

Article

One Sheet Does Not Fit All: The Dietetic Treatment Experiences of Individuals with High Eating Disorder Symptomatology Attending a Metabolic and Bariatric Clinic; an Exploratory Mixed-Methods Study

Yive Yang ¹, Janet Conti ^{1,2} , Milan K. Piya ^{1,3} , Caitlin M. McMaster ^{4,5,6,7} and Phillipa Hay ^{1,8,*} 

¹ Translational Health Research Institute, School of Medicine, Western Sydney University, Campbelltown, NSW 2560, Australia

² School of Psychology, Western Sydney University, Penrith, NSW 2750, Australia

³ Camden and Campbelltown Hospitals, SWSLHD, Campbelltown, NSW 2560, Australia

⁴ Sydney School of Health Sciences, Faculty of Medicine and Health, University of Sydney, Camperdown, NSW 2050, Australia

⁵ Eating Disorder and Nutrition Research Group (ENRG), Translational Health Research Institute, Faculty of Medicine, Western Sydney University, Campbelltown, NSW 2560, Australia

⁶ South Western Sydney Local Health District, Liverpool, NSW 2170, Australia

⁷ Ingham Institute for Applied Medical Research, Liverpool, NSW 2170, Australia

⁸ Mental Health Services, Camden and Campbelltown Hospitals, SWSLHD, Campbelltown, NSW 2560, Australia

* Correspondence: p.hay@westernsydney.edu.au

Abstract: This study aimed to explore the dietetic treatment experiences of individuals with high eating disorder (ED) symptomatology attending a metabolic and bariatric clinic. An exploratory mixed methods cross-sectional study was conducted. Eighteen participants completed the survey, which included an adapted version of the Eating Disorders Treatment Experience Survey (EDTES), the Eating Disorder Examination Questionnaire Short (EDE-QS), and quantitative and qualitative questions relating to the roles and helpfulness of a dietitian in treatment. Data regarding the most and least helpful dietitians were collected. Differences between groups were tested with the Wilcoxon signed ranks test. A reflexive thematic analysis was used to analyse open-ended responses. The mean EDE-QS score reported by participants was 20.9 ($SD = 6.0$). The dietitians who were perceived as the most helpful were those who took into consideration an individual's treatment preferences and choices ($Z = -1.96, p = 0.05$). Three themes were constructed: (1) nutrition knowledge and skills, (2) person-centred care, and (3) roles of the multidisciplinary team. Although further research is required, our findings suggest that the role of a dietitian in this setting may extend beyond weight-loss advice, and with additional training, could include individualised and collaborative supportive care that overlaps with ED treatment.

Keywords: feeding and eating disorders; dietitian; treatment experiences; lived experience; higher weight; obesity



Citation: Yang, Y.; Conti, J.; Piya, M.K.; McMaster, C.M.; Hay, P. One Sheet Does Not Fit All: The Dietetic Treatment Experiences of Individuals with High Eating Disorder Symptomatology Attending a Metabolic and Bariatric Clinic; an Exploratory Mixed-Methods Study. *Dietetics* **2024**, *3*, 98–113. <https://doi.org/10.3390/dietetics3020009>

Academic Editor: Bahram H. Arjmandi

Received: 19 December 2023

Revised: 23 January 2024

Accepted: 8 March 2024

Published: 2 April 2024



Copyright: © 2024 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

1. Introduction

Eating disorders (EDs) are complex and potentially life-threatening mental health conditions that present in individuals across a diverse range of body sizes. Whilst EDs have historically been considered as disorders of people with low body weight, extensive evidence indicates otherwise, with less than 6% of people who experience an ED presenting as clinically underweight and over half of all people with an ED in Australia living with a high weight [1–3]. Research suggests that ED symptoms are higher in individuals with a BMI ≥ 30 kg/m² when compared with individuals with a BMI in the 'adequate' range (BMI 18.5 to 24.9 kg/m²) [3,4]. Furthermore, individuals seeking or who have undergone

bariatric surgery are particularly vulnerable to having a current or lifetime history of ED features, and ED prevalence in this population is increasing. A cross-sectional study by D'Souza et al. found that the rate of current EDs in individuals planning or receiving bariatric surgery was more than double the rate of EDs in the general population [4,5].

Despite the increasing prevalence of EDs in this population, data suggest that individuals with higher body weights are less likely to be diagnosed with an ED and experience significant delays in accessing specialist ED treatment [6]. Several factors that may explain these treatment delays have been identified. First, there is a lack of standardisation in ED screening for individuals living in larger bodies, especially those seeking weight loss and bariatric surgery [7,8]. The Australian 'Management of eating disorders for people with higher weight: clinical practice guidelines', published in 2022, recommend that "all services recommending or providing weight loss advice or programs (including bariatric surgery) should screen for disordered eating, risky behaviours such as the use of unregulated weight-loss pills/supplements or laxatives, and body image concerns". However, steps to implement these screening practices in a standardised manner have yet to be taken.

Secondly, weight stigma (negative weight-related attitudes and beliefs that manifest as stereotypes, rejection, prejudice, and discrimination towards individuals of higher weights [9]) has contributed to the under-recognition and under-treatment of EDs experienced by people living in larger bodies [3]. Internalised weight stigma occurs when individuals adopt negative weight-based societal stereotypes and apply them to judge themselves and others [9]. Stronger internalised weight stigma predicts a poorer quality of life, increased ED psychopathology, and higher levels of body dissatisfaction, and is reported in people seeking bariatric surgery [3,10]. Individuals in larger bodies experiencing ED symptoms may also avoid treatment due to fear of weight stigmatisation from healthcare professionals and also have a higher rate of treatment attrition due to perceived weight stigmatisation [3,11,12]. In addition, people with an ED are more likely to present for weight loss than ED treatment, therefore emphasising the necessity for appropriate clinical and research protocols for screening, assessing, and monitoring EDs in this context [13].

Dietitians are routinely part of the treatment team for bariatric surgery, metabolic disorders, and EDs. They are therefore uniquely placed to be able to help identify and treat EDs or refer to specialist services, as well as engage people earlier in the course of an ED, given early intervention can improve outcomes [14]. This is supported by the Dietitians Australia Bariatric Surgery Role Statement, which states that a dietitian may "Identify history of disordered eating behaviours and address the re-emergence of disordered or maladaptive eating behaviours through management and referring on if needed" [15]. Despite this, there is little research to explore whether or not this occurs in dietetic practice.

Although there is extant research informing dietetic care to promote metabolic health and assist in the prevention and treatment of micronutrient deficiencies in people undergoing bariatric surgery, there is little research addressing the individual's experience of working with a dietitian. There is even less evidence examining how dietitians providing routine, non-ED-specific care may help or harm ED-symptomatic individuals in this population [16–18]. Furthermore, whilst previous research has explored lived experience perspectives of ED treatment, many of these studies primarily focused on the experiences of people with anorexia nervosa or people who live in lower-weight bodies [1,19]. Without an understanding of which parts of dietetic treatment people in larger bodies find most helpful and/or unhelpful, it is not possible to provide person-centred care that is tailored to the needs of those with high ED symptomatology, especially concerning the management of disordered eating symptoms.

