From Multidisciplinary to Transdisciplinary Care in Eating and Feeding Disorders: A Mechanism-Based Framework for Psychotherapeutic Practice

Vincenzo BONACCORSI ✉
Neurosinc, Via Paolo Bnetivoglio 62, Catania, Italy

Salvatore Bruno RISCICA ✉
DSMD ASST Valellina e dell Alto Lario, Sondrio, Italy

Article's history:
Received 17th of October, 2025; Revised 20th of November, 2025; Accepted for publication 20th of December, 2025; Available online: 27th of December, 2025; Published as research article in Volume III, Issue 3, 2025.

Cite this article:
Bonaccorsi, V., Riscica, B. (2025). From Multidisciplinary to Transdisciplinary Care in Eating and Feeding Disorders: A Mechanism-Based Framework for Psychotherapeutic Practice. *Journal of Contemporary Approaches in Psychology and Psychotherapy,* Volume III, Issue 3, 81 – 109. https://doi.org/10.57017/jcapp.v3.i3.05

Abstract:

Eating and Feeding Disorders (ED/FD) are multi-level conditions arising from dynamic interactions among biological, psychological, relational, and nutritional processes. Despite advances in multidisciplinary and interdisciplinary care, treatment remains fragmented, with parallel interventions and limited mechanistic integration.

This paper proposes a trans-disciplinary, mechanism-based framework that reorganises ED/FD care around shared constructs, coordinated mechanisms of change, unified outcome systems, and joint clinical decision-making. The model targets core transdiagnostic processes, including interoceptive dysregulation, avoidance, cognitive–affective rigidity, and relational dynamics, enabling synchronised intervention across domains and enhancing clinical coherence and continuity of care. Moving beyond role coordination, the framework shifts integration toward mechanism alignment, conceptualising treatment as a unified therapeutic system rather than a set of parallel inputs. To support real-world implementation, the model incorporates CFIR and RE-AIM frameworks, providing a structured approach to evaluating feasibility, fidelity, and sustainability.

This approach offers both a conceptual and operational advancement, with implications for service design, professional training, and outcome standardisation. Beyond ED/FD, it provides a scalable model for complex psychiatric conditions characterised by multi-level maintaining mechanisms.

Keywords: eating and feeding disorders; transdisciplinary care; psychotherapy integration; mechanisms of change; case formulation; clinical decision-making.

Introduction

Eating and feeding disorders (ED/FD) are paradigmatic examples of multi-level, dynamically maintained conditions in contemporary psychiatry. Clinically, they emerge at the intersection of genetic vulnerability, developmental trajectories of attachment and affect regulation, embodied experiences of hunger and satiety, sociocultural body norms, and the organisation of care systems across primary, specialist, and community settings (Hay et al., 2023). Advances in neuroimaging, genetics, and gut–brain research increasingly support a systems-based understanding, highlighting distributed network perturbations, particularly in reward processing, interoceptive precision, cognitive control, and habit formation, rather than single causal mechanisms.

From a psychosocial perspective, ED/FD are conceptualised as disorders of identity, affect regulation, and relational functioning, in which food and the body operate as central mediators of control, self-worth, and interpersonal positioning. These processes unfold within complex relational matrices, including families, peer systems, and digital environments, where feedback loops can either reinforce maladaptive patterns or facilitate recovery (Hay et al., 2023). Epidemiological evidence further indicates that only a minority of individuals access evidence-based treatment, while delays in care remain substantial, particularly in non-specialist pathways (Espel-Huynh et al., 2020; Dolan, et al. 2022).

Recent developments in network and systems-based models reinforce this shift away from linear causation. By analysing symptom–symptom and person–context interactions, these approaches demonstrate how cognitive, affective, and behavioural elements form self-reinforcing configurations that vary across individuals and diagnostic categories (Calvert et al., 2022). Such findings support a growing consensus that ED/FD cannot be adequately understood, or treated, within isolated disciplinary frameworks, but instead require models capable of capturing dynamic, cross-level interactions.

In response to this complexity, clinical services have progressively adopted multidisciplinary and interdisciplinary models of care. Multidisciplinary approaches allow multiple professionals to contribute to treatment, while interdisciplinary models aim to improve coordination through shared planning. However, as highlighted in foundational work on integration in healthcare (Choi & Pak, 2006, 2007, 2008; Boon & Van Baalen, 2019; Van Bewer, 2017), these models often remain constrained by disciplinary boundaries.

In practice, multidisciplinary systems frequently operate through parallel interventions, with limited integration at the level of case formulation, outcome measurement, and decision-making. Interdisciplinary models partially address this limitation, yet they often lack shared conceptual frameworks and unified mechanisms of change. As a result, treatment pathways may remain fragmented, with inconsistencies in clinical priorities, duplication of assessments, and reduced coherence in therapeutic processes.

Implementation studies in ED services further illustrate these structural limitations. Large-scale reforms, including stepped-care systems and youth-focused service models, demonstrate that improved outcomes depend not only on the availability of evidence-based interventions but also on the degree of coordination across service levels, professional roles, and organisational contexts (Bryson et al., 2024; Collantoni et al., 2023). These findings point to a “system-of-systems” dynamic, in which clinical trajectories are shaped by interactions among individual psychopathology, family systems, service organisation, and policy frameworks (Espel-Huynh et al., 2020).

These limitations highlight a critical gap in contemporary psychotherapeutic and service-oriented practice: the absence of a unified, mechanism-based framework capable of integrating disciplinary contributions into a coherent clinical system. Without such integration, treatment risks functioning as a set of loosely coordinated interventions rather than a structured, mechanism-driven process.

The concept of transdisciplinarity offers a potential solution to this gap. Unlike multidisciplinary or interdisciplinary models, transdisciplinary approaches aim to transcend disciplinary boundaries by developing shared constructs, integrated methodologies, and unified decision-making systems (Choi & Pak, 2006, 2007). This shift is not merely organisational but epistemological, requiring alignment across theoretical models, clinical reasoning, and intervention strategies.

Within psychotherapy research, transdiagnostic and mechanism-focused perspectives provide a relevant foundation for such integration. By emphasising shared processes, such as interoceptive dysregulation, maladaptive cognitive-affective patterns, and avoidance dynamics, these approaches enable the identification of common targets across diagnostic categories (Wade, 2025). In ED/FD, these mechanisms interact closely with nutritional status, medical risk, and relational environments, reinforcing the need for coordinated, cross-domain intervention strategies.

Recent empirical work on transdiagnostic and transdisciplinary treatment programmes further supports this direction, demonstrating the relevance of integrated approaches for improving clinical outcomes and reducing dropout rates in real-world settings (Maher et al., 2022; Dalgleish et al., 2020). These developments align with broader trends in contemporary mental health research, which increasingly emphasise systems thinking, implementation science, and mechanism-level integration as key drivers of effective care.

In light of these considerations, the present study aims to develop a transdisciplinary framework for ED/FD care that integrates insights from clinical psychology, psychiatry, nutrition science, and implementation science. Adopting a theory-driven conceptual approach, the paper proposes a model centred on shared case formulation, coordinated mechanisms of change, and unified outcome systems.

The contribution of this study is twofold. First, it advances a mechanism-based conceptualisation of transdisciplinary care, extending existing models of integration by explicitly linking clinical processes across domains. Second, it provides a structured framework for operationalising integration in practice, with implications for clinical decision-making, service design, and professional collaboration. By reframing ED/FD treatment as a coordinated system of interacting mechanisms rather than parallel disciplinary inputs, this approach seeks to enhance treatment coherence, adaptability, and long-term effectiveness in complex clinical contexts.

The remainder of the paper is structured as follows. Section 2 reviews the theoretical foundations of multidisciplinary, interdisciplinary, and transdisciplinary approaches in healthcare and psychotherapy. Section 3 outlines the conceptual and analytical framework adopted in this study. Section 4 presents the proposed transdisciplinary model and its core components. Section 5 discusses the clinical and organisational implications of the framework, while Section 6 concludes with key findings, limitations, and directions for future research.

1. Conceptual Foundations: From Multi- to Trans-Disciplinarity

Multidisciplinary Care

Multidisciplinary care remains the dominant organisational model in eating and feeding disorder (ED/FD) services. Within this framework, multiple professionals, typically psychiatrists, psychologists, dietitians, nurses, paediatricians, social workers, and family therapists, contribute to assessment and treatment through parallel disciplinary inputs, each grounded in distinct epistemic frameworks and clinical priorities (Bueter & Jukola, 2025). This structure ensures comprehensive coverage of key domains, including medical stabilisation, nutritional rehabilitation, and psychological intervention, which is essential given the high comorbidity and clinical risk associated with ED/FD.

However, this breadth of expertise is accompanied by structural limitations. Because disciplines operate with relative conceptual autonomy, clinical formulations and treatment plans frequently remain fragmented. Psychiatric assessments may prioritise diagnostic classification and risk management, dietetic interventions focus on metabolic and behavioural stabilisation, while psychotherapeutic approaches target maintaining mechanisms such as cognitive rigidity, affect dysregulation, and identity-related processes (Warren & Frame, 2025). Although multidisciplinary meetings aim to integrate these perspectives, they often function as informational exchanges rather than as mechanisms for generating shared conceptual models.

In ED/FD contexts, such fragmentation may lead to reduced treatment coherence. Nutritional rehabilitation may proceed without full alignment with cognitive or emotional processes, medical priorities may override psychotherapeutic pacing, and family interventions may remain insufficiently integrated with individual treatment goals. Consequently, care is delivered as a set of parallel interventions rather than as a unified, mechanism-driven process, potentially limiting overall effectiveness.

Interdisciplinary Care

Interdisciplinary care represents a deliberate effort to address the limitations of parallelism by fostering integration across professional domains. In this model, practitioners engage in shared planning, negotiate common goals, and coordinate intervention strategies, thereby enhancing conceptual alignment and collaborative decision-making (Repko & Szostak, 2020). Interdisciplinarity promotes cross-fertilisation of knowledge and acknowledges the interdependence of biological, psychological, and social processes.

In ED/FD treatment, interdisciplinary approaches have demonstrated important improvements. Nutritional interventions may be coordinated with exposure-based strategies, psychotherapists may account for the cognitive effects of malnutrition, and family-based interventions may incorporate both medical risk and psychological formulation (Lock & Le Grange, 2025). These developments contribute to a more coherent identification of maintaining mechanisms, including avoidance patterns, cognitive inflexibility, and family accommodation.

Nevertheless, interdisciplinary models remain constrained by the persistence of disciplinary boundaries. Integration typically occurs through negotiation rather than through the development of shared conceptual frameworks. As a result, tensions may arise regarding treatment sequencing, prioritisation of mechanisms, or interpretation of clinical phenomena. For example, distress during meals may be conceptualised differently across disciplines, as behavioural avoidance, physiological hyperarousal, or relational signalling, leading to partial alignment rather than full conceptual convergence.

