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Research Article

Barriers to Engagement in a Psychological Therapy group in a Multidisciplinary weight Management Program: a Qualitative Study (Hapifed-M)

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Abstract:

Background: Participant feedback is critical in assessing how interventions influenced both their learning process, cognitive, and psychological outcomes. This qualitative study explored views and barriers to engagement in a psychological therapy group program as part of a multidisciplinary Weight Management Program (WMP) from the perspectives of individuals with higher body weight (HBW).

Methods: This cohort comprised of individuals with obesity Class 3 (BMI ≥ 40 kg/m²), who were enrolled in a longitudinal WMP and had achieved a ≥10% body weight reduction. To maintain physical and mental health improvements, an in-person maintenance group focusing on consolidation of gains and relapse prevention was offered Healthy APproach to weIght management and Food in Eating Disorders-Maintenance (HAPIFED-M).

Results: Following a thematic analysis using the Framework method, positive and negative feedback was provided by 19 participants in this study, examining six key themes: (1) Positive content of therapy, (2) Positive socialization and support, (3) Positive therapist features, (4) Negative time of therapy/personal circumstances, (5) Negative process of therapy, and (6) Negative content. Barriers to engagement included a preference for alternative activities and practical impediments.

Conclusions: The findings highlight the importance of the therapeutic engagement, practical features such as timing of groups, and tailoring psychotherapy content to participant's needs in order to achieve therapeutic engagement.

Key words: executive function; qualitative study; obesity; cognitive deficits; binge eating; psychological distress; physical health; positive and negative feedback

Abbreviations (If Any)

WMP, Weight Management Program; **HBW,** Higher body weight; Healthy APproach to weIght management and Food in Eating Disorders-Maintenance, HAPIFED-M

Introduction

Higher body weight (HBW), particularly Class 3 obesity (BMI ≥ 40 kg/m²), is recognized as a significant global health issue associated with chronic physical conditions such as type 2 diabetes, hypertension, and cardiovascular disease [1]. In addition to physical health risks, individuals with HBW commonly experience mental health comorbidities, including depression, anxiety, and disordered eating [2] [3] [4] [5-8].

Many individuals with HBW engage in Weight Management Programs (WMPs) to improve health outcomes, achieve weight loss, and enhance overall quality of life, with evidence showing that such programs, particularly commercial and dietitian-led interventions, can lead to significant improvements in physical, psychological, and cardiometabolic outcomes [9] [10] [11].

Although initial weight loss is often achieved through WMPs, long-term maintenance remains a critical challenge, with most individuals maintaining only 3.0 kg (23% of their initial weight loss) 4 or 5 years post WMP [12]. A recent review by Rosenbaum et al. (2003), discussed the contributing mechanisms to weight regain following weight lost regardless of the methods used [13]. The authors reported metabolic adaptation, changes in appetite-regulating hormones, and alterations in fat cell biology as key contributors to the challenge of sustaining weight loss over the long term [13].

This pattern, often referred to as weight cycling, can negatively impact both physical and psychological well-being. Weight cycling has been associated with increased emotional distress and a sense of failure that can further hinder motivation and engagement in future weight management efforts [14]. Typically, multidisciplinary approaches including psychological, behavioral, and nutritional interventions have been incorporated in these programs with the main purpose of promoting long-term weight loss and weight maintenance [15]. However, the most significant challenge, particularly for individuals with HBW remain to be engagement and adherence to such programs. A variety of psychological, social, and practical barriers contribute to this challenge [16] [17]. Understanding participants' lived experiences is crucial for addressing these challenges effectively.

Participant qualitative feedback is critical for understanding the effectiveness of such programs and for identifying factors that may hinder or promote engagement [18] [19]. While previous studies have explored the impact of various interventions in WMPs, there is a need for qualitative research to examine the barriers and facilitators to engagement, specifically from the perspectives of individuals with HBW. It is important to explore participants' perspectives, particularly regarding the maintenance phase and the transition from clinical to community care settings [20].

In an exploratory study, we examined the community-based care needs of adults with HBW (class 3 obesity) following a WMP and found significant gaps in support during the transition from hospital to community care, including social isolation, fragmented services, and a lack of integrated care [21]. The findings of this study highlighted the urgent need for better-connected healthcare systems and ongoing support to improve long-term outcomes for individuals with severe obesity [22].