Therefore, with consideration of these gaps in knowledge, this study aims to explore treatment experiences and satisfaction with a dietitian, including what aspects of treatment have been helpful or unhelpful, from the perspective of individuals who (1) have high ED symptomatology scores, (2) are attending a metabolic and bariatric clinic, and (3) who also have (or have had) a BMI > 30 kg/m². The study also aims to understand what the

perceived role of the dietitian may be in this population and if it includes the management of ED symptomatology.

2. Materials and Methods

2.1. Design

The online survey used was based on the Eating Disorders Treatment Experience Survey (EDTES) and was adapted for the current population [20]. Eating disorder symptomatology was assessed using the Eating Disorder Examination Questionnaire-Short (EDE-QS). The survey was delivered via an online questionnaire hosted by Qualtrics (www.qualtrics.com, accessed on 11 January 2023).

2.2. Participants and Recruitment

English-speaking participants were recruited from a publicly funded multidisciplinary weight-management program in Sydney between 17 January 2023 and 6 July 2023. The clinic criteria are detailed in previous publications [21–23]. As part of routine clinical care, participants are asked to complete pre-treatment questionnaires, which also include clinical measures assessed in the clinic (e.g., weight and height). Data were collected as part of an ongoing Quality Assurance project (QA Approval CT_19_2021) and an ethics-approved study (2019_ETH08677) within the program, where consent had previously been provided to be contacted for future studies. Participants with an EDE-QS score ≥ 15 [24], or with a history of an ED, were identified and asked whether they could be approached for recruitment into the current study and provided with the participant information sheet. Before commencing the study, participants were screened to ensure they had previously seen a dietitian. Exclusion criteria included being unable to complete the survey, not having a recorded EDE-QS score ≥ 15 , not having experienced treatment with a dietitian, and being <18 years old.

2.3. Measures

2.3.1. Demographics and Background

Participants were asked questions regarding demographics (e.g., age, ethnicity, employment status, education) and clinical characteristics (e.g., height and weight, ED and mental health diagnosis, and treatment history).

2.3.2. Eating Disorder Examination Questionnaire Short (EDE-QS)

The EDE-QS is a 12-item short-form version of the Eating Disorder Examination Questionnaire, with a 4-point response scale that assesses ED psychopathology. The tool has been validated and provides a brief, reliable measure of ED symptomatology severity, and an EDE-QS score ≥ 15 has been demonstrated to be an accurate cut-off to aid in screening for clinically significant ED symptoms indicative of an ED [24,25]. Therefore, participants were selected based on an EDE-QS score ≥ 15 .

2.3.3. Eating Disorder Treatment Experiences Survey (EDTES)

This questionnaire consists of closed and open-ended questions about participants' perceptions of their ED treatment. Participants were first asked how many dietitians they had seen in the past. If participants had seen more than one dietitian, they were asked to answer two sets of the same questions, one about their most helpful dietitian treatment and one about their least helpful dietitian treatment. If participants had seen only one dietitian, they were asked questions about their experiences with the one dietitian. This was followed by multiple-choice questions focused on obtaining their general treatment history as well as investigating the perceived role of the dietitian.

Participants were then asked a series of questions adapted from the Session Rating Scale [26]. These were included to understand participants' experiences of treatment components and their perceived working alliance with the dietitian, as well as the participants' overall perceived treatment helpfulness. These questions used a sliding scale (0 to 100,

Range: 100) where 0 was associated with negative perceptions and 100 was associated with positive perceptions. The criterion validity and internal consistency of the original measures in the EDTES have been demonstrated by Mital et al. [20]. In the present sample, internal consistency was high for the adapted most helpful (Cronbach's alpha = 0.954, $n = 14$, 12 items) and least helpful (Cronbach's alpha = 0.940, $n = 14$, 12 items) dietitian treatment items.

Finally, participants were asked a series of open-ended questions about what they perceived as helpful and unhelpful about their experience(s) with a dietitian. Open-ended questions also asked participants how the treatment provided by a dietitian was similar or different to, or more or less helpful than, that provided by other members of their treatment team.

2.4. Data Analysis

2.4.1. Exploratory Quantitative Analyses

Data were cleaned and inspected for normality. Data processing and statistical analyses were completed using IBM SPSS Statistics Version 29.0 [27]. Missing values were computed via mean substitution given the small data pool (only one EDE-QS rating was missing in the current data). BMI was calculated using the provided weight and height measures.

Responses to the multiple-choice questions addressing the perceived roles of the dietitian were interpreted as the frequency and percentage of common responses (i.e., how many participants reported that they perceived the dietitian's role as being helping with meal planning, food diary keeping/logging, education about food/nutrition, etc.). If participants had seen more than one dietitian, responses were counted for each dietitian reported on.

Participant working alliance measures were reported as the median (IQR) of the sliding scale ratings. Responses for each dietitian (i.e., most helpful dietitian and least helpful dietitian) were entered as two separate values. As was conducted in the Mital et al. paper [20], ratings relating to participants' treatment preferences and choices being taken into consideration were also averaged to produce an additional variable. Due to the small sample size of participants who had seen more than one dietitian ($n = 14$), adjustments for multiple testing were not made, and differences between groups were tested with the conservative Wilcoxon signed ranks test, with p set at ≤ 0.05 .

2.4.2. Qualitative Analyses

The six phases of reflexive thematic analysis as described by Braun and Clarke (2022) [28] were employed to explore participants' treatment experiences, including patterns of meaning, across open-ended survey responses. One author (YY) read and re-read written survey responses to gain familiarity. YY then coded the responses and generated initial themes from the codes. The initial themes were further developed and reviewed with JC, PH, CM, and MP. The themes were then refined, defined, and named, and the current report was produced. This was an iterative, flexible, and recursive process that required researchers "to move back and forth through the phases as necessary" [29].

Reflexivity was practised through critically questioning how each author's background and positionality may have influenced data interpretation. All authors are clinicians (YY and CM are dietitians, JC is a clinical psychologist, PH is a psychiatrist, and MP is an endocrinologist) who have worked with people who have experienced an ED and have also conducted research on EDs. YY kept a reflective journal to document the reflexive process, and research supervision meetings with open discussions were scheduled regularly with JC, PH, CM, and MP.

3. Results

3.1. Participants

A total of 18 participants with an average age of 33.7 ($SD = 11.3$, Range: 31–67) years completed the survey. Most of the participants were female (83.3%), white (66.7%),

separated/divorced/widowed (50.0%), and living with family (66.7%). Half were undertaking paid work and most had obtained tertiary educations (88.9%). The mean BMI was 49.9kg/m² (*SD* = 12.8, Range: 28.8–80.0). Most participants (88.9%) identified as having experienced ED symptoms. Half reported a formal diagnosis with an ED and 37.5% reported receiving treatment for an ED. Participants reported binge eating disorder (BED) as the most diagnosed ED (27.8%). The mean EDE-QS score was 20.9 (*SD* = 6.0) at the time of the survey. Participants' characteristics are reported in Table 1.

Table 1. Participants' characteristics.