Moreover, interdisciplinary systems often retain discipline-specific documentation practices, outcome measures, and thresholds for clinical decision-making. These structural features can perpetuate fragmentation at the operational level, even when collaboration is improved. Thus, while interdisciplinarity represents a critical advancement, it remains insufficient for addressing the dynamic, multi-level interactions that characterise ED/FD.

Trans-disciplinary Care

Trans-disciplinary care constitutes a qualitatively distinct paradigm, moving beyond coordination toward integration at the level of concepts, methods, and decision-making systems. Rather than combining disciplinary perspectives, trans-disciplinarity seeks to generate shared constructs, shared language, and shared methodological infrastructures capable of addressing complex clinical phenomena (Van Bewer, 2017).

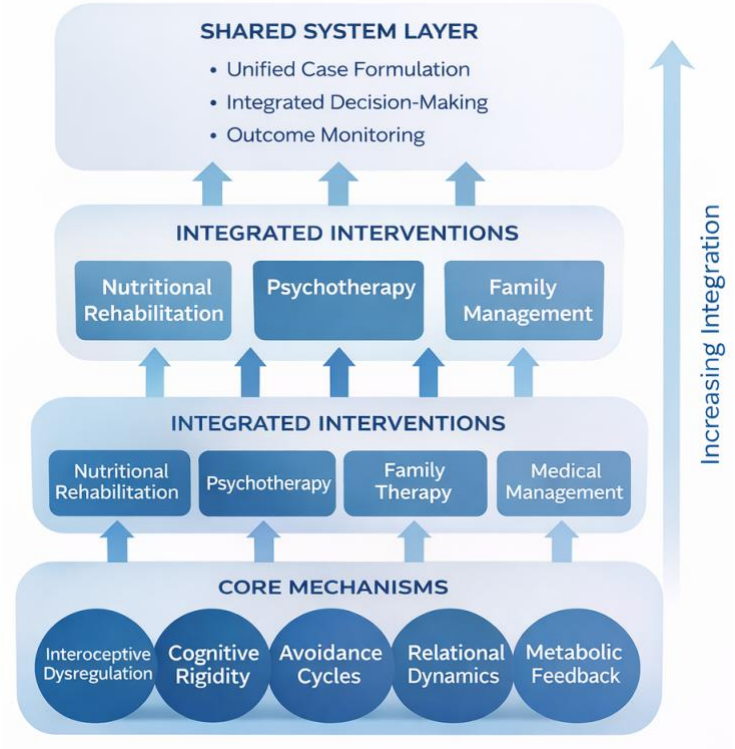
In ED/FD, this approach implies the development of integrative constructs that simultaneously capture biological, psychological, and relational processes. Examples include interoceptive dysregulation, embodied self-regulation, or relational modulation of eating behaviour, which link neurobiological processes, affect regulation, and interpersonal dynamics within unified explanatory frameworks (Kaye et al., 2020). These constructs are not owned by individual disciplines but function as shared reference points for assessment, intervention, and outcome monitoring. At the organisational level, trans-disciplinary teams adopt unified methodological infrastructures, including integrated case formulation models, shared assessment tools, coordinated timelines, and jointly developed clinical pathways. In contrast to interdisciplinary care, where disciplines align their separate methods, trans-disciplinary systems produce new, hybrid methodologies that reflect the complexity of the clinical problem itself.

This model is particularly suited to ED/FD, where neurobiological alterations, psychological maintaining mechanisms, family-system dynamics, and nutritional processes interact dynamically and reciprocally (Treasure et al. 2020). By conceptualising these processes as co-constitutive rather than hierarchical, trans-disciplinary care enables synchronised, mechanism-based intervention.

The distinction between multidisciplinary, interdisciplinary, and trans-disciplinary structures can be conceptualized along a continuum of increasing integration and shared decision-making processes (Figure 1).

The below Figure 1 illustrates a trans-disciplinary model of eating and feeding disorder (ED/FD) care structured across three hierarchical layers. The bottom layer represents core cross-domain mechanisms (e.g., interoceptive dysregulation, cognitive rigidity, avoidance cycles, relational dynamics, and metabolic feedback), which underpin symptom maintenance. The middle layer depicts integrated interventions, including nutritional rehabilitation, psychotherapy, family-based approaches, and medical management, designed to act synchronously on these mechanisms. The top layer reflects the shared system level, comprising unified case formulation, integrated clinical decision-making, and continuous outcome monitoring. The upward arrows indicate increasing levels of integration and coordination across domains, emphasising the transition from fragmented care toward a unified, mechanism-driven treatment system.

Figure 1: Trans-disciplinarity model of ED/FD care: mechanism-based integration



Source: Author's conceptualisation

Several theoretical arguments support the transition toward trans-disciplinary models in ED/FD care:

- ED/FD are characterised by non-linear dynamics, in which small perturbations in one domain can generate cascading effects across multiple systems. Network-based approaches demonstrate that symptoms form interconnected configurations with bidirectional influences between cognition, affect, behaviour, and relational processes (Forbush, Wildes, & Hunt, 2020). This complexity challenges linear and reductionist models of intervention.
- Effective treatment requires temporal and mechanistic alignment across domains. For example, exposure to food-related anxiety is more effective when coordinated with cognitive restructuring, emotional regulation strategies, and family-supported behavioural change. Similarly, medical stabilisation influences cognitive capacity and emotional processing, shaping the timing of psychotherapeutic interventions. Trans-disciplinary models explicitly design care pathways to achieve such synchrony.
- Mechanistic coherence refers to the extent to which different treatment components converge on shared underlying processes. In ED/FD, core cross-level mechanisms include interoceptive disturbance, cognitive rigidity, avoidance cycles, relational reinforcement patterns, and metabolic dysregulation (Treasure et al., 2020). Trans-disciplinary frameworks organise interventions around these shared mechanisms, enhancing consistency and therapeutic precision.
- Taken together, these considerations support a shift toward trans-disciplinarity as a more adequate scientific and clinical response to the complexity of ED/FD. Rather than coordinating parallel interventions, trans-disciplinary models restructure how knowledge is generated, integrated, and translated into clinical practice, enabling more coherent and effective treatment systems.

2. Mapping Current Clinical Pathways Against NICE NG69 (

What NICE NG69 Provides

To systematically evaluate the alignment between current clinical practice and guideline recommendations, this section adopts a structured pathway-mapping approach. NG69 recommendations are analysed across key functional domains, assessment, intervention, monitoring, and care transitions, and compared with observed patterns of implementation reported in the literature. The analysis focuses on identifying structural misalignments, defined as discrepancies between guideline-defined care components and their operational integration within clinical systems. Particular attention is given to three dimensions derived from Section 2: mechanistic coherence, intervention synchrony, and decision-system integration.

The National Institute for Health and Care Excellence guideline *Eating Disorders: Recognition and Treatment (NG69)* represents one of the most comprehensive and internationally influential frameworks for the assessment and management of eating and feeding disorders (ED/FD) (NICE, 2017). Its recommendations span early detection, risk stratification, psychological intervention, medical management, family involvement, and service organisation. Although developed within the UK National Health Service, NG69 has become a global reference point due to its systematic integration of empirical evidence across age groups and clinical settings.

A core principle of NG69 is early access to specialist assessment, supported by robust evidence that shorter duration of untreated illness is associated with improved outcomes across anorexia nervosa, bulimia nervosa, binge-eating disorder, and ARFID (Treasure et al., 2020). Accordingly, the guideline emphasises rapid triage and referral pathways, alongside training for non-specialist professionals to enhance detection in primary care, educational settings, and emergency services. This focus reflects longitudinal findings demonstrating that delayed intervention increases the risk of chronicity, medical complications, and treatment resistance (Ratnapradipa et al., 2023).

NG69 also places strong emphasis on medical safety, mandating systematic monitoring of cardiovascular status, electrolyte balance, bone health, and refeeding risk (Westmoreland et al., 2016; Baenas et al., 2024). These recommendations align with international consensus highlighting the necessity of integrated psychiatric–medical oversight in ED/FD care.

From a therapeutic perspective, NG69 endorses evidence-based interventions, including family-based treatment (FBT), enhanced cognitive behavioural therapy (CBT-E), MANTRA, interpersonal psychotherapy, and specialist supportive clinical management (SSCM), each supported by substantial empirical validation (Fairburn et al., 2009; Jansingh et al., 2020). The guideline further underscores family involvement, recommending structured engagement and collaborative goal-setting across age groups (Eisler et al., 2016).

In addition, NG69 promotes routine outcome monitoring, encouraging services to track symptom severity, medical status, and functional outcomes using validated measures. Finally, it adopts a stepped-care model, defining transitions between outpatient, community, day-care, and inpatient services based on clinical need.

Taken together, NG69 provides a robust, evidence-based specification of care components, clearly defining *what* should be delivered and *for whom*.

Structural Gaps in Implementation

Despite its generality, the translation of NG69 into routine clinical practice reveals a set of recurring structural misalignments, consistently documented across services and contexts. These misalignments can be analytically grouped into four domains: (1) conceptual integration, (2) intervention coordination, (3) measurement systems, and (4) decision-making processes.

Importantly, these gaps do not reflect deficiencies in the guideline itself, but rather arise from the organisational logic of multidisciplinary and interdisciplinary systems. A central issue concerns the absence of unified case formulations. In many services, professionals conduct and document assessments independently, relying on discipline-specific frameworks that identify different "core problems." This fragmentation reduces mechanistic clarity and often leads to inconsistencies between nutritional, psychological, and medical priorities (Bryson et al., 2024). Even when multidisciplinary meetings are in place, they tend to aggregate perspectives rather than generate genuinely shared conceptual models.

This lack of integration extends to family involvement. Although NG69 recommends systematic engagement of caregivers, implementation remains uneven, particularly in adult services, where family participation is often limited to psychoeducation or optional sessions rather than embedded within structured therapeutic processes (Gregg et al., 2021; Dehbozorgi et al., 2022). As a result, relational mechanisms that play a critical role in the maintenance and recovery of ED/FD are not consistently targeted across care pathways.

A further structural limitation lies in the separation of nutritional and psychological processes. In practice, nutritional rehabilitation and psychotherapy are frequently delivered as parallel interventions, with dietitians focusing on weight restoration and eating behaviour, while psychotherapists address cognitive distortions and emotional regulation. This division restricts opportunities for mechanism-level integration, such as leveraging nutritional exposure as a form of behavioural and emotional intervention targeting avoidance and interoceptive distress (Reilly et al., 2018, 2022). It may also generate temporal mismatches, for instance when cognitively demanding therapeutic work is initiated before sufficient physiological stabilisation has been achieved.

These challenges are compounded by inconsistencies in outcome measurement systems. Although NG69 advocates routine monitoring, it does not prescribe a standardised framework, resulting in considerable heterogeneity across services in terms of indicators used, frequency of assessment, and interpretative criteria. This variability limits comparability across cases, reduces the sensitivity of early detection of non-response, and weakens coordinated clinical decision-making (Barkham et al., 2024).