In addition, in an earlier study we found an integrated mental health and behavioural weight loss group program for people with disorders of recurrent binge eating was associated with significant improvements in general mental health and function as well as reduction in binge eating [3] named a Healthy APproach to weIght management and Food in Eating Disorders-Maintenance (HAPIFED). We modified and adapted this therapy (HAPIFED-M), for relapse prevention and to extend mental health gains for people undergoing a WMP. The aim of HAPIFED-M was to provide new knowledge for participants on the relationships between weight loss maintenance, cognitive style and mental health in a real-world setting [3] [8] [7].

The aim of current study was to explore in people with an HBW:

- the barriers to engagement in, and
- perspectives and feedback of,

a psychological therapy group program as part of a multidisciplinary WMP with a particular focus on the weight loss maintenance.

Materials and Methods

Between March 2018 and June 2021 participants were invited to participate in a group therapy program. Participants were from a clinical cohort of people who were enrolled in a multi-disciplinary WMP (including endocrinologists, dietitians, psychologists, physiotherapists, a gastroenterologist, a psychiatrist, and a specialist nurse). The WMP was conducted in a publicly funded hospital-based outpatient program in Sydney, Australia. Adults (age ≥18 years) categorised as Class 3 obesity (BMI ≥ 40 kg/m²), [23] [8] [24] [7] with at least one medical comorbidity associated with their body weight. In order to maintain physical and mental health improvements, a psychological therapy maintenance group (HAPIFED-M) focusing on consolidation of gains and relapse prevention was offered to all those in the multi-disciplinary WMP who had achieved a ≥10% body weight reduction in the WMP. The WMP has been described in previous publications [8] [7] [3]. As a publicly funded program, participants were representative of socioeconomically disadvantaged communities in New South Wales, Australia.

The present study offering a psychological therapy program on the maintenance group was approved by the Human Research Ethics Committee of Western Sydney University (H13832, August 2020) and the South-Western Sydney Local Health District Research Ethics Committee (2019/ETH12128). Participants provided written informed consent at the time of initial recruitment.

The Maintenance therapy group (HAPIFED-M)

HAPIFED-M is a manualized program [3] for individuals with a high body mass index (>25 kg/m^2) who are in a weight maintenance phase (Table 1). This program combines and adaptation of the evidence-based standard therapy for eating disorders, which is cognitive behavioral therapy – enhanced for eating disorders (CBT-E) [25] (excluding interventions for underweight individuals) with behavioral weight loss therapy and multidisciplinary strategies to promote weight loss maintenance. Additional therapy components included 2 case vignette discussion points and cognitive remediation therapy [26]. The HAPIFED-M group comprised of twelve 60-minute sessions over 12 weeks. The therapist was a psychologist, and the sessions were conducted at the site of the WMP. Each session addressed a specific topic designed to improve mental health and thinking style.

STAGE 1 INTRODUCTION
Session 1: Introduction and Psychoeducation about Weight and Behavioural Weight Loss Management
Session 2. Psychoeducation about Disordered eating and weight loss
STAGE 2 CORE SKILLS
Session 3. Mindfulness / Social Environment
Session 4: Relaxation/Barriers to Change
Session 5: Physical Activity Education / Healthy vs Excessive Exercise
Session 6: Unhelpful Thinking Styles
Session 7: Changes in eating related to Events and Moods
Session 8: Dissatisfaction with Body Weight and Shape / Body Checking, Comparison and Avoidance
Session 9: Nutritional Education and Problem Solving
Session 10: Increasing Self-Confidence
STAGE 3 PREPARING FOR ENDING
Session 11: Relapse Prevention (Part 1)
Session: 12: Relapse Prevention (Part 2)

Table 1: HAPIFED-M: 12 sessions led by Clinical psychologist [3]

Survey measures

Socio-demographic characteristics and Body Mass Index (BMI)

Socio-demographic data were obtained at baseline (pre-group), which included participants age, gender, and employment status. Participants height and body weight measured with calibrated scales during the initial presentations to the clinic at pre-group and at 12-months follow-up assessment (post-group); BMI (kg/m^2) was calculated based on height and weight [3].

Mental health outcome measure

Psychological distress was assessed by Kessler-10 (K-10) psychological distress questionnaire [27] which is used in health surveys for epidemiological and clinical purposes [27]. The Cronbach's alpha for K-10 was 0.94, indicating excellent internal consistency and moderate reliability [28]. An average score to indicate positive mental health ranges from 10-15 [29]. The Cronbach's alpha (α) for the participants of this study (n=244) was 0.78 at pre-group; and for the subset of participants (n=58) was 0.83 and 0.91 at both pre-group and follow-up, respectively.

