Received: 19 April 2023 | Revised: 25 May 2023 | Accepted: 27 May 2023

DOI: 10.1002/eat.24008

FORUM

International Journal of EATING DISORDERS WILEY

Developing a protocol to address co-occurring mental health conditions in the treatment of eating disorders

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Action Editor: Ruth Striegel Weissman

Abstract

Objective: While co-occurring mental health conditions are the norm in eating disorders, no testable protocol addresses management of these in psychotherapy.

Method: The literature on managing mental health conditions that co-occur with eating disorders is outlined and reviewed.

Results: In the absence of clear evidence to inform managing co-occurring mental health conditions, we advocate for use of an iterative, session-by-session measurement to guide practice and research. We identify three data-driven treatment approaches (focus solely on the eating disorder; multiple sequential interventions either before or after the eating disorder is addressed; integrated interventions), and the indications for their use. Where a co-occurring mental health condition/s impede effective treatment of the eating disorder, and an integrated intervention is required, we outline a four-step protocol for three broad intervention approaches (alternate, modular, transdiagnostic). A research program is suggested to test the usefulness of the protocol.

Discussion: Guidelines that provide a starting point to improving outcomes for people with eating disorders that can be evaluated/researched are offered in the current paper. These guidelines require further elaboration with reference to: (1) whether any difference in approach is required where the co-occurring mental health condition is a comorbid symptom or condition; (2) the place of biological treatments within these guidelines; (3) precise guidelines for selecting among the three broad intervention approaches when adapting care for co-occurring conditions; (4) optimal approaches to involving consumer input into identifying the most relevant co-occurring conditions; (5) detailed specification on how to determine which adjuncts to add.

Public significance: Most people with an eating disorder also have another diagnosis or an underlying trait (e.g., perfectionism). Currently no clear guidelines exist to guide treatment in this situation, which often results in a drift away from evidence-based techniques. This paper outlines data-driven strategies for treating eating disorders and the accompanying comorbid conditions and a research program that can test the usefulness of the different approaches suggested.

KEYWORDS
co-occurring mental health conditions, comorbidity, eating disorders, integrated intervention, therapist drift, treatment guidelines

The co-occurrence of two or more psychiatric disorders (i.e., comorbidity) has long been of interest in eating disorders as it can inform our understanding of the how treatment needs to be provided (Rachman, 1991). This co-occurrence is the norm rather than the exception. At least one lifetime DSM-IV disorder is present in most adults with anorexia nervosa (AN, 56.2%), bulimia nervosa (BN, 94.5%), and binge-eating disorder (BED, 78.9%) (Hudson et al., 2007). The most frequently co-occurring DSM-5 diagnoses with these three eating disorders are mood and substance use disorders (half to two-thirds) and anxiety disorders (nearly half) (Udo & Grilo, 2019). In addition to co-occurring disorders, other common comorbid features including affect regulation difficulties, negative affect, perfectionism, cognitive-behavioral inflexibility, impulse control difficulties, and deliberate self-harm (Halmi, 2018; Warne et al., 2021). Around two-thirds of people receiving treatment for an eating disorder report at least one traumatic event (Kjaersdam Telléus et al., 2021). Given the commonly adopted and widely accepted view that certain comorbid features (e.g., perfectionism, low self-esteem, interpersonal difficulties) as well as the presence of a diagnosable disorder may obstruct progress in treatment (Cooper & Fairburn, 2011), in this paper we will consider both comorbid disorders and other comorbid features, termed collectively "co-occurring mental health conditions".

Bidirectionality between eating disorders and co-occurring mental health conditions is likely with the presence of either significantly increasing odds of the occurrence of the other (Momen et al., 2022). This information, however, provides limited information about how co-occurring mental health conditions are best addressed in treating an eating disorder. Epidemiological studies are unable to inform whether co-occurrences represent static associations or dynamic connections (Rachman, 1991) that would inform clinical decision making (Rachman, 1991). More simply put, if the eating disorder is treated, will the other problem/disorder resolve, persist, or even interfere with treating the eating disorder itself? And in any of these cases, what are the relevant pathways by which these possible outcomes are achieved that may inform treatment?

