The Three Principles
At Mariposa Lodge

San Jose, California

Acknowledgements

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Introduction

Today, the program of services based on the 3 Principles of Mind, Thought and Consciousness provided by the 3 Principles Services (formerly Health Realization) Division (3PSD) is well respected and recognized within various county departments of Santa Clara County. Staff and clients from many County departments as well as community-based programs have completed classes or consultation based on the 3 Principles. Established within the Department of Alcohol and Drug Services (DADS) as an alternative treatment and training approach, having its own "certified" staff and manager, the numbers of individual who have been taught the 3 Principles reach into the thousands.

However, this was not always the case. In fact, prior to 1995, programs based on the 3 Principles did not exist in Santa Clara County. No one involved with the county had heard of the Principles. In 1994 Robert Garner, the Director of Department of Alcohol and Drug Services for Santa Clara County, heard about it and took the opportunity to attend the 1994 Annual Conference at the Claremont Hotel in Oakland, CA. As a result of attending the conference, Bob saw the Principles as providing a hopeful and positive approach to helping the population his staff served and as a way to help his staff avoid the frustration and burnout that many experienced working with this population. For Bob, this understanding seemed what he had been looking for as a way to help his department and the people it served.

The first class on the 3 Principles was conducted in June of 1994. This class reached a core group of individuals who subsequently became so inspired as to commit to learning more about the Principles and sharing them with others. DADS, contracted with Dr. Roger Mills to start a training of trainers program. One of the individuals attending this program was a counselor at Mariposa. The Mariposa research project grew out of the success of this one counselor teaching others what she had learned about the principles.

For some Principles-based counselors and facilitators, it was hard to connect to the importance of research because they see the miracles happening everyday in their classes. It just works. It just is – there is no need to prove anything, However, DADS, knowing you are only accepted in the field if you have published research, undertook the most scientifically rigorous research conducted to-date on the application of the Principles as a substance abuse treatment. It is a quantitative analysis of the impact of a rigorous course on the Principles provided to substance abusing individuals. But quantitative analysis of treatment never fully tells the story of how a treatment impacts those in treatment. You don't know what happened. We have therefore "humanized" the quantitative "hard" data with qualitative data – actual accounts by program participants on how "it works" for them. This paper therefore includes the longer unpublished version of the research report published in the American Journal of Drug and Alcohol Abuse, Vol. 33, 2007, as well as "the rest of the story."

So begin where you will with either the research or the stories.

Part One: The Rest of the Story

A Retrospective
by
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- The History of 3 Principles Training (Health Realization) at Mariposa Lodge

- The 3 Principles Difference: Illuminating what Research Cannot Measure

The History of Principles-based Teaching at Mariposa Lodge

Nestled in the foothills of South San Jose, California lies a multi-acre plot of land, home to the largest residential women's treatment facility in the county, called Mariposa Lodge. Long regarded as bedrock of sobriety for thousands, Mariposa has served the needs of the substance abusing female population for over 15 years.

Originally build by Santa Clara County in the 1970's to house the "public inebriant" as well as former inmates, this recovery facility was initially a program for the drunken men of San Jose whom the public wanted off their streets. In order to "rid the downtown of intoxicated and homeless men," a residential facility was constructed in the furthest possible region of the county to deter these hardened alcoholics from coming back into town – and temptation. For years, the property served and was run by these men; the property afforded them a detoxification facility, a shelter, a safe space, a community of their own and a chance at a sober life. The program, then called Rancho Laguna Seca, eventually allowed the admission of women, and became a haven for those who wanted to live free from the "demons" lurking in the local liquor store. Over the years, the client demographics and the program changed as the popularity of illegal drugs reached a tipping point and overflowed into the treatment community.

In May 1990, as society realized the need for recovery options for women, the facility use was reconsidered, and the property was leased by the county to Alcohol Recovery Homes, which began contracting with the county to provide recovery services for women only. Skepticism was rampant as the men left the property for their new all male facility across from Valley Medical Center Hospital. Could an eighty bed program for women only, out in the foothills, survive? Could the women and all female staff maintain such a huge campus and deal with the demands of the physical property? Could they handle the regular emergence of wild boars, bobcats and rattle snakes from the adjacent wild life preserve? Would the familiar sounds of gunfire from the county's neighboring shooting range be traumatic for the female population? Doubt and sarcasm dominated the local rumor mill; no one felt this was a set up for success. Critics however, did not realize who was at the helm of the transition, and underestimated a formidable leader in Ms. Shirley Chapman, later to become Shirley Wilson. A recovery success story herself, she knew the needs of women, *and* she knew business. Most of all she thrived on challenge and opposition and an opportunity to provide an environment that was best for her organization's clients.

Shirley commenced on a project of then unprecedented scope: establishing and maintaining a large recovery home for women, maintaining the aging and outdated facilities at the property, and perhaps her most daunting task, merging the former Rancho staff with staff from a women's program in central San Jose previously known as New Fortunes. With staff who knew nothing about women's issues but knew the facility well, trying to get used to staff who didn't know the facility but understood key differences in women's recovery, Shirley proceed to order the entire team to "all get along – period", which amazingly, they did. She dedicated herself and her staff to operating a program

that would truly reflect women's needs, and not just be a "men's program with pretty tablecloths". Utilizing a Social Model program style, Shirley designed a functional recovery home that served the psychological, social, medical and spiritual needs of women in recovery and employed women in recovery who could serve as role models for the newly sober. In true Social Model style, Shirley fashioned her staff to be women alongside other women, helping and supporting those new to recovery by utilizing each staff member's personal experience as the foundation for helping. Staff at this time were rarely professionally trained or degreed as there was not much respect in the alcohol recovery field for traditional mental health programs or advice. Most often, staff were former residents of the program. In fact, it was common for women to spend six months to a year and a half as residents of the program, and then transition into intern or staff positions and begin helping others. Blurred were the lines between "helpee" and "helper" as continuous sobriety was said to be maintained only by giving to the newcomer, thereby allowing the recovery of the old-timers – a fully reciprocal cycle. This paradigm existed and thrived at Mariposa until the late 90's, a time of great change in the recovery field.

The mid to late 90's brought new challenges to Mariposa Lodge. Common in the US, as well as in San Jose, the stigma of being "in recovery" was lessening, and more and more people were making careers out of addiction's counseling. The emergence of training and certification programs began to professionalize the recovery staff members and made Social Model recovery a less evolved option. The bio-psycho-social aspects of addictions were more seriously considered and expertise of staff increased. Simultaneously, the criminal justice field began to realize the co-occurrence of addictions and criminal behavior, and thus began referring and mandating recovery services for the incarcerated population. The explosion of these new kinds of clients, often now drug abusing rather than alcohol abusing, and bringing with them the cultural elements of the illegal lifestyle, presented a serious challenge for the staff at Mariposa. The climate evolved from a Social Model approach, no longer amenable for this highly defensive and resistant population, to a "Non-Medical" model of treatment which now included treatment plans, class and group sessions rather than variations of Twelve Step meetings. Staff member shifted their roles from fellow members in recovery to para-professionals with some degree of formal training in counseling, addictions, and group dynamics.

Yet Mariposa suffered, along with the rest of the nation and the recovery movement in general, with client treatment resistance and recidivism. Women were often forced into treatment before they were "ready"; relapse rates were high; women previously treated and released into the community returned to the program again addicted, sometimes having been assaulted or enduring violence in their home, often arrested, in danger of losing their children to the social services system, and in great need of help to save their lives and restore the well-being of their children and families. Traditional recovery methods, no matter how evolved, didn't seems to have the intended impact on this new, high risk, moderate to highly impaired population. Shirley Wilson, being ever the pioneer, was open to continuing to evolve the recovery environment in new and original ways in order to improve the chances of success at helping women to lead healthier lives.

"What will help our clients?" was Shirley's mantra. DADS program based on teaching the 3 Principles could not have asked for a riper environment.

In 1995 a quiet trend had begun at Mariposa Lodge. At the facility, a particular subset of the clientele had begun to act differently during their stay at the facility. Despite declining resources and an increasingly difficult client population – add to the equation not only clients from the criminal justice system, but also the emerging dual diagnosis population – one particular counselor seemed to be having unprecedented success with her clients. These clients were less treatment resistant (seemed to have less denial and hostility), more motivated to change (moved from external or negative motivation for treatment to internal or positive motivation), had less difficulty and disruption during treatment (less acting out behaviors, including fewer positive urine tests), and completed treatment (positive discharges) at a higher rate than other clients. The only difference between these clients and the client population at large: the 3 Principles as the treatment philosophy.

Upon hearing that a new and emerging paradigm in the field of prevention and treatment was having this impact on her clientele, the director of ARH Shirley Wilson, immediately became fascinated with the approach and attended a training to learn more about it. What she discovered surprised her. Ideas that a program on the Principles espoused were contrary to many popular recovery norms. Instead of seeing addiction as a disease, this new approach saw addiction as an innocently misaligned desire for good feeling, and relied on the resurgence of one's own innate mental health to displace the compulsion for drugs and/or alcohol. Instead of respecting and simultaneously fearing the addiction, this Principles-based approach encouraged participants to better understand their own psychological functioning as a route to self-navigation. And instead of seeing one's own thinking as damaged and in need of external correction, this approach taught it's clients to distinguish between their own learned and conditioned unhealthy thought processes and a clearer, wiser and deeper intrinsic thought process that could always be trusted. In additional, clients relapse was viewed in a new and different manner. From this new understanding, relapse was seen as an innocent attempt to feel good when temporarily lost in an unrecognized unhealthy psychological climate. As a result, clients taught the Principles did not relapse as severely or for as long and returned to appropriate levels of care more quickly and without shame, stunting some of the negative impacts of the relapse. From a practitioner perspective, rather than seeing clients as sick and damaged, clients were being seen as healthy and whole (and just a bit off track) – and, it was working! Clients in the Principles-based program became more self-sufficient, had more self-confidence and exhibited higher levels of well-being than their traditional recovery counterparts. Shirley was so impressed with not only the approach, but it's results, that she paid (on a non-profits budget) for more training, and eventually developed a staff training position within her organization to expose staff, not only at Mariposa Lodge, but at the organization's other sites as well, to the 3 Principles. Shirley realized the twofold benefit of such training for her staff. Not only would it benefit the clients, her ultimate responsibility, but it would benefit the staff and help them navigate their own well-being too – keeping in mind that the typical burnout rate for addictions professionals is a mere five years.

Although there were non-supporters, Shirley's brave move to embrace new paradigm in the field of helping paid off. Mariposa soon gained a reputation among the community as a place where women could go to learn this new philosophy and in a matter of time Shirley had staff members that were willing to dedicate themselves specifically to the application of the understanding of the 3 Principles in addictions treatment. The longer Mariposa offered Principles-based classes, the more popular they became, until soon clients from the typical milieu, some of which had failed to connect to traditional treatment themes and paradigms, actively sought out something new and professed that this understanding about the Principles was something that could really help them, not only with their addiction, but with their entire life.

Finally, in 2000, an entire dorm at the facility was dedicated to learning the Principles as a specific treatment and the first real alternative to traditional treatment had found a home. Of course, classes on the Principles as a specialized form of addiction treatment was not without its detractors, as anything new is often criticized before it can be embraced. Principles-based treatment's one Achilles' heel, its lack of scientific research, was often called upon as a serious concern, and with good reason. Addiction is a life and death endeavor for some, and treatment facilities have an obligation to care for their clients in the best manner possible given what is known. New and unknown paradigms often need decades to prove their worthiness, but Shirley knew first hand the impact this approach was has having, and was not willing to wait.

