ADDICTS AND ALCOHOLICS AS "CONSUMERS" OF PUBLICLY-FUNDED ADDICTION RECOVERY PROGRAMS

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Adopting a "consumer behavior" view of the addicts and alcoholics in publicly-funded treatment programs, this research seeks to identify the resiliencies that adult males rely on to successfully "consume" addiction recovery services. The results imply that (A) each program may call on a different combination of resiliencies and (B) these combinations appear be stable over time. This opens up the possibility that long-term outcome improvement may come from "marketing" each program to draw a higher concentration of applicants with the desired resiliencies.

INTRODUCTION

Social interventions have been defined as: "deliberate attempts by professionals to change the characteristics of individuals or groups, or to influence the pattern of relationships between individuals and/or groups" (Kelman and Warwick 1978, p. 4). The myriad of addiction treatment protocols in use today clearly fit the definition of a social intervention. Each year, over 800,000 individuals receive treatment for drug and alcohol dependency (U.S. Bureau of the Census 2001). For 1998, the total costs of treating alcohol use disorders and the attendant medical consequences alone was estimated at $26.3 billion with the Federal and the State governments bearing 38 percent of the burden (NIAAA 2000). Individuals lacking resources, employer support, or social networks often rely on publicly-funded programs to initiate their recovery. The research presented here uses substance abuse treatment as a general model of publicly-funded social interventions for the purpose of developing a marketing oriented strategy to improve program outcomes.

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Addiction recovery interventions can be viewed from a process perspective to include four basic steps:

A. Drawing Applicants to the program.
B. Applicant Screening and Selection.
C. The "treatment" or "activity" involved in the intervention.
D. "Graduation" or post intervention evaluation...the outcomes.

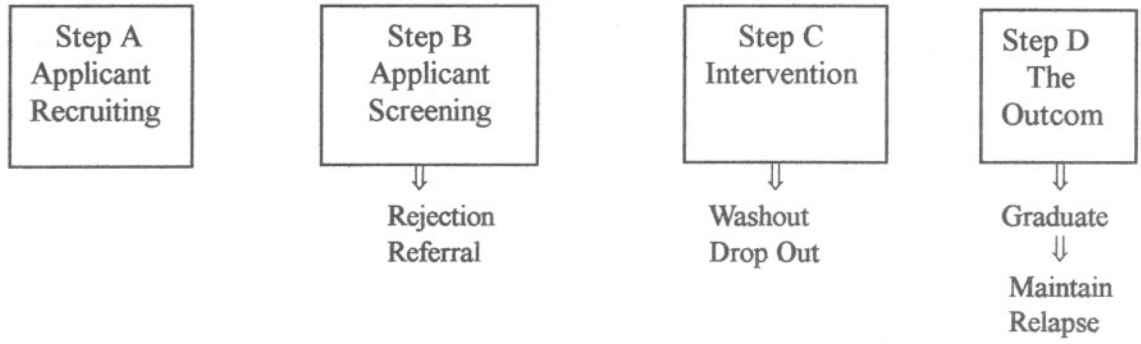
Figure One outlines the process involved in the "transition" intervention for addicts and alcoholics from detoxification (enforced abstinence) to voluntary sober living.

Improving Addiction Program Outcomes: A Brief History

In the 1970s and 1980s, improvement efforts centered finding the "silver bullet" intervention (Step C). Parloff (1980) identified 250 therapies for treating addictive behaviors. Miller and Hester (1986) found over 250 controlled studies in alcoholism treatment alone. However, Miller (1989) concluded "no one treatment was superior for all individuals, that treatment does not work as well as we'd like it to, and it does not work at all for a significant number of clients."

By the early 1990s, work on the "silver bullet" included 43 different modalities (Miller et. al. 1995) that clustered around three intervention strategies:

FIGURE ONE
Process Schematic for Substance Abuse Intervention



cognitive-behavioral therapy, motivational enhancement therapy, and twelve-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Through the mid-to-late 1990s, Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity) examined the fit between the client and the therapy hoping to improve outcomes through better Applicant Screening and Selection (Step B). Fuller and Hiller-Sturmhofel (1999) concluded that Project Match results "provide only limited support for the hypothesis that patients can be matched with optimal treatments based on patient characteristics."

