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METHODOLOGICAL ARTICLE

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A novel methodology to develop low-intensity psychological treatments

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Abstract

Introduction: Only a minority of individuals with mental health disorders receive specialist treatment. Low-intensity psychological therapies, like guided self-help, have the potential to bridge this global treatment gap. However, a systematic process for developing such therapies has not been proposed. This study proposes a systematic process for developing low-intensity psychological treatments, exemplified by a low-intensity Cognitive Behavioral Therapy (CBT) intervention for children and young people with eating disorders.

Methods: A systematic, three-step process is presented. Firstly, a common elements analysis is conducted *within* the three pillars of evidence-based practice (research, clinical expertise, and patient preferences). Secondly, a coding matrix is used to synthesize the common elements *across* these three pillars. Finally, patient and public involvement (PPI) feedback is incorporated for intervention refinement.

Results: Applying this methodology led to the development of an eight-module, low intensity CBT intervention for children and young people with eating disorders, covering topics such as regular eating, body image, social media, and managing emotional triggers.

Conclusion: The intervention derived from this novel methodology is evidence-informed and considers implementation into routine practice from the outset. This systematic approach to developing low intensity psychological interventions holds promise for closing the treatment gap irrespective of therapeutic orientation or disorder.

KEYWORDS

eating disorders, evidence-based practice, low intensity psychological intervention, methodology, qualitative, systematic review and meta-analysis

1 | INTRODUCTION

Mental health disorders are among the leading causes of disability worldwide (GBD, 2019 Mental Disorders Collaborators, 19 Mental Disorders Collaborators, 2022). The magnitude of this burden is exacerbated by the fact that only a minority of individuals with mental health disorders receive specialist treatment (Keynejad et al., 2021). This discrepancy is commonly termed the "treatment gap," and it represents a major public health concern worldwide (World Health Organization, 2022). Paradoxically, this gap persists despite significant advances in developing effective psychological treatments for a range of psychiatric disorders across the age range (Kazdin, 2022).

Numerous barriers, including geographic, financial and attitudinal factors, impede access to effective psychological treatments (Nathan & Gorman, 2015). These barriers are compounded by the limitations inherent in the dominant model of psychological services, which traditionally involve in-person sessions with highly trained professionals in clinical settings (Kazdin, 2017). Ultimately, there is a shortage of mental health professionals available to meet the demand for treatment within this model (Kazdin, 2023). Innovative strategies are needed to close the treatment gap and optimize available resources.

The concept of low-intensity psychological therapies has grown in importance over the past decade in response to this increasing demand for treatment among individuals with common mental health disorders. These therapies typically involve self-help strategies based on cognitive behavioral therapy (CBT) principles, which can be delivered in a number of flexible formats and supported by nonspecialists, such as paraprofessionals (Shafran et al., 2021). Paraprofessionals are individuals who do not possess a core mental health professional qualification but are trained to treat and manage common mental health disorders (Rusch et al., 2019). Low-intensity psychological interventions are central to the UK's Talking Therapies (formerly Improving Access to Psychological Therapies (IAPT)) program, a government-funded initiative to widen access to psychological treatment for common mental health disorders (Clark, 2018). Such interventions have the potential to reduce actual and perceived barriers to care, and can expand on the dominant model of in-person, individual psychological therapy at a clinic (Kazdin, 2023).

An increasing body of evidence supports the effectiveness of low intensity psychological treatments for a range of mental health disorders (e.g., Bennett et al., 2019; Cuijpers et al., 2019; Hazell et al., 2016; Siddaway et al., 2022; Traviss-Turner et al., 2017; Wang et al., 2024). However, psychological therapies typically involve multiple components (Dunn et al., 2019; Moore et al., 2015) and it is not clear how such treatments are developed. Developers may start intervention development with strong beliefs about its content, format or how it should be delivered (O'Cathain et al., 2019). Yet, these assumptions rely on human judgment resulting in biases in clinical practice and decision-making (Bowes et al., 2020). Adopting a systematic, evidence-informed process for intervention development helps counteract these biases and ensures more objective and rigorous decision-making in the early stages of intervention development. This can reduce the likelihood of developing an intervention that is ineffective or is never implemented in practice (O'Cathain et al., 2019). Such a systematic approach aligns with the need to document key processes and decision-making in the initial stages of intervention development (Candy et al., 2018; Hoffmann et al., 2014). Inadequate description of the development process poses challenges to the scientific method, which makes it difficult to replicate interventions, discern which underlying intervention components are effective, and draw robust conclusions about their development (Hoffmann et al., 2017). Rigor in reporting standards is particularly crucial for novel treatment approaches in gaining scientific credibility and facilitating replication (van Agteren et al., 2021).

