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Treatment Targets and Strategies for Eating Disorders Recovery: A Delphi Consensus With Lived Experience, Carers, Researchers, and Clinicians

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ABSTRACT

Objective: Long-term recovery rates following eating disorders (EDs) treatment remain low. This might be partly due to a lack of agreement between key stakeholder groups, including people with lived experience, carers, clinicians, and researchers, regarding optimal therapeutic targets and strategies. We aimed to reach a consensus across these diverse groups on the most valued treatment targets and strategies for fostering ED recovery.

Method: We used the Delphi method with two phases: (i) Survey development and (ii) Expert rating. The survey development phase included the design of an initial set of items through scoping review and feedback from a committee of 14 experts. During the survey rating, we engaged a larger panel of 185 experts who comprised the stakeholder groups: Individuals with lived ED experience ($n = 49$), carers ($n = 44$), researchers ($n = 46$), and clinicians ($n = 46$).

Results: Thirty-one targets and 29 strategies reached consensus (> 70% agreement over three rounds). Psychological-emotional–social targets including quality of life, sense of purpose, and emotion regulation, along with ED behaviors, reached the highest agreement (> 90%). Strategies reflecting an individualized approach to treatment (i.e., considering diversity, assessing

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comorbidities, and enhancing rapport) achieved the highest agreement (> 90%). Responses across groups were similar, except researchers leaning more towards consideration of weight- and eating-related targets.

Discussion: Holistic targets and individualized therapeutic strategies have consistent support from the different stakeholder groups involved in ED treatment. The agreed set of targets/strategies may be used, in triangulation with other sources of evidence, to design and evaluate coproduced and personalized interventions.

Summary

- A shared understanding of recovery-oriented goals and strategies among people with eating disorders, carers, clinicians, and researchers may contribute to informing treatment decisions.
- We found that wellbeing, purpose, healthy emotions, and regular eating were shared goals across these groups.
- Strategies that cater for diverse needs and comorbidities and promote strong therapeutic relationships were valued by all groups and may facilitate treatment involvement.

1 | Introduction

Eating disorders (EDs) are associated with high rates of mortality, physical and psychiatric comorbidities, and economic impacts (Chesney, Goodwin, and Fazel 2014; Iwajomo et al. 2021; Keski-Rahkonen and Mustelin 2016; Streatfeild et al. 2021). There has been substantial progress towards establishing evidence-based treatments for ED, which are currently recommended by clinical guidelines and include adaptations for different presentations (Hay et al. 2014; National Institute for Health and Care Excellence (NICE) 2020; Russell et al. 2023). However, long-term response rates following these treatments remain relatively modest and variable (Carter et al. 2012; Cooper and Bailey-Straebler 2015; Keel et al. 2005; Keel and Mitchell 1997; Mountford et al. 2021; Murray et al. 2019; Treasure, Duarte, and Schmidt 2020). These challenges may reflect the influence of individual factors and the complexity of treatment, which involves multiple stakeholders with varying perspectives (Monteleone et al. 2022; Russell et al. 2023). Therefore, research that seeks to distill individual differences and reconcile diverse stakeholders' perspectives are potentially important to optimize treatments.

Illustrating the impact of diverse perspectives on ED treatment, there is growing recognition of a research-to-practice gap (Freizinger et al. 2022; Kazdin, Fitzsimmons-Craft, and Wilfley 2017; Lilienfeld et al. 2013). Whilst research has validated manualized treatment protocols (Cooper and Bailey-Straebler 2015), clinicians report low adherence to these protocols (~6%–25%; (Waller 2016)) and often combine miscellaneous strategies (Lilienfeld et al. 2013; Waller 2016). In addition to the views of researchers and clinicians, emerging practice models emphasize the need of involving people with lived experience and carers in discussions regarding different evidence-based options and treatment decisions (Gagliardi et al. 2016; Slade 2017; Wetzler et al. 2020). There is growing acknowledgement that connecting with an individuals' own beliefs, values, and preferences is important to improve practice (Tringale et al. 2022).

An additional barrier is the lack of agreement around valued recovery goals (i.e., 'targets' of treatments) between people with lived experiences and those with workforce experience (Wade et al. 2021). Although some targets have different value depending on the ED presentation (e.g., weight gain and loss), there is a broader discussion regarding how traditional targets align with the perspectives of lived experience. For example, clinicians might focus on disorder-specific symptoms, but individuals living with ED prioritize holistic targets such as self-acceptance and social relationships (de Vos et al. 2017; Jennings and Phillips 2017). The lack of consensus regarding ED recovery targets is also pervasive within the research arena, where methods of measuring recovery vary substantially across studies (Bachner-Melman et al. 2018).

There is therefore a need to develop consensus across key ED stakeholder groups (i.e., researchers, clinicians, individuals with lived experience, carers) regarding important targets and intervention strategies for ED recovery. The aim of this study was to reach a consensus across these diverse groups on the most valued treatment targets and strategies from existing evidence-based packages. We utilized a transdiagnostic approach that encompassed the symptoms of all ED included in the DSM-5 (across all ages). Our justification for this approach was threefold. Firstly, different ED diagnostic categories share both symptoms and processes or mechanisms (Forbush et al. 2017; Melles and Jansen 2023; Solmi et al. 2018). Secondly, current frameworks and studies that involve multistakeholder groups support the view of recovery as a transdiagnostic construct comprising both diagnosis-specific features (e.g., weight gain and stabilization) and transdiagnostic aspects (e.g., sense of purpose, social connection) (Hower et al. 2022; Kenny and Lewis 2021). Finally, a focus on transdiagnostic treatments for ED has increased in recent years, with acknowledgment of the significant complexities of ED presentations and overlap between ED diagnostic categories, and the benefits associated with these treatments (Cooper 2017; Curzio et al. 2018; Fairburn, Cooper, and Shafran 2003; Gonzalez-Robles et al. 2018).