Finally, care transitions within stepped-care models are frequently governed by administrative or resource-driven criteria rather than by underlying clinical mechanisms. Patients may be discharged based on weight thresholds or service capacity despite ongoing cognitive–emotional vulnerabilities, or conversely remain in intensive treatment longer than necessary despite significant mechanistic improvement. Such mismatches disrupt the temporal coherence of interventions and undermine continuity of care. These structural gaps indicate that, in practice, NG69 is often operationalised through coordination rather than true integration, resulting in partial alignment of care components rather than a unified, mechanism-driven treatment system.

Why NG69 is necessary but insufficient

NG69 remains an essential foundation for eating and feeding disorder (ED/FD) care, offering a comprehensive, evidence-based framework that clearly specifies assessment procedures, therapeutic interventions, medical safety requirements, and service organisation. However, when examined from a systems perspective, the guideline can be characterised as component-complete but integration-limited, meaning that while it successfully defines what should be delivered, it provides limited operational guidance on how these components should be structurally integrated within real-world clinical pathways.

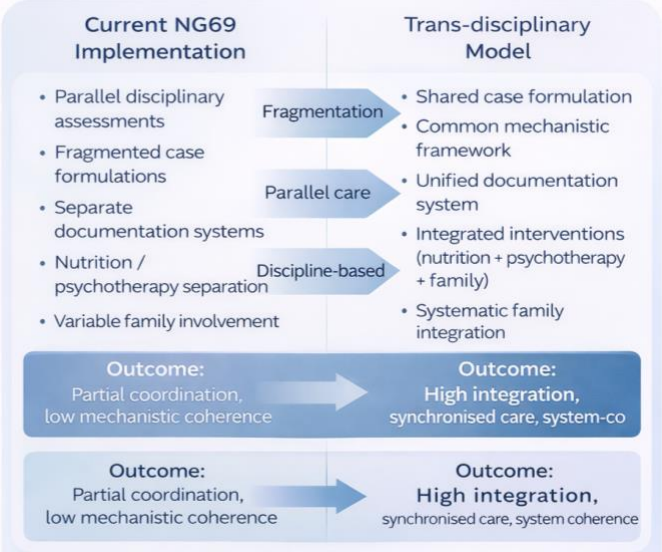
This limitation becomes particularly evident in the absence of explicit mechanisms for integration across disciplines. Although NG69 outlines key elements of care, it does not prescribe shared case formulation models, unified documentation systems, or coordinated decision-making architectures. As a result, implementation tends to default to discipline-specific interpretations, where each professional applies guideline recommendations within their own conceptual framework rather than within a collectively constructed system. This structural gap reinforces the fragmentation already observed in multidisciplinary and interdisciplinary settings, limiting the capacity of teams to operate as fully integrated clinical systems.

Closely related to this issue is the lack of a shared mechanistic language. Core clinical constructs such as “risk,” “motivation,” or “severity” are often interpreted differently across psychiatry, psychology, dietetics, and nursing, leading to implicit misalignments in treatment priorities and decision-making. In the absence of common cross-domain constructs, such as interoceptive dysregulation, avoidance cycles, or relational reinforcement patterns, coordination remains largely procedural rather than truly conceptual (Treasure et al., 2020). Consequently, interventions may be aligned at the level of scheduling or sequencing, but not at the level of underlying mechanisms.

Furthermore, NG69 does not require the synthesis of its recommendations into a single, jointly owned treatment structure. Although it endorses multiple evidence-based interventions, these are typically implemented as parallel streams rather than as components of a unified therapeutic strategy. This lack of integration can result in temporal and functional desynchronisation, where nutritional rehabilitation, psychotherapeutic processes, family interventions, and medical management are not optimally aligned. In such contexts, patients may receive technically appropriate interventions that nonetheless lack coherence at the system level.

These structural differences between current NG69-based implementation and a trans-disciplinary, mechanism-driven model are synthesised in Figure 2. This figure contrasts conventional implementations of NICE NG69, typically operationalised through multidisciplinary or interdisciplinary models, with a trans-disciplinary, mechanism-driven approach to ED/FD care. The left side illustrates current practice, characterised by parallel processes, fragmented formulations, and heterogeneous decision systems. The right side depicts a trans-disciplinary model structured around shared mechanisms, integrated interventions, and unified decision-making frameworks. The horizontal comparison highlights the transition from coordination-based care toward system-level integration, while the directional arrows emphasise the shift from discipline-specific processes to a coherent, synchronised treatment architecture.

Figure 2. Conventional NG69-based pathways versus trans-disciplinary integrated care model in ED/FD



Source: Author's conceptualisation

Taken together, these limitations indicate that NG69, while indispensable, does not fully address the organisational and epistemic requirements of complex ED/FD care. As previously outlined in Section 2, addressing these gaps requires a shift from coordination toward trans-disciplinary integration, in which shared mechanisms, synchronised interventions, and unified decision systems form the basis of clinical practice. In this sense, NG69 should be understood not as a complete model of care, but as a necessary foundation that requires further structural development to achieve mechanism-level coherence in real-world implementation.

3. A Trans-Disciplinary Framework for ED/FD Care

A trans-disciplinary framework for eating and feeding disorders (ED/FD) extends beyond the limitations of multidisciplinary parallelism and negotiated interdisciplinarity by establishing a fully integrated system of care organised around shared mechanisms, synchronised interventions, and unified decision architectures. Rather than coordinating discipline-specific contributions, this model restructures clinical practice at the level of conceptualisation, measurement, and action, generating integrative knowledge domains that belong to the clinical system as a whole rather than to individual professions.

In alignment with the structural gaps identified in Section 3, the framework directly addresses three core deficits observed in current NG69-based implementations: fragmentation of case formulations, desynchronisation of interventions, and inconsistency in decision-making systems. It does so by operationalising a mechanism-driven architecture, in which all components of care are aligned around shared explanatory constructs and dynamically coordinated across biological, psychological, relational, and nutritional domains.

At the centre of the trans-disciplinary model lies a shared case formulation system, which replaces discipline-specific narratives with a unified, mechanism-based representation of ED/FD pathology. This formulation integrates interoceptive disturbances, cognitive rigidity, emotional avoidance, relational reinforcement patterns, and metabolic feedback into a single dynamic system (Kaye et al., 2020; Treasure et al., 2020). Formulation is not merely a retrospective synthesis, but a prospective, co-constructed process that actively guides intervention design and iterative adaptation throughout treatment.

Complementing this, the framework introduces a shared outcome system, ensuring that all team members monitor the same domains at consistent intervals. Outcomes extend beyond symptom reduction to include interoceptive functioning, relational dynamics, functional recovery, and medical stability. This unified measurement structure enables real-time, mechanism-informed adjustments, replacing fragmented indicators with coherent system-level feedback (Jenkins et al., 2020).

A defining feature of the model is the emphasis on unified treatment mechanisms. Rather than viewing interventions as discipline-bound techniques, the framework identifies a set of cross-cutting mechanisms, such as interoceptive recalibration, reduction of avoidance cycles, enhancement of distress tolerance, restructuring of family accommodation, and normalisation of nutritional patterns, that are targeted simultaneously across domains. Each professional contributes to these mechanisms in complementary ways, but within a shared temporal and conceptual structure, ensuring mechanistic synchrony across interventions.

This integration is sustained through team reflexivity and adaptive role fluidity, where clinicians continuously evaluate how their assumptions, practices, and interactions influence treatment processes (McHugh et al., 2020; Zajac et al., 2021). Professional boundaries are preserved at the level of expertise but become permeable at the level of implementation, allowing flexible responses to clinical needs while maintaining systemic coherence.

Finally, the framework is explicitly embedded within implementation science, recognising that sustainable transformation requires alignment with organisational contexts. Models such as CFIR and RE-AIM provide structured approaches for evaluating feasibility, fidelity, scalability, and long-term sustainability (King et al., 2020; Reardon et al., 2025). This ensures that the framework is not merely conceptual but operationally transferable across clinical settings.

Shared Constructs

The effectiveness of a trans-disciplinary framework depends on the development of shared constructs that function as common reference points across disciplines, enabling coherent formulation, intervention alignment, and decision-making.

Interoceptive awareness and regulation constitute a central construct, given the well-documented disturbances in bodily signal processing across ED/FD (Khalsa et al., 2018; Garfinkel, et al. 2022). Constructs such as interoceptive accuracy and distress tolerance allow clinicians to align nutritional exposure, emotional regulation, and medical monitoring within a unified mechanism.

Cognitive–affective maintaining processes, including rigidity, overvaluation of weight and shape, and attentional biases, are conceptualised not as isolated psychological features but as components of broader system dynamics interacting with metabolic and relational factors. This perspective enables simultaneous targeting across behavioural, emotional, and physiological domains.

Avoidance and distress intolerance represent another cross-cutting system, linking behavioural restriction, emotional suppression, and interpersonal withdrawal. Within a trans-disciplinary model, exposure-based interventions are coordinated across team members, ensuring consistent reinforcement of approach-oriented behaviour.

Relational processes, particularly family accommodation and scaffolding, are integrated as core mechanisms rather than adjunctive considerations. Shared constructs such as relational contingency and communication coherence allow family dynamics to be systematically addressed across all phases of care (Eisler et al., 2016).

Importantly, nutritional rehabilitation is reconceptualised as a mechanistically active intervention, influencing interoception, cognition, and emotional regulation simultaneously. This reframing dissolves the traditional separation between "biological" and "psychological" treatment domains (Jowik et al., 2021; Giannese, et al. 2023).

Shared Measurement System

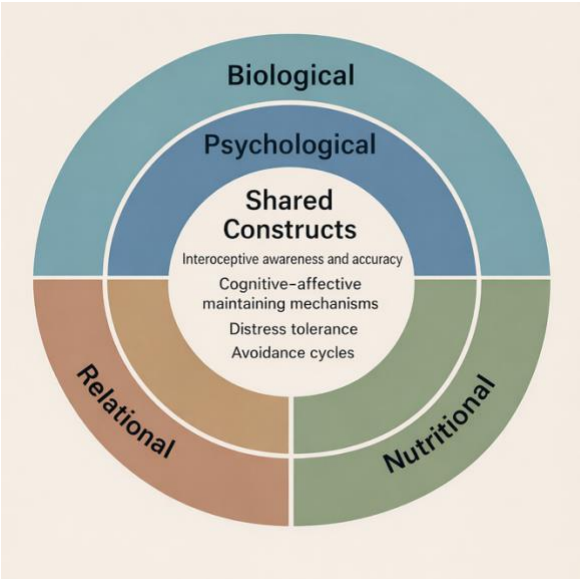
To sustain integration, the framework employs a standardised, multi-domain measurement system, administered at predefined intervals (e.g., baseline, weeks 4, 12, 24, and 52). This system ensures that clinical progress is evaluated consistently across domains and informs coordinated decision-making.

