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Letter to the Editor

Eating disorder recovery requires attention to the social lives of those affected

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Dear Editor,

Approximately 70 million people worldwide have received an ED diagnosis, with the incidence rate continuing to rise.¹ There has been a surge in the prevalence of eating concerns, said to be exacerbated by the COVID-19 pandemic.² The rate of hospital admissions, symptom severity, and assessments for EDs also significantly increased since the onset of COVID-19.² Sociocultural standards concerning dieting and the thin ideal are common in many Western societies; with weight biases, including fat shaming, remaining widespread.³ For the person with an ED, navigating daily life brings about many challenges. Recovery without the right support is very difficult.⁴ Those affected often present and re-present to GPs with chronic problems and need substantial GP time and resources. A GP armed with the appropriate knowledge and tools can play a pivotal role in supporting the management of EDs.

Here, we consider how GPs can best do this. We now know that the development and maintenance of EDs are embedded in social processes.⁵ For example, stigma may act as a barrier to ED help-seeking, diagnosis, and recovery. On the other hand, harnessing social processes (i.e. social connections) can be used in a positive way to counter dysfunctional eating and weight norms in support of recovery. Here, we offer evidence-based recommendations as to how general practice can incorporate this knowledge into everyday practice.

Despite the most common ED being binge eating disorder,⁶ EDs are often still viewed as a disorder of low body weight. This stereotype can complicate help-seeking intentions and behaviours. Where people's experience of their ED is removed from classic ED stereotypes, those affected may feel that their health concerns are minor or misplaced. Weight stigma, in particular, acts as a barrier to care and often maintains EDs for people of a higher weight.⁷ They are often encouraged to engage in disordered eating behaviours such as restrictive eating. This can happen explicitly through health professionals, family, friends, and broader society, or inadvertently through “eat less, move more” weight-loss messaging.⁷ So, people with EDs who are of a higher weight often experience 2 forms of stigma: weight stigma and the stigma associated

with an ED diagnosis.⁷ Including information about EDs in healthcare settings, to emphasize the diversity of presentations associated with ED, is particularly potent in normalizing these disorders and allowing those affected to see general practice as a good first port of call.

A stereotype of EDs as low body weight also often impairs GPs' management of EDs.⁸ Overreliance on body mass index (BMI), which remains an important diagnostic indicator for GPs in ED detection and treatment,⁸ can get in the way of diagnosis, treatment, and recovery for people who do not conform to the stereotypical presentation of EDs. A person's BMI can tell us about the level of immediate risk they face due to severe malnutrition. However, as noted above the most common ED is binge eating disorder,⁸ which does not usually result in severe malnutrition. People who live with binge eating disorder can be a healthy weight, or even overweight⁸ but are still in need of help. Reliance on BMI, then, can lead to misconceptions, late diagnosis, or misdiagnosis of atypical and subclinical EDs because ED presentations occur across a range of body types.

There are other reasons too that people might delay seeking help for their ED. Evidence suggests that people may delay seeking help as they believe that health professionals, including GPs, hold negative attitudes towards EDs.⁹ This is often linked to a widespread perception that EDs and associated behaviours are a choice⁹—a diet and lifestyle that people select. During recovery, people with EDs are often sensitive to the stigma associated with their diagnosis. A recent systematic review shows that the stigma associated with an ED diagnosis is a substantive barrier to recovery.¹⁰ ED stigma is associated with poor psychological, social, and physical health, greater ED psychopathology and higher avoidance of treatment seeking behaviours.

This type of stigma is also problematic because it limits access to social supports beyond GP surgeries. People with EDs experience social isolation. There is evidence that those affected by EDs are often subjected to misguided attempts from family and friend networks to help, that may cause conflict, stress, and loneliness.¹¹ Many years of research also suggest that dysfunctional dynamics of this nature within families can

play a role in the maintenance of EDs.¹² However, a focus on this aetiology can be unhelpful as it can damage social connections within a family further, leading those around the affected person to feel blamed and defensive.¹³ Indeed, a review of 25 years of research evaluating family-based interventions indicates family-based treatments for EDs can be promising.¹⁴ This review clearly highlights the value of a family system that counters dysfunctional weight ideals in support of recovery.