2 | Method

2.1 | Study Design

We used the Delphi method, which employs an iterative process to reach a consensus between experts (Jorm 2015). We followed the specific approach described by Verdejo-Garcia et al. (2023) as it incorporates an initial phase in which a Steering Committee (SC) designs and refines the survey before engaging the broader Expert Panel (EP). We sought a diversity of expertise by seeking researchers and clinicians working with people with ED, in addition to participants with consumer experience (people with lived/living experience of ED, carers of people with ED) (Hart and Wade 2020; Killackey 2023).

2.2 | Participants

We engaged two groups, each including representatives from the four expert groups (i.e., researchers, clinicians, people with lived/living experience of ED, and carers): (i) the SC defined the scope of the study, developed the initial survey, and ensured that the language used to describe each item was appropriate for all the participant groups; (ii) the EP completed the Delphi survey across the different iterations.

2.2.1 | Steering Committee

Members of the SC were identified through the membership and advisory board of the Australian Eating Disorders Research and Translation Centre (AEDRTC). The SC comprised 14 experts (including expertise across research, clinical, carers, lived experience of ED, and representatives from Australia, Europe, and United States). The two study coordinators (AA and LH) managed all communications.

2.2.2 | Expert Panel

Members of the EP were identified through a scoping review of 913 studies conducted on April 13, 2023 (described below), via SC recommendations, and via online advertisements in ED community groups. We specifically focussed on seeking representation from diverse geographical locations, including Asia-Pacific, Europe, and the Americas, and individuals with expertise in the full spectrum of ED diagnoses included in the DSM-5.

All participants were required to be aged 18 or over. Additional eligibility criteria differed by the expert group, although broadly focused on ensuring current ED treatment expertise. Researchers were required to be a first, last, or corresponding author for at least two ED publications within the past 5 years. Clinicians included individuals in a registered healthcare profession across both public and private sectors who had delivered an ED intervention within the past 5 years. Carers included family members or those in a close relationship with an individual with a current or previous (past 10 years) diagnosis of an ED, who had engaged in treatment. Participants with lived experience were required to have been diagnosed with a current or prior ED within the past 10 years and to have previously engaged in treatment. In recognition that participants could have experience in more than one group, we asked participants to self-nominate which of these four groups they identified most strongly with.

2.3 | Procedure

The Monash University Human Research Ethics Committee approved the study (reference MUHREC #38045). A pre-registered protocol was uploaded to Open Sciences Framework (Anderson, Hanegraaf, and Verdejo-Garcia 2023) on August 25, 2023. We describe the two phases of the study below.

2.4 | Phase 1: Survey Development/Approval

A scoping review using Scopus and PubMed was conducted by two authors (AA and LH). Search terms were chosen to capture ED (e.g., “Eating Disorder*” OR “Anorex*” OR “Bulimi*”) AND psychological interventions or recovery targets (e.g., “Treat*”, “Therapy”, “Recovery”, “Target”). An additional search was conducted to specifically identify ED articles from a lived experience perspective, which included ED and lived experience terms (e.g., “liv* experience”, “carer”). Further search parameters included articles published in English and published within the past 10 years (i.e., from 2013). Eligibility criteria included quantitative or qualitative peer-reviewed articles that focused on psychological intervention techniques or recovery targets in individuals with an ED. Our primary search revealed 891 studies, which were screened by AA and LH, with 201 studies identified as eligible. The additional lived experience search identified 303 studies, of which 34 were identified as eligible. The eligible studies were subsequently used to inform a preliminary set of items. Per our final Delphi structure, these items were separated into Section A: Intervention Targets and Section B: Intervention Strategies and were further grouped in each section according to a broad theme (e.g., individual well-being targets, skill-building techniques). Item descriptions were also provided and were informed by the scoping review, relevant treatment manuals, or American Psychological Association definitions.

The SC conducted two rounds of review. For the first round, an email was sent to the SC containing a standardized form which asked members to provide quantitative (i.e., rate how necessary this item is to include) and qualitative (e.g., suggestions for wording changes, general comments) feedback on items (including additional item suggestions) and themes. Feedback was then used to create a preliminary version of the Delphi survey on Qualtrics, which was emailed to the SC for Round 2 review, alongside the demographic surveys. In addition, a glossary of item descriptions was developed collaboratively with the SC to ensure descriptions were meaningful and comprehensible to people with lived experience and carers. The suggested changes were incorporated into a final version of the survey, which was emailed to the SC for final approval. All comments and revisions were handled by AA and LH. EG provided research support for the survey design. The final version was pilot-tested by five individuals who were independent of the SC and EP to ensure coherence of the questions and survey flow prior to launching Phase 2.

2.5 | Phase 2: Survey Rating

In Phase 2, the EP were asked to rate the importance of items in the finalized questionnaire, based on their own expertise and knowledge (Forsman et al. 2015). Items were rated using a 5-point Likert scale, including “essential”, “very important”, "moderately important", "slightly important", and "not important." We additionally included an option for "not sure/don't know." Items were worded as "How important do you think that [insert target item] is for working towards recovery from an eating disorder?" and "How important do you feel that [insert strategy item] is as part of treatment for an eating disorder?" Members of the EP were also invited to suggest new items and to provide further feedback on the items using a free-text response option. This feedback was optional. The following criteria for consensus across groups were used (Ekhtiari et al. 2022; Verdejo-Garcia et al. 2023):

- Endorsed. Items that above 70% of the EP rated as "Very Important" or above were endorsed as a priority.

TABLE 1 | Participant Characteristics by Stakeholder Group.