Symptom severity is assessed using the EDE-Q, capturing cognitive and behavioural dimensions of ED pathology (Fairburn et al., 2009), while functional impairment is evaluated through the CIA, reflecting real-world impact (Bohn et al., 2008). Interoceptive processes are monitored using the MAIA (Mehling et al., 2012; Pfeifer et al., 2025), providing insight into underlying mechanistic change.

Medical and nutritional indicators, including BMI trajectories, metabolic parameters, and exposure tolerance, ensure physiological safety and track recovery at the biological level (Donini, 2022; Mehler & Andersen, 2022). Relational dynamics are assessed using validated family measures, integrating systemic processes into outcome evaluation. The value of this system lies not in individual measures, but in their integration within a unified monitoring architecture, enabling early detection of cross-domain divergence and supporting mechanism-driven clinical adjustments.

The integration of these shared constructs across biological, psychological, relational, and nutritional domains is conceptualised as a layered system, illustrated in Figure 3. The circular layered diagram illustrates the core shared constructs at the centre of a trans-disciplinary eating and feeding disorder (ED/FD) model.

Figure 3. Trans-disciplinary ED/FD Framework



Source: Author's conceptualisation

Unified Decision Rules

To ensure coherence across biological, psychological, relational, and nutritional domains, trans-disciplinary care operationalises decision-making through a unified, mechanism-based rule system. These rules translate shared assessment data into coordinated clinical actions, reducing variability and ensuring synchronised interventions across the treatment pathway.

The operational structure of these rules is synthesised in Table 1, which systematises decision domains, mechanistic indicators, thresholds, and corresponding clinical actions within a shared team-based framework.

Table 1: Unified Decision Rules in Trans-disciplinary ED/FD Care

Decision Domain	Mechanistic Indicators	Threshold / Trigger	Clinical Action	Responsible System Level
Step-up (intensification)	Medical instability; rapid weight loss; worsening EDE-Q/CIA; low meal completion; high interoceptive distress; increased family accommodation	Any acute deterioration or multi-domain worsening	Escalation to higher level of care (e.g., day-hospital, inpatient); increase monitoring frequency; intensify family involvement	Shared team decision (medical + psychological + nutritional)
Step-down (de-intensification)	Stabilised vitals; improved cognitive flexibility; reduced avoidance; improved family scaffolding; increased interoceptive tolerance	Sustained improvement across ≥3 domains	Transition to lower-intensity care; increase autonomy; reduce supervision gradually	Shared team decision with patient/family involvement
Medical red flags	Bradycardia; hypotension; electrolyte imbalance; syncope; hypothermia; organ risk markers	Any threshold breach (Donini, 2022)	Immediate medical intervention; possible hospitalisation; override other treatment priorities	Medical-led, with full team alignment
Relapse-risk thresholds	Reduced meal regularity; increased avoidance/body checking; rising emotional reactivity; reduced family support	Early-warning pattern detected across ≥2 domains	Activate relapse-prevention protocol; increase session frequency; re-engage family support	Shared monitoring system (continuous review)
Adjunctive interventions	Persistent anxiety; emotional dysregulation; family accommodation; low engagement; early relapse signals	Mechanism-specific need identified	Introduce SSRIs (if indicated); intensify family therapy; group therapy; digital EMA tools	Tailored, mechanism-driven allocation

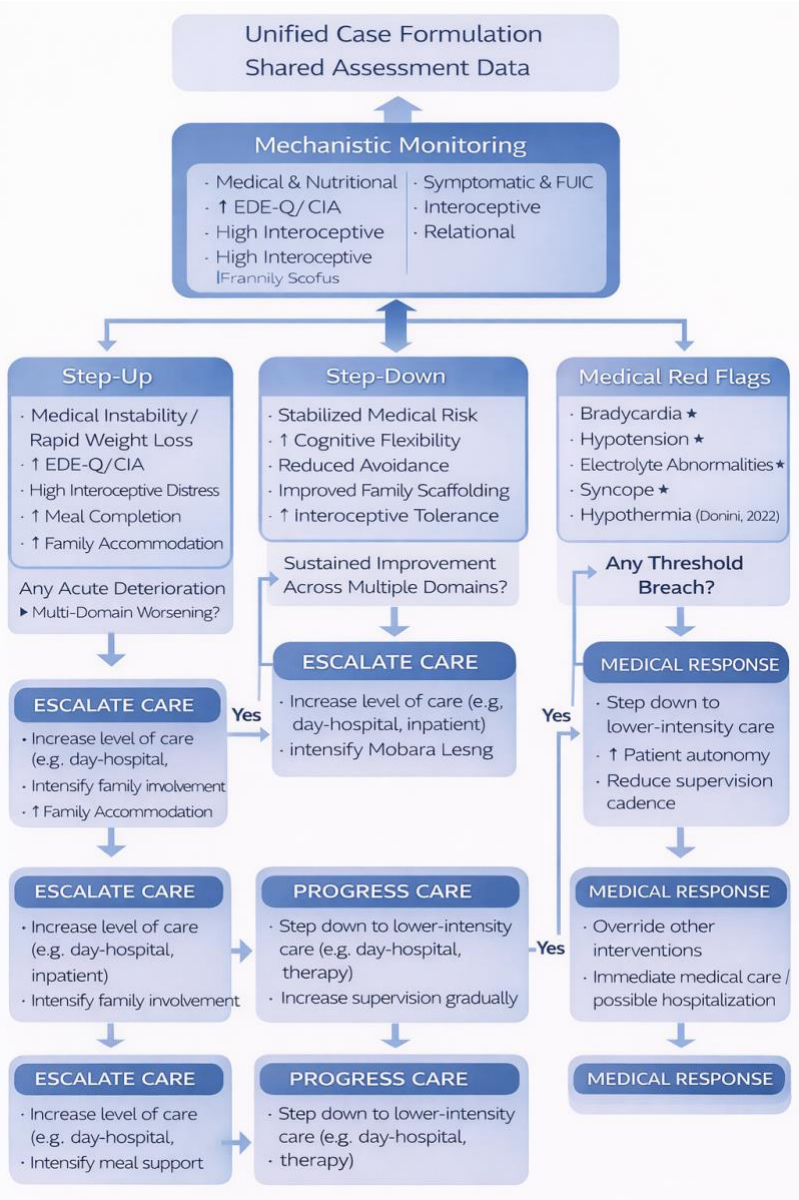
Note: EDE-Q = Eating Disorder Examination Questionnaire; CIA = Clinical Impairment Assessment; EMA = Ecological Momentary Assessment. Decision rules are applied through a shared, trans-disciplinary framework integrating biological, psychological, relational, and nutritional indicators.

Source: Author's conceptualisation

This structured decision system operationalises trans-disciplinary integration by aligning mechanisms, interventions, and system-level responses within a unified clinical architecture. While Table 1 provides a structured representation of decision rules, their dynamic application in clinical practice is illustrated through the algorithmic model presented in Figure 4.

Figure 4 presents a unified, mechanism-based decision algorithm for eating and feeding disorder (ED/FD) care within a trans-disciplinary framework. The process begins with shared case formulation and continuous mechanistic monitoring across biological, psychological, relational, and nutritional domains. Based on integrated indicators, the system dynamically guides clinical decisions across five pathways: step-up (intensification of care), step-down (de-intensification), medical red flags (urgent medical override), relapse-risk detection, and adjunctive intervention allocation. Arrows represent continuous feedback loops, emphasising that decision-making is iterative, data-driven, and synchronised across the team. The algorithm operationalises the alignment between mechanisms, interventions, and system-level responses.

Figure 4. Unified trans-disciplinary decision algorithm for ED/FD care



Note: EDE-Q = Eating Disorder Examination Questionnaire; CIA = Clinical Impairment Assessment; EMA = Ecological Momentary Assessment.

4. Clinical Pathway Structure

A trans-disciplinary framework for eating and feeding disorders (ED/FD) requires a clinical pathway that functions not as a sequence of isolated interventions, but as an integrated therapeutic system in which assessment, mechanisms, interventions, and decision rules operate in continuous synchrony. Building directly on the shared constructs (Section 3.2), unified measurement system (Section 3.3), and decision architecture (Section 3.4), this pathway translates the conceptual model into a structured, mechanism-driven clinical process.

The pathway is organised into four sequential yet dynamically interacting phases: (1) initial assessment, (2) early intervention, (3) mechanism-focused treatment, and (4) consolidation and relapse prevention. These phases are not strictly linear but interconnected through continuous feedback loops, ensuring real-time adaptation based on integrated monitoring.

4.1 Initial Assessment Phase

The initial assessment phase establishes the epistemic and operational foundation of the trans-disciplinary pathway. Unlike traditional approaches characterised by parallel discipline-specific evaluations, this phase employs a single shared assessment template, collaboratively used by all team members.

This unified structure integrates psychiatric, psychological, nutritional, medical, and relational data into a coherent system, enabling the immediate construction of a shared, mechanism-based formulation. This approach reduces redundancy, enhances diagnostic precision, and ensures that subsequent interventions are grounded in a common explanatory model (Geller et al., 2019).

Assessment is organised across four interacting domains:

- Biological: vital signs, metabolic parameters, endocrine and gastrointestinal functioning (Donini, 2022);
- Psychological: cognitive rigidity, overvaluation, emotional dysregulation, interoceptive disturbance (Aloi et al., 2024);
- Relational: family accommodation, communication patterns, expressed emotion (Eisler et al., 2016);
- Nutritional: eating patterns, fear foods, compensatory behaviours, exposure history (Baker et al., 2017; Christian et al., 2024).

These domains are not assessed independently but as interacting components of a unified system, forming the basis for mechanism-driven intervention planning.

Risk stratification further operationalises this phase by distinguishing between acute risk, psychiatric instability, and complex/chronic trajectories (Tchanturia et al., 2013; Sader et al., 2025). This stratification directly informs treatment intensity, monitoring frequency, and the degree of family involvement.

4.2 Early Intervention Phase

The early intervention phase aims to stabilise the patient while simultaneously activating the core mechanisms of therapeutic change. This stage is guided by three interrelated objectives: (1) ensuring safety, (2) mobilising key change processes, and (3) establishing a coordinated therapeutic alliance across the care system.

Medical stabilisation remains the immediate priority when acute risk is present, particularly in the context of electrolyte imbalance, cardiovascular instability, or refeeding risk. However, within a trans-disciplinary framework, medical intervention is not treated as separate from psychotherapy or nutritional care, but is embedded within a shared decision architecture that aligns biological safety with psychological readiness and nutritional progression. This integrated perspective is consistent with recent developments in cognitive-behavioural treatment for eating disorders, which emphasise the importance of early, structured, and coordinated intervention across levels of care. In adolescent populations, early intervention is especially important when perfectionism, emotional rigidity, and behavioural control are already consolidating as maintaining mechanisms, making timely and coordinated care clinically decisive (Chęć & Michałowska, 2024; Levinson et al., 2017).

