encouragement from others to seek help and lack of knowledge about help resources. Facilitators of help-seeking were reported in six studies, with the most prominent themes identified as the presence of other mental health problems or emotional distress, and concerns about health.

Discussion: Programs targeting prevention and early intervention for eating disorders should focus on reducing stigma and shame, educating individuals about the severity of eating disorders, and increasing knowledge around help-seeking pathways for eating disorders. © 2016 Wiley Periodicals, Inc.

Keywords: mental health; treatment seeking; prevention and early intervention; young people at risk

Resumen

Objetivos: Hacer una revisión sistemática de la literatura acerca de las barreras y facilitadores percibidos en la búsqueda de ayuda en un trastorno alimentario.

Método: Se exploraron tres bases de datos (PubMed, Psychinfo, Cochrane) usando palabras clave y términos de títulos médicos (MeSH). Los resúmenes recuperados ($N = 3493$) fueron doblemente revisados y los artículos relevantes ($n = 13$) fueron doblemente codificados. Se incluyeron estudios cualitativos y cuantitativos si reportaban barreras y facilitadores percibidos hacia la búsqueda de ayuda para trastornos alimentarios. Las barreras y facilitadores fueron extraídos de los artículos incluidos, y codificados por temas. Las barreras y facilitadores más prominentes fueron determinados

por el número de estudios que reportaron cada tema.

Resultados: Ocho estudios cualitativos, tres cuantitativos y dos mixtos reunieron los criterios de inclusión para la revisión. Las más prominentes barreras percibidas cuando se busca ayuda fueron, el estigma y la vergüenza, negación de y fallas en la percepción de la severidad de la enfermedad, barreras prácticas (ej. costo del tratamiento), poca motivación al cambio, actitudes negativas hacia la solicitud de ayuda, falta de estímulo de otros para buscar ayuda y falta de conocimiento acerca de cuáles son los recursos de apoyo. Los facilitadores en la búsqueda de ayuda fueron reportados en seis estudios, siendo los temas identificados como más prominentes,

Accepted 12 July 2016

Additional Supporting Information may be found in the online version of this article.

Supported by German Academic Exchange Service (DAAD) from resources of the Ministry of Education and Research (BMBF); the Australian National University; NHMRC Young and Well CRC.

*Correspondence to: K. Ali; E-mail: kathina.ali@anu.edu.au

¹ Centre for Mental Health Research, the Australian National University, Canberra, Australia

² Research School of Psychology, the Australian National University, Canberra, Australia

³ Center for Psychotherapy Research, University Hospital Heidelberg, Heidelberg, Germany

Published online 16 August 2016 in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/eat.22598

© 2016 Wiley Periodicals, Inc.

la presencia de otros problemas de salud mental o estrés emocional, y preocupaciones acerca de la salud.

Discusión: Los programas enfocados en la prevención e intervención temprana en los trastornos de la

conducta alimentaria, deben enfocarse en reducir el estigma y la vergüenza, en la educación de los individuos acerca de la gravedad de los trastornos alimentarios y en incrementar la información acerca

de los caminos para buscar ayuda para los trastornos de la conducta alimentaria.

(*Int J Eat Disord* 2017; 50:9–21)

Introduction

Eating disorders are severe and often chronic mental disorders that are associated with impaired cognitive and emotional functioning, restricted quality of life,¹ lifelong physical and psychosocial morbidity,² psychiatric comorbidity, and increased risk of mortality.³ In addition to the substantial individual and personal burden associated with eating disorders, the financial and economic impact of these illnesses is enormous.^{4,5} Although health care utilization among these individuals is elevated⁶ and evidence-based treatments for eating disorders exist,^{7–10} a systematic review undertaken by Hart et al.¹¹ concluded that the pooled proportion of participants seeking treatment was 23.2% (95% CI = 16.6, 31.4). However, variability in figures was reported in the review with proportions of participants seeking eating disorder treatment ranging from 0% in a study among middle school females¹² to 52% in a study among adult females with binge eating disorders.¹³ Further, uptake of treatment appears to differ across health care systems and populations. For example, Cachelin et al.¹⁴ and Striegel-Moore et al.¹⁵ found that women from ethnically diverse backgrounds were less likely to seek help than other women in the USA. Another study by Cachelin et al.¹⁶ reported that a majority of women from ethnically diverse backgrounds had not received treatment for their eating disorders despite seeking treatment, indicating that among these groups eating disorders are often underdiagnosed and not treated.

Although the systematic review by Hart et al.¹¹ investigated formal and appropriate treatment uptake, the authors did not examine reasons why individuals with eating disorders did not seek help. There are, however, a number of potential explanations for the low rate of help-seeking in this group. Research has demonstrated that individuals with eating disorders often fail to acknowledge the severity of their illness and have limited knowledge about the disorder and available resources (poor mental health literacy).^{17–19} Not only individuals with eating disorders, but also often the public perceive eating disorders as a lifestyle choice rather than a severe mental illness requiring professional

help.^{20,21} In addition, individuals with eating disorders often do not believe they have a problem^{22–24} or do not believe that their symptoms or behavior require treatment.^{15,25} These beliefs, in combination with a reluctance to disclose information regarding their eating behavior^{22,26} may result in delayed access to treatment. Indeed, studies have shown a median duration of 10–15 year delay between the onset of symptoms and the first approach to seeking help among people with eating disorders.²⁷

Adults and young people are also reluctant to seek professional help for other mental health problems.^{28–31} Several previous reviews have investigated the potential reasons for this lack of help-seeking.^{28–33} One systematic review investigated barriers and facilitators towards seeking help for depression, anxiety and emotional distress among young people.²⁹ The most prominent barriers included perceived stigma, poor mental health literacy, and a preference for self-reliance. Other reviews have reported that a lack of emotional competence and negative attitudes towards seeking professional help prevent individuals from seeking treatment.^{30,31}

Relatively few studies have identified facilitators of help-seeking for mental health problems. Previous reviews have found that positive past experiences, social support, encouragement from others, emotional competence, knowledge, positive attitudes towards seeking professional help, availability of treatment and trusted relationships with professionals facilitate help-seeking.^{29,30} In addition, a systematic review identified that community and educational programs aimed at increasing awareness of services and improving attitudes towards mental health and help-seeking facilitated access to services for disadvantaged young people.³² Additional facilitators identified in this study included motivation to seek support, increased severity of mental health problems and confidence in mental health professionals.