Program outcomes appear have stalled with success rates lingering in the 30-40 percent range. Treatment and client/treatment matching may not be effective modeling dimensions on which to improve outcomes.

Developing a Marketing Strategy for Improving Program Outcomes.

An alternative improvement strategy would look at Applicant Recruiting (Step A) as a marketing challenge. A program's "marketing manager" might improve outcomes over the long-term by:

1. Understanding what factors characterize successful clients.
2. Understanding what sets the successful clients apart from the unsuccessful ones.
3. Devising a marketing plan to draw more applicants who share these success characteristics.

To begin, the marketer would need a model of consumer behavior appropriate to addiction recovery and a way of measuring the intrapersonal factors that influence successful recovery.

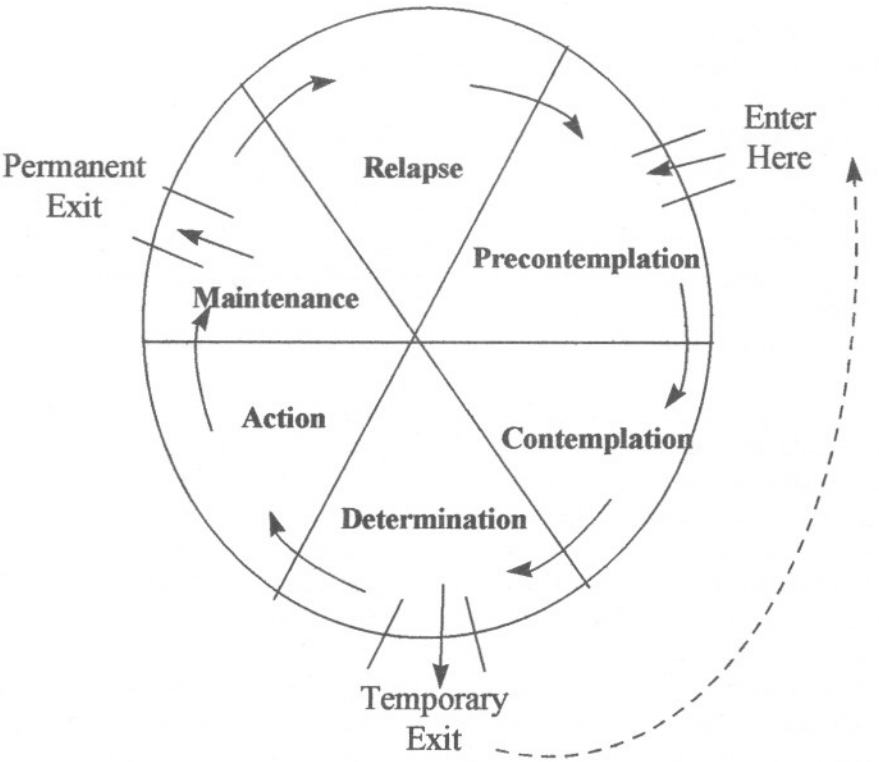
The rational, logical problem solving process at the heart of the classic Engel, Kollat and Blackwell (1973) consumer behavior model is a poor fit to the complex process of addiction recovery. The Stage Model for Change in Humans (Figure Two) (Prochaska and DiClemente 1982; Miller and Jackson 1985) mirrors the characteristics of recovery including false starts, high rates of recidivism, and difficulty in sustaining permanent change.

The question left unanswered by the descriptive Stage Model is *why* do some addicts initiate and sustain recovery while others in the same situation do not?