Nutritional rehabilitation is introduced from the outset and conceptualised not merely as a biomedical necessity, but as a mechanistically active intervention capable of influencing cognition, affect regulation, and interoceptive functioning. Structured meal plans, graded exposure to feared foods, and psychoeducation are coordinated across professionals, transforming eating behaviour itself into a therapeutic mechanism. This perspective is compatible with evidence supporting family-based and integrated treatment approaches, in which behavioural, relational, and nutritional change processes are activated in parallel rather than sequentially (Couturier et al., 2013).

At the same time, early psychological engagement focuses on key maintaining processes, including avoidance, cognitive distortions, emotional dysregulation, and maladaptive perfectionism. This early work is not intended to prematurely intensify psychotherapy, but rather to introduce a shared explanatory framework that helps patients and families understand the logic of treatment and begin engaging with change mechanisms from the beginning (Latzer & Stein, 2019). Family systems are likewise activated early, with caregivers positioned as co-regulators of distress and partners in therapeutic scaffolding. This is particularly important given accumulating evidence that family-system practices are closely associated with parental psychological functioning and the overall quality of caregiving, both of which directly influence adherence and recovery trajectories (Dunst, 2023).

4.3 Mechanism-Focused Treatment Phase

Following stabilisation, the clinical pathway transitions toward the targeted modification of the mechanisms sustaining ED/FD pathology. At this stage, treatment is explicitly organised around cross-domain mechanisms rather than discipline-specific techniques, ensuring that biological, psychological, relational, and nutritional processes are addressed within a unified therapeutic system.

Exposure-based interventions constitute a central mechanism and are systematically coordinated across domains. These interventions target internal cues (e.g., hunger, satiety, affective arousal), external stimuli (e.g., feared foods and eating contexts), and emotional states (e.g., shame, anxiety, anger). Such coordination ensures that behavioural, cognitive, and relational processes converge on shared therapeutic targets, thereby reducing avoidance and reinforcing approach-oriented behaviour. This transdiagnostic application of exposure is consistent with contemporary evidence highlighting its role not only in anxiety-related conditions but also in the treatment of complex, mechanism-driven psychopathologies (Teunisse et al., 2022).

Interoceptive training is concurrently integrated as a core mechanism of change, using body-based techniques such as interoceptive exposure, mindful body scanning, and breath-focused awareness to restore sensitivity to internal physiological signals and enhance regulatory capacity. Recent integrative and psychophysiological research underscores the centrality of interoception in emotion regulation and its role in bridging somatic and cognitive processes, particularly within mind–body interventions and across developmental trajectories (Lazzarelli et al., 2024; Pfeifer & Cawkwell, 2025).

Cognitive restructuring is embedded within real-time behavioural and relational contexts rather than delivered as an isolated cognitive technique. Within this framework, dysfunctional beliefs are challenged during active exposure, nutritional rehabilitation, and interpersonal interactions, ensuring alignment between cognition, behaviour, and relational feedback. This integrated approach is supported by meta-analytic evidence demonstrating that cognitive restructuring contributes significantly to therapeutic outcomes when embedded within broader intervention systems (Ezawa & Hollon, 2023), as well as by ecological neuroscience perspectives emphasising the dynamic interaction between cognitive processes and environmental context (Crum, 2021). Such integration strengthens mechanistic coherence across domains and prevents the fragmentation typical of discipline-bound interventions.

Finally, family systems undergo structured reorganisation, shifting from patterns of accommodation toward scaffolding, co-regulation, and coordinated limit-setting. Within a trans-disciplinary model, family processes are conceptualised as active mechanisms of change rather than contextual variables. Contemporary frameworks conceptualising emotion regulation as a family-level and co-regulated phenomenon further support this systemic integration, highlighting how caregiver responses shape both emotional processing and behavioural adaptation (Paley & Hajal, 2022). These processes are operationalised through evidence-based systemic interventions, including family-based and multifamily therapy models, which have demonstrated efficacy in promoting recovery-supportive relational environments (Eisler et al., 2016).

This phase operationalises the transition from stabilisation to mechanism-driven transformation, ensuring that all interventions, regardless of disciplinary origin, are synchronised around shared therapeutic targets within a unified clinical architecture.

4.4 Consolidation and Relapse-Prevention Phase

The final phase of the trans-disciplinary clinical pathway focuses on stabilising therapeutic gains and preventing relapse through multisystem resilience-building, ensuring that improvements achieved during earlier stages are maintained across biological, psychological, relational, and nutritional domains.

A central task in this phase is the systematic identification of residual vulnerabilities, which may persist even after apparent symptomatic improvement. These include interoceptive fragility, cognitive rigidity, emotional dysregulation, and relational instability. Emerging evidence highlights that such vulnerabilities are often embedded within broader contextual and systemic factors, including family dysfunction and environmental exposures, which may continue to shape risk trajectories if not explicitly addressed (Zhang et al., 2025). In parallel, advances in digital and sensor-based monitoring technologies provide new opportunities for capturing subtle behavioural and physiological signals, enabling more precise detection of early deviations from recovery trajectories (Presseller et al., 2022).

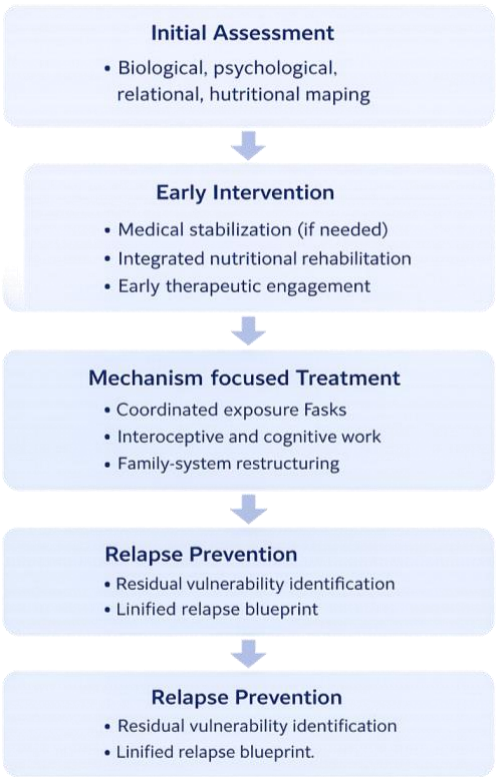
Interventions at this stage are therefore oriented toward strengthening resilience across domains. These include enhancing emotion regulation capacities, promoting cognitive flexibility and adaptive problem-solving, consolidating autonomous eating behaviours, and supporting reintegration into social, educational, and occupational roles. Family systems continue to play a critical role, transitioning from active scaffolding toward graduated autonomy support, while maintaining the capacity to respond consistently to emerging risks.

A key output of this phase is the development of a relapse-prevention blueprint, conceptualised as a shared, system-level plan that integrates early warning signals, intervention thresholds, and coordinated response strategies across domains. This approach is consistent with evidence from related fields emphasising the importance of identifying behavioural antecedents and early warning signs of relapse as part of proactive, rather than reactive, care models (Gleeson et al., 2024). Within a trans-disciplinary framework, these warning signals are not limited to symptomatic indicators but include relational shifts, interoceptive changes, and disruptions in behavioural regularity, all of which are continuously monitored within the shared decision system.

Through this structured approach, the consolidation phase transforms recovery from a state-dependent outcome into a dynamically maintained process, embedding regulatory capacities both within the individual and across the relational system.

The integrated structure of the clinical pathway, spanning assessment, early intervention, mechanism-focused treatment, and relapse prevention, is represents in Figure 5.

Figure 5. Unified Trans-disciplinary Clinical Pathway



Source: Author's conceptualisation

The flowchart illustrates the unified trans-disciplinary clinical pathway for eating and feeding disorders (ED/FD), organised into four sequential phases: Initial Assessment, Early Intervention, Mechanism-focused Treatment, and Relapse Prevention. Each phase highlights

key therapeutic tasks and points of team convergence, reflecting an integrated, mechanism-based approach that coordinates biological, psychological, relational, and nutritional processes throughout care.

5. Implementation Science and Evaluation Framework

The transition to a trans-disciplinary model for eating and feeding disorders (ED/FD) represents not only a clinical innovation but a system-level transformation affecting organisational structures, professional roles, and care processes. Such transformations require deliberate and theory-informed implementation strategies to ensure fidelity, scalability, and long-term sustainability.

Trans-disciplinary care necessitates three interdependent shifts: (1) structural integration, including shared documentation systems, unified assessment templates, and coordinated workflows; (2) cultural adaptation, involving the development of shared language, trust, role flexibility, and collaborative reflexivity; and (3) the establishment of measurable outcomes, capturing both implementation processes and clinical effectiveness. Implementation science provides the methodological foundation to guide these changes systematically, ensuring that innovations are not only introduced but effectively embedded within routine practice (Aarons et al., 2017).

Foundational work in dissemination and implementation research highlights that complex healthcare interventions require rigorous evaluation designs capable of capturing both effectiveness and contextual variability (Brown et al., 2017). Moreover, leadership alignment across organisational levels has been identified as a critical determinant of successful implementation, shaping both the strategic climate and the adoption of evidence-based practices (Aarons et al., 2014). Longitudinal research further demonstrates that implementation climate and leadership behaviours directly influence clinicians' sustained use of integrated care approaches, reinforcing the importance of organisational readiness and support (Williams et al., 2020).

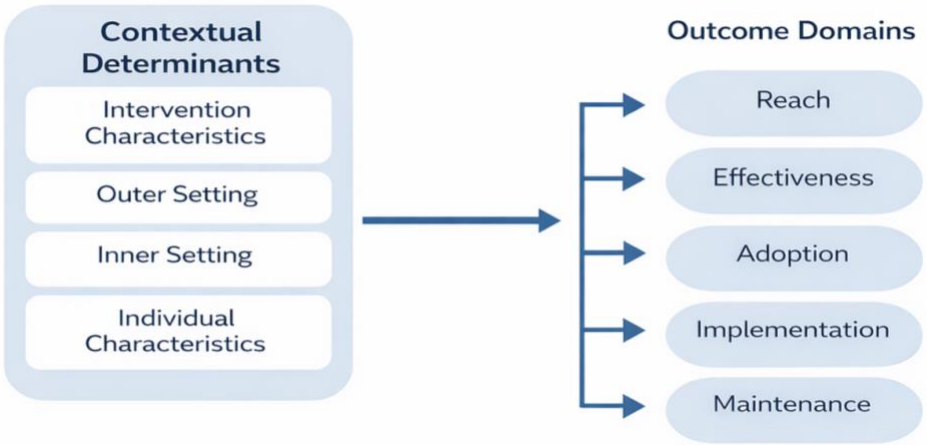
To comprehensively evaluate the trans-disciplinary ED/FD model, the proposed framework integrates the Consolidated Framework for Implementation Research (CFIR) and the RE-AIM model, capturing both contextual determinants and implementation outcomes.