While several reviews have examined barriers to and facilitators of help-seeking for mental health problems in general^{29,31,32} and one narrative review investigated barriers to access and treatment

utilization for eating disorders,³⁴ there have been no systematic reviews examining these factors for eating disorders. Individuals with eating disorders may have different beliefs about their illness compared to other mental health problems,³⁵ and there appear to be differences in the help-seeking trajectory for people with eating disorders (e.g., greater delays between the onset of symptoms and help-seeking).²⁷ An understanding of barriers and facilitators that individuals consider important and specific to eating disorders, is crucial for the development of prevention and intervention programs that aim to reduce barriers to professional care. Therefore, this systematic review aims to identify perceived barriers and facilitators towards seeking help for eating disorders in both the qualitative and quantitative literature.

Method

The current systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement.³⁶ A PRISMA checklist is available in the Supporting Information Appendix A.

Data Sources

The PubMed, PsycInfo, and Cochrane databases were searched for eligible studies using keywords, phrases and Medical Subject Headings (MeSH) terms in June 2015 (see Supporting Information Appendix B). The database search was not restricted by time of publication of the studies. The search strategy covered the following concepts: (1) help-seeking, (2) barriers and/or facilitators, and (3) eating disorders. Search terms regarding concepts 1 and 2 were based on those used by Gulliver et al.²⁹ Search terms regarding concept three were developed by the current study researchers.

Study Selection

Figure 1 shows the selection of included studies. In total, the initial database searches yielded 3,493 abstracts, of which 144 duplicates were removed. Relevant studies were then selected using a two-stage screening procedure.

Stage 1 Screening

The first stage of abstract screening involved eliminating clearly irrelevant abstracts. Two independent raters (KA, and LF or DF) then screened the remaining 3,349 abstracts for relevant studies according to the following inclusion criteria:

1. The study discussed or investigated predictors, factors, barriers, facilitators, or attitudes that may have been associated with help-seeking.
2. The study was about eating disorders.
3. The article was written in English.

This first screening stage yielded a total of 47 relevant papers.

Stage 2

The inclusion criteria were refined in the second stage and the remaining 47 papers were examined by two independent raters (KA, and LF or DF). Papers which met the following inclusion criteria were retained:

1. Participants were explicitly asked what they considered were barriers or facilitators of help-seeking for eating disorders.
2. The study was peer-reviewed and not a literature review or dissertation.
3. The study included data on help-seeking.
4. The study contained extractable qualitative or quantitative data on barriers or facilitators.

Additionally, previous reviews, key journals and reference lists of key papers were hand searched. One additional eligible study was identified using this method.¹² Finally, 13 papers were included for coding by two coders (KA and LF).

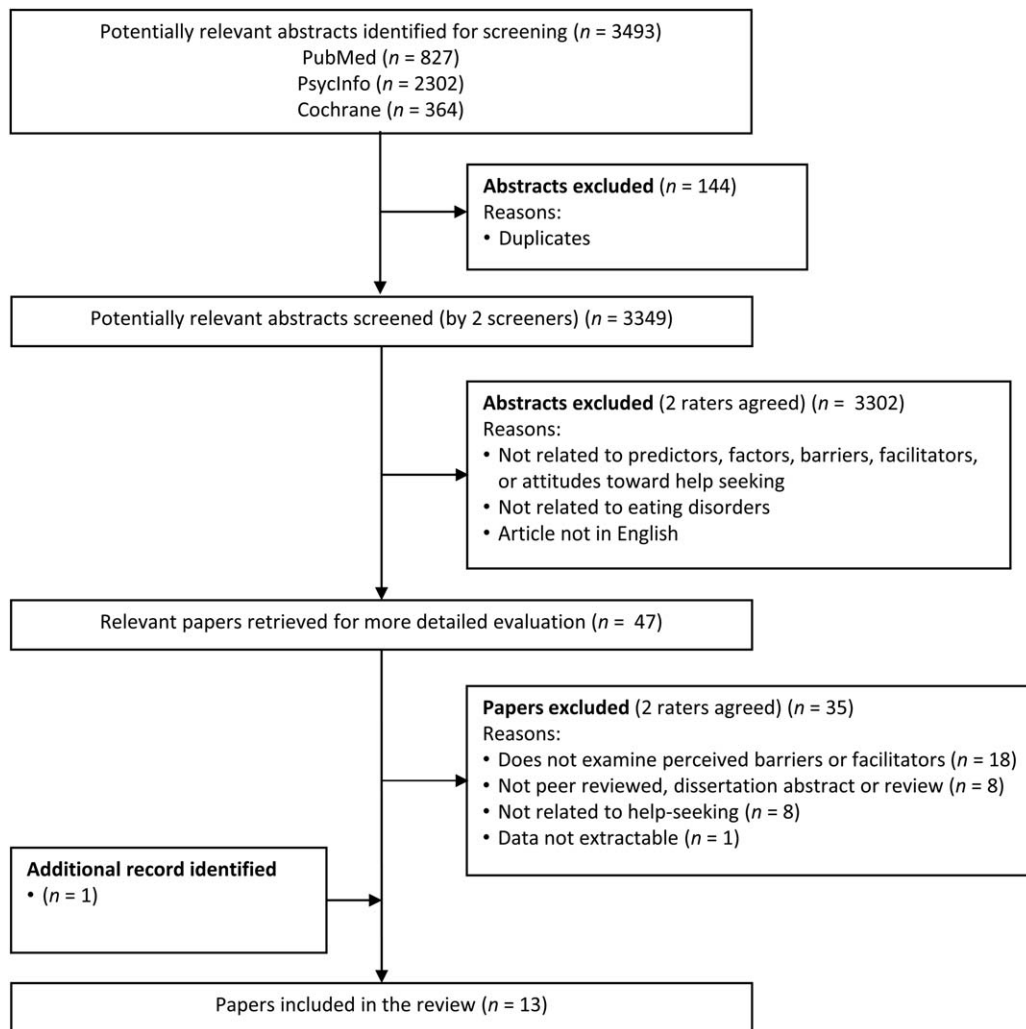
During the screening process, studies that raters mutually agreed on were retained and any disagreement was resolved by discussion between the two raters.

Coding of Studies

The 13 included studies were coded independently by two raters (KA and LF) with a preformulated coding sheet. Studies were categorized as qualitative, quantitative, or mixed-methods depending on the method used to collect data relevant to the review (perceived barriers and facilitators). Each of the studies were coded according to the following characteristics: author name, year of publication, country in which the study was conducted, sample description, sample size, symptom level at recruitment, eating disorder types assessed, age of participants (mean, standard deviation), gender (percentage), eating disorder screening tool used, research type (qualitative or quantitative), reported barriers to help-seeking, and reported facilitators of help-seeking. Any disagreement during the coding process was resolved by discussion between the two coders.