While the evidence is somewhat inconsistent, comorbidity predicts higher levels of eating disorder psychopathology across all treatments and timepoints (Linardon et al., 2017; Lydecker & Grilo, 2021; Vall & Wade, 2015), suggesting reduced benefit from existing treatment. Its presence is associated with "therapist drift", that is, failure of the therapist to deliver, or deliver adequately, the treatments they have been trained to deliver (Waller & Turner, 2016). It is unsatisfactory that the therapy that most people with eating disorders receive is likely to deviate from the evidence base.

The overall aim of this paper is to provide a framework for understanding the role of co-occurring mental health conditions in treating eating disorders. To this end we review approaches that may be useful in both assessment, formulation, and treatment. We propose a clinical protocol with associated research priorities for cases where co-occurring mental health conditions interact reciprocally with the eating disorder, thereby presenting a barrier to progress. The proposal makes use of the finding that early response (behavioral and/or cognitive symptom change), a non-specific in-treatment variable, neither a predictor nor moderator, is more consistently and robustly associated with good treatment outcome across all eating disorders than any other predictor of outcome. predictor (Linardon et al., 2017; Vall & Wade, 2015). In contrast, most other predictors, including psychopathology, are "consistently unrelated" to outcome (Linardon et al., 2017). This suggests an iterative, session-by-session measurement-based approach to treatment, where alternative strategies are considered when little impact on the eating disorder symptoms is noted, and this is determined to be due to the interacting effect of a comorbid condition.

1 | ASSESSMENT AND FORMULATION

In the absence of an explicit framework about how to address co-occurring mental health conditions, clinicians have adopted a variety of approaches during assessment when deciding what to treat. They may ask what would happen to one disorder if they had a 'magic wand' and the other disorder disappeared (Huppert & Sorka, 2022). If, for example, a patient with an eating disorder and depression responded by saying that if they did not have the eating disorder, they would not be depressed, the therapist would treat the eating disorder first, based on the view that the patient was a reliable self-reporter, and that the depression was secondary to the eating disorder. However, the assumption that patients are accurate self-reporters is not completely supported, with only moderate agreement between symptom-based and self-reported diagnoses (Davies et al., 2022).

Based on the view that much more detailed associations between the two disorders and particular symptoms are needed, another approach is to try to establish a timeline between the emergence of the disorders to establish precedence. It is then assumed that the disorder that occurred first is primary and should be addressed first or at least concurrently. This strategy is often based on the flawed assumption that a prior difficulty caused the subsequent one and that only if this is addressed can progress be made. For example, it has been recommended that clinicians focus on trauma history and associated comorbid disorders before being able to effectively treat the eating disorder (Wonderlich et al., 1997). Even if difficulties that occurred prior to the eating disorder onset have had a role in triggering the disorder, these may not be those currently maintaining either disorder. Also, this approach relies heavily on clinician judgment, known to be flawed (Dawes et al., 1989).

There is a welcome move, though somewhat challenging for clinicians (Persons et al., 2016), towards using standardized measures for assessment as well as progress outcome monitoring. Such session-

by-session measurement improves outcome (Delgadillo et al., 2018) and enables clinicians to use a more 'trial and error' approach informed by data. While there would still need to be a decision as to which disorder to focus on, there is the possibility of also tracking the symptoms of the comorbid disorder to see whether they are changing in line with the treatment of the other disorder.

A further challenge faced by the clinician is producing a formulation understanding the role of the co-occurring mental health conditions. The case formulation approach used in cognitive behavior therapy (CBT) is helpful in that, at its core, the therapist adopts an empirical hypothesis-testing approach to the treatment of each case and a personalized formulation is produced based on evidence-based theory (Persons, 2022). However, since most forms of CBTs are based on models of the maintenance of disorder-specific psychopathology, it is difficult to know how best to produce an idiographic yet empirically based formulation in the case of co-occurring mental health conditions.