Characteristic	<i>n</i> (%) or Mean ± <i>SD</i>
Total sample	18
Age (years) (mean ± <i>SD</i>)	33.7 ± 11.3 Range: 31–67
Sex (<i>n</i> (%))	
Female	15 (83.3)
Male	3 (16.7)
Ethnicity (<i>n</i> (%))	
White	12 (66.7)
Aboriginal/Torres Strait Islander/Maori/Pacific Islander	5 (27.8)
Relationship status (<i>n</i> (%))	
Married/De-Facto/In a relationship	7 (38.9)
Separated/Divorced/Widowed	9 (50.0)
Living situations (<i>n</i> (%))	
Alone/Shared accommodation	6 (33.3)
With family	12 (66.7)
Employment status ** (<i>n</i> (%))	
Paid work (full time, part-time, or casual)	9 (50.0)
Unemployed/Unemployment benefits/Pensioner	7 (38.9)
Other (i.e., student, retired, parent, unpaid volunteer)	6 (33.4)
Highest level of education (<i>n</i> (%))	
Tertiary education	16 (88.9)
BMI (kg/m²) (<i>n</i> (%))	49.9 (12.8) Range: 28.8–80.0
Eating disorder history (<i>n</i> (%))	
Identified as having experienced eating disorder symptoms	16 (88.9)
Diagnosed with an eating disorder (<i>n</i> = 16 *)	8 (50)
Received treatment for an eating disorder (<i>n</i> = 16 *)	6 (37.5)
Diagnosed BED **	5 (27.8)
Other ED diagnosis (i.e., ARFID, BED, SEED, OSFED, unknown) **	6 (33.3)
EDE-QS (mean ± <i>SD</i>)	
At time of survey	20.9 ± 6.0 ***

Abbreviations: *ARFID* (avoidant and restrictive food intake disorder), *BED* (binge eating disorder), *BMI* (body mass index), *ED* (eating disorder), *EDE-QS* (Eating Disorder Examination Questionnaire Short), *OSFED* (other specified feeding and eating disorder), *SEED* (severe and enduring eating disorder). N.B. Cell sizes <five were not reported to preserve participant confidentiality. * Only participants who identified as having experienced ED symptoms were asked these questions. ** Participants were able to select more than one response. *** Two participants had an EDE-QS score < 15 at baseline but at the time of this current survey had an EDE-QS score > 15.

3.2. Quantitative Dietitian Results

Most participants (*n* = 14, 87.5%) had seen more than one dietitian. Participant responses regarding the perceived role of a dietitian are outlined in Table 2. On inspection, there were few differences observed between groups (i.e., most and least helpful dietitian) regarding the perceived roles of a dietitian for those who saw more than one dietitian, and statistical analyses were not conducted because of low cell sizes.

Table 2. Perceived roles of a dietitian.

Role	Saw One Dietitian (<i>n</i> = 4)	Saw > One Dietitian: Most Helpful (<i>n</i> = 14)	Saw > One Dietitian: Least Helpful (<i>n</i> = 14)
	Frequency <i>n</i> (%)		
Helping with meal planning	3 (75)	7 (50)	11 (78.6)
Food diary keeping/logging	3 (75)	7 (50)	6 (42.9)
Education about food/nutrition	3 (75)	9 (64.3)	11 (78.6)
Dietetic counselling overlapping with aspects of ED treatment *	1 (25)	6 (42.9)	4 (28.6)
Addressing concerns about weight **	0 (0)	11 (78.6)	10 (71.4)
Supportive therapy ***	1 (0)	6 (42.9)	6 (42.9)
Other	1 (25)	3 (21.4)	1 (7.1)

* Dietetic counselling overlapping with aspects of ED treatment items: (1) education about how the eating disorder affects my body, (2) monitoring my physical health, and (3) helping me with my body-image concerns.

** Addressing concerns about weight items: (1) helping me with my concerns about my weight, and (2) weight-loss advice. *** Supportive therapy items: (1) talking about problems outside of food, and (2) supporting me.

The results and analyses of the adapted Session Rating Scale questions in the EDTES are shown in Table 3. Ratings relating to participants' treatment preferences and choices being taken into consideration were significantly different between groups and favoured the most helpful dietetic treatment experience ($Z = -1.96, p = 0.05$). Ratings of whether the treatment approach worked for the participant were also significantly different between the most helpful and least helpful dietetic experiences, favouring the most helpful treatment ($Z = -2.223, p = 0.026$). Whilst not meeting statistical significance, there was a statistical trend favouring feeling understood by the most helpful compared to the least helpful dietitian ($Z = -1.833, p = 0.060$).

Table 3. Working-alliance measures adapted from the Session Rating Scale.

Measure	Saw One Dietitian (<i>n</i> = 4)	Saw > One Dietitian: Most Helpful (<i>n</i> = 14)	Saw > One Dietitian: Least Helpful (<i>n</i> = 14)	Wilcoxon Signed Ranks Test *
	Median (IQR)			<i>Z</i> (<i>p</i>)
1. When I sought this treatment, I thought change was important or possible	76.0 (57.3)	86.5 (18.5)	91.0 (33.5)	-0.979 (0.328)
2. The treatment approach worked well for me	72.0 (26.5)	43.0 (53.0)	17.0 (51.5)	-2.223 (0.026)
3. The treatment approach met my hopes and expectations	69.5 (14.3)	24.5 (68.5)	16.5 (52.3)	-0.801 (0.423)
4. The treatment approach assisted me in shifting my relationship with difficult emotions	74.0 (20.8)	21.5 (64.5)	13.5 (43.3)	-1.274 (0.203)
5. The treatment approach assisted me in recovering from the eating disorder	65.0 (NA) ** (<i>n</i> = 2)	29.0 (54.8)	8.5 (51.5)	-1.334 (0.182)
6. The treatment approach assisted me in recovering from my food/eating concerns	64.0 (53.5)	28.5 (50.0)	8.5 (51.3)	-1.355 (0.176)
7. The treatment approach took into consideration my treatment preferences	55.0 (62.8)	34.5 (69.8)	12.0 (55.8)	-2.118 (0.034)
8. The treatment approach gave me freedom to make my own choices around change	56.0 (66.8)	71.0 (63.8)	27.0 (78.0)	-1.726 (0.084)
9. The dietitian/nutritionist did make me feel understood	82.5 (47.5)	46.5 (84.25)	13.0 (51.8)	-1.833 (0.060)
10. The dietitian/nutritionist did address my concerns	81.0 (19.3)	55.0 (76.3)	16.0 (41.3)	-1.538 (0.124)
11. The dietitian/nutritionist did instil hope for recovery	81.5 (14.0)	49.0 (71.8)	46.5 (63.5)	-1.049 (0.294)
12. Overall, how helpful do you think the dietitian/nutritionist was?	86.0 (7.3)	27.5 (83.0)	25.5 (54.8)	-1.328 (0.184)

N.B. Responses to questions were scored as 0 = most negative response, 100 = most positive response. * Statistical test for differences between ratings of most and least helpful dietitians (*n* = 14). ** Question only applied to those identifying as having had treatment for an eating disorder or disordered eating symptoms.

3.3. Qualitative Dietitian Results

The thematic analysis generated three primary themes from the data: (1) nutritional knowledge and skills, (2) person-centred care, and (3) roles of the multidisciplinary team. Figure 1 provides a visualisation of the relationship between themes and subthemes.

