SPIRITUAL PSYCHOLOGY AND COUNSELING
spiritualpc.net / 2022 Volume: 7 Number: 2

Research Article

The Efficacy of Health Realization/Innate Health Psycho-education For Individuals With Eating Disorders: Pilot Study*

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* The preparation of this paper was supported in part by CONNECT: The West Yorkshire Adult Eating Disorders Service. The views expressed in this paper are those of the authors and not necessarily those of Bradford Teaching Hospitals Foundation Trust, CONNECT: The West Yorkshire Adult Eating Disorders Service, Kent and Medway NHS and Social Care Partnership NHS Trust, Leeds and York Partnership NHS Foundation Trust, Light of Mind, Wayne State University, or Well of Being.
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Abstract
Eating disorders are associated with high rates of mortality, disability, and poor motivation for change. Psychological therapies are the first line treatment, yet outcomes are poor, and drop-out rates high. Health Realization/Innate Health (HR/IH) psycho-education offers an alternative intervention which can be delivered in groups engaging participants' innate capacity for well-being and resilience. Eight female participants with anorexia nervosa (mean age 27.75, SD 14.34) from the CONNECT Eating Disorders Service, United Kingdom attended and completed a 15 session HR/IH psycho-educational group facilitated by two HR/IH trained therapists in this pre-experimental, multiple single-case design pilot study. Standard general psychiatric and eating disorders clinical outcome measures were administered immediately before and after the group, and the quantitative data compared using SPSS. Qualitative feedback was gathered using a feedback questionnaire immediately after the group. Comparison of quantitative data indicated statistically significant improvement in participants' weight ($p=0.04$), body mass index (BMI; $p=0.04$), and Eating Disorder Examination Questionnaire (EDEQ) global mean score ($p=0.04$). Clinically significant positive changes were also noted for Rosenberg's Self-Esteem Scale (pre-mean=8.8; post-mean=11.9), Clinical Outcomes in Routine Evaluation (CORE; pre-mean=1.6; post-mean=1.4), and Eating Disorders Quality of Life Scale (EDQLS; pre-mean=2.0; post-mean=1.4). High levels of participant and carer satisfaction and acceptability were also demonstrated. The HR/IH psycho-educational approach warrants further study as a brief intervention for adults with eating disorders.

Keywords:
Innate Health • Three Principles • Health Realization • Eating Disorders • Anorexia Nervosa

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eISSN: 2458-9675

Received: 02.12.2021
Revision: 15.04.2022
Accepted: 25.04.2022

Citation: Felix, F., Franklin-Smith, M., Jones, W.R., Kelley, T.M., Parker, S., Sharma, V., & Skidmore, C. (2022). The efficacy of health realization/innate health psycho-education for individuals with eating disorders: Pilot study. *Spiritual Psychology and Counseling, 7*(2), 125–142. https://dx.doi.org/10.37898/spc.2022.7.2.161

DOI: 10.37898/spc.2022.7.2.161

Eating disorders are biologically based, serious mental illnesses which individuals typically acquire in mid-adolescence at a developmentally sensitive time (Klump, Bulik, Kaye, Treasure, & Tyson, 2009). About 90% of those affected are female. Lifetime prevalence for DSM-5 anorexia nervosa is estimated at 1.42% for adult females while DSM-5 bulimia nervosa is estimated at 0.46% (Udo & Grilo, 2018). The overall incidence and prevalence of anorexia nervosa and bulimia nervosa is stabilising in Western countries (Currin, Schmidt, Treasure, & Hershel, 2005; van Son, van Hoeken, Bartelds, van Furth, & Hoek, 2006) but increasingly younger people are affected.

Eating disorders have major psychological, physical and social sequelae (Hjern, Lindberg, & Lindblad, 2006) with poor quality of life (De La Rie, Noordenbos, Donker, & van Furth, 2007; Pohjolainen et al., 2009) and high health burden (Mond, Hay, Rodgers, & Owen, 2009). The adverse physical consequences of dieting, weight loss and purging behaviours can sometimes prove fatal and anorexia nervosa has one of the highest mortality rates of any psychiatric disorder (Arcelus, Mitchell, Wales, & Nielsen, 2011; Button, Chadalavada, & Palmer, 2010; Jones, Morgan, & Arcelus, 2013; Papadopoulos, Ekbom, Brandt, & Ekselius, 2009), although the introduction of specialist eating disorders services appears to have improved survival rates (Lindblad, Lindberg, & Hjern, 2006). Despite favourable outcomes in recent years, one in five adolescent onset illness go on to develop chronic eating disorders (Dobrescu et al., 2020). Less is known about the mortality rates of bulimia nervosa and 'other specified feeding and eating disorders' (OSFED), although evidence suggests that rates may be as high as that of anorexia nervosa (Crow et al., 2009). Eating disorders also exert a high burden on families and other carers (Haigh & Treasure, 2003; Winn et al., 2007).