Partnering with Santa Clara County, Department of Alcohol and Drug Services Research Institute, a scientifically sound research project was designed and implemented to study the effectiveness of teaching the Principles of Mind, Thought and Consciousness as an addictions treatment. While this study took years to complete, required incredible perseverance on the part of all involved, and will need to be replicated to insure its validity, it is a giant step forward in the understanding of the effectiveness of a program of instruction in the Principles in the substance abuse arena. Results from this study show that simply learning about the 3 Principles is a valid therapeutic approach that can achieve results at least comparable to other historic and well studies approaches.

While the Principles-based program at Mariposa is a continually evolving program due to the evolution of our understanding and the availability of qualified practitioners, it is now seen as a treatment staple for many on the road of recovery from addictions. It is an approach that is qualitatively different from other methods of recovery, and yet is still in it's infancy in terms of application and implication. Time will tell what this new paradigm holds for the substance abuse world, and the world at large. For now it is a pleasure to introduce the uninitiated and skeptical to the promise of the Principles via the accompanying research and antidotal case stories.

"The Difference: Illuminating What Research Cannot Measure"

True case stories of clients in substance abuse treatment at ***Mariposa Lodge who have learned about the 3 Principles. Names and some identifying details have been changed, and each woman's*** *race has been omitted, to protect confidentiality.*

Trisha's Story

Trisha is a 51 year old bisexual woman, a former drug addict, who now has multiple years of sobriety. To meet her today, you wouldn't image the story behind her life; her relaxed outlook and easy smile lie in sharp contradiction to her history and her struggles. Trisha openly declares her sobriety miraculous, and people who really understand her and her life, *know* this true. In fact, many people who knew Trisha prior to her recovery, literally still can not believe she is alive, let alone functioning. That she is enjoying being alive, that she finds sobriety easy and that life itself seems rewarding to her is beyond comprehension.

Trisha entered Mariposa Lodge for treatment on May 20th of 2001. This treatment admission was her twentieth attempt at treatment with Mariposa, her 54th treatment attempt in total. Trying to clean up was nothing new to her; she had been attempting to get sober since age twelve when she began seeing a Christian Science practitioner to be "healed". Persistence is a quality that saved Trisha's life, and certainly no one could accuse her of a lack of determination.

For Trisha, the treatment environment was a haven, a refuge. When her life got too horrific to bear, Trisha removed herself from it - for a rest. Many times she entered treatment freshly raped or recently beat up. Some treatments were a way out of jail for her. This last treatment episode began the same way – Trisha had almost died, trapped, lost in the Santa Cruz Mountains for three days with no food or water, coming down off of a life threatening physical and psychological addiction to alcohol, methadone and klonopin. She, to this day, has no recollection of how she got disoriented in the woods, or why she was even there. All she knows is that she came out of a blackout, alone, in the wilderness.

To understand Trisha's addiction requires an appreciation of her life. Trisha's early years were a dichotomy; raised in the Christian Science faith, she loved God fiercely with all her being, and yet hated herself with a severity few people can even grasp. Her family was dedicated to Christian and metaphysical values and was, to the outside world, the model of a loving home. Inside the home, Trisha describes a feeling of suffocating oppression; heaviness and harshness escalated into mental, verbal and physical abuse that tortured her and left her constantly running from the home others thought was so perfect and wholesome. At age eleven, Trisha discovered alcohol, and for the first time, fun; from her first drink she drank alcoholically – every day, and for the effect. Every night when Trisha returned home from a day of "fun", her mother would attack her, choking

her and screaming at her for coming home drunk once again. Her mother's anger impacted Trisha in a manner opposite its' intention; rather than preventing Trisha from drinking again for fear of the consequences, it fueled her drinking even further, pushing her into an isolated world of self-hatred and self-loathing.

> "No one could hate me more than I hated me. I resented being on earth. I hated life on earth and wanted off. I hated my parents for having me, because they didn't want me anyway. I was very suicidal . . . seriously suicidal . . . serious attempts."

Trisha's substance abuse progressed as her life continued. She graduated to more and more substances in ever increasing quantities. Her chemical dependency history includes long term relationships with not only alcohol but heroin, crank, cocaine, benzodiazepines and opiate pain medications. Staying loaded was her most important goal in life, and as a means to this objective Trisha found ways to obtain what she needed, whether it be cleaning houses and motels, stealing or prostituting. Trisha, like many others who suffer from substance abuse, also suffered mentally and often, during treatment received diagnoses that included ADHD, severe depression, dementia and personality disorders that "they didn't talk to me about", she says. In her drinking and using career Trisha, always violent, enraged and full of hate, often came face to face with the criminal justice system and thinks she was probably arrested between twenty and twenty five times for charges ranging from under the influence to drunk driving to assault and battery on police officers.

Trisha guesses she tried to kill herself seriously fifteen times, with many more near death experiences due to overdosing during blackouts. She injected herself with ammonia and with bleach on two occasions, purposefully overdosed on her antidepressants and tried to shoot herself with a gun on another occasion, leaving a bullet hole in her parent's bedroom wall. She recalls waking up many times in county hospitals after overdosing on the streets and being saved by passer-by's who called 911. When asked how she could have been schooled in such a spiritual manner and loved God so truly and intensely, yet hated herself so viciously that she wanted to die, she responded that she simply thought she really had a double personality.

In the mist of this world of pain and self-destruction Trisha, at age 37, had a baby. More than anything, Trisha loved her child and wanted to be a good mother; her child was the only reason she felt she had to stay alive, and yet she knew deeply that she was in no position to care for another human being. Eventually her child was placed with family, and Trisha, knowing this was best for her baby, could only hate herself all the more for her failures and inabilities. Her substance abuse reached new lows during this time, and she lived on the edge of death as a lifestyle. When asked how she survived, Trisha responded that "truly only the hand of a loving universe protected me from myself". Ultimately, and fortunately, she failed at killing herself with her own hatred, her substance abuse and her suicide attempts.

When she checked into rehab for the final time, barely consciousness, Trisha remembers that although she felt the same, the facility she knew so well felt different to her. For the first time, she didn't feel a condescending or patronizing attitude from the staff:

> "The usual staff attitude towards me was, 'Trisha's back again to wreak some havoc and blow out of here with another broad as a hostage'. I don't blame them – that's what I did. That's all I knew."

This time, something had changed, and despite her confusion and physical condition, Trisha noticed it. For the first time, she felt people cared about her, not the condition she was in, the position she'd put herself in, or the advice she'd ignored. Trisha felt a genuine concern from the staff, and a feeling of hopefulness for her despite her relapse history. She felt the staff saw her *now*, not through the lens of memories about her, how difficult she was, and how she had failed previously. She could tell she was being seen as healthy, as a person with possibilities, and not being seen for her behaviors, her difficulties or even her personality. When asked if it could have been *her* that had changed, Trisha was adamant:

> "No, the entire feeling at Mariposa changed", she says. "I felt it the minute I got back. I always wanted help, I was always hurting, but this time, people *loved me* even though I didn't love myself. I felt so much love I just felt like I couldn't let this staff [who believed in me] down. And the only change at the facility was "Health Realization." The staff was the same- same people. The structure was the same – same schedule, same rules. The difference was "Health Realization" had been brought to the staff – *they* were different."

Because Trisha had such a lengthy experience with 12 Step recovery, therapy, traditional psychoeducation and cognitive behavioral approaches, and because those approaches had not worked for her, she was a prime candidate for the 3 Principles-based tract at Mariposa. Treatment in this tract, a separate subprogram on the Mariposa facility, was based solely on the 3 Principles, the new paradigm based on the principles of Mind, Thought and Consciousness discovered by Sydney Banks and developed by Roger Mills, Ph.D. and George Pransky, Ph.D. as a clinical and community approach.

In treatment, Trisha's physical and psychological wounds began to heal as she learned the same principles that the entire staff had been asked to embrace to whatever degree they could. She, along with 21 other women in her unit, learned the basics of the new approach: that each human being, including her, has within them a wellspring of mental health that is accessible at all times; that this health can not be created nor destroyed, it just is. And that her mental health could only be held at a distance from her temporarily through the use of the power of Thought brought to life by Consciousness.

For the first time in her life, people pointed Trisha to what was already whole and healthy within her. Fairly quickly, coping mechanisms that had saved Trisha, and yet almost killed her at the same time, slipped away. Her mental well being reemerged and she

began to make decisions she had never before considered: engaging with her mental health team, taking medication and working in tandem with her doctor to adjust her dosages, accepting disability as a safety net to allow her access to services and support in the community until she was strong enough to return full time to the work force; staying away from unhealthy relationships and forming friendships with sober people, and finally, slowly, contacting her family and her child to earn their trust and faith. All of these decisions Trisha made on her own. No one recommended to her what she should do. Instead they asked her what she wanted for herself and accepted each answer as it came.

Treatment was long for Trisha, 7 months when the average length of stay allowed for clients by the county at that time was 45 days. Because of the severity of her addiction and her previous treatment attempts, extra time was given to her by the managed care system until she was ready to leave the facility. When asked if the extra time may have been what helped her, Trisha again seems sure it is not. Previous long term programs had failed her. She credits what she came to understand about the Principles as the critical difference for her. The change in the way the staff approached her allowed her to thaw, to trust, to try, to hope, and to learn. And, what she learned for herself about her own psychological functioning, her mental health, is what she credits with sustaining her in her recovery. Today Trisha has a life she never imaged her could have – she sees her child regularly but does not disrupt the stability of his home. She is maintaining a chemical free life, and she now works full time at Mariposa, helping other women just like herself. Her cognitive functioning has, to an astonishing degree, repaired itself. She is happy to be alive; she enjoys her life and is glad she is still on the planet. Above all she is grateful that something new emerged within the field of dependency treatment, something new that helped her save her own life. She is, to those of us that know and love her, an unbelievable miracle.

Arianna's Story

Arianna's story is similar in ways, yet also different from Trisha's. For Arianna, the impact of the Principles was very personal. It was not tied to the facility environment but rather to the purity of the Principles. Her story is as dramatic, and her recovery just as amazing, but the details of her recovery highlight important differences between a principle based and the traditional models of addiction and mental health recovery.

Arianna was born in 1970, making her 36 at the time of this interview. She describes her family life as difficult; there was a great deal of anger, frustration and disconnectedness, as well as frequent physical outbursts. While she recalls that time as painful and she also chooses not to dwell on it or even discuss it publicly out of respect to her family members.

> "It's not that I'm in denial", she says, "It's just that I have a different understanding now of what happened. At the time I didn't understand and so I took it personally; what happened to me in that environment I took personally and the older I got the less I was able to recover emotionally from the constant negativity. At the time I felt lost, alone and unsafe. That's really all you need to know to understand."

As a result of her difficult feelings, Arianna's late teens and young adulthood years included two involuntary commitments to psychiatric lockdown facilities, at least ten separate stays in juvenile hall, multiple group home placements (from which she always ran away), and in her adulthood, more than twenty arrests for various drug related offenses. Many times the authorities would place Arianna in a mental hospital instead of jail. Doctors and therapists diagnosed her with different disorders and felt her behavior was not the result of a criminal mind, but rather a manic episode. Despite these difficult times and what now amounts to a very long 'rap sheet', Arianna is grateful for her rebellious spirit as she knows it saved her life. In her mind, her choice was to either fight back and survive, or surrender to the emotional pain within her and die.

This choice to rebel instilled in her an unquestionable need to not be controlled by other people and an amazing sensitivity to people with an agenda of their own. Her tendency to revolt and need to protect herself was misunderstood by most people who, instead of seeing a healthy individual trying desperately to survive, saw a sick young woman who needed to be diagnosed and institutionalized. Her doctors saw her through different lenses, with ideas like Post Traumatic Stress Disorder and Bipolar Disorder, but really understanding Arianna and her mindset about life explains these presentations. However, her coping styles had a difficult side effect, resulting in years of incarceration and severe drug addiction – her method of coping with feelings of insecurity and wildly changing internal realities.