RESEARCH HYPOTHESIS

It is purported here that clients come to the recovery program with certain internal strengths (called resiliencies) that determine their potential to successfully "consume" the program services. It is further purported that each program draws on a different combination of resiliencies, implying that the program should be the unit of analysis for program

FIGURE TWO
The Stage Model of Change In Humans



The stage model of the process of change is adapted from James O. Prochaska and Carlo C. DiClemente (1982), "Transtheoretical therapy: Toward a More Integrative Model of Change." *Psychotherapy: Theory, Research, and Practice, 19;* 276-288. Reprinted from W.R. Miller & K.A. Jackson (1985), *Practical Psychology for Pastors.* Englewood Cliffs, NJ: Prentice-Hall, page 130.

improvement rather than the individuals who have the pathology being treated.

The research challenges are to measure resiliency consistently, to measure success in a meaningful manner, and determine which resiliencies contribute to success.

Defining and measuring resiliency

Wolin and Wolin (1993) defined seven resiliencies from their work with adult survivors of troubled families who grew up and lead productive lives without continuing the family pathology. Resiliencies include both behavioral habits (BH) and mental traits (MT).

INSIGHT: Asking yourself tough questions and giving honest answers. (MT)
INDEPENDENCE: Relating to others out of freely chosen, rational beliefs. (BH)
RELATIONSHIP: The ability to form and keep mutually gratifying relationships. (BH)
INITIATIVE: Generating projects that stretch the self, promoting growth. (BH)
CREATIVITY: Imposing order, beauty, and purpose on the chaos and pain of life. (BH)
HUMOR: Finding the comic in the tragic. (MT)
MORALITY: Informed conscience joining yourself to the self-hood of humanity. (MT)

Decades of research have produced numerous simple, paper and pencil, self-administered instruments that measure human behaviors and attributes. Rudd (1996) studied the use of psychometric tests in the addiction recovery environment. Selected scales from The California Psychological Inventory (CPI) and the Measures of Psycho-social Development (MPD) were chosen to triangulate the measures of the Insight, Independence, Relationships, Initiative, Creativity, and Morality resiliencies. The Situational Humor Response Questionnaire (SHRQ) (Martin and Lefcourt 1984) was the only scale found designed to measure the *production* of humor rather than one's reaction to humor. The test battery takes approximately three hours to complete. All raw scores can be standardized to a mean of 50 with a standard deviation of 10. This allows results to be analyzed using regression techniques with component resiliencies as the independent variables. Figure Three summarizes the key points of the test battery.

Measuring success

Success in addiction recovery programs often includes a laundry list of criteria. The list includes items measuring the client's effort, intent on exit, end state, and the environmental factors thought to impact probable success (such as support from a family or other group). Success often becomes an informal norm about how many check marks are sufficient to represent a successful intervention. The list approach is used because it is easy to obtain. The check off approach is used because it is very difficult to get group agreement on the relative weighting behind the different items in a multi-dimensional matrix of success factors.

The search for a measure of success in this research began with the usual list. Each list closely coincided with factors the program was required to report. Program managers and administrators were given an opportunity to add other factors that they viewed as measures of program success. Multiple evaluators were asked to rate the relative importance of each factor to client success. Analytical hierarchy processing (AHP) asks only for paired comparisons of two items at a time, a process with which evaluators can easily deal. The AHP software effectively "spaces" the factors to accommodate of all evaluators' viewpoints (Dyer and Forman 1991).

The AHP analysis yields a measure of success that ranges from 0 to 100 for each program based on their concept of success.

Over the last decade, this research studied three programs serving recovering addicts and alcoholics in the transition stage between detoxification and independent living. Table One compares measures of success developed for these three programs. The weights assigned to each component and or sub-component are the result of the Analytical Hierarchy Process using Expert Choice Software™.

Differences in measures of success among three programs that have the same goal lend face validity to the concept that the *program* should be the unit of analysis. While the measures of success appear to be program specific, the characteristics of the clientele for these three addiction recovery programs are strikingly similar with the exception of their ethnicity. Table Two compares client characteristics through the first year of each study. Note that the success rates for these three programs are at the high end of the typical range for similar programs.