What is needed is a more detailed or granular assessment of the co-existing features together with an assessment of how these features interact with the eating disorder. So rather than asking patients more global questions or making global clinical judgments, we need to concentrate on counterfactual questions like "if you were able to achieve your ideal body shape, would you still feel low/depressed on most days?" or "if others were not watching you eat/commenting on your eating/making your eat more, would you still wish to avoid social situations and, if so, why?" Specific, and recent instances could be reviewed, such as inquiring whether on days when the person felt better about their body, their mood was better than on a day when they did not. The incorporation of imagery in these scenarios may be helpful to elicit the underlying emotion and associated beliefs more successfully (Holmes & Mathews, 2010). The answers to these questions may contribute to an individualized formulation informed by a model specific formulation that would map these hypothesized connections, which could be tested with regular session-by-session data collection and modified as necessary.

2 | TREATMENT

Faced with these uncertainties about the potential role of comorbidity, in practice clinicians adopt a variety of treatment strategies depending on therapist assumptions or preferences and/or patient preferences and practical considerations, for example, number of sessions available. One frequent strategy is for the clinician to use multiple simultaneous interventions by mixing and matching the different techniques that seem relevant and appealing. For example, when the patient reports feeling unable to eat in front of other people because they feel judged and embarrassed, it may be tempting to do a single session of video-feedback taken from the treatment of social anxiety (Harvey et al., 2000). This is a typical way in which therapists drift (Waller & Turner, 2016), with no published data to support this type of 'mixing and matching' of interventions, despite its intuitive appeal and ubiquity.

Below we suggest a systematic framework for the treatment of eating disorders where co-occurring mental health conditions are present, summarized in Table 1.

2.1 | When the co-occurring mental health conditions appears to be a consequence of the eating disorder

Some features of co-occurring disorders appear to be closely linked or attributable to the eating disorder. Aspects of the eating disorder such as an inability to stick to overly demanding standards regarding eating/weight/shape control, and binge-eating, are often associated with self-critical thinking, low self-esteem, shame, and guilt. Sustained attempts to diet or being significantly underweight generally results in impaired concentration, poorer emotional regulation, decreased energy, poor sleep, less flexibility, and social withdrawal. Similarly, some features suggestive of an anxiety disorder such as the avoidance of socializing and eating with others, and rigid and ritualized thinking and behavior, may be closely linked to the eating disorder and/or low weight. If a careful assessment and formulation, as described above, supports the hypothesis that the eating disorder and co-occurring mental health condition may be linked in some of the ways outlined, there is a case for treatment focused solely on the eating disorder proceeding as usual. The expected outcome would be that the closely linked other condition may also improve or resolve. Evidence from the treatment of anxiety and depression suggests that focusing on one disorder benefits the other more than trying to tackle both (Craske et al., 2007; Gibbons & DeRubeis, 2008; Shafran et al., 2018). Positive effects of purely eating disorder focused treatment have been reported for mood, anxiety, borderline personality disorder and self-esteem even when these are not directly addressed (Kaidesoja et al., 2023; Mulkens & Waller, 2021; Voderholzer et al., 2021).

2.2 | When the co-occurring mental health conditions appears to be independent of the eating disorder

There are, of course, many cases where the co-existing condition does not seem likely to be attributable, or solely attributable to the eating disorder. In such cases, the co-existing condition appears more independent of the eating disorder, but it may still interact with the disorder in important ways that need to be understood. A co-existing depression may contribute to maintaining the eating disorder by interfering with the possibility of engaging the patient in treatment and change manifested by hopelessness about change, or a reduction in drive and impairment in concentration. Similarly certain severe anxiety states or substance use may interfere with the possibility of engaging people in treatment and working collaboratively for change.

TABLE 1 Treatment approaches hypothesized to be indicated for co-occurring mental health conditions and the pros and cons.