The Medical Research Council (MRC) has published various iterations of guidance on the development and evaluation of complex interventions (Campbell, 2000; Craig et al., 2008; Skivington et al., 2021). The MRC framework states that excessive focus upon definitive trial evaluation, with insufficient attention to its development, may be detrimental to the effectiveness and future implementation of such treatments. It proposes a systematic development phase with three nonlinear elements: identifying an evidence base, developing a program theory and modeling processes and outcomes (Skivington et al., 2021). However, while the MRC framework helps lay the theoretical foundation for an intervention, these guidelines are arguably under-specified on the optimal design of complex protocols.

Clark (2004) outlined a systematic process for developing cognitive behavioral treatments, involving: (i) clinical interviews and experimental paradigms to identify the core mechanisms maintaining the disorder; (ii) developing theoretical accounts to explain why these mechanisms do not self-correct; (iii) testing of these hypothesized maintaining factors through experimental studies; and (iv) developing specialized treatments that reverse or diminish these maintaining factors. This process is flexible and involves the interplay between theory development and experimental science, with a central focus on understanding patients' phenomenology (Dunn et al., 2019; Salkovskis et al., 2024). Such an objective system of treatment development has resulted in effective CBT interventions for a range of disorders but is aimed at developing *novel* interventions for disorders where the maintenance mechanisms are not established. The development of low-intensity treatments requires a different approach that incorporates existing knowledge about the maintenance of psychopathology and effective interventions. To our knowledge, no systematic method currently exists to develop low-intensity psychological treatments for common mental health disorders.

1.1 | Aims and objectives

The aim of this paper is to provide a systematic, evidence-informed process to develop low-intensity psychological interventions. It uses the development of a low-intensity CBT intervention for eating disorders in children and young people as an exemplar, but its methodology is applicable to other populations and contexts.

2 | METHODS

2.1 | A novel methodology

This novel methodology for developing low-intensity psychological interventions employs a systematic common elements approach corresponding to the three pillars of evidence-based practice: best available research evidence, clinical expertise, and patient preferences and values (Sackett et al., 1996). The approach involves

synthesizing evidence by extracting discrete clinical techniques or skills (i.e., practice elements) that are common or overlapping across programs (Chorpita et al., 2005a). Such a systematic approach facilitates replicability and has implications for the development of low-intensity interventions where evidence-based high-intensity interventions already exist.

The first step of this methodology invokes a common elements approach *within* each pillar: (i) a systematic review of the literature followed by a common elements analysis to identify existing research evidence; (ii) focus groups to capture clinical expertise and identify common elements; (iii) focus groups and individual interviews to identify common elements relating to patient values and preferences. The second step of the methodology involves synthesizing the common elements *across* the three pillars using a coding matrix. The final step involves incorporating patient and public involvement (PPI) feedback into the results of the common elements analyses to arrive at a final intervention. See Figure 1 for a visual representation of this methodology.

2.2 | Step 1: Common elements analysis *within* the three pillars of evidence-based practice

2.2.1 | Pillar 1: Identifying the research literature and conducting a common elements analysis

The research pillar of evidence-based practice relies on the most current empirical evidence of treatment efficacy and effectiveness (Sackett et al., 1996). Randomized controlled trials (RCTs) are considered the "gold standard" for determining treatment efficacy (Philips & Falkenström, 2021), and systematic reviews and meta-analyses of RCTs are positioned at the apex of the evidence hierarchy (Spring & Hitchcock, 2010).

A systematic review and meta-analysis were undertaken to evaluate the evidence for low-intensity psychological interventions for feeding and eating disorders. A systematic search for RCTs on low-intensity psychological interventions was conducted across Embase, MEDLINE, PsycInfo, CINAHL, and Cochrane Central Register of Controlled Trials (CENTRAL) from the year of inception to August 2022. The findings of this review have been published elsewhere (Davey, Allen, et al., 2023).

The review identified 39 low-intensity psychological interventions for eating disorders, predominantly based on CBT principles ($n = 31$). Notably, only one intervention for a child and adolescent population met the inclusion criteria: a parental-guided self-help FBT intervention for adolescents with anorexia nervosa (Lock et al., 2021). A CBT-guided self-care intervention for adolescents with bulimia nervosa (Schmidt et al., 2007) was identified during screening but did not meet the eligibility criteria for inclusion in the review. This intervention was a downward adaptation of an intervention used with adults in other included studies (Bailer et al., 2004; Treasure et al., 1996).