CFIR provides a multilevel taxonomy of factors influencing implementation, including intervention characteristics, outer and inner settings, individual clinician attributes, and implementation processes. Complementing this, RE-AIM evaluates outcomes across five domains: Reach, Effectiveness, Adoption, Implementation, and Maintenance, enabling a structured assessment of impact at both clinical and organisational levels (King et al., 2020; Reardon et al., 2025).

These frameworks form a dual-layer evaluation architecture, linking contextual conditions to measurable outcomes and enabling a comprehensive understanding of how and why trans-disciplinary care succeeds or fails in real-world settings. The diagram (Figure 6) integrates the CFIR framework (Contextual Determinants: Intervention Characteristics, Outer Setting, Inner Setting, and Individual Characteristics) with the RE-AIM evaluation domains (Reach, Effectiveness, Adoption, Implementation, and Maintenance). Arrows indicate how

contextual determinants influence implementation outcomes, providing a structured model for evaluating trans-disciplinary ED/FD service transformation.

Figure 6. Implementation and Evaluation Model (CFIR + RE-AIM)



Source: Author's conceptualisation

Evaluation Design

A hybrid type-2 effectiveness–implementation design is proposed, allowing simultaneous evaluation of clinical outcomes and implementation processes. This design is particularly appropriate for complex, system-level interventions, where effectiveness and feasibility are interdependent (Luft et al., 2023).

The evaluation adopts a mixed-methods approach, integrating:

- Quantitative data: symptom severity (EDE-Q), functional impairment (CIA), interoceptive functioning (MAIA), nutritional and medical indicators, and implementation fidelity metrics;
- Qualitative data: team processes, clinician perspectives, patient and family experiences, and relational dynamics within care delivery.

Such integration enables mechanism–process–outcome alignment, which is essential for understanding how trans-disciplinary interventions produce change (Babatunde et al., 2023). In addition, participatory and co-analytic approaches, where patients contribute to qualitative data interpretation, enhance the ecological validity and relevance of findings, particularly in complex care pathways (Powell et al., 2021).

Within a trans-disciplinary model, fidelity extends beyond adherence to protocol and must capture system-level integration. Accordingly, fidelity is conceptualised across four dimensions:

- Structural fidelity: presence of shared documentation systems, unified assessment tools, and integrated care protocols;
- Process fidelity: evidence of synchronised interventions, coordinated exposure, and cross-disciplinary collaboration;
- Team-level fidelity: role flexibility, shared language, and collective decision-making practices;
- Experiential fidelity: perceived coherence, continuity, and relational attunement as reported by patients and families.

These dimensions enable the quantification of trans-disciplinary integration and its association with clinical and functional outcomes. The successful implementation of trans-disciplinary ED/FD care is shaped by multiple interacting factors. Siloed systems and fragmented communication structures can significantly impede integration, whereas environments characterised by openness, collaboration, and psychological safety facilitate it (Vatanpour et al., 2013).

Professional identity boundaries may also act as barriers, as clinicians navigate tensions between specialised expertise and role flexibility. Conceptualisations of professional identity as dynamic, balancing stability and adaptability, highlight the importance of supporting clinicians through this transition (Axelsson et al., 2010).

Resource allocation, including time, training, supervision, and digital infrastructure, is critical for sustaining integrated care models. Without adequate investment, trans-disciplinary practices risk remaining superficial rather than fully embedded.

Implementation research emphasises that sustained change requires not only initial training but ongoing supervision, reflective practice, and leadership alignment to reinforce collaborative behaviours and maintain implementation fidelity (Aarons et al., 2014).

6. Discussion

The present paper advances a trans-disciplinary framework that responds directly to the structural and mechanistic limitations identified in conventional multidisciplinary and interdisciplinary models. By reorganising ED/FD care around shared constructs, unified measurement systems, and coordinated decision rules, the model shifts the locus of integration from team coordination to system-level coherence.

A central contribution of this framework is the enhancement of mechanistic alignment across domains. Rather than allowing biological, psychological, relational, and nutritional interventions to operate in parallel, the model ensures that all clinical actions converge on shared mechanisms, such as interoceptive recalibration, reduction of avoidance cycles, cognitive–affective restructuring, and relational reorganisation. This alignment transforms treatment from a set of co-occurring interventions into a dynamically synchronised therapeutic system.

Closely related is the improvement in temporal and structural continuity of care. The integration of shared case formulation, standardised measurement intervals, and unified decision rules reduces fragmentation across treatment phases. Transitions between levels of care (e.g., step-up or step-down decisions) are no longer driven by isolated indicators but by multi-domain trajectories, increasing both clinical precision and patient safety. This continuity is particularly relevant in ED/FD, where relapse risk is closely linked to breakdowns in coordination across domains.

Furthermore, the framework supports enhanced clinical effectiveness by leveraging synergistic intervention effects. Coordinated exposure, interoceptive training, nutritional rehabilitation, and family-system restructuring are not treated as independent techniques but as interdependent processes targeting the same maintaining mechanisms. This convergence increases therapeutic intensity without increasing intervention burden, thereby strengthening the potential for durable change.

The model redefines clinical responsibility as a shared, system-level function. By dissolving rigid disciplinary ownership of specific domains, trans-disciplinarity promotes collaborative accountability and positions the patient within a coherent therapeutic ecology. This shift has important implications for both clinical outcomes and team functioning, fostering a more adaptive and responsive care system.

Despite its conceptual and clinical advantages, the transition to a trans-disciplinary model entails substantial implementation challenges. As outlined in Section 5, these challenges are not merely technical but structural and cultural.

A primary barrier concerns competency development. Trans-disciplinary practice requires clinicians to operate beyond traditional disciplinary boundaries, necessitating training in shared constructs (e.g., interoception), cross-domain mechanisms, and coordinated intervention strategies. Without sustained training and supervision, there is a risk that integration remains superficial rather than mechanistically meaningful. A second challenge involves professional identity and role negotiation. The shift toward role fluidity may generate uncertainty or resistance, particularly in systems historically organised around clear disciplinary hierarchies. Addressing these tensions requires explicit frameworks for collaboration, reinforcement of professional value, and the development of shared language and conceptual models. A third constraint relates to infrastructure and workflow integration. Existing documentation systems, scheduling practices, and service structures are often designed around disciplinary silos. Implementing shared templates, unified monitoring systems, and joint decision-making processes requires organisational investment and leadership alignment.

Moreover, the model depends on sustained team reflexivity, which involves continuous evaluation of how team processes influence clinical outcomes. While essential for maintaining coherence, reflexivity is resource-intensive and may be deprioritised in high-demand clinical environments. These challenges highlight that trans-disciplinarity is not a simple extension of interdisciplinary care, but a systemic transformation requiring alignment across training, culture, and organisational design.

The proposed framework generates several implications for future research and practice.

First, there is a need for empirical validation of mechanism-based integration. While the model is theoretically grounded, future studies should examine how specific mechanisms (e.g., interoceptive change, reduction in avoidance) mediate clinical outcomes within trans-disciplinary systems. Second, the integration of digital tools offers promising avenues for enhancing real-time monitoring and intervention. Ecological momentary assessment, wearable sensors, and digital platforms can support continuous tracking of interoceptive, behavioural, and relational processes, strengthening the feedback loops central to the model. Third, the development of standardised, cross-national outcome frameworks would facilitate comparability and scalability. Harmonised measures across symptom, functional, interoceptive, and relational domains are essential for advancing both research and service evaluation.

Finally, the principles of trans-disciplinarity may extend beyond ED/FD to other complex psychiatric conditions characterised by multi-level maintenance mechanisms. This suggests a broader paradigm shift toward mechanism-based, system-oriented models of care in contemporary psychotherapy.

Conclusion

This paper proposes a comprehensive trans-disciplinary framework for eating and feeding disorders (ED/FD), addressing the persistent mismatch between the complexity of these conditions and the fragmented structures of conventional care models.

Integrating biological, psychological, relational, and nutritional domains within a unified architecture, the model advances a shift from parallel intervention delivery to a mechanism-aligned therapeutic system. Central to this transformation are shared case formulation, coordinated mechanisms of change, unified outcome monitoring, and structured decision rules, which together enable coherent, adaptive, and data-informed clinical practice.

The framework demonstrates that trans-disciplinarity enhances mechanistic coherence, allowing interventions across domains to converge on shared targets, including interoceptive functioning, avoidance processes, cognitive flexibility, and relational dynamics. This convergence not only strengthens therapeutic impact but also supports continuity of care, reducing fragmentation across treatment phases and improving long-term stability.

Importantly, the model is operationalised through an implementation-science perspective, incorporating CFIR and RE-AIM frameworks to ensure feasibility, fidelity, and sustainability. This positions the framework as both a conceptual advancement and a practically transferable model for service design.

From a psychotherapeutic standpoint, the implications are substantial. The framework redefines psychotherapy as embedded within a broader system of coordinated mechanisms, expanding its scope to include interoceptive processes, nutritional contexts, and relational dynamics. This integration enhances both the depth and ecological validity of psychotherapeutic interventions. At a broader level, the model offers a scalable blueprint for complex care systems, with potential applicability beyond ED/FD to other disorders characterised by multi-level interactions and dynamic maintenance processes.

Future research should focus on empirical testing, implementation across diverse settings, and refinement of measurement systems. Nonetheless, the present framework provides a robust foundation for advancing toward more coherent, effective, and patient-centred models of care in contemporary psychotherapy.

Credit Authorship Contribution Statement

Bonaccorsi, V. and Riscica, S.B. jointly contributed to the conceptualisation of the study, development of the theoretical framework, literature synthesis, and manuscript preparation. Both authors contributed to drafting, revising, and final approval of the manuscript.

Conflict of Interest Statement

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Acknowledgement/ Funding

The authors would like to acknowledge the contributions of clinicians and researchers working in the field of eating and feeding disorders, whose ongoing work has informed the development of integrative and mechanism-based approaches to care.

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data Availability Statement

No datasets were generated or analysed during the current study. The manuscript is based on a conceptual and theoretical synthesis of previously published literature.

Ethical Approval Statement

Not applicable. This study does not involve human participants, animal subjects, or identifiable personal data.