Participant's Quality of Life (QoL) was measured using the 12-item Short Form Survey (SF-12) questionnaire [30] which has a sound reliability and validity [31]. The scoring is from 0-100 (lowest to highest health level) with the mean and standard deviation score of 50±10 [30].

The Eating Disorder Examination Questionnaire (EDE-QS) was used to assess eating disorder symptoms over the past 7 days [30] [32]. The EDE-QS measure used in this study consists of 12 items on a four-point rating scale, ranging from 0 ("0 days" or "not at all") to 3 ("6–7 days" or "markedly") with total score between 0 to 36, where higher scores indicate more frequent and severe eating disorder symptomatology. A total score of 15 has been proposed as a threshold score to identify high risk of eating disorder [33]. Subscale scores and a global score are derived and Australian community normative data for these are published [34]. This scale has acceptable internal consistency, test–retest reliability and temporal stability.

In this study, Cronbach's α for the 12-item pool of EDE-QS was 0.82 for all the participants (n=244), 0.85 at pre-group, and 0.76 at follow-up assessment for the subset of participants (n=58). Question 10 of the EDE-QS questionnaire was used as an indicator of the binge eating frequency (question 10: On how many of these days (i.e., days on which you had a sense of having lost control over your eating) did you eat what other people would regard as an unusually large amount of food in one go?)

Feedback Questionnaire

For the purpose of the current study, a maintenance program for relapse prevention (HAPIFED-M), an invitation was sent to those participants who had achieved a ≥10% body weight reduction. A total of 56 people were invited to enrol in the current study; 35 people consented to participate of whom 30 completed the pre-group assessments; 19 participants completed the 12-weeks therapy sessions with the psychologist.

At the 12-weeks post-group assessment session, a feedback questionnaire (Table 2) was read over the phone by the study's researcher (NF) to the 19 participants who completed the 12-weeks HAPIFED-M sessions. All of them completed the feedback questionnaire.

Thank-you for providing us with feedback on your experiences in the HAPIFED-M group therapy. Would you please take a few moments to tell us:

1. What did you find helpful?
2. What did you find unhelpful?
3. What do you think could be done better in the future?

Table 2: Feedback questionnaire

Statistical and Qualitative Analysis

The descriptive statistics for sociodemographic characteristics and mental health outcome measures of the participants is presented. Categorical variables are shown as percentages; continuous variables as means and standard deviations (SD). All the analyses were conducted by using the Statistical Package for Social Sciences (SPSS), Version 28.

We analyzed open-ended responses collected by NF using a phone interview transcript. A Framework Method was utilized to conduct a thematic analysis. After familiarization with the data, initial codes were developed both inductively from the data and deductively based on the study objectives. The research team (NF & PH) created a working analytical framework which was then applied systematically across the dataset.

Key themes were identified and charted into a matrix to facilitate comparison across participants. The analysis was conducted manually, and emergent themes were reviewed and refined to ensure coherence and consistency. This process enabled a structured yet flexible approach to theme development, suitable for addressing the applied nature of the research.

Results

Table 3 presents socio-demographic characteristics and clinical features of the 19 participants who provided feedback at post group. Those who did not elect to enrol in the study (n=21), or did not attend the pre-group assessment session (n=5), or did not complete the 12-weeks therapy sessions (n=11) provided reasons and barriers that included: lack of interest due to differing personal priorities or mindset; work commitments or conflicting schedules preventing full participation; alternative preferred current activities such as health and fitness routines, intensive dieting or attending the gym daily; chronic health conditions including multiple ongoing medical issues, older age and comorbidities, particularly diabetes, impeding travel to attendance; a preference for remote participation, with some individuals favoring online classes; caregiving responsibilities, including caring for a family member at home.