Since many of these interventions primarily targeted adults, the review was supplemented by an informal review of higher-intensity CBT treatment manuals to ensure comprehensive coverage of key elements used in the treatment of children and young people with eating disorders. Two CBT treatment manuals were thoroughly reviewed: CBT-E (Dalle Grave & Calugi, 2020; Fairburn, 2008) and CBT-T (Waller et al., 2019), as they had strong empirical support. The contents page and section headings were carefully examined to identify elements, and common treatment processes and parameters were also extracted.

After identifying the literature on efficacious interventions, a common elements analysis was conducted. Common elements methodologies typically involve disentangling complex interventions

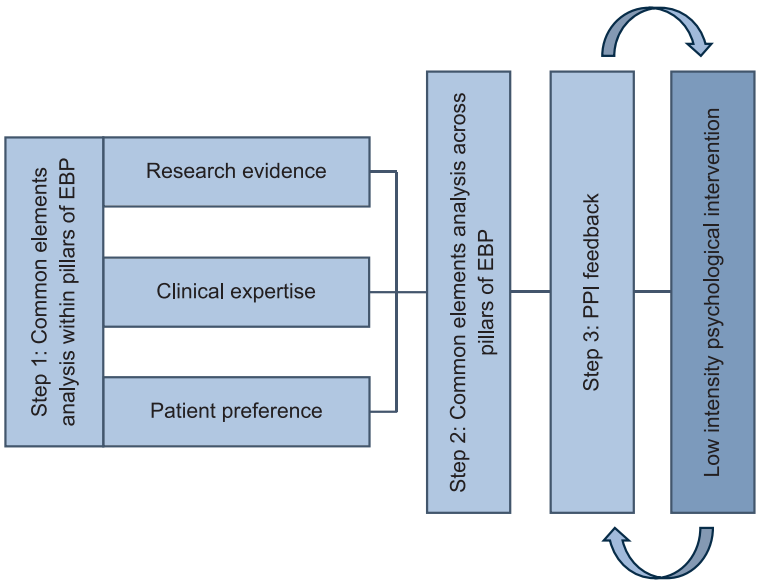

FIGURE 1 A novel systematic methodology to develop a low-intensity psychological intervention. EBP, evidence-based practice; PPI, patient and public involvement.

into discrete meaningful entities (i.e., elements) and then counting or evaluating shared elements across a selection of effective interventions (Chorpita et al., 2005a; Engell et al., 2023). Such an approach posits that elements frequently used across multiple effective interventions are more likely to contribute to positive outcomes compared to less commonly shared elements (Chorpita et al., 2005a, 2007). In essence, these common elements are more likely the "active ingredients" that contribute to positive outcomes. It is important to note that common elements do not necessarily reflect mechanisms of change in therapy (Salkovskis et al., 2024). Common elements can relate to intervention content, delivery, or other intervention practices. Utilizing a common elements approach can enhance our understanding of intervention effectiveness and guide further development and implementation (Engell et al., 2023). However, traditional common elements methodologies primarily focus on research evidence and do not account for clinician expertise or patient values and preferences, which are key tenets of evidence-based practice (Sackett et al., 1996).

To discern the core elements of the interventions identified in the systematic search, the subsequent step involved extracting module titles and lists of topics in each CBT-based low-intensity intervention. In instances where this information was not readily available, insights into the nature of the treatment were derived from the description provided by the study authors. The core elements of each low-intensity and supplementary higher-intensity intervention were compiled and compared to identify the common elements across interventions. A coding sheet was developed, categorizing the frequency of each element across interventions as low (1–3 mentions), moderate (4–7 mentions), or high (8+ mentions).

2.2.2 | Pillar 2: Focus groups to capture clinical expertise and identify common elements

In evidence-based practice, clinical expertise refers to the competency and judgment that clinicians acquire through clinical training, experience, and practice (Levant & Sperry, 2016). Clinician expertise is especially important when research on a particular clinical context or process is limited (Melchert et al., 2023). Involving practicing clinicians in the process of innovation and drawing on their expertise to develop novel interventions ensures an intervention matches the needs, capacities, and preferences of both patients and providers, as well as fits into the context of routine practice (Bleijenberg et al., 2018). Healthcare professionals with expertise in a specific area are well-placed to generate ideas for potential interventions and propose recommendations about content, format, style, and delivery (O'Cathain et al., 2019). Qualitative methodologies can offer detailed insights into how to deliver interventions, their mechanisms of action and key components to include (Maciver et al., 2021; Sekhon et al., 2017).