Psychological therapies, including Cognitive Behavioural Therapy (CBT) and the 'Maudsley Model of Anorexia Treatment in Adults' (MANTRA), are the first line treatment for eating disorders; however, eating disorders remain some of the most difficult psychiatric disorders to treat (Fairburn et al., 2013; Halmi et al., 2005) and are associated with poor motivation for change (Arcelus et al., 2011; Treasure, Duarte, & Schmidt, 2020). Furthermore, clinical outcomes are modest at best, drop-out rates are high, and the evidence base regarding treatment remains limited (Solmi et al., 2021) emphasizing the need for new interventions to be developed.

Health Realization/Innate Health and The Three Principles

Health Realization/Innate Health (HR/IH) is a simple and accessible psycho-educational intervention which can be delivered on an individual or group basis that helps individuals better understand the principle of thought and how it affects one's experience of the world. The HR/IH model teaches individuals that they can change how they react to their circumstances by becoming aware that they themselves are

creating their own experience as they respond to their thoughts and by connecting to their "innate health" and "inner wisdom". HR/IH is grounded in the insights and writings of Banks (1998, 2001, 2005) and a psycho-educational approach derived from Banks's work by Mills (1995) and Pransky (1998) which posits that people's psychological life experiences (e.g., feelings, perceptions, moods, and symptoms) are created by three fundamental, universal principles known as "The Three Principles". The Three Principles are described in detail elsewhere (Banks, 1998, 2001, 2005; Kelley, Hollows, & Savard, 2019; Kelley, Pransky, & Lambert, 2015; Pransky & Kelley, 2014) Here is a summary of them:

i. Mind: the formless energy or intelligent life force that powers people's psychological functioning.

ii. Consciousness: the ability to be conscious and the agency that enlivens people's thoughts through their senses giving them the appearance of reality.

iii. Thought: the power to form the thoughts that enter people's consciousness and become their psychological experiences.

In summary, Banks (1998, 2001, 2005) posited that people's use of Thought and Consciousness gives them the only experience they can have. In turn, people's behavior occurs in exact alignment with their continually evolving personal realities created from the "inside-out" via their use of the Three Principles. Banks (1998) stated:

> There is nothing in the world that can come to pass without Thought and Consciousness… there would be no reality without Consciousness and Thought…Consciousness gives our five senses the ability to react to life: our seeing, our smelling, our touching…This is what brings it (all) to life. But it (reality) can't come in by itself. It has to have a thought…Our thoughts in turn create our character, our behavior, and the behavior of all humanity. (p. 43)

HR/IH does not fall within the typical continuum of psychological treatment or therapy approaches. HR/IH does not target people's cognitions, affect, or behavior. Nor does it attempt to teach people various skills or techniques. Rather, HR/IH attempts to educate people about the generic nature of human psychological functioning. The efficacy of the HR/IH intervention is realized when people, as a result of awareness and sufficient understanding of the Three Principles, experience new insights regarding the following realms to which the Three Principles point simultaneously: thought recognition (TR) and innate health via a clear mind (IH/CM).

Thought Recognition

Thought recognition (TR) refers to the realization that thought is the only "reality" people can ever know and that people have the ability to see this and be conscious of it in the moment. For example, it is common for people to think that their stress

comes from external circumstances and how they are treated by others. In the HR/IH intervention, learners are assisted to understand how they can only feel stress if they are thinking thoughts that cause stress, no matter what the external situation. Instead of giving up their power to the outside world, learners realize they have autonomy over their own mental health via their understanding and use of the power of Thought. It is also common for people to learn and identify with cognitive schemas of self, others, and the environment that can obscure their innate health, generate chronic mental stress, and spawn and sustain dysfunctional coping strategies. HR/IH recognizes the innocence of people's adherence to these schemata and that everyone is doing the best they can in the moment based on how their thinking makes their lives appear to them. HR/IH intervention assists people to grasp that these "internal working models" are simply stories, abstractions, or mental structures they don't have to believe and act on.