The value of this approach is no doubt related to the fact that those affected by EDs appear to have fewer positive social interactions to support their recovery. However, there is also evidence that support groups, as well as supportive connections with family and friends, can foster recovery.¹⁵ The factors most often identified as being critical protective resources are: (i) maintenance of meaningful social group memberships,¹⁶ (ii) joining supportive social groups and finding recovery-based connections,¹⁷ and (iii) avoiding groups that encourage disordered eating behaviours or that legitimize stigmatizing beliefs.¹⁸ As such, recovery is about embedding people in functional and supportive groups and fostering positive social connections. Next, we consider why this knowledge is valuable for GPs.

Functional and dysfunctional group memberships for ED recovery

Referring patients to specialist services at the earliest opportunity and supporting them to use them is crucial for GPs. However, there is growing recognition of the importance of social groups for maintenance and recovery of health including those affected by EDs.¹⁷ While this research is in its early stages, the findings relating to the role played by social group memberships in ED development, maintenance, and recovery are promising. A sense of connection with similar others in treatment support groups can improve ED symptoms and behaviours during the treatment process. A group-based support approach for the treatment of EDs in primary care can have great value. Indeed, family therapy has shown to be highly efficacious in randomized controlled trials.¹³ These groups can offer a feeling of belonging that is the basis of reciprocal support.

Meaningful everyday connections through clubs and groups can also have positive implications for ED symptoms. Where these connections are positive, they can offer a basis for connections where disordered eating behaviours is not the focus and likely not encouraged.¹⁶ This is in line with the idea of social prescribing, where GPs and health professionals refer patients with psychosocial challenges to local community supports and activities.¹⁹ Thinking about naturally occurring social connections as well as those that can be offered through support groups can offer GPs treatment options for a patient's recovery journey. While promoting the value of social connections is important, it should happen alongside other therapeutic or treatment interventions, because successful engagement with social connections often requires additional forms of support.

General practice also has a role to play in highlighting the range of self-help approaches available to people with EDs.²⁰ Evidence suggests that people with EDs highly rate self-help groups, and support from family and close friends.²⁰ Therefore, communicating the value of maintaining meaningful everyday connections (e.g. family or friend networks) or

participating in positive support connections (e.g. ED treatment groups) is worth rehearsing with those affected by ED. These types of supports are demonstrably beneficial to ED treatment, health, and recovery trajectories.¹⁷ Advising those affected to stay in touch on a daily or weekly basis with people in their networks would be helpful. Also, it is beneficial to encourage those who are considered in recovery from an ED to have regular contact or continued involvement in support groups of which they are already members.

Social connections, though often important, are dependent on whether these connections promote social norms and values in line with a person's recovery. Some groups and social connections can damage people's health, especially in the context of EDs. For example, online groups and forums described as "pro-ana" or "pro-bulimia" offer those living with an ED to connect with each other.¹⁸ Groups such as pro-ED communities, and even ED support groups, can inadvertently maintain, support, and even promote ED behaviours because they often support and normalize unhealthy behaviours characteristic of EDs. These groups should be gently discouraged. There is clear evidence however that it is important to replace lost connections with a new supportive group.²¹ Those in recovery should be encouraged to diversify their participation in groups and join a hobby or interest group such as a musical society, a sports team, or a book club offering the all-important sense of belonging and interests and values in line with recovery. While advising the use of online communities for sources of social support and reassurance during the recovery process is valuable, the potential risks of online ED communities should also be communicated clearly to patients.

Conclusion

The wider world is replete with stereotypes of how people affected by EDs look and behave. This may affect the way people with EDs perceive themselves and how they are perceived by others in their wider social networks, including health professionals. Those affected often feel isolated and are sometimes conflicted by their own behaviour. GPs can help those affected by EDs seek out social groups that are supportive of recovery and that are likely to encourage healthy eating behaviour. Equally groups and connections that make matters worse need to be actively discouraged. A reduction in ED symptoms, growing feelings of support and belonging and a focus on recovery are just some of the benefits that accrue. The trick for GPs working to support recovery is spotting and guiding people to those social groups that can support recovery and making sure that those that do not are actively avoided.

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Authors' contributions

A-MF wrote the manuscript, with critical revisions from OTM and ATO. All authors read and approved the final manuscript prior to submission.

Consent for publication

All authors consented to the submission of this manuscript.

Conflict of interest

None declared.

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