	Panel							
	Researchers		**Clinicians**		**Carers**		**LE**	
Demographics	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
n (%)	24	23.8	25	24.8	28	27.7	24	23.8
Age mean (SD)	44.13	(12.49)	46.60	(11.44)	54.21	(8.27)	35.42	(9.25)
Gender								
Male	5	20.83	4	20.00	2	7.14	3	12.50
Female	19	79.17	20	80.00	26	92.86	16	66.67
Non-Binary	0	0.00	0	0.00	0	0.00	5	20.83
Country of Residence								
Australia	17	70.83	13	52.00	16	57.14	12	50.00
Europe	3	12.50	4	16.00	1	3.57	10	41.67
North America	3	12.50	4	16.00	8	28.57	1	4.17
Asia	0	0.00	4	16.00	0	0.00	0	0.00
South America	0	0.00	0	0.00	0	0.00	1	4.17
New Zealand	1	4.17	0	0.00	2	7.14	0	0.00
Israel	0	0.00	0	0.00	1	3.57	0	0.00
Education Level								
High school or less	0	0.00	0	0.00	0	0.00	2	8.33
Technical training	0	0.00	0	0.00	3	10.71	5	20.83
Some university	0	0.00	0	0.00	2	7.14	5	20.83
Bachelor's degree	0	0.00	0	0.00	7	25.00	5	20.83
Master's degree	1	4.17	10	40.00	9	32.14	6	25.00
Doctoral or professional degree	23	95.83	12	48.00	1	3.57	1	4.17
Other	0	0.00	3	12.00	6	21.43	0	0.00
ED experience*								
AN	22	91.67	25	100.00	28	100.0	19	79.17
BN	18	75.00	24	96.00	4	14.29	9	37.50
BED	19	79.17	22	88.00	2	7.14	6	25.00
OSFED	16	66.67	21	84.00	0	0.00	3	12.50
ARFID	6	25.00	14	56.00	3	10.71	1	4.17
Other	1	4.17	1	4.00	9	17.86	0	0.00

Note: *N* = 101, corresponding to participants who started the study and completed the anonymous survey collecting demographic and expertise information, which was accessible after completion of Round 1 of the Delphi survey (i.e., 101 out of 110 initial participants completed the additional demographic/expertise survey).

*For consumer groups (lived experience and carers), this is based on past diagnosis of the individual with an eating disorder. Current diagnoses for these groups are listed in Data S3 and S4. Individuals could select more than one eating disorder they have experience with.

- Re-rate. Items that reached > 50% but < 70% consensus were incorporated in the subsequent round to be re-rated.
- Rejected. Items that had below 50% consensus.

The procedure was iterative; expert participants were surveyed until the highest possible consensus was achieved in a maximum of three rounds. In addition to including the re-rate items, Round 2 included any new proposed items from Round 1 that were suggested by two or more EP members and were considered to fit the description of a 'target' or 'strategy'. Participants also provided optional feedback on the definitions of items during the survey process, with a glossary provided at the end of the survey.

To ensure that the EP stakeholder groups were representative of the broader community (Chipchase et al. 2012), another questionnaire was distributed alongside the Round 1 survey. This questionnaire anonymously collected information about participants' age, gender, academic degree, and location. We did not collect information on race/ethnicity as we did not consider it essential for our aims.

2.6 | Measures

Twenty-nine targets and 44 strategies were identified through the initial scoping review, which was refined by the SC based on degree of consensus to 21 treatment targets (i.e., Section A) and 35 strategies (i.e., Section B). The 21 treatment targets were grouped into six domains (Individual Wellbeing, Emotions, Social Support and Connectedness, Cognition, Eating Disorder Symptoms, and Carer Knowledge and Insight), and the 35 strategies were grouped into six domains (Social Support and Communication, Skill Building, Self-Understanding, Behavioral Strategies, Cognitive Strategies, and Health and Physical Wellbeing). In the first survey, at the end of each domain, participants could propose new items that had not been covered. At the end of Section A and B, participants were also asked to provide qualitative feedback about the survey items and factors which may have influenced their responses.

3 | Results

3.1 | Participants' Characteristics

Of the 185 members who were invited to participate, 59% (*n* = 110) participated in the first round of the Delphi survey. Of these 110 participants, 101 additionally completed the demographic survey. The demographic data of these participants is provided in Table 1; additional data specific to each stakeholder group is provided in Data S1–S4. There were broadly equivalent numbers of participants across each of the stakeholder groups, with sample sizes exceeding minimal expectations for the Delphi method