In contrast to traditional cognitive and narrative therapies which tend to focus on an individuals' dysfunctional thinking, HR/IH focuses on "innate health" and the role of "mind, thought and consciousness" in creating an individual's experience of life (Mills, 1995; Pransky, 2003). HR/IH does not set out to change an individual's thoughts by encouraging "positive thinking" or "reframing" negative thoughts into positive ones. In contrast HR/IH recognises that one's ability to control one's thoughts is limited and the effort to do so can itself be a source of stress. Instead, individuals are encouraged to consider that their "minds are using thought to continuously determine personal reality at each moment" (Mills, 1995; Pransky, 2003). Furthermore, HR/IH holds that the therapeutic "working through" of personal issues from the past to achieve wholeness is unnecessary as people are already "whole and healthy" (Mills, 1995). According to HR/IH, one's "issues" and memories are just thoughts and an individual can react to them or not (Pransky, 2011). Therefore HR/IH addresses personal insecurities and dysfunctional patterns "en masse", aiming for an understanding of the "key role of thought", an understanding that ideally allows the individual to step free at once from a large number of different patterns all connected by insecure thinking (Mills, 1995). With this approach, it is rare for the HR/IH practitioner to delve into the specific content of thought beyond the identification of limiting thoughts and when such thoughts are considered to be limiting or based on insecurity, the counsellor simply encourages the individual to disengage from them (Pransky, 2003).

Innate Health via a Clear Mind

Innate health via a clear mind (IH/CM) captures the realization that people have all the mental well-being, common sense and resilience they need already inside them and that this health surfaces whenever the personal mind quietens. In other words, when the personal mind quietens, the default setting of innate health engages.

Furthermore, HR/IH psycho-education assists people to realize they have a built-in self-monitoring system; a reliable way of knowing whether they are using the power of Thought in their best interest or against themselves; their feelings. Using the signal of a discomforting feeling to see that their thoughts are not serving them well in that moment, people can get back on track, so to speak, and rekindle their innate health as the personal mind quietens.

HR/IH and eating disorders

As eating disorders are characterized by persistent and pervasive content-focused thinking patterns (i.e., misuses of the power of Thought), HR/IH psycho-education offers an alternative approach to traditional therapies and provides hope particularly where standard first line interventions may have been unsuccessful in promoting recovery or where there is limited motivation for change. In addressing eating disorders, HR/IH does not attempt to access health and recovery through traditional behavioral methods, coping strategies, or by changing or controlling people's thinking. HR/IH focuses instead on assisting people with eating disorders to grasp an insight-based understanding of the "inside-out" creation of psychological experiences and the nature of healthy psychological functioning. The goal of HR/IH is to help people realize how their unawareness or limited understanding of the Three Principles, TR, and IH/CM makes them prone to misusing the power of Thought which can generate chronic mental stress, obscure their innate health, and maintain eating disorder symptoms and behaviors. With sufficient understanding of the Three Principles, TR, and IH/CM people are empowered to use the Three Principles in their best interest and, in turn, free up their own inner well-being, resilience and their body's innate intelligence to return them to health.

HR/IH in other cohorts

The benefits of HR/IH have been described in a number of other at risk cohorts including at risk youths (Green, Ferrante, Boaz, Kutash, & Wheeldon-Reece, 2021; Kelley, 2003a; Kelley, 2003b; Kelley, Alexander, & Pransky, 2017; Kelley, Pransky, & Sedgeman, 2014; Kelley, Wheeldon-Reece, & Lambert, 2021), prisoners and offenders (Kelley & Lambert, 2012; Kelley et al., 2017; Kelley, Hollows, Lambert, Savard, & Pransky, 2018; Kelley et al., 2019) and refugees (Halcon, Robertson, & Monsen, 2010; Halcón, Robertson, Monsen, & Claypatch, 2007). HR/IH also appears beneficial in maximising effectiveness in schools, business and prospective criminal justice professionals (Kelley et al., 2015; Polsfuss & Ardichvili, 2008; Rees-Evans & Pevalin, 2017).