Despite trying to get clean and sober since her early twenties, Arianna approached her middle 30's suicidal, mentally ill, and gravely substance dependence. She had nearly killed herself numerous times, at one point almost losing her arm, and her life from an

abscess due to intravenous drug use that spread towards her heart. Eventually she contracted hepatitis and in the late stages of her using, became critically ill. Of those difficult years she recalls,

> "It's mind blowing how your soul simply *cannot* be stamped out, not even by yourself."

Finding herself in the county jail once again, Arianna was mandated to a series of classes that included a class that taught the Principles. It was in this therapeutic boot camp that she met a DADS Principles based instructor. She describes the majority of the classes there as painful or not helpful. This class, however, stood out as different to her.

> "I looked like I was present and accounted for, but I wasn't. I was in a fog. Being in and out of custody so often, everything was a blur to me. But this teacher's class, it did something to me . . . Her class was the only class I wanted to go to because I liked the way I felt there. It was different. For the first time, I wasn't treated like a case or a number, or given a label. I was told I had *wisdom* – It was a completely different message than I was given – ever. I was completely opposite from my other classes. It was opposite and it was accurate."

To appreciate the context of this comment requires understanding Arianna had participated in literally thousands of hours of therapy, counseling and various programs designed to help her change her behavior. Some she found temporarily helpful, although not sustaining. She describes this kind of help as having an unwelcome consequence of often overwhelming her with how sick and damaged she was and which she found painful and confusing. In fact, Arianna had been labeled "treatment resistant" due to her inability to significantly change despite interventions.

In the class on the Principles Arianna found something different. She found, even without clerarly understanding the class material, she instantly felt better and more hopeful. She liked what she heard, but at the same time, in other classes she was hearing a variety of ideas about why she was addicted, why she was in custody and what she should do about it:

> "It was confusing because my other classes told me something different; they told me that I was sick and needed to work on myself. I knew I liked the Principles class and that they were telling me the truth – I could feel it. But because I was attending other classes that told me the opposite of the Principles, the message wasn't pure; it wasn't consistent. I think that's why when I got out, I got caught back up."

Arianna was released from custody, and was picked up by her boyfriend who was still using. She pick up her old life where she left off and got caught up again using, landing in jail once again, this time having stolen a car and been picked up under the influence. "I knew what to look for this time though," she says. Arianna went straight towards

Principles classes, and listened to the instruction about her psychological health. This time, upon her release from custody she was mandated to a drug treatment facility.

At the residential treatment program, during her first ten days in treatment, Arianna was given traditional Twelve Step based treatment. She found herself intensely dissatisfied, feeling once again not helped and seen by professionals as sick. Remembering her experience with Principles class while in custody, she approached the administrative staff demanding that she be allowed to change therapeutic milieus or else she would leave treatment. Leaving treatment, because she was mandated by the court, would have meant that Arianna would have gone back to jail and had to face the judge who at that time was contemplating sending her to prison - but she didn't care.

> "I couldn't tolerate the negative approaches to getting better. I would get a sinking feeling, a hopeless feeling. I knew it wouldn't work for me, and not because I had an attitude, but because I instinctively knew. I knew the truth. "

At the time, the facility was participating in a pilot program using and researching the effect of pure Principles based addiction treatment. Arianna was moved into "B Lodge", the Principles-based tract at Mariposa. She says she instantly found a better feeling, a better fit, for herself. After two weeks of twice a day classes, in which the three principles were repeated to her over and over again without the interference of other approaches, Arianna says,

> "I woke up one morning and came to class and as the teacher was talking about the Principles. I was overcome with this beautiful feeling. I had sort of been feeling lighter with each day since attending the classes but this day was different. I became completely clear. Not intellectually, but in my heart. The weight of thirty two years of a traumatized psyche vanished and I was released. It was so beautiful I have never to this day been able to describe accurately what exactly it is I experienced but I understood that I was healed and the healing came from inside of me, from this beautiful feeling. I went into a state of pure well being. My mind got *totally* still for a minute and I got well."

Often manic, Arianna distinguishes this feeling from the hyper euphoria she was used to,

> "It was real," she says, "everything on this whole planet looked different to me, which was strange because I wasn't expecting that. It was strange because I hadn't expected, or even thought it was possible that I could get my life problems solved, and yet my mind peeled back and I SAW. I felt clear. I saw what I had been searching for and that it had been there within me all along. I was not excited, but instead I was very quiet inside, very calm. And it lasted and lasted."

Until this experience, Arianna reports she always struggled with cravings for drugs, which she never felt she could control. Instead she would simply resort to getting high to relieve the intense feelings of anxiety inside herself. One of the things that surprised her most was that after her insight the idea of drugs no longer occurred to her.

> "My cravings disappeared completely. All my compulsiveness left me. I felt sick thinking about drugs, I didn't even want them."

Arianna's peace of mind and lasted for quite a while and she recalls only periodically being disturbed over daily life. However, she found being in B Lodge and attending daily classes on the Principles, her feelings cleared up right away.

> "It was so important to have that time at Mariposa where it was purely just the Principles and people who understood them. The teachers were *pure* and *clear*. They were deep and they could handle any question, or explain any issue I had and relate it back to how the Principles worked. That was so key for me to have that continual teaching during that stage of my learning. Without it, I would have just tried to figure it out intellectually without really understanding. The truth just kept being shown to me over and over again. There was never any exception or diversion."

Approximately five weeks into treatment Arianna left the safety of the facility on a pass to appear in court. While in the community, in fact just outside the court room, Arianna was offered drugs by a friend from her past. She remembers *watching* her own mind create a craving, which she says lasted inside of her for several hours. It was the first time she had ever experienced craving – and *not* used. She credits her ability to wait out the craving to her understanding of how the human mind functions to create reality.

> "I didn't have to use, because I understood where my feeling, my craving, was coming from. I saw the memories come into my mind as thoughts, and as that happened I felt myself get sick in my stomach. Then I had a brand new thought, the thought that I didn't have to use. It was a jump in my understanding. I saw thought in action, like a movie. I saw *thought* creating. My physical body was feeling my thought. My physical body had nothing to do with life or the drug, but just my thoughts. It wasn't seeing the drug that triggered me, it was my own mind. She continued, my main prison in life," she says, "was my mind. No one had ever explained my own mind to me," she says. "Never had all the other ideas and concepts and theories been completely set aside for me to just get some time to consider the truth – just the truth of how my own mind had been holding me hostage. I finally knew what the *real* kind of control was, the good kind of control. I felt pure positive power. I saw the danger was not outside me, but that the danger was only my own thoughts. Simultaneously, I knew that I needed to get back to Mariposa immediately. I knew how to take care of myself and get myself calmed

> down and back to safety. I had a choice then, which I never had before. It was beautiful."

Not only did Arianna not use, she returned to treatment to share what she had learned, and to continue to learn more. Arianna feels this extended amount of time in a concentrated setting where she learned just the Principles, and not anything else, helped her get unshakably clear about her own psychological functioning and mental well being. The focus on health, rather than disease or illness, showed her what she had inside herself to work with – something that had never been damaged by her very difficult life.

> "All it took for me to be healed was to understand. And what it took for me to understand was to be in an environment where someone else who understood, could explain it to me clearly. I was pointed to the principles *behind* my life, not to the destruction *in* my life. There was nothing in my life to help me – looking at that did nothing for me except make me feel bad. I needed to know where it all came from. The mental and emotional distress I was experiencing didn't come from my family, my life experiences or anywhere else . . . it came from how my mind held the experience and what it meant to me, and all that was within my own mind."

Arianna successfully completed treatment and processed through the county's managed care system into a sober living home and outpatient treatment. She continued attending classes on the Principles offered by HRSD and feels that these classes helped her deepen and support her understanding.

> "I didn't have to work at not being addicted," she says. "I have no triggers or real urges anymore. I didn't even have to work on all my crazy behaviors either. Everything has worked itself out naturally -- I just feel better having some understanding, and that feeling helps me have a better, more productive life. I also saw I wanted to take my understanding deeper. I knew I had only begun to understand these principles and I wanted to know more. Actually you couldn't have kept me away from these classes; I wanted to attend and to find deeper and deeper levels of health within myself."

That is not to say her life after treatment was easy; Arianna faced many serious challenges including finishing her dealings with the legal system, dealing with complicated family and relationship issues, and completing a year of intense treatment for hepatitis. Arianna has had her ups and downs, but her own certainty in her mental well-being has grounded and anchored her. She knows she isn't damaged, and she knows to look to the power of Thought within herself whenever she is unsettled or unhappy.

Today Arianna is an A student in college, has completed several years of training to be an instructor of the Principles, and now teaches people what she knows about the Principles and health and well-being.

Everyone from recovering women in treatment to police officers are looking to understand the mentality of an addict. Of her understanding of the Principles, she says,

> "It was life saving, not only life saving but this understanding has given me the ability to experience a quality of life that is far beyond what I had ever imagined possible for someone like me."

Today Arianna is not only *not* substance dependent; she is one of the most powerful teachers of the Principles in the County. She is living example of the power of innate health. She is proof positive of what can happen to anyone who can hear the power of the message of the principles.

Bernadette's Story

Bernadette's story completes our trio. While she shares some common traits with her Mariposa sisters, her story adds something completely new to our appreciation of the impact learning about the Principles has on women seeking recovery from substance abuse. Bernadette's life is an example of the unknown power of Principles to affect not only psychological well being, but physical well being as well. She, while being another woman who looked hopeless under the influence, has shown all of us the power of human resiliency, regardless of circumstance or condition – including relapse. She is an inspiration and teacher to those who will come after her, but even more so to those of us who came before her -- and were at one time, her teachers.

Bernadette is what you would call a "professional", a career woman who is now in her late 50's. She was born in Pennsylvania, one of three girls with a brother who was born at the same time she had her own son. She was raised in an idyllic middle-class home that she describes as "high in expectation and low in tolerance". She was raised to be polite, to succeed and achieve, while also marinated in a bigoted and prejudicial ideology. Her rebelliousness against her family's fixed and rigid ideas, which initially protected her from adopting the family philosophy, evolved into a way of life for her, an obsessive, "you can't make me" attitude which included a complete disrespect for all authority. She was pregnant with her own child by age seventeen and had already embarked on her career of emotional "fixing" . . . a career she nurtured along side her work career. She fixed with men, she fixed with working, with being a 'star', with making money, and later with getting married (four times) and with drinking a lot. She calls it "a lot of success and bizarre sickness going on simultaneously."

By her late 30's she was ill from her alcoholism – much to her own surprise. A series of blackouts (conscious behavior that is unrecorded in memory) coupled with the obvious and embarrassing lapses, as well as a severe physical dependence on alcohol illuminated her unrecognized shift from 'liking' drinking to 'needing' alcohol to physically and psychologically make it through the day. In 1984 Bernadette went to her first Alcoholics Anonymous gathering where she was welcomed with warmth and love. At that time, she embarked on a thorough application of the twelve steps in order to try once again to 'fix' herself, this time through the program's suggested footwork and spiritual surrender.

While she did find some sobriety, she says she doesn't remember ever feeling *peaceful*. The intensity of her recovery and her lack of inner confidence resulted in relapses for her, a common and almost predictable aspect of recovery for most. She entered formal treatment at a local hospital program in 1986, achieved more time sober, relapsed again and re-entered treatment again, interestingly enough at Mariposa in 1992. At that time, Mariposa was a purely Twelve Step based, social model recovery program and Bernadette fit herself right in, staying for five months and again achieving some time sober, six years to be exact. She remembers that phase of life, sometimes sober and sometimes trying to get or stay sober, as an interesting time. She refers to her sober time then as "rigorous sobriety", meaning she was sober at times, and working *hard* at it. When she wasn't sober she found she would just simply "wake up drunk" – she

remembers no conscious decision to drink. When asked to explain how that happened, she says, "I think I was in so much internal chaos that I didn't even realize what I was thinking."