Data Analysis

Thematic analysis was conducted on barriers and facilitators from the eight qualitative, three quantitative,

FIGURE 1. Flow chart for different stages of the systematic review.

and two mixed-methods studies that were included in the review.³⁷ Themes of qualitative studies were created based on coding individual barriers and facilitators of each study into subthemes, and key themes accordingly (see Supporting Information Appendix C). For quantitative studies, barriers and facilitators were extracted and tabulated accordingly. In total, 15 key barrier themes and 10 key facilitator themes were identified.

Risk of Bias

To evaluate the methodological quality of the included studies, relevant quality ratings proposed by Glasziou, Irwig, Bain, and Colditz³⁸ for quantitative data and Mills, Jadad, Ross, and Wilson³⁹ for qualitative data were used. Two authors (KA and DF) coded all studies according to these criteria. Studies that employed mixed methods were coded with respect to quality criteria for quantitative research given that most data relevant to this study

were collected using quantitative measures. Any disagreement was resolved by discussion.

Results

Study Characteristics

Detailed characteristics of the included qualitative ($n = 8$),^{17,18,22,23,25,35,40,41} quantitative ($n = 3$),^{12,26,42} and mixed-methods studies ($n = 2$)^{14,24} are described in **Table 1**. An overview of these characteristics including the year of publication and country in which the study was conducted, sample description and characteristics of participants, and the employed methodologies is provided below.

Origin and Year of Studies. The majority of studies were conducted in the United States (62%), and the remaining studies were from Australia, England, Germany, and Norway. All studies were published

TABLE 1. Included qualitative studies ($n = 8$), quantitative studies ($n = 3$), and mixed-methods studies ($n = 2$)

#	Author (Year) Country	Sample Description and Recruitment Number of Recruited Participants	Symptom Level at Recruitment	Eating Disorder (AN, BN, BED, EDNOS)	Age (Mean, SD) Sex (% Women)	Method Outcome Measure and Response Rate (for Quantitative Studies)
Qualitative Studies						
1	Akey et al. ¹⁷ (2013) USA	Men and women living with an ED recruited via fliers in eating disorder recovery centers in the US and online sites providing eating disorder recovery resources. $N = 34$	88% demonstrated behaviors and attitudes indicative of an ED 12% were recovering from an ED 72% reported a current or past ED	Not specified	$M = 25$ ($SD = 8.3$) Women = 91% ($n = 31$)	Interviews
2	Becker et al. ^{26a} (2010) USA	Ethnically diverse women and male with current or past eating or weight concerns, symptoms or problems. Previous participants in the National Eating Disorders Screening Program (NEDSP) who indicated willingness to participate in future studies. $N = 32$	Not specified	Not specified	College age = 44% Women = 91% ($n = 29$)	Semi-structured, open-ended, telephone interview
3	Evans et al. ⁴⁰ (2011) Australia	Community women with bulimic type ED. Participants derived from the Health and Well-Being of Female Australian Capital Territory (ACT) Residents Study. $N = 57$	ED symptoms of clinical severity	BN ($n = 7$; 12%), BED ($n = 8$; 14%), EDNOS ($n = 30$; 53%), sub-threshold ED ($n = 12$; 21%)	$M = 33$, ($SD =$ not reported) Women = 100%	Telephone interview
4	Gulliksen et al. ²³ (2014) Norway	Women treated for AN within past 2 years. Participants recruited from five clinical institutions in Norway. $N = 34$	Diagnosis of AN (22 outpatients, 12 inpatients)	AN	$M = 28$, ($SD =$ not reported) Women = 100%	Semi-open, participant-centered interview
5	Hepworth et al. ³⁵ (2007) Australia	Women with past or present ED symptoms. Participants recruited via advertisements in newspapers, university bulletins, and local gyms. $N = 63$	Past or present ED symptoms	BN (44.2%), BED (26.9%), BN and AN (11.5%), BN and BED (5.8%), EDNOS (11.6%)	$M = 38.8$, ($SD = 12.28$) Women = 100%	Semi-structured interview
6	Leavy et al. ¹⁸ (2011) UK	Referrals from GP to specialized ED clinic, who did not attend. Contacted via letter explaining study. $N = 13$	Not reported	AN, BN, BED	Not reported Not reported	Interviews
7	Reyes-Rodriguez et al. ²⁵ (2013) USA	Latina women with a history of or current ED or sub-threshold symptoms. Participants recruited through advertisements and outreach in diverse Latino community centers, mental health clinics, and by referrals from health providers. $N = 5$	History of or current ED or subthreshold symptoms	Not reported	$M = 31.2$ ($SD =$ not reported) Women = 100%	In-depth interviews
8	Schoen et al. ⁴¹ (2011)	Female university students with past or current history of diagnosable	Women who had experienced or	Not reported	$M = 23$ ($SD =$ not reported) Women = 100%	In-depth semi-structured interview

TABLE 1. Continued

#	Author (Year) Country	Sample Description and Recruitment Number of Recruited Participants	Symptom Level at Recruitment	Eating Disorder (AN, BN, BED, EDNOS)	Age (Mean, SD) Sex (% Women)	Method Outcome Measure and Response Rate (for Quantitative Studies)
USA						
Quantitative studies						
9	Becker et al. ^{22a} (2004) USA	ED. Participants recruited via advertisement on campus. <i>N</i> = 14 Universal sample of university students. Participants identified by previous participation in the NEDSP. <i>N</i> = 289	were currently experiencing a diagnosable ED 50% had concerns about ED	Not specified	<i>M</i> = 24.7 (<i>SD</i> = 10.2) Women = 91% (<i>n</i> = 263)	Structured interview Response rate: 93%
10	Maier et al. ⁴² (2014) Germany	Former in-and outpatients of a major child and adolescent mental health service. Participants invited anonymously. <i>N</i> = 36	Not reported	AN	<i>M</i> = 19.3 (<i>SD</i> = 2.0) Women = 100%	Survey (QSAN) Response rate: ~48%
11	Meyer ¹² (2001) USA	High school junior and senior females. Participants recruited from a rural public school and a suburban public school in the US. <i>N</i> = 283	Diagnosed ED (<i>n</i> = 38; 16%) Symptomatic (<i>n</i> = 78; 33%) Asymptomatic (<i>n</i> = 122; 51%)	BN (<i>n</i> = 2; 5.3%), BED (<i>n</i> = 6; 15.8%), AN (<i>n</i> = 1; 2.6%), Sub-threshold BN (<i>n</i> = 19; 50%), BN without bingeing (<i>n</i> = 10; 26.3%)	<i>M</i> = 17.8 (<i>SD</i> = not reported) Women = 100%	Survey (Q-EDD, ATSPPH-SF, self-developed questions for help-seeking) Response rate: ~34%
Mixed methods studies						
12	Cachelin et al. ^{24a} (2001) USA	Ethnically diverse sample of women with ED. Participants recruited from an urban community via flyers posted in local organizations. <i>N</i> = 61	Met DSM-IV criteria for ED	BED (<i>n</i> = 33; 54.1%), BN (<i>n</i> = 17; 27.9%), AN (<i>n</i> = 5; 8.2%), EDNOS (<i>n</i> = 6; 9.8%)	<i>M</i> = 30.5 (<i>SD</i> = not reported) Women = 100%	Telephone interview Survey (self-developed questions on barriers)
13	Cachelin et al. ^{14a} (2006) USA	Mexican American (MA) and European American (EA) women. Participants recruited as part of a larger study in the urban Los Angeles area. <i>N</i> = 145	Diagnosis of ED	AN (<i>n</i> = 15; 10.3%), BN (<i>n</i> = 53; 36.6%), BED (<i>n</i> = 47; 32.4%), EDNOS (<i>n</i> = 30; 20.7%)	<i>M</i> (MA) = 27.8 (<i>SD</i> = not reported) <i>M</i> (EA) = 28.8 (<i>SD</i> = not reported) Women = 100%	Telephone interview Survey (self-developed questions on barriers)