Socio-demographic	n=19	
Characteristics	Number	%
Gender		
Female	14	73.7
Male	5	26.3
Age groups		

18-44	4	21.0
45-64	9	47.4
65 and above	6	31.6
Mean age (SD)	*57.4(12.1)*	
Employment status		
Full/Part Time	3	16.7
Unemployed/other/not employed	4	22.2
Retired/pension	11	61.1
Weight (kg)	123.9	
Body Mass Index (BMI)	44.6	
SF12-PCS	38.9	
SF12-MCS	42.3	
Total K-10 score	19.7	
Total EDEQ score	12.9	
EDEQ-10 (BE)	0.6	

Table 3: Pre-group socio-demographic characteristics of the participants (n=19)

Employment status missing for one participant. Non-completers are not presented due to low numbers and potential breach of confidentiality, all were women, aged ≥45 years, and none were employed; BMI: Body Mass Index (kg/m^2); PCS & MCS: Physical & Mental Component Scores of SF12 [30]; K10: The Kessler Psychological Distress Scale [28]; EDEQ-10: Eating Disorder Examination Questionnaire short form [35]; EDEQ-10 (BE): question 10 of EDEQ-10 questionnaire indicating the binge eating frequency.

Theme 1: positive content of the therapy

- **Content of Therapy**: many participants found the information shared in therapy sessions helpful (e.g., "thoughts and ideas were good.", or "information was useful"). They appreciated the focus on eating behaviours, food-related advice, and mindfulness exercises (e.g., "helpful thing about it was mindfulness"). However, some also noted that the delivery of the content could have been improved (e.g., "lack of animation", "unclear communication").
- **Therapist and delivery**: some participants in their responses highlighted positive interactions with the therapist (e.g., "The therapist was easy to talk to"). The content about mindfulness was beneficial for some, but others wanted more practical advice related to nutrition and food preparation (e.g., "actual food related content and dietitian needed", "talk about food and how to cook it to make it healthier". "We don't have great eating habits, talk about changing food").

Theme 2: positives of socialization and support

- **Group interaction**: many participants valued the opportunity to interact with others in the therapy groups (e.g., "nice to have others understand"). They appreciated the shared experience and the understanding of others' struggles.
- **Social connection**: participants felt comforted by knowing others understood their struggles. However, some were disappointed by low attendance or no-shows, which limited the potential for social support (e.g., "disappointing that people didn't turn up").

Theme 3: negative aspects of therapy

- **Personal circumstances**: many participants could not attend sessions due to personal reasons such as medical issues (e.g., surgery, illness, hospitalization), work commitments, or family matters (e.g., caring for a sick relative). These circumstances disrupted their ability to engage fully in the therapy (e.g., "I felt sick and was about to faint. Just released from hospitalization" or "Dad was unwell").
- **Timing issues**: several participants' responses indicated that the timing of the sessions was inconvenient. Some preferred sessions in the evening or on weekends, and others found the timing of the therapy sessions not suited to their schedules (e.g., "timing of the session, am/pm and weekend the only thing I could think".

Theme 4: negative aspects of the process

- **Format and structure of therapy**: participants expressed dissatisfaction with the process, noting that the content sometimes felt repetitive, rushed, or incomplete. Some felt that the sessions lacked depth and didn't provide enough useful, tailored information (e.g., "Very confusing- chat for 2-3 mins about feeling hungry, reminder and enforcing, reading labels, adding a few general ideas, delivery was rushed, too much for little time").
- **Too general or basic**: some participants felt that the sessions were too generalized and did not address their specific needs, especially after surgery or when facing unique challenges (e.g." how to get into that mindset of saying I can still have food but different portions. I went to a group after operation that prepares you for the operation and afterwards").

Theme 5: positive suggestions for improvement

- **Suggestions for future sessions**: participants expressed the desire for more tailored content, such as specialized advice on food substitution, gardening, goal setting, and dealing with stress. They also mentioned that more in-depth, longer sessions with follow-up would improve the experience.
- **Dietitian inclusion**: several participants requested that dietitians be involved in the sessions to provide more practical and food-focused advice. Some suggested including more guidance on how to prepare healthier meals and substitute foods in recipes (e.g. "Would be good to have a dietitian next time to teach us and be there to help us and answer our questions").

Theme 6: Negative Content

- **Lack of relevance and clarity:** some participants found aspects of the program content to be confusing, irrelevant, or poorly aligned with their personal needs. Brief discussions, such as talking about hunger for only a few minutes, were perceived as lacking depth or therapeutic value. Others felt the focus of the group was unclear, with some attendees more interested in food-related topics than the psychological support being offered. For those not in the maintenance phase of their weight journey, the content felt mismatched, leading to comments like, "It wasn't helpful for me," and "nothing really stuck with me."
- **Unengaging and emotionally triggering activities:** activities such as games were also criticized, with one participant stating, "my brain doesn't work with them," finding them boring and unengaging. Additionally, some content was described as emotionally triggering, prompting early dropout from the group. These responses highlight the need for more relevant, emotionally sensitive, and individualized content to ensure meaningful engagement and support participant retention.