To this end, a consensus meeting, involving 19 healthcare professionals, was held to discuss low-intensity psychological treatments for eating disorders (see Davey, Bennett, et al., 2023). In addition, two qualitative focus groups were conducted with 10 healthcare professionals working in child and adolescent eating disorder services, recruited via convenience sampling. A range of professions were represented, including clinical psychologists, mental health nurses, a consultant psychiatrist, a CBT therapist, an assistant psychologist, and a clinical support worker. The focus groups deliberately included those likely to deliver the intervention (the low-intensity workforce) alongside those likely to supervise them, and those involved in service organisation and delivery. The collective experience of these healthcare professionals varied, spanning outpatient and inpatient settings within the NHS, private practice, and the charity sector. Further details of the participants can be found in Supporting Information S1: Material 1.

Focus group discussions were guided by a flexible topic guide and explored healthcare professionals' views on the suitability of guided self-help interventions for children and young people with eating disorders. These discussions are reported elsewhere by Davey et al. (2024). Focus groups also specifically asked healthcare professionals about useful content for a guided self-help intervention and how it might be structured and delivered. These findings are reported here.

Focus groups were audio-recorded and transcribed verbatim. Each transcript underwent line-by-line coding and suggestions for intervention content were extracted. The data were analyzed inductively (directed by the content) and semantically (reflecting the content). A comprehensive list of proposed topics for the intervention was subsequently compiled and systematically compared across focus groups to identify common elements. Each element was coded based on its frequency within and between the focus group discussions, categorized as low (1–2 mentions), moderate (3–4 mentions) or high (5+ mentions).

2.2.3 | Pillar 3: Focus groups and interviews to identify common elements with respect to patient values and preferences

The third pillar of evidence-based practice consists of patient values and preferences (Sackett et al., 1996). Values encompass patients' attitudes and perceptions towards specific healthcare options, and preferences are best understood as something desired by patients after accounting for their values (Tringale et al., 2022). Patient values and preferences are considered the "lynchpin" in shared clinical decision-making (Melchert et al., 2023; Spring, 2007).

Engaging patients in the development phase is recommended to help maximize the likelihood of acceptability, effectiveness, and subsequent adoption of an intervention (Sekhon et al., 2022; Wight et al., 2016). Patients hold critical knowledge to ensure a mental health intervention aligns with the needs and preferences of the population served (Bell et al., 2023; Bergmark et al., 2019). Interventions are more likely to be adopted by patients if they offer intrinsic value for the patient in managing their condition, or improve critical aspects of their functioning and wellbeing (Biagianti et al., 2017). Involving children and young people with eating disorders in the development of this

low-intensity psychological intervention is therefore axiomatic to this goal. Given the central role parents play in their child's treatment (McArdle, 2019; Wilksch, 2023), it also paramount to include them in the intervention development process.

Children and young people with lived experience of eating disorders, as well as parents/carers, were recruited via convenience sampling. Five qualitative focus groups and four semistructured interviews were conducted, comprising 11 children and young people (age 13–19 years; 1 male) and 12 parents/carers. Anorexia nervosa was the predominant diagnosis among children and young people ($n = 8$), and all had current or past treatment from a specialist eating disorder service. Separate focus groups were held for children and young people, and parents. Details of the participants can be found in Supporting Information S1: Material 1.

The topic guides were tailored accordingly for each stakeholder group but covered the same topics as the healthcare professionals' focus group: suitability of guided self-help for children and young people with eating disorders, and preferences towards the content, structure and modes of delivering guided self-help. The former findings are detailed in Davey, Micali, et al. (2024), and the latter findings are reported here.

Suggestions for intervention content were extracted through line-by-line coding of the transcripts. A list of specific topics and design features proposed by children, young people, and parents was compiled for potential integration into the intervention. The proposed content was then systematically compared across focus groups and interviews to identify common elements. Each element was coded based on its frequency within and between the interview and focus group discussions, categorized as low (1–4 mentions), moderate (5–9 mentions) or high (10+ mentions).

2.3 | Step 2: Common elements analysis *across* the three pillars of evidence-based practice

In Step 1, each element was coded (high, moderate, or low) based on its frequency *within* each respective pillar of evidence-based practice. In Step 2, these codes were synthesized to identify common elements *across* the three pillars. A coding matrix was devised to systematically select the practice elements for inclusion in the intervention. Elements were organized along the Y-axis, with the three pillars of evidence-based practice on the X-axis. Operationalization criteria were defined to aid systematic selection: an element had to feature across at least two pillars, meeting a minimum requirement of either two moderate ratings or three low ratings, to be included in the intervention.

2.4 | Step 3: PPI feedback to inform intervention refinement

PPI plays a crucial role in ensuring that intervention content is relevant and meets the needs of the target population, which increases the likelihood of successful implementation and engagement (Bombard et al., 2018; Sekhon et al., 2017). The final step of intervention development was to conduct member checking on the results of the common elements analyses and proposed intervention.