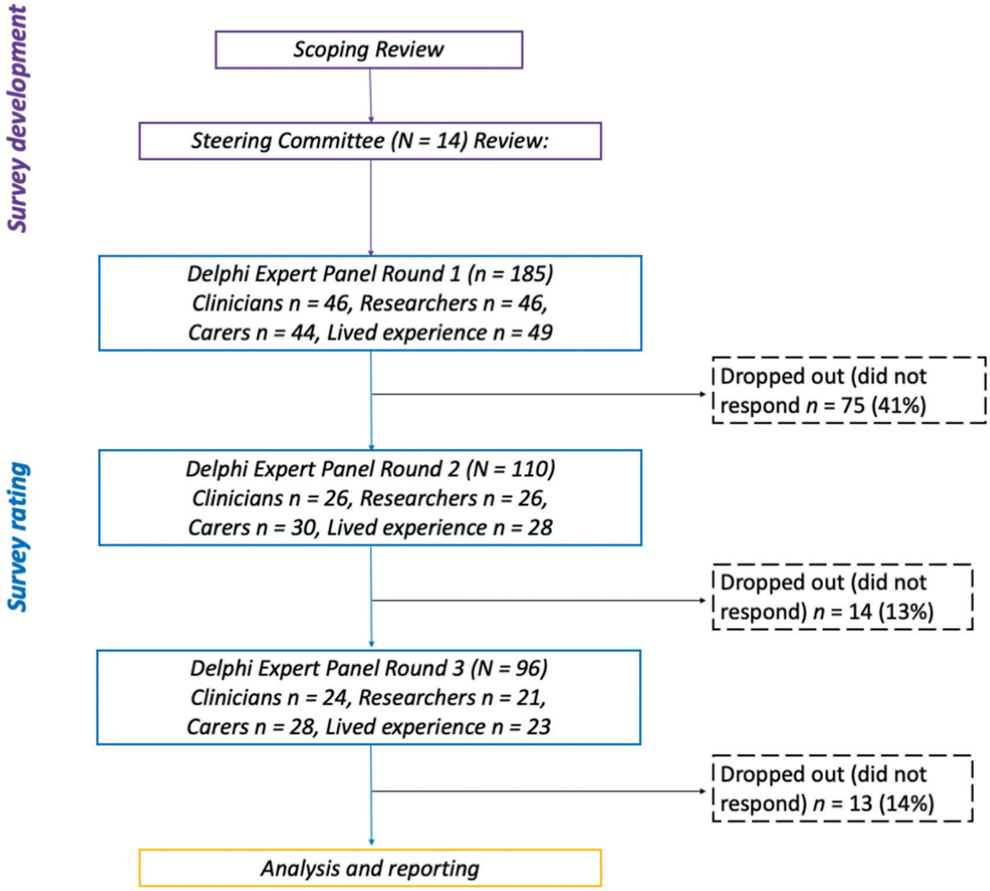

FIGURE 1 | Flow chart of the study procedure. We had two groups of participants: The Steering Committee who completed the survey development phase (in purple), and the Expert Panel who completed the survey rating phase (in blue).

(Akins, Tolson, and Cole 2005) and representation of consumer or work experience across all ED diagnostic categories.

Response rates for Rounds 2 and 3 of the Delphi survey were 87% ($n = 96$) and 86% ($n = 93$), respectively, which was broadly even across stakeholder groups. Figure 1 summarizes the study procedure and sample sizes across the two phases of the study.

3.2 | Delphi Survey Results

Figure 2 displays the overall flow and response rates for the Delphi process, as well as the number of items endorsed, re-rated, or rejected in each round.

At the end of Round 1, 18 of the 21 targets and 11 of the 35 strategies were endorsed as Very Important or Essential to ED recovery. Qualitative feedback fields gave rise to 12 new targets and 7 new strategies that were suggested by at least two participants. These were entered into the second round alongside three targets and 16 strategies which met criteria for re-rating. At the end of Round 2, 12 additional targets and 14 strategies had been endorsed, whilst one target and six strategies met the criteria for an additional round of rating. By the end of Round 3, 31 targets and 29 strategies were endorsed by > 70% of the EP. Figure 3 displays the pooled experts' responses for each item across the three survey rounds. Tables 2 and 3 list the endorsed targets and strategies (respectively), and we provide the glossary definitions in Data S5 and S6. Two targets and 13 strategies failed to achieve endorsement across Delphi rounds (see Data S7).

3.3 | Treatment Targets

Consensus was reached across most of the treatment targets (31/33), including all original items ($n = 21$), and 10 additional items brought up during the iterative Delphi process. Five treatment targets reached over 90% consensus, including quality of life (95.50%), sense of purpose and meaning (92.79%), the ability to hold, process, and respond to difficult emotions (91.89%), reducing ED behaviors (91.89%), and engaging in sustainable eating habits (90.11%). There appeared to be broad consensus across stakeholder groups (denoted by > 70% ratings per group, 16/31 targets), with some exceptions. Only the researcher group did not reach consensus on the following items: increasing self-awareness and understanding, self-care, family functionality, social support, self-attunement, and impulse control and reducing cognitive distortions and social pressure around shape and size. Both the researcher and