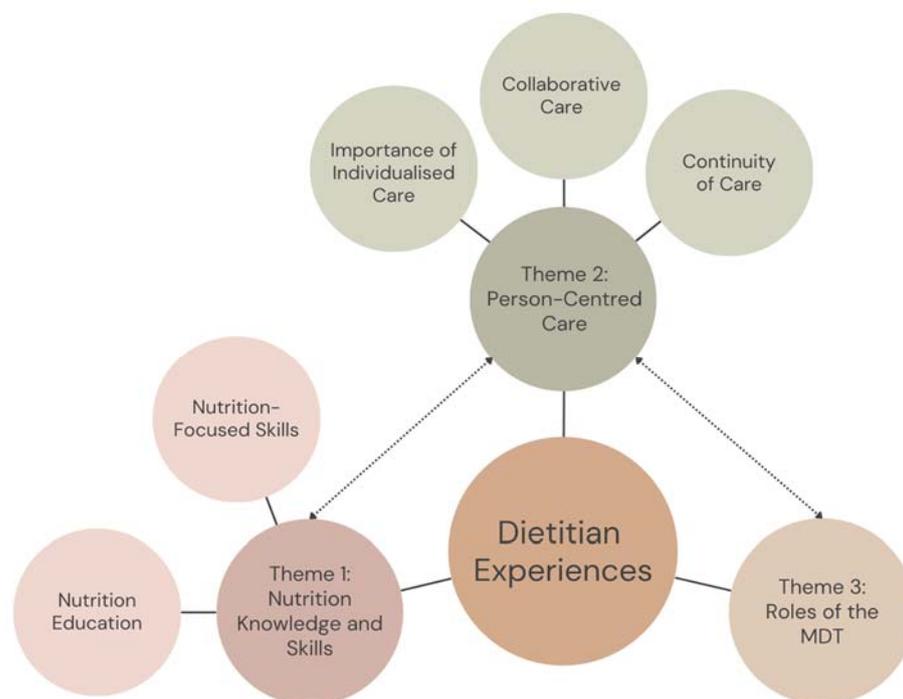


Figure 1. Summary of themes and subthemes.

3.3.1. Theme 1: Nutrition Knowledge and Skills

Subtheme 1(a): Nutrition Education

Nutrition education was mentioned by several participants as being a helpful part of dietetic treatment. Learning “*interesting and varied information*” (P403) about the “*consequences of poor eating choices*” (P403) and being made “*More... aware of what I was doing to myself*” (P624) allowed participants to understand how their food choices impacted their body.

“I’ve learned that I am doing what is needed to fuel my body with solid nutrition.” (P317)

“[The dietitian] help[ed] me to understand why my body reacts the way that it does when I fast or binge eat” (P265)

“I did gain more awareness of nutritional values of certain foods.” (P3)

“advising me on different things to try and what foods to avoid” (P548)

Here, the dietitian’s expertise in “*food nutritional values*” (P43) and physiology provided the participants with information about how their bodies functioned and how they could “*fuel*” their bodies. One participant noted that this was not part of their care and “*would have liked food and nutrition to be part of the discussion*” (P317). However, other participants found the information provided by the dietitian to be inadequate and one participant perceived their dietitian to be “*uninformed*” (P207).

“I felt like my questions weren’t been [sic] answered fully, as I assumed they didn’t have the answers and I was just ignored or not answered at all. How can we all have the same metabolism when I’m insulin-resistant and have PCOS? ... I have no answers.” (P265)

“This was the least helpful person in the office for ulcerative colitis care. There wasn’t any dietary help other than to avoid fibre completely and don’t eat foods that trigger response.” (P317)

In these instances, participants were frustrated by the information provided by their dietitians because it was not perceived to be tailored to their unique needs, nor were they provided with the information that they were seeking. This is exemplified by P357, who described their least helpful dietetic treatment as *“not in depth and not specific to my needs”*.

Subtheme 1(b): Nutrition-Focused Skills

Participants commented on several nutrition-focused skills that they perceived as helpful in their dietetic treatment. One skill set that was mentioned multiple times was meal planning and portion-size awareness building.

“... meal plans and guidance around portion control and recipes and ideas helps with energy in and energy out proportions” (P357)

“Helping with a meal plan that works around my numerous allergies and intolerances including Coeliac Disease, also giving ideas around portion sizes and recipes are helpful” (P83)

Implicit in these accounts was that these participants were ready to listen to the dietitian’s advice and guidance on meal planning, recipe ideas, and portion sizes. For other participants who were also likely preparing for change, the absence of these interventions was noted as not meeting their needs, for example, *“I would of liked a food plan of what to eat daily” (P51)* and *“A more in depth approach and coaching around food choices would be useful” (P357)*. On the other hand, some participants identified that these interventions *“did not work”*:

“It was difficult to adhere to any dietary plans for me so this ... did not work for me. I find it very difficult to live the regimented lifestyle that is required by a restricted diet laid out by dietitians. I do not consider this their fault, it is mine and as such I need to take control of my lifestyle as it is apparent to me that the only person to achieve weight loss is myself.” (P43)

“Portion control [was unhelpful], because it made me want more, more hungrier.” (P549)

“Usually the dietitian talks about what I eat, what I want to change, and tells me to keep a food diary. But it doesn’t really help with anything” (P51)

These extracts highlight the challenges that can arise when the dietitian’s recommendations or approaches are not matched to an individual’s readiness to change. As a result, efforts made by the dietitian to facilitate behaviour change through more action-oriented strategies such as meal plans, portion control, and food diaries, inadvertently exacerbated an individual’s struggles to elicit change within themselves. Implied in these extracts is a mismatch where the intervention provided by the dietitian was not consistent with their patient’s stage of change, i.e., the participant did not think change was possible and felt helpless about changing their eating. This had the effect of participants blaming themselves (*“fault, it is mine” (P43)*) and/or the dietitian (*“didn’t really help with anything” (P51)*) and may have led to a parallel process of helplessness in the therapeutic relationship. The result of this process is the dietitian pursuing action-oriented strategies to resolve their own feelings of therapeutic impotence, which are ultimately countertherapeutic.

3.3.2. Theme 2: Person-Centred Care

Subtheme 2(a): “One Sheet Does Not Fit All”—The Importance of Individualised Treatment

Dietetic treatment that was tailored to the participant was desired, and many participants identified when this was lacking by expressing a want to be *“treated like an individual person” (P207)* and *“listen[ed] to” (P243)*:

“[I would have liked] To be dealt with as an individual (that is, get to know me and my issues) to tailor treatment and not just apply a 1 size fits all approach.” (P3)

“Listen to the client, if they don’t follow the textbook rulings then you need to be flexible and move away from the one sheet fits all and stop printing out the same recommendation for all patients. Sit and plan, take time to get to know what the patient requires rather than already preparing a treatment for them.” (P243)

“[I would have liked] For them to be more understanding and to realise that everyone is different. We are not all textbooks, we are all different.” (P83)

Within these excerpts, the participants conveyed a longing to be *“heard and understood”* (P317), to be seen as *“not [just] their history”* (P207), and to be treated as individuals rather than as a *“textbook”* (P243, P83). This extended to participants wanting personalised advice that took into consideration their circumstances, such as *“specific food goals, lifestyle and allergies/intolerances”* (P357).