In 1996 Bernadette was given devastating news; her increasing levels of physical pain were explained by a diagnosis that now hung heavily on her body: rheumatoid arthritis. She was given large doses of three different arthritis medications to help her deal with her physical illness, and incorporated the disciplines of regular exercise and pain management .

For several years after the diagnosis she continued to stay sober, but eventually the tedium of day-after-day pain issues led her back to the desire for numbness promised by alcohol. At age 53, sick from alcohol, Bernadette returned to treatment at Mariposa. Seventeen years total of Twelve Step recovery, including diligent step work, faithful meeting attendance, being sponsored and sponsoring others was still no match for her drinking and pain. She was detoxed and moved into the new Principles-based treatment tract – a last ditch attempt to offer her something new in hopes it would help a woman who had already received the best the field had to offer.

Bernadette seemed to blossom in the new program, learning things that were eye opening for her. In one of her first Principles-based treatment groups, Bernadette remembers one of her counselors leaning over to her and telling her, "Bernadette, you aren't broken." She calls this her 'landmark moment' - the moment when she first saw *hope*. When asked why that statement was so important to her she replied,

> "I had been in the ER's for years because of how sick I was. I was dying – dying from my drinking and deteriorating from the arthritis. I had no confidence that I could get well again. I had tried to get sober for eighteen months straight – tried and failed. That was the first time I saw *myself* differently. I saw hope."

That moment allowed Bernadette to become interested in learning something different. She had not realized there was a new approach to addiction entering the treatment field. She was interested and hopeful enough to listen. She attended regular lectures on the Principles of learning about Thought, Mind and Consciousness.

> "Next I heard about THOUGHT. Not my thinking, but THOUGHT. I noticed what they said was true. I was creating. I noticed, just around the facility, how much I was making up and it propelled me into a state of ongoing insight. I recognized the 'habits' of thinking that were part of my addiction, too."
>
> "Now keep in mind, I had been on a spiritual pursuit all my life, attending workshops, classes, churches, following new age philosophies, astrology, meditation, anything I thought would help me. And so the idea of MIND settled in nicely for me. We are all

> connected to life energy. That's true. When I heard the science of it, the logic spoke to my own personal spirituality."

Bernadette completed treatment and transitioned to the community. Six months passed, and Bernadette returned to Mariposa after a relapse. This time, she knew exactly what happened. Someone very important to her died suddenly and she didn't know how to handle the overwhelming pain except to drink. Because Bernadette had found hope again, she did know what to do to get her bearings back despite her alcohol induced haze, and she readmitted herself into treatment.

After a brief stay, she discharged again to the community only to return after drinking several months later, this time over the shock of a good friend stealing a very large sum of money from her. This last treatment admission was a look at Bernadette that no one wanted to see. She was wheeled back into treatment at Mariposa in a wheelchair. Those who saw her could not believe the physical deterioration we were witnessing. This once feisty and passionate woman, now hunched over, shaking and feeble looked like she might be beyond the point of return. Honestly, some staff members felt Bernadette's needs were greater than the facility could handle, but the county's managed care policies saved the day. They insisted Mariposa admit her to treatment.

Once again, she was received into the Principles-based program where the staff knew she was whole and healthy despite her relapses. Her treatment plan was customized more specifically, focusing this time on how the Principles created both her hope for recovery and a beautiful life, as well as her feelings of emotional pain, devastation and betrayal. This additional treatment episode was the tailoring of the principles that Bernadette needed and it took her understanding to a deeper level, a level that is still, to this day, maintaining her and her sobriety.

> "Understanding three psychological principles helped with the intense busy-ness in my head. I had been so busy for so many years and as I saw that that was me, in the moment, making up so much, it got quieter up there. Living in reality is remarkably simple. It's much easier than it was to live in my head."

> "I realized the difference between 'coping' and 'recognition' – coping with all the stuff I made up, thinking I had to deal with it all, and realizing that I was the thinker. *Realizing that one truth changed everything*. I realized how joyful life can be. I've realized that in order to struggle with anything, I first have to have made up ideas about how (or who) it should be. Now I know the experience I'm having is being created by me, so I'm not so terrified of it. It takes the fear away; I can see how silly most of my ideas are. That I'm the creator, now there's one principle for every occasion – it applies to everything!"

Bernadette completed treatment at Mariposa and transitioned to the community with a new found sense of peace. Recovery was now simple and easy for her, and to date she has five years sober. She feels this place of recovery she has found now is different.

> "If I'm accelerating in my head, if I'm not peaceful, it gets my attention really quickly. I've had more peace in the past few years knowing how my mind works then I had in my whole life, even in my years sober."

> "When I was drinking, I was coping with my biology. When I was sober [before], I was coping with my psychology. Now, I'm not coping with anything; I'm at peace. I'm calm. I'm not thinking about drinking or not drinking – drinking one way or the other isn't in my mind anymore. I respect that my biology cannot tolerate alcohol and that's the end of it. There's nothing else to think about!"

Looking at Bernadette's level of peace, it's hard to understand that the past five years have not been easy for her. What's obvious is that she is not drinking over anything. In fact, she has carried on with a beautiful feeling despite her life challenges. Usually you can find her laughing even though she's had difficult things to deal with, including a lump in her breast (not cancer, thankfully), her significant other of eleven years undergoing six medical procedures and almost dieing and her son going off to serve in the war in Iraq. You wouldn't really expect this woman to be carefree and content, and yet she is. She beams and infects you with her amazing feeling state. "I've learned to pull my imagination back," she says with a real smile.

Interestingly, especially to her doctors, is Bernadette's progress with her rheumatoid arthritis. This woman, once unable to walk, nearly crippled and heavily medicated has gone two thirds of a year off all arthritis medications. She attributes this amazing physical progress to a knowing about her herself,

> "Before I was under the constant illusion that I needed something to be ok . . . . a guy, a job, a book . . . something. I imagined my well being was somewhere – somewhere else. Now, my well being is never missing. I also know I am not my body."

Today Bernadette stands strong and stable; she works full time at a major university and calls her job the "job my whole life has prepared me to do". In her spare time she teaches classes on the Principles to women addicted to alcohol and other drugs. She has written many short essays on the principles and her experience of physical pain, and she is an award winning poet with a published book of poetry to her credit. She cooks, enjoys her partner and is beyond everything else, a humbling inspiration to all of us.

Part Two

"A Comparison of Health Realization (3 Principles) and 12-Step Treatment"

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An unpublished longer version of the article appears in"The American Journal of Drug and Alcohol Abuse" Vol. 33:2007, 207-215 "A Comparison of Health Realization and 12-Step Treatment in Women's Residential Substance Abuse Treatment Program" http://dx.doi.org/10.1080/00952990601174758

Abstract

The purpose of this study was to compare a relatively new therapeutic option for substance abuse treatment, Health Realization 3 Principles-based, and Twelve Step approaches offered in women's residential programs. The study was sponsored by a large California county's Department of Alcohol and Drug Services, which had offered Health Realization 3 Principles-based treatment for a number of years. This study constitutes the first systematic evaluation of Health Realization as a substance abuse treatment program for adult women in a residential treatment setting. This was a randomized study with two observations- admission and nine months post-admission. The results showed that clients in both Health Realization and Twelve Step treatment exhibited comparable outcomes on domains such as substance use, criminal justice involvement, employment, housing, adverse effects of substance use and psychological wellbeing. Substance use declined significantly between admission and follow-up in both treatment groups, irrespective of duration of treatment. Similarly, adverse effects of substance use declined between admission and nine-month follow-up. Health Realization and Twelve Step treatment offered comparable benefits for women in residential substance abuse treatment programs.

Key words: Health Realization Treatment, residential treatment, comparison study

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Introduction

In recent years, there has been a discernible shift toward "proven" treatment models for substance abuse treatment. The emphasis on proven substance abuse treatments has been promoted by the National Institutes of Health, principally by NIDA & NIAAA and the Substance Abuse Mental Health Services Agency. As a result, some substance abuse treatments, used for decades without formal appraisal, are being subjected to rigorous evaluation of treatment outcomes. Changes in the standards of evidence for treatment effectiveness have led to greater scrutiny of traditional 12-Step treatment programs, despite decades of use in alcohol and drug treatment facilities. Project Match, a multi-site study, was funded by NIAAA to examine three different substance abuse treatment approaches- Twelve-Step, Cognitive Behavioral and Motivational Enhancement Therapy- and to ascertain the differences (if any) in short-and long-term substance use outcomes. Partly as a result of this trend, new therapies have a different provenance from older treatment models. New treatments are based on theoretical models that are subjected to rigorous tests from the very outset and only then introduced into treatment facilities. Consequently, new therapies are required to meet a minimum standard of effectiveness and offer evidence of demonstrable benefits to clients to be considered comparable alternatives to existing therapies.

In this paper, we describe Health Realization's 3 Principle-based treatment as a new approach to substance abuse treatment and compare it to Twelve-Step treatment in two women's residential treatment programs. The purpose of this study was to see whether Health Realization's 3 Principles-based approach was equivalent to other standard therapies offered in women's residential programs. The study was sponsored by a large California county's Department of Alcohol and Drug Services, which had offered Health Realization's 3 Principles-based treatment as therapeutic option for a number of years. The increased demand for evidence-based and proven treatment programming by funding agencies and treatment providers served as the primary motivation for undertaking an evaluation of Health Realization's 3 Principles-based approach as a substance abuse treatment model.

The therapeutic approach in Health Realization, detailed below, centers on the process of returning individuals to healthy thinking by illuminating the general nature of psychological functioning. To our knowledge, therapeutic effectiveness of Health Realization's approach for adult clients has not been previously evaluated or published in a peer-reviewed journal. A search under the terms "Health Realization," in one public database- Pub Med and two commercial databases- Psychological & Behavioral Sciences Collection and Biomedical Reference Collection- uncovered two citations for Health Realization, neither which evaluated treatment outcomes among adult clients. We believe that this study constitutes the first systematic evaluation of Health Realization's 3 Principles-based approach as a substance abuse treatment program for adult women in a residential treatment. This paper reports the results of this randomized study of Health Realization's 3 Principles-based approach as a substance abuse treatment model for adult women.

Comparisons of Substance Abuse Treatment therapies: Evidence from research

Local substance abuse treatment systems frequently offer multiple therapeutic options for their substance abuse clients. Managers and counselors alike have long recognized that one therapeutic approach does not "fit' everyone and that a range of therapeutic alternatives are required to serve clients with different needs. Therefore, the issue of comparability of alternative therapies becomes an important question for local treatment programs seeking to provide services for an increasingly diverse client

population. A recurrent question in programming decisions is this: Are different treatment modalities equally effective in reducing substance use and improving psychosocial functioning for clients? For many programs, this is not simply an academic question; it relates directly to the practical issues of cost effectiveness and provision of equal treatment to clients. Unproven or ineffective treatments are expensive for local programs because they involve multiple episodes of treatment over the long term. The issue of equity of treatment is equally important to program staff, who wants to offer clients a choice among equally effective therapies. Counselors are understandably reluctant to treat clients with new therapies unless they are assured of essentially similar treatment outcomes and more specifically, reduced use of substances at the end of treatment.

The evidence from the treatment outcomes research literature indicates that the difference among substance abuse treatment models is less significant than the difference between receiving and not receiving treatment (Groppenbacher, Bemis-Batzer, & White, 2003). Project Match, the influential NIAAA study that compared the effectiveness of different treatments, revealed few significant differences in alcohol usage among clients in different programs (Project MATCH Research Group, 1997). Project Match tested the hypothesis that clients who were matched to "appropriate" treatment would tend to experience better post-treatment outcomes. At 15-month follow-up, clients in all three programs studied - CBT, Twelve Step Facilitation and Motivational Interviewing- experienced significant reductions in drinking (as measured by drinks per day), exhibited fewer psychosocial symptoms & drinking consequences, and reported more days of employment. However, clients in Twelve Step Facilitation were more likely to remain abstinent for several months after treatment, although the differences in abstinence rates by program were not as large at the 3-year follow-up as the initial assessments seemed to indicate (Project MATCH Research Group, 1998).