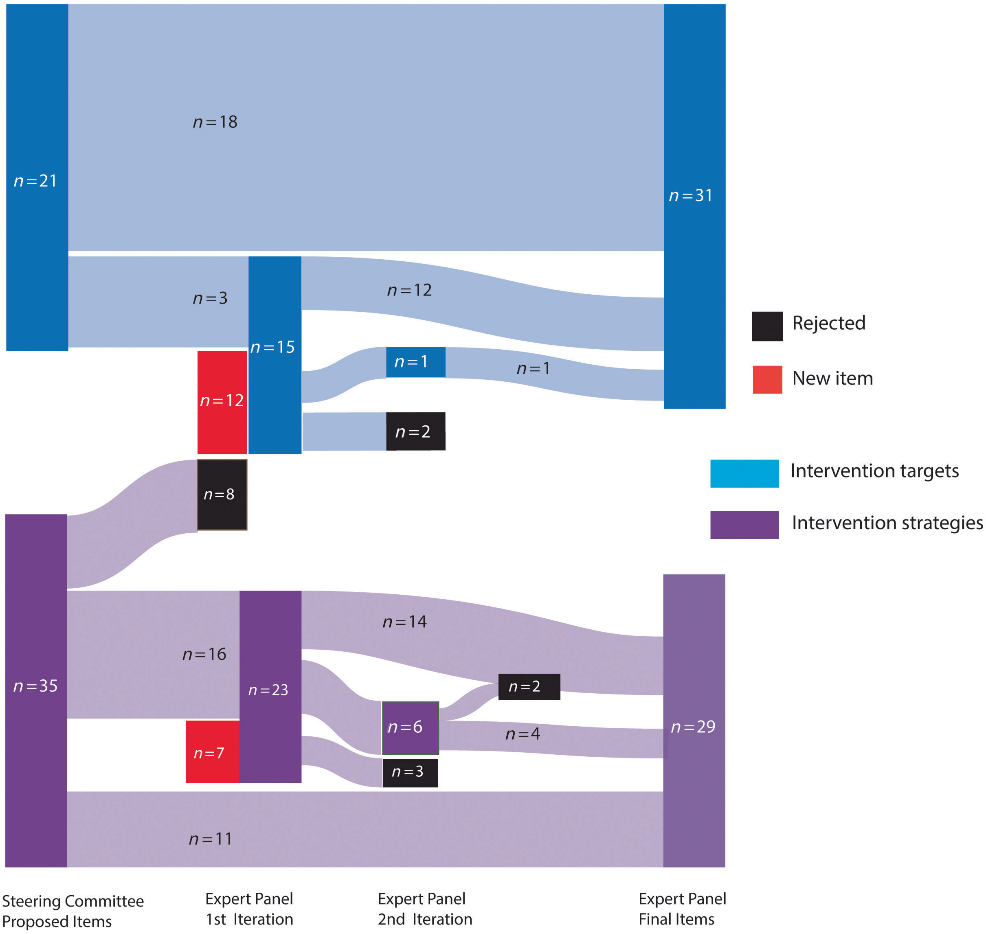

FIGURE 2 | Diagram adapted displaying the flow of the Delphi surveying process. It shows the number of items initially proposed by the Steering Committee for the two areas of interest (intervention targets and strategies) and how these were endorsed, rejected, or re-rated by the Expert Panel across the three consecutive rounds. Continuous flux from left to right signifies endorsed items.

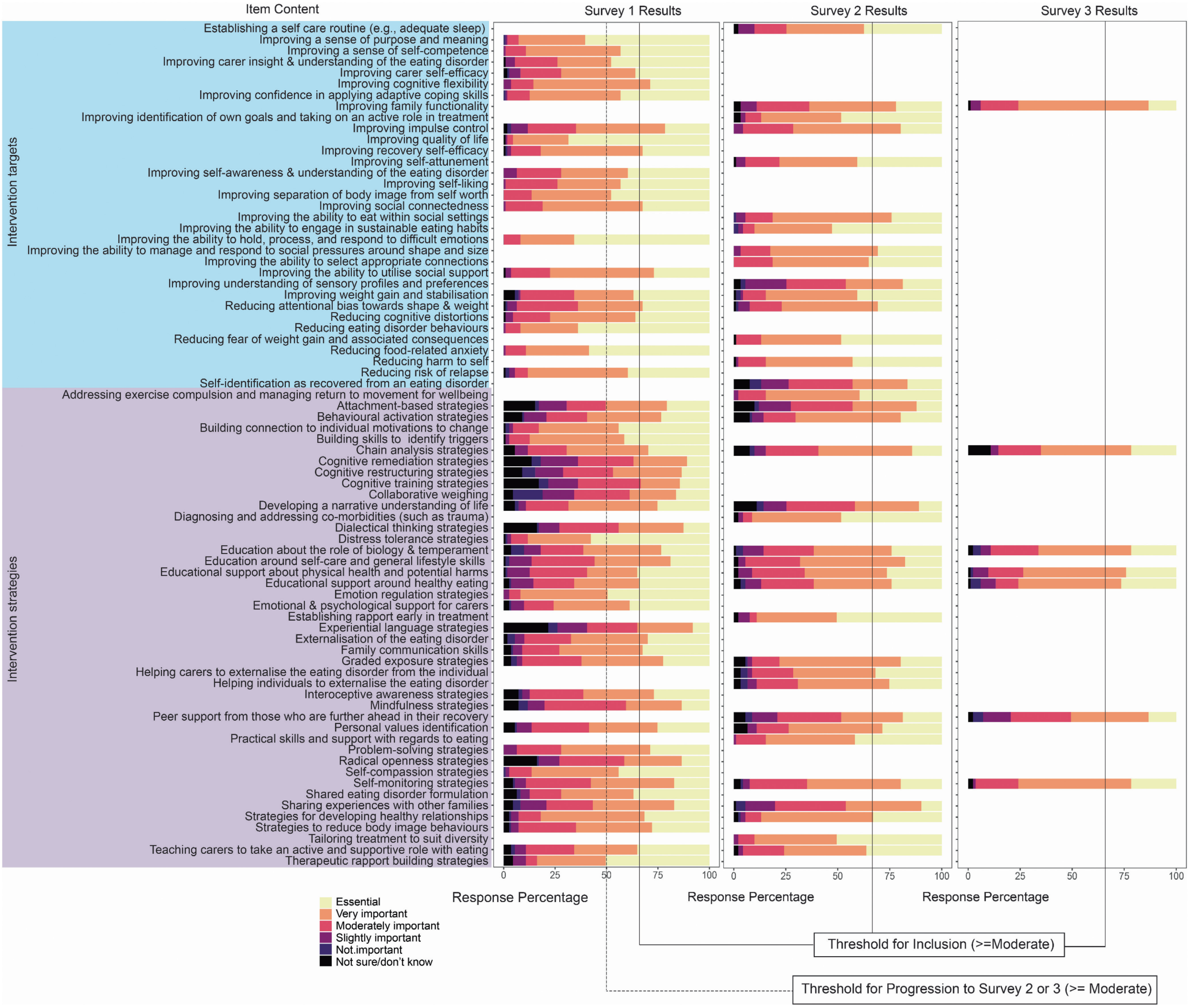

FIGURE 3 | Expert panel participants' pooled responses to each survey item across the three consecutive rounds, grouped by item category.

clinician group did not reach consensus for reducing attentional bias towards weight and shape, increasing self-liking, and increasing carer insight and understanding. In contrast, the lived experience group did not reach a consensus for weight gain and stabilization or increasing the ability to eat within social settings. Finally, only the carer group reached a consensus for improving carer self-efficacy.