The evidence bases regarding the use of HR/IH in individuals from healthcare settings, however, remains limited. Banerjee, Howard, Manheim, and Beattie (2007)

evaluated the use of HR/IH as a therapeutic option for substance misuse treatment for adult women in a residential treatment setting comparing it to a standard 12-step treatment program. In this relatively large study sample (n=333) participants who were allocated to the HR/IH program showed significant improvements in substance abuse, general positive affect, anxiety and depression equivalent to clients who received standard 12-step substance misuse treatment although these findings could possibly have been explained by cross-contamination between the two therapeutic approaches. Sedgeman and Sarwari (2006) examined the effect of an HR/IH psycho-educational seminar on stress and anxiety in HIV-positive patients which showed improvements in stress and anxiety levels which were maintained at 1-month follow-up. El-Mokadem, DiMarco, Kelley, and Duffield (2020) examined the efficacy of HR/IH mental health education for improving the mental and physical health for people diagnosed with chronic fatigue syndrome. Compared with a waiting list control group, participants exposed to HR/IH showed a significant increase in mental and physical wellbeing and a significant decrease in fatigue, depression, anxiety and pain interference. Following their exposure to HR/IH, control participants showed a significant increase in well-being and a significant decrease in fatigue, anxiety and pain interference. Post-intervention improvements for participants in both groups were maintained at six month follow-up.

The study that follows is the first to test the efficacy of HR/IH for improving the mental and physical health of people diagnosed with eating disorders. The aim of this study was to evaluate the efficacy and acceptability of the use of a HR/IH psycho-educational intervention in a group setting in individuals with eating disorders.

Materials and Methods

The study was conducted at the CONNECT eating disorders service in the United Kingdom which offers specialist treatment to adults with eating disorders across the West Yorkshire and Harrogate region covering a population of 2.6 million people. The study was approved by the Leeds and York Partnership NHS Foundation Trust Clinical Effectiveness Team.

Participants

This was a pre-experimental, multiple single-case design pilot study (Vlaeyen, Onghena, Vannest, & Kratochwill, 2021) utilising purposive sampling due to limited resources (Palinkas et al., 2015), for which all service users accessing the CONNECT community service during the recruitment period (June-August 2018) were eligible to participate. Inclusion criteria for the study were that the participants had a diagnosis of an eating disorder, were currently engaged in community treatment with the CONNECT service, were willing to attend all the group sessions and complete pre-

and post-group outcome measures. A study information sheet containing information about the study was sent to all service users accessing community treatment during the recruitment period and those who expressed an interest in joining the group were contacted by the group facilitators to arrange a telephone or face-to-face contact to provide further information on the group, answer any questions and seek consent.

In total, 8 female patients took part in the intervention and all eight completed all 15 sessions. All participants described themselves as "White British" and their mean age was 27.75 years (SD 14.43). Duration of illness ranged from 1 to 40 years with a mean illness duration of 8.5 years (SD 11.96).

Materials

Participants who agreed to take part in the study were provided with an information pack developed by the research team. This pack included a summary of the principles underpinning HR/IH and two HR/IH related books (Johnson, 2016; Neil, 2013) which they were encouraged to read prior to the commencement of the group. The group was delivered in parallel to the service user's standard treatment pathway with the CONNECT service.

The group was facilitated by two members of the CONNECT service, one a drama therapist and the other a psychological therapist, both of whom were certified HR/IH practitioners and together had over 10 years of experience in the HR/IH approach. The group programme consisted of 15 sessions delivered on a 1-2 weekly basis

Table 1.
HR/IH Group Programme

Session Number	Session Content
1	Introduction – What is Innate Health? In what ways is this similar/different to what you already know? Why will it be useful?
2	What are the Three principles? Inside out vs outside in. How is this understanding relevant to me and my eating disorder?
3	Story of recovery from anorexia nervosa (expert patient) and how this understanding has changed their life – group discussion.
4	Where our experience of life is coming from, including our experience of our eating disorder.
5	Understanding the true source of all overwhelm/stress.
6	Feelings and our psychological Immune system.
7	Innate Resilience and how to access it
8	Carer's session: Recovered anorexia nervosa patient and her mother: Group discussion.
9	Human beings not human doings.
10	Guest speaker: Group discussion.
11	Trusting the guide inside.
12	Understanding the Eating disorder as a habitual coping strategy.
13	Relapse and what that really means.
14	Relationships with our selves and others.
15	Check in and refresher session.

over the course of three months between September and December 2018. Sessions were interactive in nature each lasting 2 ½ hours and covered a wide range of HR/IH related topics including an overview of HR/IH, the Three Principles, an HR/IH model of stress, resilience, feelings and the psychological immune system and an HR/IH model of understanding eating disorders, relationships, relapse and family and carers. Detailed content of each session is available in Table 1. Participants were also asked to read and watch specific resources from the HR/IH online portal at www.realchange.info in-between sessions.