Other smaller studies corroborated the main findings of Project Match for alcohol & other substances. Like Project Match, these studies also showed higher abstinence rates at follow-up among clients treated in Twelve Step programs as compared to clients in other treatment programs. Similarly, these studies found little difference in outcomes among treatment programs. A multi-modality study of

veterans found comparable post-treatment outcomes among clients treated in therapeutic communities (TC), Twelve Step and psychosocial rehabilitation while clients treated in undifferentiated (eclectic) programs had the least positive outcomes (Moos, Moos, & Andrassy, 1999). Another study of veterans found no significant differences in treatment outcomes between Twelve Step treatment and CBT (Finney, Ouimette, Humphreys, & Moos, 2001). These results appear to suggest that participation in a substance abuse treatment programs yields positive outcomes, irrespective of the specific therapeutic model. At the same time, it also appears that a particular treatment model may be unsuited to clients with specific conditions. CBT is believed to be inappropriate for persons with multiple drug addictions or severe psychiatric symptoms (Gottheil, Weinstein, Sterling, Lundy, & Serota, 1998), and less effective for alcoholic persons (Litt, Kadden, Cooney, & Kabela, 2003). Similarly, the religious overtones and highly structured format in Twelve Step programs may not appeal to many clients. Given the wide diversity of responses to treatment, it is not surprising that the number of therapeutic options for substance abuse treatment continues to expand.

Two Approaches To Treatment: Twelve Step & Health Realization

Substance abuse treatment therapies vary along two distinct, though crosscutting dimensions or continuums; one that is characterized by the relative emphasis on cognitive and behavioral components in comparison to experiential factors and the second, an implicit theory of behavioral change. Evidence-based treatment approaches can be placed along a continuum that ranges from predominantly cognitive to predominantly experiential treatment approaches, with many therapies incorporating elements of both. Predominantly cognitive-behavioral therapies such as Cognitive Behavioral Therapy and Community Reinforcement Model are derived from theoretical frameworks that incorporate variants of social (cognitive) learning theories and behavioral theories as well as theoretical assumptions about change in substance use behavior, implied by these theoretical constructs. Social learning theory, the health belief model, the trans-theoretical model (of stages of change) and the theory of planned behavior have dominated theories of behavioral change, particularly in health-related behavior (DiClemente & Scott, 1997). By contrast, theories that emphasize emotional or experiential factors as motivation for behavioral

change are less numerous, though widely used in practice due to the popularity of 12-Step programs, which are based on a theory of change that emphasizes emotional distress ("hitting bottom") as a precondition for behavioral change.

Twelve Step Treatment : The 12-Step model and its variants-Hazelden, Wilmar or Minnesota models-are probably the most widely used substance abuse treatment therapies in local programs (Humphreys, 2003). The general principles of 12-Step treatment and the implied theory of behavioral change have been explored in several research studies. Further 12-step programs have been studied in real-life settings as well as in randomized studies, permitting the exploration of different facets of the therapeutic process (Finney, Noyes, Coutts, & Moos, 1998; Fiorentine & Hillhouse, 2000, 2003; Morgenstern, Bux, Labouvie, Blanchard, & Morgan, 2002; Polcin, Prindle, & Bostrom, 2002), including the experiential basis of behavioral change (Bell, Montoya, Richard, & Dayton, 1998) and post-treatment outcomes (Fiorentine, 1999; Moos, Finney, Ouimette, & Suchinsky, 1999; Ouimette, Finney, & Moos, 1997).

The Twelve-Step process is anchored in six key principles: admission of powerlessness, responsibility, affirmation, ritual, forgiveness and fellowship (Bristow-Braitman, 1995). Research studies note that the internalization of 12-step principles appear to be key to successful treatment outcomes. Acceptance of the Twelve Step principles is positively related to post-treatment abstinence and ongoing participation in self-help groups (Fiorentine & Hillhouse, 2000, 2003), and the level of exposure to 12-Step ideology predicts post-treatment participation in self-help groups (Morgenstern, Frey, McCrady, Labouvie, & Neighbors, 1996; Ouimette et al., 1997). However, the posited motivation for behavioral change in 12-step theory- the experience of extreme psychological distress ("hitting bottom") - was not supported by evidence in one study (Bell et al., 1998). The hypothesized effects of emotional distress in seeking treatment seeking were not borne out, although clients in residential treatment did exhibit lower self-esteem, which is consistent with the experience of acute emotional distress as a motivation for treatment (Bell et al., 1998).

Introduction to Health Realization Principles: Health Realization's approach does not fall within the typical continuum of treatment or therapy approaches in that it does not target cognitions, affect, behavior or social reinforcement, nor is it based on other theories of behavioral change. It is distinct from other approaches in that its goal is to educate individuals as to the generic nature of psychological functioning, and through this educational process increase an individual's level of psychological awareness, thereby engaging innate resiliency, which in turn produces change.

Health Realization's psycho-educational approach is based on the philosophy of Banks (1998) and a treatment approach developed by Mills (1995) and Pransky (1998; J. Pransky). Banks (1998) posits that all human experience is generated by three psychological principles. . Understanding these three principles, rather than targeting the products of them (a person's thinking process and its contents, as well as feelings and behaviors) is the focus of the approach and the route to sustainable change. These principles are referred to as Mind, Thought and Consciousness. A discussion of the principles can be found in Banks, (1998) and Mills & Spittle (2001). Specifically, Health Realization's approach does not focus on the content of thought, but rather on these three principles that create the process of thought (Mills & Spittle, 2001; G. Pransky, 1998; J. Pransky, 2003). While at times seeming linguistically similar to cognitive models, Health Realization's approach focuses on these three principles that create what we think, not what is thought about (Banks, 1998).

Health Realization's Approach to Substance Abuse Treatment: While the physical addiction and withdrawal may be addressed medically, the purview of Health Realization's approach is to address psychological addiction. In Health Realization's 3 Principles-based approach, mental health and recovery from the addictive process is not accessed through behavioral methods, coping strategies, or by changing or controlling human thinking. Health Realization's 3 Principles based addiction treatment is focused on understanding the nature of one's own healthy psychological functioning at the level of insight or realization (Howard & Mansheim, 2003). The goal of treatment is to show clients how their level of psychological functioning created the need for compulsive relief, and how through awareness and insight

their level of functioning can return to an innately healthy set point which will provide a natural immunity to substance abuse and dependence, in addition to preventing other dysfunctional behaviors.

Within the addictions field, the emphasis on a set of principles that create reality differentiates Health Realization from various Twelve Step approaches. The focus on innate health, as opposed to disease or disorders, differentiates Health Realization's approach from Twelve Step approaches, which are based on the belief that the person has a chronic disease that must be dealt with for life (Howard & Mansheim, 2003; Pransky, Mills, Sedgeman, & Blevens, 1997). For a comparison of these approaches see Table 1.

Table 1 – Comparison of Substance Abuse Treatment methods

Model or Approach:	Substance Abuse viewed as:	Goal:	Methods:	End Results:
Twelve Step/Anonymous models	Disease	Sobriety (complete, long term abstinence) through spiritual awakening	Meetings,12 step work with sponsor, working with others	Recovery from substance abuse, change in thought process from self centered to other focused, making amends, service, spiritual growth
Health Realization/3 Principles	Way to get relief from distress at current level of understanding. Lack of understanding of how principles create experience, which leads person to seek relief from stressful experience through addictive behaviors.	Increased level of understanding leads to insights about the principles, which results in a healthy thinking process	Gain an understanding of Principles via classes, ed groups, and/or individual sessions with teacher or counselor	Improved level of understanding which allows access to a healthy state of mind, bringing contentment, therefore no need to engage in addictive behaviors

Although the 3 Principles-based approach is relatively new within the psychological field, it has amassed a wealth of preliminary outcome studies. However, this approach has not yet been rigorously researched within its substance abuse application, and has only begun to be researched within the general mental health area (Mills, 1995; J. Pransky, 2003). In earlier efforts based on the 3 Principles, there is evidence to suggest that clients undergoing Health Realization's 3 Principles-based treatment report a decrease in depressive symptoms and increase in self-esteem and positive changes in marriages and personal relationships (Mills, 1995 pp. 13-14; G. Pransky, 2003). A recent controlled study that examined the effects of Health Realization's treatment with a population having diagnoses of schizophrenia and major depression reported encouraging results (McMahan & Fidler, 2003). Clients in a county vocational

and social skills training agency were either assigned to Health Realization's class on the principles or remained in their usual training program. Clients in the Health Realization's group received 30 hours of education about the principles. McMahan and Fidler (2003) reported significant decreases in anxiety and depression, and an increase in positive affect and self-efficacy with clients receiving Health Realization's training, as compared to the clients in the traditional group. Health Realization's group also reported positive effects on relationships with self and family, interpersonal communications and overall feelings of well-being.

Hypothesis of Equivalence: Previous studies of treatment outcomes appear to indicate that any substance abuse treatment yields positive outcomes in most instances and some treatment is better than no treatment, though treatment effects can be differentiated in terms of specific outcomes e.g. length of abstinence. For programs, the critical factor in the decision to adopt a new therapy for substance abuse treatment is often a pragmatic one, i.e., a demonstration that the new treatment is at least as good or clinically comparable to an existing treatment. In this paper, we seek to test the proposition that Health Realization's 3 principles-based treatment yields "equivalent" benefits to Twelve Step-based treatment for clients in a women's residential facility. The primary outcome of interest is that the difference between two treatments (Twelve Step and Health Realization) is not meaningful in a clinical sense and that the outcomes for clients are equally beneficial. The notion of formal equivalence testing has been explored in some recent articles (Cribbie, Gruman, & Arpin-Cribbie, 2004; Newman, S., & Feaster, 2003) as has the distinctions between clinical and statistical significance (Thompson, 2002). Although formal equivalence testing offers an alternative conceptual framework to standard hypothesis testing to show that two treatments are "about the same" in terms of post-treatment effects on clients, it requires prior information about what constitutes equal outcomes. In this paper, we operationalize equivalence in less formal terms and in terms of an absence of significantly poor client outcomes on key measures.

Data & Methods

Location of Study: The study was conducted at two women's residential treatment facilities located in two northern California counties. The primary site was located in a large California

county (referred to as the in-county program) in the San Francisco Bay Area. The in-county women's residential program offered a choice, at the same location, of Twelve Step Therapeutic treatment or Health Realization's treatment. A second women's residential treatment facility, located in an adjoining county, was selected as the comparison site (out-of-county program). It was chosen because it was also a women's residential treatment facility that offered a program of comparable duration (approximately 45 days), used a social model Twelve Step approach and had treatment staff that had never been exposed to the Health Realization approach. While both in-and out- of-county residential treatment programs offered Twelve Step treatment, the in-county program incorporated more elements of Cognitive Behavioral Therapy and the out-of-county program, the Social Model. The Institutional Review Board of the in-county program approved and monitored the study.

Program description: The in-county substance abuse program operates under a "continuity of care" model, which requires clients to be stepped down from more intensive (residential) to less intensive (outpatient) treatment. Residential treatment in the in-county system is designed to stabilize clients rather than a stand-alone program and clients are expected to continue treatment in an outpatient setting. Admission to outpatient treatment in the in-county system was mandatory (following residential treatment) for any client who wished to remain in the system of care and access sober living and transitional housing after residential care. Clients admitted to outpatient treatment following residential Health Realization's 3 principles-based treatment were mostly treated in programs modeled on Twelve Step treatment.