Data collection and analysis

All three of these transition programs draw their clients primarily from detoxification programs or

FIGURE 3

Category	California Psychological Inventory CPI (1)	Measures of Psychosocial Development MPD (2)	Situational Humor Response Questionnaire SHRQ(3)
Questions/Time	462 - 45 min.	112 - 20 min	21 - 20 min.
Type of Question	True-False	5-point Likert Scales	Multiple Choice
Insight	Self-acceptance	Identity/Identity Confusion Ego Integrity	Not Applicable
Independence	Independence	Autonomy/Shame and Doubt	N.A.
Relationships	Communality	Intimacy/Isolation	N.A.
Initiative	Achievement via Independence or via Conformity	Initiative/Guilt	N.A.
Morality	Tolerance	Trust/Mistrust	N.A.
Humor	N.A.	N.A.	SHRQ
Creativity	Flexibility or Intellectual Efficiency	Generativity/Stagnation	N.A.
Reliability Coefficient	.52-.74 (Average = .72)	.67-.80	.70-.83
Norms	Yes	Yes	Yes

TABLE ONE
Measures of Success for Three Studies of Adult, Male, Recovering Alcoholics and Addicts

Category	Blacks, Washington, DC 1994-1995*	Native Americans Minneapolis, MN 1995-1996**	Multi-Cultural Minneapolis, MN 1998-1999***
Progress in Twelve Step Program	.278	.091	.322
Progress Toward Financial Stability	.085	.251	.048
Financial Condition at Exit of Program	.140	.202	Not identified as a separate measure.
Sponsor Relationship	.180	.098	.160
Quality of post-program living situation	.307	.199	.220
Adherence to the Red Road	Not Applicable	.159	Not Applicable
Directly Addressing non-addiction issues that hinder recovery.	Not identified as a separate measure.	Not identified as a separate measure.	.097
Directly addressing the issues that drive the client's addiction.	Not identified as a separate measure.	Not identified as a separate measure.	.153
Maximum Total Success score	1.00 x 100 = 100	1.00 x 100 = 100	1.00 x 100 = 100

* Rudd (1996) ** Rudd (1997) ***Rudd (1999)

TABLE TWO
Comparing The Samples in Three One-Year Studies of Adult Males in Addiction Recovery Programs

Category	Blacks Washington, DC 1994-1995*	Native Americans Minneapolis, MN 1995-1995**	Multi-Cultural Minneapolis, MN 1998-1999***
Number of Beds	39	20	28
Total Clients	82	66	118
Clients Tested	63%	23%	60%
Successful Completions	53%	40%	42%
Average Days Stay	63	30	46
Age Distribution			
19-30	7	24	25
31-40	34	31	55
41-50	21	14	33
51-60	9	1	4
Highest Education Attained by Test Takers			
<7th grade	0	0	3
7-8-9	2	3	16
10-11-12	48	13	74
13-14 (Associate)	19	1	18
15-16 (College)	6	0	4
17+ (Graduate)	1	0	0

* Rudd (1996) ** Rudd (1997) *** Rudd (1999)

drug court assignments. All three programs have a short acclimation period at the beginning where the client has few other demands on his time. During the acclimation period, clients volunteer to take the test battery. Tests are identified only by the last four numbers of the client's social security number. Test scorers have no link to individual client identities. A client's progress is measured against the original checklist. This minimizes development of an evaluation during the research. The expanded success measures are gleaned from the program files and from one-on-one interviews with program counselors at the end of the client's stay in the program. Case file reviews also allowed the gathering of key demographics (race, marital status, education, etc.). Test results scored at a site away from the program operation site.

Finally, SPSS™ statistical software was used to analyze the distribution of client attributes and resiliencies and to perform linear regression modeling.

REGRESSION RESULTS FROM THE YEAR ONE OF EACH PROGRAM

In all models, the Measure of Success was regressed on the resiliency factors in combination. Resiliencies remain in the model if the regression coefficient is significant at the .10 level or better. All analyses involve two assumptions. If a client flat-lined, i.e., had little or no strength in any of the seven component

resiliencies, it was assumed that success would approach zero. This assumption forces the regression model through the origin, i.e., does not allow negative success at zero resiliency. The second assumption only clients who lasted long enough for the program to have an effect should be used in the regression. The cut off was set at 15 days.