Notes: ED = eating disorder, AN = anorexia nervosa, BN = bulimia nervosa, BED = binge eating disorder, EDNOS = eating disorders not otherwise specified.

Measures: QSAN = questionnaire on stigmatization in patients with anorexia nervosa, Q-EDD = questionnaire for eating disorder diagnosis, ATSPPH-SF = attitudes towards seeking professional psychological help—short form.

Response rates not included for qualitative studies.

^aStudies were from the same research groups and recruited from the same population.

TABLE 2. Barrier themes from quantitative, qualitative, and mixed-method studies (*n* = 13)

#	Barrier Theme	# of Studies
1	Stigma and shame (subthemes: stigma, discrimination, eating disorders are not psychological problems, shame, not wanting others to know)	11
2	Denial/failure to perceive severity of the illness/lack of awareness (subthemes: denial, failure to perceive the severity, lack of awareness)	9
3	Practical barriers (subthemes: cost, transportation, inconvenience, time, childcare)	8
4	Fear of losing control/fear of change/low motivation to change (subthemes: fear of losing control, low motivation to change, positive aspects of the illness)	8
5	Negative attitudes towards treatment/perceived insufficiency of professional help (subthemes: fear and doubt about treatment, personal characteristics of the provider)	7
6	Lack of encouragement/support from others, lack of understanding from others	6
7	Knowledge of resources/not knowing how to ask/access help	4
8	Accessibility to help/support/treatment	4
9	Self-sufficiency	3
10	Inability of others to provide help	3
11	Mental health/eating disorder literacy	2
12	Use of other resources	2
13	Previous negative experience with treatment	2
14	Not wanting to hurt others/concern for others	1
15	Comorbidity (depression/anxiety)	1

TABLE 3. Facilitator themes from qualitative studies (*n* = 6)

#	Facilitator Rheme	# of Studies
1	Other mental health problems and emotional distress	6
2	Health problems	5
3	Concern with body weight	4
4	Friends and family encouragement	3
5	Eating related concerns	3
6	Symptom severity	2
7	Desire to get better	1
8	Body image	1
9	Access to services	1
10	Interference with life roles	1

between 2001 and 2015 (initial search was not restricted by time of publication of the studies).

Sample Description and Sample Size. The included studies mainly recruited adult women with eating disorders, with few studies focusing on college or high school students. Sample sizes ranged from 5 to 289 (median = 36) across all studies.

Type of Eating Disorder Examined and Symptom Level. The type of eating disorders examined in the studies included anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified. The majority of participants in the included studies (85%) was currently experiencing or had experienced an eating disorder at the time of recruitment.

Participant Age and Gender. The mean age of participants from the studies ranged from 18 to 39 years. In more than half of the studies all participants were women.

Methodology. All included qualitative studies involved interviews, including telephone, semi-structured, structured, and in-depth interviews.

The three quantitative studies used survey methods (standard, validated measures, and unvalidated measures developed specifically for the study). The two mixed-methods studies employed telephone interviews and surveys.

Perceived Barriers and Facilitators

Analysis of Qualitative and Quantitative Studies. Barriers and facilitators from each study were extracted, collated, and coded into subthemes. The relevant subthemes were aggregated into key barrier and facilitator themes developed from terminology used by the reviewed literature. Accordingly, 15 different key barrier and ten different facilitator themes emerged. For details of the thematic analysis see Supporting Information Appendix C. Themes from the studies containing quantitative data (three quantitative studies and two mixed-methods studies) were extracted and integrated with associated barrier themes from the qualitative studies. None of the quantitative studies explored facilitators.

Barrier themes. **Table 2** provides a summary of the identified barrier themes from the analysis ordered according to how many studies reported barriers/facilitators associated with each theme. The most frequently mentioned barrier was stigma and shame (85%), closely followed by denial of and failure to perceive the severity of the illness (69%), practical barriers (e.g., cost, time; 62%), low motivation to change (62%), and negative attitudes towards treatment (54%). In addition, lack of encouragement and support from others was identified in half of the studies.

TABLE 4. Quality ratings of studies using qualitative methods ($n = 8$)

Study	1. Were the Data Transcribed Verbatim?	2. Were Interview Questions Predefined?	3. Was the Interviewer Trained?	4. Was Saturation Mentioned?	5. Was There a Description of How the Themes Were Derived from the Data?	6. Were Findings Analysed by More than One Assessor?	7. Were Participant Answers Reviewed for Clarification?	8. Were Quotes from the Original data presented?	9. Did the Study Report Ethical Review?
Akey et al. ¹⁷	✓	✓		✓	✓	✓	✓	✓	✓
Becker et al. ²⁶	✓	✓			✓	✓	✓	✓	✓
Evans et al. ⁴⁰	✓	✓		✓	✓	✓	✓	✓	✓
Gullikson et al. ²³	✓	✓		✓	✓	✓	✓	✓	✓
Hepworth et al. ³⁵	✓	✓			✓	✓	✓	✓	✓
Leavy et al. ¹⁸	✓	✓			✓	✓	✓	✓	✓
Reyes-Rodriguez et al. ²⁵	✓	✓	✓		✓	✓	✓	✓	✓
Schoen et al. ⁴¹	✓	✓	✓		✓	✓	✓	✓	✓

Facilitator themes. Facilitators of seeking help for eating disorders were examined in relatively few ($n = 6$) of the qualitative studies compared to barriers. **Table 3** summarizes the ten facilitator themes that emerged from the analysis. The most prominent facilitator was the presence of other mental health problems and emotional distress; this factor was identified in all of the studies which reported facilitators.