The in-county Health Realization residential program was a recent addition to the treatment options available at the site, which had offered mainly Twelve Step treatment for several years. Furthermore, a separate Health Realization track had been specifically created for the purposes of this study. As a result of its newness, Health Realization's treatment program was staffed by counselors with less experience and opportunities to have honed their therapeutic skills as compared to counselors in Twelve Step programs at both residential sites, who had many years of experience and therapeutic skills acquired over time. Health Realization's program was also subjected to greater staff turnover during the

study period. Counselors who had originally been trained in Health Realization 3 principles-based treatment left during the study period. Replacement Health Realization instructors taught the classes for the remainder of the study but not all were substance abuse counselors, and none were employees of the treatment facility as was the original HR staff.

Research Design: This was a randomized design with three groups – two groups received some form of Twelve Step based treatment, and one received Health Realization's principles-based treatment. Participants in the in-county program were randomly assigned either the Twelve Step Therapeutic or Health Realization's program, while participants in the out-of-county program were offered only social model Twelve Step treatment. The second Twelve Step program was included to enable the authors to estimate potential problems due to cross-contamination between Health Realization and Twelve Step at the in-county program as the staff within the in-county program had been exposed to both approaches. At the in-county residential program, counselors in the Health Realization principles-based treatment track used only the principles-based HR approach; counselors in the Twelve-Step Therapeutic track used Twelve Step theory and concepts (powerlessness, surrender, etc.) as well as correlated cognitive behavioral interventions (trigger management, relapse planning, etc.) These Twelve Step Therapeutic staff members had also previously been exposed to the 3 principles of the Health Realization program though they did not systematically incorporate these principles into their treatment approach. Typically, in-county clients were placed in a treatment program (Health Realization or Twelve Step Therapeutic) and remained there for the duration of treatment unless there was a clinically approved reason for changing from one to the other program. Although clients at this location were placed in one of the two "tracks" and the classes were separated, clients did share community space (cafeteria, social areas, etc.) These factors created the potential for confounding due to cross-contamination. Potential threats from contamination are common in field studies and occur in residential programs because clients are able to move from one treatment to another and exchange information with each other (Dennis, 1990). A design with two Twelve-step groups, one with a potential for cross-contamination and one without, allowed us to

estimate the contamination effect. In the absence of contamination, the two Twelve-step groups would be expected to exhibit the same response to Twelve –Step principles between baseline and follow-up.

Subject Selection, Randomization & Data Collection Procedures: All study participants were recruited between April 2000 and April 2002. All admissions to in-and out-of-county programs during the recruiting period were eligible for inclusion into the study. Exceptions were made in cases where the intake coordinator determined that a client needed to be placed in specific program. At the in-county program, clients were assigned by the intake coordinator to either the Twelve-Step or Health Realization programs using a two-step randomization process. Clients were first randomized into the study or out of the study in order to achieve balance in the recruitment conditions. Clients randomized into the study had the choice of either participating in the study or not. Clients who consented to participate in the study were randomly assigned to either Twelve Step or Health Realization's 3 principles-based treatment. (Clients were also given the choice of not participating in the randomization process and entering a program of their choosing). At the out-of-county program, clients were recruited over the same period and with the same procedures except that they were randomized to a study or no-study condition, so that the rate of entry was comparable. All clients at this site were treated in a Twelve-Step program.

URN randomization (Wei, 1978) was used during the earlier part of the study to assign clients in the in-county residential treatment site to different groups and ensure baseline balance on children at home, criminal justice referral, race, sexual orientation and age. Although the computer program provided an elegant way of randomizing the clients, it was discontinued due to logistical problems. A manual urn method was instituted for random assignment and post-hoc analysis of the balancing procedures showed that balance was achieved. Four hundred and thirty nine clients were randomized to participate in the study or no-study condition during the recruitment period. A total of 333 clients were randomized into the study condition. Of these, 188 clients were randomized to Health Realization's treatment group and 221 to the Twelve-Step treatment group (114 in the in-county program and 107 in the out-of county program).

Clients who agreed to participate were asked to read and sign an informed consent form that described the study, the randomization procedure, confidentiality of client interviews, measures taken to protect client data and the incentive for participation (a $20.00 grocery certificate). Clients who did not want to be randomly assigned to a treatment group were treated as refusals for the purposes of this study. Clients who consented to participate in the study were interviewed as close to admission as possible and then contacted approximately nine months later for the follow-up interview. The federal government's Center for Substance Abuse Treatment recommends six months post-treatment as the minimum length of follow-up, because clients who have been successful for that amount of time are likely to continue to be successful (Center for Substance Abuse Treatment, 1995; Hoffman & Harrison, 1988; McLellan, Alterman, Woody, & Metzger, 1992). Furthermore, abstinence at six-month post-treatment has been found to be a reasonably good predictor of longer term outcomes (5 years post-treatment) (Weisner, Ray, Mertens, Satre, & Moore, 2003).

Of the clients interviewed at baseline, 69.4% (232) were re-interviewed at the 9-month follow-up. Baseline and follow-up data were available for 80 clients in the Primary Site Health Realization treatment program, 81 for the Primary Site Twelve-Step program and 70 for the Comparison Site Twelve Step program.

A follow-up rate of 69% is sufficiently large to minimize problems due to follow-up attrition bias in substance abuse populations. One recent study found that models based on a 60% sample were fairly representative of models based on 90-100% follow-up (Hansten, Downey, Rosengren, & Donovan, 2000). Further, the same study also found that follow-up rates were more sensitive to follow-up protocols rather than client characteristics.

Variables, Measures & Data Collection: Standard socio-demographic and substance use information collected at baseline for the programs' management information systems was reported at follow-up and supplemented by standardized instruments examining substance use consequences and psychological status. Data on demographic characteristics, substance abuse history and other client characteristics were gathered from computerized client admission files from the Primary and Comparison

Sites. At admission, clients provide information on age, marital status, number of children & children less than 3 years of age, education, employment, prior arrest history, referral source and other relevant demographic information. Also included in the admission files are data on substances used, frequency of use, route of administration, age at first use and recent needle use. These data are routinely collected from clients by program staff and entered into a database, maintained by the Department of Alcohol & Drug Services in both counties.

Substance use: Substance use was measured using self-reported usage at both admission and 9-month follow-up; usage data at admission was obtained from the computerized records created for each client at intake. Substance use items at follow-up queried clients as to whether they had used any substance in the past 30 days, the substance(s) used in the past 30 days and the frequency of use of the primary substance in the past 30 days. Substance use at follow-up was coded as a dichotomous variable with "0" denoting no substance use in the past month (9 month follow-up) and "1" denoting any use in the past 30 days.

Housing, arrests and demographic information: Legal and housing outcomes are particularly important in terms of re-integration of substance abuse clients back into the community, a goal public treatment systems view as their mandate. Data on housing stability and arrests were gathered via self-report at the 9-month follow-up. Clients were asked whether they were living in permanent or temporary housing (shelter, a treatment facility, short-term housing, and jail) or if they were not housed at all (homeless). Data on arrests included whether they had been arrested since entering treatment (since the baseline interview) and the number of times they had been arrested. They were also asked their current legal status (probation, parole, diversion program, incarcerated or none of the above). Arrests at follow-up were coded with a "0" for no arrests and a "1" for one or more arrests since admission to treatment. Labor force status was coded with a "1" for participating in the labor force (this included both employed and those seeking employment) and a "0" for not participating in the labor force.

Consequences of substance use: The consequences of substance use at baseline and follow-up were measured using the Inventory of Drug Use Consequences (InDUC-2R) (Miller, Tonigan, &

Longabough, 1995). The InDUC–2R is a parallel form of the Drinker Inventory of Consequences (DrInC), developed by Project MATCH staff and subsequently modified to include other drugs. The InDUC–2R scale consists of 50 items and five subscales: physical consequences, intra-personal, social responsibilities, interpersonal and impulse control. Global InDUC scores were computed for baseline and follow-up waves.

The InDUC –2R was found to have good test-retest reliability in a small clinical sample of women and excellent sensitivity to change in drug use at 3-month follow-up (Tonigan & Miller, 2002). Large effect sizes were found for reduced use of presenting drug (d=1.35), any illicit substance (d=1.29) and alcohol & illicit substances (d=1.26). Results from an analysis of three samples (female outpatient, male outpatient, and mixed-gender inpatient clients) showed that the recent (past 3 months) consequences scales were more reliable than lifetime consequences scales.

Psychological status: The RAND Mental Health Inventory (henceforth MHI) was selected to measure psychological functioning at baseline and 9-month follow-up. The MHI is a 36-item scale (Davies, Sherbourne, Peterson, & Ware, 1988) that was developed by RAND for its Health Insurance Experiment study. Some items were incorporated into the SF-36 scale, which has been widely used to measure physical and psychological functioning. An earlier version of the inventory was used in a study of a Health Realization/Community Empowerment program (Borg, 1997) and in a Santa Clara County vocational program study. In both, significant improvements were noted from pre- to post- test when compared to naturalistic control groups. The MHI measures frequency or intensity of symptoms over the past month. The MHI is made up of two global scales – Psychological Distress and Psychological Well-Being and six sub-scales: General Positive Affect, Emotional Ties, Life Satisfaction, Anxiety, Depression, and Loss of Behavioral/Emotional Control.

The Mental Health Inventory has robust psychometric properties. Cronbach's alpha for the entire MHI was high for the combined-site Health Insurance Experiment study (a=. *96*, 5089 subjects). Like other mental health scales, the subscales have been found to have both discriminant validity, being uncorrelated with general physical and social health factors (Stewart, Ware, & Brooks, 1979), and

convergent validity, being correlated with other measures of life events, social contacts and resources, chronic diseases, acute physical symptoms, and general health perceptions [Davies, 1981 #41; Donald, 1982 #42]

For this study, three of the subscales were selected for analysis: Anxiety, General Positive Affect, and Depression. Anxiety and depression are common psychosocial states among clients being admitted to substance abuse treatment and are often related to substance use (Charney, Palacios-Boix, Negrete, Dobkin, & Gill, 2005; Kranzler, Del Boca, & Rounsaville, 1996) and treatment outcomes have been found to be related to levels of these factors at intake. Reduction in or cessation of substance use generally alleviates depression and anxiety and increases general positive affect, though treatment outcomes depend on the severity and number of disorders at intake (Charney et al., 2005). Including the subscale that measured depression was selected to determine if the programs improved clients' mood.

Sample characteristics at baseline & follow-up: The 331 clients who participated in the study represented a young, racially & ethnically diverse group of women in treatment for substance abuse. (see Table 2) The baseline sample of women clients in residential treatment were 46% White, 32% Latino, 13% African American and 8% all other races. The mean age of study participants was 35 years and their mean number of years of education was 12 years. Only 25% of the women clients had children, and over 90% were either not currently married or had never been married. The majority of participants (92%) were unemployed and not seeking employment at admission to treatment. The most commonly abused substances were methamphetamines (46%), followed by alcohol (20%) and cocaine (16%). Slightly under half the participants (47%) reported poly-drug use and 62% reported using a substance daily. The most common route of administration was smoking (57%) following by oral ingestion (27%) and only 14% reported injecting a substance. However, about 20% also reported using needles in the past year, even though they may not be currently using them. The average age at first use of a substance was 19.8 years.

Highlighted variables show balance factors, which indicate similar distribution in each of the treatment groups of white versus minority clients, children, criminal justice referral and age.

Clients who were interviewed at follow-up did not differ significantly from those that were not with respect to age (t=.370, p=.71), length of stay in treatment (t=.80, p=.43), race (χ= 1.30, p=.52) or type of substance used (χ=.19, p=.90). However, the two groups did differ with respect to number of children; women without children made up a larger proportion of clients who could not be reached for a follow-up interview.