The regression models were built using the SHRQ and CPI scores. The process was repeated using the SHRQ and the MPD. This allowed for internal triangulation of the models. Table Three details the regression models from the study of adult, Black males in Washington, DC.

This program was operated by a not-for-profit agency under contract to the Washington, DC Department of Social Services. Ninety-six (96) percent of the clients were Black and four (4) percent were Caucasian. The research involved three different transition houses (two for those with addiction problems only and one for those with a dual diagnosis of drug problems and mental health issues). The model indicated that two resiliencies (Humor and Morality) could explain up to 84 percent of the variation in success.

Treatment was based on twelve-step treatment. While the spiritual nature of the twelve-step approach was recognized, the program relied more on the strength of the "fellowship of recovering addicts" as its main theme. The importance of linking to others (the Morality resiliency) was not surprising. The impact of the Humor resiliency was surprising. While dark, satiric humor was a part of the everyday interaction in the transition houses, program operators viewed humor as more of mechanism for coping with the various personalities in the house than as a key to successful program completion.

Table Four summarizes the modeling results from a study of Native American adult males in Minneapolis. The complexity of the model was not surprising since the earlier study had similar instability until the sample counts reached 50. The model may explain up to approximately 89 percent to 95 percent of the variation in success.

This program was operated by a Native American-sponsored social service agency. Most of the clients had County or Tribal funding support. Treatment involved a modified version of the twelve-step approach overlaid with a strong focus on adhering to the "Red Road". This latter element sought to reawaken or strengthen the clients' belief in and acceptance of their respective Native American cultural heritage. The low weight given to the "Red Road" (only 15.9 out of 100) was disappointing to the program director.

Table Five summarizes the regression models from the first year of a study of Black adult males and Caucasian adult males in Minneapolis. The program was run by a non-denominational, Christain social agency. Most of the clients had either County or State support with only a small portion of private pay patients. The model shows that Humor, Initiative, and Morality may explain 76 percent to 79 percent of the variation in client success. The positive contribution from the Morailty and Initiative resiliences has face validity in a program that encourages personal responsibility for one's actions *and* active participation in the groups' effort to understand and live with their individual addictions.

With three studies for comparison, it now appears that individual programs do draw on different sets of resiliencies. Three programs, three distinct resiliency profiles explaining high percentages of client success. Obviously there are limitations to extrapolating from three modest-sized pilot studies conducted amidst all the chaos and turmoil that normally accompanies not-for-profit, social intervention programs. Nonetheless, it appears that first-year resiliency analysis may support the research hypotheses that:

1. Significant differences in the keys to success do appear by program.
2. A manageable number of component resiliencies may hold the key to success for a program.

However, for a marketing approach to program outcome improvements to be effective, the factors

TABLE THREE
Regression Models for 53 Adult, Black Males
Washington, DC. (1994-1995)

Scales in the Model	Measure of Success = + B1 x CR1 ... Bn x CRn
CPI/SHRQ	+.68 x HUMOR +.76 x MORALITY RSquared = .843 Standard Error of the Estimate = 24.9
MPD-P/SHRQ	+.91 x HUMOR -.52 x INITIATIVE +.84 x MORALITY RSquared = 82.8 Standard Error of the Estimate = 26.0

Note: All regression coefficients significant at the .10 level or better

TABLE FOUR
Regression Models for 15 Adult, Native Americans
Minneapolis, MN (1995-1996)

Iteration Name	Measure of Success = B1 x CR1 ... Bn x CRn
CPI/SHRQ	+2.57 x Relationship - 3.25 x Initiative + 2.87 x Creativity RSquared = .887 Standard Error of the Estimate = 26.8
MPD-P/SHRQ	+3.45 x INSIGHT1 - 4.87 x INSIGHT2 + 2.47 x CREATIVITY RSquared = .949 Standard Error of the Estimate = 20.0

Note: INSIGHT1 is a measure of the consistency of a client's identity whereas INSIGHT2 is a measure of how meaningful or significant their lives have been. These clients know who they are (+ sign on INSIGHT1), but do not think much of what they have been (- sign on INSIGHT2).
Note: All regression coefficients significant at the .10 level or better.

