Patient-Identified Challenges and Coaching Preferences at Entry into a GLP-1 based Digital Care Programme

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BACKGROUND & OBJECTIVE

- Understanding patients' **self-identified challenges** and **support preferences** at programme entry enables **personalised, non-assumptive coaching** that **meets patients where they are**, rather than a one-size-fits-all approach.
- This study reports findings from **structured onboarding questions** administered to patients entering a **UK-based digital GLP-1 weight management coaching programme.**

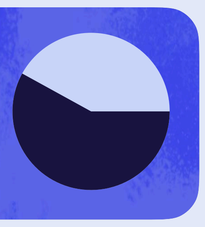
METHODS & DESIGN

Between February and April 2026, 3,831 people entering GLP-1 based digital coaching completed a structured onboarding questionnaire (78% female). Two questions were analysed descriptively with sex stratification:

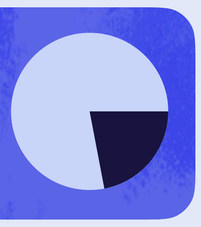
- Self-identified primary challenge at programme entry (single-select, 10 options — see Table 1)
- Coaching support preferences (multi-select, 13 options across "what I get" and "how it's delivered" — see Table 2)

Results

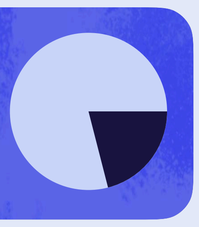
58%
OF PARTICIPANTS WERE GLP-1 MEDICATION-NAIVE



22%
HAD BEEN TAKING MEDICATION FOR MORE THAN ONE MONTH



21%
HAD STARTED WITHIN THE LAST MONTH



Primary Challange

Cravings, emotional eating, or feeling out of control around food was the leading challenge for both sexes (43% overall; 44% female, 42% male) — more than 3x the next most common response.

Poor sleep or low energy was a consistent second (13% female, 15% male).

The remaining options each account for 5–8%, with the clearest sex divergence in physical symptoms (8% female vs 6% male) and low confidence (6% female vs 4% male) — both weighted more heavily by female patients.

"Clear plans and structure" (12%/15%) and "practical tips I can try straight away" (11%/12%) were the top preferences across both sexes.

Females most commonly selected "warm, positive and encouraging support" (9%) and "feeling understood rather than judged" (9%).

Males more frequently selected "gentle reminders and nudges" (10%) and "a coach who actively guides me when needed" (8%).

OVERALL AND SEX -STRATIFIED DISTRIBUTION OF RESPONSES: PRIMARY CHALLANGE AT PROGRAMME ENTRY

Female Male

F RANK	FEMALE N · %	ANSWER · OVERALL N · %	MALE N · %	M RANK
#1	1,253 · 44%	Cravings or emotional eating 1,601 · 43%	348 · 42%	#1
#2	364 · 13%	Poor sleep or low energy 488 · 13%	124 · 15%	#2
#3	235 · 8%	Physical symptoms 282 · 8%	47 · 6%	#6
#4	180 · 6%	Routine or home life barriers 259 · 7%	79 · 10%	#3
#4	180 · 6%	Not knowing what to eat 228 · 6%	48 · 6%	#5
#7	158 · 6%	Not sure yet 212 · 6%	54 · 7%	#4
#6	169 · 6%	Low confidence / not knowing where to start 204 · 6%	35 · 4%	#9
#8	147 · 5%	Stress or low mood 191 · 5%	44 · 5%	#8
#9	144 · 5%	Finding time/motivation to move 189 · 5%	45 · 5%	#7
#10	36 · 1%	Managing medication 41 · 1%	5 · 1%	#10

OVERALL AND SEX-STRATIFIED DISTRIBUTION OF RESPONSES: SUPPORT PREFERENCES.

Overall Female

WHAT I GET

	N	Overall	Female
Clear plans and structure	2,085	12%	12%
Practical tips I can try straight away	1,940	11%	11%
Help breaking things down into small steps	1,433	8%	8%
Flexibility and choice in how I make changes	1,221	7%	7%
Understanding the "why" behind what I'm doing	1,031	6%	6%
Help problem-solving real-life situations	590	3%	4%

HOW IT'S DELIVERED

	N	Overall	Female
Warm, positive and encouraging support	1,527	9%	9%
Gentle reminders and nudges	1,515	9%	9%
Feeling understood rather than judged	1,425	8%	9%
A coach who actively guides me when needed	1,365	8%	8%
A pace that feels manageable for me	1,237	7%	8%
Keeping things focused on taking action	976	6%	5%
Space to talk things through	635	4%	4%

PERCENTAGES REFLECT PROPORTION OF ALL SELECTIONS. RANKED BY OVERALL N.

IMPLICATIONS - PRIMARY CHALLENGE

- **Food psychology, not knowledge, is the primary barrier.** Cravings and emotional eating dominate (43% overall — more than 3x the next most common challenge). Coaching should target the psychological relationship with food, not fill a nutrition information gap.
- **Energy dips are a medication-expectation gap, not just a side effect.** Fatigue is common early on and can demoralise patients who expect quick gains — naming this proactively, before patients raise it, matters clinically.
- **Challenges are heterogeneous, including real ambivalence.** Patients arrive with a spread of priorities, and 6% aren't sure yet what their biggest challenge is. Goal-setting should flex to the presenting challenge and treat "not sure yet" as an opening to explore, not a disengagement signal.

IMPLICATIONS - SUPPORT PREFERENCES

- **Structure and practicality are the floor, not the differentiator.** Both sexes rank clear plans and practical tips top — coaching quality shows up in how that structure is delivered, not whether it exists.
- **Delivery should be sex-informed and patient-led.** Female patients weight emotional attunement (warmth, feeling understood); male patients weight autonomy and rationale (the "why", flexibility, guided action).
- **"Understood, not judged"** is a top-four need for female patients — a psychological-safety signal, not a soft extra, given the shame that often surrounds food and weight.
- **Male patients want the "why" before the plan.** Explaining rationale, not just issuing instructions, is likely to land better with this group.

Patients don't want more nutrition knowledge They need support that meets them psychologically, and adapts to who they are.