Five participants from the qualitative study—three young people with eating disorders and two parents—were invited to contribute to the intervention development as PPI representatives. They reviewed the intervention materials and participated in one-on-one feedback discussions with the first author *(initials removed for peer review)* via Zoom. Intervention materials were provided up to a week in advance of the meeting, along with a prompt sheet highlighting key areas for consideration. Drawing on their lived experiences, the PPI representatives shared insights and suggestions, and critically evaluated factors like clarity, comprehensiveness, sensitivity, and potential barriers to engagement. This process ensured the intervention addressed the needs and preferences of children and young people with eating disorders. Each PPI representative was compensated with a £100 voucher, in accordance with NIHR INVOLVE guidelines.

3 | RESULTS

3.1 | Outcomes of step 1 and step 2: Common elements within and across the three pillars of evidence-based practice

A tabular overview of the process to identify common practice elements across the three pillars of evidence-based practice can be found in Table 1. High ratings are represented by ★, moderate by •, low by ▾, and ✓ indicates that an element met the criteria for inclusion in the intervention. All practice elements that featured across at least two pillars, meeting a minimum requirement of either two moderate ratings or three low ratings, were included, with the exception of regular weighing which was included for patient safety (Waller & Mountford, 2015).

Given the importance of patient preference (Sackett et al., 1996), elements deemed important by patients (indicated by high or moderate ratings in the patient preference pillar) that did not meet the aforementioned criteria were included in a supplementary guide for young people/parents or in a resource signposting to additional sources of support, as indicated by the symbol □ in Table 1.

3.1.1 | Additional factors to consider

Findings from the focus groups and interviews highlighted the need to personalize the guided self-help intervention for children and young people with eating disorders. Key strategies included (i) tailoring module selection and order based on the patient's specific needs and (ii) delivering the intervention in a format that aligns with patient preferences. There was no consensus on the proposed format: some participants preferred written workbooks, while others favored the interactivity of an app or online platform. An interactive

TABLE 1 Common elements across the three pillars of evidence-based practice to inform the development of a CBT-guided self-help intervention for children and young people with eating disorders.

Practice element	Research evidence *low (1–3 mentions) moderate (4–7 mentions) high (8+ mentions)*	Clinical expertise *low (1–2 mentions) moderate (3–4 mentions) high (5+ mentions)*	Patient preference *low (1–4 mentions) moderate (5–9 mentions) high (10+ mentions)*	Meets operationalization criteria
Body image	★	★	★	✓
Psychoeducation	★	★	★	✓
Signposting to alternative sources of support	★	★	★	✓
Preparing for change	★	★	•	✓
Regular eating	★	★	▾	✓
Relapse prevention	★	★	▾	✓
Real-time self-monitoring	★	•	▾	✓
Identification and management of dysfunctional thoughts	★		▾	✓
Identification and management of emotional triggers	★		•	✓
Meal plans	•	•	•	✓
Stopping purging behaviors	•	•	▾	✓
Dietary restraint and dietary rules	•	▾	▾	✓
Exposure to feared foods	•	▾	▾	✓
Problem-solving	•	▾	▾	✓
Assertiveness	•	★		✓
Personalized formulation	•		★	✓
Navigating social media	▾	★	▾	✓
Goal setting	▾	•	•	✓
Lived experience stories/case vignettes	▾	•	•	✓
Low self-esteem	▾	•	•	✓
Self-compassion	▾	•	•	✓
Behavioral experiments	▾	•	▾	✓
Reducing excessive exercise	▾	•	▾	✓
Interpersonal difficulties	▾	•		
Activity scheduling	▾		▾	
Perfectionism	▾		▾	
Collaborative weighing	▾			×
Coping with cravings and urges	▾			
Improving relationships	▾			
Risky behaviors (e.g., alcohol and drug use)	▾			
Self-soothing/relaxation techniques	▾			
Step-by-step plan to reach weight loss in the long-term	▾			

TABLE 1 (Continued)

Practice element	Research evidence *low (1–3 mentions) moderate (4–7 mentions) high (8+ mentions)*	Clinical expertise *low (1–2 mentions) moderate (3–4 mentions) high (5+ mentions)*	Patient preference *low (1–4 mentions) moderate (5–9 mentions) high (10+ mentions)*	Meets operationalization criteria
Work problems	▾			
Navigating celebrations		•	▾	
Self-harm		•	▾	
Anxiety		▾	•	□
Depression/low mood			★	□
Tips for parents on how to communicate with child			★	□
Self-care for parents			•	□
Tips on how to discuss ED with others (e.g., friends)			•	□
Autism			▾	
Building resilience			▾	
Embracing puberty			▾	
Loneliness			▾	
Sleep			▾	
Tips for handling specific situations (e.g., asking for a menu without calories)			▾	
Trauma			▾	

Note: ★ = high rating; • = moderate rating; ▾ = low rating; ✓ = meets criteria for inclusion in intervention i.e., element had to feature across at least two pillars, meeting a minimum requirement of either two moderate ratings or three low ratings; □ = inclusion in supplementary guide or resource signposting to alternative sources of support.