TABLE FIVE
Regression Models for 71 Adult Males,
Black, Caucasian, and Other, Minneapolis, MN (1998-1999)

Scales in the Model	Measure of Success = B1 x CR1+.....+Bn x CRn
CPI/SHRQ	+1.564 x Morality RSquared = .791 Standard Error of the Estimate = 34.5
MPD-P/SHRQ	+.76 x HUMOR + .75 x INITIATIVE RSquared = .760 Standard Error of the Estimate = 36.5

Note: All regression coefficients significant at the .10 level of better.

contributing to successful consumption of program services need to be stable over time.

STABILITY OF THE RESILIENCY MODEL OVER TIME

To address the issue of model stability, the Multi-Cultural Study in Minneapolis was extended to 33 months. Regression analyses were run on all twelve-month time periods (5/98-4/99 through 11/99-10/00). The data shows a slow evolution of the model as outlined in Table Six.

There are three possible explanations for the slight drift in the model:

1. A slight increase in the ratio of Caucasian clients to minority clients. Analysis shows that both Black and Caucasian clients' success depends on Initiative. However, Black clients' success depended more on Humor and Morality while Caucasian clients' success depended more on Relationships.
2. Significant turnover in counselor ranks during years two and three of the study may have required program participants to take a more active role in program execution at some times.
3. Encouraged by early results of the study, the program operators appear to have made two subtle changes in their approach by:

    a. Relying on a Primary Care program housed at the same facility and operated under the same philosophy for a higher percentage of their Transition clients. Anecdotal evidence suggests that clients from their own Primary Care Program tended to fare better that outside referrals.
    b. Adhering even more strongly to the underlying belief in the power of the spiritual component of the program supported by the Morality resiliency.

Even with these changes, the drift is slow enough to allow the use of marketing communications strategies in the Applicant Recruiting (Step A) to draw more clients with the requisite resiliences.

CONCLUSIONS

The AA/NA style twelve step program, the basis of all the studies presented here, has been shown to be an effective intervention. Where outcome differences between the therapeutic methods were in evidence in Project MATCH, "they tended to favor the Twelve Step Facilitation Process". Further, the "continuous abstinence for outpatients endured throughout the 12 months of follow" made the Twelve Step Facilitation Process "favorable to other well tested approaches for the treatment of alcohol problems" (Glaser, et al.1999).

Marketing communications campaigns, based on resiliency modeling, may improve outcomes as more "high potential" clients *choose* to be involved with a program that fits their resiliency profile. The informed self-match has been shown to have some impact on outcomes in alcohol treatment (Donovan and Mattson 1995). Miller (1993) comments that for many treatment programs, client selection was "susceptible to influence". Miller adds that procedures used to "sell" the intervention to potential subjects is an area "often unmentioned in proposals or reports".

IMPLICATIONS FOR THE "MARKETING" OF ADDICTION RECOVERY PROGRAMS

While it appears that the basis exists for a marketing approach to improve recovery program outcome, there is a major barrier left to surmount. The biggest barrier to extending the marketing concept to publicly-funded addiction recovery programs may be convincing the marketing discipline that addicts would respond to marketing efforts. Examining an existing campaign that creams the market for high potential clients might help.

A resiliency-based advertising campaign for a hospital-based addiction recovery program was running in the Washington, DC area during the time of the study there (1994-1995). The television advertising for the program opens with a man in a plexi-glass booth walking in circles at ever increasing speeds. The voice over starts... "You take drugs so you can get more done...you take more drugs to get

TABLE SIX
Stability of the Success Regression Models for
Multi-Cultural Males in Addiction Recovery Program
Minneapolis, MN Over Time (1998-2000)

Category	5/98 - 4/99	5/99 - 4/00	11/99 - 10/00
Significant Resiliencies	Initiative Humor Morality	Initiative Humor Relationships Creativity	Initiative Humor Creativity
RSquared Range	.76 - .79	.74 - .78	.74 - .76

more done"... repeating as the subject accelerates out of control. The voice over continues... "If you have a problem with drugs...or know someone who does...we can help." The ad ends with specifics of the hospitals program, the contact information, and a plea to make contact.