Discussion

The current study aimed to investigate participants' perspectives, feedback and barriers to engagement in an in-person group therapy program that had a focus on weight loss maintenance that was embedded in a multidisciplinary WMP. We used the Framework method for thematic analysis and identified six key themes that highlighted both the positive and negative aspects of the therapy, including: (1) Positive content of therapy, (2) Positive socialization and support, (3) Positive therapist features, (4) Negative time of therapy/personal circumstances, (5) and Negative process of therapy, and (6) Negative content. This research found that therapeutic engagement will only be achieved with attention to both systemic factors and therapy content that is person centered.

Theme 1: Positives of the content of therapy highlights that participants generally found the therapy sessions helpful, particularly regarding the focus on eating behaviours, food-related advice, and mindfulness exercises. These elements align with existing evidence that integrated psychological and nutritional interventions can enhance mental health outcomes and reduce disordered eating in individuals with HBW [2, 3, 6]. However, some noted that the delivery could have been improved, such as clearer communication or more engaging presentation.

Theme 2: Positives of socialization and support indicates that participants valued the opportunity for group interaction and the sense of comfort derived from shared experiences, echoing findings that social support is a key facilitator in weight management engagement [18, 19]. However, there was frustration with low attendance, which limited the potential for full social support an issue also noted in prior evaluations of WMPs [17].

Theme 3: Negative aspects of therapy revealed that personal circumstances, such as medical issues or family commitments, prevented some participants from attending sessions regularly, consistent with previous research identifying these as key obstacles to engagement in WMPs [16, 17].

Additionally, Theme 4: Negative aspects of the process pointed out that participants were dissatisfied with the structure and format of therapy, particularly that some sessions felt rushed, repetitive, or lacking depth underscoring the challenge of maintaining participant adherence in real-world, outpatient settings [22]. A common concern was that the therapy content was too general and did not address specific needs, especially post-surgery.

Theme 5: Positive suggestions for improvement showed that participants wanted more tailored content, including practical advice on food substitutions and stress management, along with longer sessions and follow-up. Aligning with evidence that dietitian-led interventions improve cardiometabolic and quality-of-life outcomes [11], many suggested that the inclusion of dietitians in the therapy process would improve the relevance and applicability of food-related guidance.

Finally, Theme 6: Participants expressed that some therapy content was unclear, superficial, or misaligned with their needs. Brief discussions, such as those about hunger, were seen as lacking depth, and some felt the group focus was more on food than psychological support. This disconnect particularly affected those not yet in the maintenance phase, leading to reduced engagement, reinforcing the importance of stage-appropriate and emotionally sensitive therapy content to reduce disengagement and promote retention [3, 7]. Additionally, certain activities, like games, were viewed as unhelpful or boring, and some content was described as emotionally triggering, prompting early dropout. These findings highlight the need for more personalized, emotionally sensitive, and stage-appropriate content to improve therapeutic engagement and participant retention.

Overall, the positive outcomes appear to exceed the negative effects, especially when it comes to the content of therapy and the social support aspects. However, the negatives related to session structure, the generality of content, and attendance issues highlight significant areas that need attention. The positive feedback regarding content and social support aligns well with the suggestions for improvement, such as the desire for more tailored, practical advice and longer, more in-depth sessions.

The findings of this study suggest several areas for potential improvement in the therapy program. Tailoring the content more specifically to the individual needs of participants, particularly those post-surgery or facing unique challenges, would address concerns that the therapy felt too general. A more structured and engaging delivery of content is also necessary to maintain participant engagement and ensure that key points are communicated clearly.

Given the positive feedback regarding social support, it may be valuable to strengthen group dynamics and ensure consistent attendance. Addressing attendance issues could involve creating flexible scheduling options, such as evening or weekend sessions, to better accommodate participants' personal commitments or introducing virtual/ online sessions. Incorporating dietitians into the therapy sessions could enhance the practical aspects of the program, providing participants with more concrete guidance on meal planning, food substitutions, and healthier cooking practices.

Finally, expanding the session length and providing follow-up opportunities could enhance the depth and effectiveness of the program. These changes could help address the feedback that sessions sometimes felt rushed or incomplete. In summary, the therapy program has a solid foundation, but the findings indicate that making it more personalized, interactive, and practical could significantly improve participants' experiences and outcomes.