“[I would have liked] Dietary plans and meal suggestions that were able to be made at home with a family instead of being on shakes for years. These are not sustainable nor economical nor the right image for people to be portraying to teenage girls in the household. Promoting healthy eating as a family should be considered rather than individual responsibility. (P243)

“Each dietitian recommended a different type of shake, most said they were lactose free but still made me sick!” (P207)

“[The dietitian] recommended Optifast shakes and unrealistic options for my lifestyle—like salad for lunch and shake for breakfast/dinner. Have kids.” (P513)

Furthermore, dietetic care that was focused on advice-giving was perceived by some participants as *“not sustainable”* and *“unrealistic”*, ultimately leading to a lack of change and the participants perceiving the dietitian as unhelpful. Being given handouts (*“sheet[s]”*) was emblematic of this generic care:

“the endless supply of information sheets that came with not much-perceived value.” (P3)

“dietitian provided printouts only and general advice only” (P403)

“just given paper with recipes which made no sense to me after telling her I didn’t know how to cook” (P613)

“It was more handouts and what everyone else followed by the recommended diet menu given [and] made by them.” (P265)

“maybe someone who even wanted to be in that job. She clearly didn’t even want to be there. Just throwing papers at me” (P612)

For these participants, handouts provided by the dietitian were perceived as a lack of interest in their care and contributed to a sense that the dietitian *“didn’t even want to be there”*. By receiving what was perceived as general and non-specific care, participants felt like the dietitian did not see them as individuals (e.g., had *“blinkers on”*—P83) and one participant suggested that the dietitian may have been *“directed at meeting the goals of the office in a positive light”* (P317) instead of focusing on their care. This highlights the often invisible pressure on dietitians to produce nutritional change in the people with whom they work and the assumption that nutrition education will result in change for all individuals. Alternatively, when care was tailored to the participant’s unique nutritional needs, such as when a dietitian *“Help[ed] with a meal plan that works around my numerous allergies and intolerances including Coeliac Disease”* (P357), this was perceived as the most helpful aspect of dietetic treatment.

Subtheme 2(b): Collaborative Care

Collaborative care that centred on supporting the person’s autonomy was perceived positively by participants. The relationship between participants and their dietitians was a

factor that was frequently noted as contributing significantly to the treatment experience. Participants identified that dietitians who provided helpful care were also ones who related to and supported them.

“Understanding of what I am going through. . . Positive attitude, honest and straight to the point. . . Very supportive. . . Reassuring me that it’s ok to slip up from time to time” (P265)

“Reminder to never say never. . . Never give up, always start again” (P549)

In these extracts dietitians who provided “reassurance” and encouragement were perceived positively, thus highlighting the importance of compassionate treatment that cultivates a therapeutic relationship and builds up hope for the person (“never give up”). Shared experiences also helped one participant to further feel connected with their dietitian:

“She had a weight problem she made me feel understood. She didn’t speak down to you, and asked things like, “Do you think you could try this?” She talked to me and asked me questions, didn’t just tell me to do things. And she’d say to me, “I want to know what you don’t like”. If dietitians have been around people with a weight problem (like a close friend or family) or have had a weight problem they understand more what you’re going through. She spoke to me like a friend. . . She shared that she had to watch what she ate as well.” (P83)

Here, appropriate self-disclosure from the dietitian about their own lived experience of “weight problem[s]” fostered a sense of safety for the participant. Furthermore, treating participants “as an adult makes a big difference” (P548) as the dietitian’s prioritisation of the participant’s expertise in themselves contributed to the sense of feeling “understood”. In contrast, dietitians who did not centre the individual’s experience elicited negative responses:

“Telling me what to do. . . Not helpful. . . Very boss[y]. . . Not very understanding” (P624)

“I went to the [dietitian] and wrote down everything I’d eaten and she looked at it, pushed the book towards me and said, “I’ve seen people in the hospital who eat less than you and have lost more weight than you.” (P83)

Disregarding a participant’s autonomy or having a judgmental attitude had the effect of (inadvertently) eroding the therapeutic relationship, with one participant emphasising this by comparing the support they received from social media groups: “Facebook groups are so much more helpful and supportive than [the dietitians at the clinic] have been” (P83).

Subtheme 2(c): Continuity of Care

Participants expressed a desire for uniform and consistent care in their interactions with dietitians, emphasising the limitations imposed when this was not provided:

“Having numerous dieticians was restrictive to treatment as no consistency to continue my treatment or ongoing relationship with dietician [sic]” (P357)

“They all have something different to say, each to their own. They all have a different education background so it’s whatever avenue you want to take in the end.” (P513)

These participants highlighted the challenges associated with having multiple dietitians, identifying a lack of “relationship” building and contradicting information as sources of frustration. This resulted in what one participant summarised as “Irregular and uninformed” (P207) dietetic treatment. Other participants echoed these sentiments and would have liked “A bit more 1 on 1 time” (P548), especially “More [appointments] and from the same dieti[t]ian” (P207), indicating a preference for a sustained and trusting relationship with a single professional.

Barriers to communication and treatment accessibility were also of concern for participants, as demonstrated in the following extracts:

“I had my surgery and the dietitian I see at the moment, I tried to ring but couldn’t get through. She rang back a week later.” (P83)

“More time with her—she went on maternity leave.” (P83)

These instances where the dietitian was unavailable further emphasised the value participants placed on continuity and reliability in their care. One participant also accentuated the financial burden of treatment, expressing disappointment with the cost of services as they *“Expected a better price[.] I remember it being very expensive”* (P513). Moreover, the suggestion for *“A support group Or [sic] online support group or phone consult support group”* (P624) demonstrated a recognition of the need for additional care.

3.3.3. Theme 3: The Roles of the Multidisciplinary Team

Participants’ experiences emphasised the differing roles of a multidisciplinary team (MDT)-care approach in providing holistic care. Dietitians who were considered more helpful were those who were *“more in depth”* (P559):

“They are less worried about my blood pressure and that side of things which doctors and everyone else checks. They are focused more on what will help me be healthy. You can give up cigarettes or alcohol, but you can’t give up food—understanding the difference and being supportive makes a difference.” (P548)

This participant noted the unique focus that their dietitian had on fostering a supportive environment and acknowledging the challenges of altering food habits as opposed to focusing solely on medical care components. However, another participant identified that the dietitian’s role in their treatment was *“Food specifically”*, whilst other MDT members focused on the *“feelings of food, physical exercise and hormonal impacts”* (P357). Here, emotional considerations emerged as pivotal, as *“feelings of food”* were identified as significant aspects of care. This perspective was shared by other participants:

“I had to write down my moods as well and this made me feel understood as well.” (P83)

“It is difficult because it is a mental health problem and you need to get your head right, that’s the important part. I don’t think they could do that much different. Support in mental health would be good but I don’t know if they can.” (P548)

This desire for mental health to be addressed by dietitians highlights a grey area in treatment roles, specifically between dietitians and health professionals who focus on psychological care (e.g., psychologists) and the nuanced interplay between dietetics and mental health care within an MDT framework. Psychologists were cited as providing valuable support by multiple participants:

“Psychologist offered more helpful support regarding emotional factors” (P403)

“Seen a psychologist and they care about your background history [and] not so much what you’re eating. They’re more about self belief.” (P513)

“Private paid regular psychologist has done more than the whole irregular team at the . . . clinic” (P207)

Inherent in the psychologist’s role was *“emotional”* support and supporting the person to believe in themselves, an aspect of dietetic treatment that was also identified as helpful in subtheme 2(b). A service-provider challenge was the need for regularity and consistency in the care provided by the MDT members, mirroring the desire for consistency in dietetic treatment outlined in subtheme 2(c). The importance of continuity in MDT care was reiterated by other participants:

“The most helpful thing I feel is the consolidation aspect of the treatment team’s message [provided by dietitian]” (P3)

“There is no follow-up. I don’t know if it’s because I’m a public patient.” (P83)

Coordinated care was identified as a key component of effective treatment, with these participants valuing the *“consolidation”* of messages from the MDT (including the dietitian) and expressing concern when there was a lack of follow-up, particularly by participants receiving care within the public system.