Treatment approach	Indicated when	Pros	Cons
Focus on the eating disorder	Comorbid condition appears to a consequence of the eating disorder	Data from studies in other areas and eating disorders show benefit	Engagement (not paying attention to other problems); efficiency; can be a challenge for therapists
Multiple sequential interventions—either before or after addressing the eating disorder	Co-occurring mental health conditions appears independent of the eating disorder and prevents engagement, thus may need to be addressed first	Facilitates engagement in treatment	Resources; efficiency; engagement; may not be feasible if sessions are restricted
	Co-occurring mental health conditions will likely not impact treatment and can be addressed after treatment if required	Co-occurring mental health conditions may remit without focus	
Simultaneous/integrated interventions	Co-occurring mental health conditions interact reciprocally with the eating disorder and is a barrier to progress	Engagement; potentially better outcomes	Little data or guidance about how to achieve
Multiple simultaneous interventions (mix and match)		Engagement; therapist preference	Overwhelming; no data; diluted efficacy
Alternate interventions- between or within sessions		Engagement; some indication that those with complex psychopathology do better with this approach	Confusing for therapist and patient; potential dilution
Modular approach		Fidelity to protocol but flexible with data-driven guiding algorithm	Can be overwhelming; do not have algorithm for eating disorders
Unified/transdiagnostic approach		Holistic; integrated; some supporting data in other emotional disorders	Tends to be more generic; lose benefits from disorder specific interventions

Where the co-existing condition may be an obstacle because it prevents even the initiation of, or first steps towards change, there is a case for thinking that such obstacles should be addressed prior to treatment for the eating disorder (Fairburn et al., 2008), either with the use of medication or other forms of psychological treatment. Then, once sufficient change is achieved, treatment for the eating disorder may proceed as usual. Again, careful assessment will be required as outlined above. There may, of course, be further potential practical constraints in following this form of sequential treatment in terms of the number of sessions available. This may mean abbreviating the eating disorder treatment to do fewer sessions than a protocol mandates, and an abbreviated treatment of the other disorder. This becomes more challenging when dealing with more than one comorbid disorder.

There may be cases where the co-existing condition seems largely independent of the eating disorder and, although present, does not seem to interact with the eating disorder, or at least not to directly maintain or exacerbate it (e.g., some relationship difficulties). In such cases, a treatment focused on the eating disorder may still be successful while leaving the other condition unchanged, or general strategies acquired during treatment such as, for example, problem-solving may be applied successfully to address this other problem. If, however, the co-existing problem remains, this could be re-assessed after treatment ends and further intervention could be offered if warranted. This approach may also be subject to the practical constraints of a limited number of sessions being available.

2.3 | When the co-occurring mental health conditions interacts reciprocally with the eating disorder and is a barrier to progress

Much more challenging are cases where the co-existing condition interacts with the eating disorder in a reciprocal way that maintains aspects of both disorders, for example, a co-existing obsessional-compulsive disorder where fear of food contamination may result in restricted eating which then further exacerbates concentration on contamination fears, or where binge eating and purging may be used as ways of regulating emotions and avoiding processing trauma, thereby exacerbating the need for control over eating and increasing further vulnerability to unhelpful eating disorder behavior. There are also a range of other co-existing conditions, whether these be health-related (e.g., higher weight, Type 1 diabetes), traits (e.g., perfectionism) or social relationships (e.g., severe interpersonal difficulties) where similar considerations may apply.

While one option where lack of progress is apparent is the use of more intensive approaches (e.g., Chen et al., 2017), we are concerned in this paper with cases where lack of progress is plausibly determined to be due to an interaction with a comorbid condition. In

such cases we believe the direct way to address this would be an initial exploration of concurrent and possibly integrated interventions to tackle the comorbid condition. There are no current clearly accepted or evidence-based models of maintaining mechanisms on which to base individual formulations, no integrated treatments of this type, nor perhaps even agreement about what their precise form should be. There is clearly a need to develop and test models that can more flexibly include the role of interacting conditions, apart from the current, often default practice, of mixing and matching discussed earlier.