PDF workbook was suggested as a potential middle ground. Participants recommended making the intervention available in multiple formats to provide options. They were also explicit that careful consideration should be given to the specific developmental needs of children and young people. See Davey et al. (2024) for more details.

The focus groups and interviews also identified specific features to incorporate into the intervention. Firstly, extensive discussions took place regarding the heterogeneous nature of eating disorders and the diversity in gender, ethnicity, and body size among those affected. It was emphasized that self-help materials should include imagery and case vignettes that are inclusive of all presentations and backgrounds. Secondly, there was consensus that while some young people prefer abundant information about eating disorders, others may find it overwhelming. To address this, it was suggested that information be provided in "bite-sized chunks" with links to external resources for further reading if desired. Thirdly, young people expressed a need for dedicated spaces to record their thoughts and feelings to gain insight into their difficulties and recognize patterns in their behaviors. Lastly, stakeholders highlighted the importance of including rewards; setting and accomplishing challenges with a reward as motivation was deemed beneficial for recovery.

3.2 | Outcomes of step 3: PPI feedback

In the final stage of treatment development, member checking (Mays, 2000) was conducted to solicit feedback from five PPI representatives regarding the content and structure of the intervention. Several specific suggestions to improve the intervention were made, leading to iterative revisions based on their feedback. The specific ways in which their feedback influenced the final intervention design can be seen in Table 2. Notably, concerns were raised about the potential for regular weighing to increase anxiety and eating disorder psychopathology (e.g., weight preoccupation, urges to engage in compensatory behaviors). There was consensus that the rationale for weighing needs to be clearly explained to alleviate concerns and enhance understanding of its purpose. Furthermore, there was apprehension that learning about other disordered eating behaviors might inadvertently encourage their adoption. To address these concerns, contingencies were included in the intervention to allow young people to skip sections irrelevant to their presentation (e.g., self-induced vomiting, laxative misuse). There were also extended discussions about the challenges of parenting a young person with an eating disorder and its impact on parental wellbeing. It was considered essential to provide a resource to assist parents in supporting their child through self-help

TABLE 2 Amendments to the intervention based on suggestions from the PPI representatives.

PPI suggestion	Amendment based on suggestion
Concerns that regular weighing would increase distress and eating disorder psychopathology	Included the rationale for weekly weighing in Module 1—exposure to weight allows the young person to directly test some of the core cognitions underlying their eating disorder (i.e., consuming calorie-dense foods, and/or dropping compensatory behaviors leads to uncontrollable weight gain)
Need to be careful with terminology to ensure that the language used is not triggering	Several amendments were made to the module content based on further discussion and suggestions by the PPI representatives
Concerns that learning about all disordered eating behaviors may encourage young people to adopt these behaviors	Introduced contingencies throughout the intervention to allow young people to skip sections considered not relevant to their eating disorder presentation Made the examples of behaviors less specific (e.g., changed the diet rule "I won't eat until 7 pm" to "I won't eat until the evening")
Helpful to have plenty of open-text boxes for reflections	Added more open-text boxes throughout the intervention to allow young people to write down their reflections
Did not like use of the word "navigating" in the title for the body image module	Changed the name of the module from "body image and navigating social media" to "body image and social media"
Important to provide information to help parent support young person and seek support for themselves	Created a 'Supporting your child' resource which includes information for parents on how to support their child to use the intervention and seek support for themselves
Important to consider the impact an eating disorder can have on a sibling and how parents can support the sibling	Added a section to the "Supporting your child" resource on advice for parents supporting siblings, including signposting to an external website

intervention and to direct them to additional sources of support for their own mental health and wellbeing.

3.3 | Low-intensity CBT intervention for children and young people with eating disorders

The intervention is designed for children and young people with anorexia nervosa, bulimia nervosa, binge eating disorder and other specified feeding or eating disorder (OSFED; atypical anorexia nervosa, bulimia nervosa of low frequency and/or limited duration or binge eating disorder of low frequency and/or limited duration). An a priori decision was made not to target avoidant restrictive food intake disorder (ARFID) due to fundamental differences in underlying motivations for food restriction or avoidance, the absence of binge eating and purging, and the specific features of body image disturbance (Cañas et al., 2021; Zimmerman & Fisher, 2017).