The ad clearly mimics addiction's downward spiral. The "You take drugs" comment is a very powerful, emotional connection to the addict's Insight resiliency. " If you know someone..." essentially skims the market for addicts connected to a support system (the Relationship resiliency and the Morality resiliency). The campaign differentially targets potential clients with three specific resiliency factors.

Unlike this hospital, most publicly-funded addiction recovery programs do not have advertising budgets. Most of the marketing occurs one-to-one between program staff and potential applicants, between program staff and client assessors at the referring agencies, or by word of mouth between addicts on the street and at AA/NA meetings. The change of "media" in no way lessens the importance of getting the right message to the right audience. This same principle applies to publicly-funded addiction recovery programs. Emphasizing the kinds of resiliencies that foster success in all channels of communication should gradually increase the percentage of applicants who exhibit these resiliencies and slowly improve program success.

RECOMMENDATIONS

Several additional extensive applications of the research methodology are needed to confirm the reliability of the technique. These could involve replication of the research reported here or the broadening of the test base into other types of social interventions.

Strong and Rudd (1997) argue for a component resiliency approach to public job training programs. The history of publicly-funded attacks on systemic unemployment is littered with the carcasses of past programs (The Great Depression Era Civilian Conservation Corps and Works Projects Administration, the Manpower Development and Training Act of 1962, the Comprehensive Employment Training Act of 1973, the Job Training and Partnership Act of 1982, etc., etc., etc.). As of early 1995, there were 154 federal programs spending over $13 billion annually on employment assistance (Carnevale 1995). Mr. Carnevale, Chairman of the National Commission for Employment Policy, reporting on a meta-analysis of existing programs, suggested that improving workforce preparation would involve, among other elements, empowering and enabling the customer with choice and information. A strong component resiliency assessment of an employment-training program might be a welcome addition to the testing of the resiliency methodology.

Spousal abuse and family violence "treatment" generally centers on one of two intervention strategies: leave the relationship or repair the

relationship. Clients with no Relationship resiliency asked to abandon a major relationship may be unable to replace it, eventually drifting back into the abusive relationship. Clients with strong Relationship resiliency may waste valuable energy trying to save a destructive relationship if forming new, mutually beneficial relationships is easy for them. Resiliency analysis could help both types of programs improve outcomes by encouraging informed self-matching.

By extending the testing to a wider variety of social interventions, perhaps the resiliency model, which focuses on the strengths an individual brings to the challenge of change, can begin to replace the pathology models, which focus on what is wrong with the individual, as the primary lens through which society views the social intervention arena.

REFERENCES

Carnevale, A. (1995), *Understanding Federal Training and Employment Programs*, Washington, DC. U.S. Department of Labor: National Commission for Employment Policy.

Donovan, D., and M.E. Mattson, (1995). "Alcoholism Treatment Matching Research: Methods and Clinical Issues" in *Journal of Studies on Alcohol*, Supplement 12. The Center of Studies on Alcohol, Rutgers University, Piscataway, NJ: Rutgers University, 5-14.

Dyer, Robert F., and Ernest H. Forman, (1991). *An Analytical Approach to Marketing Decisions*, Englewood Cliffs: Prentice Hall.

Engel, J.F., D.T Kollat,. and R.D. Blackwell, (1973). *Consumer Behavior, 2nd Edition*, New York: Holt, Rinehart, and Winston, 58.

Glaser, Frederick B. Nick Heather, D. Colin Drummond, John W. Finney, Lars Lindstrom, Stephen Sutton, M. Soyka, Tim Stockwell, Wayne Hall, Christine Godfrey, Luis San, E. Gordis, R. Fuller, Juan C Negrete,. and Jim Orford,(1999), "Comments on Project MATCH: Matching Alcohol Treatments and to Client Heterogeneity" *Addiction*, 94(1), 31-70.