Table 2. Selected characteristics of study participants at baseline by treatment group (n=338)

	In-county HR	**In-county 12 Step**	**Out-of-county 12 Step**	**Total**
	115	115	108	338
	%	**%**	**%**	**100%**
Race/ethnicity				
Latino/Hispanic	**32.2**	**40.0**	**23.1**	**32.0**
Non-Latino White	**47.0**	**49.6**	**42.6**	**46.4**
African-American	**12.2**	**7.8**	**20.4**	**13.3**
Native American	**1.7**	**0.9**	**2.8**	**1.8**
Asian/PI	**6.1**	**0.0**	**2.8**	**3.0**
Other	**0.9**	**1.7**	**8.3**	**3.6**
Marital Status				
Never married	45.2	52.2	43.5	47.0
Currently married	7.8	9.6	11.1	9.5
Not currently married	47.0	38.3	45.4	43.5
Number of children				
No children	**71.3**	**74.8**	**78.7**	**74.9**
1 or more children	**28.7**	**25.2**	**21.3**	**25.1**
Admission employment status				
Unemployed, not looking	95.7	86.1	95.4	92.3
Unemployed, looking	0.9	2.6	0.9	1.5
Employed	3.5	11.3	3.7	6.2
Criminal Justice referred	**22.6**	**21.7**	**25.9**	**23.4**
Other referrals source	**77.4**	**78.3**	**74.1**	**76.6**
Primary drug				
Heroin	6.1	7.8	11.1	8.3
Alcohol	22.6	17.4	18.5	19.5
Methamphetamines	47.0	55.7	36.1	46.4
Cocaine	14.8	9.6	25.9	16.6
Marijuana/Hashish	4.3	5.2	1.9	3.8

All other substances	5.2	4.3	6.5	5.3
Polydrug use	**46.1**	**46.1**	**49.1**	**47.0**
Frequency of use				
No use prior month	7.0	7.0	32.7	14.8
1-3 X past mth	7.0	5.2	13.9	8.5
Weekly use	19.2	17.4	7.9	13.3
Daily use	67.0	70.4	45.5	61.6
Route-administration				
Oral	24.3	23.5	19.8	22.7
Smoking	55.7	57.4	56.4	56.5
Inhalant	7.8	7.8	5.9	7.3
Injection	12.2	11.3	17.8	13.6
	Mean	Mean	Mean	
Grade Level	12.0	11.9	12.2	
Age first use (in yrs)	19.8	20.2	19.5	
Age (in yrs)	**35.8**	**33.5**	**36.2**	

Data Analysis: Data were analyzed using SPSS (Version 12.0). Logit loglinear analysis was used to examine three outcomes-substance use, arrests and labor force status. Logit loglinear analysis allows analysis of models with categorical outcomes with categorical predictors, and estimation of contribution to the outcome of each level of a categorical variable. Thus, it is possible to examine the direct effect on treatment outcomes of the type of treatment and length of treatment. The measures of association in logit models-entropy & concentration are analogous to the effect size measures like R^2 in linear regression models. When entropy and concentration are not significant, the tested model is essentially no different from the independence model. Adverse consequences of substance use between admission and follow-up were analyzed using repeated measures GLM procedure. As both the baseline and follow-up data are analyzed in the GLM procedure, any differences are effectively controlled at baseline. Thus, we are able to examine changes over time rather than simply outcomes at follow-up. The within-subjects effects are tested first with the Mauchly Sphericity test, which determined whether adjustments were required for the F-test. If the sphericity assumption is not met, then the F test overestimates the strength of the association.

Results

The analysis focused on two questions posed earlier in this paper: Were the two different substance abuse treatment programs equally effective in reducing substance use, adverse effects of substance use and promoting psychosocial functioning as indicated by labor force participation, reduced likelihood of arrest and psychological well-being? In this section, we examine treatment effects on discrete behavioral domains such as substance use, which is specifically targeted in Twelve Step programs, and psychological functioning, which is the focus of Health Realization's program treatment.

Changes in substance use, arrests and labor force status: Three outcomes-substance use, arrests and labor force status-measured at 9-month follow-up were coded as dichotomous variables and analyzed using SPSS' logit loglinear analysis. These indicators provide a measure of the level of social functioning following treatment. Self reported substance use at follow-up was examined first. Similar models were tested for arrests and labor force status at follow-up. There were three treatment groups – Health Realization's principles-based program and two Twelve Step programs – and three levels of length of stay in residential treatment (up to 30 days, 31-60 days, more than 60 days).

Table 3. Multinomial logit of substance use, labor force participation and arrests at follow-up (n=232)

	Estimate	**SE**	**Z**	**Significance**
Substance use at follow-up				
No Use at follow-up	.868	.345	2.518	.012
No Use * Less than 30 days in tx	-.336	.384	-.873	.383
No Use * 31-60 days in tx	-.510	.360	-.873	.157
No use * HR	.350	.340	1.029	.303
No use * 12 Step (out-of county)	.184	.382	.483	.629
Post-admission arrests				
Not arrested post admission	1.912	.475	4.022	.000
Not arrested * Less than 30 days in tx	-.381	.522	-.730	.466
Not arrested * 31-60 days in tx	-.347	.502	-.692	.489
Not arrested * HR	.692	.500	1.384	.166
Not arrested *12 Step (out-of county)	-.114	.493	-.231	.818
Labor force participation at follow-up				
In labor force	.338	.323	1.045	.296
In labor force * Less than 30 days in tx	.353	.360	.981	.326
In labor force *31-60 days in tx	.179	.338	.531	.595
In labor force * HR	-.258	.324	-.799	.424

In labor force *12 Step (out-of county)	-1.069	.366	-2.919	.004

The results of the logit loglinear analysis of substance use at follow-up are shown in Table 3 section 1. A strong association between substance use at follow-up and treatment and length of stay was found (Entropy p=.013, Concentration p=0.016) indicating that the null hypothesis of independence can be rejected. The main effects analysis shows that the likelihood of clients reporting no substance use at follow-up was significantly higher than any substance use (Z=2.518, df 1, p=.0112). However, the results also indicate that there were no significant differences among treatment groups with respect to substance use at follow-up. Similarly, none of the interactions between substance use at follow-up and length of stay in treatment were significant. Substance use declined across all treatment groups and lengths of stay in residential treatment.

Comparable effects were found for self-reported arrests at follow-up; the likelihood of not being arrested was significantly greater than the likelihood of arrest at follow-up (Z=4.022, df 1, p=.000). The association between the predictor variables and arrests at follow-up was significant (Entropy p=.018, Concentration p=.014). There were no significant interaction effects between substance use and treatment group membership or length of residential stay. The likelihood of not being arrested declined across all treatment groups and duration of residential treatment.

In contrast with substance use and arrests at follow-up, there was only inconsistent evidence for association between labor force status and treatment group and length of stay. One measure of association was significant (Entropy =.045), while the second measure -Concentration-was not significant at the .05 level. Similarly, the main effects analysis showed that there were no significant differences in the likelihood of being in the labor force or not being in the labor force (Z=1.045, df 1, p=.296). However, there was one significant difference between treatment groups; clients from the out-of-county Twelve Step treatment program were less likely to be in the labor force at follow-up than clients from the two in-county treatment programs (Z=2.919, df 1, p=.004).

Adverse consequences of substance use: In addition to substance use and arrests, we also examined changes in adverse consequences of substance use between admission and follow-up. We hypothesized that adverse consequences would be more likely to be reported by clients who experienced difficulty in reducing substance use, finding permanent housing and employment. The independent variables in the model were: treatment group, length of treatment and substance use, housing status and employment at follow-up. The results are shown in table 4.

The main effects analysis indicated that there was significant change (decline) in self reported adverse consequences between admission and follow-up (f=432.6, df 1, p=.000). The Within-Subjects effect was first tested using the Mauchly Sphericity test to determine whether adjustments were required for the F test. (If the sphericity assumption is not met, then the F test overestimates the strength of the association). We then examined interaction terms to see if the decrease in adverse consequences were constant across all levels of the factors. No significant interactions were found for treatment group membership and adverse effects, indicating that the decline in adverse consequences did not differ significantly between treatment groups. However, significant interactions effects were found between substance use at follow-up and adverse consequences (F=7.761, df 1, p=.006) and between length of treatment and adverse consequences at follow-up (F=5.016, df 1, p=.026).

Table 4 – Repeated Measures (GLM) analysis of adverse effects of substance use at follow-up (n=232)

	Type III SS	**DF**	**F**	**Eta sq**
InDUC (Tests of Within-Subject Effects)				
InDUC	400226.29	1	463.61***	.679
InDUC * Treatment group	3179.02	2	1.81	.017
InDUC * Length of stay	4330.64	1	5.02*	.022
InDUC * Substance use at follow-up	6700.14	1	7.76*	.034
InDUC * Housing at follow-up	1715.67	1	1.99	.009
InDUC * Labor force status at follow-up	89.61	1	0.10	.000

Adverse affects of drug use measured with Inventory of Drug use Consequences (InDUC).
Significance -*** =.000; ** = .001, ** =.05

Clients who reported not using substances in the past 30 days also exhibited a lower mean score on the INDUC at follow-up (lower scores denote fewer adverse consequences). The mean for non-users was 13 points lower than users at follow-up (Mean =49.6 versus 62.6). Though a significant interaction was found for length of treatment and adverse consequences, the relationship between the two was more complicated than expected. Clients in treatment for more than 60 days had a higher score on adverse consequences at follow-up than clients with fewer days in treatment (Mean = 58.18 versus 54.10). This may indicate that clients requiring a longer period of treatment exhibited higher severity at admission, and thus experienced a slower change in substance-use related behavior during the same period of observation (9 months post-admission).

Psychological functioning at follow-up: The two treatment approaches – Twelve Step and Health Realization 3 principles-based – place a markedly different emphasis on the mediating effect of psychological functioning. The model of behavioral change, implied by the therapeutic principles of the latter, considers improved psychological functioning a necessary precondition for changes in substance abuse behavior. Consequently, we hypothesize that clients in the Health Realization principles-based program would exhibit higher levels of psychological functioning at follow-up.

Table 5 – Repeated Measures of Within-Subjects Effects (GLM) analysis of psychological functioning at follow-up (n=232)

	Type III SS	**Df**	**F**	**Eta sq**
General Positive Affect				
General Positive Affect (GPA)	5323.92	1	53.37**	.192
GPA * Treatment group	704.21	2	3.53*	.031
GPA * LOS	59.77	1	0.59	.011
GPA * Substance use at follow-up	2034.92	1	20.40**	.083
GPA * Housing at follow-up	257.31	1	2.58	.003
GPA * Labor force status at follow-up	566.45	1	5.68*	.025
Anxiety				
Anxiety	3238.06	1	50.18***	.183
Anxiety * Treatment group	868.65	2	6.731**	.057
Anxiety * LOS	92.05	1	1.462	.006
Anxiety * Substance use at follow-up	492.64	1	7.634*	.033
Anxiety * Housing at follow-up	78.37	1	1.214	.005

Anxiety * Labor force status at follow-up	753.32	1	11.67**	.050
Depression				
Depression	483.50	1	29.54***	.117
Depression * Treatment group	127.84	2	3.91*	.034
Depression * LOS	17.58	1	1.74	
Depression * Substance use at follow-up	278.65	1	17.02***	.071
Depression * Housing at follow-up	.513	1	.031	.000
Depression * Labor force status at follow-up	190.06	1	11.6**	.049

General wellbeing, anxiety and depression measured using subscales of Mental Health Inventory.
Significance -*** =.000; ** = .001, ** =.05

Psychological functioning was measured using three subscales of the Mental Health Inventory – general positive affect (henceforth GPA), anxiety and depression. The three psychological outcomes were measured as continuous variables and were analyzed with SPSS repeated measures GLM (Generalized Linear Model) procedure. The results are shown in Table 5.