We consider these findings suggest the importance of addressing both the psychological and practical aspects of weight management interventions to enhance engagement and long-term outcomes for individuals with HBW. These insights contribute to the understanding of how to tailor weight management interventions to better suit the unique needs and challenges faced by individuals with HBW, ultimately aiming to improve engagement, therapeutic outcomes, and long-term success in WMPs [36] [37].

Future research could focus on exploring personal barriers that hinder therapy attendance, such as medical or family issues, to develop strategies for improving engagement. Additionally, studying the impact of tailored content, particularly for post-surgery participants, could provide valuable insights into how personalized therapy influences outcomes. Research on

incorporating dietitians into therapy and enhancing social support dynamics in group settings would also be beneficial to improve the overall effectiveness of the program.

Participants appreciated the therapy's content, especially regarding eating behaviours, mindfulness exercises, and social support, but they expressed dissatisfaction with its generality and lack of depth. Common concerns included session timing, low group attendance, and personal barriers preventing consistent participation. To address these issues, recommendations include offering more personalized therapy, improving session engagement, incorporating dietitians, and increasing scheduling flexibility by offering an online or hybrid sessions. Strengthening group dynamics and ensuring consistent attendance would also enhance social support, making the therapy more effective for participants.

Strengths and Limitations

This is a real-world study in an outpatient multidisciplinary WMP. The population studied had class 3 obesity, where data is significantly lacking. The main limitation of this study was that the feedback was only from a small sample size. The analysis was a content analysis, and the interview was not designed to explore people's experiences in depth. A further limitation was a reliance on self-reported assessments, which may be subject to reporting and recall biases. However, the strength of the study was that we obtained feedback from the entire sample whether or not they perceived they have improved.

The nature of the qualitative research such as this present study is that it is subjective and may not generalize. Future research should build on this qualitative study with experimental methods to test the hypothesis generated for example, the efficacy of a revised therapy manual that has a capacity to more person centered and the reducing the barriers that were identified in the delivery of the therapy.

Conclusions

Weight loss maintenance is one of the major challenges facing people with HBW who participate in WMPs. We present results to better understand how a focused psychological group therapy may help people in this critical phase of treatment. The findings highlight the importance of therapeutic engagement, as well as practical elements such as the timing of therapy sessions and content that is tailored to participants' needs. Designing therapy programs should be seamlessly integrated with the broader weight management approach to avoid conflicting or redundant messaging. For individuals with eating disorders, it is crucial to prioritize mental health by addressing key areas such as adaptive functioning, interpersonal difficulties, mood regulation, emotional tolerance, and trauma. These aspects must take precedence above weight-related concerns to ensure a comprehensive and effective treatment plan.

Ethical Statement

Ethics Approval

This study was approved by the Human Research Ethics Committee of Western Sydney University (H13832, August 2020) and the South-Western Sydney Local Health District Research Ethics Committee (2019/ETH12128). Participants provided written informed consent at the time of initial recruitment

Declaration of Helsinki Strobe reporting guideline

This study was conducted in accordance with the Declaration of Helsinki.

Data Availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Author Contributions

Conceptualisation, M.P. and P.H.; methodology, M.P., N.F., and P.H.; formal analysis, M.M. and N.F.; investigation, M.P., N.F..; resources, M.P.; data curation, M.M. and N.F.; writing-original draft preparation, N.F.; writing-review and editing, M.P., M.M., and P.H. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

P.H. receives sessional fees and lecture fees from the Australian Medical Council, Therapeutic Guidelines publication, and New South Wales Health Education and Training Institute and royalties from Hogrefe and Huber, McGraw Hill Education, and Blackwell Scientific Publications, and she has received research grants from the NHMRC and ARC. She is the Chair of the National Eating Disorders Collaboration Steering Committee in Australia (2019-current) and was Member of the ICD-11 Working Group for Eating Disorders (2012–2018) and was the Chair of the Clinical Practice Guidelines Project Working Group (eating disorders) of RANZCP (2012–2015). She has prepared a report under contract for Shire Pharmaceuticals (July 2017) and received travel and consulting fees for educational activities from Takeda (formerly Shire). M.P. has received travel and consulting fees for educational activities from Takeda Pharmaceuticals, Novo Nordisk, Eli Lilly, Johnson and Johnson, and iNova Pharmaceuticals and was on the guideline development committee for the National Eating Disorder Collaboration 'Management of eating disorders for people with higher weight: clinical practice guideline (2022)'. All the views in this paper are their own.

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