Risk of Bias

No study met all quality criteria. Overall, the majority of qualitative studies ($n = 7$) was of good quality, with studies meeting seven or eight criteria out of nine. One study only met five criteria. All included quantitative studies met either three or four out of five criteria. Details are displayed in **Tables 4** and **5**.

Discussion

This systematic review aimed to identify perceived barriers and facilitators towards seeking help for eating disorders. In total, 13 eligible studies were identified from which 15 types of barriers and 10 facilitators were extracted. There was a paucity of quantitative studies and few studies investigated young people (aged 15–24) although this group represents a key target for prevention programs and interventions.⁴³ The broad range of barrier and facilitator themes (those with a minimum of five or more individual barriers or facilitators identified from included papers in the qualitative thematic analysis) are discussed in the context of existing research.

Prominent Barrier Themes

Stigma and Shame. The most frequently identified barrier in the current study was stigma and shame about seeking help. Findings are consistent with other reviews of help-seeking for mental health problems.^{28–31} Significantly, Roehrig and McLean²¹ and Ebner and Latner²⁰ have found that stigmatizing attitudes among university students are greater towards individuals with eating disorders than those with depression. In particular, studies have reported that people with eating disorders were more likely to be blamed for their disorder and to be perceived as using their illness for attention seeking.^{21,44,45} This is consistent with the interpretation that eating disorders are often considered a lifestyle choice rather than an illness.²⁰

A number of studies in the present review reported stigmatizing attitudes of families, friends

TABLE 5. Quality ratings of studies using quantitative methods ($n = 5$)

Study	1. Study Participants Well Defined (Time, Place, Personal Characteristics)?	2. Selection Random or Consecutive?	3. Participant Rate >80% OR If Participant Rate Is Low, Comparison Respondents/Nonrespondents Described?	4. Standardized, Validated Questionnaire OR Clear Description of What Outcomes were measured?	5. Did the Article Report Ethical Review?
Becker et al. ²²	✓	✓	✓	✓	
Cachelin et al. ²⁴	✓	✓		✓	
Cachelin et al. ¹⁴	✓	✓		✓	✓
Maier et al. ⁴²	✓	✓		✓	✓
Meyer ¹²	✓	✓	✓	✓	

and health professionals surrounding eating disorders,^{17,25,26,42} a phenomenon described by Griffiths, Christensen, Jorm, Evans, and Groves⁴⁶ as perceived stigma. Similarly, previous research has shown that adult women with eating disorder symptoms believed that people with bulimia nervosa would be discriminated against and they might therefore not wish to disclose their problems.¹⁹ In addition, one of the included studies reported that participants' negative attitudes about eating disorders—described as personal stigma by Griffiths et al.⁴⁶—was a barrier to help seeking.²⁵ Consistent with research for other mental health problems,⁴⁷ the belief that seeking treatment is a weakness and the perception by others that eating disorders are not real illnesses were reported by studies among university students and adult women from the general population included in the current review to contribute to a lack of help-seeking.^{14,26} In addition, participants with eating disorders in many of the reviewed studies reported feelings of shame and embarrassment.^{14,24,26,35,40} This is consistent with findings from a study of adult women which reported significantly higher levels of shame among people with eating disorders compared to a control group.⁴⁸ Further, the authors found a strong relationship between shame and disclosure in therapy. It is of interest that all studies in the current review that focused on ethnically diverse samples identified stigma as a common barrier among participants.^{14,24,25}

Denial and Failure to Perceive the Severity of the Illness.

Another prominent barrier identified in the current review was denial, a lack of awareness or a failure to perceive the severity of the problem. This was consistent across included studies that examined clinical samples^{17,18,24,25} and at-risk samples.^{22,23} Some of the included studies indicated that individuals with eating disorders do not necessarily consider their disordered eating behavior to be problematic^{12,23,42} which in turn prevents them from seeking help. Furthermore, individuals with eating disorders have a tendency to compare themselves to others and believe that others' symptoms are more severe

than their own.¹⁷ It is of note that denial appears to be a particularly common barrier towards help-seeking for eating disorders, indicating that eating disorders may not be considered as or perceived to be real or serious mental illnesses.²¹

Previous reviews of help-seeking for mental disorders have similarly reported difficulty in identifying symptoms of mental illness as a barrier, indicating a lack of understanding symptoms of the illness.^{29,30} A national comorbidity survey in the US reported that less than half of the respondents with various disorders perceived a need for professional help.⁴⁹ In addition, previous reviews^{29,30} and large survey studies in the US, Canada, and the Netherlands^{50,51} have reported that individuals with mental health problems prefer to rely on themselves rather than to seek professional help, a finding which might be due to a lack of insight into the problem. One study that investigated help-seeking for major depression specifically reported a failure to perceive the severity of the illness and the belief that they could handle the problem on their own as barriers to seeking help.⁵²

Practical Barriers. Practical factors associated with accessing treatment, including cost, transportation, and lack of time emerged as an important barrier towards help-seeking. Previous studies on help-seeking for mental health problems have reported similar findings, particularly in rural areas and among people from potentially disadvantaged groups.^{29,32,53} Although the included studies in the present review did not focus on rural areas, these practical barriers were similarly important, especially among ethnically diverse samples. In particular, financial difficulties were endorsed as a barrier by a majority of women with eating disorders from ethnically diverse backgrounds²⁴; however, no difference in treatment seeking between women of different ethnicities was found.

Fear of Losing Control Over the Illness and Fear of Change. The fear of losing control over their illness and the fear of change were important barriers to help seeking, which may be particularly important

to individuals with eating disorders. Given the evidence that individuals with eating disorders have low motivation for change,³⁵ it is unsurprising that these factors prevent help-seeking. Included studies have shown that people with eating disorders are afraid of gaining weight,³⁵ have a fear of losing the positive aspects of the eating disorder,¹⁸ and feel that they are not ready for change.²⁵ Participants in these studies reported that their eating disorder was an important part of their identity and provided them with a sense of control.^{18,23} Consequently this had a negative impact on their help-seeking behavior.

Negative Attitudes Towards Professional Treatment/Perceived Insufficiencies of Professional Help. Some studies from this review found that negative attitudes towards professional help, including doubt and fear about treatment, personal characteristics of the provider (e.g., lack of providers with same ethnic background, language barriers), and a lack of trust in providers impeded the help-seeking process.^{12,14,17,18,24,40} These concerns have been identified in previous reviews of barriers to help seeking for other mental health problems suggesting that individuals perceive the characteristics of the potential help resource (e.g., ability to help, credibility, race) as very important.^{29,54–56} In addition, Becker et al.²⁶ highlighted how social stereotypes could act as a barrier to care and how experiences were qualitatively different for those who were in a minority group compared with those who were not. Their study showed that participants from a nonminority group reported that family members and clinicians failed to view eating disorders as of clinical concern, but participants from ethnic-minority backgrounds reported that clinicians did not believe that eating disorders occurred in certain groups such as African-Americans.