The treatment comprises eight modules (Table 3) delivered through an illustrated interactive workbook with diverse imagery, character-based vignettes, reflection boxes, and where applicable, links to reputable resources. Each module has its own workbook and accompanying home practice tasks, which the young person is encouraged to try between sessions. Rewards for progress are encouraged throughout the intervention. Intervention materials are supported by weekly sessions with a guide. The order in which modules are completed is decided collaboratively between the guide and young person based upon their personalized formulation and treatment goals. Further details about the intervention can be found in Davey et al. (2024).

The intervention was evaluated in a proof-of-concept pilot study involving six female adolescents with eating disorders (Davey, Bryant-Waugh, et al., 2024). Findings from both quantitative and qualitative data suggest that the intervention was feasible and acceptable, and associated with a reduction in eating disorder psychopathology.

4 | DISCUSSION

The aim of this paper was to provide a systematic, evidence-informed process for developing low-intensity psychological interventions. It proposed that the first step is to use a common elements approach within the three pillars of evidence-based practice (Sackett et al., 1996): research evidence, clinical expertise, and patient values and preferences. The second step is to synthesize the common elements across the three pillars. Elements had to meet operationalization criteria (feature across at least two pillars with at least two moderate or three low ratings) to be included in the intervention. The final step involves members checking with PPI representatives to further refine the intervention to ensure acceptability.

Engaging in this process to develop a low-intensity intervention for children and young people with eating disorders led to the development of eight modules delivered on a weekly basis. Preliminary data from a proof-of-concept pilot study suggests that the intervention in its current format is feasible and acceptable, and associated with a reduction in eating disorder psychopathology (Davey, Bryant-Waugh, et al., 2024). This intervention can be considered "evidence-informed," without additional evaluation, based on its development and grounding in empirically supported interventions. However, a randomized controlled trial is needed to evaluate its efficacy.

There are several methodological options for developing a low-intensity psychological intervention where an evidence-based

TABLE 3 Treatment modules which comprise CBT-guided self-help for children and young people with eating disorders resulting from novel methodology.

Module	Description
1. Understanding my eating difficulties	The aim of this module is to provide key information about eating disorders, including what keeps them going, and to help the young person think about what is maintaining their eating disorder. The young person will also identify goals for the intervention.
2. Eating more regularly	The aim of this module is to help the young person understand the relationship between what they are eating and their energy levels. It will also introduce ways to improve the structure of their eating to facilitate future meal planning and the types of food that they eat.
3. Reducing dieting	The aim of this module is to help the young person identify and challenge any strict diet rules maintaining their eating disorder, including rules around when to eat, what to eat and how much to eat.
4. Doing things differently	The aim of this module is to provide the young person with some strategies to reduce and manage weight control behaviors, such as self-induced vomiting, laxatives and exercising excessively.
5. Body image and social media	The aim of this module is to provide some strategies to help the young person tackle concerns around their body image. It will also discuss the role of social media in body image and ways to use social media in a more positive way.
6. Learning to feel good about myself	The aim of this module is to provide the young person with some effective ways to improve their self-esteem.
7. Managing emotional triggers	The aim of this module is to explain the link between events, emotions and eating. It will help the young person to consider healthier ways to cope, including how to solve day-to-day problems. It also provides some tips on how to improve assertive communication.
8. Planning for the future	The aim of this module is to help the young person maintain the progress they have made. It will support the young person to develop a plan for managing slips or setbacks which may happen in the future.

higher-intensity intervention already exists. The simplest is for treatment developers to abbreviate the existing intervention and select the elements they consider most important based on their clinical expertise. However, such an approach is inherently flawed due to biases (Bowes et al., 2020) and emphasizes one pillar of evidence-based practice over others. Applying the common elements approach within the pillars allows for the integration of user experience and perspectives, clinical expertise, and research evidence. The systematic integration of common elements across the pillars, followed by refinement with PPI input, is proposed to result in a low-intensity treatment that reflects best practice, can be implemented in routine services, and meets the needs of its intended population.

The exemplar intervention outlined here comprises eight modules, each designed as a meaningful unit with the potential to achieve specific treatment outcomes (Chorpita et al., 2005b). It cannot yet be determined which modules are most effective ("core") and which should be optional. Once treatment efficacy is established, dismantling studies can be used to parse the current intervention to identify its active ingredients (Salkovskis et al., 2024).