4. Discussion

4.1. Summary of Findings

This exploratory study investigated satisfaction with dietetic treatment experiences from the perspectives of individuals experiencing high ED symptomatology, who were attending a metabolic and bariatric clinic. A secondary aim was to understand the perceived role of a dietitian and if it included the management of ED symptomatology. The findings indicate that participants perceived the role of a dietitian to focus primarily on addressing concerns about their weight and traditional aspects of nutritional care such as meal planning, food diaries, and education about nutrition. Interestingly, dietitians who were rated as more helpful were those perceived to take into consideration the participant's treatment preferences and choices, understand their challenges in changing eating behaviour and match the treatment intervention to their readiness to change. Some participants also perceived the dietitian's role to include counselling aspects that overlap with dietetic ED treatment and the provision of supportive therapy. In addition, coordinated care and continuity were identified as key components of effective treatment, both in relation to the dietitian as well as the MDT.

Dietetic treatment usually incorporates nutrition education and menu planning to facilitate behaviour change in the person seeking treatment [30,31]. The majority of participants from this study reported these traditional aspects of care to be part of their dietitian's role, and some found these helpful. However, these were not necessarily considered the only roles of the most helpful dietitians. Additionally, many participants commented on difficulties in adhering to the dietitian's dietary suggestions and, consequently, reported negative experiences. In these cases, a factor that contributed to the poor experience was that the participant was not ready for change or did not think that change was possible. Motivational interviewing research suggests that when individuals are not ready to change, changes suggested by healthcare professionals can be perceived as coercive or forcible, leading to 'pushback' [32]. Conversely, validation, listening, and affirming personal choice can build collaboration and resolve ambivalence by eliciting change talk within the individual. Participants valued feeling understood by the dietitian and desired treatment that took into consideration their treatment preferences (including their readiness to change) and that was tailored to their circumstances (e.g., lifestyle and co-morbidities). In this way, the findings of this study are consistent with the existing literature and reinforce the significance of a strong therapeutic alliance in predicting positive treatment responses and experiences [20,33–36]. Integral to this was the use of a collaborative approach to treatment that centred around the participants' autonomy. Future research is needed to explore both the 'what' and the 'how' of dietetic treatment for EDs, that is, the content and process of what dietitians do and what is optimal for people with whom they work. This includes research to inform the upskilling of dietitians in how dietetic treatments are delivered to people living with disordered eating and in larger bodies (including in the therapeutic relationship) and matching dietetic treatments to a person's unique needs, preferences, and readiness to change.

Multiple participants identified that mental health concerns intertwined with their eating struggles, despite bariatric and metabolic clinics not traditionally being considered mental health settings. This observation aligns with the participants' elevated EDE-QS scores, indicative of clinically significant ED symptoms [25]. Dietitians who assumed a holistic role were perceived favourably, and some participants reported that their dietitian incorporated elements of care frequently associated with dietetic ED treatment, such as addressing body-image concerns, providing education about how disordered eating can affect the body, and talking to participants about problems outside of their relationship with food. This may be reflective of the limited mental health support in treatment for people living in larger bodies in the Australian health context, and the participants' subsequent desire for these services to be available [37]. Additionally, whilst most participants identified as having experienced ED symptoms, and 27.8% reported a diagnosis of BED, only 37.5% reported receiving treatment for an ED. These findings are in line with the

results of a systematic review by Hart et al. [38] which suggests that 30–75% of individuals with a diagnosable ED seek weight-loss treatment, whereas only 23.2% seek ED treatment. Considering the previously demonstrated high rate of clinically significant ED symptoms in this population, it is concerning that only a small proportion have undergone treatment for disordered eating [21]. Weight stigma and healthcare providers who practice weight-normative treatment models may contribute to patient avoidance and lead to the inadequate recognition and treatment of EDs in individuals living in larger bodies [3,11].

Additionally, dietetic interventions in these contexts frequently include guidance on weight loss, and there is minimal evidence to guide clinical practice [30]. In contrast, approaches that normalise eating patterns and alleviate symptoms of disordered eating and BED often diverge from recommendations for weight loss [3]. Furthermore, data from meta-analyses indicate that behavioural weight loss is at best linked to short-term moderate weight loss for individuals experiencing binge eating disorder [39]. Therefore, there is a need for more research to investigate the specific elements of treatment provided by dietitians that prove beneficial in this demographic and what additional training is required to address outcomes other than weight loss for people living in larger bodies. In addition, there is a need for enhanced screening practices for EDs before the implementation of weight loss interventions and investigations into what role a dietitian may play in this process [13].

Those participants who saw multiple dietitians found that it diluted their therapeutic relationship, potentially leading to dissatisfaction and poorer outcomes. Worsening this was that contradictory information could also be provided. It was also found that participant emphasis on continuity of care extended to the MDT setting. It is important to note that participants greatly valued the consistency of care providers, and high staff turnover and a lack of funding within an overburdened public health system make this difficult to achieve and result in poorer patient outcomes [40–42]. This presents an additional barrier to the provision of individualised care as dietitians are put under unrealistic expectations to engage individuals in active behaviour change with limited time and resources. A product of this is the provision of non-specific treatment, such as in the form of handouts that were perceived by participants as being unhelpful. There is a need to address this common health service dilemma at an organisational level to improve staff retention and provider continuity to allow for the development of a robust therapeutic alliance.

4.2. Strengths and Limitations

The current study contributes novel insights into the understanding of dietetic treatment experiences of individuals in larger bodies experiencing high ED symptomatology, filling a gap in the existing literature. The adoption of a mixed-methods study design incorporating both quantitative and qualitative analyses enabled a more comprehensive understanding of treatment experiences through triangulation. Furthermore, the study sample was sufficiently large for qualitative analysis and the reliability and internal consistency of the EDTES were high, enhancing the robustness of the findings. The high completeness of the dataset and the use of a replicable methodology also enhanced the study's credibility and potential for replication in future research.

This notwithstanding, several limitations must be acknowledged in the interpretation of these findings. Given the exploratory nature of the study, the sample size for quantitative analysis was relatively small and adjustments for multiple testing were not conducted. Therefore, caution should be taken in interpreting inferential statistics due to the inherent risk of type 1 and type 2 errors. Nevertheless, the quantitative results were consistently aligned with qualitative findings and were in line with the conclusions of prior research regarding treatment preferences [34]. The EDTES survey is also a relatively new instrument with limited use to date. Further testing and validation to establish its reliability and applicability in varied populations is warranted. The dietetic treatments received by individuals were also not standardised, and some had received treatment specifically for an ED, making it difficult to extricate data about specialist ED dietitians from those providing

more generalised advice. Finally, the study's sample was composed predominantly of ethnically white females from a single clinic in a predominantly English-speaking country, thus limiting the generalisability of the findings. Future research could replicate this study in a larger and more diverse sample across multiple clinics to enhance the external validity of findings. Furthermore, investigating potential moderating variables, such as socio-demographic factors and comorbidities, could elucidate nuanced influences on treatment experiences.