Lack of Support from Others. Lack of support, encouragement, and understanding from others was also reported as a perceived barrier to help-seeking for eating disorders. In particular, included studies reported lack of family support, a lack of understanding from peers, the unwillingness of others to provide help, and a feeling that no one could do anything about the eating disorder as help-seeking barriers.^{17,22,26} Consistent with this finding, a previous review has identified social support or encouragement from others as facilitators of seeking help for mental health problems indicating the important role of significant others (e.g., family and friends) during the help-seeking process.²⁹ Given that people with mental health problems and eating disorders in particular tend to

prefer to seek help from informal sources such as family and friends,^{57,58} these social networks might encourage treatment seeking and have a major impact on the help-seeking process.

Knowledge of Resources. The lack of knowledge about resources and the inability to articulate the need for help also emerged as barriers to help-seeking, a result that has been similarly reported in other reviews of mental health conditions.^{29,30,32} This is consistent with the finding that low mental health literacy (i.e., knowledge and beliefs about mental health problems and available treatments) has impacts on help-seeking for mental disorders.³¹ Participants from the studies included in the current review reported that not knowing where to go and what type of treatment exists prevented them from seeking help for their eating problems.^{14,24}

Prominent Facilitator Themes

Overall, the literature on facilitators of help-seeking for mental health problems is sparse. Likewise, the investigation of facilitators in the present review was limited and only qualitative responses could be examined because facilitators were not investigated in quantitative studies.

Other Mental Health Problems and Emotional Distress. In contrast to a review by Gulliver et al.²⁹ which reported positive past experience as the major facilitator for young people, the most prominent facilitator towards help-seeking for eating disorders in the current review was the presence of other mental health problems, including depression, anxiety and emotional distress. In addition, the concern about general health problems (e.g., fatigue, abdominal pain, somatic concerns) promoted help-seeking. Whilst one study¹⁸ reported that experiencing multiple mental health problems (e.g., depression and anxiety) was a barrier to seeking help for eating disorders, the other studies that addressed this issue found that participants perceived that comorbid mental health problems facilitated their help seeking due to a desire to feel less depressed²³ or in response to feeling overwhelmed by health or emotional problems.³⁵ However, it is important to note that given that the majority of studies included in the current review focused on those with diagnosed eating disorders, the association between comorbid mental disorders and help seeking may apply only to this group.

Quality of Studies

The overall quality of included studies was good. However, none of the qualitative and quantitative

studies satisfied all methodological criteria. There is a need for more rigorous evaluations of perceived barriers and facilitators in order to draw more reliable conclusions. Given that most of the included studies relied on retrospective self-reports regarding past experience, the results must be treated with caution. Furthermore, the majority of studies in this review recruited individuals with clinical eating disorders limiting the investigation of barriers and facilitators to this specific target group. Given that disordered eating behaviors appear on a continuum, factors that impede help seeking should be investigated in more diverse populations including individuals who are at risk for developing an eating disorder. In addition, eliciting perceptions from health care providers and caregivers may offer further insight into how help-seeking may be increased for individuals experiencing eating disorders.

Limitations

This review has several limitations. First, three databases were searched to identify relevant studies, but not all relevant studies may have been captured by these sources. However, previous reviews and key journals were hand searched to address this limitation and resulted in one additional paper that satisfied the inclusion criteria. Second, the search only focused on English-language papers. However, a number of included studies investigated ethnically diverse samples, including data from Spanish-speaking participants which reduces the level of bias that findings are only relevant for English-speaking populations. Another potential limitation is that this review used frequencies of themes and the number of studies reporting each theme from qualitative research to tabulate barriers, which might not accurately reflect the relative importance of each barrier and might lead to potential bias. For example, the importance of some topics might be overemphasized by this methodology. Furthermore, it is not possible to draw more reliable conclusions since the strength of the relationship between barriers and help-seeking was not investigated in the studies which constituted the review. However, given the lack of research in this field, this method offers useful information to generate future research and to inform the development of interventions addressing barriers towards help-seeking. In addition, several of the included studies were from the same research groups,^{14,24} utilized overlapping study samples or recruited from the same population groups.^{22,26} This may have biased the results of the review. Finally, the review was limited to

consumer-perceived barriers and facilitators towards help-seeking for eating disorders neglecting other potentially influential factors (e.g., personality traits, duration of disorder) of which the individuals themselves may not be aware.

Implications for Future Research

There is a paucity of quantitative studies examining perceived barriers and facilitators towards help-seeking for eating disorders. Such quantitative studies are needed to further understand the relative importance of each barrier and to examine whether barriers can be changed or circumvented. In particular, as previous research has indicated that barriers and facilitators may change over time,⁵⁶ it might be beneficial to measure these factors quantitatively at different stages of the illness. For example, quantitative studies could examine whether barriers differ across at-risk or clinical samples which potentially impacts the design of prevention and early intervention programs.

Significantly, there is currently no validated measure of multiple barriers towards help-seeking for eating disorders. Although validated questionnaires exist for specific barriers (e.g., stigma²⁰) the development of a broader integrated measure could contribute to more quantitative and nuanced research in this area.

The majority of studies focused on investigating barriers to help-seeking among adult women with current or past eating disorders and an effort was made to include ethnically diverse community samples in some of the studies. Although the heterogeneity of papers did not allow a more detailed analysis, findings suggest that barriers may be generalized across ethnic groups.^{14,24–26} Cachelin et al.,¹⁴ for example, showed that Americans from Mexican compared to European backgrounds endorsed similar barriers that impeded help-seeking. However, the lack of research among younger people is concerning given that the onset of eating disorders most often occurs during adolescence or young adulthood.^{43,59,60} Research shows that many young people engage in unhealthy weight control behaviors such as fasting, vomiting and use of laxatives.⁶¹ In addition, the fear of gaining weight and being distressed about weight and shape is common among young girls.⁶² Elevated weight and shape concerns have been found to be common risk factors for the development of eating disorders.⁶³ It is crucial to understand factors that influence young people's help-seeking when they are at-risk of developing an eating disorder in order to address these factors at an

early stage. This is particularly the case given that one in eight young women is affected by eating pathology by the age of 20.⁴³ Future research should use both qualitative and quantitative methods to examine barriers to professional care in this high-risk population to inform programs aimed at increasing awareness and knowledge of eating disorders.