Measures

The following clinical outcome measures were administered immediately before the first group session and immediately after the final group session:

Weight and body mass index (BMI). Weight (kg) and height (m) were measured by the group facilitators which were used to calculate the participants body mass index (BMI) (weight/height^2).

Eating Disorders Examination Questionnaire (EDEQ). The Eating Disorder Examination Questionnaire (EDEQ) (Fairburn & Beglin, 1994) is a brief and widely-used, self-report measure of eating disorder psychopathology (Mond, Hay, Rodgers, & Owen, 2007; Mond, Hay, Rodgers, Owen, & Beumont, 2004a; Mond, Hay, Rodgers, Owen, & Beumont, 2004b). Derived from the Eating Disorder Examination (EDE) interview (Fairburn & Cooper, 1993), which is well-recognised as the gold-standard assessment tool for eating disorders, it has four subscales (dietary restraint, eating concerns, shape concerns and weight concerns), which measure the frequency of eating disorder behaviours and attitudes and reflects the severity of the psychopathology of the eating disorder, and a global score which is an overall measure of eating disorder psychopathology. The EDEQ assesses both severity and diagnostic items over the previous 28 days and has been shown to perform well in its ability to detect cases and exclude non-cases of the more commonly occurring eating disorders in a community setting (Mond et al., 2008). The psychometric properties of the EDEQ have been extensively investigated in various study populations, including individuals with eating disorders receiving specialist treatment, and the measure has been found to have strong psychometric properties, including total internal consistency of 0.9 and test-retest reliability ranging from 0.81-0.94 across four domains of eating disorder psychopathology (concerns about dietary restraint; concerns about eating; concerns about weight; concerns about shape) (Gideon et al., 2018; Luce & Crowther, 1999; Mond et al., 2004a; Mond et al., 2004b; Peterson et al., 2007). Strong convergent validity between the EDEQ and EDE has also been demonstrated in both clinical and general population samples (Berg, Peterson, Frazier, & Crow, 2012; Fairburn & Beglin, 1994; Mond et al., 2004a; Mond et al., 2004b).

Clinical Outcomes in Routine Evaluation (CORE). The Clinical Outcomes in Routine Evaluation (CORE) (Evans et al., 2002) is a 34 item scale self-report questionnaire designed to measure change in the mental health of adults in the context of psychotherapy service delivery and assesses a number of domains including client well-being, problems and symptoms, functioning and risk. Psychometric validation studies have reported good reliability ratings, with internal consistency for the subscales ranging from 0.75-0.94 (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005; Evans et al., 2002; Jenkins & Turner, 2014).

Rosenberg's Self–Esteem Scale. The Rosenberg self-esteem scale (Rosenberg, 1965) is used to assess global self-esteem and is one of the most widely used self-esteem tests among psychologists and sociologists. The scale is a 10 item Likert scale with items answered on a four point scale and has presented with high ratings in reliability areas; internal consistency 0.77, minimum coefficient of reproducibility >0.90, test-retest reliability 0.85 (Rosenberg, 1965; Silber & Tippett, 1965).

Eating Disorders Quality of Life Scale (EDQOL). The Eating Disorders Quality of Life Scale (EDQOL) (Engel et al., 2006) is a 25 item Likert scale self-report questionnaire designed to measure health related quality of life (HRQoL) in individuals with eating disorders which contributes to four subscales (psychological, physical/cognitive, work/school, and financial) which combine to produce an overall quality of life score. Higher scores indicate lower eating disorders related HRQoL and measures of both reliability (internal consistency 0.94; test re-test reliability 0.93) and validity appear to be in the range of adequate to very good (Engel et al., 2006).