5. Conclusions

This exploratory study emphasised the importance of tailoring dietetic care to accommodate individual preferences in treatment for people experiencing high ED symptomatology. The imperative for a strong therapeutic alliance developed through consistent care was also demonstrated. The results indicate that the dietitian's role may extend beyond weight-loss advice for those attending a bariatric and metabolic clinic. This role may include supportive counselling, working with an individual's readiness to change, and motivational approaches, similar to strategies used in the dietetic treatment of EDs. However, more research is required to understand what additional training dietitians require to address ambivalence to nutritional change, and how dietitians can help enhance screening for EDs prior to weight-loss interventions. Future research should also further explore what aspects of care a diverse range of people in larger bodies experiencing high ED symptomatology find helpful, or unhelpful, about dietetic treatment.

Author Contributions: Conceptualisation, Y.Y., P.H., J.C., M.K.P. and C.M.M.; methodology, Y.Y., P.H., J.C., M.K.P. and C.M.M.; validation, Y.Y., P.H., J.C. and M.K.P.; formal analysis, Y.Y., P.H., J.C., C.M.M. and M.K.P.; investigation, Y.Y.; resources, M.K.P., P.H. and J.C.; data curation, Y.Y.; writing—original draft preparation, Y.Y.; writing—review and editing, Y.Y., P.H., J.C., M.K.P. and C.M.M.; visualisation, Y.Y.; supervision, P.H., J.C., C.M.M. and M.K.P.; project administration, Y.Y.; funding acquisition, Y.Y. All authors have read and agreed to the published version of the manuscript.

Funding: Y.Y. is the recipient of a Research Training Program Stipend Scholarship from the Australian Government, Department of Education and Training.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the South Western Sydney Local Health District Human Research Ethics Committee (reference: 2022/ETH01239, date of approval: 11 October 2022).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgments: The authors would like to thank the participants as well as the staff from the South Western Sydney Metabolic Rehabilitation and Bariatric Program (SWS MRBP) in Camden Hospital who helped with recruitment. The Eating Disorders Treatment Experiences Survey was designed by Janet Conti, Phillipa Hay, and Tanya Meade.

Conflicts of Interest: P.H. and M.P. have been funded by Takeda Pharmaceuticals for speaking engagements as consultations. All other authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

References

1. Paxton, S.J.; Hay, P.; Touyz, S.W.; Forbes, D.M.; Girolsi, F.S.; Doherty, A.; Cook, L.; Morgan, C. *Paying the Price: The Economic and Social Impact of Eating Disorders in Australia*; Butterfly Foundation: Sydney, Australia, 2012.
2. da Luz, F.Q.; Sainsbury, A.; Mannan, H.; Touyz, S.; Mitchison, D.; Hay, P. Prevalence of obesity and comorbid eating disorder behaviors in South Australia from 1995 to 2015. *Int. J. Obes.* **2017**, *41*, 1148–1153. [[CrossRef](#)] [[PubMed](#)]
3. Ralph, A.F.; Brennan, L.; Byrne, S.; Caldwell, B.; Farmer, J.; Hart, L.M.; Heruc, G.A.; Maguire, S.; Piya, M.K.; Quin, J.; et al. Management of eating disorders for people with higher weight: Clinical practice guideline. *J. Eat. Disord.* **2022**, *10*, 121. [[CrossRef](#)]
4. D'Souza, C.; Hay, P.; Touyz, S.; Piya, M.K. Bariatric and Cosmetic Surgery in People with Eating Disorders. *Nutrients* **2020**, *12*, 2861. [[CrossRef](#)] [[PubMed](#)]

5. Hay, P.; Mitchison, D.; Collado, A.E.L.; González-Chica, D.A.; Stocks, N.; Touyz, S. Burden and health-related quality of life of eating disorders, including Avoidant/Restrictive Food Intake Disorder (ARFID), in the Australian population. *J. Eat. Disord.* **2017**, *5*, 21. [[CrossRef](#)] [[PubMed](#)]
6. McEntee, M.L.; Philip, S.R.; Phelan, S.M. Dismantling weight stigma in eating disorder treatment: Next steps for the field. *Front. Psychiatry* **2023**, *14*, 1157594. [[CrossRef](#)] [[PubMed](#)]
7. Conceição, E.M.; Utzinger, L.M.; Pisetsky, E.M. Eating Disorders and Problematic Eating Behaviours Before and After Bariatric Surgery: Characterization, Assessment and Association with Treatment Outcomes. *Eur. Eat. Disord. Rev.* **2015**, *23*, 417–425. [[CrossRef](#)] [[PubMed](#)]
8. Sogg, S.; Lauretti, J.; West-Smith, L. Recommendations for the presurgical psychosocial evaluation of bariatric surgery patients. *Surg. Obes. Relat. Dis.* **2016**, *12*, 731–749. [[CrossRef](#)] [[PubMed](#)]
9. Tylka, T.L.; Annunziato, R.A.; Burgard, D.; Daniélsdóttir, S.; Shuman, E.; Davis, C.; Calogero, R.M. The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. *J. Obes.* **2014**, *2014*, 983495. [[CrossRef](#)] [[PubMed](#)]
10. Lawson, J.L.; LeCates, A.; Ivezaj, V.; Lydecker, J.; Grilo, C.M. Internalized weight bias and loss-of-control eating following bariatric surgery. *Eat. Disord.* **2021**, *29*, 630–643. [[CrossRef](#)] [[PubMed](#)]
11. Mensinger, J.L.; Tylka, T.L.; Calamari, M.E. Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image* **2018**, *25*, 139–147. [[CrossRef](#)] [[PubMed](#)]
12. Phelan, S.M.; Burgess, D.J.; Yeazel, M.W.; Hellerstedt, W.L.; Griffin, J.M.; van Ryn, M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes. Rev.* **2015**, *16*, 319–326. [[CrossRef](#)]
13. McMaster, C.M.; Paxton, S.J.; Maguire, S.; Hill, A.J.; Braet, C.; Seidler, A.L.; Nicholls, D.; Garnett, S.P.; Ahern, A.L.; Wilfley, D.E.; et al. The need for future research into the assessment and monitoring of eating disorder risk in the context of obesity treatment. *Int. J. Eat. Disord.* **2023**, *56*, 914–924. [[CrossRef](#)] [[PubMed](#)]
14. Yang, Y.; Conti, J.; McMaster, C.M.; Hay, P. Beyond Refeeding: The Effect of Including a Dietitian in Eating Disorder Treatment. A Systematic Review. *Nutrients* **2021**, *13*, 4490. [[CrossRef](#)] [[PubMed](#)]
15. Bariatric Surgery Interest Group, Dietitians Australia. *Bariatric Surgery Role Statement*; Dietitians Australia: Phillip, Australia, 2020.
16. Osland, E.; Powlesland, H.; Guthrie, T.; Lewis, C.-A.; Memon, M.A. Micronutrient management following bariatric surgery: The role of the dietitian in the postoperative period. *Ann. Transl. Med.* **2020**, *8*, S9. [[CrossRef](#)] [[PubMed](#)]
17. Kostecka, M.; Bojanowska, M. Problems in bariatric patient care—Challenges for dietitians. *Wideochirurgia Inne Tech. Mató Inwazyjne* **2017**, *12*, 207–215. [[CrossRef](#)] [[PubMed](#)]
18. Diabetes Interest Group, Dietitians Australia. *Diabetes Role Statement*; Dietitians Australia: Phillip, Australia, 2021.
19. Noordenbos, G.; Oldenhave, A.; Muschter, J.; Terpstra, N. Characteristics and Treatment of Patients with Chronic Eating Disorders. *Eat. Disord.* **2002**, *10*, 15–29. [[CrossRef](#)] [[PubMed](#)]
20. Mital, R.; Hay, P.; Conti, J.E.; Mannan, H. Associations between therapy experiences and perceived helpfulness of treatment for people with eating disorders. *J. Eat. Disord.* **2022**, *10*, 80. [[CrossRef](#)] [[PubMed](#)]
21. Piya, M.K.; Chimoriya, R.; Yu, W.; Grudzinskas, K.; Myint, K.P.; Skelsey, K.; Kormas, N.; Hay, P. Improvement in Eating Disorder Risk and Psychological Health in People with Class 3 Obesity: Effects of a Multidisciplinary Weight Management Program. *Nutrients* **2021**, *13*, 1425. [[CrossRef](#)]
22. Medveczky, D.M.; Kodosi, R.; Skelsey, K.; Grudzinskas, K.; Bueno, F.; Ho, V.; Kormas, N.; Piya, M.K. Class 3 Obesity in a Multidisciplinary Metabolic Weight Management Program: The Effect of Preexisting Type 2 Diabetes on 6-Month Weight Loss. *J. Diabetes Res.* **2020**, *2020*, 9327910. [[CrossRef](#)]
23. Kobuch, S.; Tsang, F.; Chimoriya, R.; Gossayn, D.; O'Brien, S.; Jamal, J.; Laks, L.; Tahrani, A.; Kormas, N.; Piya, M.K. Obstructive sleep apnoea and 12-month weight loss in adults with class 3 obesity attending a multidisciplinary weight management program. *BMC Endocr. Disord.* **2021**, *21*, 227. [[CrossRef](#)] [[PubMed](#)]
24. Gideon, N.; Hawkes, N.; Mond, J.; Saunders, R.; Tchanturia, K.; Serpell, L. Development and Psychometric Validation of the EDE-QS, a 12 Item Short Form of the Eating Disorder Examination Questionnaire (EDE-Q). *PLoS ONE* **2016**, *11*, e0152744. [[CrossRef](#)] [[PubMed](#)]
25. Prnjak, K.; Mitchison, D.; Griffiths, S.; Mond, J.; Gideon, N.; Serpell, L.; Hay, P. Further development of the 12-item EDE-QS: Identifying a cut-off for screening purposes. *BMC Psychiatry* **2020**, *20*, 146. [[CrossRef](#)] [[PubMed](#)]
26. Duncan, B.L.; Miller, S.D.; Sparks, J.A.; Claud, D.A.; Reynolds, L.R.; Brown, J.; Johnson, L.D. The Session Rating Scale: Preliminary psychometric properties of a “working” alliance measure. *J. Brief. Ther.* **2003**, *3*, 3–12.
27. IBM Corp. *IBM SPSS Statistics for Mac, Version 29.0*; IBM Corp: Armonk, NY, USA, 2022.
28. Braun, V.; Clarke, V. *Thematic Analysis: A Practical Guide*; SAGE: London, UK, 2022.
29. Byrne, D. A worked example of Braun and Clarke’s approach to reflexive thematic analysis. *Qual. Quant.* **2022**, *56*, 1391–1412. [[CrossRef](#)]
30. Dietitians Australia. What Dietitians Do in Weight Loss Surgery. Available online: <https://dietitiansaustralia.org.au/sites/default/files/2023-02/Bariatric-Surgery-Role-Statement-2023.pdf> (accessed on 14 December 2023).
31. Dietitians Australia. Diabetes Role Statement. Available online: <https://dietitiansaustralia.org.au/sites/default/files/2022-02/Diabetes-Role-Statement-2021.2.pdf> (accessed on 14 December 2023).