2.3.1 | Alternate interventions

One method may be alternating interventions with clinicians doing eating disorder treatment 1 week (or in one half of the session), and then tackling the other difficulty the following week (or second half of the session). This has the appeal of engagement and can emphasize the interconnection between the two disorders but may run the risk of being confusing for patient and therapist, encouraging therapist drift. Robust data on this approach are not available, despite the "half session" approach that has been used for some time in CBT-Enhanced (CBT-E; Fairburn et al., 2009) for people with complex co-occurring mental health conditions being offered the broad form of the treatment (CBT-Eb) while those with less complexity receive the form focused solely on the eating disorder (CBT-Ef). For example, within this model, half a session would be dedicated to interpersonal psychotherapy in cases where interpersonal difficulties were determined to be a barrier to progress. The only evaluation to date suggests that of the complex subgroup of patients, designated by the therapist after 4 weeks of treatment, 60% of those who received CBT-Eb had a global Eating Disorder Examination score below 1.74 at 60-week follow-up compared to the 40% of those who received CBT-Ef (Fairburn et al., 2009). The reverse pattern of findings was consistently present among the less complex patients, with CBT-Ef proving superior to CBT-Eb.

2.3.2 | Modular approach

Modular approaches to the treatment of co-occurring mental health conditions (MATCH) (Chorpita et al., 2005), provide an example in which multiple co-occurring disorders can be addressed, in this case anxiety, depression, behavioral problems and trauma (Weisz et al., 2012). When used with children, this intervention uses a 'top problem assessment' (like goal-based outcomes) completed by children and parents independently using a rating of the top three problems, that is, identified as most important to them. This information is used to determine which disorder to treat first, and that disorder is addressed unless the session-by-session monitoring indicate a lack of sizeable response within the first few sessions (Weisz et al., 2011). Such a lack of response would invoke the guiding algorithm and an assessment of what might be interfering with progress in terms of the comorbid disorder. The comorbid disorder may then be addressed and once the interference has been removed, the treatment of the original disorder can recommence. In the eating disorders, perhaps a roughly similar strategy could involve starting by addressing aspects of psychoeducation and early behavioral change common to the evidence-based approaches to eating disorders (self-monitoring, weighing, regular eating) for all patients and then using session-by-session data to assess early change. A lack of response would invoke an assessment of what was interfering with progress and would need to be addressed either together with the eating disorder (if it seems if is truly interacting) or first before resuming eating disorder treatment. Of course, we currently lack guiding algorithms in eating disorders.

2.3.3 | Transdiagnostic approach

Another potentially elegant way to treat both the eating disorder and the co-occurring mental health conditions is through targeting transdiagnostic processes. This approach recognizes that disorders can share common etiological and maintenance processes and perhaps avoids many of the problems we have discussed (Fusar-Poli et al., 2019). Theoretically one might expect a simpler and more efficient therapy that may deliver better outcomes. To date, however, the evidence does not support this suggestion. A meta-analysis across 24 transdiagnostic randomized controlled trials (RCTs) for depression and anxiety (Newby et al., 2015) showed that transdiagnostic treatments outperformed comparison conditions with moderate effect sizes for anxiety, depression and QOL. There was, however, a significantly smaller effect size for the four studies that included a treatment as usual comparison condition as opposed to inactive controls. Transdiagnostic approaches originated across different classes of eating disorders (Fairburn et al., 2003) rather than across disorders, where the latter area of research has largely restricted its focus to anxiety and depressive disorders. The Unified Protocol of Barlow and colleagues (Barlow et al., 2017) and other transdiagnostic interventions (Dalgleish et al., 2020) aim to tackle both anxiety and depression by focusing on their common maintaining mechanisms. Although there is growing empirical support for these interventions, their proponents rarely hypothesize the outcome for the treatment will be superior to a disorder specific approach or lead to a paradigm shift in clinical care (Fusar-Poli et al., 2019). Instead, they consider their value to be simplification in terms of training, lower attrition and potential increased efficiency compared to the delivery of multiple interventions.