4.1 | Strengths and limitations

To our knowledge, this is the first paper to propose a systematic process for developing a low-intensity psychological intervention. It presents a novel and rigorous methodology that can be applied to any common mental health disorder. While CBT for eating disorders was the focus, the approach is not limited to this treatment modality or disorder and can be generalized to other psychotherapies and disorders. For example, the methodology could be used to develop a trauma-focused guided self-help intervention for children and young people with posttraumatic stress disorder (PTSD), using the interventions identified by Siddaway et al. (2022) as the foundation for the research evidence pillar. Researchers could also conduct a qualitative study involving healthcare professionals, young people with PTSD, and their parents to address the clinical expertise and patient preference pillars. Finally, a common elements analysis could be performed within and across these pillars, with PPI input for further refinement.

This methodology complements existing processes for developing novel, high-intensity treatments (Clark, 2004), and integrates current understanding of the maintenance of psychopathology and effective interventions to develop a low-intensity treatment. It is not yet known how this methodology will compare to others that may be developed in future, but it provides a starting point for the systematic development of low-intensity treatments. The development process adhered to the MRC's framework for the development and evaluation of complex interventions (Skivington et al., 2021). It integrates evidence-based elements and strategies from well-established treatments with formative qualitative research to contextualize the intervention for the target population and considers implementation in routine practice from the outset. The resultant intervention warrants evaluation using established methods such as randomized

controlled trials but can be considered an evidence-informed intervention that can be applied across healthcare settings to close the treatment gap.

The content of low-intensity CBT interventions varies widely and is often poorly described, which can hinder replication, impair implementation, and limit meaningful further research (Candy et al., 2018). Detailed information about the development process and the intervention is presented to allow transparency for stakeholders who may wish to access, evaluate, or replicate the intervention. The content is derived from publicly available resources and is therefore not restricted by intellectual property issues. This approach offers advantages, such as not reinventing established practices ("the wheel") and utilizing evidence-based content. Such an open approach to science facilitates rapid intervention development and evaluation. However, some individuals or organizations may hold ownership over specific content ("spokes of the wheel"). Therefore, obtaining permissions and providing appropriate acknowledgment to content originators is essential. This ensures ethical and legal compliance while also fostering transparency and integrity in the intervention development process. All content authors have granted permission for their material to be adapted for the current intervention, with credit given to their contributions.

Although this work is formative by design, several limitations must be considered when interpreting the process described here. The first refers to the nature of the qualitative study samples in Step 1 of this methodology. In this particular example, the sample was small and self-selected. There was a lack of demographic diversity across all stakeholder groups, with most participants being White British and female; no fathers were represented in the parent sample. Anorexia nervosa was the predominant diagnosis, likely an artifact of the help-seeking population among youth with eating disorders (Nicula et al., 2022; Simic et al., 2022). Additionally, healthcare professionals primarily represented psychology disciplines within specialist child and adolescent eating disorder services. Focus groups involving a wider range of demographics, healthcare disciplines, and settings would have better corroborated the proposed topics and features for inclusion in the intervention.

The second limitation pertains to the fact that, although a systematic approach was employed, the intervention team may have been biased towards content ideas that align with their therapeutic orientation and the project narrative. This highlights the importance of transparency and documentation regarding the decision-making process to facilitate replication (Candy et al., 2018; Hoffmann et al., 2014). The research team acknowledges that other approaches, such as family-based treatment (Lock et al., 2021), dialectical behavior therapy (Carter et al., 2020), and compassion-focused therapy (Kelly & Carter, 2015), might have offered valuable elements for the intervention. A third limitation is that the operationalization criteria for inclusion—requiring an element to feature across at least two pillars with at least two moderate or three low ratings—were established on practical rather than scientific grounds to ensure that the intervention would have a limited number of sessions. Additionally, the thresholds for categorizing ratings as "low," "medium," and "high" varied across the pillars. Future studies may want to standardize these criteria.

4.2 | Practical considerations

There are practical considerations to attend to before adopting this novel methodology to develop a low-intensity psychological treatment. The extensive formative work that informed the common elements matrix (Table 1) required considerable resources but provided valuable insights for potential content and features for inclusion in the intervention. (*Removed for peer review*) developed this intervention as part of her PhD, funded by a Child Health Research Studentship at UCL Great Ormond Street Institute of Child Health in the UK. Data collection and the systematic process of intervention development spanned approximately 6 months. Although time-consuming, this process is less resource intensive than creating a completely novel intervention and results in an evidence-informed intervention.

5 | CONCLUSION

This approach has important implications for developing low-intensity psychological treatments. Rather than arbitrarily selecting components of high-intensity interventions for modification into low-intensity ones, a systematic process involving key stakeholders has been proposed. Such a process holds promise for increasing the speed of development of such interventions and their implementation in clinical practice, helping to meet the demand for brief, effective interventions for those currently unable to access them.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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PEER REVIEW

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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