Gough, H.G. (1987), *California Psychological Inventory: Administrators Guide*. Palo Alto: Consulting Psychologists Press.

Hawley, G.A. (1988), *MPD: Measures of Psychosocial Development: Professional Manual*. Odessa: Psychological Assessment Resources.

Kelman, H.C., and D.P Warwick, (1978), " The Ethics of Social Intervention: Goals, Means, and Consequences," in *Ethics and Values in Applied Social Research*, Newbury Park: Sage, 1988.

Martin, R., and H.M. Lefcourt, (1984), "The Situational Humor Response Questionnaire," *Journal of Personality and Social Psychology*,47, 147-155.

Miller, Richard K., and Susanne Hiller-Sturmhofel, (1999), "Alcoholism Treatment in the United States," *Alcohol Research & Health,* 23(2), p. 69-78.

Miller, W.R. (1989) "Matching Individuals with Interventions," *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, New York: Pergamon Press.

Miller, W.R. (1993), "Behavior Treatment for Drug Problems: Where Do We Go from Here?" *Behavioral Treatments for Drug Abuse and Dependence*, NIDA Monograph 137. Rockville: NIH, 303-321.

Miller, W.R.; J.M. Brown, T.L. Simpson, N.S. Handmaker, T.H. Thein, L.F. Luckie, H.A. Montgomery, R.K. Hester, and J.S. Tonigan (1995), "A Methodological Analysis of Alcohol Treatment Outcomes Literature," *Handbook of Alcoholism Treatment Approaches: Effective Alternatives,* 2nd ed. Needham Heights: Allyn & Bacon, 1-45.

Miller, W.R., and R.K. Hester, (1986), "The Effectiveness of Alcoholism Treatment," *Treating Addictive Behaviors*, New York: Plenum Press, 121-174.

Miller, W.R., and K.A. Jackson,(1985), *Practical Psychology for Pastors*, Englewood Cliffs: Prentice-Hall, 130.

NIAAA, National Institute on Alcohol Abuse and Alcoholism (2000), *Tenth Special Report to the U.S. Congress on Alcohol and Health*, Washington: U.S. Department of Health and Human Services.

Parloff, M. (1980), "Psychotherapy and Research: An Anaclitic Depression," *Psychiatry*, 43, 279-293. Project MATCH Research Group.

Parloff, M. (1997), "Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Posttreatment Drinking Outcomes," *Journal of Studies on Alcohol*, 58(1), 7-27.

Prochaska, J.S., and C.C. DiClemente (1982), "Toward a Comprehensive Model of Change," *Treating Addictive Behaviors*, NY: Plenum Press, 3-28.

Rudd, David V. (1996), *Individual Resiliency as a Framework for Understanding the "Consumers" of a Transitional Housing and Addiction Recovery Support Program*, Ann Arbor: UMI Dissertation Service.

Rudd, David V. (1997), "An Affordable Strategy for Understanding the Outcomes and Improving the Performance of the Next Generation of Social Intervention Programs" *Electronic Proceedings of the 37th Annual NAWRS Workshop*, Atlanta: National Association for Welfare Research and Statistics. Available at www.nawrs.org.

Rudd, David V. (1999), "Resiliency Profiling as the Key to Program Outcome Improvement," *Electronic Proceedings of the 39th Annual NAWRS Workshop,* Cleveland: National Association for Research Welfare and Statistics. Available at www.nawrs.org.

Strong, K.C., and David V. Rudd, (1997), "A New Model of Job Training for Economic Rebirth," *Journal of Employment Counseling*, Alexandria: American Association of Employment Counselors, 123-132.

U.S. Bureau of the Census, (2001), *Statistical Abstract of the United States: 2001*, Washington: U.S. Department of Commerce.

Wolin, S., and S. Wolin (1993*), The Resilient Self: How Survivors of Troubles Families Rise Above Adversity*, NY: Villard Books.