References

Aarons, G. A., Ehrhart, M. G., Farahnak, L. R., & Sklar, M. (2014). Aligning leadership across systems and organizations to develop a strategic climate for evidence-based practice implementation. *Annual Review of Public Health*, *35*, 255–274. https://doi.org/10.1146/annurev-publhealth-032013-182447

Aloi, M., Rania, M., Lo Coco, G., Carcione, A., Castellini, G., Waldherr, K. & Segura-Garcia, C. (2024) Editorial: Psychosocial risk factors in the development, maintenance and treatment outcome of eating disorders. *Frontiers in Psychology* 15: 1486941. https://doi.org/10.3389/fpsyg.2024.1486941

Axelsson, R. M., Dahlgren, M. A., & Dahlgren, L. O. (2010). Conceptualising Professional Identification as Flexibility, Stability and Ambivalence. In: Billett, S. (eds) Learning Through Practice. Professional and Practice-based Learning, Volume 1. Springer, Dordrecht. https://doi.org/10.1007/978-90-481-3939-2_7

Babatunde, S., Ahmed, S., Santana, M. J., Nielssen, I., Zelinsky, S., & Ambasta, A. (2023). Working together in health research: a mixed-methods patient engagement evaluation. *Research Involvement and Engagement*, *9*(1), 62. https://doi.org/10.1186/s40900-023-00475-w

Baenas, I., Etxandi, M., & Fernández-Aranda, F. (2024). Medical complications in anorexia and bulimia nervosa. Complicaciones médicas en anorexia y bulimia nerviosa. *Medicina Clinica*, *162*(2), 67–72. https://doi.org/10.1016/j.medcli.2023.07.028

Baker, J. H., Schaumberg, K. & Munn-Chernoff, M. A. (2017). Genetics of Anorexia Nervosa. *Current Psychiatry Reports*, *19*, 84. https://doi.org/10.1007/s11920-017-0842-2

Barkham, M., Broglia, E., on behalf of The SCORE Consortium (2024). Routine outcome monitoring (ROM) and feedback in university student counselling and mental health services: Considerations for practitioners and service leads. *Counselling and Psychotherapy Research*, *24*, 459–471. https://doi.org/10.1002/capr.12694

Boon, M., & Van Baalen, S. (2019). Epistemology for interdisciplinary research - shifting philosophical paradigms of science. *European Journal for Philosophy of Science*, *9*(1), 16. https://doi.org/10.1007/s13194-018-0242-4

Bohn, K., Doll, H. A., Cooper, Z., O'Connor, M., Palmer, R. L., & Fairburn, C. G. (2008). The measurement of impairment due to eating disorder psychopathology. *Behaviour Research and Therapy*, *46*(10), 1105–1110. https://doi.org/10.1016/j.brat.2008.06.012

Brown, C. H., Curran, G., Palinkas, L. A., Aarons, G. A., Wells, K. B., Jones, L., Collins, L. M., Duan, N., Mittman, B. S., Wallace, A., Tabak, R. G., Ducharme, L., Chambers, D. A., Neta, G., Wiley, T., Landsverk, J., Cheung, K., & Cruden, G. (2017). An Overview of Research and Evaluation Designs for Dissemination and Implementation. *Annual Review Public Health*. *38*, 1-22. https://doi.org/10.1146/annurev-publhealth-031816-044215

Bryson, C., Douglas, D., & Schmidt, U. (2024). Established and emerging treatments for eating disorders. *Trends in Molecular Medicine (Eating Disorders Special Issue*), 30(4), 392-402. https://doi.org/10.1016/j.molmed.2024.02.009

Bueter, A., & Jukola, S. (2025). Multi-professional healthcare teams, medical dominance, and institutional epistemic injustice. *Medicine, Health Care, and Philosophy*, *28*(2), 219–232. https://doi.org/10.1007/s11019-025-10252-z

Calvert, G. H. M., & Carson, R. G. (2022). Neural mechanisms mediating cross education: With additional considerations for the ageing brain. *Neuroscience & Biobehavioral Reviews*, *132*, 260-288. https://doi.org/10.1016/j.neubiorev.2021.11.025

Chęć, M. & Michałowska, S. (2024). Cognitive behavioral therapy for adolescents with eating disorders, with particular regard to clinical perfectionism. *Psychiatria Polska*, *58*(5), 773–788. https://doi.org/10.12740/PP/175717

Choi, B. C. K., & Pak, A. W. P. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. *Clinical and Investigative Medicine*, *29*(6), 351–364. https://pubmed.ncbi.nlm.nih.gov/17330451/

Choi, B. C. K., & Pak, A. W. P. (2007). Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: 2. Promotors, barriers, and strategies of enhancement. *Clinical and Investigative Medicine,* *30*(6), E224–E232. https://doi.org/10.25011/cim.v30i6.2950

Choi, B. C. K., Pak, A. W. P. (2008). Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: 3. Discipline, inter-discipline distance, and selection of discipline. *Clinical and Investigative Medicine*, *31*(1), E41–E48. https://doi.org/10.25011/cim.v31i1.3140

Christian, C., Butler, R. M., Burr, E. K., & Levinson, C. (2024). An Intensive time series investigation of the relationships across eating disorder-specific fear responses and behaviour urges in partially remitted anorexia nervosa. *Journal of Anxiety Disorders*, Volume 102, 102804. https://doi.org/10.1016/j.janxdis.2023.102804

Collantoni, E., Meregalli, V., Manara, R., Meneguzzo, P., Tenconi, E., & Favaro, A. (2023). Volume and complexity of the thalamus in Anorexia Nervosa: An exploratory evaluation. *European Eating Disorders Review*, *31*(2), 349–359. https://doi.org/10.1002/erv.2965

Couturier, J., Kimber, M., & Szatmari, P. (2012). Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *Interantional Journal of Eating Disord*ers, *46*(1), 3–11. https://doi.org/10.1002/eat.22042

Crum, J. (2021). Understanding Mental Health and Cognitive Restructuring With Ecological Neuroscience. *Frontiers in Psychiatry*, *12*, 697095. https://doi.org/10.3389/fpsyt.2021.697095

Dalgleish, T., Black, M., Johnston, D., & Bevan, A. (2020). Transdiagnostic approaches to mental health problems: Current status and future directions. *Journal of Consulting and Clinical Psychology, 88*(3), 179–195. https://doi.org/10.1037/ccp0000482

Dehbozorgi, R., Fereidooni-Moghadam, M., Shahriari, M., & Moghimi-Sarani, E. (2022). Barriers to family involvement in the care of patients with chronic mental illnesses: A qualitative study. *Frontiers in Psychiatry*, *13*, 995863. https://doi.org/10.3389/fpsyt.2022.995863

Dolan, S. C., Khindri, R., Franko, D. L., Thomas, J. J., Reilly, E. E., & Eddy, K. T. (2022). Anhedonia in eating disorders: A meta-analysis and systematic review. *International Journal of Eating Disorders, 55*(2), 161–175. https://doi.org/10.1002/eat.23645

Donini L. M. (2022). Eating disorders: a comprehensive guide to medical care and complications (4th Ed): Edited by Philip Mehler and Arnold Andersen. Eating and Weight Disorders: EWD, *27*(8), 2987–2988. https://doi.org/10.1007/s40519-022-01479-3

Dunst, C. J. (2023). Meta-Analyses of the Relationships between Family Systems Practices, Parents' Psychological Health, and Parenting Quality. *International Journal of Environmental Research and Public Health, 20*(18), 6723. https://doi.org/10.3390/ijerph20186723

Eisler, I., Simic, M., Hodsoll, J., Asen, E., Berelowitz, M., Connan, F., Ellis, G., Hugo, P., Schmidt, U., Treasure, J., Yi, I., & Landau, S. (2016). A pragmatic randomised multi-centre trial of multifamily and single-family therapy for adolescent anorexia nervosa. *BMC Psychiatry*, *16*(1), 422. https://doi.org/10.1186/s12888-016-1129-6

Espel-Huynh, H. M., Zhang, F., Boswell, J. F., Graham Thomas, J., Thompson-Brenner, H., Juarascio, A. S., & Lowe, M. R. (2020). Latent trajectories of eating disorder treatment response among female patients in residential care. *International Journal of Eating Disorders, 53*, 1647–1656. https://doi.org/10.1002/eat.23369

Ezawa, I. D., & Hollon, S. D. (2023). Cognitive restructuring and psychotherapy outcome: A meta-analytic review. *Psychotherapy (Chicago, Ill.)*, *60*(3), 396–406. https://doi.org/10.1037/pst0000474

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., Wales, J. A., & Palmer, R. L. (2009). Transdiagnostic cognitive-behavioural therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *The American Journal of Psychiatry*, *166*(3), 311–319. https://doi.org/10.1176/appi.ajp.2008.08040608

Garfinkel, S. N., Schulz, A., & Tsakiris, M. (2022). Addressing the need for new interoceptive methods. *Biological Psychology*, 170, 108322. https://doi.org/10.1016/j.biopsycho.2022.108322

Giannese, D., D'Alessandro, C., Panichi, V., Pellegrino, N., & Cupisti, A. (2023). Nutritional Treatment as a Synergic Intervention to Pharmacological Therapy in CKD Patients. *Nutrients*, *15*(12), 2715. https://doi.org/10.3390/nu15122715

Gleeson, J. F., McGuckian, T. B., Fernandez, D. K., Fraser, M. I., Pepe, A., Taskis, R., Alvarez-Jimenez, M., Farhall, J. F., & Gumley, A. (2024). Systematic review of early warning signs of relapse and behavioural antecedents of symptom worsening in people living with schizophrenia spectrum disorders. *Clinical Psychology Review,* 107, 102357. https://doi.org/10.1016/j.cpr.2023.102357

Gregg, L., Adderley, H., Calam, R., & Wittkowski, A. (2021). The implementation of family-focused practice in adult mental health services: A systematic review exploring the influence of practitioner and workplace factors. *International Journal of Mental Health Nursing*, *30*(4), 885–906. https://doi.org/10.1111/inm.12837

Hay, P., Aouad, P., Le, A. et al. (2023). Epidemiology of eating disorders: population, prevalence, disease burden and quality of life informing public policy in Australia - a rapid review. *Journal of Eating Disorders*, 11-23. https://doi.org/10.1186/s40337-023-00738-7

Huckins, L. M., Signer, R., Johnson, J., et al. (2022). What next for eating disorder genetics? Replacing myths with facts to sharpen our understanding. *Molecular Psychiatry*. *27*(10), 3929-3938. https://doi.org/10.1038/s41380-022-01601-y

Jansingh, A., Danner, U. N., Hoek, H. W., & van Elburg, A. A. (2020). Developments in the psychological treatment of anorexia nervosa and their implications for daily practice. *Current Opinion in Psychiatry, 33*(6), 534–541. https://doi.org/10.1097/YCO.0000000000000642

Jowik, K., Tyszkiewicz-Nwafor, M., & Słopień, A. (2021). Anorexia Nervosa-What Has Changed in the State of Knowledge about Nutritional Rehabilitation for Patients over the Past 10 Years? A Review of Literature. *Nutrients*, *13*(11), 3819. https://doi.org/10.3390/nu13113819

Kaye, W. H., Wierenga, C. E., Bischoff-Grethe, A., Berner, L. A., Ely, A. V., Bailer, U. F., Paulus, M. P., & Fudge, J. L. (2020). Neural Insensitivity to the Effects of Hunger in Women Remitted from Anorexia Nervosa. *The American Journal of Psychiatry*, *177*(7), 601–610. https://doi.org/10.1176/appi.ajp.2019.19030261

King, D. K., Shoup, J. A., Raebel, M. A., Anderson, C. B., Wagner, N. M., Ritzwoller, D. P., & Bender, B. G. (2020). Planning for Implementation Success Using RE-AIM and CFIR Frameworks: A Qualitative Study. *Frontiers in Public Health*, *8*, 59. https://doi.org/10.3389/fpubh.2020.00059