3.4 | Intervention Strategies

Consensus was reached across 29/42 intervention strategies; of these, 21 were original items developed by the SC, five were novel items raised during the Delphi process, and three were original items that were altered based on feedback during the Delphi process (see Table 2). Four strategies reached above 90% consensus, including diagnosing and addressing comorbidities (93.26%), emotion regulation strategies (91.89%), establishing rapport early in treatment (91.01%), and tailoring treatment to suit diversity (90.11%). Seventeen of the 29 items did not reach consensus across all four groups. The researcher group did not reach a consensus level for self-compassion strategies, practical skills, and support with regard to eating, educational support around healthy eating, emotional and psychological support for carers, and educational support about physical health and potential harms. Neither the LE nor the researcher groups reach a consensus on teaching carers to take an active and supportive role with eating and interoceptive awareness strategies. Additionally, the LE group did not reach a consensus for graded exposure strategies, clinicians did not reach a consensus for behavioral activation strategies, and carers did not reach a consensus for personal values identification strategies. Neither the researcher nor clinician groups reached a consensus for helping carers externalize ED, problem-solving strategies, or education around self-care and general lifestyle skills. Researcher and carer groups did not reach a consensus for chain analysis strategies, whilst the LE and carer groups did not reach a consensus for creating a shared ED formulation. Finally, only the carer group reached a consensus for teaching family communication skills, and only the LE group reached a consensus for teaching individuals to externalize their ED.

TABLE 2 | Endorsed Treatment Targets Items Across Groups in Order of Overall Consensus Percentage.

	Consensus %				
Item	**Total sample**	**Researchers**	**Clinicians**	**Carers**	**Lived experience**
Improving quality of life	95.50	96.15	100.00	93.33	92.86
Improving sense of purpose and meaning	92.79	92.31	96.3	86.67	96.43
Improving the ability to hold, process, and respond to difficult emotions	91.89	92.31	92.59	93.33	89.29
Reducing eating disorder behaviors	91.89	96.15	96.30	90	85.71
Improving the ability to engage in sustainable eating habits*	90.11	94.74	91.30	81.82	92.59
Improving identification of own goals and taking on an active role in treatment* (individual wellbeing)	89.77	89.47	95.65	77.78	86.36
Improving sense of self-competence (individual wellbeing)	89.19	80.77	92.58	90	92.86
Reducing food-related anxiety	89.19	96.15	85.19	93.33	82.14
Reducing risk of relapse	88.29	96.15	92.59	73.33	92.86
Reducing fear of weight gain and associated consequences*	87.78	89.47	82.61	81.82	92.59
Improving confidence in applying adaptive coping skills	87.39	88.46	81.48	96.67	82.14
Separation of body image from self-worth	86.49	80.77	85.19	93.33	85.71
Improving cognitive flexibility	85.59	73.08	81.48	96.67	89.29
Reducing harm to self*	85.56	84.21	73.91	95.45	85.19
Improving weight gain and stabilization**	85.56	94.74	86.96	63.64	92.59
Improving the ability to manage and respond to social pressures around shape and size*	82.42	63.16	82.61	86.36	92.59
Improving recovery self-efficacy	81.98	84.62	85.19	80	78.57
Improving the ability to select appropriate connections**	81.32	68.42	73.91	90.91	88.89
Improving the ability to eat within social settings*	81.32	84.21	82.61	63.64	92.59
Improving social connectedness	81.08	84.62	74.07	93.33	71.43
Improving self-attunement*	78.89	47.37	86.96	95.45	77.78
Reducing attentional bias towards weight and shape	77.78	68.42	60.87	90.91	85.19
Improving the ability to utilize social support	77.48	69.23	70.37	90	78.57

(Continues)

TABLE 2 | (Continued)

Item	Consensus % Total sample	Researchers	Clinicians	Carers	Lived experience
Reducing cognitive distortions	77.48	69.23	85.19	83.33	71.43
Improving family functionality*	76.83	50.00	76.19	83.33	100.00
Establishing a self-care routine*	76.40	47.37	65.22	92.59	86.36
Improving self-liking	73.87	61.54	66.67	83.33	82.14
Increasing carer insight and understanding of the eating disorder*	73.87	57.69	59.26	75.00	100.00
Improving self-awareness & understanding of the ED*	72.07	57.69	81.48	78.57	70.00
Increasing carer self-efficacy*	72.07	57.69	59.26	67.86	100
Improving impulse control*	71.43	52.63	73.91	70.37	86.36

*Refers to items that were suggested by members of the Expert Panel in Round 1 of the Delphi surveys.
**Refers to items that were modified based on feedback from the Expert Panel in Round 1 of the Delphi surveys.

3.5 | Qualitative Feedback

Several EP members highlighted the importance of the stage of treatment, type of ED, age of the individual with the ED, and social context when rating items. For example, there was broad feedback that weight stabilization was an important target for AN rather than ED more broadly and may be more important early in treatment. Carer targets and family-based strategies were noted to be more applicable to children and youth with an ED and to depend on the role and capacity of the carer. Distinctions were made by several members between physical and psychological recovery, where the importance of psychological targets such as sense of purpose and meaning and recovery self-efficacy were highlighted for enabling the achievement of "a life beyond the ED." There were also several comments suggesting that certain strategies might be more applicable to subgroups within ED diagnoses: For example, for individuals with a longstanding ED. Finally, several people highlighted the importance of an individualized approach, stating that all strategies and targets endorsed were important for EDs generally but should be tailored to the individual.