3 | SUGGESTED PROTOCOL FOR MANAGING CO-OCCURRING MENTAL HEALTH CONDITIONS AS A BARRIER TO EFFECTIVE TREATMENT

Overall, the evidence to date would suggest that trying to decide the best way to treat the eating disorder where there is co-occurring

mental health conditions before treatment commences is often likely to be unproductive, except for co-occurring mental health conditions that prevent initiation of change to the eating. The problem at present is that we may not yet have the means to accurately identify some of these relationships before treatment begins. Undertaking an analysis of the relationship of co-existing conditions with eating disorders may require "independent behavioral tests" of each disorder, treating one and seeing to what degree the two are functionally dependent (Rachman, 1991). This is consistent with the evidence that suggests baseline variables are not as useful in predicting treatment outcomes as the approach of trying a treatment and reviewing early response. In other words, hypotheses formed during assessment and formulation are best tested and reviewed in data-informed approaches in the early stages of eating disorder focused therapy as part of an iterative process or a systematic trial-and-error approach built on commencing the standard intervention for an eating disorder, utilizing collaborative review, identification of obstacles to change and reformulation as necessary.

In suggesting a 4-step protocol (Table 2), we are guided by three areas of evidence. First, sessional measurement shared with the patient improves retention and outcome (Delgadillo et al., 2018). Brief validated tools that could be utilized include the ED15 (Tatham et al., 2015), the EDE-Q7 (Grilo et al., 2015; Jenkins & Davey, 2020; Klimek et al., 2021; Machado et al., 2020), the GAD-7 (Spitzer et al., 2006) and PHQ-9 (Kroenke et al., 2001). Second, as with all types of psychopathologies, gains in CBT for eating disorders are made by the eighth to tenth session, after which there is no further reliable improvement (Rose & Waller, 2017; Saxon et al., 2017). Third, in the face of slow early change, changing strategy may improve outcome such that it is commensurate to that of people who exhibit early change (Chen et al., 2017).

TABLE 2 Four-step protocol when treating eating disorders where co-occurring mental health conditions is present and potentially acts as a barrier to effective treatment of the eating disorder.

Step	Strategy
1	Assessment and Formulation of eating disorder and comorbidities, identifying top three problems identified collaboratively among the patient, a significant other where possible, and the clinician. Include baseline psychometric assessment of eating disorder and the top three comorbid problems.
2	Commence standard treatment. Use sessional measures of disordered eating shared openly in session, review progress collaboratively in sessions 4–6, and reassess top three problems for use in this review.
3	Review. If progress, focused therapy for the eating disorder can continue. Where little progress in reducing disordered eating is evident, review with patient (and significant other, as appropriate) which of the three top problems (co-occurring mental health conditions) are the most problematic in terms of impeding progress. Other issues unrelated to comorbidity may emerge at this point which need attention.
4	Where comorbidity is identified as a barrier, choose (1) alternate, (2) modular, or (3) transdiagnostic strategy to tackle co-occurring mental health conditions. Continue to use sessional measure of disordered eating and review co-occurring mental health conditions when triggered by lack of progress over four adjacent sessions, opting for a data-driven change in treatment if progress is still not evident.

Hence, Step 1 involves assessment and formulation that notes the presence of comorbid traits or disorders with priority assessed collaboratively with the patient, a significant other where possible/appropriate, and the clinician. This requires baseline psychometric assessment of the eating disorder and the top three comorbid problems. Then the second step would be to commence an evidence-based therapy for the eating disorder and the use of a brief sessional measure that can inform a review of progress at sessions 4–6. Prior to the review session the psychometric assessment used at baseline should be readministered to inform the discussion. In the face of good progress, focused therapy for the eating disorder can continue but, if there is inadequate progress, Step 3 involves use of the data collected to discuss and assess whether the obstacle to progress seems likely to be the comorbid condition and, if so, agreeing collaboratively with the client that this should be addressed in therapy moving forward. Should it be determined that it is not a comorbid condition but some other reason for the slow progress (e.g., intense fear of weight regain) then perhaps more intense (different levels of care) but still eating disorder focused treatment would be appropriate. In Step 4 any of the three options we outlined above (alternate, modular, or transdiagnostic) can be adopted in tandem with ongoing sessional measures and regular ongoing evaluations of progress. Like the approach used in MATCH, four data points in a row that suggest poor progress would trigger another review session. At this stage we have insufficient data to suggest which of these three options are preferred, so the clinician may wish to adopt the approach that, in discussion with the patient, seems most appropriate, acceptable and/or feasible.