Tests of within subject effects showed that the main effect of GPA was significant (F=53.37, df 1, p=.000), indicating that the scores for general positive affect increased significantly between admission and 9-month follow-up for the entire sample. Moreover, significant interaction effects were found for treatment group (F=3.53, df 1, p.031), substance use at follow-up (F=20.40, df 1, p=.000) and labor force status at follow-up(F=5.68, df 1, p=.018). Significant interaction effects in repeated measures GLM indicate that changes in GPA between admission and follow-up were not constant across all levels of the independent variables. An examination of pair-wise comparisons of treatment groups showed that the GPA scores at follow-up were higher among clients in the out-of-county Twelve Step treatment program as compared with the in-county Twelve Step programs, though the difference was barely significant (diff=3.10, p=.052) (p=.052). Similarly, no significant differences in GPA were observed between clients treated in Health Realization and Twelve Step treatment. Pair-wise comparisons also revealed that non-users had a significantly higher mean score on GPA than users at follow-up (mean diff = 6.11, p=.000).

The level of anxiety, as measured on the anxiety subscale, declined significantly between admission and follow-up across all treatment groups (F=53.37, df 1, p=.000). As with changes in GPA,

the interaction between treatment group and anxiety was significant (F=6.731, df 2, p=.001) as were interaction effects for substance use at follow-up (F=7.63, df 1, p=.006) and labor force status (F=11.67, df 1, p=.001). Unexpectedly, an examination of pair-wise comparisons of mean anxiety scores by treatment group showed no significant differences among the treatment groups. Similarly, the pairwise contrasts (in means) between clients in and out of the labor force at follow-up were not significant. Consistent effects were detected for substance use at follow-up; pair-wise contrasts for substance use showed that clients who reported using substances at follow-up had a significantly higher anxiety score than those who did not use substance at follow-up (Mean Diff=4.06, p=.000).

Tests of within subject difference in depression scores revealed a significant decline between admission and follow-up (F=29.54, df 1, p=.000). Significant interaction effects were found for depression and treatment group membership (F=3.91, df 2, p=.022), substance use at follow (F=17.02, df 1 p=.000) and labor force status at follow-up (F=11.61, df 1, p=.001). As in the case of anxiety, pairwise comparisons unexpectedly failed to find that depression scores were significantly different by treatment group. In contrast, an examination of pairwise contrasts showed that the depression scores of clients who reported not using substances at follow-up were 2 points lower than those that used substances (p=.000).

The analysis of measures of general positive affect, anxiety and depression did not support the proposition that clients in Health Realization principles-based treatment would exhibit better psychological functioning at follow-up. Further analysis was undertaken to explore the hypothesis that a higher level psychological functioning was associated with cessation of substance use. (see Table 6)

Table 6 – Logistic regression analysis of psychological status at follow-up as predictors of substance use (n=232)

	Substance use
	Odds Ratio
Treatment program:	
Health Realization	1.106
Out-of-county 12 Step	1.461
Length of stay:	
31-60 days	1.441

60+ days	.577
Daily use of substances at admission	1.737
Daily use of substances at follow-up	-
Arrests prior to admission	1.178
Education	-
General positive affect	.931*
Anxiety at follow up	.982
Depression at follow-up	1.064
Adverse consequences of drug use	-

Reference categories for variables in three logistic regression models: Treatment program-In-county 12 Step; Length of stay – 30 days or less; Use at admission – not daily use; Use of substances at follow-up – not daily use; Arrests-No arrests prior to admission;
Significance -*** =.000; ** = .001, ** =.05

The predictors of substance use at follow-up was modeled using a logistic regression with three covariates (scores on general positive affect, anxiety and depression at follow-up) and four factors – treatment group, length of treatment (< 30 days, 31-60 days, 60+ days) and two crude proxies for severity at admission (frequency of use at admission and arrests prior to admission). As results in Table 6 show, there was a small, but significant decrease in the odds of substance use at follow-up with increasing scores on general positive affect. However, neither depression scores nor anxiety scores at follow-up significantly altered the odds of not using drugs (the estimated odds were close to 1 for both variables).

Discussion

The aim of this current study was to evaluate a new substance abuse treatment approach-Health Realization's 3 principles - and determine whether it yielded results comparable to Twelve-step treatment, particularly with respect to reduction in substance use and improvement in psychosocial functioning among women clients in residential substance abuse treatment programs. The results revealed that substance use declined significantly between admission and follow-up across all treatment groups and duration of treatment, as indicated by significant results obtained in the logit loglinear analysis. Similarly, adverse effects of substance use also declined across all three groups, as indicated in the main effects obtained through repeated measures GLM analysis. Similar results were found for arrests and labor force status, and psychological well-being, anxiety and depression at 9-month follow-up. In other

words, clients who received Health Realization principles-based treatment exhibited comparable outcomes to clients who received Twelve-Step treatment.

These results are consistent with the general findings in the substance abuse literature, which suggests that treatment generally yields benefits for clients, often irrespective of the specific type of treatment received. This feature of substance abuse treatments were highlighted in the Project Match study results (Project MATCH Research Group), which found that very different treatment approaches- Cognitive Behavioral Therapy, Motivational Enhancement Therapy & Twelve Step- led to similar levels of abstinence post-treatment. In addition to replicating the general findings in the field of substance abuse treatment, these findings suggest that Health Realization treatment constitutes viable treatment option for women substance abuse clients.

Of particular interest was the observed decline in adverse consequences of substance use reported at follow-up. This was to be expected following treatment, as it is logical for client to experience fewer adverse effects due to reduced use or no use at follow-up. Clients in treatment generally reduce substance use and consequently, experience fewer adverse effects. In our study, all three groups experienced comparable decline in mean scores on the INDUC scale. Additional analysis confirmed that clients who reported not using substances at follow-up were also less likely to report adverse consequences.

A surprising finding was that clients with longer length of stay scored higher on the adverse consequences scale at follow-up than those with shorter stays. We speculate that clients who stayed longer exhibited higher severity at admission, but we were not able to confirm this hypothesis. We did not explicitly measure severity at admission, and the proxy measures of addiction severity (frequency of use, needle use and polydrug use) proved to be inadequate substitutes. It may be the case that clients with more severity in clinical symptoms not only require longer stays in residential treatment, but also may require a substantially longer period of treatment than they obtain. Project Match (Project MATCH Research Group) reported that clients with higher severity of psychiatric symptoms had significantly fewer days of abstinence than clients with less severe symptoms.

The findings indicate improvement in general positive affect across all three treatment groups, with clients in the out-of-county program exhibiting slightly higher average scores on these measures. Additionally, the level of anxiety and depression declined for all three groups, irrespective of treatment approach. These findings are encouraging because they indicate that clients receiving Health Realization treatment based on instruction of the principles, exhibited improvements similar to those in Twelve-Step treatment. However, the result was unexpected because Health Realization principles-based treatment specifically targets positive well-being and these were the measures in which Health Realization had expected to provide substantial improvement over the other treatment approaches. Improvements in well-being are viewed in Health Realization treatment as the primary mechanism through which changes in substance use behavior are mediated. Indeed, in our analysis, we found support for the proposition that clients who reported higher levels of well-being were also less likely to report using substances.

We speculate that there were a number of reasons why the expected psychological benefits of Health Realization treatment were not found at 9-month follow-up. As described in an earlier section, Health Realization principles-based counselors were less experienced and had fewer opportunities to hone their therapeutic skills in applying the principles in this setting; grounding and depth of understanding of the 3 principles by the Health Realization practitioners are known to have an application to the model and it is unknown how more seasoned practitioners would have affected client outcomes. Staff turnover may have also had an adverse impact on the effectiveness of Health Realization 3 principles-based treatment. To what extent, staff turnover affected the fidelity of the Health Realization program cannot be measured, but it undoubtedly affected the relationship between clients and staff. Despite problems with delivery of Health Realization 3 principles treatment, it is encouraging to note that clients were not adversely affected and exhibited comparable outcomes to those treated in standard Twelve-Step programs. The area of therapeutic alliance between counselor and client is an area for future Health Realization research in general, and may be a fruitful avenue for research in an era of funding and staff shortages.

Another factor that may have produced less than expected psychological benefits from the 3 Principles-based treatment was the lack of outpatient Health Realization principles-based treatment for

those requiring continuing services after residential treatment (for the Health Realization and in-county Twelve Step Therapeutic clients), which may have had the effect of diluting the effects of 3 principles-based treatment for these clients. Thus, clients may have been unable to practice the 3 principles or develop a better understanding of its therapeutic principles once they left residential treatment, and in fact may have been counseled in a manner that conflicted with the 3 principles approach. In addition, some clients had external mandates (court or probation directives) to attend Twelve Step meetings in the community once released from residential treatment. This may have further contributed to the dilution of 3 principles based treatment for some study participants. It should be noted that the general recovery support system is biased at this time toward Twelve Step type recovery and it is unclear how this may have affected Health Realization clients or the study results.

The Health Realization program practitioners involved in this study were encouraged that Health Realization program clients showed even comparable outcomes despite these complications; it is unknown if Health Realization program clients would have scored differently without these challenges, and this would be an area of future research interest in attempting to replicate the study with conditions for Health Realization being more stable and suitable in a subsequent effort. Although Health Realization 3 principles-based treatment has been practiced for over 20 years, this is first randomized, control group study undertaken to evaluate the therapeutic equivalence of this treatment modality. This study showed that the treatment outcomes for Health Realization program clients were comparable to those achieved by clients in Twelve Step treatment. The study design controlled for baseline client characteristics known to affect treatment outcomes-gender, age, presence of children and referral by the criminal justice system. Previous studies of Health Realization have generally focused on community rather than individual level interventions (Mills, 1995). Community members receiving Health Realization programs reported returning to school, gaining employment, and graduating from college. Communities that implemented Health Realization programs reported reduced substance use by community members and removal of drug dealing from the community itself (Pransky et al., 1997; J. Pransky, 1998).

This study demonstrated that Health Realization produces comparable treatment benefits to Twelve-Step treatment. Clients who chose Health Realization did as well on key measures of well-being than those treated with more conventional therapies. Health Realization 3 principles-based substance abuse treatment appears to be a reasonable alternative approach for clients who seek holistic treatment approaches. Although we did not specifically identify the clients who benefited from most from Health Realization treatment, it may well be the case that it is an option for those seeking less structured or externally dictated treatment options, or those seeking a more secular approach or a health/individual empowerment based approach.

This study has left the authors with a number of unanswered questions that should be pursued in future research. In particularly, we wonder whether the fact that Health Realization was offered as an option in a predominately Twelve Step facility limited the impact of the Health Realization treatment. What would be the therapeutic benefit of having Health Realization 3-principles based services in outpatient settings in addition to residential treatment? Are HR clients more self critical of their own level of well-being after learning the approach than they were previously, at least as compared to their Twelve Step counterparts? Another issue for future research is the relative frequency of relapse and return to treatment for clients treated in Twelve Step treatment compared to Health Realization's 3 Principles-based treatment. Future research should also include comparisons with other therapeutic options such as cognitive behavioral therapy.

Finally, we note some weaknesses in our study. We could not control entirely the cross-contamination between the two approaches and to a smaller degree during, and a very large degree after residential treatment, so it is highly likely that few clients actually received "pure" Health Realization's 3 Principles-based treatment. The study was designed to filter out the contamination effects of between in- and out- out-of-county treatments, but not between the two in-county programs. We did not measure the relative dosage of Twelve-Step and Health Realization's 3 Principles-based treatment received by clients in the in-county program (other than number of days in treatment). Furthermore, the measures of

psychological well-being were perhaps not sufficiently sensitive to captured nuanced changes among clients treated in Twelve Step and Health Realization treatments.

This last factor is particularly relevant for evaluating the impact of Health Realization's 3 Principles-based services, which focuses on individual self-realization and the development of positive affect as a necessary precondition for change in substance use behavior. Further, a design with only two observations is unsuited to understanding a process of recovery and establishment of psychological well-being over time. It may well be the case that clients will experience lower positive well-being following cessation of substance use before experiencing an improvement in their psychological state. Longitudinal study with multiple measurements would surely yield a better understanding of temporal unfolding of this process.

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