Khalsa, S. S., Adolphs, R., Cameron, O. G., Critchley, H. D., Davenport, P. W., Feinstein, J. S., Feusner, J. D., Garfinkel, S. N., Lane, R. D., Mehling, W. E., Meuret, A. E., Nemeroff, C. B., Oppenheimer, S., Petzschner, F. H., Pollatos, O., Rhudy, J. L., Schramm, L. P., Simmons, W. K., Stein, M. B., Stephan, K. E., … (2018). Interoception and Mental Health: A Roadmap. *Biological Psychiatry. Cognitive Neuroscience and Neuroimaging*, *3*(6), 501–513. https://doi.org/10.1016/j.bpsc.2017.12.004

Krukowski, R., Kim, H., Stansbury, M., Li, Q., Sen, S., Farage, G., & West, D. (2020). Importance of Multiple Reinforcing Comments and Areas for Change in Optimizing Dietary and Exercise Self-Monitoring Feedback in Behavioral Weight Loss Programs: Factorial Design. *Journal of Medical Internet Research*, *22*(11), e18104. https://doi.org/10.2196/18104

Latzer, Y., & Stein, D. (2019). Introduction: Novel perspectives on the psychology and psychotherapy of eating disorders. *Journal of Clinical Psychology*, *75*(8), 1369–1379. https://doi.org/10.1002/jclp.22786

Lazzarelli, A., Scafuto, F., Crescentini, C., Matiz, A., Orrù, G., Ciacchini, R., Alfì, G., Gemignani, A., & Conversano, C. (2024). Interoceptive Ability and Emotion Regulation in Mind-Body Interventions: An Integrative Review. *Behavioral Sciences (Basel, Switzerland)*, *14*(11), 1107. https://doi.org/10.3390/bs14111107

Levinson, C. A., Brosof, L. C., Vanzhula, I. A., Bumberry, L., Zerwas, S., & Bulik, C. M. (2017). Perfectionism Group Treatment for Eating Disorders in an Inpatient, Partial Hospitalization, and Outpatient Setting. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, *25*(6), 579–585. https://doi.org/10.1002/erv.2557

Lock, J., & Le Grange, D. (2025). *Treatment Manual for Anorexia Nervosa: A Family-Based Approach*. 3rd Edition New York: Guilford Press. ISBN: 978-1462558803

Luft, H., Brown, R., & Lauver, D. (2023). A hybrid type 2 effectiveness-implementation design to evaluate a community-based, heart-healthy intervention for women of low socio-economic status. *Applied nursing research : ANR*, *71*, 151686. https://doi.org/10.1016/j.apnr.2023.151686

Maher, A., Cason, L., Huckstepp, T., Stallman, H., Kannis-Dymand, L., Millear, P., Mason, J., Wood, A., & Allen, A. (2022). Early maladaptive schemas in eating disorders: A systematic review. *European Eating Disorders Review*, *30*(1), 3–22. https://doi.org/10.1002/erv.2866

McHugh, S. K., Lawton, R., O'Hara, J. K., & Sheard, L. (2020). Does team reflexivity impact teamwork and communication in interprofessional hospital-based healthcare teams? A systematic review and narrative synthesis. *BMJ Quality & Safety*, *29*(8), 672–683. https://doi.org/10.1136/bmjqs-2019-009921

Mehler, P.S., Andersen, A. E. (2022). Eating Disorders: A Guide to Medical Care and Complications. 3rd Ed. Baltimore (MD): Johns Hopkins University Press. ISBN: 978-1421443584. https://doi.org/10.56021/9781421443591

Mehling, W. E., Price, C., Daubenmier, J. J., Acree, M., Bartmess, E., & Stewart, A. (2012). The Multidimensional Assessment of Interoceptive Awareness (MAIA). *PloS one*, *7*(11), e48230. https://doi.org/10.1371/journal.pone.0048230

National Institute for Health and Care Excellence (NICE). *Eating Disorders: Recognition and Treatment*. NICE Guideline NG69. London: NICE; 2017. https://www.nice.org.uk/guidance/ng69

Paley, B., & Hajal, N. J. (2022). Conceptualizing Emotion Regulation and Coregulation as Family-Level Phenomena. *Clinical Child and Family Psychology Review*, *25*(1), 19–43. https://doi.org/10.1007/s10567-022-00378-4

Pfeifer, G., Cawkwell, S. (2025). Interoceptive ageing and the impact on psychophysiological processes: A systematic review. *International Journal of Psychophysiology*, Volume *207*, 112483. https://doi.org/10.1016/j.ijpsycho.2024.112483

Powell, C., Ismail, H., Cleverley, R., Taylor, A., Breen, L., Fylan, B., Alderson, S. L., Alldred, D. P., & the ISCOMAT Programme Team (2021). Patients as qualitative data analysts: Developing a method for a process evaluation of the 'Improving the Safety and Continuity of Medicines management at care Transitions' (ISCOMAT) cluster randomised control trial. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *24*(4), 1254–1262. https://doi.org/10.1111/hex.13257

Presseller, E. K., Patarinski, A. G. G., Fan, S. C., Lampe, E. W., & Juarascio, A. S. (2022). Sensor technology in eating disorders research: A systematic review. *The International Journal of Eating Disorders*, *55*(5), 573–624. https://doi.org/10.1002/eat.23715

Reardon, C. M., Damschroder, L. J., Ashcraft, L. E., Kerins, C., Bachrach, R. L., Nevedal, A. L., Domlyn, A. M., Dodge, J., Chinman, M., & Rogal, S. (2025). The Consolidated Framework for Implementation Research (CFIR) User Guide: a five-step guide for conducting implementation research using the framework. *Implementation Science*: IS, *20*(1), 39. https://doi.org/10.1186/s13012-025-01450-7

Reilly, E. E., Lavender, J. M., Berner, L. A., Brown, T. A., Wierenga, C. E., & Kaye, W. H. (2018). Could repetitive negative thinking interfere with corrective learning? The example of anorexia nervosa. *The International Journal of Eating Disorders, 52*(1), 36-41. https://doi.org/10.1002/eat.22997

Reilly, E. E., Gorrell, S., Brosof, L., Lock, J., & Le Grange, D. (2022). Characterizing changes in obsessive-compulsive symptoms over the course of treatment for adolescent bulimia nervosa. The *International Journal of Eating Disorders*, *55*(10), 1342–1351. https://doi.org/10.1002/eat.23782

Repko A. F., & Szostak R. (2020). *Interdisciplinary Research: Process and Theory.* 4th Edition Thousand Oaks (CA): SAGE Publication Inc. ISBN: 978-1544398600

Ratnapradipa, K. L., Jadhav, S., Kabayundo, J., Wang, H., & Smith, L. C. (2023). Factors associated with delaying medical care: cross-sectional study of Nebraska adults. *BMC Health Services Research*, *23*(1), 118. https://doi.org/10.1186/s12913-023-09140-0

Schaumberg, K., Anderson, L. M., Reilly, E., & Anderson, D. A. (2014). Patterns of compensatory behaviors and disordered eating in college students. *Journal of American College Health*, *62*(8), 526–533. https://doi.org/10.1080/07448481.2014.930468

Sader, M., Halls, D., Kerr-Gaffney, J., Waiter, G., Gillespie-Smith, K., Duffy, F., & Tchanturia, K. (2025) Neuroanatomical Associations with Autistic Characteristics in those with Acute Anorexia Nervosa and Weight-Restored Individuals. *Psychological Medicine*, *55*, e1120. https://doi.org/10.1017/S0033291725001047

Tchanturia, K., Lloyd, S., & Lang, K. (2013). Cognitive remediation therapy for anorexia nervosa: Current evidence and future research directions. *International Journal of Eating Disorders*, *46*(5), 492–495. https://doi.org/10.1002/eat.22106

Teunisse, A. K., Pembroke, L., O'Gradey-Lee, M., Sy, M., Rapee, R. M., Wuthrich, V. M., Creswell, C., & Hudson, J. L. (2022). A scoping review investigating the use of exposure for the treatment and targeted prevention of anxiety and related disorders in young people. *JCPP Advances*, *2*(2), e12080. https://doi.org/10.1002/jcv2.12080

Treasure, J., Duarte, T. A., & Schmidt, U. (2020). Eating Disorders. *The Lancet, 395,* 10227*,* 899 - 911. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30059-3/abstract

Van Bewer V. (2017). Transdisciplinarity in Health Care: A Concept Analysis. *Nursing Forum*, *52*(4), 339–347. https://doi.org/10.1111/nuf.12200

Vatanpour, H., Khorramnia, A., & Forutan, N. (2013). Silo effect a prominence factor to decrease efficiency of pharmaceutical industry. *Iranian Journal of Pharmaceutical Research*, *12*(Suppl), 207–216. https://pmc.ncbi.nlm.nih.gov/articles/PMC3813367/pdf/ijpr-12-207.pdf

Wade, T. D., Pennesi, J-L, & Pellizzer, M. (2025). Identifying transdiagnostic psychological processes that can improve early intervention in youth mental health. Australian & New Zealand *Journal of Psychiatry*, *59*(4), 307-314. https://doi.org/10.1177/00048674241312803

Waller, G., & Beard, J. (2024). Recent Advances in Cognitive-Behavioural Therapy for Eating Disorders. *Current Psychiatry Reports*, *26*, 351–358. https://doi.org/10.1007/s11920-024-01509-0

Warren, A., & Frame, L. A. (2025). Restoring a Healthy Relationship with Food by Decoupling Stress and Eating: A Translational Review of Nutrition and Mental Health. *Nutrients*, *17*(15), 2466. https://doi.org/10.3390/nu17152466

Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical Complications of Anorexia Nervosa and Bulimia. *The American Journal of Medicine*, *129*(1), 30–37. https://doi.org/10.1016/j.amjmed.2015.06.031

Williams, N. J., Wolk, C. B., Becker-Haimes, E. M., & Beidas, R. S. (2020). Testing a theory of strategic implementation leadership, implementation climate, and clinicians' use of evidence-based practice: a 5-year panel analysis. *Implementation Science*, *15*(1), 10. https://doi.org/10.1186/s13012-020-0970-7

Zajac, S., Woods, A., Tannenbaum, S., Salas, E., & Holladay, C. L. (2021) Overcoming Challenges to Teamwork in Healthcare: A Team Effectiveness Framework and Evidence-Based Guidance. *Frontiers in Communication*, *6*, 606445. https://doi.org/10.3389/fcomm.2021.606445

Zhang, W. Y., Yang, K., Zhai, Y. C., Miao, Q. S., & Cui, Y. H. (2025). Mental vulnerability, family dysfunction, and digital exposure: Overlooked burdens in populations with noncommunicable chronic diseases. *World Journal of Psychiatry*, *15*(12), 112122. https://doi.org/10.5498/wjp.v15.i12.112122