From this review it would appear that stigma and shame, as well as denial and failure to perceive the severity of the illness are prominent barriers to help-seeking for eating disorders. Awareness and prevention programs should focus on educating young people about the devastating impact of these illnesses and encouraging them to seek help for their problems. In contrast to practical barriers, such as cost and time, most of the identified barriers are modifiable and can be changed over time. Future research should seek to identify methods for reducing these modifiable barriers, such as stigma, shame, denial, lack of eating disorder literacy, and negative attitudes towards treatment. Addressing these barriers could increase help-seeking behavior and uptake of treatment among those in need.

Conclusion

Determining the factors that impede or facilitate help-seeking for eating disorders is critical in tackling this serious mental illness. It is clear that more quantitative research is required to better understand these factors, particularly among young people who are at-risk of developing eating disorders. Meanwhile, awareness and prevention programs should focus on reducing stigma and shame around eating disorders, and educating people about these illnesses, their impact, and available resources.

This project was conducted within the Australia-Germany Joint Research Cooperation Scheme. The project was resourced by the Young and Well CRC. The Young and Well CRC is established under the Australian Government's Cooperative Research Centres Program.

References

1. Klump KL, Bulik CM, Kaye WH, Treasure J, Tyson E. Academy for eating disorders position paper: Eating disorders are serious mental illnesses. *Int J Eat Disord* 2009;42:97–103.
2. Treasure J, Claudino AM, Zucker N. Eating disorders. *Lancet* 2010;375:583–593.
3. Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. *Curr Opin Psychiatry* 2006;19:389–394.
4. Access Economics. Positive family functioning: Department of Families, Housing, Community Services and Indigenous Affairs, 2010. available at: https://www.dss.gov.au/sites/default/files/documents/positive_family_functioning.pdf
5. Gatt L, Jan S, Mondraty N, Horsfield S, Hart S, Russell J, et al. The household economic burden of eating disorders and adherence to treatment in Australia. *BMC Psychiatry* 2014;14:338.
6. Striegel-Moore RH, DeBar L, Wilson GT, Dickerson J, Rosselli F, Perrin N, et al. Health services use in eating disorders. *Psychol Med* 2008;38:1465–1474.
7. Brownley KA, Berkman ND, Sedway JA, Lohr KN, Bulik CM. Binge eating disorder treatment: A systematic review of randomized controlled trials. *Int J Eat Disord* 2007;40:337–348.
8. Bulik CM, Berkman ND, Brownley KA, Sedway JA, Lohr KN. Anorexia nervosa treatment: A systematic review of randomized controlled trials. *Int J Eat Disord* 2007;40:310–320.
9. Hay P. A systematic review of evidence for psychological treatments in eating disorders: 2005–2012. *Int J Eat Disord* 2013;46:462–469.
10. Hay P, Bacaltchuk J, Stefano S, Kashyap P. Psychological treatments for bulimia nervosa and bingeing. *Cochrane Database Syst Rev* 2009 ; [serial on the Internet]. ; (4): Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000562.pub3/abstract>.
11. Hart LM, Granillo MT, Jorm AF, Paxton SJ. Unmet need for treatment in the eating disorders: A systematic review of eating disorder specific treatment seeking among community cases. *Clin Psychol Rev* 2011;31:727–735.
12. Meyer DF. Help-seeking for eating disorders in female adolescents. *J Coll Stud Psychother* 2001;15:23–36.
13. Cachelin FM, Striegel-Moore RH, Elder KA, Pike KM, Wilfley DE, Fairburn CG. Natural course of a community sample of women with binge eating disorder. *Int J Eat Disord* 1999;25:45–54.
14. Cachelin FM, Striegel-Moore RH. Help seeking and barriers to treatment in a community sample of Mexican American and European American women with eating disorders. *Int J Eat Disord* 2006;39:154–161.
15. Striegel-Moore RH, Dohm FA, Kraemer HC, Taylor CB, Daniels S, Crawford PB, et al. Eating disorders in white and black women. *Am J Psychiatry* 2003; 160:1326–1331.
16. Cachelin FM, Veisel C, Barzegarnazari E, Striegel-Moore RH. Disordered eating, acculturation, and treatment-seeking in a community sample of Hispanic, Asian, Black, and White women. *Psychol Women Quart* 2000;24:244–253.
17. Akey JE, Rintamaki LS, Kane TL. Health belief model deterrents of social support seeking among people coping with eating disorders. *J Affect Disord* 2013;145:246–252.
18. Leavey G, Vallianatou C, Johnson-Sabine E, Rae S, Gunpath V. Psychosocial barriers to engagement with an eating disorder service: A qualitative analysis of failure to attend. *Eat Disord* 2011;19:425–440.
19. Mond JM, Hay PJ, Paxton SJ, Rodgers B, Darby A, Nilsson J, et al. Eating disorders "mental health literacy" in low risk, high risk and symptomatic women: Implications for health promotion programs. *Eat Disord* 2010;18:267–285.
20. Ebner DS, Latner JD. Stigmatizing attitudes differ across mental health disorders: A comparison of stigma across eating disorders, obesity, and major depressive disorder. *J Nervous Mental Dis* 2013;201:281–285.
21. Roehrig JP, McLean CP. A comparison of stigma toward eating disorders versus depression. *Int J Eat Disord* 2010;43:671–674.
22. Becker AE, Franko DL, Nussbaum K, Herzog DB. Secondary prevention for eating disorders: The impact of education, screening, and referral in a college-based screening program. *Int J Eat Disord* 2004;36:157–162.
23. Gulliksen KS, Nordbo RH, Espeset EM, Skarderud F, Holte A. The process of help-seeking in anorexia nervosa: Patients' perspective of first contact with health services. *Eat Disord* 2015;23:206–222.
24. Cachelin FM, Rebeck R, Veisel C, Striegel-Moore RH. Barriers to treatment for eating disorders among ethnically diverse women. *Int J Eat Disord* 2001;30: 269–278.
25. Reyes-Rodriguez ML, Ramirez J, Davis K, Patrice K, Bulik CM. Exploring barriers and facilitators in eating disorders treatment among Latinas in the United States. *J Latina o Psychol* 2013;1:112–131.