4 | Discussion

We surveyed expert opinion to develop consensus among diverse stakeholders on the most important treatment targets and strategies for fostering recovery in people with ED. Expert groups reached agreement on 31 intervention targets and 29 strategies. Agreement was very high for targets (94% of proposed items) and similar to previous multistakeholder Delphi studies looking at ED treatment strategies (69%); percentage agreement in prior treatment strategies consensus ranged from 66% to 80% (Field et al. 2023; Hart and Wade 2020; McMaster et al. 2020). Previous research in ED and other mental disorders has similarly shown greater agreement rates for intervention targets relative to treatment strategies (Vanderlinden et al. 2007; Verdejo-Garcia et al. 2023). There are other potential explanations for the high level of agreement on targets. First, it might be a result of the specific Delphi approach used, in which the SC carefully designs survey items prior to expert surveying (Ekhtiari et al. 2022; Verdejo-Garcia et al. 2023). Second, it has been previously suggested that, in the context of multistakeholder Delphi studies, increased awareness about the presence of diverse perspectives (all with a high level of investment in the topic) may lead to increased agreement rates (McMaster et al. 2020). In this vein, our findings reflect a shared understanding between key contributors to the treatment process of value-based targets and strategies. This agreed-upon set of targets/strategies should not replace the evidence base but provide a new stream of evidence to guide different investigation approaches (e.g., coproduction, individualized care packages) and collaborative treatment decisions (Slade 2017; Wetzler et al. 2020).

The expert-endorsed targets overlap with growing research emphasizing the importance of person-centred goals such as purpose, self-competence, and quality of life (QoL) (Foran, O'Donnell, and Muldoon 2020; Miskovic-Wheatley et al. 2023). They mostly align with the set of targets that previous studies clustered and defined as psychological-emotional–social criteria (Emanuelli et al. 2012; Noordenbos 2011). When appraising the potential relevance and applications of the large set of targets that we identified, it is important to consider that: (i) they do not represent discrete entities but interconnected "levers" such that, for instance, improving psychological/emotional features will positively impact social function and vice versa; (ii) in addition to an overall agreement, ranking or prioritization has proven useful in previous attempts to define meaningful treatment targets and an endorsement level > 90% can be used as a decision heuristic (Bryant et al. 2023; Hart and Wade 2020). Interestingly, improving QoL reached the highest consensus, with > 90% endorsement across groups. However, QoL measures are not commonly utilized in research or clinical decision-making (Miskovic-Wheatley et al. 2023). It is also interesting to contrast the prioritization that emerged from our study relative to earlier research. Specifically, past studies

TABLE 3 | Endorsed treatment strategies items across groups in order of overall consensus percentage.

Item	Consensus %				
	Total sample	Researchers	Clinicians	Carers	Lived experience
Diagnosing and addressing co-morbidities (such as trauma)*	93.26	84.21	95.65	85.19	100.00
Emotion regulation strategies	91.89	88.46	96.30	93.33	89.29
Establishing rapport early in treatment*	91.01	94.74	95.65	81.48	86.36
Tailoring treatment to suit diversity*	90.11	73.68	95.65	92.59	95.45
Strategies to reduce body image behaviors**	88.76	84.21	91.30	92.59	77.27
Distress tolerance	88.29	80.77	85.19	90.00	96.43
Building skills to identify triggers**	87.39	80.77	88.89	86.67	92.86
Self-compassion	86.49	69.23	88.89	90.00	96.43
Addressing exercise compulsion and managing return to movement for well-being*	84.62	78.95	73.91	88.89	95.45
Practical skills and support with regards to eating*	84.62	68.42	78.26	92.59	95.45
Therapeutic rapport building	83.78	88.46	96.30	73.33	78.57
Building connection to individual motivations to change	82.88	84.62	85.19	73.33	89.29
Graded exposure strategies	82.56	73.68	86.96	81.48	68.18
Developing healthy relationships	81.98	84.62	85.19	83.33	75.00
Personal values identification strategies	78.82	73.68	86.96	59.26	77.27
Self-monitoring strategies	77.78	83.33	90.48	72.72	76.47
Teaching carers to take an active and supportive role with eating	77.53	52.63	73.91	100.00	68.18
Educational support around healthy eating	76.82	66.67	85.71	86.61	82.35
Behavioral activation strategies	76.19	73.68	52.17	81.48	72.73
Emotional & psychological support for carers	75.68	57.69	77.78	90.00	75.00
Educational support about physical health and potential harms	74.39	66.67	80.95	73.90	88.24
Helping carers to externalize the eating disorder from the individual**	73.86	47.37	52.17	96.30	81.82
Family communication skills	72.97	69.23	66.67	93.33	60.71
Chain analysis strategies	72.97	62.50	80.95	61.90	100.00
Problem-solving	72.07	61.54	66.67	80.00	78.57

(Continues)

TABLE 3 | (Continued)

Item	Consensus %				
	Total sample	Researchers	Clinicians	Carers	Lived experience
Shared eating disorder formulation	72.07	73.08	88.89	66.67	60.71
Helping individuals to externalize the eating disorder	71.59	52.63	69.57	66.67	86.36
Interoceptive awareness strategies	70.79	47.37	82.61	74.07	68.18
Education around self-care and general lifestyle skills	69.66[a]	52.63	65.22	70.37	81.82

*Items that were suggested by members of the Expert Panel in Round 1 of the Delphi surveys.
**Items that were modified based on feedback from the Expert Panel in Round 1 of the Delphi surveys.
[a]Percentage consensus rating was rounded up to 70 and therefore met criteria for endorsement.

involving patients and clinicians identified weight and appearance evaluation-related targets as most valued (Emanuelli et al. 2012). Conversely, in our study, likely reflecting evolving mindsets and increased consideration of lived experience input (Austin et al. 2023; Bryant et al. 2023), the more holistic psychosocial criteria reached the same level of prioritization as "reducing EDs behaviour" and "sustainable eating habits."