Qualitative feedback questionnaire. At the end of the group, participants were invited to complete a feedback questionnaire, designed by the authors and completed with the group facilitators, to gather qualitative data relating to the effectiveness and acceptability of the intervention. Items included in the qualitative feedback questionnaire is detailed below:

i. What did you think about the structure and delivery of the HR/IH group?

ii. What could have been better/different regarding the structure and delivery of the group?

iii. Did you find learning about HR/IH interesting?

iv. In your own words what do you believe is the main message that the HR/IH group tried to communicate to you?

v. Has learning about HR/IH helped you see anything fresh/new about your eating disorder? If so, in what ways?

vi. What do you think was the most helpful thing that you have learned?

vii. Has learning about HR/IH impacted your sense of hope for recovery? Increased / decreased/stayed the same

viii. Have you found anything unhelpful in learning about HR/IH?

ix. If you had a friend who was suffering with an eating disorder would you recommend the HR/IH group to them?

x. Has this intervention changed/impacted your feelings about opting into formal treatment with CONNECT? If so, in what ways?

xi. Has the HR/IH group changed/impacted your sense of identity? If so, in what ways?

xii. Is there anything else you would like to say about the HR/IH group?

Findings

Table 2:
Descriptive statistics for the participants

Test Statistics

		Age	Pre-Weight (kg)	Post-Weight (kg)	Pre-BMI	Post-BMI	Pre-EDEQ Score	Post-EDEQ Score	Pre-CORE Score	Post-CORE Score	Pre-Rosenberg Score	Post-Rosenberg Score	Pre-Quality of Life Score	Post-Quality of Life Score
N	Valid	8	8	8	8	8	7	6	7	6	6	7	5	6
	Missing	0	0	0	0	0	1	2	1	2	2	1	3	2
Mean		27.7500	46.4250	48.2500	17.5125	17.9888	3.1000	2.2833	1.6014	1.3467	8.8333	11.8571	2.0320	1.3900
Median		22.0000	48.4000	50.4000	17.5500	18.3000	3.3000	2.1000	1.6800	1.4400	9.5000	12.0000	1.6000	1.3800
Mode		20.00	39.50	40.20[a]	17.10	18.40	1.10[a]	1.20[a]	.80[a]	.41[a]	1.00[a]	1.00[a]	1.44[a]	.32[a]
Std. Deviation		14.34025	4.60458	4.66935	.48237	.88794	1.33417	.94110	.62208	.62513	5.38207	7.19788	.71744	.78707
Range		42.00	12.10	12.80	1.30	2.79	3.70	2.40	1.79	1.68	14.00	21.00	1.56	2.38

a. Multiple modes exist. The smallest value is shown

Table 3*:*
Results of the Wilcoxon Signed Rank t-test

Test Statistics[a]

	Post-Weight (kg) - Pre-Weight (kg)	Post-BMI - Pre-BMI	Post-EDEQ Score - Pre-EDEQ Score	Post-CORE Score - Pre-CORE Score	Post-Rosenberg Score - Pre-Rosenberg Score	Post-Quality of Life Score - Pre-Quality of Life Score
Z	-2.100[b]	-2.100[b]	-2.023[c]	-1.483[c]	-1.604[b]	-1.604[c]
Asymp. Sig. (2-tailed)	.036	.036	.043	.138	.109	.109

a. Wilcoxon Signed Ranks Test
b. Based on negative ranks.
c. Based on positive ranks.

Eight females diagnosed with anorexia nervosa participated in this intervention and completed all 15 sessions. A summary of their pre- and post-intervention data can be found in Table 2. The results show that, on average, participants' weight increased by 2.2kg over the course of the intervention, which had a positive impact on their BMI. For two of the eight participants, BMI increased from below 18.5 to above 18.5, and one participant's BMI increased to 19.3. Furthermore, positive changes were observed in the EDEQ global mean score, the CORE, the EDQOL and the Rosenberg Self-Esteem Scale.

Given the small number of participants, non-parametric t-tests (Wilcoxon Rank) were conducted. The results indicated a statistically significant difference in the participants' weight, BMI and EDEQ global mean score. However, the results for the CORE, Rosenberg Self-Esteem Scale and EDQOL were not statistically significant (Table 3). Further review of the data indicated that for the pre-intervention EDEQ global mean score, two participants had a score within the clinical range (≥4). The post-intervention score was missing for one of these participants and the other participant's score dropped to within the normal range (3.1). For the pre-intervention Rosenberg Self-Esteem Scale, five participants scored below the clinical cut-off (<15) whilst post-intervention three participants were within the normal range and two showed no change.