32. Arbuckle, M.R.; Foster, F.P.; Talley, R.M.; Covell, N.H.; Essock, S.M. Applying Motivational Interviewing Strategies to Enhance Organizational Readiness and Facilitate Implementation Efforts. *Qual. Manag. Health Care* **2020**, *29*, 1–6. [[CrossRef](#)] [[PubMed](#)]
33. Swift, J.K.; Callahan, J.L. The impact of client treatment preferences on outcome: A meta-analysis. *J. Clin. Psychol.* **2009**, *65*, 368–381. [[CrossRef](#)] [[PubMed](#)]
34. Delevry, D.; Le, Q.A. Effect of Treatment Preference in Randomized Controlled Trials: Systematic Review of the Literature and Meta-Analysis. *Patient* **2019**, *12*, 593–609. [[CrossRef](#)] [[PubMed](#)]
35. Windle, E.; Tee, H.; Sabitova, A.; Jovanovic, N.; Priebe, S.; Carr, C. Association of Patient Treatment Preference With Dropout and Clinical Outcomes in Adult Psychosocial Mental Health Interventions: A Systematic Review and Meta-analysis. *JAMA Psychiatry* **2020**, *77*, 294–302. [[CrossRef](#)] [[PubMed](#)]
36. Yang, Y.; Conti, J.; McMaster, C.M.; Piya, M.K.; Hay, P. “I Need Someone to Help Me Build Up My Strength”: A Meta-Synthesis of Lived Experience Perspectives on the Role and Value of a Dietitian in Eating Disorder Treatment. *Behav. Sci.* **2023**, *13*, 944. [[CrossRef](#)] [[PubMed](#)]
37. Gooley, M.; Bacus, C.; Ramachandran, D.; Piya, M.; Baur, L. Health service approaches to providing care for people who seek treatment for obesity: Identifying challenges and ways forward. *Public Health Res. Pract.* **2022**, *32*, e3232228. [[CrossRef](#)] [[PubMed](#)]
38. Hart, L.M.; Granillo, M.T.; Jorm, A.F.; Paxton, S.J. 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. [[CrossRef](#)] [[PubMed](#)]
39. Hilbert, A.; Petroff, D.; Herpertz, S.; Pietrowsky, R.; Tuschen-Caffier, B.; Vocks, S.; Schmidt, R. Meta-analysis on the long-term effectiveness of psychological and medical treatments for binge-eating disorder. *Int. J. Eat. Disord.* **2020**, *53*, 1353–1376. [[CrossRef](#)] [[PubMed](#)]
40. Hewko, S.; Oyesegun, A.; Clow, S.; VanLeeuwen, C. High turnover in clinical dietetics: A qualitative analysis. *BMC Health Serv. Res.* **2021**, *21*, 25. [[CrossRef](#)] [[PubMed](#)]
41. De Vries, N.; Lavreysen, O.; Boone, A.; Bouman, J.; Szemik, S.; Baranski, K.; Godderis, L.; De Winter, P. Retaining Healthcare Workers: A Systematic Review of Strategies for Sustaining Power in the Workplace. *Healthcare* **2023**, *11*, 1887. [[CrossRef](#)] [[PubMed](#)]
42. De Vries, N.; Boone, A.; Godderis, L.; Bouman, J.; Szemik, S.; Matranga, D.; de Winter, P. The Race to Retain Healthcare Workers: A Systematic Review on Factors that Impact Retention of Nurses and Physicians in Hospitals. *Inquiry* **2023**, *60*, 00469580231159318. [[CrossRef](#)]

Disclaimer/Publisher’s Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.