The intervention strategies that reached consensus could be used, in triangulation with other sources of evidence, to develop novel interventions using evidence-based frameworks (Gagliardi et al. 2016; Tringale et al. 2022) and/or to inform treatment planning in the context of collaborative frameworks such as the shared decision-making model (Himmerich et al. 2019; Jansingh et al. 2020; Slade 2017). Nonetheless, it is important to note that shared decision-making approaches have not yet generated sufficient evidence regarding their ability to improve clinical outcomes, although they have shown benefits for specific user-reported outcomes agreed upon by the stakeholders involved (Aoki et al. 2022; Shay and Lafata 2015). Thus, the use of participatory research-based findings like those reported here should not bypass the established scientific evidence and should be considered in the context of their limitations, including those related to increased subjectivity (Grove and Meehl 1996; Walfish et al. 2012). One potential benefit of participatory research involving patients and carers is increased involvement in the treatment process (Aoki et al. 2022). Interestingly, three of the four strategies which received above 90% endorsement were not specific to any intervention approach, and instead appeared to reflect an individualized approach to ED treatment; a view that was echoed by qualitative feedback. Specifically, addressing comorbidities such as trauma, establishing rapport early in treatment, and tailoring treatment to suit diversity were prioritized across groups. Although current practice guidelines (Crone et al. 2023; National Institute for Health and Care Excellence (NICE) 2020) recommend a focus on individual and diverse factors, there is a need for more research exploring the role of these factors in ED treatment (Halbeisen, Brandt, and Paslakis 2022).

A strength of this study was the diversity of expert groups. Inclusion of the voices of people with lived experience is a growing area (M. Slattery et al. 2020), with several established benefits, including the facilitation of research that has real-world significance to individuals with ED (Music et al. 2022; Wade et al. 2021). Importantly, our methodology meant there was equal weighting across two 'workforce' groups (ED researchers and clinicians) and two 'consumer' groups (individuals with LE and carers), and that the perspectives of these groups were sought from survey design through to the interpretation of results (i.e., via our Steering Committee); in alignment with principles of coproduction (P. Slattery et al. 2020). An additional strength is that attrition rates were low across Delphi rounds (75.4%), which is above the level of 70% that is required to ensure attrition does not bias results (Jorm 2015).

Nonetheless, there are several limitations to consider. We took several steps to prevent biases, including anonymization of the Delphi survey responses, and assessor blinding. We nonetheless acknowledge that there is overrepresentation of Australian participants and thus the extent to which our findings generalize to other cultures remains to be established. Although our initial scoping review fit our study purpose, this review was not systematic in nature, and therefore, it is possible that certain items within the literature were missed. Notably, our consensus did not include some important targets for patient health, such as risk of starvation and suicide. This is an important limitation, and we should emphasize that our results should not be viewed as taking precedence over safety priorities such as those reflected in these omitted targets in potential treatment applications. Relatedly, since participatory research has not yet generated certain evidence regarding the ability to improve treatment outcomes, our findings should also be applied with caution and never bypass established scientific evidence. Furthermore, our sample comprised predominantly female participants, with limited representation of male (14.8%) and non-binary (5.0%) individuals. This is important given that these groups are largely unrepresented in the broader ED research literature (Bryant et al. 2022; Field et al. 2023; Halbeisen, Brandt, and Paslakis 2022) and the emphasis on diversity that emerged within our findings. Although the overall sample size was large, the sizes of the specific stakeholder groups were more modest although in all cases beyond minimal expectations for the Delphi method (Akins, Tolson, and Cole 2005). We also acknowledge qualitative feedback that pointed to factors that may have influenced item ratings, for example, ED diagnostic category, stage of treatment, and age. These and other factors such as need for weight gain, presence/absence of bingeing or purging behaviors, and biological features are important considerations that were outside the scope of this study, which stands as a limitation. It is likely that our broader focus contributed to the large number of targets selected (Hart and Wade 2020) as well as their holistic nature, with many targets likely being relevant not only across the spectrum of ED but also for mental disorders more broadly. Future studies with a greater focus on specific diagnoses would complement our findings.

5 | Conclusion

A multistakeholder panel of ED experts endorsed prioritizing psychological–emotional–social targets and individualized strategies that consider comorbidities, diversity, and treatment collaboration.

Author Contributions

Lauren Hanegraaf: conceptualization, formal analysis, investigation, methodology, writing – original draft. **Alexandra Anderson:** conceptualization, investigation, project administration, writing – review and editing. **Erica Neill:** investigation, project administration, writing – review and editing. **Emily Giddens:** data curation, formal analysis, methodology, project administration, writing – review and editing. **Evelyn Boon:** investigation, writing – review and editing. **Emma Bryant:** investigation, project administration, writing – review and editing. **Shannon Calvert:** funding acquisition, investigation, validation, writing – review and editing. **Bronwyn Carroll:** investigation, writing – review and editing. **Fernando Fernandez-Aranda:** investigation, validation, writing – review and editing. **Sam Ikin:** investigation, writing – review and editing. **Maya Luna:** investigation, writing – review and editing. **Fiona Mitchell:** investigation, writing – review and editing. **Rebecca Murphy:** conceptualization, investigation, writing – review and editing. **Andrea Phillipou:** investigation, writing – review and editing. **Julian Robinson:** investigation, writing – review and editing. **Christina Wierenga:** conceptualization, investigation, writing – review and editing. **Simon Wilksch:** conceptualization, investigation, writing – review and editing. **Sarah Maguire:** conceptualization, funding acquisition, investigation, resources, writing – review and editing. **Antonio Verdejo-Garcia:** conceptualization, funding acquisition, methodology, project administration, resources, supervision, writing – review and editing.

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Ethics Statement

This study protocol was reviewed and approved by Monash University Human Research Ethics Committee, approval number MUHREC #38045.

Consent

Written informed consent was obtained from all participants.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

All data generated or analyzed during this study are included in this article and its Data S1 files. Further enquiries can be directed to the corresponding author.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.