Post-intervention participant feedback revealed that all eight participants felt that the duration and frequency of the HR/IH sessions were appropriate. Only one participant did not feel that their aims of the HR/IH group had been met whilst six reported that HR/IH gave them a new perspective of their eating disorder. Six participants reported an increased feeling of hope with regards to their eating disorder following the group. All 8 participants and 6 family members who attended the family and carers HR/IH session reported that this specific aspect of the intervention had been helpful. Suggestions for areas of improvement included the use of more "real life case scenarios" during the HR/IH sessions and for facilitators to allow more time for group discussions.

Discussion

This preliminary study is the first to examine the use of HR/IH for individuals diagnosed with eating disorders. The results of this study suggest that the HR/IH group intervention should be further studied as a potential intervention for eating disorders. Our results show an overall improvement in specific eating disorder and general psychiatric pathology measures in a relatively brief time period (three months) compared to other standard eating disorder interventions and appeared to be acceptable and beneficial to patients as well as family and carers. HR/IH is therefore an especially significant option at this time, where no clear superior or inferior psychological treatments exist in the race to treat people with eating disorders (Solmi et al., 2021).

HR/IH attempts to point people with eating disorders to new insights regarding the Three Principles, TR, and IH/CM. HR/IH posits that once these insights are grasped, people can begin to use the power of Thought in their best interest, their innate health, resilience and healing processes will be released (Kelley, Pettit, Pransky, & Sedgeman, 2019; Sedgeman, 2005). Our findings suggest that HR/IH may offer an alternative framework to understanding and challenging the typical core eating disorder psychopathology and thinking patterns that underlie conditions such as anorexia nervosa and bulimia nervosa. Shifting the therapeutic focus towards understanding the "nature" of Thought and its unrecognized misuse as a root cause of disordered eating and distress as opposed to a more traditional thought "content" centered approach, as adopted by standard first line interventions such as CBT and MANTRA, offers a new paradigm in addressing the often chronic ruminative thinking styles of people with eating disorders.

Clinicians have agreed that sustaining hope for recovery is an important aspect of treatment (Webb et al., 2022). Most participants in this study described increased feelings of hope following the group which appears to be an important prognostic factor in the outcome of eating disorders with hopelessness hampering both motivations to change and engagement with treatment (Siegfried & Bartlett, 2015). HR/IH elicits hope via the recognition that each person has within themselves the capacity to regain a healthy psychological perspective. With hope, comes specific and achievable goals, and this in turn opens the road to recovery (Hannon, Eunson, & Munro, 2017). If hope can be transmitted as seen in this relatively brief psycho-educational group intervention, then it offers promise as a cost-effective treatment for a large number of patients that might otherwise not be reached by traditional therapeutic models.

Despite the positives, our findings should be considered in the context of some important limitations. Firstly, as this was a pre-experimental, multi single-case design pilot study and all participants were receiving standard eating disorder treatment

alongside the HR/IH intervention, the validity of our findings remains unclear. Secondly, the small sample size and single-centre study design increases the risk of type II error and the generalizability of our findings (Faber & Fonseca, 2014).

The authors however posit that a well-designed small research studies can be a valuable contribution to the literature; as long they are carefully interpreted. There are many fields where small studies with sample size n<10 is commonplace, and the benefits include ethical and resource considerations, where new interventions are tested (Morgan, 2017). The aim of this study was to evaluate the efficacy and acceptability of the use of a HR/IH psycho-educational intervention in a group setting, and this would include the consideration of ethical risk. Small samples are often necessary when the hypotheses and/or interventions being investigated relate to chronic illnesses in vulnerable populations. Furthermore, The current state of statistical analysis is highly dependent on large samples, which can greatly inhibit research regarding new interventions for people with chronic illnesses such as anorexia nervosa. Compared to the general population, the number of people with anorexia nervosa is relatively small and therefore it is difficult to recruit large numbers of individuals willing to participate in a new, non-medical, intervention. As we have now considered the efficacy and acceptability of this new intervention, the limitations of this study could now be addressed in future studies by including a larger sample size and a matched control group to allow for between-group and within-group comparisons.

Acknowledgements

The authors would like to thank the CONNECT administration team based at the Newsam Centre, Seacroft Hospital (Leeds and York Partnerships NHS Foundation Trust) for their administrative and technical support during the course of this project.

Declaration of Interest Statement

The authors declare that they have no known competing interests or personal relationships that could have appeared to influence the work reported in this paper.

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