4 | TESTING THE PROTOCOL: RESEARCH PRIORITIES

Several research questions are suggested by the protocol. In the third step of the protocol, we need to be able to answer the question "What is not enough progress?". While many different studies identify slow progress in the early phase of treatment as an indicator of treatment outcome, this has been measured in different ways, with the majority taking either reduction in binge and/or purge behavior (or weight regain in the case of underweight) or decreases in the global EDE-Q score over the first 4–6 weeks (Chang et al., 2021) as indicators of progress. A transdiagnostic formula that can be developed and tested to quantify how much progress is required in this early stage to increase the likelihood of good outcome is required to guide clinical decision making.

In addressing the question "which comorbid condition needs to be tackled?", effort needs to be focused on identifying any comorbid conditions that indicate/are associated with slow early progress, as

opposed to overall outcome which is the current dominant strategy in treatment studies. Application of regression models or machine learning approaches may be useful to identify important comorbid correlates of slow progress that are associated with poorer outcome across the different eating disorders. Also worth considering are clinician-generated recommendations concerning the identification and management of important comorbidities through methodology such as Delphi studies and focus groups. We also note that in some cases the incorporation of the opinion of a significant other may be useful, but further research is required to ascertain when this is developmentally appropriate and helpful.

The fourth step of the protocol is our biggest area of "known unknowns", namely: (1) how do we successfully address problematic co-occurring mental health conditions, which could be another diagnosis or an underlying trait and (2) what is the ideal structure in which to do this – alternate, modular or transdiagnostic. Tackling the first part of these unknowns requires a multiplicity of available evidence-based modules that can be used flexibly and in a variety of combinations to suit needs and formulation, such as that currently being tested for depression and anxiety (Black et al., 2018). A promising pathway to more rapid development of suitable modules is the testing of single session interventions (SSIs). Rather than at the outset engaging in costly and lengthy randomized controlled trials, the ability to recruit substantially larger and more diverse populations than is usually possible in eating disorder research and to learn how such groups react to single theory-driven targeted interventions, may be a preferred approach to generate and evaluate new interventions for further elaboration. Information gained by well powered trials of brief interventions has the potential to improve our understanding of what maintains these disorders and how to address obstacles to progress (Cooper & Shafran, 2023; Schleider et al., 2023; Wade, 2023).

Tackling the second part of the unknowns requires less reliance on traditional parallel-group RCT designs and greater use of sequenced methods (Grilo et al., 2011) or adaptive treatment designs, which have been used relatively sparsely to date in the eating disorder field (e.g., Chen et al., 2017; Grilo et al., 2020). In these designs, treatment is tailored to early response. More research is also required using robust comparisons of transdiagnostic approaches (one approach for both the eating disorder psychopathology and co-occurring mental health conditions) compared to a specific diagnostic approach (Fusar-Poli et al., 2019).

5 | SUMMARY

Most eating disorders are associated with comorbidities which, in the absence of evidence and guidelines for how these should be approached, is associated with an increased likelihood of therapist drift. This situation is profoundly unsatisfactory for patients and their families. We have suggested a 4-step protocol to adopt in the face of co-occurring mental health conditions that is data-driven and iterative and is consistent with what we currently know about effective treatment. The usefulness of such a protocol needs to be tested in future research.

AUTHOR CONTRIBUTIONS

Tracey Wade: Conceptualization; writing – original draft; writing – review and editing. **Roz Shafran:** Conceptualization; writing – original draft; writing – review and editing. **Zafra Cooper:** Conceptualization; writing – original draft; writing – review and editing.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ACKNOWLEDGMENT

Open access publishing facilitated by Flinders University, as part of the Wiley - Flinders University agreement via the Council of Australian University Librarians.

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How to cite this article: Wade, T. D., Shafran, R., & Cooper, Z. (2023). Developing a protocol to address co-occurring mental health conditions in the treatment of eating disorders. *International Journal of Eating Disorders*, 1–9. https://doi.org/10.1002/eat.24008