26. Becker AE, Hadley Arrindell A, Perloe A, Fay K, Striegel-Moore RH. A qualitative study of perceived social barriers to care for eating disorders: Perspectives from ethnically diverse health care consumers. *Int J Eat Disord* 2010; 43:633–647.
27. Oakley Browne MA, Wells JE, McGee MA. Twelve-month and lifetime health service use in Te Rau Hinengaro: The New Zealand mental health survey. *Aust New Zealand J Psychiatry* 2006;40:855–864.
28. Barker G, Olukoya A, Aggleton P. Young people, social support and help-seeking. *Int J Adolesc Med Health* 2005;17:315–335.
29. Gulliver A, Griffiths K, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry* 2010;10: 113.
30. Rickwood D, Deane F, Wilson C, Ciarrochi J. Young people's help-seeking for mental health problems. *Aust e-J Adv Mental Health* 2005;4:1–34.
31. Rickwood DJ, Deane FP, Wilson CJ. When and how do young people seek professional help for mental health problems? *Med J Aust* 2007;187(7Suppl): S35–S39.
32. Brown A, Rice SM, Rickwood DJ, Parker AG. Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia-Pacific Psychiatry Off J Pac Rim Coll Psychiatr* 2016;8:3–22.
33. Mojtabai R. Unmet need for treatment of major depression in the United States. *Psychiatr Services* 2001;60:297–305.
34. Thompson C, Park S. Barriers to access and utilization of eating disorder treatment among women. *Arch Women's Mental Health* 2016. DOI: 10.1007/s00737-016-0618-4
35. Hepworth NPSJ. Pathways to help-seeking in bulimia nervosa and binge eating problems: A concept mapping approach. *Int J Eat Disord* 2007;40:493–504.
36. Moher D, Liberati A, Tetzlaff J, Altman D. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ (Clin Res Ed)* 2009;339:b2535.
37. Liamputtong P, Ezzy D. *Qualitative Research Methods*. Melbourne: Oxford University Press, 2005.
38. Glasziou P, Irwig L, Bain C, Colditz G. *Systematic Reviews in Health Care*. Cambridge: Cambridge University Press, 2001.
39. Mills E, Jadad AR, Ross C, Wilson K. Systematic review of qualitative studies exploring parental beliefs and attitudes toward childhood vaccination identifies common barriers to vaccination. *J Clin Epidemiol* 2005;58:1081–1088.
40. Evans EJ, Hay PJ, Mond J, Paxton SJ, Quirk F, Rodgers B, et al. Barriers to help-seeking in young women with eating disorders: A qualitative exploration in a longitudinal community survey. *Eat Disord* 2011;19:270–285.
41. Schoen EG, Lee S, Skow C, Greenberg ST, Bell AS, Wiese JE, et al. A retrospective look at the internal help-seeking process in young women with eating disorders. *Eat Disord* 2012;20:14–30.
42. Maier A, Ernst JP, Müller S, Gross D, Zepf FD, Herpertz-Dahlmann B, et al. Self-perceived stigmatization in female patients with anorexia nervosa—Results from an explorative retrospective pilot study of adolescents. *Psychopathology* 2014;47:127–132.
43. Stice E, Marti CN, Rohde P. Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. *J Abnorm Psychol* 2013;122:445–457.
44. Mond JM, Robertson-Smith G, Vetere A. Stigma and eating disorders: Is there evidence of negative attitudes towards anorexia nervosa among women in the community? *J Mental Health* 2006;15:519–532.
45. Crisp A. Stigmatization of and discrimination against people with eating disorders including a report of two nationwide surveys. *Eur Eat Disord Rev* 2005;13:147–152.
46. Griffiths KM, Christensen H, Jorm AF, Evans K, Groves C. Effect of web-based depression literacy and cognitive-behavioural therapy interventions on stigmatising attitudes to depression. *Randomised Controlled Trial* 2004;185: 342–349.
47. Corrigan P. How stigma interferes with mental health care. *Am Psychol* 2004;59:614–625.
48. Swan S, Andrews B. The relationship between shame, eating disorders and disclosure in treatment. *Br J Clin Psychol Br Psychol Soc* 2003;42:367–378.
49. Mojtabai R, Olfson M, Sampson NA, Jin R, Druss B, Wang PS, et al. Barriers to mental health treatment: Results from the national comorbidity survey replication. *Psychol Med* 2011;41:1751–1761.
50. Sareen J, Jagdeo A, Cox BJ, Clara I, ten Have M, Belik SL, et al. Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. *Psychiatric Services (Washington, DC)* 2007;58:357–364.
51. Urbanoski KA, Cairney J, Bassani DG, Rush BR. Perceived unmet need for mental health care for Canadians with co-occurring mental and substance use disorders. *Psychiatric Services (Washington, DC)* 2008;59:283–289.
52. Blumenthal R, Endicott J. Barriers to seeking treatment for major depression. *Depress Anxiety* 1996;4:273–278.
53. Handley TE, Kay-Lambkin FJ, Inder KJ, Lewin TJ, Attia JR, Fuller J, et al. Self-reported contacts for mental health problems by rural residents: Predicted service needs, facilitators and barriers. *BMC Psychiatry* 2014;14:12.
54. Wohler Y, Dantas JA. Barriers accessing mental health services among culturally and linguistically diverse (CALD) immigrant women in Australia: Policy implications. *J Immigrant Minority Health Center Minority Public Health* 2016. DOI: 10.1007/s10903-016-0402-6
55. Priester MA, Browne T, Iachini A, Clone S, DeHart D, Seay KD. Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *J Subst Abuse Treat* 2016;61:47–59.
56. Hom MA, Stanley IH, Joiner TE Jr. Evaluating factors and interventions that influence help-seeking and mental health service utilization among suicidal individuals: A review of the literature. *Clin Psychol Rev* 2015;40: 28–39.
57. Mond JM, Marks P, Hay PJ, Rodgers B, Kelly C, Owen C, Paxton SJ. Mental health literacy and eating-disordered behavior: Beliefs of adolescent girls concerning the treatment of and treatment-seeking for bulimia nervosa. *J Youth Adolesc* 2007;36:753–762.
58. Prouty AM, Protinsky HO, Canady D. College women: Eating behaviors and help-seeking preferences. *Adolescence* 2002;37:353–363.
59. Favaro A, Caregaro L, Tenconi E, Bosello R, Santonastaso P. Time trends in age at onset of anorexia nervosa and bulimia nervosa. *J Clin Psychiatry* 2009;70:1715–1721.
60. Keel PK, Baxter MG, Heatherton TF, Joiner TE Jr. A 20-year longitudinal study of body weight, dieting, and eating disorder symptoms. *J Abnorm Psychol* 2007;116:422–432.
61. Larson NI, Neumark-Sztainer D, Story M. Weight control behaviors and dietary intake among adolescents and young adults: Longitudinal findings from project EAT. *J Am Dietetic Assoc* 2009;109:1869–1877.
62. Jacobi C, Hayward C, de Zwaan M, Kraemer HC, Agras WS. Coming to terms with risk factors for eating disorders: Application of risk terminology and suggestions for a general taxonomy. *Psychol Bull* 2004;130:19–65.
63. Micali N, Ploubidis G, De Stavola B, Simonoff E, Treasure J. Frequency and patterns of eating disorder symptoms in early adolescence. *J Adolesc Health Off Publ Soc Adolesc Med* 2014;54:574–581.

Copyright of International Journal of Eating Disorders is the property of John Wiley & Sons, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.